Quality & Safety Committee Minutes of the Meeting held on 18 November

Summary of Questions & Answers

Agenda Item 5.4.1 Delivery Unit Review of Ophthalmic Diagnostic & Treatment Centre (ODTC) – Progress Report

***Question**: What are the follow up numbers beyond their target date?*

***Answer:** There are currently 826 Ophthalmic Diagnostic Treatment Centre (ODTC) patients identified as past their target date for follow up.*

***Question:** What impact has the development of the ODTCs had so far in the past 12 months in reducing follow up cases?*

***Answer:** The ODTC clinics were cancelled as part of the COVID restrictions. Activity has commenced but at a much smaller capacity, which is reducing our ability to continue to address the follow up backlog.*

The community ODTC scheme, which will allow for a cohort of the follow up patients to be seen within the community where funding was secured in 2019-2020 and carried forward into this year's funding also remains at a standstill due to connectivity issues within the local practices with the digital Electronic Patient Record (EPR) system currently being led by Welsh Government (WG).

***Question:** Is it possible to have timescales in the action plan to give further assurance and to scrutinise?*

***Answer:** The only two areas without a timescale within the ODTC action plan are the following:*

1. *Include dedicated time for virtual review in consultant job plans and establish dedicated (not ad hoc) virtual review clinics;*
2. *Agree a common vision for Ophthalmology Services in Cwm Taf, including a clear role for ODTCs. The funded plan, with agreed staffing levels and activity trajectories, should be included within the Health Board's Integrated Medium Terms Plan (IMTP) and longer-term plan.*

There is a planned Royal College review which is led by Stuart Hackwell and Ruth Alcolado, which incorporates these issues within the action plan with the ophthalmology consultants engagement so would be difficult to gauge a timescale for this.

***Question:** Further assurance around the harm reviews to show improvement work would be helpful?*

***Answer:** The Root Cause Analysis (RCA) for the Macular harm review work, has proved to be successful in leading service change and development – even throughout the COVID period. Introduction of additional capacity has been created by implementing a non-medical injector pathway, as well as*

additional accommodation and the outcome of this has eliminated significant risk within the service.

The Average delay in days is ~1 vs over 60 days in September 2019.

There is focus now to ensure that this service is maintained at this capacity, and to ensure that this is the capacity moving forward. There will be requirement for a significant investment within resource for staffing and this will form part of the overall service review.

The RCA for the Diabetic Retinopathy service and the Glaucoma service remains incomplete but there is a plan for this to be finalised by December 2020.

The Harm review meetings continue with the support of the consultants, senior nurse and patient safety team.

Agenda Item 5.4.2 Delivery Unit Review on Cardiology to Cardiac Surgery Follow Up – Progress Report.

Comment: *Timescales in the action plan would be welcomed for further assurance and scrutiny.*

Answer*: The action plan has been updated and uploaded to admincontrol. Recommendation will always be Amber 1 is an ongoing process as we have staff turnover. But Staff in post have now been trained. Recommendation 2 will be Amber is ongoing as electronic referral process require update first. The Hospital to Hospital referrals system is with NHS Wales Information Systems (NWIS). Recommendation 3 is Amber as although in place requires further update. Recommendation 4 is amber due to recent Integrated Locality Group (ILG) split and work now required to confirm how the service will be managed across the three sites. Recommendation 4 should be green for Merthyr Cynon (MC) this is no longer our preferred process.*

Comment: *Rag rating on the plan is not correct for some actions.*

Answer: *See above response*

Question: *There appears to be huge onerous tasks and responsibilities on the Cardiac Nurse Facilitator. What or are there plans to engage more Consultants in the process?*

Answer: *The consultants are fully engaged with the process and the named consultant of the week often speak directly with the consultants at the University Hospital of Wales (UHW) or MCC when referring patients there. In addition they support the Cardiac Nurse Facilitator in her role. The prioritisation process for Merthyr Cynon (MC) and Rhondda Taff Ely (RTE) is now electronic and is consultant led.*

Question: *What are the future plans for resourcing in Prince Charles Hospital (PCH) and Royal Glamorgan Hospital (RGH) to drive the improvement plan?*

Answer: *A cardiology remodelling business case has been developed for RTE and MC with significant investment ask.*

Question: *The ICT issues re merger of PAS systems and the WPAS interface should this be referred to the Digital Committee?*
Answer: *A response to this question was provided during the meeting.*

Agenda Item 5.5 Rationale for the Opening of the Field Hospital and Assurance received by Gold to inform the Decision.

