Quality & Safety Committee

Tue 24 January 2023, 13:30 - 16:30

Virtually via Microsoft Teams

Agenda

13:30 - 13:30
0 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Jayne Sadgrove, Committee Chair*

1.2. Apologies for Absence

Information *Jayne Sadgrove, Committee Chair*

1.3. Declarations of Interest

Information *Jayne Sadgrove, Committee Chair*

13:30 - 13:30
0 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Pet Therapy

Discussion *Nikkita Williams, Ward Manager*

13:30 - 13:30
0 min

3. CONSENT AGENDA

3.1. FOR APPROVAL

3.1.1. Unconfirmed Minutes of the meeting held on 15 November 2022

Decision *Jayne Sadgrove, Committee Chair*

3.1.1 Unconfirmed Minutes QSC 15 November 2022 QSC 24 January 2023.pdf (15 pages)

3.1.2. Unconfirmed Minutes of the In Committee Meeting held on 17 November 2022

Decision *Jayne Sadgrove, Committee Chair*

3.1.2 Unconfirmed Minutes In Committee QSC 17 November 2022 QSC 24 January 2023.pdf (3 pages)

3.1.3. Committee Annual Cycle of Business

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

3.1.3a Committee Cycle of Business - Cover Paper QSC 24 January 2023.pdf (2 pages)
3.1.3b Quality Safety Committee Cycle of Business QSC 24 January 2023.pdf (4 pages)

3.1.4. Quality & Safety Committee Terms of Reference

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

3.1.4a Quality & Safety Committee Terms of Reference Review - Cover Paper QSC 24 January 2023.pdf (3 pages)
3.1.4b GC01 Standing Orders - Schedule 3.8 - Quality & Safety Committee ToR - Review January 2023 QSC 24 January

2023.pdf (11 pages)

3.2. FOR NOTING

3.2.1. Action Log

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

3.2.1 Action Log QSC 24 January 2023.pdf (12 pages)

3.2.2. Forward Work Programme

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

3.2.2 Quality & Safety Committee Forward Work Programme QSC 24 January 2023.pdf (10 pages)

3.2.3. Safeguarding Annual Report

Information *Greg Dix, Director of Nursing*

3.2.3a QS Safeguarding annual report QSC 24 January 2023.pdf (4 pages)
3.2.3b Safeguarding Annual Report 2022 QSC 24 January 2023.pdf (39 pages)

3.2.4. Quality Governance - Regulatory Review Recommendations and Progress Updates

Information *Greg Dix, Director of Nursing*

To include CHC National Surveys and Quality Monitoring Review

3.2.4 Quality Governance Regulatory Reviews QSC 24 January 2023.pdf (8 pages)

3.2.5. Progress Report 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability

Information *Julie Denley, Deputy Chief Operating Officer*

3.2.5a Learning Disabilities 6 month Improvement report QSC 24 January 2023.pdf (8 pages)
3.2.5b Improving care Improving Lives Action Plan updated 14 Dec 2022 QSC 24 January 2023.pdf (4 pages)

3.2.6. CTMUHB Nosocomial Covid-19 Incident Management Programme

Information *Greg Dix, Director of Nursing*

3.2.6 CTM Nosocomial COVID-19 Incident Management Programme December 2022 QSC 24 January 2023.pdf (8 pages)

13:30 - 13:30
0 min

4. MAIN AGENDA

4.1. Matters Arising not Contained within the Action Log

Discussion *Jayne Sadgrove, Committee Chair*

13:30 - 13:30
0 min

5. GOVERNANCE

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

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

5.1a - Organisational Risk Register Q&SC Cover Paper January 2023.pdf (4 pages)
5.1b- Appendix 1 - Master Organisational Risk Register - Final January 2023 (Recovered) - Q&S COMMITTEE - V2.pdf (10 pages)

5.2. Update Report on progress following Internal Audit on Concerns & Welsh Risk Pool

Review on Claims/Redress/Inquests

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

5.2 IA and WRP Actions QSC 24 January 2023.pdf (4 pages)

5.2.1. Learning From Events Reports

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

5.2.1 Learning From Events Reports QSC 24 January 2023.pdf (6 pages)

5.3. Datix Cymru – Incident Reporting

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

5.3 Datix Cymru Incident Reporting QSC 24 January 2023.pdf (5 pages)

5.4. CTMUHB Quality and Safety Framework 2022-2025

Discussion *Greg Dix, Director of Nursing*

5.4a Quality & Safety Framework Cover Report QSC 24 January 2023.pdf (4 pages)
5.4b Quality & Safety Framework QSC 24 January 2023.pdf (23 pages)

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0 min

6. IMPROVING CARE

6.1. Maternity & Neonatal Improvement Programme Update

Discussion *Suzanne Hardacre, Director of Midwifery/Sallie Davies, Deputy Medical Director*

6.1a Maternity and Neonatal Improvement Programme Update V4.0 11.1.23 QSC 24 January 2023.pdf (18 pages)
6.1b APPENDIX 1 Maternity Neonates Assurance Framework - FINAL Version 5.0 December 2022 QSC 24 January 2023.pdf (2 pages)

6.2. Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

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

6.2 Ty Llidiard Update QSC 24 January 2023.pdf (14 pages)

6.3. Quality Dashboard

Discussion *Greg Dix, Director of Nursing*

6.3a Quality Dashboard Report QSC 24 January 2023 updated 25.01.23.pdf (40 pages)
6.3b QPAR_All Wales_Summary Dashboard_Nov22 QSC 24 January 2023.pdf (1 pages)
6.3c QPAR_CTM_Summary Dashboard_Nov22 QSC 24 January 2023.pdf (1 pages)
6.3d Data Details_All Wales Dashboard QSC 24 January 2023.pdf (2 pages)
6.3e Data Details_UHB Dashboards QSC 24 January 2023.pdf (2 pages)
6.3f 20221212 Compliance Summary Alerts QSC 24 January 2023.pdf (2 pages)
6.3g 20221212 Compliance Summary Notices QSC 24 January 2023.pdf (4 pages)

6.4. Report from the Chief Operating Officer

Discussion *Gethin Hughes, Chief Operating Officer*

6.4 COO's Report on Overarching Issues QSC 24 January 2023.pdf (11 pages)

6.5. Monitoring and Reporting of Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity.

Discussion *Ana Llewellyn, Mental Health Care Group Nurse Director*

6.5 Reporting and Monitoring CHC FNC QSC 24 January 2023.pdf (10 pages)

6.6. Deep Dive into CAMHS

Discussion *Ana Llewellyn, Mental Health Care Group Nurse Director*

6.6 CAMHS Deep Dive QSC 24 January 2023.pdf (17 pages)

6.7. Liberty Protection Safeguards Preparation

Discussion *Greg Dix, Director of Nursing*

To include Court of Protection and Actions to Mitigate

6.7 Liberty Protection Safeguards QSC 24 January 2023.pdf (6 pages)

6.8. Child T - Child Practice Review

Discussion *Greg Dix, Director of Nursing*

6.8 Child T Child Practice Review QSC 24 January 2023.pdf (6 pages)

13:30 - 13:30
0 min

7. ANY OTHER BUSINESS

7.1. Highlight Report to Board - Verbal

Information *Jayne Sadgrove, Committee Chair*

7.2. How did we do in this meeting

Discussion *Jayne Sadgrove, Committee Chair*

13:30 - 13:30
0 min

8. DATE AND TIME OF NEXT MEETING THURSDAY 16 MARCH 2023 AT 9AM

13:30 - 13:30
0 min

9. CLOSE OF MEETING

Agenda Item Number: 3.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 15 November 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member & Vice Chair of the Committee (Chair)
Jayne Sadgrove	Vice Chair of the Health Board
James Hehir	Independent Member
Nicola Milligan	Independent Member
Dilys Jouvenat	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Dom Hurford	Executive Medical Director
Hywel Daniel	Executive Director for People
Lauren Edwards	Executive Director of Therapies & Health Sciences
Gethin Hughes	Chief Operating Officer
Debbie Bennion	Deputy Executive Director of Nursing
Sallie Davies	Deputy Executive Medical Director
Louise Mann	Assistant Director Quality, Safety & Safeguarding
Cally Hamblyn	Assistant Director of Governance & Risk
Sharon O-Brien	Assistant Director of Nursing & People's Experience
Stephanie Muir	Assistant Director of Concerns & Claims
Suzanne Hardacre	Director of Midwifery & Nursing – Children & Families Care Group
Ana Llewellyn	Primary Care, Community and Mental Health - Care Group Nurse Director
Carole Tookey	Planned Care - Care Group Nurse Director
Richard Hughes	Unscheduled Care – Care Group Nurse Director
Jenny Oliver	Governance & Patient Experience Manager
Esther Flavell	Clinical Lead for Mortality Review
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Becky Gammon	Head of Nursing, Professional Standards & Education
Chris Beadle	Head of Operational Health, Safety & Fire
Liza Thomas-Emrus	WISE Clinical Lead (In part)
Shelina Jetha	Maternity & Neonates Improvement Programme Manager (In part)
Emma Samways	NWSSP Internal Audit Services
Gaynor Jones	Royal College of Nursing (RCN) Convenor
Rowena Myles	Cwm Taf Morgannwg Community Health Council
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Observing:

Melanie Barker	Deputy Director of Therapies & Health Sciences (Observing)
Mary Self	Mental Health Care Group Medical Director (Observing)

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

In opening the meeting, C Donoghue, Committee Vice Chair provided a welcome to all those present, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted by the Vice Chair.

1.2 Apologies for Absence

Apologies for absence were received from:

- Kelechi Nnoaham, Executive Director of Public Health;
- Greg Dix, Executive Director of Nursing;

1.3 Declarations of Interest

No interests were declared

2.0 SHARED LISTENING AND LEARING

2.1 Patient Experience Story

L Thomas-Emrus shared a presentation with Members which related to the work being undertaken by the Wellness Improvement Service (WISE) which included a patient's experience of using WISE and the positive impact the service had on their health and wellbeing.

The Committee Vice Chair welcomed the presentation and story, which she had found to be very inspirational and uplifting.

D Hurford advised that the service had been very impactful and added there was significant potential scope to expand this service to patients with chronic pain, long term conditions and patients suffering with Mental Health needs. Dr Thomas-Emrus advised that contact is being made with patients in these areas to explore if the service could be of benefit to them.

G Hughes extended his congratulations to the Team for establishing this service quickly and advised that this service could benefit a large proportion of patients on the Health Board's waiting lists who were currently awaiting treatment and procedures. G Hughes added that consideration would need to be given as to how the service could be expanded to help reduce demand in other areas.

R Myles also welcomed the presentation and advised that she found the scheme to be impressive and sought clarity as to whether the service was available across the whole of the Health Board and how patients could access the service. Dr Thomas-Emrus confirmed that the scheme was available across the Health Board and advised that the Team try to target the communities who were more affected by ill health and regularly encouraged GP's to refer into this service. Dr

Thomas-Emrus advised that there was a CTM WISE website which included a 'refer here' button which enabled GP's to refer into the service. Members noted that posters regarding the service were also being displayed within local community areas and GP surgeries.

In response to a question raised by L Edwards regarding onward referrals, Dr Thomas-Emrus advised that the message being communicated is that whilst patients are waiting to see a specialist for their condition, the self-management method would be trialled to see if this improved the condition of the patient, which may result in those patients then not requiring further treatment e.g. Physiotherapy. L Edwards advised that the impact this could have on waiting lists was significant.

In response to a question raised by J Hehir as to whether other potential benefits were being measured, for example, reducing long-term medication use, Dr Thomas-Emrus confirmed that medication usage was being measured and added that whilst the majority of patients wished to take less medication, they also felt anxious about stopping them. Members noted that the Team were working with the Pain Consultant Lead in relation to the possible introduction of group clinics where the aim would be to reduce medication usage.

The Committee Vice Chair extended her thanks to Dr Thomas-Emrus for sharing the excellent presentation and advised that the Committee looked forward to hearing how the service progresses in the future.

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

3 CONSENT AGENDA

3.0 For Approval/Noting

3.1.1 Unconfirmed Minutes of the Meeting held on the 20 September 2022

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

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

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

3.1.3 Quality & Safety Committee Terms of Reference

Resolution: The Quality & Safety Committee Terms of Reference were **APPROVED**.

3.2.1 Committee Action Log

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

3.2.2 Committee Annual Cycle of Business

Resolution: The Report was **NOTED**.

3.2.3 Quality & Safety Committee Forward Work Programme

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

3.2.4 Welsh Ambulance Services NHS Trust Patient Experience Report

Resolution: Members **NOTED** that due to the potentially identifiable information captured within the report, the Welsh Ambulance Services NHS Trust Patient Experience Report would be discussed at the In Committee Quality & Safety Committee taking place on Thursday 17 November 2022 on this occasion

3.2.5 Quality Governance – Regulatory Review Recommendations and Progress Updates

Resolution: The Report was **NOTED**.

3.2.6 Health & Care Standards Annual Report

Resolution: The report was **NOTED**.

3.2.7 National Prescribing Indicator (NPI) Annual Report

Resolution: The report was **NOTED**.

3.2.8 Clinical Education Annual Report

Resolution: The report was **NOTED**.

3.2.9 Clinical Audit Quarterly Report

Resolution: The report was **NOTED**.

3.2.10 Nosocomial Covid-19 Incident Management Programme

Resolution: The report was **NOTED**.

3.2.11 Human Tissue Authority Act Progress Report

Resolution: The report was **NOTED**.

3.2.12 Annual Review 2021-2022 – Welsh Risk Pool and Legal & Risk Services

Resolution: The report was **NOTED**.

4. MAIN AGENDA

4.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

5. GOVERNANCE

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

C Hamblyn presented the report and advised Members that work was being undertaken to align risks to the new Care Group model and advised that the Risk Assessment Procedure was also currently out to consultation.

N Milligan made reference to Risk 4080, Failure to Recruit Sufficient Medical and Dental Staff and advised that no update had been provided against this risk since July 2022. N Milligan requested that timeframes be added to the Task & Finish Groups referenced against this risk. D Hurford advised that all risks aligned with Medical and Dental Staffing had now been amalgamated into one Medical Productivity Group risk and advised that whilst explicit timelines had not yet been made for the Task & Finish Groups, some tasks had already been completed with some tasks taking longer to complete. D Hurford agreed to ensure that interim timeframes were captured in the Organisational Risk Register. In response to a concern raised by the Committee Vice Chair, D Hurford advised that work is underway to ensure the same staff were not sitting on multiple groups.

N Milligan made reference to Risk 5267, which related to the risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses. N Milligan advised that she was concerned that no reference had been made to the targeted intervention programme and suggested that this be considered in future updates. Furthermore, as this risk amalgamated risks 4106 and 4157 the opened date should reflect the original timeframes, it was also requested that the risk score be reviewed in light of its similarities to risk 4080. D Bennion provided assurance that these actions would be undertaken outside of the meeting.

G Hughes advised that following the alignment of risks to the new Care Group model it is his suggestion that the Executive Leadership Group meet to review the Organisational Risk Register to ensure there is moderation and calibration in terms of narrative and scoring.

P Roseblade advised that she also had concerns in relation to consistency of risk scoring and welcomed the work that would be undertaken to calibrate the whole risk register. In response to a question raised by P Roseblade as to when the review of the backlog of Learning From Events Reports was likely to be completed, S Muir advised that she would be happy to present a progress report to a future meeting of the Committee.

P Roseblade made reference to Risk 4152 which related to the care of patients with mental health needs on the acute wards and advised that reference was made to reducing the scoring with no reference made as to how this would be achieved and what had changed in order to reduce the scoring. C Hamblyn advised that she would ask the risk lead to provide an update in readiness for the next meeting.

P Roseblade advised that it would be helpful if the Committee could have an update at a future meeting on the Welsh Community Care Information System (WCCIS) given the number of risks relating to this as to how the system was working and what further investment was required. A Llewellyn advised that a report was being presented to the Executive Team shortly and added that she would be happy to provide an update to a future meeting of the Quality & Safety Committee.

J Hehir highlighted that there were a number of risks that were subject to financial dependencies, for example, posts pending confirmation, and advised that the risk scoring may require review in terms of the probability of the risk becoming realised. C Hamblyn advised that risk leads have been asked to consider this when updating their risks in terms of any other mitigation in addition to financial resources that are being considered.

The Committee Vice Chair welcomed the work that was being undertaken to develop the Risk Register further.

Resolution: The report was **NOTED**

Action: Medical Director to ensure interim timeframes were captured for the Task & Finish Groups referred to in relation to Risk 4080.

Action: Risk Score allocated to Risk 5267 to be updated and reviewed against the risk score allocated against the medical workforce risk.

Action: Update to be sought from the Risk Lead in relation to Risk 4152, Care of Patients with Mental Health Needs on the Acute Wards as to how the scoring against this risk would be reduced and what had changed to reduce the scoring

Action: Report to be presented to a future meeting of the Committee in relation to progress being made to address the Learning From Events backlog.

Action: Update to be provided to a future meeting in relation to progress being made in relation to the Welsh Community Care Information System.

5.2 **Datix Cymru Assurance Report**

K Jenkins-Forrester presented the report. Members noted that a review had been undertaken which identified that whilst there was a slight decrease in the numbers of incidents reported this decrease would have been expected following the introduction of a new system with numbers of incidents reported being fairly

consistent to pre pandemic levels. Members noted that there had been a reduction in the numbers of incidents being reported for clinically challenging behaviour, which was in the process of being explored.

D Jouvenat referred to Page 6 of the report which advised that the effective and inefficient extraction of data continued to be challenging and added that a number of reports on the agenda today also highlighted issues with the new Datix Cymru system. D Jouvenat recognised that this area of concern is being addressed nationally and sought clarity as to what progress is being made to address the concerns with the current system. K Jenkins-Forrester advised, that like other Organisations, Cwm Taf Morgannwg Health Board had built their legacy systems to reflect the Board's specifications and metrics. Other reports to Committee have highlighted some of these are currently unavailable, for example the falls investigation tool within Datix Cymru does not capture if a fall is avoidable/unavoidable on conclusion of an investigation. This has been escalated to the All-Wales Group for discussion as to whether this question remains valid and is to be included.

P Roseblade advised that the report referred to a decrease of 50% in incidents reported regarding staff and sought clarity as to whether this was an inputting issue or an extraction of data issue and also whether it related to a staff training issue. K Jenkins-Forrester advised that this related to clinically challenged behaviour incidents and added that a review was being undertaken to determine the reasons behind this and whether further targeted training was required in specific areas.

The Committee Vice Chair advised that it would be helpful if an update could be provided to the Committee at a future meeting to determine the root cause of the issues being experienced.

Resolution: The report was **NOTED.**

Action: Update to be provided to a future meeting determining the root cause of the issues being experienced in relation to the new Datix Cymru System.

5.3 Health, Safety & Fire Sub Committee Highlight Report

D Jouvenat presented the report reflecting that the Datix Cymru concerns already discussed had also been considered at length in the Sub Committee meeting hence the escalation via the highlight report. . H Daniel advised that work is underway with the Chief Operating Officer to determine Care Group attendance at future Sub Committee meetings.

Resolution: The Report was **NOTED**.

5.4 Infection, Prevention & Control Committee Highlight Report

D Bennion presented the report and highlighted that Joint Advisory Group (JAG) Accreditation had been highlighted as an area or concern for escalation by Committee members. G Hughes advised that in relation to JAG accreditation,

the planning process had commenced and the Business Case process was underway with Welsh Government. Members noted that JAG had been made aware of the next phase of the plan and the Health Board were awaiting formal confirmation of feedback from JAG in relation to the plan.

In response to clarification sought by P Roseblade as to whether issues being experienced within the laundry service in relation to reduction of capacity was having an impact on Infection, Prevention & Control, D Bennion advised that whilst she had not been made aware of any issues, she would be happy to confirm the position outside the meeting.

Resolution: The report was **NOTED**.

Action: Confirmation to be provided outside the meeting as to whether reduction of capacity issues being experienced within the laundry Service was having an impact on Infection, Prevention and Control.

6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

S Hardacre and S Davies presented the report. Members noted that the Independent Maternity Services Oversight Panel would be standing down their oversight at the end of 2022 and noted that the Team were on target to complete all actions by the end of March 2023. Members noted that a discovery report would now be prepared by the Programme Team for submission to Welsh Government.

The Committee Vice Chair extended her congratulations to the Team for their achievements in enabling the service to be taken out of Special Measures. J Sadgrove echoed the comments that had been made by the Committee Vice Chair and advised that clarity would be required as to what steps would now need to be taken to take the service out of Targeted Intervention and added that she expected focus would now need to be placed on the pace of change within Neonatal Services.

In response to a question raised by J Sadgrove as to what was being done to improve the decline being seen in the old Cwm Taf area in relation to speed and timeliness of booking and whether any lessons could be learnt from Bridgend on this matter, S Hardacre advised that there were multiple booking processes in place and steps were being taken to address these issues. Members noted that a report had been developed as to how the issues could be addressed.

In response to a query raised by J Sadgrove as to when the next MBRRACE report would be available, S Hardacre advised that whilst the national report was launched fairly recently, the local report had not yet been received. S Hardacre added that the Health Board does not appear to be an outlier in any area.

P Roseblade welcomed the format of the report presented which had improved significantly over the last 18 months and highlighted that there were a number of abbreviations contained within the report which had not been explained within the abbreviation section. S Hardacre advised that she would ensure this was addressed for the next iteration of the report.

H Daniel extended his congratulations to S Hardacre and the Team for the work that had been undertaken over the last few years. H Daniel also drew attention to the reference to the Healthcare Inspectorate Wales staff survey which identified a few areas of improvement in relation to staffing. S Hardacre advised that feedback from staff had not been positive and highlighted issues that the Team were already aware of, for example, leadership and culture and the relationships between staff and the senior management team. Members noted that the issues were in the process of being addressed and work was being undertaken with the Peoples Services Team in relation to sickness absence issues.

The Committee Vice Chair advised that the Committee were expecting updates in relation to the processes in place for women experiencing ectopic pregnancies and the Gynaecology Pathway. In response, S Hardacre advised that reports had been prepared and advised that she would be happy to share these at the next meeting.

In concluding the report, the Vice Chair expressed thanks on behalf of the Committee to all those involved for their commitment to improving maternity and neonatal services.

Resolution: The report was **NOTED.**

Action: Abbreviations to be explained in the next iteration of the report.

Action: Updates in relation to the processes in place for women experiencing ectopic pregnancies and the Gynaecology Pathway to be shared at the next meeting.

6.2 Ty Llidiard Progress Report

L Edwards presented the report. Members noted that the National Collaborative Commissioning Unit (NCCU) undertook a supportive visit to the Unit recently where informal positive feedback was received. Members noted that formal feedback was now awaited.

The Committee Vice Chair welcomed the report and advised that she was pleased to see the improvements being made.

In response to a question raised by N Milligan as to whether the reference made to inappropriate behaviour in table 1 related to staff or patients, A Llewellyn provided a response via the meeting chat and advised that Table 1 related to patient safety incidents. The inappropriate behaviour related to young people.

J Sadgrove welcomed the report which she found to be really clear and welcomed the progress that had been set out and the co-production work that was being undertaken with service users particularly in relation to activities. J Sadgrove sought an update in relation to the extensive Estates work that had been identified by the NCCU. Members noted the areas being prioritised.

Resolution: The report was **NOTED.**

6.3 Quality Dashboard

L Mann presented the report and highlighted the key matters for the attention of the Committee. Members noted that there were now only two Patient Safety Notices that the Health Board needed to achieve compliance against.

J Sadgrove welcomed the progress that had been made in relation to achieving compliance against Patient Safety Notices and advised that she was pleased to attend the recent launch of the Listening & Learning Framework and welcomed the news that the Welsh Risk Pool were supporting the Health Board in relation to Learning From Events. J Sadgrove thanked L Mann for her commitment to improving the report, which has significantly matured and continues to evolve.

P Roseblade made reference to 'safe to starts' and queried what would happen in the event that a service was deemed not safe to start. C Tookey advised that each unit determines whether they are safe to start by reviewing staffing levels, any incidents that may have occurred overnight and the position of the Accident & Emergency Department in the morning. Members noted the update that no concerns had been escalated by Ward and Senior Nurses indicating that services were not safe to start, and that in the morning meetings assurance was sought that areas were appropriately staffed and that key quality metrics reviewed. R Hughes suggested that a report is provided to the next meeting outlining how the Health Board is further strengthening the quality and safety elements of how the service operates on a day-to-day basis.

