# AW/HIW QUALITY GOVERNANCE FOLLOW UP REVIEW (MAY 2021) – ACTION PLAN

| Ref | | Recommendation made in November 2019 | A summary of progress made by April 2021<br>(AUDIT WALES ASSESSMENT) |
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| | **R1** | **The Health Board must agree organisational quality priorities and outcomes to support quality and patient safety. This should be reflected within an updated version of the Health Board's Quality Strategy.** | **The Health Board has defined what high quality care means but its ambition to agree quality priorities, set out in a quality strategy, has been significantly delayed due to the pressures of the pandemic. In 2019, we found that the Health Board had not articulated organisational quality priorities. The Health Board's Quality and Patient Safety Governance Framework (Quality Governance Framework) implemented in June 2020 defines high quality care as care that is safe, timely, effective, efficient, equitable and patient-centred. These domains provide the framework against which organisational quality priorities can be identified, and their success measured.**<br><br>**During 2020, the Health Board planned to develop a Three-year Quality Priority Strategy in partnership with the local community, staff, and other key stakeholders. The Health Board appointed an Associate Medical Director with responsibility for quality improvement to take forward development of the strategy with engagement and coproduction with the three ILGs. However, progress has been delayed significantly given the availability of locality teams and re-deployment of staff to respond to the pandemic. Nonetheless, it is important that progress is now made on developing the Quality Priority Strategy. Since completing our fieldwork the Health Board has indicated its intention to integrate the Quality Strategy into the Health Boards Integrated Health and Care Strategy which is due to be published by Autumn 2021.** |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **1.1** | **DoN** | Organisational quality priorities are expressed within the CTMUHB Annual Plan and IMTP for 2020-23 (see R2) It is anticipated that the Quality Priority Strategy will align to the organisational strategy work.<br><br>The AMD for Quality is leading on this supported by Assistant Director of Quality, Safety and Patient Experience. | **End Nov 2021** |

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| | | The quality strategy is being progressed and the quality priorities have been published in the QGF. The QGF will be updated to reflect and align with the overall HB strategy once published. Success will be measured by the connection of the strategy to the everyday function of the HB – through our agreed quality governance architecture, quality metrics and performance, and in the experience of our staff and patients – connecting us to the overall vision and demonstrating how the thread provides connectivity to understanding the reason for our work. | |
| **1.2** | **DoTH** | One Deputy DoTh and two Assistant Director of Therapies and Health Science posts will be advertised in July 21 these roles will strengthen quality and patient safety functions for therapists and healthcare scientists and work as part of the Executive function and strengthen succession planning. | **X-Ref R3** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R2** | The Health Board needs to take a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically;<br>a- The BAF reflects the objectives set out in the current IMTP and the Health Board's quality priorities<br>b- The risk management strategy reflects the oversight arrangements for the BAF, the quality and patient safety governance framework and any changes to the management of risk within the Health Board<br>c- The quality and patient safety governance framework must support the priorities set out in | **The Health Board has made good progress in this area through the introduction of the new risk management strategy which reflects the new operating model and has good alignment with the Quality Governance Framework.**<br><br>**The Board Assurance Framework used by the Health Board is continuing to evolve to reflect the new operating model and strategic objectives.**<br>In January 2020 the Board approved the new Board Assurance Framework (BAF). This was seen as an interim step prior to undertaking the significant work needed on the Health Board's processes for managing and identifying risk, agreeing the Health Boards risk appetite, and agreeing the principal risks.<br><br>During 2020, the Health Board took the first step towards updating the current BAF by undertaking a comprehensive review of its risk management approach. In September 2020, the Health Board agreed the key threats and principal risks that would affect the achievement of their strategic objectives and gained formal agreement from the Board of its current risk |

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| | | the Quality Strategy and align to the values and behaviours framework<br>d- Terms of reference for the relevant committees, including the Audit Committee, QSRC[1] and CBM[2], reflect the latest governance arrangements cited within the relevant strategies and frameworks. | appetite. In November 2020 the Board received the new organisational risk register following a large-scale review of risks by the ILGs and the corporate departments. Work to define the mitigating actions and to identify the controls and sources of assurance is ongoing. Once complete, the Health Board intends to produce a more detailed Board Assurance Framework. The Health Board has also articulated its intention, by the end of 2021, to develop a Board Assurance Report (BAR), which will detail the principal risks rather than the operational risks as currently defined in the risk register.<br><br>**There has been a comprehensive review of the Health Board's risk management approach since our 2019 review.** The revised risk management strategy and Risk Management policy were agreed by the Board in January 2021, after significant work by the Health Board to fundamentally review its approach and reflect the new locality based operational model. The new strategy clearly sets out the risk management process from service to board as described in the Quality, Patient Safety and Governance Framework, as well as articulating the intended plans for the Board Assurance Report process. The risk assessment Procedure was also reviewed and approved by the Management Board in January 2021 which further supports the risk approach and process within the Health Board.<br><br>**Significant progress has been made on developing and implementing the Quality Governance Framework, however, more work remains to fully embed it within the organisation**. Since our review there have been many iterations of the framework with the latest version setting out the structures and processes that need to be in place operationally and strategically within the Health Board. The framework clearly defines high quality care (see progress against recommendation 1) and aligns to the organisation's Values and Behaviours. During the pandemic it has been easier to operationalise the Quality Governance Framework at an organisation and ILG level, but work to embed the governance structures within the Clinical Service Groups (CSGs) which sit beneath the ILGs is ongoing.<br><br>**Terms of references for relevant committees have all been updated to reflect the new scheme of delegation and operating framework**. In January 2021 the terms of reference and Health Board scheme of delegation were revised to reflect the updated risk management arrangements. The Health Board took the opportunity to update and revise the terms of reference for each committee following changes to the governance framework after our 2019 |

[1] In December 2019 the Quality, Safety and Risk Committee became the Quality and Safety Committee, and the Audit Committee became the Audit and Risk Committee
[2] Clinical Business Meetings were stood down following the introduction of the new operating mode introduced in April 2020