Question*: Noted in the report is the concern regarding Fire Regulations. What are the mitigation's to reduce the risk. Is this a risk on the Organisational Risk Register?*

Answer: *The Head of Health, Safety & Fire is currently working with the Fire Team to address the fire risk assessment for the field hospital. Once completed any risk(s) will be escalated to the Organisational Risk Register as appropriate in accordance with the Risk Management Strategy.*

Agenda Item 5.2.2 Merthyr Cynon ILG Quality & Safety Report

Question: *Pages 3/4: Unlike the Rhondda and Taf Ely Locality report, there are no details of the number of the harm reviews carried out so far. Is this because no reviews have yet taken place or is it simply a different reporting approach?*

Answer: *Harm reviews are being undertaken. In view of the report being a public document, Merthyr & Cynon (MC) Integrated Locality Group (ILG) did not wish to include unvalidated data: the data is undergoing clinical validation, particularly in relation to harm reviews relating to cancer care. One patient with lung cancer has had an extensive case review by the Multi-Disciplinary Team (MDT) and that case will be reviewed by the first multidisciplinary harm review panel, due to be scheduled for December 2020. All cases of patients spending longer than 12 hours in the Emergency Department (ED) have been reviewed and no harm has been identified in those cases.*

Question*: External assurance: Healthcare Inspectorate Wales (HIW): Ward 7 Ysbyty Cwm Cynon (YCC): compliance with mandatory training is an ongoing issue across the Health Board. There is a review and process improvement being undertaken by Workforce: when is this likely to make the changes necessary to support delivery of improvement on the ground?*

Answer: *Compliance with training has been affected by COVID particularly face to face training such as CPR and fire.*

Question: *Paragraph 2.27: Were the concerns cases closed prematurely, given the need to reopen them? If so, what steps are being taken to prevent reoccurrence?*

Answer: *The concerns management process has developed and concerns relating to care in Merthyr Cynon ILG are now responded to by the MC ILG team. Where a concern response generates further questions, either new questions as a result of receiving the information in the response, or should they feel that we have not adequately answered their questions, we will reopen the original concern rather than create a new one. This does not necessarily reflect a concern being closed prematurely. Having said that, we are further developing the concerns response processes within the ILG: we aim to ensure that our responses address all the concerns raised and invite correspondents to contact the ILG team if they have further questions or feel any concerns remain unaddressed.*

Question: *What parts of the 15 point outbreak plan are not being complied with?*

Answer*: The outbreak plan advises to limit movement of patients between wards and maintain bubble contacts. Due to the pressures on the site we continue to work towards this on a risk based approach with additional COVID red wards being created, now four. The bubble contacts have also had to be mixed on occasions to create one bubble amber ward. All has been scrutinised by OCT.*

Question*: You give examples of some compliance – what are your key issues of compliance that you still have concerns with?*

Question: *It is imperative that harm reviews and identified potential harm reviews are conducted and are in place. There appears to be some issues with these being done. What timeframe are we looking at for the ILGs implementation?*

Answer: *The multidisciplinary harm review panel is being established, as it is in other ILGs, with the first meeting to be scheduled in late November/early December. '104 day' cancer harm reviews are being undertaken [see previous response]. 12-hour breach harm reviews are being undertaken [see previous response]. The intention is that a harm review element is embedded in both the Follow up Outpatients Not Booked (FUNB) review and Referral to Treatment Targets (RTT) prioritisation processes to ensure they produce meaningful results and outcomes. There is ongoing discussion regarding detail in these areas, to ensure clinicians are fully supported to include this work in their clinical care delivery.*

Question: *Healthcare Inspectorate Wales (HIW) Ward 7 – one outstanding action in regards to statutory and mandatory training – what is the plan?*

Answer: *Compliance with training has been affected by COVID particularly face to face training such as CPR and fire.*

Question: *Noted 81 Serious Incidents (SI's) open – When will we see progress re: compliance with the timeframes?*

Answer: *Plans to strengthen the governance team with the appointment of an additional Patient safety Improvement Manager (PSIM) will support the clinical teams to progress the completion of all Serious Untoward Incidents (SUI's) that are outside of the compliance framework. Additionally, a central resource has been allocated to each ILG to support the investigation and closure of SI.*

Agenda Item 2.1 To Receive the Unconfirmed Minutes of the meeting held on 8 September 2020

Question*: Is there an update on progress for the short stay/observation unit that had been anticipated to open in September, is it possible to include the plans on how this area will be staffed in the response?*

Comment: *A governance query. As part of our scrutiny and assurance processes members now ask questions in advance and the answers are recorded in the minutes. This supports the ability to have a consent agenda. However, a number of questions at the last Quality & Safety (Q&S) Committee were not answered in advance and in addition concern was expressed about the answers to some questions (**QSC20/113 final paragraph)**. The minute in each of the cases listed below indicates that answers will be provided following the meeting. Have they been provided? If so, for assurance they now need to be recorded in this (November) meeting's minutes.*

- ***QSC/20/111*** *Advance Question 2*
- ***QSC20/116*** *Advance Questions 1&2*
- ***QSC/20/119*** *Advance Question 2.*

Answer: *The introduction, during the first wave of COVID, of the facility to ask questions in advance of Board and Committee meetings was aimed at reducing the length of time spent in meetings and ensure that thorough scrutiny was still afforded to the business of the Health Board. It also supported the introduction of the consent agenda. Answers provided by Health Board Officers to questions asked prior to meetings should, wherever possible, be addressed fully, in advance of the meeting to the satisfaction of the members of the Board/Committee in question. The continued, and more recent significant impact of the second wave of COVID, has inevitably impacted on the timeliness of officers responding, and in some cases, has resulted in some questions not being answered in advance of the meeting despite best efforts.*

It cannot be emphasised enough, that establishing the mechanism of seeking answers to questions in advance of a meeting does not prevent questions being asked, or followed up at the meeting if they have not been answered to the satisfaction of the Committee or Board member. If colleagues feel the facility of Questions & Answers (Q&As) prior to meetings no longer supports the more effective use of time spent in the meetings, or causes undue pressure on Independent Member (IM) or officer colleagues, then we will review the process."