J Hehir drew attention to the never event referenced in the report and sought assurance that no harm had come to the patient. Members noted that the patient had been reviewed and would continue to be monitored and noted that steps were being put into place to ensure that an incident like this did not happen again.

In recognising L Mann's imminent departure from the Health Board, the Committee Vice Chair extended her thanks to L Mann for all of the work that she had undertaken in this area and for the support she had provided. The Committee Vice Chair added that she would be sorely missed within the Health Board when she leaves for her new role.

Resolution: The report was **NOTED**

Action: Report to be provided to the next meeting outlining how the Health Board was further strengthening the quality and safety elements of how the service operated on a day-to-day basis.

6.3.1 First Quality & Safety Report: Mental Health Care Group

A Llewellyn presented the first Quality & Safety report from the Mental Health Care Group and highlighted the key areas for Members attention.

The Committee Vice Chair made reference to the integrated patient record and questioned what the associated costs and timescales were likely to be. A Llewellyn advised that there had been some challenges in relation to WCCIS, which was the preferred method across Wales and advised that a report was being presented to the Executive Team on this matter for further discussion.

In response to a question raised by N Milligan as to whether there was Trade Union representation on the Quality Improvement Board, A Llewellyn advised that the establishment of this group is in its infancy, however the intention is that invites would be extended to Trade Union representatives in due course as appropriate.

P Roseblade welcomed the report and made reference to the Pereto chart contained on page 4 and added that it was interesting to see the makeup of the incidents that had occurred. A Llewellyn advised that this chart had been key to helping the Team develop their own quality dashboard given that the Health Board's integrated dashboard only required reporting against two of these metrics. J Sadgrove also welcomed the report which allowed for a targeted discussed on Mental Health services at the Committee.

The Committee Vice Chair extended her thanks to A Llewellyn for presenting a very clear and concise report.

Resolution: The report was **NOTED**.

6.3.2 Care Group Exception Reports

Members noted that the Integrated Locality Group Legacy Exception reports had been included as appendices to the Quality Dashboard report.

6.4 Report from the Chief Operating Officer

G Hughes presented the report and highlighted the challenges that the Health Board continues to face within Ophthalmology, the work undertaken by the Primary Care Team to address the recent cyber-attack on the ADASTRA system and the work being undertaken by Teams to strengthen assurance processes in relation to Cancer Services. Members noted that a deep dive into cancer performance would be presented to the Planning, Performance & Finance Committee in December and G Hughes advised that he would be happy to share this with Members for information if required.

G Hughes also extended his thanks to R Hughes and the Team for the reopening of the Minor Injuries Unit at Ysbyty Cwm Cynon. Members also noted the work being undertaken to address ambulance handover delays and the commitment in place from staff to address the issues being experienced.

The Committee Vice Chair advised that she noted the complexities outlined in the report and the work that was being undertaken to address the issues.

P Roseblade advised that whilst she recognised the difficulties in resolving some of these issues, she felt that the report provided reassurance as opposed to assurance and added that the report was not clear on the expected actions and outcome measures, particularly within Ophthalmology. P Roseblade added that whilst she recognised that In Committee updates had previously been provided to the Committee regarding ophthalmology, Independent Members were required to hold the organisation to account as part of their role.

P Roseblade further advised that as there was no update contained within the report in relation to red release it was challenging for Committee Members to be assured that a plan was in place. G Hughes advised that this information was being presented to the Planning, Performance & Finance Committee and added that the same report could be shared with the Quality & Safety Committee if Members would find that helpful. Members noted that work was being undertaken to develop an overarching dashboard for Improving Care. J Sadgrove suggested that further discussion is undertaken outside the meeting on reporting to Planning, Performance & Finance Committee and the Quality and Safety Committee as whilst duplication should be avoided between Committees this should be balanced with Members being provided with sufficient information/evidence to allow for detailed scrutiny and gaining of assurance.

In response to a question raised by D Jouvenat in relation to discharge lounges and what impact these would have on the issues being experienced regarding discharge delays, G Hughes provided assurance that this was a very successful model which used to be in place previously and would be used for patients who were waiting for ambulances to transfer them home. Members noted that this system was already in place at Prince Charles Hospital.

In response to a question raised by R Myles in relation to self-presenting patients and the possible reasons as to why they were self-presenting, G Hughes advised that there were a variety of reasons which included family members conveying their relatives to hospital if they were unable to wait for an ambulance as a result of ambulance delays, with some patients opting to access healthcare through presenting themselves at the Emergency Department directly. L Edwards advised that work was being undertaken to determine why patients were presenting themselves later for treatment, particularly within Stroke Services.

The Committee Vice Chair extended her thanks to G Hughes for presenting the report and added that she was fully appreciative of the work that was being undertaken.

Resolution: The report was **NOTED.**

Action: Further discussion to be undertaken outside the meeting on reporting to Planning, Performance & Finance Committee and the Quality and Safety

Committee as whilst duplication should be avoided between Committees this should be balanced with Members being provided with sufficient information/evidence to allow for detailed scrutiny and gaining of assurance

6.5 WHSSC Quality & Patient Safety Committee Chairs Report

D Jouvenat presented the report and advised that reassurance was provided to WHSSC that the Quality & Patient Safety Committee Chairs Reports were being shared with the Health Board's Quality & Safety Committee. The Committee Vice Chair advised that she was pleased to hear that positive feedback was shared in relation to Cwm Taf Morgannwg.

Resolution: The report was **NOTED.**

6.6 Learning from Mortality Reviews

D Hurford advised Members that the Health Board had a very robust mortality review process in place.

E Flavell presented Members with the report and highlighted the key matters for Members attention.

The Committee Vice Chair welcomed the report and queried whether more staff would be needed to undertake this work moving forwards. D Hurford advised that all Doctors were given Supporting Professional Activities (SPA) time to undertake other pieces of work and added that a mandate would be introduced which would mean that every Doctor would need to undertake one mortality review as part of their SPA each year and advised that this would be cost neutral to the Health Board.

J Hehir advised that mortality reviews were helpful in regards to duty of candour as the reviews would identify what had happened and that lessons had been learnt and shared, which would help in time to reduce the number of concerns being received.

In response to a question raised by P Roseblade as to what process was in place for the review of discharge notes to determine whether they were accurate, D Hurford advised that the reviews were undertaken by the Medical Examiner service who review whether the discharge was appropriate or not.

Resolution: The report was **NOTED.**

6.7 Quality Strategy

L Edwards presented the Quality Strategy and advised that an earlier draft had previously been endorsed by the Committee. Members noted that some typographical errors had been identified prior to the meeting which would be addressed.

Resolution: The Quality Strategy was **ENDORSED**

6.8 Civica – People's Experience Feedback System

S O-Brien presented the report which provided an update on progress made to date in relation to the implementation of the Civica system.

In response to a question raised by N Milligan in relation to the heat map and the benchmark that had been set of 85, J Oliver advised that this was a benchmark being used across Wales and advised that this needed to be considered in the context of the number of surveys that had been completed.

N Milligan advised that if the heat map was taken at face value, it showed that the Health Board was failing to meet the fundamentals of care and added that it was not evident what the Health Board were doing to address some of the issues identified. S O'Brien advised that an action plan can be entered into the system which could be updated by staff and would enable observation of progress being made against the action plan. S O'Brien added that whilst the feedback responses from patients was improving, the use of the system to record patient feedback needed to be maximised.

In response to a question raised by P Roseblade as to the reasons behind the poor data recorded during September, J Oliver advised that the Health Board was very much reliant on engagement from patients and families and added that alternative methods for requesting feedback were being considered.

J Hehir advised that moving forwards it would be helpful if a run rate could be included in the report to help identify themes and issues. S O'Brien advised that the report had been presented to the Committee to highlight the potential of the system and added that regular updates would be presented to the Committee on progress made.

Resolution: The report was **NOTED**.

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

A Llewellyn presented the report.

Resolution: The report was **NOTED**.

6.10 Ward Based Nursing Assurance Report

R Gammon presented the report and highlighted the key matters for the attention of the Committee.

N Milligan advised that she was pleased to hear that plans would be shared with ward and departmental staff as appropriate and sought clarity as to how compliance around documentation would be measured. R Gammon advised that the welsh nursing care record had not yet been rolled out to all areas and added that steps would need to be taken to move away from paper-based documentation and there would be a need to ensure that everyone was using the same documentation.

The Committee Vice Chair extended her thanks to R Gammon for presenting the report.

Resolution: The report was **NOTED**.

6.11 Welsh Ambulance Services NHS Trust Patient Experience Report

Due to the potentially identifiable information within the report, members noted that this report would now be discussed at the In Committee session taking place on 17 November 2022.

7. ANY OTHER BUSINESS

P Roseblade referenced the recent learning from Healthcare Inspectorate Wales (HIW) following a visit to a site in Aneurin Bevan Health Board and noted the lessons identified particularly in terms of controlled drugs and sought assurance from the Health Board as to the use and management of this area of activity via a report to the next meeting

Action: Report to be presented to the next meeting in relation to the position regarding the use of controlled drugs.

8. HOW DID WE DO IN THIS MEETING TODAY?

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

P Roseblade advised that noting the comments made by G Hughes earlier in the meeting in relation to sharing of reports that had been presented to other Committee's, it was important that duplicate reports were not shared between Committee's and added that the Quality & Safety Committee would require assurance on Quality & Safety issues as opposed to performance issues. Members noted that this would be discussed further outside the meeting.

Action: Discussion to be held outside the meeting in relation to duplication of reports to Committee meetings

9. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 1.30pm on Tuesday 24 January 2023.

Agenda Item Number: 3.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 17 November 2022 as a Virtual Meeting via Microsoft Teams

Members Present:

Jayne Sadgrove	Vice Chair of the Health Board (Committee Chair)
James Hehir	Independent Member
Nicola Milligan	Independent Member
Carolyn Donoghue	Independent Member
Patsy Roseblade	Independent Member
Dilys Jouvenat	Independent Member

In Attendance:

Lauren Edwards	Executive Director of Therapies & Health Sciences
Hywel Daniel	Executive Director for People (In part)
Gethin Hughes	Chief Operating Officer
Debbie Bennion	Deputy Executive Director of Nursing
Sallie Davies	Deputy Executive Medical Director
Cally Hamblyn	Assistant Director of Governance & Risk
Louise Mann	Assistant Director Quality, Safety & Safeguarding
Chris Beadle	Head of Health, Safety & Fire
Stephanie Muir	Assistant Director, Concerns & Claims
Sarah James	Deputy Chief Operating Officer
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

1.2 Apologies for Absence

Apologies for absence were received from:

- Greg Dix, Executive Director of Nursing
- Kelechi Nnoaham, Executive Director of Public Health
- Dom Hurford, Medical Director
- Carl Verrecchia, Care Group Service Director
- Ana Llewellyn, Care Group Nurse Director

1.3 Declarations of Interest

No declarations of Interest were received prior to the meeting.

2 MAIN AGENDA

2.1 Patient Falls and Absconsions: Lessons Learnt Report

The Committee Chair advised Members that a meeting had been held with relevant Executive Leads where it was agreed that this and future updates to Committee would focus upon the patient safety aspects of the learning from absconsions and the management of the risks in these areas.

L Mann shared a presentation with Members which outlined the work being undertaken to prevent any further absconsion incidents. The following key points were noted by Members:

- A Health Board wide Absconsions Policy and Strategy were being developed with work being undertaken in the interim to manage the position until the Policy had been finalised;
- Areas of particular concern have been identified and targeted attention will be placed in these areas.
- The lead Executive is the Executive Director of Nursing.
- The action plan that had previously been developed in response to the HSE investigation would be aligned with this piece of work as appropriate.

A detailed discussion was held by Members and it was agreed that a further update would need to be presented to the Committee which provided further assurance on the progress being made.

The Chief Operating Officer also agreed to undertake a review of the processes in place for patients who report to Accident & Emergency with head injuries and then leave the department before they have been seen by a Clinician. G Hughes agreed to present an update at a future meeting of the Committee.

Resolution: The presentation was **NOTED**.

Action: Further update to be presented to the Committee on progress being made with this piece of work

Action: Report to be presented to a future meeting of the Committee outlining the processes in place for patients who report to the A&E department with a head injury and then leave the department before being seen by a Clinician.

2.2 Welsh Risk Pool and Legal Services Annual Review - CTMUHB

S Muir presented the report. Members recognised the challenging resource position in the Concerns Function and the significant impact this is having on the timeliness and ability to respond and manage concerns raised through the Putting Things Right Regulations under redress. It was noted that this position is resulting in cases being transferred and progressed via the claims route resulting in further delays for those raising concerns and increased financial pressures for the Health Board. Members noted that the operational aspects in terms of resourcing is for the Executive Leadership Group to consider, however

the Committee has a role in terms of strategic oversight and assurance that this risk is being managed.

Members noted that the Health Board was comparable with similar sized organisations in regards to the data contained within the report and noted that improvements could be made in relation to learning from incidents.

The Committee Chair extended her thanks to S Muir for presenting the report and advised that the Committee noted the issues being experienced in relation to the closure of redress cases.

Resolution: The report was **NOTED**.

2.3 WAST Patient Experience Report

D Bennion presented the report and highlighted the key matters for the attention of the Committee.

Following concerns raised by Committee Members, a detailed discussion was held in relation to the poor performance against red release at the Princess of Wales Hospital. G Hughes advised that significant work was being undertaken to address the issues and agreed to provide a detailed update to the next In Committee Session.. Members noted that the possibility of an additional session before the next planned meeting in January would be explored.

Resolution: The report was **NOTED**.

Action: Further update to be presented to an In Committee Session on the actions being undertaken to address red release performance at the Princess of Wales Hospital.

3. ANY OTHER BUSINESS

The Committee Chair extended her thanks to L Mann for all of the support she had provided to the Quality & Safety Committee and wished her good luck in her new role.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on Monday 30 January 2023 at 2.30pm

AGENDA ITEM
3.1.3

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL CYCLE OF BUSINESS

Date of meeting	24 January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Corporate Governance
Approving Executive Sponsor	Chief Executive
Report purpose	FOR APPROVAL

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 The Cycle of Business covers the period 1 January 2023 to 31 December 2023.

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

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

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

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

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Committee is asked to APPROVE the Committee Cycle of Business.

Quality & Safety Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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

The Cycle of Business covers the period 1st January 2023 to 31st December 2023.

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

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

Quality & Safety Committee Cycle of Business (1st January 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	16 May 2023	June 2023	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Action Log	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Report	Director of Corporate Governance	Annually					✓							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually	✓											
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually					✓							
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	✓		✓		✓		✓		✓		✓	
WHSSC Quality & Patient Safety Committee Annual Report	Director of Corporate Governance	Annually							✓					
Putting Things Right Annual Report	Director of Corporate Governance	Annually							✓					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually	✓											
Health & Care Standards Annual Report	Director of Nursing	Annually											✓	
Welsh Ambulance Services NHS Trust Patient Experience Report	Director of Nursing	Quarterly	✓				✓				✓			
Infection, Prevention & Control Committee Exception Reports	Director of Nursing	As and when required												
Infection, Prevention & Control Report (Annual Report and Mid-Year Update)	Director of Nursing	Bi-Annually			✓						✓			

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	16 May 2023	June 2023	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Quality Governance – Regulatory Review Recommendations and Progress Updates (to include Healthcare Inspectorate Wales, Delivery Unit, Community Health Council)	Director of Nursing	All regular meetings when needed	✓		✓		✓		✓		✓		✓	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					✓							
Cancer Services Annual Report	Medical Director	Annually					✓							
Prescribing Annual Report	Medical Director	Annually											✓	
RADAR Committee Highlight Reports (Annual Report and Mid-Year Update)	Medical Director	Bi-Annually			✓						✓			
Clinical Audit Quarterly Report	Medical Director	Quarterly			✓				✓				✓	
Clinical Audit Annual Plan	Medical Director	Annually			✓									
Clinical Education Annual Report	Director of Nursing	Annually											✓	
Individual Patient Funding Request Annual Report	New Chair being appointed	Annually							✓					
Health, Safety & Fire Sub Committee Highlight Reports	Director for People	Quarterly			✓				✓				✓	
Radiation Safety Committee Highlight Reports	Director of Therapies & Health Sciences	Bi-Annually			✓						✓			
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			✓						✓			
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	✓						✓					
Ombudsman's Annual Letter	Director of Nursing	Annually									✓			
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					✓						✓	
GOVERNANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Welsh Risk Pool Review of Claims, Redress Cases and Inquests – Progress Against the Action Plan	Director of Nursing	Quarterly	✓				✓				✓			
IMPROVING CARE														
Maternity & Neonates Services Improvement Programme	Director of Nursing/Medical Director	All regular meetings	✓		✓		✓		✓		✓		✓	
Quality Dashboard to include: • Delivery Unit Performance Dashboards; • Care Group Quality & Safety Highlight Reports; • Updates from the Shared Listening & Learning Forum	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	16 May 2023	June 2023	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Care Group Spotlights Presentations	Director of Nursing/Chief Operating Officer	All regular meetings *(2x Care Groups per meeting)*	✓		✓		✓		✓		✓		✓	
Thematic Spotlight Presentations	Director of Nursing/Chief Operating Officer	All regular meetings as required	✓		✓		✓		✓		✓		✓	
Report from the Chief Operating Officer *(to include Planned Care Improvement Programme Progress Report (to include Follow Up Outpatients Not Booked and Harm Reviews)*	Chief Operating Officer	All regular meetings	✓		✓		✓		✓		✓		✓	
Stroke Services Progress Report	Director of Therapies & Health Sciences	Bi-Annually			✓						✓			
Mortality Indicators and Mortality Reviews	Director of Public Health/Medical Director	Bi-Annually			✓								✓	
Ty Llidiard Progress Reports	Director of Therapies & Health Sciences	All regular meetings	✓		✓		✓		✓		✓		✓	
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually							✓					

AGENDA ITEM
3.1.4

QUALITY & SAFETY COMMITTEE

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

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Chief Executive
Report purpose	ENDORSE FOR BOARD APPROVAL

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

ACRONYMS	
SO's	Standing Orders

1. SITUATION/BACKGROUND

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

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

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

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

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

Whilst the Terms of Reference were approved by the Committee and then Board in November 2022, further amendments needed to be made, mainly in relation to Committee attendance.

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

3.1 If endorsed for approval the amendments will be received for approval at the Health Board meeting in March 2023.

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

4. IMPACT ASSESSMENT

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

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

5. RECOMMENDATION

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

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

Schedule 3.8

BOARD COMMITTEE ARRANGEMENTS

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

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

Review January 2023

INTRODUCTION

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

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

CONSTITUTION & PURPOSE

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

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

The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.
- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.

- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

SCOPE AND DUTIES

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

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

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

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

Strategy

- Oversee and monitor the development and implementation of the UHB's Strategies for patient quality and safety and staff workplace health & safety:
  - **Patient Quality and Safety**
    - Provide assurance to Board on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for CTMUHB
    - Provide assurance to the Board in relation to the Quality Governance Framework.
    - Contribute to and oversee the development of the Health Board's Annual Quality Statement
    - Monitor quality via the Quality Dashboard
    - Approve the content of the CTMUHB Annual Quality Statement which relates to the committees work programme
  - **Workplace Health & Safety**

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

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

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

Policies and Procedures
- Approve appropriate Policies (once reviewed and endorsed by the appropriate sub group) and where appropriate any related Procedures.

- Oversee the register of policies, ensuring that it is maintained, and that all assigned policies are subject to review at least every three years.

~~**Research & Development**~~

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

Commented [CH(U-CG1]: Research & Development activity will now be reported via the Population Health & Partnerships Committee and has been included within their Terms of Reference.

Quality Improvement activities

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

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

Patient Experience

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

Concerns

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

Staff Experience

- Receive assurance that there are appropriate systems in place to support workplace health & safety and to listen to staff views, embracing the principles of the Listening Organisation, in order to promote effective team working

and staff satisfaction to provide the best possible outcomes for patients.
- Receive assurance that the workforce is appropriately selected, trained and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained.

DELEGATED POWERS

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

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.

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

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

Sub Committees
The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

The Quality & Safety Committee has established the following sub-committee:
- Health, Safety and Fire Sub Committee

This Sub Committee supports the Health Boards statutory obligation by virtue of the Health and Safety at Work etc. Act 1974 (Section two sub-section seven) to establish and maintain a Health and Safety

Committee*: "it shall be the duty of every employer to establish in accordance with Regulations (i) a safety committee having the function of keeping under review measures taken to ensure the health and safety of his employees and such other functions as prescribed".*

ACCESS

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

MEMBERSHIP

Members:

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

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

Attendees

- Executive Nurse Director
- Executive Medical Director
- Executive Director of Public Health
- Executive Director of Therapies and Health Sciences
- Executive Director for People
- Chief Operating Officer
- Director of Corporate Governance / Board Secretary
- Deputy Executive Director of Nursing
- Assistant Director of Governance & Risk
- Assistant Director of Quality & Safety
- Care Group Nurse Director / Medical Director
- Community Health Council Representative
- Staff side representative
- ~~Staff side safety chair or vice chair~~

Commented [CH(U-CG2]: Staff Side Safety Chair/Vice Chair is a member of the Health, Safety & Fire Sub Committee so not required for attendance at the Quality & Safety Committee.

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

By Invitation:

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

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

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

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

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

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Corporate Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and

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

COMMITTEE MEETINGS

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

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

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

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

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

Circulation of Papers

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

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

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

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

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

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

The Director of Corporate Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

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

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

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

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

- sharing of information

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

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

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

CHAIR'S ACTION ON URGENT MATTERS

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

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

REVIEW

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

ACTION LOG QUALITY & SAFETY COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at January 2023)
6.1	19 July 2022	**Response to 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability** Progress report to be presented to the Committee in six months.	Director of Primary, Community & Mental Health Services	January 2023	**On agenda** On agenda for the 24 January 2023 meeting.
6.3	19 July 2022	**Quality Dashboard** Committee Members to reflect on what areas they would like future Spotlight Reports to focus on.	Committee Members	September 2022 Now January 2023	**In progress** Members will be asked at the end of discussion on the Quality Dashboard report what area they would like to spotlight on the for the next meeting
6.1	15 November 2022	**Maternity Services & Neonates Improvement Programme** Abbreviations to be explained in the next iteration of the report. Updates in relation to the processes in place for women experiencing ectopic pregnancies and the	Director of Midwifery / Deputy Medical Director	November 2022 Now January 2023	**On agenda** Report on the agenda for the January 2023 meeting and includes the relevant updates.

		Gynaecology Pathway to be shared at the next meeting.			
5.3	20 September 2022	**Monitoring Continuing Healthcare and Funded Nursing Care Activity** Further update to next meeting	Nurse Director, Bridgend Locality	November 2022 Now January 2023	**On agenda** On agenda for the January 2023 meeting
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	Ongoing	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Medical Director to ensure interim timelines were put	Medical Director	January 2023	**In progress** In recognising similar themes with this risk and the Nursing Workforce risk the Medical Director is going to link in with the Director of

		into place for the Task & Finish Groups referred to in relation to Risk 4080.			Nursing and Director for People to consider reframing this risk altogether and as part of that process will ensure that any mitigating actions are set out clearly with agreed timeframes.
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Update to be sought from the Risk Lead in relation to Risk 4512, Care of Patients with Mental Health Needs on the Acute Wards as to how the scoring against this risk would be reduced and what had changed to reduce the scoring	Nurse Director – Mental Health Care Group	24 January 2023 Now 16 March 2023	**In progress** The Assistant Director for Governance & Risk will raise this action with the new Care Group Service Director at the end of January 2023 when they are planned to meet.
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Report to be presented to a future meeting of the Committee in relation to progress being made to address the Learning From Events backlog.	Assistant Director of Concerns and Claims	24 January 2023	**On agenda** Report is on the agenda for the meeting taking place on 24 January 2023

5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Update to be provided to a future meeting of the Committee in relation to progress being made in relation to the Welsh Community Care Information System.	Nurse Director – Mental Health Care Group	16 March 2023	**In progress** Report to be developed for the March 2023 meeting. Added to the forward work programme.
5.2	15 November 2022	**Datix Cymru Assurance Report** Update to be provided to a future meeting to determine whether issues being experienced were as a result of coding issues or staff training issues.	Head of Concerns and Business Intelligence	24 January 2023	**In progress** Report being prepared for the January 2023 meeting. Forward work programme updated
6.3	15 November 2022	**Quality Dashboard** Report to be provided to the next meeting outlining how the Health Board was further strengthening the quality and safety elements of how the A&E service operated on a day-to-day basis.	Assistant Director of Quality & Safety	24 January 2023	**In progress** Verbal update to be provided to the Committee in January 2023 as part of the Quality Dashboard report. Written report to be presented to the March 2023 meeting.
6.4	15 November 2022	**Report from the Chief Operating Officer** Further discussion to be undertaken outside the meeting on reporting to	Assistant Director of Governance & Risk	January 2023 Now March 2023	**In Progress.** Exploring with Executive Leads how we ensure reports retain the relevant Committee focus i.e. PPF Committee focusses upon

		Planning, Performance & Finance Committee and the Quality and Safety Committee as whilst duplication should be avoided between Committees this should be balanced with Members being provided with sufficient information/evidence to allow for detailed scrutiny and gaining of assurance			activity and Performance & Q&S Committee focusses upon the quality/harm aspects etc to avoid duplication – understanding that there is a balance around the right information and the right time.
7	15 November 2022	**Any Other Business** Report to be presented to the next meeting in relation to the position regarding the use of controlled drugs.	Medical Director	March 2023	**In progress** Added to the forward work programme for March 2023
9	15 November 2022	**How Did we do in this meeting today?** Discussion to be held outside the meeting in relation to duplication of reports to Committee meetings	Assistant Director of Governance & Risk	January 2023 Now March 2023	**In Progress.** Exploring with Executive Leads how we ensure reports retain the relevant Committee focus i.e. PPF Committee focusses upon activity and Performance & Q&S Committee focusses upon the quality/harm aspects etc to avoid duplication – understanding that there is a balance around the right information and the right time.