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| | | | review. These will now be subject to an annual review as part of the ongoing governance processes and is captured in the cycles of business for Board Committees. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **2.1** | **DoG** | We will introduce a revised approach to the Board Assurance Framework and separate Board Assurance Report. | **End Dec 2021** |
| **2.2** | **DoG** | Board Development Sessions will be undertaken to review and identify the Risk Appetite, Risk Tolerance levels and grading of principal risks aligned to the new Integrated Healthcare Strategy and the direction of travel for the Health Board – i.e. not necessarily cautious across all risk domains. The Health Board's Risk Appetite Statement will consequently be reviewed. | **End Sept 2021** |
| **2.3** | **DoN** | The Health Board's overarching quality priorities published within the IMTP/Annual Plan for 2020-23 are as follows:<br>• Strengthened focus on quality on strategic planning;<br>• Individuals' voices are better heard;<br>• Shared learning and continuous quality improvement;<br>• Risk better articulated, shared and mitigated;<br>• Strengthened two-way 'point of service delivery' to Board sight; and<br>• Extensive review and improvement of the management of concerns and serious incidents.<br><br>Review of the Quality Governance Framework to reflect the developed quality strategy and enhanced governance processes within ILG's . The revised framework will provide improved granular detail in respect of ILG | **Quality Governance Framework reviewed and approved by Q&S Committee by December 2021** |

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| | | governance that wasn't available at the previous refresh in November 2020. System testing through attendance at CSG/ILG Q&PSE governance meetings will be introduced for evidence/assurance that the framework is embedded. | |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R3** | Ensure there is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:<br>a- Strengthening of the role of the Medical Director and Clinical Directors in relation to quality and patient safety<br>b- Clarify the roles, responsibilities, accountability, and governance in relation to quality and patient safety within the directorates<br>c- Ensure there is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety | **The Health Board has taken steps to strengthen responsibilities in relation to quality and patient safety both across the executive team and within its ILGs.**<br><br>**Collective responsibility for Quality and Safety is now shared by the four clinical executive directors.** The Medical Director, the Executive Nurse Director, the Executive Director of Therapies and Health Sciences and the Director of Public Health have specific responsibilities for quality and safety, as well as professional leadership across their respective disciplines, with the Executive Director of Nursing acting as executive lead. This is clearly set out in the Health Board's Quality Governance Framework. The capacity of the clinical executive directors has been reduced for a number of years because of the challenge of recruiting a substantive Director of Therapies and Health Sciences. Since our last review, the Health Board did recruit substantively, however, this post became vacant once more. This post is now filled on an Interim basis by the Executive Director of Therapies and Heath Sciences from Cardiff and Vale University Health Board who works across both Health Boards, the Health Board is also recruiting a full time Clinical Director for Allied Health Professionals (AHPs) to ensure professional leadership and capacity.<br><br>**The Health Board has clarified the roles and responsibilities for quality and patient safety within the new ILGs and CSGs**. The Quality Governance Framework aligns to the operating model that was introduced in April 2020. Responsibilities at an operational level for quality and patient safety are defined by the Quality governance Framework, which sets out the process and structure for the ILGs and their respective CSGs. The new operating model is helping to improve the focus on quality. For instance, ILGs are held to account by the Director of Operations, Nurse Director, Medical Director and Chief Executive for the delivery of high-quality patient centred care in line with the Quality Governance Framework.<br><br>**The Health Board has invested in additional capacity to support quality and patient safety at a corporate and ILG level.** The Health Board has invested in new roles to support quality and patient safety. Within the nursing management team, new posts include an Assistant Director |

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| | | | for Nursing and peoples experience, Deputy Executive Director of Nursing, a Head of Corporate Nursing, and a Senior Nurse for Professional Standards and Quality Assurance. The Medical Director has also established several new roles for Associate Medical Directors to lead on development of the quality strategy and clinical audit. The Health Board has also recently established a Quality Improvement team and appointed an Associate Medical Director for Quality Improvement and the Director of Improvement started in post in April 2021. The Health Board is also in the process of establishing the systems and infrastructure to support the Health Board's improvement work. Newly appointed Nurse Directors are in place for each of the three ILGs, and they are responsible for supporting quality governance, which is a shared responsibility across the three ILG senior leaders. In addition, each ILG also has a Head of Quality and Safety in place to support the quality governance agenda. Their role is to support the work of quality and patient safety within the ILGs, linking with the central Patient Care and Safety Team and the Assistant Director for Quality, Safety and Safeguarding. Over the past few months ILGs locally have also started to recruit additional governance staff to address their capacity issues as there are differences in the team sizes across the ILGs. The Bridgend and Merthyr Cynon ILG also have a new appointed Head of Midwifery for their respective obstetric units under the leadership of our Director of Midwifery who commenced in post in Jan 2020 |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **3.1** | **MD** | Robust interim arrangements to be agreed to cover role and accountabilities of Medical Director until substantive appointment is made. | **July 2021** |
| **3.2** | **CoS** | Review Operating Model and ILG/System Group Structure to evaluate effectiveness. | Formal review to follow appointment of key roles, anticipated by end March 2022. |
| **3.3** | **DoTH** | Appoint the AHP CD. | **August 2021** |
| **3.4** | **DoTH** | One Deputy DoTh and two Assistant Director of Therapies and Health Science posts will be advertised in July 21 these roles will strengthen quality and patient safety functions for therapists and healthcare scientists and work as part of the Executive function and strengthen succession planning. | **Interviews scheduled by August 2021** |

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| **3.5** | **DoN** | Quality metrics capturing a greater breadth of HB services and functions, including population health measures, have been agreed and reviewed at the ILG performance meetings, Quality & Safety Committee and Board. The new measures will utilise, where possible, control limits, targets and trajectories. Once for Wales will support the HB to benchmark against other HBs. | **Scorecard data available by end Oct 2021** |
| **3.6** | **DoN** | As indicated above development of the Quality Strategy will commence at pace and align with the organisational strategy as it becomes available. | **Quality Strategy in place by November 2021.** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R4** | The roles and function of the QSRC need to be reviewed to ensure that it is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety governance framework and key corporate [organisational] risks for quality and patient safety. This should include the following;<br>a- Implement the sub-groups to support QSRC must be completed ensuring there is sufficient support (administratively and corporately) to enable these groups to function effectively<br>b- Improvements to the content, analysis, clarity, and transparency of information presented to QSRC<br>c- Focus should be given to ensure the Quality and Patient Safety Governance Framework is used to improve oversight of quality and patient safety across the whole organisation, including Bridgend services. This should be accompanied by the necessary resource for its timely | **Although some aspects of this recommendation have been superseded, there has been good progress with establishing the new governance framework and reporting.**<br><br>**Plans for implementing subgroups to support the Quality, Safety and Risk Committee[3] were stood down following a revision to the Patient and Safety Governance Framework, therefore this element of the recommendation is superseded.** The Quality and Patient Safety Governance Framework has evolved in response to the new operating model introduced in April 2020. Quality governance arrangements have been established within each ILG and each ILG reports on quality and patient safety matters directly to the Quality and Safety Committee.<br><br>**The quality of information presented to the Quality and Safety Committee for assurance and scrutiny is improving.** The Committee routinely receives quality and patient safety reports from each ILG and an organisation wide Patient Safety Quality report. These reports cover all service settings including acute, primary and community and mental health services. They also include a set of overarching Health Board wide quality metrics. The reports contain information across a wide range of quality indicators and enable scrutiny of patient experience across all three ILGs in a standard template which enables comparisons. The content covers all service areas, and ILGs are encouraged to flag areas of incidents, claims and complaints (concerns), and risks, and there is appropriate narrative to provide assurance. Reports are delivered by the ILG teams themselves, which enables oversight and scrutiny from |