Agenda Item 2.3 Once for Wales Concerns Management System

***Question**: Frequent concerns raised by staff in relation to Datix is the lack of feedback/response following a report. **5.3b Page 2** supports this with 35.2% of midwives who completed a survey say they have not received feedback from a Datix. In an attempt to encourage staff to continue completing Datix how are we addressing this to ensure we share lessons learned to improve practice and do not foster the "what is the point" attitude?*

***Answer:** As with the current CTM system, the new system will contain the automatic feedback message (summary of lessons learned) that is activated on completion of an investigation of an incident. This is just one mechanism of ensuring that feedback is provided to reporters and there is ongoing engagement with responsible managers to ensure processes in relation to incident management facilitate proactive feedback.*

Comment:** This paper, which describes a major IT implementation programme, should be presented to the Digital & Data Committee for information **(added to the action log).

Agenda Item 2.4 Health, Safety & Fire Sub Committee Terms of Reference

***Note:** The first sentence of the ToR is incomplete: "In accordance with CTMUHB [missing words], the Quality & Safety Committee may" etc.*

***Question:** The ToR are in the main written as if this Sub-Committee of Quality & Safety reports directly to the Board rather than the Quality & Safety Committee. Is this the correct governance line? For example:*

- *Quality & Safety Committee is responsible to the Board for health and safety, yet the Delegated Powers section reads as if the sub-committee has those responsibilities in its own right rather than carrying them out on behalf of the parent committee (Page 3).*

- *The Health, Safety & Fire Committee is a sub-committee of Quality & Safety Committee. Yet it seems to have the authority to set up its own sub-committees (Page 4).*

- *Reporting & Assurance (Page 5) has mixed reporting lines.*

***Answer**: The Terms of Reference have been amended and re-uploaded to provide further clarity*

Agenda Item 2.5 Amendment to the Standing Orders – Quality & Safety Committee Terms of Reference

***Comment:** They have not included the Health, Safety & Fire Committee – this needs to be added.*
***Answer:** The Health, Safety & Fire Sub Committee is already referenced on page 6 of the Terms of Reference.*

Agenda Item 2.6 Committee Action Log

***Question:** Under 20/065 – could we have further assurance on progress as to when a report will be available and is there anything specific that the Committee now needs to know about that could affect patient care and safety?*

Answer**: There is progress around the facilitation meetings which are going ahead. We have also had progress on the other outstanding points in the action plan. Only two are outstanding and they are to do with audit and data. I am currently chasing resolutions to this **(action log updated).

Agenda Item 2.7 Policy Management Improvement Plan (Clinical & Non Clinical Policies)

***Question:** What processes are being put in place to trigger review of policies in future?*

***Answer:** It will remain the responsibility of the Policy Author to initiate a review of the policy within the required review period, usually three years. The intention is that this will be supported by a trigger/reminder from the Corporate Governance Team once all the policies have been risk assessed and captured in a newly developed policy master library. The "Policy on Policies" captures the responsibilities for review which includes policies being reviewed earlier than planned in the light of changing practice, legislation or Welsh Government guidance/ policy changes etc. The author of the individual document is responsible for ensuring this takes place.*

***Question:** How will legislative or case law change trigger a review of a non-clinical policy? How will change in guidance from clinical bodies trigger a review of a clinical policy?*

***Answer:** All Health Boards in Wales receive frequent updates on national guidelines and policies from a number of sources for example, Patient Safety Alerts, National Institute for Clinical Excellence (NICE) etc. In responding to these updates the Health Board trigger clinical policy reviews as appropriate. To support this the Clinical Audit Team in CTM are*

developing a new system (AMaT) to log all updates received to allow them to be prioritised and disseminated to trigger any policy reviews that might be required. Other triggers for clinical policy development include development of new service and ways of working. The ILG structure supports closer collaboration with teams across all three locality groups to ensure timely and effective review of clinical policies where a need is identified.

Question: *Are the clinical policies being risk assessed to determine priority for review in line with the non-clinical policies?*
Answer: *The AMaT process mentioned above, will support the lead team to assess and prioritise all in-coming policy demands.*

Question: *2.2 – Noted 111 policies and procedures have been risk assessed. What is the number of the remaining policies outstanding and have we got a deadline for completion?*
Answer: *As at the end of October there were approximately 170 policies still requiring risk assessment. The deadline for completion was initially the end of September 2020, this deadline was significantly impacted by the resurgence of infections in response to Covid-19. A new deadline has not yet been set due to the current demand placed upon functions within the Health Board. The position will be reviewed in early December and a further deadline considered in order to progress this activity by the end of the financial year.*

Question: *2.4 – What is the position on the review of the policies, the reference in 2.4 does not give that assurance?*
Answer: *The revised "Policy on Policies" is planned for approval by the 31st March 2021. If all activity and alignment with Clinical Policies can be completed sooner approval will be sought at the Health Board in January 2021.*

Agenda Item 2.8 NHS Wales Shared Services Partnership Legal & Risk Services – Impact & Reach Report