PREVIOUSLY REPORTED Completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at January 2023)
7.8	November 2021	**Maternity & Neonates Services Improvement Programme Report** Discussion to be held with P Roseblade outside the meeting regarding the assurance chain that was currently in place.	Committee Chair	January 2022	**Completed** We are now transitioning from MNIB into business as usual processes for improvement
5.1	24 May 2022	**Organisational Risk Register** Health, Safety & Fire Sub Committee Annual Report to be presented to a future meeting of the Committee. Annual Report to include a summary of all the fire risks contained within the risk register	Director for People	November 2022	**Completed** - HS&F sub Committee Annual Report on Q & S agenda for meeting on 15th November 2022.
5.1	24 May 2022	**Organisational Risk Register** Review to be undertaken outside the meeting regarding risks 816 and 3698 which had both been on the risk register for some time.	Director of Corporate Governance	July 2022	**Completed** The September Organisational Risk Register noted the following updates in relation to these risks: • 816 - this risk was approved for removal from the from the ORR (but will remain on the service risk register) as

					it is captured in the overarched planned care recovery risk 4491. COO Reviewed 7.9.2022. • 3698 – to close as duplicate risk of 3788. • 3788 - Update 4.11.21: CNS post has been appointed to, awaiting start date. A meeting to be held on 17th November to discuss further options of support to the waiting list. Update: CNS now in post. Plans to recommence around repatriation of the SLA with SB UHB for April 23. Risk has been reduced to a 12.
6.1.4	24 May 2022	**Maternity Metrics Report** Focus to be placed at the next meeting on progress being made in relation to pace of change and improvements being made within Neonatal Services.	Deputy Medical Director	July 2022	**Completed** Report discussed at the July 2022 meeting
6.7	24 May 2022	**Response to 'Improving Care, Improving Lives' National Care Review for**	Director for Primary, Community &	July 2022	**Completed** Report discussed at the July meeting

		Inpatients with a Learning Disability The report to be deferred to the July meeting for further discussion.	Mental Health Services		
3.2.11	19 July 2022	**Individual Patient Funding Request Panel (IPFR) Annual Report** Update to be provided as to whether a clinical representative had now been secured for the IPFR panel	Director of Public Health	September 2022	**Completed** Confirmation provided that the Locality Director for Nursing at Merthyr & Cynon ILG has agreed to attend the All Wales IPFR Panel
6.2	19 July 2022	**Maternity & Neonates Improvement Programme Highlight Report** Revised target dates to be identified against actions where target dates have slipped.	Director of Midwifery	September 2022	**Completed** Revised target dates included within this report
6.3	19 July 2022	**Quality Dashboard** Delivery Unit Dashboards to be appended to the Quality Dashboard moving forwards	Assistant Director of Quality & Safety	September 2022	**Completed** Dashboards have now been included as appendices to the Quality Dashboard Report.
6.5	19 July 2022	**Chief Operating Officer's Report** Spotlight Report to be presented to the next meeting of the Committee on the pressures being experienced within the Emergency Departments.	Assistant Director of Quality & Safety	September 2022	**Completed –** Included as an appendix to the Quality Dashboard Report for Sept 2022 meeting
6.5	19 July 2022	**Chief Operating Officer's Report**	Chief Operating Officer	September 2022	**Completed** Action Plan shared with Committee Members by email on 23 November 2022.

		Updated Ophthalmology Action Plan to be shared with Members			
6.5	19 July 2022	**Chief Operating Officer's Report** Communication and listening issues with staff working in the Emergency Departments to be discussed with the Integrated Locality Group	Chief Operating Officer	September 2022	**Completed** Weekly informal catch up sessions held with the Emergency Department Senior Consultants and Deputy Chief Operating Officer. Weekly Task & Finish Groups are also held with ED as part of the 6 Goals programme of work. The newly appointed Clinical Director will also contribute to senior communication into all Emergency Departments across the Health Board.
6.6.4	19 July 2022	**Primary Care Quality & Safety Report** Confirmation to be provided outside the meeting regarding the position with Church Street Dental Practice in Merthyr Tydfil and whether they are accepting any NHS patients.	Primary Care Clinical Director	September 2022	**Completed** Confirmation provided outside the meeting that Church Street in Merthyr Tydfil have handed back their NHS contract and letters have been issued to the patients. On further investigation, this was one of the practices that the Health Board were aware of and the Primary Care Quality & Safety report should have stated Merthyr instead of Aberdare.

					For assurance this is a small practice and all the NHS patients will be able to be taken on by neighbouring NHS dental practices.
5.1	19 July 2022	**Organisational Risk Register** Response to be provided to Committee Members outside the meeting regarding the queries raised against some of the risks.	Director of Corporate Governance	September 2022	**Completed:** Response shared with Committee Members on 9 September 2022 regarding Risks 4887, 4721, 1133 and 5014
2.1	20 September 2022	Update on implementation of the CIVICA system to be added to committee forward work plan.	Assistant Director of Quality & Safety	November 2022	**Completed:** On agenda for November 2022.
2.1	20 September 2022	Letter on behalf of the Committee Chair to be sent to those involved in the Patient Story to formally thank them for sharing their patient experience with the Committee	Assistant Director of Nursing & Peoples Experience	November 2022	**Completed** Verbal thank you extended to those involved in sharing their patient experience with Committee members.
5.1	20 September 2022	Organisational Risk Register - Q & S Committee risks : • Update on risk status of the CTMUHB laundry service	Chief Operating Officer / Deputy Chief Operating Officer	November 2022	**Completed:** Update on risks shared (with Committee Members and attendees) via email on 3rd November 2022

		• Risk 4149 – update required on the impact from the mitigating actions in relation to waiting lists and additional clinics • Risk 4512 - update on the current status and further detail as to the mitigations that were working well.			
6.6	20 September 2022	**Primary Care Quality & Safety Report** Confirmation to be provided as to whether dental patients had been contacted to confirm their revised dental practice allocation following their previous practice no longer accepting NHS patients.	Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities)	November 2022	**Completed** Confirmation received that all patients have been written to informing them of alternative access to dental service.
6.6	20 September 2022	**Primary Care Quality & Safety Report** Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities) to write on behalf of the Committee Chair to the Out of Hours service manager to acknowledge their work following national IT outages	Deputy COO (Primary Care, Community, Mental Health and Learning Disabilities)	November 2022	**Completed** Letter drafted and sent to the Head of Urgent Primary Care.
6.7	20 September 2022	**Stroke Services Progress Report** Update due in six months	Executive Director, Therapies and Health Sciences	March 2023	**Completed** Report to be presented to the March 2023 meeting. Added to the Cycle of Business

5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Risk Score allocated to Risk 5267 to be reviewed against the risk score allocated against the medical workforce risk.	Deputy Director of Nursing	24 January 2023	**Completed** Review undertaken and risk score has been amended to 20 and the risk narrative has been updated within the risk register
5.4	15 November 2022	**Infection, Prevention & Control Committee Highlight Report** Confirmation to be provided outside the meeting as to whether reduction of capacity issues being experienced within the Laundry Service was having an impact on Infection, Prevention and Control.	Deputy Director of Nursing	January 2023	**Completed** Confirmation provided to Members outside the meeting on 3 January 2023 by email that the Lead Infection, Prevention & Control Nurse has confirmed that she was not aware of any issues related to the report of reduced capacity at the laundry.

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

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

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request from the Director of Corporate Governance following discussion held at Health, Safety & Fire Sub Committee raising this as an area of concern	Additional Item	Datix Cymru – Assurance Report	Director of Corporate Governance	Report presented to the November 2022 meeting. Further assurance report to be presented to the January 2023 meeting. **On agenda**
Actions agreed at the September Quality & Safety Committee – Request made by the Committee Chair	Incorporated into Maternity and Neonatal Update	• Report on processes in place for women who are experiencing ectopic pregnancies • IMSOP Publication • Gynaecology pathway	Director of Nursing	Planned for January 2023 **– On agenda**
Request from the Chair following MHAMC Agenda Planning	Item Deferral as MHAM Committee only monitors the application of the MH Act.	Update on the new Liberty Protection Standards	Director of Nursing	Planned for January 2023 – **On agenda**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Request from Strategic Planning & Commissioning Manager	Item deferred from November to January to allow for consultation period.	CYP 16-17 year's Acute Admission Policy – For Approval.	Strategic Planning & Commissioning Manager	Planned for January 2023 **– Now deferred to March 2023 to allow for formal consultation to be undertaken on the policy**
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Learning From Events Backlog – Progress Report	Assistant Director of Concerns & Claims	Planned for January 2023 **– On agenda**
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Quality Dashboard. Report to be provided to the next meeting outlining how the Health Board was further strengthening the quality and safety elements of how the A&E service operated on a day-to-day basis.	Assistant Director of Quality & Safety	Planned for January 2023 **– On agenda for the In Committee session taking place on 30 January 2023.**
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Report to be presented to the next meeting in relation to the position regarding the use of controlled drugs.	Medical Director	Planned for March 2023
Email request received from the Director of Nursing on 30 December 2022	Additional Item	Macmillan Wales Cancer Patient Experience Survey – Briefing Note	Director of Nursing	Planned for March 2023

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request received from the Head of Corporate Governance & Board Business	Additional Item	Independent Member Walkround Protocols	Director of Nursing	Planned for March 2023
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Welsh Community Care Information System Progress Report	Nurse Director – Mental Health Care Group/Director of Digital	Planned for March 2023

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Completed Activity From the Forward Work Programme:

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

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

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Additional report received by email from the Director of Midwifery	Additional Item	Maternity Services Self-Assessment against Maternity National Assurance Framework for Wales	Director of Nursing	27 July 2022 In Committee – **Completed**
Long standing action on Board Action Log. Agreement given by the Medical Director for a report to be shared with Quality & Safety Committee outlining the progress made against the plans	Additional Item	Safe, Sustainable and Accessible Emergency Medicine and Minor Injury and Illness Services for the People of Rhondda Taff Ely	Medical Director	19 July 2022 – An update on progress has been included in the Rhondda Taf Ely Integrated Locality Group report to the July meeting. **Completed**
Email request received from the Director of Corporate Governance	Additional Item	Learning From Events Report – Progress Update	Director of Corporate Governance	19 July 2022 – An update has been included as an appendix in the Quality Dashboard report - **Completed**
Email Request received from the Committee Chair	Additional Item	Neuro Development Disorder Services – Plans to Address Performance	Chief Operating Officer	20 September 2022 – Update included in the Chief Operating Officers Report. **Completed**

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

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request received from the Head of Planning & Commissioning	Additional Item	Transition and Handover from Children to Adults Health Services	Director of Strategy and Transformation	20 September 2022 – **Completed**
Email Request received from the Head of Assets, Governance & Technical Services	Additional Item	Estates Policy for Approval – PAT Testing Policy	Director of Finance	20 September 2022 – **Completed**
Email Request received from the Assistant Director Quality & Safety	Additional Item	Quality Strategy	Director of Therapies & Health Sciences	19 July 2022 – Completed and Ongoing **Completed** - Quality Strategy received and endorsed at the November 2022 meeting.
Email request from the Director of Nursing	Additional Item	Civica System - Progress Report and Report Examples	Director of Nursing	**Completed –** Report received at the November 2022 meeting
Email request received from the Committee Chair	Additional Item	CTMUHB peer review report and action plan	Chief Operating Officer	**Completed –** Report received at the November 2022 meeting.
Agenda Item agreed at the June Quality & Safety Committee Agenda Planning session	Additional Item	National Maternity & Neonates Assurance Tool	Director of Nursing/Deputy Medical Director	20 September 2022 Learning from Mortality Reviews is captured on the November 2022 agenda. **Completed** – Report received at the November 2022 Meeting

AGENDA ITEM
3.2.3

QUALITY & SAFETY COMMITTEE

SAFEGUARDING ANNUAL REPORT

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire O'Keefe – Head of Safeguarding
Presented by	Greg Dix – Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Safeguarding Executive Group	(23/01/2023)	The recommendation is to endorse for approval

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DoLS	Deprivations of Liberty Safeguards
LPS	Liberty Protection Safeguards
CTMSB	Cwm Taf Morgannwg Safeguarding Board

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg Safeguarding Board and Corporate Safeguarding Team for the Health Board produce an Annual Report every year. These reports are developed to summarise and inform

the public and other practitioners of Safeguarding activity throughout the year.

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

2.1 The Health Board's Safeguarding Annual Report (Appendix A) has been produced to give an overview of the safeguarding activity undertaken throughout the health board in 2021/22. The COVID pandemic resulted in Safeguarding practices being developed and adapted to address some of the increased safeguarding issues that were affecting the communities of CTM. The report demonstrates the effective leadership, commitment and operational support in all aspects of Safeguarding and Public Protection across Cwm Taf Morgannwg University Health Board and how the UHB complies with legislation, external standards and good practice guidance.

2.2 The Cwm Taf Morgannwg Safeguarding Board has produced an Annual Report for 2021/22; this has been produced to reflect multi-agency safeguarding activity across CTM. All partner agencies have contributed to the board work and worked collaboratively to meet the objectives of the Boards' safeguarding plans. This Annual Report presents an overview of the work that the Cwm Taf Morgannwg Safeguarding Board carried out in 2021/2022 in pursuit of the aim to ensure that the people of Cwm Taf Morgannwg are safeguarded from abuse, neglect or other forms of harm.

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

3.1 Sharing learning across Cwm Taf Morgannwg has continued to be a priority for both the Safeguarding Board and Health Board for this year. Action plans and recommendations from safeguarding statutory practice reviews need to be effectively disseminated across the Health Board for learning. It is anticipated that this will be achieved through the Safeguarding Executive and Safeguarding Operational Groups. In addition, CTMUHB also have a Listening & Learning Forum for wider cross Organisational sharing and a repository of learning available to all colleagues via our intranet.

3.2 Training compliance for the Health Board remains low for 2021/22; this is primarily due to the accessibility of training during the COVID pandemic. Many staff were re-deployed, resulting in other patient facing training taking priority. This has now been addressed with all training being reviewed, multi-agency and now being available on virtual platforms. In addition, the Corporate Safeguarding team are providing bespoke training for those who need it urgently due to the nature of their work or on identification of any need.

3.3 Referrals have continued to increase this year, particularly those relating to child protection concerns. This has placed additional pressures to deliver all training packages throughout the Health Board. It is vitally important that staff are aware of the increased risks to both children and adults. Therefore, other resources such as seven minutes briefings have been disseminated to share learning and good practice.

3.4 Throughout 2021/22 numbers have been consistent in respect of those people suffering from the effects of domestic abuse. With continued increased numbers of those suffering from mental health issues. In addition, several of our professional concerns involved staff who were victims or perpetrators of abuse. In partnership with Rhondda Cynon Taf Local Authority and through The Police Commissioners Office funding, The Health Board have a health Independent Domestic Violence Advisor based at its Royal Glamorgan Emergency Department. This person has facilitated further bespoke training, supported numerous patients and staff members to receive ongoing support. Further plans include, working collaboratively with other service groups to raise awareness and provide appropriate advice and support. This will ensure that staff have increased awareness of how to recognise and refer concerns identified around domestic violence, as well as better support to colleagues.

3.5 Compliance with Deprivation of Liberty Safeguards continues to feature on the risk register with a rating of 16. The delay in authorisation has resulted in patients being unlawfully deprived of their liberty. The implementation of the Liberty Protection Safeguards has been delayed and is now expected in October 2023. There is appropriate representation from CTMUHB at the All Wales Groups, this will ensure that CTMUHB's planning and preparation is in line with other Health Boards. Welsh Government funding has been successfully secured to recruit and increase resources in order to improve preparedness and clear the backlog of DoLS authorisations. The appointment of a Mental Capacity Act Practice Facilitator has enabled the team to support clinical areas and provide bespoke training to several General and Community hospital sites.

3.6 The Health Board's Safeguarding Maturity Matrix and Improvement Plan has been approved at the Safeguarding Executive Group and will address any matters highlighted within the Annual Report. The Improvement Plan can be made available to Committee Members upon request.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or whom it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The Annual Report's produced by the Corporate Safeguarding Team and Safeguarding Board provide an overview of Safeguarding Activity for the CTM region in 2021/22.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the report.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Annual Report
2021/22

Safeguarding & Public Protection

Standard 2.7

Safeguarding Children & Adults at Risk

Safe Care


Social Services & Well-being (Wales) Act 2014
Health & Care Standards Safe Care 2.7
Disclosure & Barring Service Code of Practice
Social Services & Well-being (Wales) Act 2014 Part 6 Looked After Children
Counter Terroism & Security Act 2015
Social Services & Well-being (Wales) Act 2014 Part 7 Safeguarding Children & Adults
Safeguarding People
Criminal Justice Act 2003
Children Acts 1989 & 2004
Female Genital Mutilation 2003 & Amended Serious Crimes Act 2015
Violence Against Women Domestic Abuse & Sexual Violence (Wales) Act 2015
Mental Capacity Act 2005 & Mental Health Act 2007
Well-being of Future Generations (Wales) Act 2015

The report demonstrates the effective leadership, commitment and operational support in all aspects of Safeguarding and Public Protection across Cwm Taf Morgannwg University Health Board and how the UHB complies with legislation, external standards and good practice guidance.

Assurances:

- To ensure that UHB meets its duties under Part 2 of the Well-being of Future Generations (Wales) Act 2015, in that the Sustainable Development Principle is applied and consideration is given to the impact of current decision making on people living their lives in Wales in the future.
- To ensure the UHB discharges its duties under the Social Services & Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 [Looked After Children] & Part 7 [Safeguarding Children & Adults at Risk].
- To ensure the UHB complies with section 47 [child protection investigations] of the Children Act 1989 and sections 25,27 and 28 [duty to cooperate to safeguard & promote welfare children] of the Children Act 2004;
- To ensure the UHB complies with the requirements as the Supervisory Body and Managing Authority for the Deprivation of Liberty Safeguards (DoLS) as outlined in the Mental Capacity Act 2005 and amended in the Mental Health Act 2007.
- To ensure the UHB discharges its duties as a Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency under s325 Criminal Justice Act 2003;
- To ensure the UHB discharges its duties under the Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 [develop and implement a local strategy with the Local Authority]
- To ensure the UHB complies with s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police].
- To ensure the UHB discharges its duties under the Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour].
- Oversee an on-going process of self-assessment and improvement against Safe Care Standard 2.7 of the Health & Care Standards in Wales;
- To provide assurance to the Board that arrangements to secure governance, risk management & internal control are suitably designed and applied effectively.

What does Safeguarding & Public Protection look like in CTMUHB?

Since April 2019 Cwm Taf Morgannwg Health Board incorporates the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a total population of almost 440,000. Services are also provided to those living within neighbouring authorities.

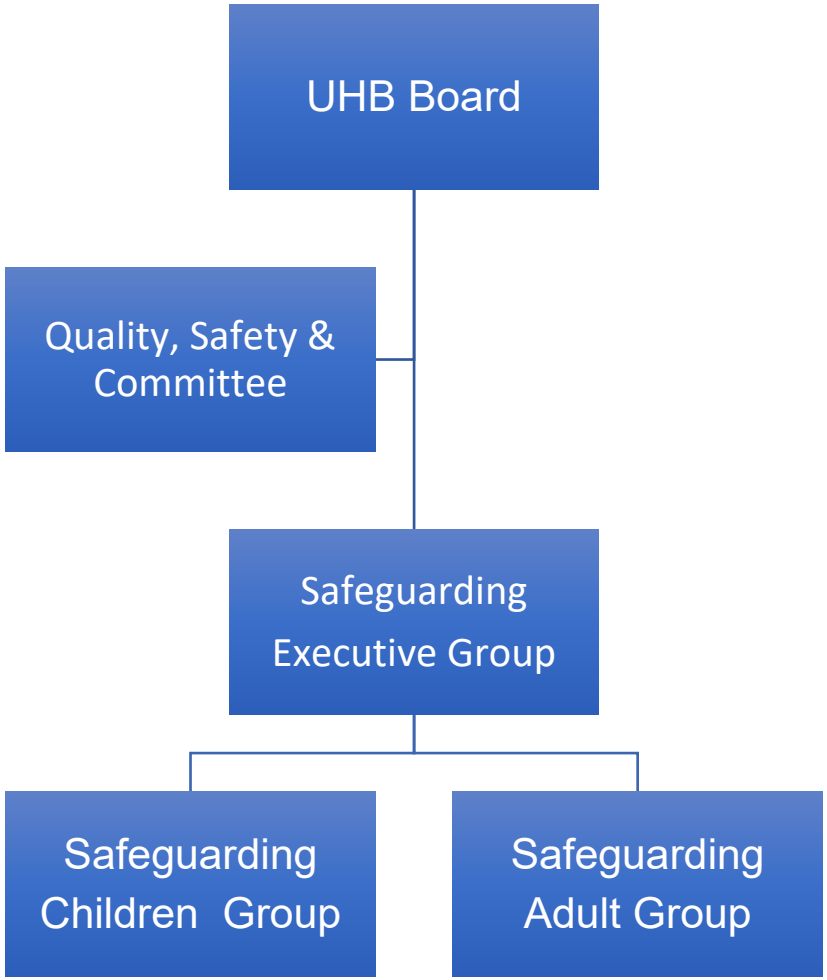
- **Safeguarding** in Cwm Taf Morgannwg involves working with our partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm and actively prevent them from becoming at risk of abuse, neglect or other kinds of harm.
- **Public Protection** seeks to protect, promote and improve the health, safety and well-being of our population across Cwm Taf Morgannwg.