[3] This committee was replaced in December 2019 with the Quality and Safety Committee.

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| | | implementation, internal communications, and training. | Independent members. Our observations of Board and Quality and Safety committee meetings found appropriate levels of scrutiny and challenge with candid responses from officers. The improvements to the quality reports are positive and include the use of trend information but fall short of setting targets or thresholds where further work or escalation may occur, for instance if pressure ulcer occurrence in one ILG area goes higher than expected. There is an ambition to move to live dashboards to improve analysis and data interrogation and discussions have started to move this forward by the end of 2021. Plans have also been developed by the Nursing Directorate to introduce a 'focus on' section in the Health Board Quality and Safety report to address issues requiring greater interrogation and triangulation, and this will be presented to the next Q&S Committee in July 2021. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **4.1** | **CoS** | Meeting structure to sit under Management Board being developed to support the operational oversight and Health Board wide co-ordination and learning. | **Revised HB management meeting structure in place by end 2021** |
| **4.2** | **DoG** | Report writing training is being delivered, focussing on improving the quality of reports presented to Committees and Board. | **50 Report Authors to be trained by end Oct 2021** |
| **4.3** | **DoG** | Scrutiny toolkit being developed for Independent Members to support focussed scrutiny at Committees and includes expectations around quality of papers and information. | **Scrutiny toolkit to go live – August 2021** |
| **4.4** | **DoN** | An initial 'focus on' report has been submitted at the May Q&SC as part of the CTM Quality Dashboard and the second one due at the July Q&S. The subject for the focus of this supplementary support is decided by the Chair of Q&S and provides responsive 'deep dive' analysis, scrutiny and interrogation of data. | **Next Q&S 'Focus on' Q&S report July 21 – Medication errors.** |
| **4.5** | **DoN** | Quality & patient safety reports received at Q&S Committee from each ILG. Agreed metrics outlined in March 2021 Management Board that are being operationalised by performance management colleagues, | **By end Dec 2021** |

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| | | after which time, targets will be set with trajectories in SPCs. | |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R5** | Independent members must be appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them. | **Independent Members receive appropriate support through the provision of an induction programme and ongoing development to support them in their scrutiny role.** Our 2019 review identified opportunities to improve induction and development programmes for Independent Members (IMs) to support their work and effectiveness. Since then, the Health Board has introduced a more structured induction programme for IMs, which compliments the Welsh Government's all Wales induction process. Local support for IMs is provided by the corporate governance team. During 2020, all IMs received an appraisal with the Chair of the Health Board and the Director of Governance. Training needs were identified and Personal Development Plans (PDPs) recorded. A programme of external evaluation and observations of Independent Members (IMs) has taken place with feedback given on their performance. There has also been work on engagement and relationships, team building, coaching, direction-setting, scrutiny and the relationship between the Board and its committees. The initial external evaluation of this work has shown positive improvements in areas such as scrutiny of information, and improved relationships between board members. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **5.1** | **DoG** | Feedback from the Deloitte Board Development Programme (commissioned by WG) and the feedback from David Jenkins (Independent Advisor to the Board) will influence the basis for the Board Development Programme for 2021/2022 and beyond. | **March 2022** |
| **5.2** | **DoG** | A significant turnover of Board Members (Executive and IM) will take place in the first half of the financial year so individual and collective development needs will be accounted for by;<br>Induction Programme (in place)<br>Board Development Programme to be supported by relevant professional bodies. | **Commence Oct 2021** |

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| **5.3** | **CEO/DoG** | Personal Development Plans for all Board Members in place in line with Board Development. | **July 2021** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R6** | There needs to be sufficient focus and resources given to gathering, analysing, monitoring, and learning from patient experience across the Health Board. This must include use of real-time patient feedback. | **The Health Board has instigated a number of improvements related to this recommendation, to improve how it learns from patient experience. However, the pandemic response has impeded its ability to further progress and embed these improvements**. In response to our review in 2019, the Health Board began the development of a comprehensive three-year Patient Experience Strategy, however, its completion and implementation has been impeded by the pandemic response, and we have not received an update on its progress and a completion date from the Health Board in this regard. Attention will be needed to complete this strategy which underpins the Health Board's approach to patient experience.<br><br>The Health Board has implemented a Shared Listening and Learning Forum, and its inaugural meeting was held on 17 February 2021. The forum has been established as part of the Health Board's framework for listening to and learning from incidents and patient or staff concerns and experiences, and to promote and support a learning culture. We reviewed the forum's draft Terms of Reference, which appear appropriate. It is chaired by the Executive Director of Nursing and will meet quarterly, reporting directly to the Management Board. It is, however, too early for us to judge the forum's effectiveness, and the impact it has made on patient experience and learning.<br><br>Patient stories now form a regular part of the Board and sub-committee meetings, which was not always the case previously. The patient stories provide an opportunity for Board members to gain an insight into the experiences of individuals using the Health Board's services. A consequence of the pandemic has been the curtailment of executive and independent board member's patient safety walkabouts, which includes visiting ward and patient areas. However, there are plans to resume the programme of visits in due course when safe to do so.<br><br>The ILGs have introduced dedicated leads to manage patient feedback, concerns, and incidents. This has improved reporting to the Quality and Safety committee, as well as the local ILG Quality, Safety and Patient Experience meetings. We saw evidence that themes and trends are identified, but there is recognition more could be done to share and embed learning across the ILGs. |