Question: *Will this report be shared with the Audit and Risk Committee?*

Answer: *It wasn't our intention to – I suggest we take to Quality & Safety and if deemed necessary, refer it to Audit & Risk Committee (or simply share with colleagues for information via email).*

Agenda Item 2.9 Covid 19 Lessons Learnt Report

Question: *2.9c Absolutely support the need for staff voices to be heard by Board, how do you plan on "new " leaders enabling this given some of the concerns raised are lack of communication from senior teams.*

Answer: *The lack of leader's communication point was raised in the first wave and was based around the new ILG structure. It was raised a few*

times regarding one specific directorate. The ILG directors when aware of this issue addressed it directly. It was included as a reminder to all to listen. New leaders have emerged during the pandemic. Many came to the fore during the development of each ILG's Bronze teams. They were clinicians who would (in general but not all) previously not envisaged a formal leadership role. Many of these, after the experiences they have had, have now taken on formal roles within ILGs. As such their voices will be heard in a formal structure.

Also for Medicine three of the new Assistant Medical Directors (AMDs) (appointed during the last few months) are new to leadership roles and previously unexperienced new colleagues are becoming Clinical Leads across CTM. There has been a concerted effort to open the leadership roles and as such new voices have joined. Hearing voices is also a key reason for establishing the "Clinical Sounding Board" with Paul Mears. This will be a twice monthly virtual catch up of colleagues from all areas and all backgrounds having the chance to voice concerns and give advice on ideas and direction.

***Question:** Appendix 2 Leadership and Management Lessons. Paragraph three. I understand that the ILGs will be required to do further work in respect of their deprived communities who have been disproportionately affected by Covid-19. As the Community Health Council (CHC) has representatives in these three areas, is this an area where the CHC could make a useful contribution?*

***Answer**: Further work within and across ILGs should be undertaken to ascertain why deprived communities seem to be worse hit and essentially to determine what advice and support is needed to tackle. COVID-19 has brought into sharp focus the impact of health inequalities across CTM.*

***Question:** What is the plan to give further assurance that the recommendations made have been acted upon?*
***Answer**: Hopefully the above answer goes some way to providing assurance. There is a genuine culture change happening across CTM where staff, from all areas, are stepping forward and providing leadership. How we continue this is and continue with the assurance is difficult to evidence. Potentially, when the COVID pressure has subsided, we could collate a worksheet of all those in a leadership role together with their time in that, and previous leadership role. Updating this regularly would show where new people step forward and their roles.*

Agenda Item 2.10 Shared Listening & Learning Forum

***Question:** I was interested in the proposed Shared Listening and Learning Forum, which I understand is to provide more focus on patient experience. As the CHC's purpose is to reflect patients' experience in its reports, would they be invited to participate in this group? As you are aware we have not been able to carry out our visits due to the pandemic, but we are using other methods to obtain views from patients and the public.*

Answer: *I think this is a very welcome suggestion and it would be great to have you involved. It will be a management forum rather than a Committee or sub-committee so is subject to confidential information but we can manage that with your support. We are currently refining the draft Terms of Reference and we can include a Community Health Council (CHC) representative.*

Agenda Item 5.2 Integrated Locality Group Reports

Question*: The level of demand in all three EDs is noted, together with the impact on ambulances. Have all ambulance delays been reported on Datix? Do the Serious Incidents (SIs) listed include the longest delays (at least 12 hours+)? Are the services safe?*

Answer: *Yes ambulance delays are reported on Datix. There is no drop down for these so they go in as treatment delays. This has been escalated to the Datix team to have a drop down code. We have met as three ILGs with the WAST governance team. A table top exercise has been planned for 12 delays and reported as SI.*

Question: *The Committee has asked for harm reviews to be conducted and the progress made in doing these in Rhondda Taff Ely and Bridgend ILGs is appreciated. The delay in even starting the reviews in Merthyr Cynon is a matter of real concern. When will the harm caused to patients in that area begin to be assessed and then completed?*

Answer: *As explained in previous responses, harm reviews are being conducted in MC ILG in relation to cancer delays and ED 12-hour breaches. This is in line with the other ILGs where the initial focus for harm reviews is also in the domain of cancer care. The harm review process in relation to FUNB and RTT has not been established as a separate activity from clinician review of FUNB (including any contacts triggered/actions taken) and RTT prioritisation (which was undertaken as part of the RTT reviews in the resetting CTM agenda): it is the clarity of articulation of that process that is needed. The requirement for a separate process to be documented would represent re-work where FUNB/RTT review has been completed already. The intention is that going forward separate documentation will be completed at the time of FUNB review or RTT prioritisation.*

Comment: *The real progress made by all three ILGs in the restructure of data to improve reliability and utility of information and also in risk management is noted and welcomed.*

Answer: *The comment above has been noted.*

Question: *The hospitals are experiencing high levels of bed occupancy, much related to delays in discharge. What steps are being taken to improve flow?*

Answer: *The discharge policy has been reviewed to remove the requirement of 14 day isolation for home packages. The 28 day rule is limiting ability to discharge to a care home with Elderly Mentally Infirm (EMI) residential and nursing a key concern. This is being taken forward by a silver cell approach and in partnership with the Local Authority (LA). We are also looking to support EMI residential LA owned homes with our bank staff. Awaiting proposal from RCT LA.*