Strategic Objectives for Safeguarding and Public Protection:

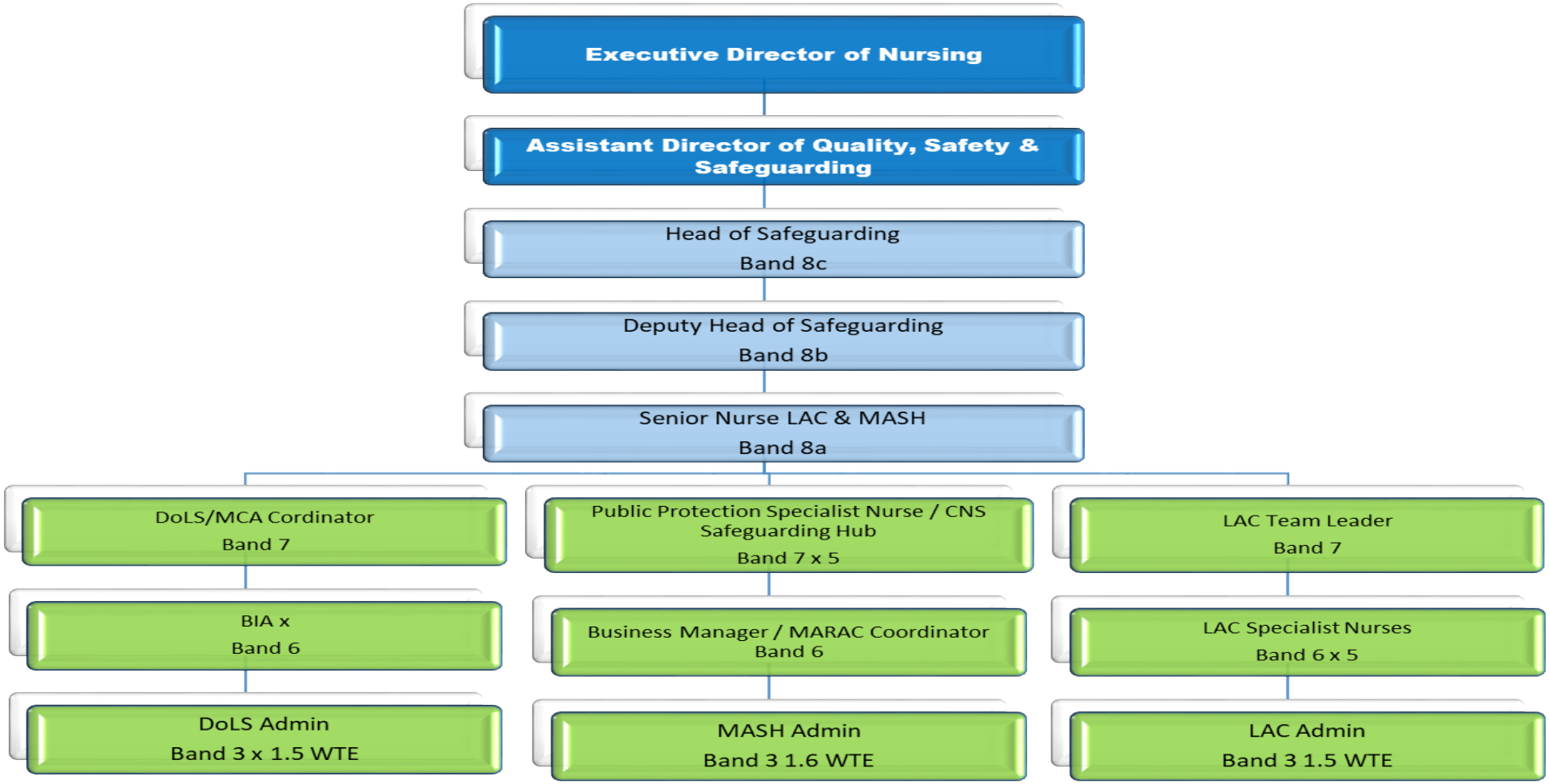
- There are effective measures in place to safeguard people and protect children and adults at risk.
- There is effective inter-agency co-operation in planning and delivering safeguarding and public protection services and in sharing information.

The UHB works within regional partnership arrangements.

CTMUHB Governance Arrangements & Reporting Structure



Corporate Safeguarding Team



Lead Roles in Safeguarding within CTMUHB

Executive Director of Nursing: UHB Executive lead for safeguarding

Assistant Director of Quality, Safety & Safeguarding: Assistant to the Director of Nursing and UHB executive lead for quality, patient safety and safeguarding.

Head of Safeguarding: Strategic lead responsibility for key aspects of the Health Board's Public Protection and Safeguarding Statutory Responsibilities

Deputy Head of Safeguarding: Operational lead responsibility for key aspects of the Health Board's Public Protection and Safeguarding Statutory Responsibilities

Senior Nurse Children Looked After Team & MASH: Oversee and line manage senior staff within both the Looked After Children's team and Multi-Agency safeguarding Hub.

Nurse Specialists Public Protection & MASH Business Manager: Work within the Cwm Taf Morgannwg Multi-Agency Safeguarding Hubs (MASH) in RCT and Bridgend.

Deprivation of Liberty Safeguards Team: Oversee the process within the UHB and undertake the responsibilities of the Supervisory Body.

Independent Board Member/Children's Champion: A member of the Safeguarding Executive Group.

Independent Board Member/Vulnerable Adults: A member of the Safeguarding Executive Group.

Other staff have specific responsibilities for safeguarding have clinical supervision by the Head or Deputy Head of Safeguarding.

Safeguarding Midwife: Midwife for Safeguarding Children.

Clinical Nurse Specialist: Child Protection Medical Hub at Royal Glamorgan Hospital.

Clinical Nurse Specialist for adoption.

Localities: Health visitors and school nurses receive their child protection supervision from five locality based specialist nurses for safeguarding children.

Named Doctor Child Protection: The Named Doctor is supported by two locality based consultant paediatricians who have dedicated sessions for child protection and who ensure peer supervision/review is available to their colleagues.

CAMHS: The Head of Nursing and the Senior Nurses across the Network have lead safeguarding responsibilities for their areas. CAMHS colleagues also receive supervision and safeguarding support from the nurse specialists for safeguarding children.

Adult Mental Health: The Criminal Justice and Forensic Mental Health Service provides specialist assessments, treatment advice and liaison services for service users who come into contact with criminal justice services. They represent the UHB at MAPPA meetings.

Safeguarding Children

Child Sexual Exploitation

Children Looked After

Adult at Risk

VAWDASV

DoLS

Mental Capacity Act

Radicalisation & PREVENT

Offender Management

Allegations Made Against Professionals

MASH

Training

Safeguarding Board

Safe Recruitment

Safeguarding Children

Our Aim

To ensure that children and young people in Cwm Taf, up to the age of 18, are protected from abuse, neglect or other kinds of harm and are prevented from becoming at risk of abuse, neglect or other kinds of harm and they live in an environment that promotes their wellbeing.

To ensure that the UHB complies with the related legislation and Procedures:

- Social Services & Wellbeing (Wales) Act 2014 – Part 7
- Children Acts 1989 & 2004
- Wales Safeguarding Procedures

How Will We Do This?

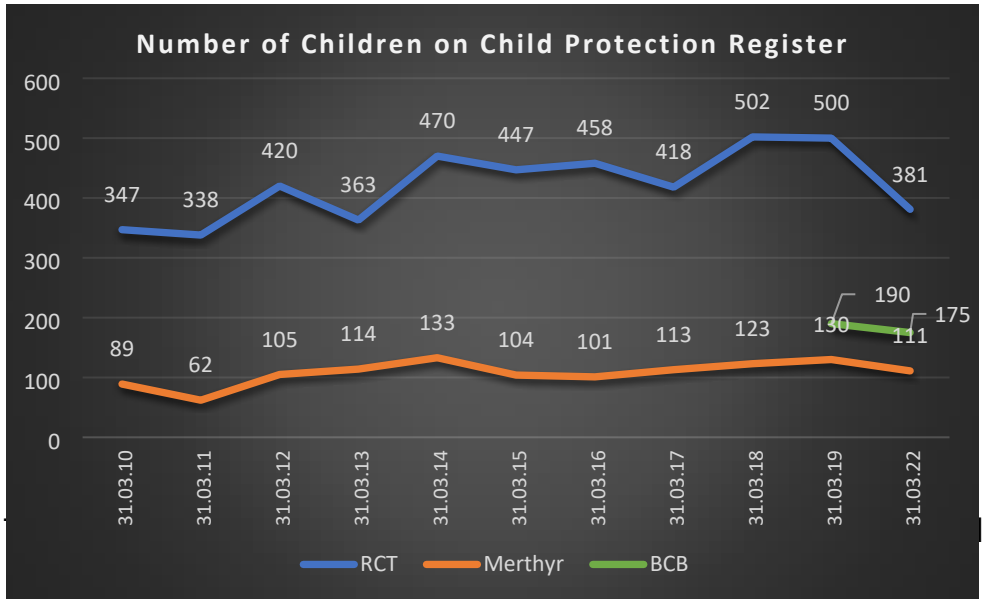
By ensuring that there are effective interagency safeguarding processes and practice in place, supported by robust quality assurance and information sharing systems.

Good communication across all disciplines of health and joined up working in respect of identifying learning.

What Did We Do?

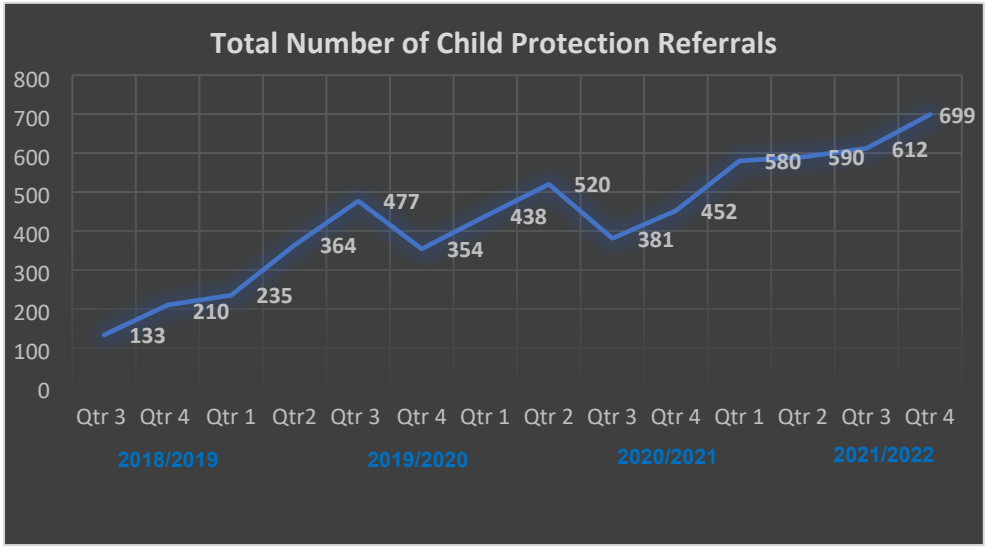
At March 2022 the number of children on the Child Protection Register in Cwm Taf Morgannwg (CTM) was (667) with Merthyr Tydfil (111); Rhondda Cynon Taf (381) and Bridgend (175).

All three Local Authorities have reported a significant increase in those families accessing Local Authority early help services.



There is no current National database publishing up to date numbers for those children placed on the Child Protection Register in Wales. Data for 2021-2022 above is taken from local performance reports provided on a quarterly basis from the Local Authority to the Regional Safeguarding board.

There has been a reported national increase in safeguarding activity. All areas within CTM have seen an increase in referrals and strategy meetings. There has been 2,481 health referrals submitted to Children Services, this has increased form 1,693 in 20/21. Referrals are predominantly received from Emergency departments. It is considered that this may be attributed to additional training that has improved recognition to response.



In 2021/22, 270 child protection medicals were undertaken compared to 134 in the previous year. The Child Protection Medical Hub opened in January 2021. Children aged 2 – 17 years are seen at the Hub, all children under two years old or those accessing health care through Accident and Emergency are seen on Paediatric wards.

This year, significant work has continued in partnership with the paediatric team to improve the child protection medical process, with the Hub being an integral part of the improvement plans.

This year has tragically seen 11 cases of unexpected child deaths, including two homicides and two suspected deaths by suicide. Five of the deaths occurred within the Bridgend area, resulting in the Cwm Taf Morgannwg Safeguarding Board commissioning an Independent Rapid Review. Several of the cases were considered for a Child Practice Review in line with the statutory guidance published by Welsh Government in November 2016. Three met the criteria for a Child Practice Review and two others required additional reviews to identify learning and improvements. The Cwm Taf Safeguarding Board published two Child Practice Reviews for the year of 2020/21.

Early learning has been identified from the homicides and child deaths. Following local investigations and the recommendations of the rapid review, an action plan was developed to monitor improvement activities throughout CTMUHB.

Included in the 11 cases of unexpected deaths were 2 were suspected deaths by suicide. The Cwm Taf Morgannwg Suicide Prevention Steering Group continues to review all suspected deaths by suicide to identify themes and learning for all organisations.

What Did We Learn?

From multi-agency audit and reviews, the following learning themes were identified:

- The importance of effective communication between professionals. Including health professionals, particularly when abuse or neglect is suspected.
- The importance of professional curiosity when working with children and families where there are safeguarding concerns.
- The importance of escalating concerns regarding inter-agency safeguarding practice. When children are identified as being at a continued risk of harm despite professional involvement.
- Need for actively considering the voice, wishes and feelings of the child within safeguarding processes.
- The importance of effective multi-agency working when there is suspected physical abuse or non-accidental injury.

Good Practice themes identified:

- Increased awareness and appropriate referral among frontline staff to recognise children who are suffering with poor mental health or at risk of self-harming behaviours.
- The Child Protection Medical Hub has been widely evaluated positively by other practitioners, families and children. It provides a child friendly environment, that facilitates timely medicals for children where there is suspected physical abuse and/or neglect.
- Improved working relationships between safeguarding and services within the wider health board.

Next Steps

Maintain effective safeguarding practice in Cwm Taf Morgannwg:

- Participate fully in Child Practice Reviews to identify and implement learning throughout the Health Board.
- Undertake multi-agency and UHB quality assurance activities
- Continue to work closely with frontline services and facilitate improved information sharing in a timely manner.
- Continue to improve the process of sharing learning from audits and reviews to ensure the Health Board are able to make appropriate improvements in practice.

Barriers

- It is anticipated that the repercussions of the COVID 19 pandemic will continue to affect safeguarding practice. It is vital to ensure that the Health Board are prepared to respond to issues related to the pandemic recovery.

- Safeguarding remains everybody's business, key messages around safeguarding children and young people is essential. Working together to safeguard is a key priority, this will be achieved through effective collaboration, training and education with partner agencies and colleagues within CTMUHB.

Child Sexual Exploitation (CSE)

Our Aim

To tackle the coercion or manipulation of children and young people into taking part in sexual activities. CSE is a form of sexual abuse involving an exchange of some form of payment which can include money, mobile phones and other items, drugs, alcohol, a place to stay, 'protection' or affection. The vulnerability of the young person and grooming process employed by perpetrators renders them powerless to recognise the exploitative nature of relationships and unable to give informed consent.

How Will We Do This?

- Prevent and protect children and young people from sexual exploitation;
- Provide responsive, appropriate and consistent support to those identified as being subject to or at risk of Child Sexual Exploitation

- Contribute to the identification, disruption and prosecution of perpetrators.

- Provide education and training to health professionals in a position to identify children at risk.

What Did We Do?

The lead for CSE within the Corporate Safeguarding Team has developed partnerships with other professionals and agencies.

As a partner in the work of Cwm Taf Safeguarding Board:

- Contributed to the CSE needs assessment and audit of CSE cases across the Health Board.
- Contributed to Individual Risk Management plans within Multi-Agency CSE meetings.
- Participated in the planning and implementation of the multi-agency process for pooling intelligence in relation to perpetrators, and contextual safeguarding with view to enhancing the focus of criminal and safeguarding interventions.

- Established links within sexual health and Accident and Emergency to update practice in respect of CSE. This has included the use of the Child Sexual Exploitation Risk Questionnaire (CSERQ) assessment tool.

As a partner in the Public Health Wales Safeguarding Network:

- CSE training has been reviewed and has also been incorporated into bespoke training sessions. It continues to be incorporated into Level 2 & 3 training packages for NHS Wales.
- A Public Protection Nurse attends six weekly Multi-Agency Exploitation Group. In addition, the Health Board are contributing to the development of a Regional Exploitation strategy.

What Did We Learn?

- Sharing of identified 'hot spots', trends & individuals of concern across Cwm Taf Morgannwg.

- The importance of recognising the increase in online exploitation during the COVID pandemic.

- Exploitation is now seen more widely, it is no longer a forum for reviewing only sexual Exploitation. This facilitates wider networking and joined up working with Child Adolescent Mental Health Services, third sector and statutory services.

Next Steps

- Develop data in relation to prevalence in Cwm Taf Morgannwg University Health Board (CTMUHB).
- Continue to identify local multi-agency and UHB trends and issues.

- Further encourage the use of the CSERQ in CTMUHB, to aid in identification and risk assessment for those at risk of CSE.
- Ensure consistent health representation at all CSE strategy meetings.

Barriers

The recognition of exploitation of young people requires practitioners to exercise professional curiosity. Ongoing training and education is required to update practitioners of the risks to exploitation. Colleagues working within busy clinical environments require training and resources that can aid in the recognition and referral of safeguarding concerns.

Children Looked After (CLA)

Our aim:

To ensure that our Children Looked After are as healthy and happy as they can be and that they have access to health care services that they may need.

To ensure compliance with related legislation:

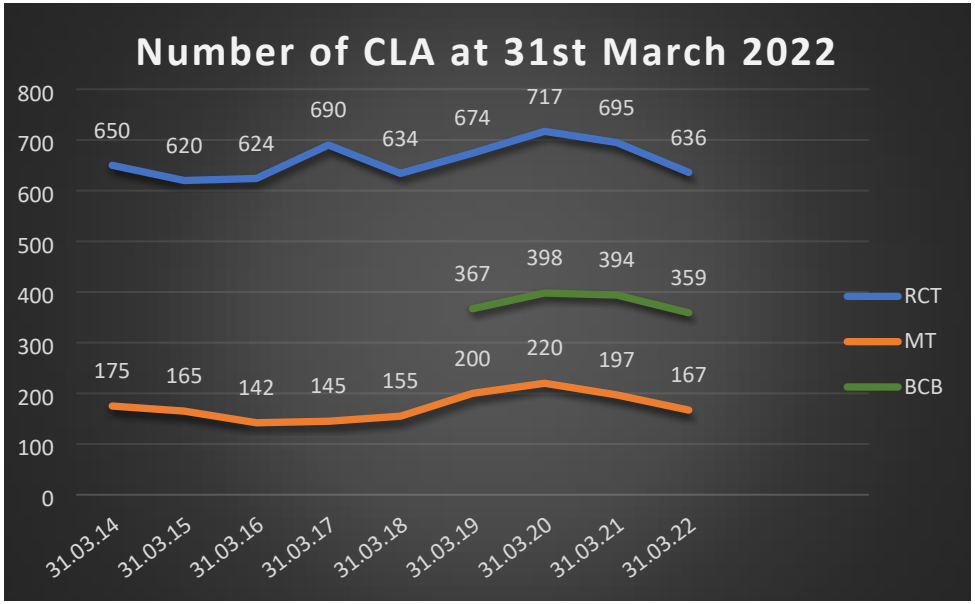
- Social Services & Well-being (Wales) Act 2014 – Part 6
- Toward a Stable Life and Brighter Future 2007 [statutory health assessments]

How will we do it?

- Undertake timely assessment and health planning for Children within the CTMUHB footprint.
- Ensuring equal access to relevant universal and specialist health services and meeting the statutory requirements for health provision

- Ensuring there are effective interagency CLA processes and practices in place to support health needs
- Robust quality assurance and information sharing systems.

What did we do?



The social services and well-being act (2014) places a statutory duty to provide health services for care experienced children this included completion of statutory Health Assessments. The number of care experienced children has increased during the year, across all three local authorities, and there has also been an increase in the number of children who are moving placements frequently. Statutory health assessments for Children Looked After are undertaken every 6 months for children under 5 years of age and annually for children over 5 years of age. Assessments for children less than 5 years of age are undertaken by a Paediatrician and the Health Visitor.

All assessments for children over 5 years of age are undertaken by the specialist nursing team, or are commissioned from the placing health authority. CTMUHB undertake assessments for children and young people placed within CTMUHB, irrespective of local authority of origin.

There has been a steady increase in unregistered placements for both children and young people which will continue to be problematic, this is in part due to a national shortage of registered placements along with a well published policy decision from Welsh Government to move towards "not for profit residential settings".

Out of County Placements

March 2022 indicates there were 312 children looked after placed within Cwm Taf Morgannwg (CTM) from other Local Authorities compared to 308 last year so this number appears to be consistent. There have been 254 of CTM children placed out of county, similarly this number undeviating from pervious figures. Out of county children within CTM are particularly at risk of inequity of health service

provision; being isolated from their home area and family, in addition to the issues related to poor information sharing, notification systems and contact between placing services and CTMUHB. Although there is ongoing work both locally and nationally to improve these processes.

Statutory assessments for Looked After Children from Cwm Taf Morgannwg 'home' local authorities placed out of county are requested for completion by the host health authority. The CLA team receive similar requests by other health board to undertake assessments for children who are place within the CTMUHB footprint.

Children Looked After and Child Adolescent Mental Health Service (CAMHS).

This cohort of children have a clear association of increased risk of poor mental health and CLA and CAMHS are working together, to develop processes that support timely and seamless referral and discharge to service. This includes working with CAMHS so that when young people are moved out of the CTMUHB footprint that care is continued until CAMHS services within the new placement are able to take over. This process supports continuity of care to the most vulnerable and prevents cessation of support and treatment whilst a referral is processed within the new placement area.

Unaccompanied Asylum-Seeking Children (UASC)

A young person judged to be under 18 years of age, without an adult to care for them, is entitled to the same services as other looked after children and have the same rights to health care as UK nationals. In Cwm Taf in 2021/2022, there were 2 known placements as part of the National UASC arrangements. In November 2021 the national transfer scheme became mandatory for all local authorities including those within the CTMUHB, this will lead to an evitable increase in these figures.

What did we learn?

- There was a total of 1598 of CLA children and Young People residing in Cwm Taf Morgannwg Health Board aged between 0-17 years at March 2022.

- The COVID pandemic has affected the Looked after Childrens service dramatically. The current staff were redeployed for several periods to support the testing and vaccination programmes, with the most recent over December 2021 through until February 2022.

- Resource reduction had a direct impact on work, with the team having to work in a more imaginative ways in response to reduced capacity. The team continues to work in a hybrid way.

- This blended approach has involved RAG rating health assessments as per public health Wales guidance. Face to face assessments were prioritised for those children identified as being the most vulnerable, and the development of local standards to support this process.

- Processes between the CLA team and the Health Visiting service have been improved, to support timely completion of the under-five health assessments.

- The COVID vaccination programme for children was implemented locally in December 2021 and there was multi agency work across the three local authorities and health to ensure a seamless process for CLA children. The local authorities ensured that foster carers and residential staff had appropriate consent documentation, and health staff were supported in this process to provide reassurance around consent.

- Ongoing work is being undertaken between the CLA team and local authority and Paediatric staff to ensure when children require planned treatment, that all relevant personnel are aware of the consent requirements, to prevent treatment cancellation.

- Publication of the Assessment Framework for Looked After Children, which informs and supports good standards of care.

Next Steps

- To improve the number of statutory assessments completed in a timely manner.
- To establish fair and consistent re-charging arrangements for secondary and specialist health care services with other health boards, whereby Local Authorities outside of CTM place children looked after within Cwm Taf Morgannwg.
- To continue ongoing work with CAMHS that will support the emotional health and needs for CLA children and young people.
- Through partnership training, all health care professionals working with children looked after need the skills and knowledge to understand how they can support the emotional wellbeing of looked after children and young people.

Barriers

With many Children Looked After Teams experiencing similar issues with restrictions imposed by the COVID pandemic, there is a risk that vulnerable children may experience delays in receiving their health assessment. Effective communication is key in identifying those that need

prioritisation. The work around expanding the health care needs form will only support this process.

The ongoing effect of post COVID health provision impacts on the entire population, such as delays around dental care and orthodontic care.

The Covid-19 pandemic impacted upon the ability of specialist nursing staff to undertake face to face health assessments. This has been mitigated by alternative contact arrangements via telephone or face time – these methods of communication have been very successful and welcomed by some young people.

Adult at Risk

Our Aim

To ensure that adults in Cwm Taf, over the age of 18, are protected from abuse, neglect or other kinds of harm and are prevented from becoming at risk of abuse, neglect or other kinds of harm and they live in an environment that promotes their wellbeing.