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| | | | The Health Board implemented a Friends and Family Test (FFT) tool across the organisation to collect and report real-time patient feedback. It was piloted in early 2020 and subsequently rolled out across the Health Board. However, this was halted due to the pandemic and in April 2021 the Health Board are implementing the new national 'Civica' patient experience feedback monitoring system. There is a commitment to ensuring patient feedback is captured, and the impact of this should be seen in the near future. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **6.1** | **DoN** | Health Board purchased CIVICA (captures population feedback using a patient insight software platform) | **Purchased May 2021, Pilot site Maternity to go live July 21 with full implementation dependent on company.** |
| **6.2** | **DoN** | The shell of the CTM version of the Civica system has been built, and the population of surveys into the system has commenced. The Patient Reportable Experience Measures (PREM) surveys have been uploaded to the system. Links to the survey have been generated and are being tested with members of the Maternity Service Forum, while the automation function is finalised. Project Manager starts in post 12th August and once in post they will be asked to provide a detailed project plan and roll out programme for the project. | **Project Plan for roll out due by end September 2021** |
| **6.3** | **DoN** | Webpage on SharePoint set up to support learning & excellence across Health Board. Development of a social media site for the L&LF to use analytics on the social media and SharePoint site to explore the extent of colleague engagement and posting. Feedback from participants will be analysed in relation to what they have learned and how this has impacted upon their practice. For the medium and longer term would expect to see learning and improvement being applied in the workplace through our established quality metrics and patient experience feedback. | **Web-page 'go live' - July 2021** |

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| **6.4** | **DoG** | Reintroduce Exec/IM Patient Safety walkabouts when safe to do so/COVID restrictions allow. | **Programme of visits to re-commence August 2021** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R7** | There needs to be improved visibility and oversight of clinical audit and improvement activities across directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning. | **Good progress has been made by the Health Board in addressing visibility and oversight of clinical audit, but it could be better targeted to areas of organisational risk.** In December 2019, the Health Board approved additional funding to strengthen the Clinical Audit and Quality Informatics Department's ability to monitor compliance with participation, and to improve the quality of data used for all national audits. The additional funding has increased staffing with the appointment of a Deputy Assistant Medical Director for Clinical Audit, a dedicated clinical audit manager to lead on compliance with the national audit programme, a Quality Informatics Manager with responsibility for improving clinical data in Health Board systems and a Deputy Head and Lead Nurse for Clinical Effectiveness. The additional resources are helping the Health Board to utilise the audit findings to inform quality improvement initiatives and service redesign, such as establishing major trauma centres at the Princess of Wales and Prince Charles Hospitals in partnership with the ILGs.<br><br>Oversight of the clinical audit programme is improving at a strategic level. The Audit and Risk Committee has received the clinical audit forward plan, and in February 2021 it also received, for the first time, a quarterly update report outlining progress of the plan. As part of its forward work plan the Quality and Safety committee plans to receive quarterly updates on the clinical audit plan. We would expect these updates to identify outcomes from the audit, actions being taken to share learning and to provide the committee with a source of assurance on the quality and safety of care being delivered. There is also the opportunity for clinical audit to be targeted to areas of organisational risk such as the impact on patients of Emergency Department overcrowding. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **7.1** | **MD** | Training Programme for clinicians on the Clinical Audit and NICE Compliance Monitoring IT software (AMaT) being developed for clinical audit. | Module to be rolled out **from August 2021**. |
| **7.2** | **MD** | Training module for ward & area audits being rolled out. | **March 2022** |

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| **7.3** | **MD** | Appointment of Deputy Head and Lead Nurse for Clinical Effectiveness and Deputy AMD for Clinical Effectiveness, a programme of work was established in **January 2021** to create a NICE Reference Group (NRG) to review and manage all priority NICE guidelines and standards. | **To be launched by end October 2021** |
| **7.4** | **MD** | A review of clinical audit risk log management process to enhance early detection of risks and outcomes of national audits to support learning & best practice to be completed. The review will ensure alignment with the new ILG assurance and governance framework to support early review of outcomes of national audits to support monitoring of identified risks, learning from audit findings and to promote the sharing of best practice. | **End August 2021**. |
| **7.5** | **MD** | ILG specialty clinical audit forward plans. | Sign off **by end Sept 2021.** |
| **7.6** | **MD** | Resource review for HB Clinical Audit Service is being developed to ensure correct and sufficient skill mix in the team**.** | **Management Board consideration by end August 2021.** |
| **7.7** | **MD** | Undertake audit of compliance against Royal College of Emergency Medicine (RCEM) Standards for ED to identify baseline and inform continuous improvement programmes and improve compliance against the standards. | **June 2021.** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R8** | The Health Board needs to clarify accountabilities and responsibilities for quality and patient safety within directorates. This must include a review of the Heads of Nursing role in relation to site management and quality and patient safety. | **The Health Board has made progress in clarifying the accountabilities and responsibilities for quality and patient safety across ILGs and within the CSGs, but more work is needed to ensure these improvements are embedded.** Accountability and responsibility for quality and patient safety has been strengthened across the ILGs with the introduction of appropriate directives within accountability letters issued by the Chief Executive to the Director of Operations. The letters emphasise the need for quality and patient centred care, and |