Rhondda Taff Ely Integrated Locality Group Report

Question: *Pages 4/5: Following confirmation by the Harm Review Panel, how quickly will patients and/or their families be contacted to inform them that harm has taken place? Have the four cancer patients who have suffered harm (out of the 26 reviewed so far) been contacted? What support do we provide for these patients?*

Answer: *The four cases of harm identified to date were reported pending further clinical validation. This has now been undertaken for the Moderate and Severe harms reported; with the result of one of the cases progressing through the SI process. The harm review process is a precursor to the SI process and patients or their next-of-kin will be contacted by an identified 'patient liaison officer' as outlined in the Health Board's SI toolkit. Once the Harm Review Panel has confirmed the level of harm, SI RAPID meetings will be convened within 72 hours (where clinician availability allows) or as soon as possible. The support offered will be undertaken in line with Putting Things Right and will include consideration of redress.*

Question*: Page 5 - How many ED 12 hour breaches resulted in harm to the patient. What about 52 week RTT and FUNB patients (the availability of a separate ophthalmology FUNB harm report - agenda item 5.7 - is acknowledged)?*

Answer: *We are not aware of any harm resulting from 12 hour breaches in the ED. The harm review meetings will be starting this week. The commencement of Harm Review Panels for 52 week RTT and FUNB patients have been delayed due to Covid-19 operational pressures. Review forms completed to date for 52 week RTTs have not identified any clinical harm resulting from the delays.*

Comment: *congratulations on the UKAS accreditation of the Biochemistry service.*
Answer: *The comment above has been noted*

Question: *HIW Quality check Ward A1 Ysbyty Cwm Rhondda (YCR): it is important for patient safety that policies and procedures are current and reflect current guidance. Is there a plan for reviewing and updating policies and procedures for this area?*

Answer: *The IP&C Policy had been drafted and is going through the process of consultation and approval. The Action Plan produced following*

the inspection report states that this will be completed next month and the work is on course to be completed pending approval at the IPC group. The importance of regular review of all our written control documents is recognised and the UHB Clinical Policies Working Group sits bi-monthly to scrutinise and approve new Policies and revised 3 yearly updates.

Comment: *The increasing number of medical administration incidents highlighted in the dashboard is noted and the decision to monitor this closely is supported.*

Answer*: The comment above has been noted*

Question*: Putting Things Right formal 30 day target of 85%, RTE is 62% for October – what is the plan to improve?*

Answer: *A staggered trajectory of improving compliance towards the 85% target is planned however this trajectory is likely to be impacted by Covid-19 as all concerns require significant clinician input to produce. The ILG Quality Team has established regular governance meetings with Heads of Nursing and Quality Managers for our Clinical Service Groups (CSGs) which will enable close oversight of timescales. Additional staffing resource has recently been approved for the ILG Quality Team which will support the provision of timely and high quality responses.*

Question: *HCAI's are high – what more can we do to improve – are there still concerns over staff compliance of wearing of masks and socially distancing and if there are any issues what is the plan?*

Answer: *We have decluttered the ward areas and increased cleaning regimes. Staff have been reminded of their obligations to social distance and RTE have a low rate of staff infection compared to the community population. Regular review of working practices and quick investigation of reported breaches continue.*

Question: *Intensive Treatment Unit (ITU) Capacity – RTE Quality – are we using high dependency beds for patients on C-PAP in ward areas to take some of the demand away from ITU beds?*

Answer: *Patients requiring CPAP are traditionally managed on the wards in the RGH and have continued to be throughout the COVID-19 pandemic. The ITU capacity and occupancy figures refer to beds for patients who are invasively ventilated. Although CPAP is used on ITU it will not be the reason for which the patient has been admitted.*

Question: *ITU – do we have the equipment in ITU and PPE to now deal with the second wave?*

Answer: *PPE supply is currently good but is still in high demand across the world resulting in fragile supply chains. ITU equipment is not a material problem restricting capacity. Staffing is the biggest constraint on capacity.*

***Question**: Noted that SI's have increased – what is the improvement plan and learning? Also can we be confident that RCA's are being adequately carried out and have we got the right resource to deal with this?*

***Answer:** The number of SIs reported during the first two quarters of the year fell below the baseline due to a lowering of the reporting threshold by Welsh Government. Since the reporting requirements were reinstated, this has naturally led to an apparent increase but is reflective of the reporting arrangements. RCAs are supported by the involvement of a Patient Safety Improvement and all RCA reports are quality-assured using the Health Board's SI toolkit form by both the Locality Head of Quality and the Locality Nurse Director. Action plans are consistently produced to ensure that recommendations from RCAs are implemented. A newly-formed Central SI team will also support the production of patient-focused and timely RCAs going forwards as well as working closely with the ILGs to address the RCAs overdue for completion.*

***Question**: What is the improvement to tackle the high medication incidents?*

***Answer**: Medication incident safety huddles named 'Druggles' have been piloted. The wider roll-out across the acute hospital site has been delayed due to Covid-19 related operational pressures but remains a high priority as soon as clinical capacity allows. To date there has been no clear pattern of trends or themes that require wider learning and improvement. Incidents continue to be investigated on an individual basis in accordance with the Health Board incident management procedure.*