To ensure that the UHB complies with the related legislation:

- Social Services & Wellbeing (Wales) Act 2015 – Part 7

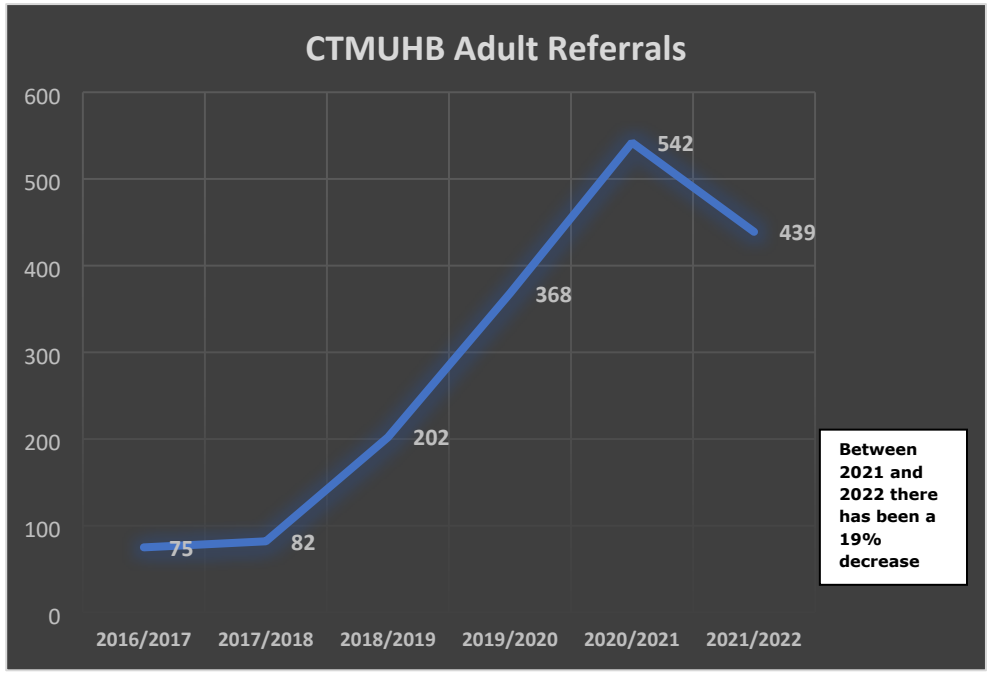
How Will We Do This?

By ensuring that there are effective inter-agency safeguarding processes and practice in place, supported by robust quality assurance and information sharing systems.

What Did We Do?

- All Adult Safeguarding Reports are made to the Local Authority to decide if the threshold for enquiries is met.
- There have been 439 adult at risk referrals in 2021/2022. This is a 19% decrease from last year.
- The highest category of abuse reported continues to be Neglect. Neglect accounts for 63% of all safeguarding referrals. The second highest is for physical abuse.
- There have been 113 referrals made in respect of avoidable pressure damage and 29 avoidable falls. The Public Protection nurses attended the Pressure Ulcer (PU) and Falls scrutiny panels on a regular basis to ensure safeguarding representation and to provide operational support for decision making in the clinical areas.
- A Standard Operational Procedure (SOP) for Pressure Damage referrals has been proposed, this will assist the management of avoidable PU incidents that have occurred within the Health Board. This work is in collaboration with the 3 Local Authorities and the implementation of this is planned to commence in 2023, the delay is due to resource with the MASH team and the ability to fulfil an additional role for scrutiny of the referrals.

Number of referrals received from CTMUHB



Adult Practice Reviews are undertaken in line with the Welsh Government guidance published in November 2016.

- The Board published 3 Adult Practice Reviews and 1 Domestic Homicide Review during the year and these are available on the Cwm Taf Morgannwg Safeguarding Board website.

What Did We Learn?

From the multi-agency reviews undertaken, the following learning themes were identified:

- The impact of Adverse Childhood Experiences in adulthood, sudden bereavement and loss.
- The importance of evidence practice supporting step down from care delivery.
- For young people who are approaching adulthood, transition arrangements should be considered at key points within their journey, in particular for those who are living away from their originating area.
- When young people move into another local authority area, having been a child looked after, and support is provided via leaving care arrangements by the originating authority, good practice for the originating authority would be to notify the local authority in which they move to.
- All agencies to review current training to ensure it includes trauma informed practice.
- When working with complex cases consider referrals to the Complex Case Panel which provides a multi-agency opportunity to review individuals who present with a significant level of risk.
- Working with someone who is difficult to engage: it is important to distinguish between contact and real engagement.
- A multi-agency self-neglect policy to be developed.
- Where there is potential risk wider multi agency information to be sought to inform decision making.
- All agencies should have in place their own policies and mechanisms for clear and accurate record keeping, in line with General Data Protection Regulation.
- Professional curiosity and management oversight should inform analysis of risks and strengths before deciding on any actions.

The learning and themes identified from the reviews are circulated and shared at the Safeguarding Operational Group for wider learning.

During the COVID19 pandemic there has been evidence of ongoing collaborative working between the health Board and the Local Authorities, despite the restrictions posed and

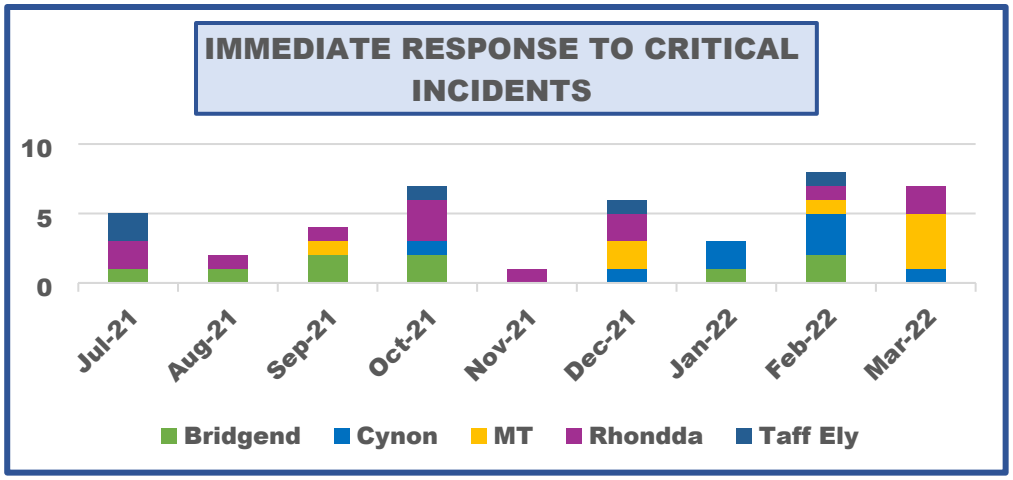
increased pressures. This work has continued remotely, for the majority of this year.

Next Steps

Maintain effective safeguarding practice in Cwm Taf Morgannwg:

- By participating in all safeguarding processes.
- Undertake multi-agency and UHB quality assurance activities.
- Share quality and relevant information in a timely manner.
- A Suicide Prevention Steering group was set up in July 2020. This group was established for health professionals to identify any gaps and/or opportunities to improve co-ordination and collaboration. This work continues to develop with the adoption of the Immediate Response Group (IRG) protocol as the regional response to all suicides that meet the definition of a critical incident.

The Public Protection Nurse's attend all Immediate Response Groups (IRG) meetings to share any relevant information, look at themes and concerns to ensure any actions are carried forward for Health. Where relevant, this is linked with the Health Board's incident management process and any required investigation for the Health Board.



- To implement a consistent and robust process for the management of pressure damage across the health board and a timely, effective referral pathway to Local Authorities in line with the Wales Safeguarding Procedures.
- The Self-neglect policy was implemented within CTM, continued awareness to be raised within the health board.
- To identify any themes and trends across the Health Board that requires additional safeguarding oversight.

Barriers

- Continued recovery from the pandemic, causing increased pressures on the team.

- Delay in the implementation of new processes, due to increased workload and resources.

- Training delivery resources and restrictions/availability on clinical staff attendance.

Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)

Includes Honour Base Violence/Female Genital Mutilation/ Sexual Exploitation/ Human Trafficking/Modern Slavery.

Our Aim

Individuals who are victims of violence against women, domestic abuse and sexual violence are treated and supported in a way that optimises their potential and life chances.

To ensure the UHB complies with the related legislation:

- Violence Against Women Domestic Abuse and Sexual Violence (Wales) Act 2015
- Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015)
- Domestic Abuse Act 2021

How Will We Do This?

- Continue to implement the Cwm Taf Violence Against Women Domestic Abuse Sexual Violence strategy with the Local Authorities.
- Comply with the VAWDASV National Training Framework.
- Ensuring that there are effective interagency processes and practice in place.
- Report identified or disclosed incidents of Female Genital Mutilation in those under 18 to the police.

What Did We Do?

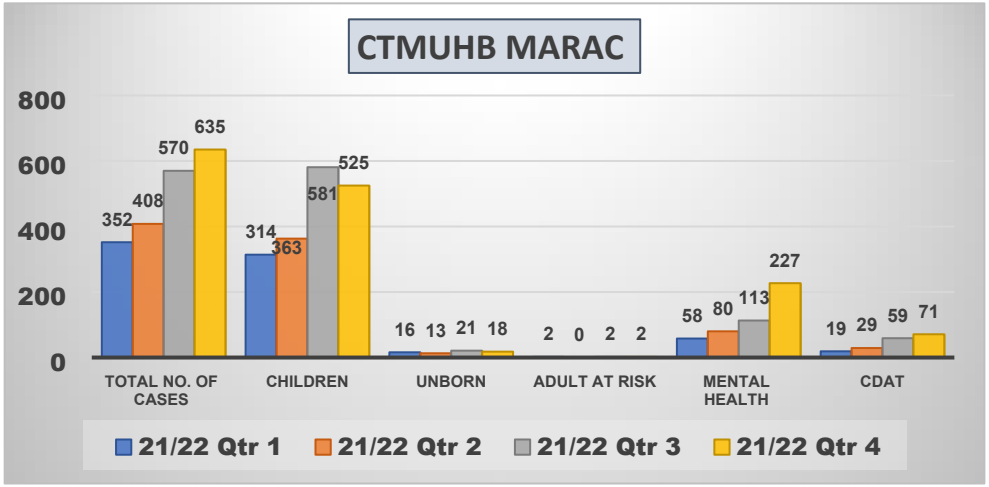
- 1965 cases assessed at daily domestic abuse discussions held in the Multi Agency Safeguarding Hub as opposed to 1200 in 2020/2021.

- 1783 children associated with those reviewed at Multi Agency Risk Assessment Conference (MARAC) as opposed to 1211 in 2020/2021.

- 68 unborn babies reviewed at MARAC as opposed to 39 in 2020/2021.

- 478 adults identified with mental health issues as opposed to 266 in 2020/2021.

- 178 adults known to Community Drug and Alcohol Team reviewed as opposed to 91 in 2020/2021.



- There was one Domestic Homicide Review undertaken in 2021/2022.

  In November 2021 a new MARAC process commenced within Rhondda Cynon Taf and Merthyr Tydfil. This involved no daily cases, only MARAC meetings once a week. The appointment of a Health MARAC Coordinator has ensured that there is a consistent health presence at these meetings. Health information is shared timely with partner agencies and concerns fed back to relevant service groups.

- In February 2022 a new Health Independent Domestic Violence Advisor (IDVA) was appointed to commence a pilot at the Royal Glamorgan Hospital. The post is funded by the Police Commissioners office until April 2025 for which the post holder has been provided an honorary contract by CTMUHB.

  In collaboration with RCTCBC it is envisaged that this pilot will allow for the IDVA to collate data and evidence that this role is essential to providing early intervention to victims of domestic violence accessing health services. In addition, the role of the Health IDVA will be one that provides advice and support to staff members, along with acting quickly to provide victims of domestic violence with prompt specialist services.

What Did We Learn?

- Evidence suggests that there is an association between domestic violence and deprivation; with areas of deprivation experiencing higher numbers of incidents than less deprived areas.

- There are a high volume of incidents of domestic violence reported to South Wales Police. Including an increase of

incidents whereby young people have been the perpetrator of violence.

- 2021/2022 saw a positive increase of 54.5% in Health referrals to MARAC, this is possibly due to continued support from the MARAC Co-ordinator along with the new IDVA. Also, the uptake in staff attending Ask and Act training.

- Improvement of sharing information to health colleagues. This will increase the safety, health and wellbeing of victims – adults and their children and reduce the risk the perpetrator may pose to staff.

- Increase in routine enquiry within midwifery services and appropriate referral to services. Both Midwifery and Health Visiting will be conducting 6 monthly Routine Enquiry audits. This will show where services can improve in identifying those at risk of domestic abuse.

- School Nursing and Health Visiting service fully engaging with new MARAC process. Both services provide relevant health information on a weekly basis to be shared at RCT/MT & Bridgend MARAC and attend where necessary.

Next Steps

- Continue to promote group 1 VAWDASV Training – target 100%

- Bespoke Ask & Act (VAWDASV) training has been undertaken with the emergency department at RGH with good results, a number of referrals have been submitted following this training. This training will be delivered to all Emergency Departments across CTMUHB.

- An ongoing priority for CTM Safeguarding Board is to reduce the effects of domestic violence on children and adults at risk. Corporate Safeguarding is fully cooperating and leading on supporting this priority within our region.

- Contribute to the ongoing commissioned Domestic Homicide Reviews. Incorporate the learning from practice reviews and Domestic Homicide Reviews into training.

Barriers

- It is not yet clear how the new Domestic Abuse Act 2021 will interface with the Violence Against Women domestic Abuse and Sexual violence (Wales) Act 2015

- The population within CTMUHB experiences the highest levels of domestic abuse reporting of all police force areas.

- Improved working relationships between GP practices and Safeguarding would provide further opportunities to provide more robust safety planning for high risk people suffering domestic violence

Deprivation of Liberty Safeguards & Mental Capacity (DoLS & MCA)

Our Aim

DoLS: To protect people who for their own safety and in their own best interests need care and treatment that may deprive them of their liberty but who lack the capacity to consent and where detention under the Mental Health Act 1983 is not appropriate at that time.

MCA: To ensure staff understand the implications of Mental Capacity Act 2005 and can implement it in their practice.

To ensure that the UHB complies with the related legislation:

- Mental Capacity Act 2005 (amended in Mental Health Act 2007)

How Will We Do This?

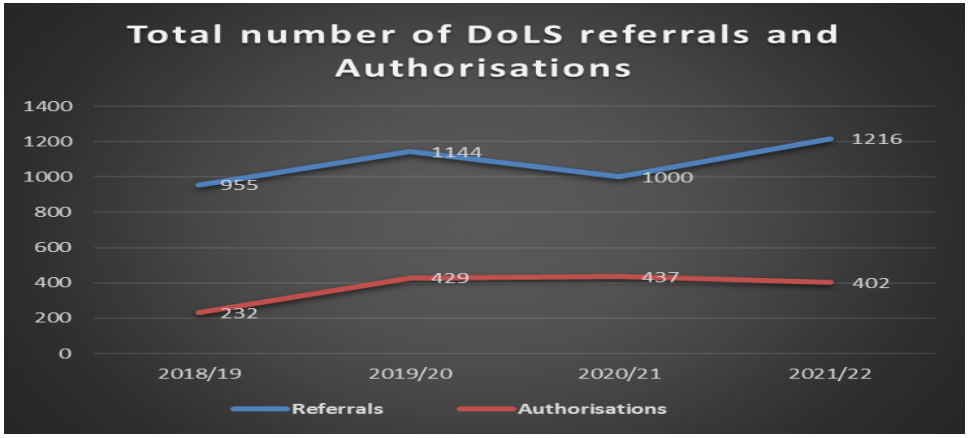
Deprivation of Liberty Safeguards (DoLS): By ensuring that the UHB follows the defined legal processes and

discharges the functions of the Supervisory Body and the Managing Authority.

Mental Capacity Act (MCA): The five key principles must be followed when working with a patient aged 16 and over who might lack capacity.

- A presumption of capacity
- Support to make decisions
- Right to make unwise decisions
- Best interest
- Least restrictive option

What Did We Do?



- 1216 Applications were made. An increase of 20% on previous year.
- 412 DoLS authorisations completed.
- 23 Cases referred to Court of Protection, that required the Health Board to be a party to proceedings. An increase of 60% based on last year.
- CTMUHB has been represented in All Wales Liberty Protection Safeguards (LPS) Steering Group and LPS National Minimum Dataset Group. As well as the regional steering group for Cwm Taf which included Merthyr Tydfil, Bridgend and Cwm Taf County Borough Councils.
- Using Welsh Government funding a Mental Capacity Act (MCA) Practice Development Manager was employed to oversee MCA support and Liberty Protection Safeguards (LPS) transition. Due to the delay in LPS implementation this role has focussed on embedding the MCA into everyday clinical practice, through bespoke training and support in various speciality areas.
- Involved in various improvement / planning groups across the Health Board.

- DoLS / MCA Training compliance across the Health Board has increased to 62% from 55%.

What Did We Learn?

- 689 applications were withdrawn – linked to regaining capacity, detention under the Mental Health Act, transfer to another Managing Authority, discharge of patients and death.

  The waiting list this year has been averaging around 120 people. This equates to a waiting time of 12-14 weeks. 71% applications made are for Urgent Authorisations. This is a decrease of 6% based on last year

- The increase in Court of Protection cases is a result of increased usage of Paid Representatives to act as RPR, who can represent the persons objections to elements of their care and most often discharge.

Next Steps

- Reduce the DoLS waiting list to below 40 at any given time.

- The DoLS team are planning on utilising Welsh Government funding to employ three additional Best Interests Assessors to complete DoLS assessments to achieve the goal above.

- A newly created post of DoLS/MCA and LPS Training Educator commenced employment in February using this funding and will be working towards preparing colleagues within the Health Board for the implementation of LPS.

- Due to the delay in the publication of the LPS, the Health Board are focussing on embedding the MCA into everyday practice to aid the transition from DoLS to LPS.

- The DoLS Team are providing workshops and improving the information provided on share point to assist wards with Mental Capacity Assessments, Court of Protection cases and how to manage their DoLS authorisations.

- A new DoLS auditing tool is awaiting approval through the AMAT department for implementation Health Board wide. The goal is for wards to self-assess their DoLS referral forms to ensure that the information received is of sufficient quality.

- Working towards a new Court of Protection process that will result in an improved identification of responsible professionals and gathering of Court Ordered evidence.

- Depending on the publication of the LPS the Health Board may be implementing the LPS towards the start of 2024.

- A newly created post of DoLS, MCA and LPS Training Educator commenced employment in February using the Welsh Government funding and will be working towards:

  Mandatory training being updated at Level 1, 2 and 3, which will incorporate Mental Capacity Act and DoLS as a new stand-alone session.

- The implementation of a Mental Capacity Act team that will be available to all clinical areas throughout the hospitals further embedding the MCA into everyday practice and supporting staff with complex MCA issues that arise on the ward.

- Participation in focus groups designed to improve and raise awareness of the importance of the Mental Capacity Act and its delivery to patients that are currently in hospital.

Barriers

- As training compliance improves, the numbers of applications increase resulting in the waiting list increasing and capacity to for the Best Interest Assessor's to respond within the set timescale diminishes.

-

- With the increase of urgent applications, the ability to respond within the timescale reduces significantly.

PREVENT

Terrorism Strategy

Preventing someone from being radicalised, is no different from safeguarding individuals from other forms of abuse or exploitation.

Prevent does not require health staff to do anything outside of what is required during the course of their usual duties.

The challenge is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs

correctly, and is aware of and can locate available support through their organisation.

What Did We Do?

Referrals are made to Channel Panel, the government's anti-radicalisation programme, by Cwm Taf Morgannwg University Health Board. The Head of Safeguarding or Deputy Head of safeguarding attend Channel panel to ensure information is shared.

Channel accepts referrals for anyone who displays a vulnerability to violent extremism, regardless of age. Sharing information about suspected radicalisation should be seen as no different to sharing concerns for vulnerable people subject to grooming or exploitation.

Members of the corporate safeguarding team have developed lead roles around radicalisation and attend Channel Panel.

What did we learn?

Following the explosion outside of Liverpool Women's Hospital in November 2021, CTMUHB have worked with the training department to ensure the Wales online training is accessible to colleagues through the Electronic Staff Record (ESR) system.

A 7 minute briefing was developed to highlight risks and signs of concerns that would assist colleagues in recognition to response. This has been disseminated across CTMUHB and is available in the Health Boards Intranet site.

Next Steps

There is a requirement for all NHS staff to be trained in PREVENT and be able to act on concerns.

An e-learning package is available to CTMUHB to allow for all staff to complete training. This will support the identification and referral of those individuals at risk of radicalisation.

Colleagues will be encouraged to attend this training through briefings, the Health Boards level 3 training and the Intranet pages.

Barriers

Radicalisation training is not mandatory in Wales. Appropriate training for staff is available as an e-learning package. However, this needs to be added to the training matrix on ESR so that staff compliance can be measured.

Offender Management

Our Aim

To create safer communities and reduce crime by planning, commissioning and delivering community safety related services and activities as a statutory member of the Cwm Taf Community Safety Partnership.

To ensure the UHB complies with the related legislation:

- Criminal Justice Act 2003 – duty to cooperate in Multi-Agency Public Protection Arrangements (MAPPA)

How Will We Do This?

Ensuring that there are effective inter-agency offender management processes and practice in place, supported by robust quality assurance and information sharing systems.

Participate in MAPPA meetings and implement health actions.

Participate in the work of the relevant regional partnerships:

- Community Safety Partnership
- Offender Management Board
- Serious & Organised Crime Board
- MAPPA Senior Management Board – Violent & Sexual Offenders

PARTNERSHIP PILOT PROJECTS

- WISDOM: Wales Integrated Serious & Dangerous Offender Management
- Women's Pathfinder: Diversion from Criminal Justice processes
- DRIVE: Working with perpetrators of Domestic Abuse

Next Steps

Maintain effective inter-agency offender management practice in Cwm Taf Morgannwg.

The Head of Safeguarding attends all level 3 MAPPA meetings to ensure appropriate Safeguarding representation.

Allegations Made Against Professionals

Our Aim

To ensure that patients/clients are safe in our care. To ensure that staff understand they have a duty to report concerns about the behaviour of other staff members.

Raise awareness with our staff that their behaviour outside of work can directly impact on their working role.

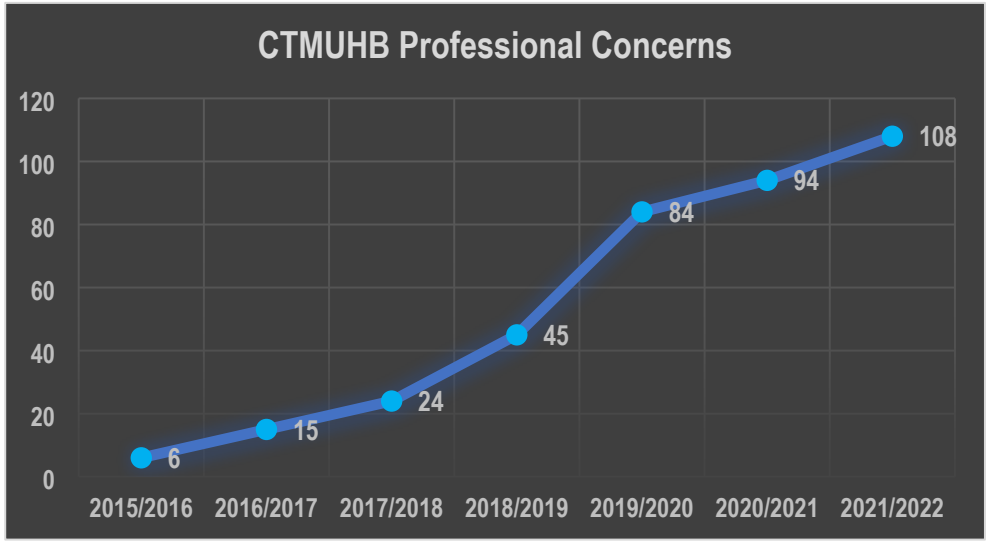
How Will We Do This?

Ensuring that there are effective inter-agency safeguarding processes and practice in place. That these are supported by robust Human Resources processes and risk assessments to ensure a proportionate response to concerns whilst safeguarding our patients/clients.

What Did We Do?

There were 108 health board staff implicated in allegations of abuse or cause for concern about a person who works with children or adults at risk, this is compared to 94 in 2020/2021.

- 13 related to child protection concerns
- 41 related to adult protection concerns
- 57 were due to professional conduct concerns



What did we learn?

Many of the professional concerns raised have been in regards to professional and personal conduct. There has been a significant increase in 2021/22, whereby cases of conduct have involved alcohol. A large number of professional concerns, have also been in relation to incidents of domestic violence. There has been a national increase in cases of domestic violence, alcohol misuse and poor mental health during the COVID pandemic. Since many of our CTMUHB workforce also reside within the CTM footprint, it is not unreasonable to consider that these issues have also affected

them. Therefore, those involved in professional concerns are always offered support from occupational health, wellbeing and third sector services.

Next Steps

- Continue to raise awareness among staff on the impact of private behaviour/conduct on their working life. Professional conduct and values and behaviours, has also been incorporated in to the adults and children at risk safeguarding training package. The training delivery and development of the Domestic Abuse policy is aimed to guide managers to identify both perpetrators and victims within our workforce, to provide the appropriate support and ongoing advice.