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| | | | appropriately highlight that ILGs and CSGs are accountable for delivering high quality services in line with the quality framework, and that high-quality clinical leadership, supported by strong service management is critical.<br><br>The Health Board has taken steps to strengthen clinical leadership across the organisation with a greater emphasis on quality and safety. This includes reviewing the accountability and responsibility of the Heads of Nursing roles within each ILG in relation to site management and quality and safety. In 2019 we found that the Head of Nursing was assuming responsibility for a number of non-clinical and estates related issues. In addition, as a consequence of taking over responsibility for the Bridgend County Borough Council, only two of three acute sites had a substantive Head of Nursing in post (Merthyr and Cynon and Rhondda and Taff Ely) and there were disparities in their responsibilities. However, since the implementation of three ILGs, a Head of Nursing role is now in place for the Bridgend locality. Accountabilities and responsibilities for this role are now clearly defined and are consistent across each ILG. In addition, there has been further recruitment to support quality and safety with the appointment of a Head of Nursing, a deputy Head of Nursing and a dedicated Head of Quality and Safety for each ILG.<br>Each ILG holds Patient Safety and Experience meetings, chaired by the ILG Nurse Director to provide assurance. This is a positive development albeit one that is continuing to develop and our observations found that more coverage is needed in certain areas such as Infection, Prevention and Control. However, the Quality Governance Framework does not clearly articulate the quality governance arrangements for the CSGs that sit below each ILG. It has not been possible for some governance meetings to take place at CSG level due to the demand on clinical resources during the pandemic. Internal Audit's recent audit of Community and Adult Mental Health Services also found that the governance arrangements within the CSG were not clear with a lack of clarity about how they operate and function. This is an area that requires strengthening. In addition, whilst accountability and responsibility of the Heads of Nursing is clearly articulated, there appears to be an over-reliance on the Heads of Nursing to represent an overall clinical perspective during key quality and safety meetings, with limited input from medical teams. Due to the pandemic, the Health Board has had to delay its work on the clinical leadership and management development programme. This has impeded progress in terms of further embedding the quality and safety agenda within CSGs. This issue requires attention to ensure that responsibilities in relation to quality and safety are jointly demonstrated by both nursing and medical staff. Some of the formal quality and governance mechanisms established by the Quality Governance Framework were temporarily stood down during recent pandemic outbreaks and have recently been re-established, it therefore has been difficult to fully review |

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| | | | the processes. Whilst the Health Board has taken steps to address this recommendation, it is clear that these improvements remain at an early stage and still need attention to ensure they are being embedded across the organisation. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **8.1** | **DoTh** | The commencement of the newly appointed AHP CD will give greater assurance of quality and patient safety for therapy services spanning across the 3 ILGs. This post also strengthens the leadership function in AHP services and sharing of good practice and patient centred care across the UHB. This will be further strengthened with new appointments in the Executive DoThs team. | **August 2021** |
| **8.2** | **DoN** | There is still work ongoing however with the progress at the pace it is, the quality & safety system is becoming more robust daily.<br>Within 3 months the processes will be embedded fully across CTM. | **March 2022** |
| **8.3** | **DoN** | Quality & Patient Safety Meetings within CSG's are developing within ILG's – these are at differing levels of maturity and it is anticipated that these meetings will be consistent across all CSG's with specific speciality data dashboards by March 2022. CSG's are held to account within the ILG Q&SPE meetings and this is subsequently reflected in ILG performance management meetings and reports to Q&S. | **March 2022** |
| **8.4** | **DoN** | Corporate/Central services such as Safeguarding & IPC report regionally in to each ILG Q&PSE meetings. | **COMPLETE** |
| **8.5** | **DoN** | Establish Listening & Learning Forum – Quarterly | **COMPLETE** |
| **8.6** | **DoN** | Quality Governance Framework to reflect enhanced governance processes | **Review to be reported to Dec 2021 Q&S Committee** |

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| **8.7** | **DoN** | Centralisation of PSA/PSN process status mapping in progress with a plan/process mapping | **Paper to Q&S September 21** |
| **8.8** | **DoN** | Centralisation and Audit of Locssips & Natssips to improve patient safety standards. | **Plan and process paper to Management Board July 2021** |
| **8.9** | **DoN** | Central Patient Safety Network – a safety II paradigm approach creating an environment where things are most likely to go right; to measurably reduce near misses, incidents and enhance organisational improvements. | **Planned paper for Q&SC September 2021** |
| **8.10** | **DoN** | Ensure the ILG Q&S Meetings receive a formal report from their ILG IPC and Decontamination meetings. | **End September 2021** |
| **8.11** | **MD/DoN** | Establish Joint Maternity & Neonatal Improvement Board. | **COMPLETE** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R9** | The form and function of the directorate governance committees and CBMs must be reviewed to ensure there is<br>a- Clear remit, appropriate membership, and frequency of these meetings<br>b- Sufficient focus, analysis, and scrutiny of information in relation to quality and patient safety issues and actions<br>c- Clarity of the role and decision-making powers of the CBMs. | **Governance arrangements at an operational level have been strengthened. Since our 2019 review CBMs have been removed following the introduction of the new operating model. This recommendation is therefore superseded.** As stated previously, in April 2020 the Health Board made significant changes to the way it organises and manages its business, most notably establishing the three clinically led ILGs. The CBM process has been replaced.<br><br>Routine executive oversight of the ILGs is now maintained through the Integrated Locality Group performance reviews between the ILG triumvirate and the Executive Director of Operations. The Medical Director, Director of Planning & Performance, Director of Finance and Executive Director of Nursing also attend depending on their availability. These meetings are supported by the ILG business partners for quality and safety, workforce, planning and finance. Consistency of these meetings is ensured with a template slide pack covering information on quality, complaints and incidents, risks, finance, sickness absence and performance. These meetings are an improvement on the CBMs with a clear remit and sufficient focus on information across quality and safety issues. The Group ILG Directors are also formal members of the Management Board[4] (MB) enabling them to escalate issues and concerns. |

[4] The Management Board is the executive team responsible for service delivery, which meets bimonthly to discuss operational delivery across the Health board

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| | | | At the time of our follow-up work, minutes and actions from Integrated Locality Group Performance reviews were not formally shared within the Management Board meetings, and there is a need to strengthen arrangements for MB oversight of issues raised at ILG level, and action taken in response as this would improve the clarity of decision making. However due to the pandemic a number of the planned the Integrated Locality Group Performance review meetings were stood down and were restarted in March 2021 following the Health Board moving out of the emergency pandemic response phase. Therefore, more time is needed to fully realise the benefits of this process. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **9.1** | **CoS** | Review being undertaken to review Executive Meetings and Management Board to ensure effective use of time and robust reporting. | Review / analysis complete by – July 2021<br>Changes enacted to revised meeting structure – August 2021 |
| **9.2** | **CoS** | It has been over a year since the ILG structure was implemented by the Health Board. It is accepted that the new operational structure was implemented during COVID and therefore there is a requirement to allow the ILG teams to 'test and adjust' in a post-COVID environment. It is accepted by the organisation that some level of operational review should be carried out to look at what is working well and what elements of the structure may require tweaking to support effective decision-making. | Formal review to follow appointment of key roles, anticipated by end March 2022 |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021**<br>**(AUDIT WALES ASSESSMENT)** |
| | **R10** | The Health Board must ensure there are clear and comprehensive risk management systems at directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers. This must be reflected in the risk strategy. | **The Health Board has made good progress in addressing the serious concerns we identified in relation to risk management arrangements and has invested in dedicated support for governance and risk.** Since our 2019 review, the Health Board has reviewed its risk management systems and aligned them to the new operating model. This has been a root and branch review looking at arrangements from service to board. To ensure clarity, the Health Board has implemented a new Risk Management Strategy approved at Board in January 2021. |