***Question:** MRSA and E-Coli infection rates are increasing – what is the plan for improvements?*

***Answer:** As per the report we have identified this as an issue and are working on an action plan with IPC. The COVID HCAI outbreak has diverted a lot of resources away from this, however, I will get a verbal update from IP&C about the proposed action plan.*

<u>Bridgend Integrated Locality Group Report</u>

***Question:** Page 5: Harm reviews have commenced; is it intended that the outcome of the reviews will be reported to the Quality & Safety Committee once the work is finalised and conclusions drawn?*

***Answer**: The harm review panels will report into the locality Quality & Safety Committee and form part of the ILG Quality & Safety report to the Health Board Quality & Safety Committee, the cancer harm reviews will also be reported into the Cancer Board chaired by Executive Medical Director.*

Comment: *5.2.3d - Some of the review dates need reviewing.*

Answer: *Noted will ensure this is updated for the next report.*

Question: *2.33 removal of ligature points. This is clearly urgent and the allocation of funds to address it is appropriate. What is the timescale for completion? Is this related to the issue reported in 2.45 and 2.46?*

Answer*: Yes this is linked to Q2.45 and Q2.46. The planned anti ligature works to our adult acute assessment Ward 14 and PICU on the Princess of Wales Hospital site is currently out to tender and due to start shortly. This will be followed by the works to Angelton clinic which has been assessed as lower risk. This work will be completed in early 2022.*

Question: *External inspections. As in Merthyr Cynon, compliance with statutory and mandatory training remains an issue. The involvement of ILG Workforce is noted: is there a plan and what is the timescale for addressing the issue?*
Answer*: Summary headlines November 2020*

- *0.18 Increase since last reported position of* ***49.48%*** *to a current* ***49.66%***

  The learning and development Business Partner is working with the Workforce & Organisational Development (WOD) Team aligned to Bridgend ILG for a targeted approach on raising compliance. Equality and Diversity and Information Governance has been highlighted as low compliance, with an agreed target of 90% to be achieved. Following completion of these e-learning modules there will be a focus on the remaining e-learning modules with individuals as follows;

  - *Dementia Awareness*
  - *COVID – 19*
  - *Environmental waste & energy*
  - *Improving Quality Together bronze*
  - *Domestic abuse*

  Increasing Safeguarding Training compliance is also a focus across Clinical Service Groups and the ILG, further work will take place between Learning & Development, WOD and Safeguarding Partners.

  As there is a hold on classroom training, there has been a focus on Ward/Department Fire compliance and the remaining e-learning, as a 'quick win' Learning & Development are requesting that the Health & Safety team run a campaign, or series of adverts explaining the Ward/Department Fire training, again to support an increase in compliance, as it has been noted that there appears to be some confusion around the responsibility of the Fire Warden and the skills

required. We are aware that Fire training is being trialled with the Executive Team and as an ILG would welcome the opportunity to trial this and move forward on a plan to raise compliance, linked to the Fire Enforcement Notice issued in Bridgend ILG.

Question: *Serious Incident Investigating Officers undertaking reviews – is there enough capacity and resource and are you satisfied that the skills required to undertake the reviews are available?*

Answer: *Presently there are no capacity or resource issues. Where we feel we need an independent investigator or do not have the specialist skills, we source an independent investigating officer.*

Question: *Ligature Programme – Noted anti ligature work ongoing – could we have further information on what areas are still not compliant and how often are risk assessments being done, e.g. daily or each shift? Will need further assurance?*

Answer: *Both the adult and older people's services complete monthly quality reviews which include an environmental audit of ligature risks. Patient risks are mitigated by special observations and relational support where necessary. On Ward 14, which has been identified as our highest risk area, staffing levels have been increased during the night shift and two of the higher risk bathrooms have been taken out of use. The activity area has also been closed when not in use, specifically at night. Environmentally, whilst a small number of bedrooms in Ward 14 and PICU were upgraded prior to transition into CTMUHB, and which provide some anti-ligature facilities, the remaining planned work will not be fully completed until early 2022. Healthcare Inspectorate Wales (HIW) are revisiting Angelton clinic on 3 December to further discuss the timetable for completing the works and the risk assessment process.*

Question*: Are there any concerns that Llynfi Ward is impacting on patient safety or quality?*

Answer: *Lynfi ward is now closed and works due to start to remodel and increase capacity. The outbreak is being investigated as part of the independent review commissioned by the Health Board.*

Question: *HIW Tier 1 Quality Checks – have any taken place?*

Answer: *Please see 2.42-2.45 this lists the checks that have taken place and links to the reports.*

<u>Agenda Item 5.2.4 Quality Dashboard</u>

Question: *Pages 5/6: Do we know how our figures/trends compare with other Health Boards in Wales, particularly with regard to, for example, number of serious incidents and complaints, and mortality rates?*

Answer: *It is a really difficult question and something we always get asked is how do we compare – it is not straightforward as we all record on Datix differently and therefore are comparing within different parameters.*

The Once for Wales system will enable standardisation and benchmarking. We currently compare unfavourably to Cardiff & Vale (C&V) in terms of compliance responses, but they have a significantly larger resource in terms of governance teams. It goes without saying however that we need to improve in this sense within CTM.