- Raise profile of appropriate use of social media.

- Ensure Ask and Act training emphasises the importance of supporting staff within CTMUHB.

- Health Care Support workers (HSCW) are recorded as being the highest category of the workforce associated with professional concerns. The Safeguarding team will resume the delivery of training face-to-face in the monthly HCSW induction programme as of May 2022.

- The Public Protection Nurses are now responsible for professional concerns by each Integrated Locality Group with the data being a standard agenda item on the reports submitted to the bi-monthly Quality, Safety and Patient Experience meeting. Monthly analysis of the themes and trends is submitted to the Deputy Head of Safeguarding for continued oversight.

Multi-Agency Safeguarding HUB (MASH)

Our Aim

Through collaborative working with our partner agencies, that children and adults at risk in the Cwm Taf Morgannwg area are able to live safe lives.

How Will We Do This?

MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a more timely and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved.

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

COVID required changes in practice, with partner agencies moving to home working through periods of lockdown and in line with Government guidance. The MASH within Cwm Taf region continues to be facilitated on a virtual platform. In order to have greater resilience in health resources within MASH and in response to the child deaths within Bridgend, all Public Protection Nurses have worked as one team out of Bridgend MASH.

This co-location has facilitated improved working relationships within the Bridgend region and centralised the health resource, therefore encouraging emotional support for those working out of MASH.

What Did We Do?

The involvement of health professionals in MASH is seen as particularly important. Their information and perspective are crucial to decision making for all safeguarding and particularly in multi-agency teams.

The CTM MASH Health Team have continued to locate themselves within the HUB. This has provided access to relevant IT systems and supported the ability to provide on call advice to staff members during crucial times. Alongside partner agencies, processes have been adapted to ensure

effective sharing of information and decision making in respect of safeguarding people.

There is a Business Manager and four full time Specialist Nurses for Public Protection, with considerable experience in safeguarding and multi-agency working. The seniority of the posts reflects the high-level decision making required and confidence in challenging and negotiating with other professionals and agencies.

What Did We Learn?

MASH focuses on sharing intelligence and information to provide better informed decisions about risks to individuals without delay. This early intervention aims to prevent or offset the risks to individuals and reduce repeat referrals.

Following the Bridgend Rapid Review and subsequent audits, work has commenced to improve information sharing within the Bridgend MASH, utilising an information platform used within Cwm Taf, whilst an alternative system is sourced. Health has ensured that information is effectively shared and stored in respect of children at risk and those discussed at strategy meetings.

Safeguarding concerns were received from a range of professionals including Social Workers, Teachers, Care Home staff, Health Visitors, doctors, emergency services and third sector organisations. Referrals were also received from members of the public via the local authorities' contact centres/one stop shops.

Next Steps

To continue to facilitate the contribution of key UHB staff in strategy discussion, information sharing and decision making.

To streamline the work of health staff within MASH to ensure that the information shared with partners on behalf of the UHB is of good quality. This will form part of the ongoing work to develop improved information sharing throughout agencies.

Barriers

The pace and volume of work generated within MASH and the subsequent demand for information and contribution from MASH Nursing Staff and key practitioners remains a challenge.

ICT related issues in terms of labour intensive information gathering and sharing from health systems to MASH systems.

Differing working models between Cwm Taf and Bridgend MASH sometimes presents difficulties in timely and effective communication between health and other partner agencies. Work is ongoing to facilitate a hybrid method of working.

Training

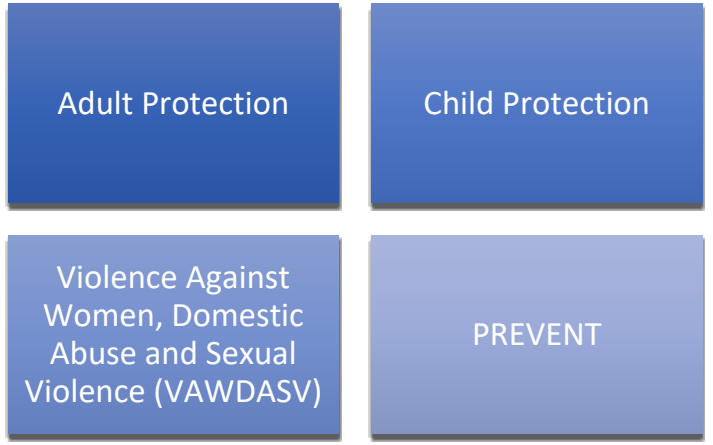
Our Aim

To ensure CTUHB staff are sufficiently trained and competent to be alert to the potential indicators of abuse, including concerns about behaviour of staff, and know how to act and report on those concerns in order to fulfil statutory safeguarding duties under the Children Act 1989 & 2004, the Social Services and Well-being (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence Act 2016 and the Counter-Terrorism and Security Act 2011.

How Will We Do This?

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

- There are four key dimensions of Safeguarding Training:



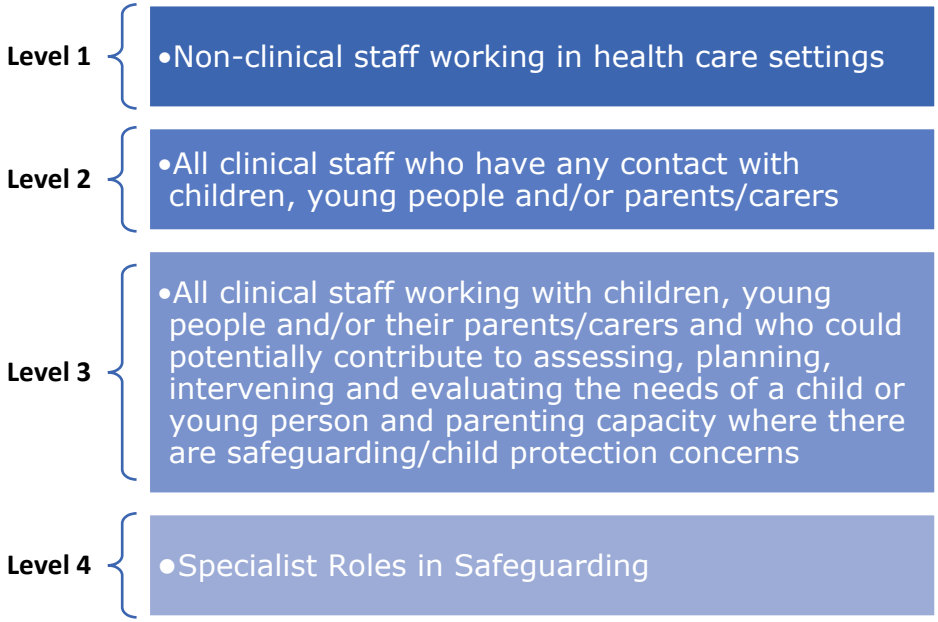
- Additional Specialist Safeguarding/Public Protection Training:

The CTUHB Safeguarding Training Strategy will be updated in light of the new Wales standards being developed. It will describe the level of training competency required for each role in relation to children or adults at risk & these have been assigned to each role on ESR. The strategy will be consistent with the Royal Colleges Intercollegiate Safeguarding Children

Training Document and Adult Safeguarding Levels and Competencies for Health Care Professionals 2019. This will incorporate both medical and nursing staff competencies.

Safeguarding Children and Adults at Risk

This is required at a number of different levels:



Violence Against Women, Domestic Abuse and Sexual Violence

The Act places a statutory duty on the UHB to train all staff in VAWDASV in line with the National Training Framework and there is an e-learning package available to staff on ESR.

Work is underway nationally to update Level 2 (Ask and Act) and Level 3 (enhanced knowledge for certain professionals and those within a champion role). Cwm Taf Morgannwg are actively participating in this work.

All training has been reviewed this year to incorporate learning from Practice Reviews and Domestic Homicides. Training is predominantly delivered via a virtual platform, this has increased the capacity and eased attendance for practitioners.

PREVENT

This training for all NHS staff is a requirement under the UK Government's Anti-Terrorism Strategy using the UK WRAP Programme.

What Did We Do?

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

The Safeguarding Board's Training and Learning Group (TALG) is attended by the UHB Deputy Head of Safeguarding and works to develop the multi-agency training calendar and identify any gaps in provision. Many of the key themes from legislation and local safeguarding learning have been incorporated into the multi-agency training programme.

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

Training has been delivered to Emergency Departments, Tier 4 CAMHS provision, Junior Doctors and student Nurses studying at the University of South Wales.

Safeguarding training in the UHB is managed via the Electronic Staff Record. Population of the safeguarding competencies on ESR enable the Learning & Development team to develop both the UHB training needs analysis for safeguarding and to provide quarterly activity reports to the Safeguarding Children Group and Safeguarding Adult Group.

The need for Level 4 training is identified on an individual basis and managed via the Personal Development Review process.

The Safeguarding Team has undertaken a number of events and exercises in 2021/22 to embed safeguarding culture and awareness across the health board including a greater presence on social media and activities during Regional Safeguarding Week.

Recommendations:

- Monitoring the uptake of safeguarding training of CTUHB staff and targeting areas of low engagement and departments making high numbers of safeguarding referrals.
    - Improved monitoring of training compliance for Doctors and Registrars. ESR is not currently used by Doctors, resulting in difficulties in identifying those that require updates.
    - Utilise virtual platforms to offer specific safeguarding training and to allow for recorded webinars to be delivered across the UHB.
    - Widen the availability of training facilitators through train the trainer activities and working collaboratively with Health Board Clinical Nurse Specialists for Safeguarding.

What Did We Learn?

From available data reviewed Children and Adult at risk safeguarding compliance has reduced, impacted by the pressures of the COVID pandemic and subsequent re-deployments.

VAWDASV e-learning compliance is lower than legislative requirements. The challenge for the next year is to achieve 100% compliance.

Safeguarding Children & Adult training continues to be evaluated well despite its delivery on a virtual platform.

Next Steps

Changes have and will be made to the delivery of safeguarding training for the HB. Safeguarding training for Adults and Children will be available both virtually and face to face. Bespoke Level 3 training for adults and children will also be offered to areas of low compliance, where there is an importance to ensure that staff have an appropriate level of knowledge and skills.

To target specific service areas for improvement and maintenance in response to the current and forecasted compliance, particularly with regards to the e-Learning for VAWDASV.

All new CTMUHB staff to be assigned a competency level for Adult and Children's Safeguarding and compliance to be monitored through Electronic Staff Record (ESR).

Adopting a prudent approach to training delivery by combining subject matters such as Child Sexual Exploitation with FGM, Modern Day Slavery and Hate Crime and subject to clarification of the educational requirements for Modern Day Slavery and Hate Crime.

In order to firmly embed a safeguarding culture and practice within the organisation it is imperative that alternative methods of raising awareness and learning are utilised appropriately such as electronic options, home access and social media use.

Barriers

The safeguarding and public protection agenda and related training requirements continues to expand thereby increasing the commitment of safeguarding staff in devising and delivering training packages.

The current Welsh Government trend to expect 100% compliance is a significant challenge for the UHB as is the number of staff hours 'lost' to services as a result of mandatory training requirements.

To enable increase in attendance at level 3 training requires increased accessibility. The current pool of facilitators is small, therefore limiting the training dates available.

Safeguarding Board

Our Aim

Safeguarding in Cwm Taf Morgannwg is overseen by the regional multi-agency Cwm Taf Morgannwg Safeguarding Board with responsibility for:

- Safeguarding Children & Adults at Risk
- Deprivation of Liberty Safeguards
- The Multi-Agency Safeguarding Hub (MASH)

The responsibilities and functions of the Board are set out in the statutory guidance under Part 7 of the Social Services and Wellbeing (Wales) Act 2014.

How Will We Do This?

The Board has an overall responsibility for challenging relevant agencies so that:

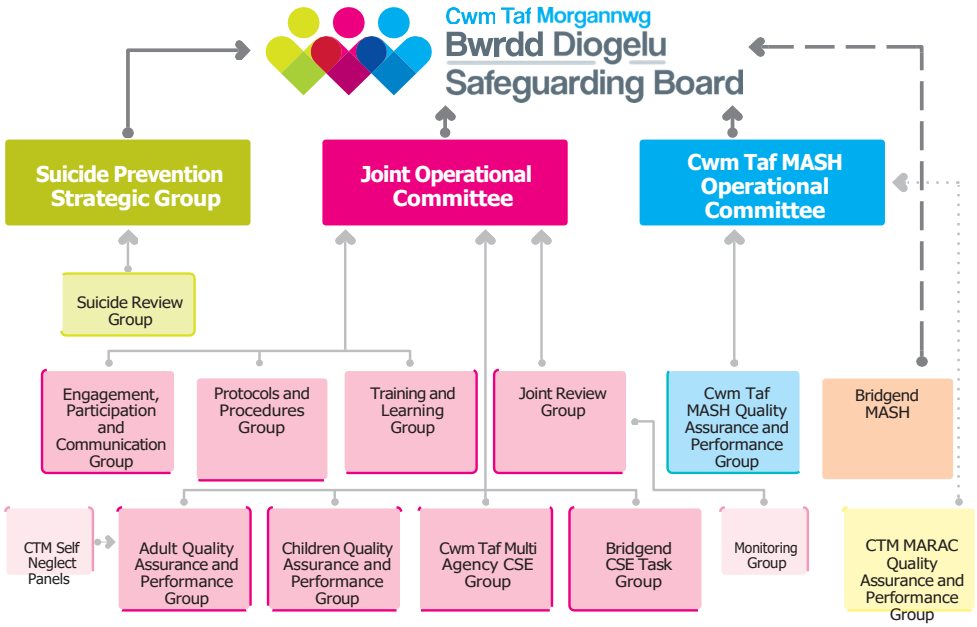
- There are effective measures in place to protect children and adults at risk who are experiencing harm or who may be at risk as the result of abuse, neglect or other kinds of harm.
- There is effective inter-agency co-operation in planning and delivering protection services and in sharing information.

The functions of the Board are implemented via a number of committees and sub groups which sit within the overall structure. A performance and risk management framework is in place to enable these groups to report on key issues to the Board.

What Did We Do?

- The UHB is represented on the Safeguarding Board by the Assistant Director of Quality Safety and Safeguarding and the Head of Safeguarding.
- Individuals from the Corporate Safeguarding Team represent the UHB on the committees and subcommittees that implement the functions of the Safeguarding Board.
- The collaborative work undertaken between Health, partner agencies and the Regional Safeguarding Board is documented in the Cwm Taf Morgannwg Safeguarding Board Annual Report.

APPENDIX 2:



- The UHB makes a financial contribution to supporting the effective working of the Board as required in the statutory regulations.
- The Board has published its Annual Plan for 2021/22. These priorities were agreed by all Board partner agencies at a Board Development Day earlier in 2021. The Annual Plan can be accessed at; www.cwmtafmorgannwgsafeguardingboard.com

AGENDA ITEM
3.2.4

QUALITY & SAFETY COMMITTEE

REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATE RELATING TO HEALTHCARE INSPECTORATE WALES (HIW) AND CWM TAF MORGANNWG COMMUNITY HEALTH COUNCIL (CHC) VISITS AND REPORTS

Date of meeting	24th January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lydia Thomas, Head of Quality and Patient Safety Louise Mann, Assistant Director, Quality, Patient Safety & Safeguarding
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
HIW	Healthcare Inspectorate Wales
GP	General Practitioner
CMHT	Community Mental Health Team
CIW	Care Inspectorate Wales

ED	Emergency Department
CHC	Community Health Council
WISE	Wellness Improvement Service

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales (HIW) activity and correspondence since the last report for committee in November 2022. Due to the bi-monthly nature of these meetings, this report will cover the 7 week period from the previous report.

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

This report will additionally include updates and key messages from the Community Health Council (CHC) activity within the health board.

1.2 ***HIW Process Updates;***

i. HIW have recently reviewed their onsite GP inspection methodology. They have recently had their first inspection which has taken place using this new approach. The new methodology involves looking in more depth at timely access, safe care, risks associated with lack of planning, patient safety alerts, vaccine management, safeguarding and scope of practice. This approach has already successfully helped HIW to identify areas where patient safety could be improved.

ii. HIW have also informed the health board of their new process for releasing inspection reports of specific services. Owing to the importance and sheer number of people who come into contact with Emergency Departments, Maternity Services, and inpatient Mental Health units across Wales, they have made the decision that HIW will brief the Welsh Government, all Members of the Senedd, media outlets and key stakeholders under embargo, immediately before publishing a report of this type. As part of their continued commitment to support improvement across Wales, they feel this will inevitably mean the sharing of both positive examples identified through assurance and inspection work, in addition to the potential for negative findings to be shared. The health board will continue to work closely with HIW, our internal

communications colleagues & external stakeholders to support this new process.

1.3 ***Community Health Council (CHC) Update:***

i. The CHC visited Ward 1 & 2 at Angelton Clinic in Glanrhyd Hospital on 10th November 2022. This is the first onsite visit post Covid-19 pandemic. The Health Board has not yet received a report following this visit. The feedback will be included in the next report.

ii. In November 2022, the CHC published a report for CTMUHB waiting times for elective surgery and how this is impacting on patients and carers experience. This report heard from patients and carers in the Cwm Taf Morgannwg area about the delays to their care, and the impact this is having on their everyday life for themselves and their families. They also heard from people through their social media channels and via their National survey.

The health board responded to express the challenges remaining for recovery post elective surgery since the COVID-19 pandemic. To address the delays, the following actions are ongoing to ensure patients are getting treated as quickly as possible;

- Protected surgical beds for day of surgery to avoid cancellations
- Operations in private sectors to support with backlog
- Elective Orthopaedic services expanding at Royal Glamorgan Hospital to allow more surgery to be performed
- Enhancement of day surgery case activity to avoid hospital admission for recovery
- WISE service (Wellness Improvement Service; this service provides non-medical intervention to improve people's health and wellbeing whilst being on specific waiting lists)
- Physiotherapy waiting list pilot for those patients waiting for hip and knee surgery. This pilot includes content on how patients can 'wait well' for surgery and is aimed at those on a waiting list whose health is likely to decline whilst they wait, known as deconditioning.
- Ophthalmology services under review to address those waiting for treatment and surgery. This includes the pooling of waiting lists to ensure patients are offered the next available date regardless of geographical area and a choice to attend any one of the sites for equity of care.

The Health Board are committed to listening to patients voices and emphasises the communities are at the centre of all improvement work.

2.0 Quarter 3 (26th October- 19th December 2022) HIW activity across Cwm Taf Morgannwg University Health Board included:

Number of Unannounced	**1**
Number of Announced	**1**
Number of patient/staff concerns via HIW	**0**
Number of concerns raised through Fieldwork	**0**
Number of ongoing improvement plans	**3**

2.1 **Unannounced Inspections:**

There has been 1 unannounced inspection in quarter 3 of this reporting period.

Angelton Clinic: Glanrhyd Hospital 14- 16th November 2022

During this unannounced inspection, immediate assurances were requested following the visit. The health board were required to provide assurances around specific risk assessments and the availability of specific tools to prevent self-harm attempts. A more detailed improvement plan was submitted to HIW at the end of November. A date has yet to be provided for the publication of the final report. Further updates will be provided in the next report.

2.2 **Update following unannounced Inspections:**

i. Princess of Wales Hospital Emergency Department 17th- 19th October 2022

Immediate actions were taken in relation to the checking of emergency resuscitation trollies. An overarching action plan is in progress and required to be submitted to HIW by mid- December. It is expected for the final report and action plan to be published by HIW 18th January 2023.

ii. Maternity Service: Prince Charles Hospital 27th- 28th September 2022

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

It was previously anticipated the full report would be published by HIW on 29th December 2022, however this has been delayed due to operational reasons and is now expected to be published on 18th January 2023

2.3 **Announced Inspections:**

There has been 1 announced inspection in quarter 3 reporting period.

Community Mental Health Team (CMHT) - Maesteg Hospital

CMHT inspection visit by HIW and Care Inspectorate Wales (CIW) to the Health Board and Bridgend Council was undertaken on 13th and 14th December 2022. The selected CMHT is Bridgend North CMHT, Maesteg Hospital. The inspection was conducted over two days. Initial verbal positive feedback has been received. HIW undertook the review of the CMHT in Maesteg as part of the national thematic CMHT review that started before the pandemic where, in 2019, at least one CMHT in each health board area was visited. The two days focused on three thematic areas of: quality of patient experience; safe and effective care; and quality of leadership and management. The informal feedback was received verbally this week ahead of a formal written report expected at a later date, yet to be announced. HIW is expected to publish the final report on their website on 16th March 2023.

2.4 **Future Planned HIW activity**

i. Surgery Governance Arrangements

A review of the governance arrangements within Surgery is anticipated within the next few months. A date has not yet been received however, this is anticipated to be February 2023. This is part of the joint review into governance arrangements by HIW & Audit Wales. A vast amount of evidence has been collated to be sent to HIW ahead of the review.

2.5 **No Public Concerns raised via HIW**

2.6 **Local Reviews:**

i. Discharge Arrangements for Adult Mental Health Patients:

As part of HIWs annual reviews programme for 2021-22, they have undertaken a local review to consider the arrangements in place within Cwm Taf Morgannwg University Health Board (CTMUHB), when discharging adult patients (aged 18-65), from inpatient mental health services to the community. They are reviewing:

'Do the current arrangements for the discharge of patients from inpatient mental health services into the community support the delivery of safe, effective and timely care?'

An embargoed report has been received by the Health Board for factual accuracy checking and to be returned to HIW by early January 2023. At this stage, the health board are not required to submit an action plan. In line with HIW review process, this will be requested at a later date. The current scheduled publication date by HIW is 16th February 2023.

2.7 **National Reviews:**

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

A National Review is underway, reviewing patient flow with a focus to gain a greater understanding of the challenges that health care services face in relation to how patients flow through healthcare systems. A verbal update previously received from HIW reported the field work is still ongoing in health boards across Wales. An overarching report of findings from all health boards will be published in one report. The health board will not receive an individual feedback report. It is expected that the report will be published between January and February 2023. A date has not yet been confirmed.

ii. National Review of Ophthalmology Services

In January 2017, HIW published its review of 'Ophthalmology Services Thematic Report 2015-16'. The report made 22 recommendations for improvement, for NHS healthcare services in Wales to consider. The Health Board provided an update against these recommendations in 2019 and have recently been asked for a further update in relation to progress. A number of areas have been identified for reporting progress on including the examples below noting this is not an exhaustive list:

- Issues relating to patient referral process
- Quality of referrals being sent to rapid access pathway
- CHC reported concerns around lack of information provided within secondary care prior to treatment
- Concerns around set monitoring for follow-up patients
- More clarity required in relation to evolving role of Optometrist

- Inadequate IT systems to capture useful date (limited awareness of capacity and demand data)
- Lack of public awareness in relation to general eye care

The health board requested for an extension to the deadline for the updated action plan due to the clinical pressures and strike action within the service. An extension was granted by HIW with a new submission date of 13th January 2023 being agreed.
Further updates will be provided in the next report.

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

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

3.0 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

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

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Subject to the findings and outcomes of the HIW reviews.
Related Health and Care standard(s)	Staff and Resources
	All of the Healthcare Standards Governance, Leadership & Accountability Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.

	• Report for information on HIW activity • No service or staff impact in direct response from report, this is considered through the improvement action plans Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Subject to the findings and outcomes of the HIW reviews
Link to Strategic Goals	Improving Care

5.0 RECOMMENDATION

The Committee are asked to **NOTE** the report.

AGENDA ITEM
3.2.5

QUALITY & SAFETY COMMITTEE

PROGRESS REPORT '*IMPROVING CARE, IMPROVING LIVES*', NATIONAL CARE REVIEW FOR INPATIENTS WITH A LEARNING DIABILITY.

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Abraham Head of Mental Health & Learning Disabilities Commissioning
Presented by	Julie Denley, Deputy Chief Operating Officer (COO), Primary Care, Community and Mental Health
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
MH&LD Care Group QSRE	7.12.22	SUPPORTED
Learning Disability Commissioning and Performance meeting	21.12.22	SUPPORTED

ACRONYMS

MH	MENTAL HEALTH
LD	LEARNING DISABILITIY

CTP	CARE AND TREATMENT PLAN (MENTAL HEALTH MEASURE 2010)
CTMUHB	CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
SBUHB	SWANSEA BAY UNIVERSITY HEALTH BOARD
CVUHB	CARDIFF AND THE VALE UNIVERSITY HEALTH BOARD
HCF	HOUSING WITH CARE FUND
MHA	MENTAL HEALTH ACT
MCA	MENTAL CAPACITY ACT
PBS	POSITIVE BEHAVIOR SUPPORT

1. SITUATION/BACKGROUND

1.1 This report is intended to provide a progress report on the 'Improving Care Improving Lives' national review of inpatients with a Learning Disability,(LD) and the CTM UHB action plan to support its recommendations.