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| | | | Corporate support for Risk Management has been improved through the appointment of an Assistant Director of Governance and Risk. This post supports the executive directors, ILGs and the Heads of Quality and Patient Safety to ensure a consistent approach to describing and scoring risks, compiling risk registers and identifying mitigation actions. This has facilitated an increased focus on risk and driven the improvements that have been delivered.<br><br>There has been a Health Board wide review of risks at a corporate, ILG and CSG level. This was a large piece of work undertaken at a time of considerable service pressures and is to be commended. The product of this work was the revised organisational risk register, which was presented to the Board in November 2020. This is a significant improvement since the previous risk register, however there is recognition within the Health Board that more work is needed to improve the mitigations and actions as described. Also some aspects of the CSG risk registers are still being updated to ensure they are accurately reflected within the Integrated Locality Group registers.<br><br>The Risk Management Strategy sets out a clear route from service to board, showing the process for escalating risks through the ILG management tiers within the new operating model based upon risk score. Whilst there is evidence that risks are de-escalated where appropriate to do so, there is still more work to do in relation to where risks scoring less than eight are captured. At the time of our follow-up work, the Health Board had prioritised the capture of risks scoring nine and above on the Datix system given the ongoing response to the pandemic. However, where ILGs, CSGs or corporate teams identify risks that score 1-8, these are captured on local risk registers and not the Datix system. The Health Board acknowledges the risks of maintaining parallel systems and of the need to ensure clarity regarding the process for de-escalation. Internal Audit's recent [5] assessment of one CSG found evidence that not all risks are escalated appropriately, again demonstrating the need to ensure that the improvements made at ILG level are still to be embedded across the CSGs. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **10.1** | **DoG** | Risk Training: including the development of a Training Needs Analysis (TNA) in line with All Wales developments, dissemination of the TNA across the Health Board, new | **31st October 2021** |

[5] Link to IA report when available

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| | | risk training programmes which are aligned to the new TNA. | |
| **10.2** | **DoG** | All ILG risks reviewed and updated following change in Operating Model. | **31st October 2021** |
| **10.3** | **DoG** | Clear and consistent grading of risks that are calibrated and moderated across the Health Board. | **31st October 2021** |
| **10.4** | **DoG** | An efficient risk management process which is seen as efficient and not cumbersome – linked to the new Once For Wales Risk Management System. | **30th April 2022 - external dependency as an All Wales System** |
| **10.5** | **DoG** | Implement recommendations from Internal Audit on Risk Management to strengthen risk identification, management and assurance. | **March 2022** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R11** | The oversight and governance of DATIX must be improved so that it is used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a directorate or corporate level, and formal mechanisms to identify and share learning. | **Oversight and governance of DATIX is improving with more use made of information at corporate and ILG levels within the organisation. Further work is needed on strengthening organisational learning from incidents, claims and complaints (concerns).** There is now clarity as to where the ILG Datix teams sits within the Health Board's structure, reporting through the Health and Safety team to the executive Director for People. The Health Board has indicated that these new accountability arrangements will be reviewed over the next three to six months.<br><br>There is now a renewed focus on ensuring that quality and patient safety is a priority. Mechanisms to improve oversight and scrutiny at an executive team level are in place. The Executive Director of Nursing and the Assistant Director of Quality, Safety and Safeguarding chair a short weekly meeting to review the previous week's complaints and incidents in conjunction with the quality metrics for nurse staffing levels. At the beginning of December 2020 a report to the weekly executive Director-led Patient Safety weekly meeting identified that more than 600 incidents had occurred within the prior six months that were yet to be allocated for investigation. The Health Board is working to address this backlog of investigations and completion of the appropriate fields within the Datix system, prioritising |

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| | | | these based on the severity of harm. Whilst the Health Board has informed us that since our work it has developed investigation and serious incident trackers to enhance monitoring in relation to incident management, more work is required to ensure that opportunities are taken for identifying early learning following incidents.<br><br>Use of Datix has improved, although there are some issues with the access to information at the Integrated Locality Level which is affecting their ability to produce localised reports. This is being addressed by the Datix team but does required a considerable amount of work. The Health Board will be implementing the Once for Wales system In July 2021.<br><br>Information provided by the Health Board indicated that it was not able to accurately identify staff who could investigate incidents and undertake root cause analysis. Additionally, the Welsh Risk Pool (WRP) recently expressed concerns over the time being taken by the Health Board to complete timely Learning from Events Reports (LFER) in line with WRP reimbursement procedures. This has been a challenging area for the Health Board due to the high numbers of legacy and maternity cases and the WRP has expressed concerns around the quality and timeliness of information submitted by the Health Board. In response, further work and progress has been made, and a task force established with weekly progress meetings with a commitment made by the Health Board to submit all LFER by the 31 March 2021. We have also been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module, which has enabled accurate tracking and monitoring of attendance.<br><br>The Assistant Director of Quality, Safety and Safeguarding holds biweekly meetings with the ILG Heads of Quality and Patient Safety with the aim of ensuring that appropriate actions are taken in response to complaints and incidents. Within the ILGs the monthly Quality and Patient Experience Meetings also scrutinises information from Datix to look at trends and analysis. All three ILGS have identified that analytical capacity is a barrier to using this data effectively and are recruiting to analytical support posts as a consequence. The ILGs have also identified that there is further work to do in addressing training needs for staff in relation to DATIX and ensuring that the right people have access to the system. The January 2021 report to the Quality and Safety committee provided reassurance that feedback from incident reporting through DATIX was improving, however there is further work required to improve the quality of feedback provided to the reporter. |