We have a good relationship with the C&V UHB Patient Care & Safety am and can provide their data in relation to 30 complaints response and SI's as an example albeit not directly comparable:

> *C&VUHB: Complaints we have approximately 3,000 per year and current performance time is 84% for 30 working days (CTM – 65%)*
>
> *In September and October 502 concerns were received (CTM – 259), which is a significant increase when compared with the 338 received in July and August. The numbers are slightly less than September and October of 2019 when 596 concerns were received (CTM – 265).*
>
> *The 30-working day performance for this period was 84%.*
>
> *In September and October we reported 38 SI's*
> *The top three C&VUHB reported categories of Serious Incidents reported overall during this timeframe include:*
>
> *Behaviour (including suicide, serious self-harm, absconsion)*
>
> - *Patient accidents/falls*
> - *Unexpected deaths or severe harm*
>
> *CTM:*
>
> 1. *Maternity – Obstetrics & Gynaecology*
> 2. *Mental Health*
> 3. *Head, Neck & Ear Nose and Throat (ENT)*

Question: *Page 13: The number of potential Hospital Acquired Infections seems to have increased significantly in September (although it is recognised that the total number of cases in the quarter ending 30 September is not very different from the previous quarter). Is there any reason for the surge in cases in September?*

Question: *Page 14: The C.difficile rate has increased significantly over recent months; does the Infection, Prevention and Control Team have sufficient capacity given the additional pressures and demand imposed by the Covid-19 pandemic?*

***Question**: Metrics - HAIs MSSA, E Coli rates increasing what is the plan for improvement?*

***Answers:** There has been a reduction in S.aureus bacteraemia and gram negative bacteraemia (E.coli, Klebsiella and Pseudomonas bacteraemia) compared to the same period last year. There has been a slight increase in the number of C.Difficile cases compared to last year.*

There was an increase in C.Difficile cases in September 2020….total of 18 cases, 10 healthcare associated infections and 8 community acquired infections. Two health care associated cases were identified on Ward 9, Prince Charles Hospital and 2 cases on Ward 20, Princess of Wales Hospital. The IPC team increased their presence on both wards at this time and there have been no further cases on either ward since September 2020. 44% of the C.Difficile cases identified in September were community acquired infections.

To give some background, from April to September 2020 there have been 75 cases of C.Difficile infection across CTM. Over half the cases are community acquired (53%). We need to address the community acquired cases in order to see a reduction in our overall C. Difficile numbers. We also need to improve antimicrobial stewardship and strengthen the RCA process in secondary and primary care.

Additional resource is needed to appoint a dedicated IPC team for primary care. Without investment the current team is unable to deliver the targeted interventions needed to improve IPC practice/antimicrobial stewardship which will ultimately benefit secondary care and improve outcomes for patients. We need to introduce a whole system approach for IPC spanning primary and secondary care and community hospitals. This will also help reduce the community acquired S.aurues bacteraemia and E.coli bacteraemia

COVID has been a priority for the IPC team during the past few months and we have been under resourced due to long term sickness and vacancies. Recruitment is underway to address the vacancies and I hope to appoint into both posts next week. I'm also hoping that the IPC Nurse on long term sick will return to work in the coming weeks. We have also asked the bank office to ask for expressions of interest for a registered nurse to join the IPC teams over the winter period to support the IPC teams on each of the 3 DGH sites.

Plans for improvement over the coming weeks/months –

- *IPC team to discuss all alert organisms in the weekly IPC meetings. Escalate any concerns/issues raised to the ILGs*
- *Work with ILG Nurse Directors to strengthen RCA process for all C.difficle cases and preventable bloodstream infections*
- *Continue to support the COVID response offering additional IPC training/donning and doffing training*

- *Reinstate level 2 IPC training in the classroom setting as the COVID situation allows*
- *Analyse sources of the blood stream infections to introduce targeted interventions*
- *Learn from incidents/share learning*

Agenda Item 5.2.5 Primary Care Quality & Safety Report

Question: *Page 3: Whilst recognising that the flu vaccination programme is not yet finished, is the number of Health Board staff having the vaccination likely to be significantly higher this year. Will the flu vaccination programme be completed in good time for the innoculation team to be ready to participate in the Covid-19 programme even if the vaccine becomes available a little earlier than expected?*
Answer: *Indications so far are that there has been an increase in interest in the influenza vaccine from our staff. However data collection will continue into 2021 so we won't have a final figure available until next May. Yes, we anticipate that should a vaccine become available earlier than expected that we will have sufficient vaccinators to deliver to the priority groups.*

Question*: Waiting list for Aural removal of wax concerning. Is there a plan for Ear wax management?*
Answer: *Yes there is a plan being implemented to reduce the waiting list and progress is being made. I received the update on Friday, too late for me to include in the report. Additional clinics have started over the weekends and will continue up until Christmas. As was stated in the report the waiting list pre COVID was 4-6 weeks. By June /July it had risen to 900 patients with a 9 month waiting list. With the Saturday working (6 Saturdays) up until Christmas plus the regular clinics the figure will be reduced to 572 patients on the waiting list and a 17 week wait. This also includes a number of follow up patients being discharged as they no longer need to be seen.*

Agenda Item 5.3 Maternity Services Update

Comment*: 5.3a Page 6 Key achievement I believe should probably read August 2020-February 2021.*