1.2 Link to the national review: https://gov.wales/written-statement-review-adult-learning-disability-patient-provision-managed-or-commissioned-nhs

1.3 An initial report was presented to the committee on the 19th July 2022.

1.4 The recommendations for the national review have since been adopted within the Learning Disability Strategic Action Plan 2022 to 2026, (WG 2022). Section 3.1 of the accompanying Delivery Plan places a joint responsibility on Health and Social Care for reducing unnecessary admissions to hospital for people with LD through; increased community based crisis prevention and early intervention, accessible high quality specialised care and timely discharges to care closer to home.

1.5 Link to strategy: Learning Disability Strategic Action Plan 2022 to 2026 | GOV.WALES

1.6 Both Specialist Inpatient and Community LD services are provided to CTM UHB by SB UHB through a long-standing service level agreement. The delivery of these specialist LD services are monitored by the

Performance and Commissioning Group, which is attended, by CTM and CV UHB as commissioners and SB UHB as providers.

1.7 CTM UHB Deputy Chief Operating Officer (COO), Primary Care, Community and Mental Health currently chairs the LD Commissioning and Performance meeting with SB UHB and CV UHB. The scope of this forum is to review the quality performance and cost effectiveness of the service provided to CTM and CV UHB from SB UHB. Central to the monitoring of the service has been the recent development of an integrated performance dashboard developed with SBUHB.

1.8 WG agreed the financial disaggregation of the LD budget in 2019 from SB to the three regional UHB's, however to date this has not been completed. This matter has been escalated through the UHB's Chief Executives for resolution.

1.9 CTM UHB directly manages the access to specialist hospital beds and care home placements through the NHS Wales National Framework. These placements are subject to approval from the MH & LD Clinical Placement Panel which is the process for ensuring packages of care funded by the Health Board are necessary, proportionate and subject to ongoing review.

1.10 Demand and capacity within specialist LD care home and supported living options are a priority area for the LD sub group of the Regional Partnership Board (RPB) arrangements.

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

2.1 Since February 2022 all Health Boards in Wales are required to audit the number of inpatients with a LD receiving specialist care. The audit program from September 2022 will be coordinated through the Delivery Unit on a quarterly cycle.

2.2 The initial audit in April 2020 identified 30 CTM UHB inpatients receiving specialist inpatient care. Consecutive audits in February and September 2022 identified 25 and then 24 respectively.

2.3 In the September 2022 audit, 21 CTM inpatients with LD were reported to be receiving specialist care. 4 patients were receiving acute care and the remaining 17 were in continuing care hospitals. 4 of those in

continuing care were inpatients in independent hospitals whilst the remaining 17 inpatients were inpatients within SB UHB.

2.4 The national position identified 147 inpatients across Wales reported in February 2022 and 134 in September 2022. A national reduction of 13 in year.

2.5 The initial 'Improving Lives, Improving Care' report made a number of recommendations specific to commissioners of LD services which are themed into the following 5 areas. The report will provide an updated position on the action plan included in annex 1.

2.5.1 **Inpatient LD services should be designed to meet the specific needs associated with gender, age and concurrent mental health conditions including dementia and autistic spectrum disorder.**

SB UHB have published its 3-year Modernisation program for its specialist LD services. The regional LD Performance and Commissioning meeting is responsible for reviewing and prioritising this program.

Capital investment into Hafod Y Wennol Assessment and Treatment Unit (AATU) and two Continuing Care Units (Bryn Y Afon and Meadow Court) all of which are located in CTM UHB footprint. The purpose of this development is to create a range of inpatient services equipped to meet the needs of those people with LD and complex needs, aiming to avoid the need for out of area placements and a transition pathway to community living.

Hafod Y Wennol service has been live since September 2021 and to date two CTMUHB patients have been repatriated from more secure Independent Hospital placements closer to home. The service has prevented 1 patient escalating to more secure care within the independent sector.

Capital refurbishment of Bryn Yr Afon is completed and able to offer step down opportunities from the AATU's. Unfortunately, plans for the refurbishment of Meadow Court has been delayed due to a lack of Capital funds available in SBUHB this financial year.

The MDT at these sites has been strengthened with the recruitment of dedicated Occupational Therapists, Psychology and Behavioural Therapists and additional Health Care Support Worker posts.

The provision of secure inpatient LD services is not feasible through the current SBUHB estate. Early consultation with the regional Health Boards about how this could be provided has begun. The development of these services will be further informed following the outcome of the Welsh Health Specialised Services Committee (WHSSC) revised MH & LD strategy.

2.5.2 **Inpatient services should be seen as last resort over community care, utlised for the least amount of time and have established transition pathways for those no longer needing hospital based care.**

CTM UHB are taking an active role in the development of alternative commissioning models in the community for people with LD. These alternative specialist supported living options are consistent with the national and local strategic direction of care closer to home in the least restrictive setting, whilst empowering people to have greater choice and control over their lives.

Since the previous report CTM UHB has worked with Rhondda Cynon Taf Local Authority (RCT LA) to increase its enhanced supported living facilities in the area. The 'Elm Rd Project' in RCT provides specialist accommodation and support for 5 people with a LD as an alternative to more restrictive models of care.

Further expressions of interest have been made to the RPB in November 2022 for HCF Capital investment for additional enhanced supported living capacity across the region.

Developing sustainable models of crisis and preventative care for people with LD in the community has been supported with the planned implementation of the Learning Disability Intensive Support Team (LDIST). The recruitment for the LDIST has been delayed and its deadline for implementation breached. This matter will be escalated through the Performance and Commissioning arrangements with SB UHB.

2.5.3 **Where inpatient care is required, each patient will be allocated a care coordinator who will be responsible for ensuring all aspects of the care and treatment are regularly reviewed with the patient, families, providers and local teams.**

Each CTM UHB patient has been allocated a Care Coordinator under the Mental Health Measure 2010. All inpatients have received a multidisciplinary review within the last 12 months.

Under the direction of the Commissioning and Performance Group the quality and accountability of the service provided by SBUHB is monitored. This Group continues to operate a risk register to identify areas of concerns and how they are being managed. The commissioning group also receives any Healthcare Inspectorate Wales inspection reports and reviews progress against any actions identified.

2.5.4 **There are evidenced based approaches to reducing restrictive practices and where necessary they are individual to the patient and subject to regular review.**

CTM UHB supports the publication of the national Reducing Restrictive Practices Framework https://gov.wales/reducing-restrictive-practices-framework

The framework requires commissioned services to provide an individualised approach to managing behaviors that challenge – known as Positive Behavioural Support (PBS).

All patients with complex LD with behaviors that challenge will be required to have a PBS plan. At every review interval the commissioning case managers and care coordinators will ensure these are in place and reflect the needs of the individual patient.

Restrictive practices are reported to CTM UHB provided through the SBUHB performance dashboard or the NHS Wales Secure hospital framework for independent hospitals.

2.5.5 **All inpatients who require detention under the Mental Health Act or Deprivation of Liberty Safeguards are subject to regular review.**

The legislative frameworks that apply to hospital settings include the Mental Health Act (MHA), Mental Capacity Act (MCA) and the rights of an informal patient. The MHA and MCA mandate the frequency of the review periods for each set of legislation. An informal patient should not be restricted and should be assessed as having capacity to agree to their care and treatment, and understand their right to leave hospital at any time.

The ongoing review of inpatients Legal status will be assessed and reviewed through the aforementioned statutory arrangements. Any breaches will be reported through the respective Health Boards Mental Health Act monitoring committee and Safeguarding procedures for MCA.

MHA and MCA activity for SB UHB inpatients will continue to be reported and monitored through existing Performance and Commissioning arrangements.

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

Assurance

3.1 In the two and half years since the initial report was published, the numbers of CTM UHB inpatients with a LD has reduced from 30 to 21.

3.2 The specialist LD services provided by SBUHB to CTMUHB will continue to be monitored and reviewed via the LD Commissioning and Performance group**.**

3.3 Establishing a dedicated MH&LD Commissioning Team has improved the accountability and assurance over the quality of care for patients from Independent hospitals commissioned via the NHS Wales Secure Hospital Framework.

3.4 The Regional Partnership Board (RPB) LD group will be developing further business cases to access HCF Capital funding to increase accommodation and support options in the region.

Risks

3.5 Continued funding via HCF is key to the development of good quality, community based, supported living accommodation services. These services are essential to minimise the need for and support transition out of hospital based care.

3.6 Delays in the transformation of specialist LD services could lead to inappropriate use of inpatient services.

3.7 Regional LD Planning and Partnership capacity to coordinate the CTM regional action plan.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	To provide assurance that inpatient care is regularly reviewed, provided in the least restrictive setting and subject to the appropriate legal framework.
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below: Safe Care Effective Care Governance , Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 Discuss and note the content of this report.

5.2 Discuss if there is any further information the committee may want in relation to this work.

ACTION PLAN FOR IMPROVEMENT	
Reference (Claim / Incident / Complaint)	**Improving Care Improving Lives (WG 2020)** **Nation Review of Adults with a Learning Disability in Inpatient care**
Directorate	**Mental Health**
Lead Officer for Action Plan (name & title)	**Mark Abraham**
Date action plan commenced	**1st April 2020**
Synopsis of Concern	In February 2020 Welsh Government published its national review Inpatients with a Learning Disability (LD). The scope of the review included all Welsh adults with a diagnosis of a LD being cared for in inpatient beds provided or commissioned by NHS Wales; this included beds within NHS England and NHS Wales, and beds in the independent hospital sector. Link to report – https://gov.wales/written-statement-review-adult-learning-disability-patient-provision-managed-or-commissioned-nhs This national care review found no immediate safety concerns and did not identify anyone who needed removing from their current placement. The review did however make a number of recommendations which were specific to providers and commissioners of learning disability services in Wales. CTMUHB are the commissioners of Inpatient LD services from both the NHS, through a service level agreement with SBUHB, and on an individual basis via the Independent Hospital sector. This action plan will therefore seek to address the recommendations to commissioners under the following 5 themes.

Review undertaken

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
Inpatient Learning Disabilities should be designed to meet the specific needs associated with, gender, gender and comorbid mental health conditions such as dementia and autism.		SBUHB Transformation of Specialists LD services	HYW capital investment complete and accepting admissions. Bryn Y Afon Capital Investment ongoing due to complete May 2022. Delays to Meadow Court due to lack of Capital funds 2022/23.	LD Performance and Commissioning Group	DoPCCMH	1st June 2022 (Bryn Yr Afon Completed May 2022.) Further Capital investment subject to WG funding.
		MH & LD Commissioning Team to review all Independent Hospital placements annually.	100% compliant with annual reviews.	Continuing Health Care Panels	Heads of Nursing & Head of Commissioning	1st April 2020
		CTMUHB engagement in National commissioning & procurement processes.	CTMUHB engagement in the NCCU Secure services review and WHSSC Strategic review for the provision of Specialist Inpatient LD services.	DoPCMH forum	Head of Commissioning	1st April 2022
Inpatient services should be seen as last resort over community care. Where Inpatient care is necessary there should be clear		Regional development of Specialist Supported Living options for people with complex needs.	3 schemes live in BCBC. 1 in development in RCT. Accommodation & Support models seen as	DoPCMH forum / RPB LD group	Head of Commissioning	1st Dec 2022 (Completed with opening of Elam Rd RCT) Ongoing

Review undertaken

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
transition pathways for discharge.			key priority for the region. Additional regional demand and capacity work to be completed.			investment required from HCF)
		LD Intensive Support Teams expansion into CTMUHB	SBUHB Transformation report – Quarter 2 2022/23 implementation plan.	LD Performance and Commissioning group	DoPCCMH	1st September 2022 (Delayed due to recruitment issues until early 2023)
All Inpatients should be allocated a Care Coordinator under the Mental Health Measure 2010.		SBUHB to allocate Care Coordinators under the MHM 2010.	March 2022 Performance Dashboard CTP Compliance 100%	LD Performance and Commissioning group	DoPCCMH	1st April 2020
There are evidenced based approaches to Reducing Restrictive Practices (RRP).		Staff training required on RRP framework including Positive Behavioural Support.	CTM Commissioning Case Managers 100% Complaint with PBS awareness. SBUHB have an internal training program for PBS.	MH & LD Commissioning Business meeting/ LD Performance and Commissioning group	Senior Nurse MH & LD Commissioning	1st April 2020
		RRP reporting framework	NCCU have included RRP as an outcome measure within the revised Hospital Framework. SBUHB RRP steering group established and incidents to be reported via the performance dashboard.	MH & LD Commissioning Clinical meeting / LD Performance and Commissioning group	Senior Nurse MH & LD Commissioning / DoPCCMH	1st April 2022

Review undertaken

Recommendation	Risk rating	Action needed	Progress & Evidence	Monitoring Arrangements (State HB group where progress is reported)	By who	Deadline date for completion (Use traffic light system to indicate status) & insert date of completion
All Inpatients should be safeguarded by the most appropriate legal framework.		Review of the Legal Framework for all CTMUHB Inpatients with LD.	Copys of the Monthly MDT minutes from SBUHB. MHA/MCA reporting via SBUHB Performance Dashboard	CTM LD Operational Group / LD Performance and Commissioning group	Head of Commissioning / DoPCCMH	1st April 2020

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

Review undertaken

AGENDA ITEM
3.2.6

QUALITY & SAFETY COMMITTEE

CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Carole Tookey, Nurse Director for Planned Care
Presented by	Carole Tookey, Nurse Director for Planned Care
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Nosocomial COVID-19 Incident Management Programme Group	29/12/2022	ENDORSED FOR APPROVAL

ACRONYMS	
CHC	Community Health Council
COVID-19	COVID-19 is an illness caused by a strain of coronavirus called SARS-CoV-2. This virus is responsible for the global pandemic since 2020.
CTMUHB	Cwm Taf Morgannwg University Health Board
DU	NHS Wales Delivery Unit
HCAIs	Health Care Associated Infections

IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PHW	Public Health Wales
PTR	Putting Things Right
RGH	Royal Glamorgan Hospital
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

1.0 The purpose of this report is to provide the Quality and Safety Committee of Cwm Taf Morgannwg University Health Board with assurance regarding the progress and delivery of the CTMUHB Nosocomial COVID-19 Incident Management Programme. This is linked to the National Nosocomial COVID-19 Programme (NNCP).

1.1 On 25 January 2021, the Quality & Safety Team at the NHS Wales DU were commissioned by Welsh Government to develop a national Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19. In March 2021, the National Framework for the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published and updated in October 2021.

1.2 In January 2022, the Minister for Health and Social Care announced £9m additional funding over 2 years to increase the pace of the implementation. The key outcome of the programme will be to provide a high level of assurance that all patient safety incidents of nosocomial COVID-19 are investigated in line with the requirements of the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.

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

PROGRAMME OVERSIGHT

2.0 Delivery pace has increased significantly in Quarter 3 now that the team is well established and the investigation approach embedded. A monthly completion target has been established to ensure that all investigations can be completed within the life span of the programme and this paper provides assurance that the team is currently delivering only slightly outside of the completion trajectory.

2.1 The Head of Programme will be leaving the Health Board for a new job role prior to the new financial year. Whilst delivery pace should be able to be sustained, their departure would leave governance and leadership weaknesses and therefore this position will be re-recruited to for the remainder of the programme.

2.2 Current programme spending is within allocated budget and the allotted funding for 2023/24 is fully accounted for in planned workforce spend. There is a small unfunded workforce spend at the beginning of 2024/25 but this has been reduced by recent staff turnover in the team as newly appointed posts will not extend past the end of financial year for 2023/24.

2.3 Nosocomial COVID-19 cases recorded after the 30 April 2022 will also be subject to the requirements of the National Framework and PTR regulations. The Delivery Unit has confirmed that the approach to managing and investigating HCAIs as patient safety incidents will be included in the refreshed version of their Nationally Reportable Incidents Policy.

WORK STREAMS

2.4 Establish team, investigation methodology and governance arrangements

2.4.1 A further clinical investigator has commenced in post and additional non-clinical support will also bolster the patient contact and support arm of the team in the New Year. An administrative position has become vacant however and a recent attempt at recruitment has been unsuccessful. This unfilled vacancy means that team resource is having to be diverted to complete necessary administrative tasks including physical selection of medical records.

2.4.2 Data validation activity against PHW reporting and the internal Nosocomial COVID-19 investigation database continues. This is being supported by PHW Epidemiology colleagues and CTMUHB Clinical Audit as part of hospital Mortality Review processes.

2.4.3 The Nosocomial database now allows for swift and accurate data reporting on completion figures for monthly national submissions.

2.4.4 The CTMUHB Nosocomial COVID-19 Incident Management Programme Group continues to run on a bi-monthly basis to ensure the Health Board's SRO is sighted on progress and risks.

2.5 Investigations and quality assurance

2.5.1 The status of investigation work is presented in **Appendix 1.**

2.5.2 As of 30 November 2022, 16% of the total number of investigations have been completed.

2.5.3 Investigation delivery pace has increased significantly and care review panels have remained quorate in the face of heavy operational and frontline pressures. Scrutiny in these panels has helped to develop the quality of investigations and ensure that the investigation scope remains appropriate.

2.5.4 Audit work to provide assurance on the quality and consistency of the non-clinical aspects of the investigation process has demonstrated a pleasing level of accuracy and audits will be undertaken on a monthly cycle throughout the programme to provide continued assurance.

2.6 Stakeholder, patient and family contact

2.6.1 The Programme Communications Lead is ensuring that public facing information about the programme remains up-to-date on the Health Board website. The post-holder will also act as a point of liaison for the recently-appointed National Communications and Engagement officer.

2.6.2 Attendance at Care Review Panels from frontline clinicians ensures that important feedback and learning is being heard and allows for wider cascade and dissemination. It is likely however that frontline pressures have prevented wider engagement of less senior clinical members of staff. Invites and encouragement will continue to be offered and staff are updated via the intranet and staff briefings.

2.6.3 Proactive contact into the patient-facing helpline remains at a low level and to date, little feedback or engagement has been received following issue of investigation reports and PTR responses to patients or their relatives. This will continue to be monitored and if, team capacity allows, feedback may be sought through the use of the Civica Patient-Reported Experience Measure system.

2.6.4 All public-facing correspondence has been reviewed by the national CHC Lead for the programme, who also joined the team on site for a day to understand the team's investigation approach. Positive and constructive feedback was shared on how the team is ensuring the lived experience of patients and relatives is captured and learnt from.

2.7 Thematic learning and improvement

2.7.1 The team has been working through incidents of nosocomial acquisition of COVID-19 from the Royal Glamorgan Hospital during 'Wave 2' of the pandemic. 'Wave 2' was the time period from late summer 2020 to early spring 2021, one of the most pressured periods of the pandemic.

2.7.2 Thematic learning from clinical investigations and the care review panel process includes the following: the difficulties created by extreme levels of demand – this resulted in communication with families at times being below the standard we would ordinarily expect; laboratory testing capacity being overwhelmed, with delays in COVID-19 test results being available; very tight bed capacity meaning that risk-assessed decisions regarding the placement of individual patients were often needed; COVID-19 testing guidelines changing often and the rigorous testing regimes being challenging to maintain during periods of peak demand; possible evidence of divergence in medical prescribing practice between hospital sites. A reassuring picture has emerged about the level of clinical record-keeping, the quality of clinical care and the degree of consideration given to managing the logistical challenges associated with bed capacity and COVID-19 patient status.

2.7.3 Thematic learning from our discussions and correspondence with affected patients and families is largely focused on the importance and lasting impression created by the relationship and contact with the clinical teams. It has been disappointing to hear that a number of families were not kept updated when their relative was transferred between different wards and found it difficult to make contact, with phone calls going unanswered. Other families however have been keen to highlight the positive trusting relationships that were built with staff and the compassion shown, particularly in terms of end of life care.

2.7.4 Themes will be monitored as the team progresses onto reviewing other CTMUHB hospital sites, as well as being alert to novel site-specific learning.

2.7.5 This local-level learning is supplemented by national-level learning around issues such as DNACPR completion, the availability of bereavement services and the impact of COVID-19 within commissioned services and care placements. A national Learning and Experience Collaborative has been established to share these themes.

2.7.6 Learning is being shared and implementation overseen through the Shared Listening and Learning Forum, IPC Committee and the Bereavement working Group

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

3.0 To receive assurance that delivery pace is now reaching the target level for full programme completion by April 2024.

3.1 To note the emerging learning from Royal Glamorgan Hospital 'Wave 2' reviews which has been shared through care review panels and will be brought forward into wider Health Board learning settings.

3.2 To be advised that a full programme risk register is being reviewed bi-monthly at the Nosocomial COVID-19 Incident Management Programme Group and the overarching Programme risk is also reviewed at the Infection, Prevention and Control Group. Currently there are no risks that meet the threshold for escalation to the Organisational Risk Register.

4. IMPACT ASSESSMENT

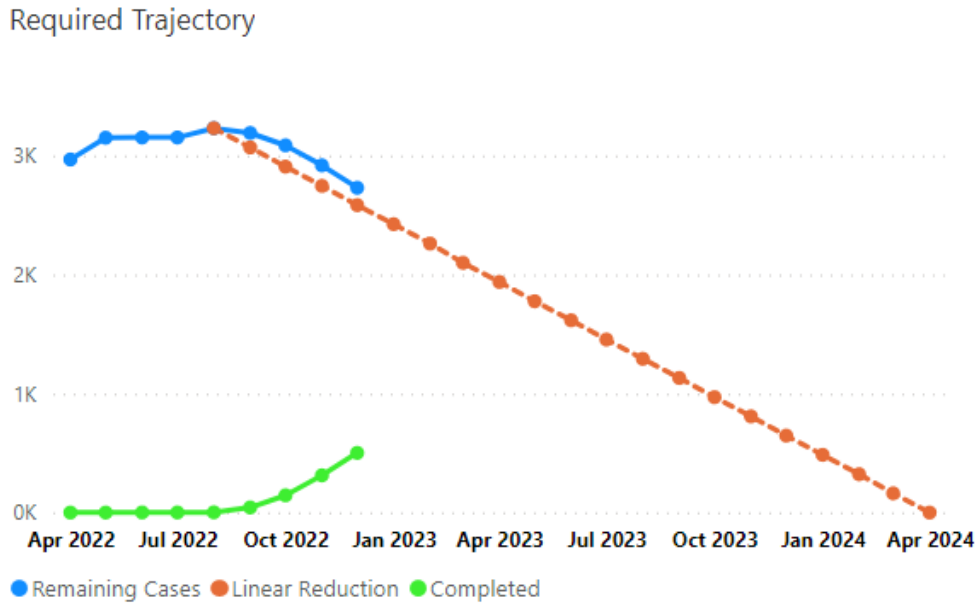
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Large numbers of our population were affected themselves or lost relatives as a result of nosocomial COVID-19 infection. This report details key steps in addressing their concerns and learning for future infection management or pandemic responses.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Relevant to all Healthcare Standards
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) Any new or altered services would have their own EIA undertaken.
Legal implications / impact	Yes (Include further detail below)
	Any incidents where a breach of duty or qualifying liability is believed to exist will follow appropriate legal process. The Health Board will work closely with NWSSP Legal and Risk services.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Dedicated fixed term workforce will be recruited. The funding stream is confirmed and provided by Welsh Government. No additional financial impact is anticipated other than through existing legal Redress and Claims provision.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

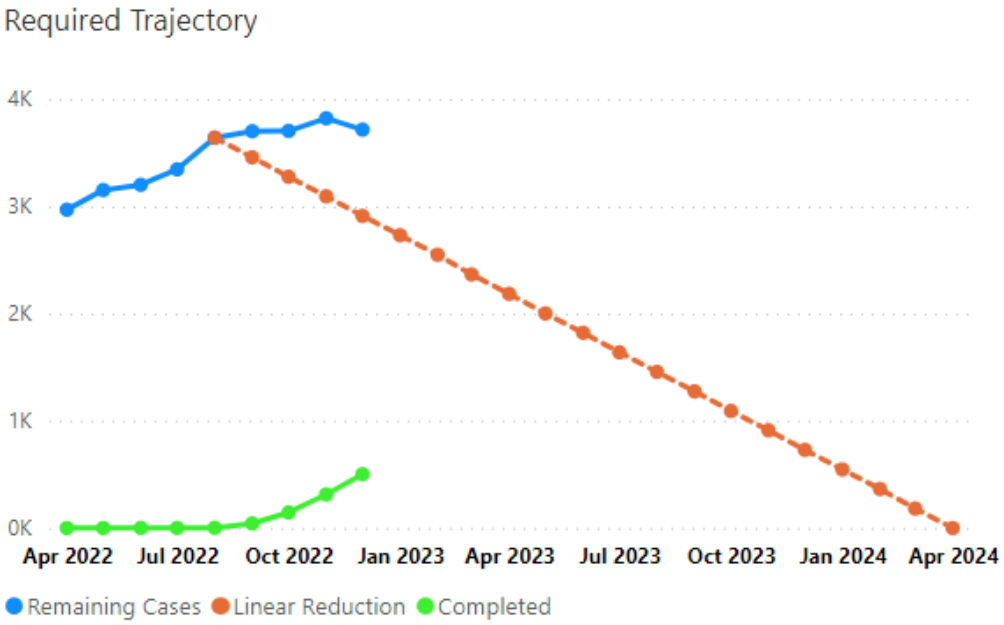
5.1 The Quality & Safety Committee is asked to **NOTE** this report.