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| | | | As noted earlier in the report, the Health Board has also established a Shared Listening and Learning forum which reports to the management board. Part of the forum's remit is to oversee the Health Board's framework for listening and learning from quality and patient/staff related concerns and experiences. In addition, it champions a patient and staff safety culture and facilitates learning and sharing good practice. The forum's inaugural meeting was held in February 2021 with all ILGs presenting themes, issues and learning from incidents, claims and complaints (concerns). Whilst this is a positive development, it is too early to assess the effectiveness of this forum. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **11.1** | **DoN** | Datix Management being moved from H&S function (DoPpl) into Patient Experience function (DoN) to align with the development of Once for Wales. The tool will be a key mechanism to feed the Listening & Learning Forum of the Health Board. | **transfer by July 2021, incident module due October 21** |
| **11.2** | **DoN** | Training is provided to staff ahead of introduction of the new RLDatix Once for Wales, on each relevant module. Training will include feedback to reporter (ie claims & redress 07/06/2021). | **Incident Module will go live in October 2021** |
| **11.3** | **DoG** | An independent review has been commissioned by WRP to assess the Health Boards management of claims, including the systems, processes and resources in place to complete timely LFERs. The report will make recommendations that the Health Board will consider implementing to strengthen the current arrangements. | **Independent Report due Sept 2021** |
| **11.4** | **DoG** | Ensure all LFERs deadlines agreed with WRP are adhered to. | **July 2021** |
| **11.5** | **DoG** | Ensure LFERs have local ownership and are shared across the HB localities, identifying themes and trends. | **December 2021** |

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| **11.6** | **DoN** | Review all backlog incidents to eliminate duplicates and ensure correctly identified/categorised. | **October 2021** |
| **11.7** | **DoN** | Clear the backlog of all legacy incidents. | **January 2022** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R12** | The Health Board must ensure staff receive appropriate training in the investigation and management of concerns. In addition, directorate staff need to be empowered to take ownership of concerns and take forward improvement actions and learning | **Whilst the Health Board has made progress with addressing this recommendation, oversight of training corporately, and within each ILG, requires further attention.** Our 2019 review identified the need to improve the oversight and management of concerns. This included the operational processes for investigating and learning from concerns. Training on concerns management has been prioritised and has been provided across the Health Board for relevant individuals delegated with the responsibility for managing the concerns process. In addition, the Health Board's concerns policy was also reviewed and approved by the Board in August 2020. Training requirements for managing concerns are identified within the policy. Whilst at the time of our work ILGs were not able to accurately report on the proportion of their staff who have received training to investigate concerns, incidents or undertake root cause analysis, we have been informed that since February 2021 the Health Board has developed and launched its own root cause analysis module enabling it to track who has received this training.<br><br>There now appears to be consistency of approach and clearer accountability in relation to concerns management across each ILG, with concerns managed within the relevant CSG before gaining ILG approval, and subsequent submission to the corporate concerns team for final response approval. We saw examples of this within quality and safety and experience groups across the ILGs, where there was evidence that staff at local level are taking greater ownership and responsibility for a concern, and for implementation of improvements where required. To further strengthen concerns management processes, recent recruitment has increased the size of locality and corporate concerns teams. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **12.1** | **DoG** | Restructuring of Exec lead for Concerns, Claims and PTR from Director of Nursing to Director of Governance. | **July 2021** |
| **12.2** | **DoG** | Appointment of a Head of PTR (Interim 8b). | **June 2021** |

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| **12.3** | **DoG** | Appointment of Head of Legal, Concerns and Redress (8c). | **Oct 2021** |
| **12.4** | **DoG** | An audit of Concerns has been included in the Health Boards Annual Audit Plan for 2021/22. The Health Board will use the audit recommendations to strengthen the systems, processes and resources in place to investigate and manage concerns. | **Report Due August 2021** |
| **12.5** | **DoG** | CTM Improvement Team supporting Concerns Mapping identifying a consistent approach that can be applied across the Health Board. Outcome and implementation to be informed by the internal audit. | **End March 2021** |
| **12.6** | **DoN** | Continue to roll out the RCA training module and monitor attendance of ILGs on the training. | **Dec 2021 and on-going** |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021 (AUDIT WALES ASSESSMENT)** |
| | **R13** | The Health Board must ensure the timely development of a Values and Behaviours Framework with a clear engagement programme for its implementation | **The Health Board has made good progress in developing and rolling out its Values and Behaviours Framework, although it has needed to adjust the implementation timescales as a result of the pandemic.** At the time of our 2019 report, the Health Board was launching a programme of work to develop a Values and Behaviours framework for the organisation. Listening events were held with staff, patients, and service users between November 2019 and February 2020 to help identify the issues that such a framework would need to address. The outbreak of the pandemic meant further work on the Values and Behaviours Framework was delayed until June 2020. However, when the work resumed the Health Board was able to take account of staff experiences of responding to the pandemic and gather baseline information about staff well-being. In total the Health Board collected around 6,445 pieces of feedback from staff, stakeholders and the local community which informed the framework.<br><br>To inform the development of its Values and Behaviours Framework, the Health Board undertook a series of listening events, engaging with approximately 8,000 people, including patients and staff. External consultants were appointed to support this work and to develop the engagement methodology. The work appears to have had a positive impact on the development of the framework and in planning for the Patient Experience Strategy. The Health |

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| | | | Board formally launched the Framework on World Values Day, 15 October 2020. There was a live interactive session with a keynote presentation from Professor Michael West on compassionate leadership in the NHS. More than 2,000 staff participated in the event. The framework was also publicised on the Health Board's intranet and social media channels.<br><br>A detailed implementation plan is in place to embed the Values and Behaviours and this is monitored by the People and Culture Committee. Staff whom we interviewed were generally positive about the Values and Behaviours Framework. The Health Board recognises that it will take time to fully embed the Values and Behaviours across the organisation and to enhance employee experience.<br><br>In order to help embed them, the Health Board is revising its leadership programmes to incorporate the values and behaviours. The Values and Behaviours are reflected in key Health Board documents and they are visible on its website. They are also reflected in the Terms of Reference for the ILGs. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **13.1** | **DoPpl** | Launch Phase | **COMPLETE** |
| **13.2** | **DoPpl** | Embed Phase | **6 to 12 Months (June 2022)** |
| **13.3** | **DoPpl** | Values-Based Team Workshops, delivered | **From April 2021 onwards** |
| **13.4** | **DoPpl** | Values Cafés | **Delivered from March 2021 onwards** |
| **13.5** | **DoPpl** | Values-Based Leadership Workshops, currently under development. | **Delivered in 2021-22** |
| **13.6** | **DoPpl** | Values-Based Recruitment process and training. | **Developed by June 2021** |
| **13.7** | **DoPpl** | Values-Based Appraisal (PADR) process and training. | **Developed by September 2021** |
| **13.8** | **DoPpl** | Reinforcement Phase<br><br>To include:- | **12 months beyond** |