Question: *5.3b - What plans are in place to address the survey results that 35.2% of those completing the survey report they do not get feedback from a Datix? Lack of response could potentially result in a laissez faire attitude of not completing.*

Answer: *We are reviewing the feedback mechanism (action to be completed by December 2020). We are investigating if it is possible to mandate as a field so that an incident cannot be closed unless feedback field completed.*

Question: *5.3b Disappointing to note there is still a feeling of a blame culture Page 3 & 4 with Datix meetings turning into a "blame" meeting and senior nurse walk about being seen as negative with no recognition of anything that has gone well of which I am sure there must be lots of examples given the amount of work that has taken place to address issues. What plans are in place to address these ongoing issues?*

Answer: *We are careful to ensure that learning is shared with an ethos of 'appreciative inquiry' i.e. – what went well as well as what can be improved. We regularly send letters/emails of thanks as a result on clinical reviews/investigations. Culture takes time to change and we will continue to work with staff to promote positive learning, and actively listen and respond when staff share concerns.*

Question: *SUIs - When will the backlog be cleared is there a plan and have we a deadline/timescale?*
Answer: *We are working on a trajectory of completing 2-3 SI's per week – we anticipate between 15-23 weeks but are progressing well. Additional resource has been identified from the corporate team to undertake 5 SI's and support the final quality assurance.*

Agenda Item 5.4.4 Delivery Unit Management Review of Patient Safety Incidents and Concerns

Comment: *The plan commencing on page 320 is in portrait instead of landscape so the columns of the plan appear on different pages. Please reload it in landscape so that it can be read.*

Answer: *The document has been shared with Members via email due to upload issues to admincontrol.*
Comment: *Similarly the table commencing on page 385 needs margins or column widths adjusting to allow the final (8th) column of the table to appear on the same page as the first seven columns.*

Answer: *The document has been shared with Members via email due to upload issues to admincontrol.*

Comment*: In parts of the plan for improvement the timescales are not correlating against the position in the report.*

Comment: *The plan does not appear to have up to date timescales. Would also give further assurance if actions were included in the plan is this possible.*

Question: *Quality and Safety Walkabouts - plan states they have been re-instated is this an error?*

Answer: *Walk rounds referenced in the Audit Wales/HIW plan refers to the area of activity which was previously in place; there was a requirement to*

reintroduce the Executive Director Walk Rounds and the Partnership Dignity Visits. I have raised the question regarding the reintroduction of both and was advised that due to the COVID-19 situation these were to remain on hold and my understanding was that these will be further reviewed this month (November). I have the is as an agenda item for Mondays Executive Director meeting for any update however, it may be that G Dix can update from Management Board – in addition to this when I have spoken with S O'Brien about the same, the response is that there may not be a requirement for these (Executive Walk Rounds & Patient Dignity Visits (PDVs)) as these could be superseded by the Ward Accreditation work S O'Brien and her team are leading on. We were supposed to have a meeting with G Dix last month to discuss however, this was cancelled. I have not been made aware that the Executive Director Patient Safety Walk-rounds or the Partnership Dignity Visits have recommenced and I have previously led on both of these activities.

Agenda Item 5.7 Update on Follow Up Outpatients Not Booked to include an update on the Ophthalmology Position Statement

Question: *Page 2: Are we intending to hold patient/family meetings for the 13 patients (so far) who have suffered moderate harm?*

Answer: *All patients identified as having suffered severe harm have been reported as SIs (either clustered or individual). The Macular cluster RCA has been recently signed off by the Executive Directors and a decision is awaited from the Deputy Executive Director of Nursing in conjunction with Claims and Patient Experience leads as to how to approach and progress contacting and informing the affected patients or their next of kin. The approach will consider all the principles of Being Open and the Putting Things Right regulations, including provision of Redress. A Senior Nurse for Ophthalmology Governance has been appointed on a fixed term basis to oversee this programme of patient engagement and support.*

All patients identified as having suffered Moderate harm will also be considered under Redress arrangements and will be included in the programme of patient engagement.

Question: *Page 4: What support are we providing to patients who have suffered severe (and moderate) harm?*

Answer: *All patients identified as having suffered Severe harm have been reported as SIs (either clustered or individual). The Macular cluster RCA has been recently signed off by the Executive Directors and a decision is awaited from the Deputy Executive Director of Nursing in conjunction with Claims and Patient Experience leads as to how to approach and progress contacting and informing the affected patients or their next of kin. The approach will consider all the principles of Being Open and the Putting Things Right regulations, including provision of Redress. A Senior Nurse for*

Ophthalmology Governance has been appointed on a fixed term basis to oversee this programme of patient engagement and support.

All patients identified as having suffered Moderate harm will also be considered under Redress arrangements and will be included in the programme of patient engagement.

Question: *Page 8: Will the Royal College review consider the capacity of our current workforce to meet the level of demand within and across the communities served by CTM?*

Answer: *As part of the service review the Royal College will consider our estate capacity, the work force and the skill mix within the workforce in light of the historic activity of the unit. They will not however carry out a population based view of the expected population demand as this is outside their area of expertise.*

Question: *Do we have any indication of when the Royal College of Ophthalmology will be commencing their review in view of the continuing risks identified in the report?*

Answer: *We have not been advised of a start date by the College.*