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| | | Culture Workshops;<br>Repeat Culture Survey. | |
| | | **Recommendation made in November 2019** | **A summary of progress made by April 2021<br>(AUDIT WALES ASSESSMENT)** |
| | **R14** | The Health Board must develop a stronger approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken in the Princess of Wales hospital. | **The Health Board has started to develop a stronger approach to organisational learning, although the pandemic has impeded progress against this recommendation.** In 2019, we found a lack of formal processes to identify and share learning for improvement across the organisation to support the delivery of safe and effective care. Additionally, in 2019, the NHS Wales Delivery Unit also raised concerns about the management and learning from serious incidents and never events.<br>We have highlighted the Health Board's current position regarding learning and improvement in response to concerns and patient and staff feedback (recommendation 12). Progress has been made in strengthening the overall responsibility and management of clinical and serious incidents across the Health Board. A clinically-led Serious Incident team has been established, alongside a more robust process for the management of incidents, and learning resulting from them. Supporting this, the Health Board has implemented a Serious Incident Tool kit. This tool has reportedly assisted with consistency in managing incidents, and supported sharing learning. The Serious Incident team undertakes a monthly clinical audit and super audit (quarterly) in collaboration with the Patient Care and Safety Team. The findings and actions for learning from these audits are reported through the locality Quality, Safety and Executive groups, and into the Quality and Safety Committee.<br>The Health Board is also establishing an improvement function called 'Improvement CTM', which will bring together learning from audit activity and concerns. Improvement CTM is expected to empower the Health Board's workforce to take responsibility for implementing continuous improvement through organisational learning. This is still early in its implementation and therefore too early to assess its effectiveness.<br>It was widely reflected to us that tackling the issue of improving organisational learning has been a challenge for the Health Board as a consequence of the pandemic response. Whilst there is some evidence of a stronger approach being taken to organisational learning, we have limited evidence at this time to be assured that learning is being effectively disseminated to all areas of the organisation and frontline staff. Minutes and observations found evidence of learning being shared within CSG and ILG quality and safety meetings. However, there is a need to strengthen overall arrangements for sharing learning across the ILGs. The Health |

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| | | | Board is aware of this and hopes this will improve, particularly with the Heads of Quality and safety now in post across all ILGs<br>Our observations of CSG and ILG quality and safety meetings found that external activity such as HIW inspections are being regularly discussed to ensure that action is taken to address recommendations, and learning is disseminated across CSGs and the Health Board. The previously mentioned Shared Listening and Learning forum will also focus on the learning and dissemination of findings and recommendations from external reviews, audits, and inspections. However, there is limited evidence to demonstrate that wider learning beyond the clinical area being inspected is shared effectively across all other clinical areas and with staff, particularly with those on the front line who are responsible for day-to-day care of patients.<br>Assurances are given to the Quality and Safety Committee about learning from incidents, but the reports do not provide examples of the learning and how it is being applied or shared more widely across the organisation. This is an aspect that needs to be strengthened.<br>Our previous review found that opportunities for learning following the Bridgend transfer in relation to undertaking FFTs had not been taken. In 2019, staff within Princess of Wales Hospital felt there had been little consideration of the benefits for patients and staff through the use of FFT, and its use for real-time patient feedback. However, since our review, the Health Board has embraced this learning and implemented the FFT throughout each site. |
| | **CTM Lead** | **Further Actions** | **Completion Date** |
| **14.1** | **DoN** | A clinically-led Serious Incident team has been established and the Health Board has implemented a Serious Incident Tool kit. | **COMPLETE** |
| **14.2** | **DoN** | Utilise the '7 minute briefings' to capture learning and produce a digestible document across ILGs to support a repository of learning. | **By end Sept 2021** |
| **14.3** | **DoN** | Ensure a 'spotlight on' section within the Q&SC report to highlight an area of concern (determined by the committee) to provide an opportunity to give further detail and assurance/mitigating actions from across the organisation to Q&SC. | **COMPLETE** |

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| **14.4** | **DoN** | Executive Director led Patient Safety meeting in place and meets weekly with Exec Director Nursing and Midwifery, Deputy Nurse Director, Assistant Director Therapies, Director of Corporate Governance, Assistant Director of Nursing & People's experience, Medical Director, Assistant Director Quality & Safety, Director of Improvement to review, mitigate and learn from;<br>• Complaints<br>• SIs<br>• Falls / Pressure Damage<br>• Inquests<br>• Compliments | **COMPLETE** |
| **14.5** | **DoN** | Implementation of PREMS and CITRIX system to gather data on patient experience to inform learning and service enhancement and improvement. Project has been initiated and Project Manager appointed. | **Phased implementation from September 21 onwards** |
| **14.6** | **DoN** | New Improvement Directorate created bringing together Quality Improvement, Innovation, Value Based Healthcare and PMO in order to coordinate a range of important areas with a constant focus on improving quality for the benefit of staff and patients.<br>QI Mission - Working together with our people, patients and partners to understand areas for quality improvement and develop the capability, capacity and delivery mechanisms across the whole health system to deliver improved outcomes for our patients and improved working practices for our people aligned to the principles of Prudent and Value Based Health Care. | **COMPLETE** |
| **14.7** | **DoN** | New Innovation and Improvement board created (sub board of Management Board) and launched focusing on Capability, skills, culture and delivery of QI and innovation and bringing together cross organisational learning. | **COMPLETE** |

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| **14.8** | **DoN** | Revision of QI training and deployment plan across CTM. | **August 2021** |
| **14.9** | **DoN** | First Improvement into Practice cohort scheduled. | **Sept 2021 onwards** |
| **14.10** | **DoN** | Implementation of ILG QI Faculty. Resource recruitment completed (clinical, nursing, pharmacy and therapies) with 1 session per week to focus on ILG specific QI and learning. | **COMPLETE. Launch scheduled with roadshows in July 21.** |
| **14.11** | **DoN** | QI 12 month rolling programme of activity being developed. | **Deploy Sept 2021 onwards** |
| **14.12** | **DoN** | Staff ideas scheme for targeted challenges and QI programs being developed and online portal being build. Comms plan being developed to officially launch. | **Launch Sept/Oct 2021** |
| **14.13** | **DoN** | Work being undertaken with IC to scope work to develop and deploy a model ward and operational best practice guide to improve flow, quality and patient safety. | **July 2021** |