Appendix 1

CTM Nosocomial Dashboard (Waves 1-4)



CTM Nosocomial Dashboard (Waves 1-4 and live reporting)



*Data correct as of 15/12/22

CTM Case status

	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022)	Live 01/05/2022 -
Total Incidents	479	1488	314	952	985
Not Started	316	589	233	831	849
Under Investigation	155	385	81	121	136
Downgraded / Recategorised	0	6	0	0	0
Referred to Scrutiny Panel	0	20	0	0	0
Completed Investigations	8	488	0	0	0

*Data correct as of 30/11/22

AGENDA ITEM
5.1

Quality & Safety Committee

ORGANISATIONAL RISK REGISTER

Date of meeting	24th January 2023

FOI Status	Open

If closed please indicate reason	Not applicable – Public Meeting

Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive

Report purpose	FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	December 2022 / January 2023	RISKS REVIEWED
Executive Leadership Group	16 January 2023	RISKS REVIEWED AND MANAGEMENT SIGN OFF RECEIVED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

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

2.1 The Executive Leadership Group supported "Guiding Principles: Quality Governance & Accountability during the Operating Model Transition" where the following transitional arrangements have been agreed:

- **Organisational Risk Register:** Workshop approach to realign risks on the Organisational Risk Register led by Nurse Directors. Timeframe: Realignment to complete by 31.1.2023. Assistant Director of Governance and Risk and COO Team met with each Care Group Leadership Group to review and agree assigned risks on the Organisational Risk Register.

2.2 Care Group Directors have undertaken the initial alignment of risks on the Organisational Risk Register to the new Care Group model and are in the process of undertaking detailed reviews on risks assigned to their areas.

2.3 Service / Winter pressures along with planning to respond to the impact of Industrial Action has posed significant challenges which should be recognised in light of the ability to keep pace with the timeframes to undertake this review and update risks this period.

2.4 The Assistant Director of Governance & Risk and Chief Operating Officer are holding a workshop with Executive Leads in January 2023 to review the Organisational Risk Register in terms of consistency of risk scoring, robustness of narrative and review of actions being taken to mitigate risks.

2.5 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. 359 members of staff trained to date.

2.6 Risks on the organisational risk register have been updated as indicated in red.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Diagnostics, Therapies and Specialties Care Group

- Datix ID 3131 - Mortuary Capacity. Risk scored at a 20.
- Datix ID 2721 - Capacity to deliver POCT training to Health Board Nursing Staff. Risk scored at a 16.
- Datix ID 5323 - Fluoroscopy Room has become Obsolete. Risk scored at a 15.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Patient Care & Safety

- Datix ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses. Risk score increased from a 16 to a 20.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

People and Culture Directorate

- Datix ID 4679 - Absence of a TB vaccination programme for staff. Target score reached and risk closed.

All Care Groups

- Datix ID 4253 – Ligature Points – Inpatient Services.

Rationale for closure and/or removal from the Risk Register is captured in Appendix 1.

3.4 DISCUSSION POINTS

Changes to Risks

The Executive Medical Director is initiating a review of Datix Risk ID 4590 - Critical Care Pharmacist Resource and Datix Risk ID 5214 - Critical Care Medical Cover, with the view to amalgamate these two risks.

Emerging Risks

As part of the review of current risks following alignment to the new Operating Model new risks and changes to risks are in development to come forward to a future iteration of the Organisational Risk Register.

3.5 **Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):**

Consequence						
	5			3337 4772 5207 5323	4080 3826 4887 5214	4743
	4				4149 4458 4148 4798 4906 4908 5014 4152 3585 3133 1133 4479 4940 4722 2721	4491 4632 4071 4721 4103 4217 5036 4907 4922 3131 5254 5267
	3					4691 4732 4920 3993 4512 4590 2808 4971
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for the Risk Register item.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3131	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24.	Quality & Safety Committee	20	C4xL5	C3xL2	New risk escalated to the Org Risk Register in January 2023	05.03.2018	05.1.2023	5.2.2023
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	03.01.2023	31.01.2023
5254	Executive Director of Nursing.	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	October 2022: Invest to save bid has been developed and submitted, which requests 2 Redress Handlers, this should give some capacity, however focus will be on addressing the current backlog. Some resource has been identified through the operating model, which should give some capacity within the current legal service. Impact assessment being undertaken to assess resources needed to manage expected workload when Duty is introduced. Board Development session being arranged to raise awareness of accountabilities of Board in compliance with the Duty of Candour and Duty of Quality (Oct 2022) where local implications will be shared. Update December 2022: Invest to save bid unsuccessful, therefore alternative options for funding being explored. National impact assessment is being developed, which will be reviewed and localised for CTM. New operating model, should give some limited capacity, however, focus will be to target the backlogs within the department.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	07.10.2022	19.12.2022	31.01.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022.	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors. Update December 2022 - The Covid-19 Information Manager position was re-advertised in December for shortlisting in the New Year. Whilst the success of this latest recruitment exercise is unknown the risk score will remain unchanged. Review 31.1.2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	20.12.2022	31.01.2023
5214	Executive Medical Director / Chief Operating Officer	Planned Care Group	Care Group Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Critical Care Medical Cover	If: Depleted Consultant Intensivist numbers at Princes Of Wales (POW) continue as a result of medical reasons, retirement and unable to recruit to vacant posts. No Middle Grade medical tier at POW. Consultant intensivist delivered service. Then: Without Middle Grade tier positions the ability to attract and recruit Consultants will be limited. Resulting in: the Health Board being unable to deliver safe patient care with gaps in rota. Potential for days and nights to not be consultant covered. No medical team to manage patients.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care.	Workforce business proposal to fund Middle Grade tier to ELG. Digital solution to provide safe cross site Consultant cover for RGH and POW, requires IT solution across POW and RGH. Develop workforce modelling for next 2 years and 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change).	Quality & Safety Committee People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	19.8.2022	20.09.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption		IF: The Medical Records Filing library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Relocation of Case Notes from POW/Bridgend Off-site Store to Glanrhyd Site. Timeframe 19.8.2022 Replace racking and review office environment of POW filing Library. Timeframe 30.01.2023 Creating additional long term storage space. Timeframe 31.07.2023 Update 31.10.2022 - Approx. 30,000 records have already been redistributed across POW, North Road Offsite Store and Glanrhyd Library, to improve conditions at POW. Work is still ongoing at POW to redistribute records safely. Original broken rack mostly vacated but other racks holding notes have similar issues. Glanrhyd partly vacated by SBUHB but not fully available for use yet. The Medical Records Department plan to relocate 10 Registration Medical Records staff to the Library Offices in this space. Proposal put forward by an Operational Services Manager to relocate additional 17 Appointment Booking Centre staff into these same offices and also the Library area. This Library space is already identified for boxed records, compromising room for future growth and safer storage; this will affect the ongoing position at POW and North Road. Risk to be reviewed in 6/52, when SBUHB should have fully vacated and a decision made as to who/what will occupy remaining space at Glanrhyd Library. Update January 2023 - Relocation of Case Notes Action: 30,000 case notes relocated to Glanrhyd. This action was closed 16.12.2022.	Digital & Data Committee & Quality & Safety Committee	20	C5xL4	10 C5xL2	↔	27.10.2021	16.12.2022	30.01.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update September 2022 - Continue delivery of the Planned Care Recovery Actions. Reconfiguration orthopaedic inpatient operation. Commissioning the insourcing of the workforce to deliver to Theatres. Amalgamation of Health Board wide capacity plans. Significant work ongoing in relation to FUNB which is being captured in the performance reports. Update October 2022 – Procurement exercise commenced 20 Oct 22 re the insourcing of the workforce to deliver to Theatres. Recruitment to theatres transformation role from 28 Oct 22. Amalgamation of Health Board wide capacity plans. Significant work continuing in relation to FUNB which is being captured in the performance reports.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options - Cancer performance is monitored through the more rigours monthly performance review process. each ILG now reports actions against an agreed improvement trajectory. Weekly monitoring led by the Chief Operating Officer to monitor progress. Pathology backlog clearance plan funded and in delivery.	Update September 2022 - Score remains unchanged. Recovery actions continue with focus on Urology and Lower GI. Improvements are being recognised in Gynae and Breast Surgery which are currently ahead of plan. Cancer treatments remain higher than pre-Covid levels. Update October 2022 - Score remains unchanged. New Cancer Assurance cycle from November 2022. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels. Update December 2022 - Score remains unchanged. Health Board is now in targeted intervention for cancer. Additional assurance meeting with WG, WCN and DU underway. New cancer assurance cycle from November 2022 embedding. Recovery actions continue with focus on Urology, Lower GI and Dermatology. Improvements are being recognised in Gynae and Breast Surgery which remain in line with plan. Cancer treatments continue to be higher than pre-Covid levels. Referral rates are higher than pre Covid, but reducing from their highest levels. Challenges remain with diagnostic capacity, short term outsourcing has improved wait times, but longer term solution needed. The mobile endoscopy unit is also providing additional capacity, and reducing waiting times, but a longer term solution is required for after this. 104+ day harm review panels are paused on two sites, recruitment underway for administration support to recommence.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	23.12.2022	31.1.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialist's) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	24.11.2022	31.1.2023
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / QBSR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maestegg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	November 2022 update: WLI activity commenced W/C 11th November in an attempt to clear the >104 week backlog, primarily for stage 1 long waiting cataracts. Ongoing clinical and non-clinical validation work is being carried out on all pathway stages with a number of patients being removed as treated or no longer requiring treatment. An application has been made to the Governance Board to appoint an extended nursing team specifically for harm reviews - awaiting outcome. Nursing review is being carried out to measure utilisation and productivity. Ongoing discussion with Cardiff &Vale in relation to using the Vanguard theatres between January and March 2023. Revised SOP shared with community optometrist to consider carrying out new patient glaucoma referrals - awaiting SEWROC outcome. COO and MD met with the Ophthalmologist to outline future plans and expectations. Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients, CTM currently have 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	23.12.2022	30.1.2023
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Regional and National Stroke Programme Boards established • Unified, evidence-based pathway developed for thrombectomy • Bristol thrombectomy service becoming 24/7 in Autumn • Oversight of performance via regular SSNAP audit results, Performance Dashboard updates and Quality and Safety Committee reports • Full engagement from clinical teams in HIW review of flow of stroke patients in May 22. National report due in Spring 2023.	**Update 3.1.2023 -** Recruitment process ongoing as part of CTM Consultant Recruitment Drive. The CSGs continue to work with medical staffing agencies to aid the recruitment of a Locum Consultant following the resignation of Consultant Stroke Physician at Prince Charles Hospital. Development of a CTM stroke consultant rota, with joint working between PCH and POW consultants to enable a more stable rota. Continued dialogue with Cardiff and Vale UHB to look at long term solutions, feeding into the South Wales Central Regional Programme Board. •Regional developments with Cardiff and Vale UHB continue, with a further meeting of the regional programme board held on 22nd November. Key links being established to the National Stroke Programme Board to ensure congruence between the national stroke programme and the South Wales Central stroke network programme. •Fortnightly Stroke Pathway Task and Finish Group meetings continue. Review of priorities and risks undertaken within the Task & Finish meetings, nominated leads identified and priority actions are being progressed at pace. Work underway to review demand/capacity and therapies workforce gaps, exploring potential improvements to data streams and review of pathways for TIA across CTM. •CTM Stroke Strategy Group established to drive forward the strategic development of stroke services across CTM UHB, with work streams for acute stroke and rehabilitation care pathways and early intervention/prevention. First meeting of strategy group took place 8th December and moving forward will receive updates and assurance from Task and Finish Groups. •Work is underway in CTM UHB in preparation for forthcoming 24/7 access to Thrombectomy at Bristol. This includes plans to get radiographer approved CT angiograms at same time as plain CT scans, to minimise delays in suitable patients, and CT reports (including out of hours) within 30 minutes, together with planned additional training for middle grade doctors. •National relaunch of FAST campaign planned by the Stroke Association. Local plans to raise awareness amongst those at high risk of stroke in primary care being developed by Public Health Wales in conjunction with primary care colleagues.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	3.1.2023	31.1.2023

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4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Llidiard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACMG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan 31/05/2022 Demand & capacity review 30/06/2022 Workforce redesign 30/06/2022 Dedicated Pathology IT resource 30/06/2022 Accommodation review 30/06/2022 Novation of Equipment to the Managed Service Contract 30/09/2022 19.10.2022: Outsourcing continues to LDPath - incidents/complaints regarding delays have been received POCT training room is now being used for IHC Some new equipment has been Recruitment drive and capacity planning continues. Update 30.12.2022 Outsourcing to continue in Q4, backlog clearance has helped reduce internal turnaround time for cancer diagnostics to around 10 days (with exception of complex sampling) some serious incidents have been reported through from what was expected to be routine samples but have returned and confirmed cancer samples (gynaecology). Macmillan have supported a 3 year post for haematology. Service Director awaiting response from Executive colleagues regarding sustainable funding post 2026 from SLA repatriation. Bid to continue use of LD Path outsourcing being prepared for 2023-2024 while regional collaboration discussions progress in tandem. Improvement team have been approached to undertake a process mapping exercise to see if we can "lean out" the processes in cellular pathology and haematology. In addition Wales Cancer Network has been approached to support Demand and capacity as internal resource are not adequate to assist in a timely fashion.	Quality & Safety Committee	20	C4 x L5	6 (C3xL2)	↔	02.03.2022	30.12.2022	31.01.2023
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update September 2022 – Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	03.11.2022	31.12.2022
4907	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. The Health Board has secured Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Update September 2022: The Health Board are starting to realise the risk with evidence of redress cases being moved into claims due to delays, which are being settled for less than £25k, which is non reimbursable through WRP procedures for a claim, however can be reclaimed under redress. An invest to save bid has been developed to address the redress backlog. Update October 2022: Invest to save bid has been developed and submitted. Some resource has been identified through the proposed Quality Governance Operating Model, which should provide some capacity within the service. Update December 2022 - A considerable redress backlog remains, with CTM realising the risk of cases being transferred out of redress into claims, therefore having inability to recoup full costs. This continues to pose a significant reputational and financial impact on the Health Board. Invest to save bid has been unsuccessful therefore other funding options are being explored. Some limited capacity has been identified through the operating model review in respect of quality, safety and governance, however, more resource will be required to begin to manage cases in a timely manner.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	19.12.2022	31.01.2023
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months – there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses. Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out continues on all sites. ENHANCED SUPERVISION Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests. The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023	Quality & Safety Committee	20	C4xL5	C4xL3	↑ Increased in January 2023	25.10.2022	04.01.2023	04.02.2023
2721	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity to deliver POCT training to Health Board Nursing Staff	Currently there is insufficient POCT staff resource to effectively deliver essential training to Nursing/Medical/HCSW staff across the HB. In addition there is no training facility to deliver this training to large cohorts of staff, this is an issue across the HB. The POCT testing repertoire has significantly increased, and will continue to increase across the HB as the drive for near patient testing increases.	POCT have worked with L&D to move POCT glucose e-learning refresher training to ESR (this can prove troublesome and the training dept. have removed their support). Issue has been previously escalated to HoN. Temporary staff from Covid funding has alleviated some of the pressure (post currently vacant). Working with training dept. to try an block book training rooms, but this is difficult as there are no definitive timescales. Some cascade training in place (also a risk of dilution of scientific knowledge)	SBAR in progress to describe current issues with delivery of POCT training and recommendations on how this can be improved moving forward. Covid funding has been agreed previously for POCT (Band 4) until March 23. This post is currently vacant, therefore we need to recruit into this post 30.12.22: Discussion of risk and options to be discussed at Improving Care Board in January 2023.	Quality & Safety Committee	16	C4xL4	C2xL2	New risk escalated to the Org Risk Register in January 2023	27.02.2017	31.10.2022	31.01.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4149	Chief Operating Officer	Mental Health Care Group	Clinical Service Group Manager - CAMHS.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain Child and Adolescent Mental Health Services	**If:** The Health Board continues to face challenges in the CAMHS Service (covering locality CAMHS in CTM and Swansea Bay as well as specialist CAMHS services commissioned by WHSSC - Inpatient Unit at Ty Llidiard and FACTs service) **Then:** there could be an impact in maintaining a quality service **Resulting in:** recruitment and retention challenges and detrimental impact on wellbeing of existing workforce, long waiting times; inability to implement new models of care required to meet increasing demand; supporting patient pathways via services and standards of care planning required by the All Wales Mental Health Measure. If the specialist WHSSC commissioned services are not sustained the impact would be far reaching given the population they serve (inpatient - South Wales, FACTs -whole of Wales) and would result in more complex patients not being supported and treated in Wales. Difficulties remain with waiting times for specialist CAMHS; recruitment of key staff and ability to implement new model of care and the new neurodevelopmental service remains challenging.	o Reported local and Network pressures across the CAHMS Network with variable problems dependent on the area of the network. o Updates provided to Management Board on developing service model to address reported issues and additional investment secured to increase capacity within the service and to address service pressures. Waiting list initiatives in place whilst staff recruitment is being progressed. o Service Model developed around Core CAHMS in Cwm Taf Morgannwg which includes agreement with General Paediatrics to take the lead on Neurodevelopmental Services and shared care protocols with Primary Care. o New investment impact being routinely monitored internally via the SMT and via monitoring meetings with the ILG Monthly commissioning meeting discussions taking place across the Network in relation to service pressures and funding. Additional funding received for investment in services • Implementation of the Choice and Partnership Approach (CAPA) with a new service model introduced ensuring the service aligns itself with All Wales Mental Health Measure. All referrals accepted to CAMHS will now receive a Part 1 Mental Health Assessment to determine the level of support required. Performance is being reported and monitored via monthly performance meetings • A number of service reviews in relation to Ty Llidiard undertaken and monitored via Q,S&R Committee. Additional nursing leadership implemented and progress on required action plans and proposed staffing model. Business case being drafted for additional investment to support staffing model in March 22. Workshops scheduled with WHSSC to review service specification and gap analysis. First workshop took place on 15th Feb 22. Staff and stakeholder consultation event took place in April. Improvement Board set up and improved reporting to WHSSC on actions taken and progress being made. Survey undertaken with colleagues demonstrating improvement. • Community CAMHS in both CTM UHB and Swansea Bay UHB are carrying out WLI via the planned care recovery (PCR) scheme. The additional clinics and dedicated team for assessment and single point of access have helped to reduce waiting times in CTM UHB to approx. 4 weeks. Number of patients on CTM waiting list has reduced from 365 to just over	Risk reviewed and updated the controls Ongoing improvement in community CAMHS performance in relation to waiting list - Swansea Bay waiting list reduced down from 462 to 90 in September. CTM waiting list reduced from 365 in May 2022 to 200 in September. Work ongoing to improve compliance with part 1a and 1b. New SIF MH bids funding received and in progress of recruitment. Further work required for community CAMHS performance on part 2, improvement plans in both areas. Continued improvements being made in the escalation plan for Ty Llid via the Improvement Board. values and behaviour leadership survey undertaken which demonstrates good feedback from colleagues on improvement but also helps identifies areas for improvement. FACTs service - consultant interviews taking place on 1st November. Progressing recruitment plan to address vacancies Update 29.11.2022 - Improvement in compliance for SB CAMHS for MHM Part 1a 83% in October and backlog addressed. Slight improvement for CTM CAMHS in MHM Part 1a but waiting list has increased due to increased demand in October. SB meeting Part 2 compliance but numbers reported low. Improvement plan in place for CTM Part 2 compliance. Continued improvements being made in Ty Llidiard, NCCU attended in November and reviewed clinical notes and positive feedback. Awaiting formal feedback via WHSSC escalation meeting on 5th December. Weekly audit reviewing clinical records in place using QI methodology and demonstrating improvement. Ty Llidiard Away Day planned in December to focus on developing the team approach. New therapies lead starting in December, FACTs service - consultant appointed awaiting start date. Ongoing recruitment to vacancies in service. Plan to advertise clinical lead role once consultant has been appointed	Planning, Performance & Finance Committee & Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	01/01/2015	29.11.2022	31.01.2023
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. 02/08/21 - Operational lead for Decontamination has requested assurance from the lead endoscopy decontamination officer in POW. Timeframe 30.11.2021. 15.12.2021 - risk peer reviewed and agreed that the risk remains as a 20. Development of a business case to create a single centralised decontamination facility on the POWH site has commenced with Welsh Government Funding support. Business case expected to be completed by Spring 2022. Availability of WG funding to create the unit remains a risk. Update June 2022 - Risk reviewed at Infection Prevention Control committee 28/06/2022 and update provided - JAG have agreed to extend accreditation in Princess of Wales for a further 6 months and have requested a progress report on plans for central decontamination. Update: Lead IPC Nurse and Deputy Executive Nurse Director reviewed the Action Plan with no updates reported for August. 17/08/22 - contingency plan being developed with key service users. Central decontamination facility at detailed design stage and business case should be ready for submission by end of January 2023 Update 6.1.2023 - actions as reported in August 2022 currently on track. Next review scheduled for January 2023.	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	6.1.2023	31.01.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	12.10.2022	07.03.2023
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update: December 2022 Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the Health Board. As of December 2022 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months (DG DW 21/11/2022). Review Date: 28/02/2023	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	8.12.2022	28.02.2023
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. June 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion. Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCLI staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to ID4458 & ID3826.Update: Awaiting update from Capital team to confirm start date for next phase of works. Patient toilet is the next priority. Update from Capital Team 6.5.2022: The ILG have been requested to provide availability for a prioritisation meeting for the 22/23 limited discretionary funding that is available - this will need to be discussed alongside their outstanding risks and prioritised for funding. Update June 2022 - Additional toilet works not yet commenced. Agreement from Capital / Estates teams to undertake the work. No start date yet. Update 3.11.2022 - WG funding secured to have works undertaken. CTM capital team progressing ASAP.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	3.11.2022	30.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2022 review of this risk the control measures have been revisited and streamlined. - Prioritisation assessment is being undertaken on the urgent authorisations. - A hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - As at February 2022, the DoLS Team have now returned to full establishment which will support the resilience within the function. - A temporary Best Interests Assessor has now commenced with the Health Board whose role will be to focus on reducing the backlog. This post have been extended for a further year following CTMUHB being granted further WG funding to address the backlog. - A temporary Practice Educator has also been appointed whose role will be to prepare the Health Board for the Liberty Protection Safeguards and ensure that all staff are trained in the Mental Capacity Act. This post has been extended for a year following CTMUHB being granted further WG funding. - From February 2022, the DoLs Training has been revised and is running virtually on a monthly basis. - Audits are undertaken by the DoLS Team to look at compliance across the Locality Groups with the support of AMaT. - Capacity issues are also being supported by addition resources sourced through CTM Staff Bank. August 2022 Update: As a result of enhanced WG funding MCA training has been reviewed an delivered virtually and face to face across sites within CTMUHB. Both YCC and YCR staff have received bespoke training in response to concerns raised by the DU. In addition, training has been agreed and planned to be delivered to service groups within all three ILG. Compliance is being monitored through the Safeguarding Executive Group. Quarter 1 had the highest recorded number of referrals in a quarter, this coincides with the additional training. It is reassuring that the referrals are correctly identifying those people who need urgent and standard DoLS.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update July 2022 - funding of £90K received to facilitate continued improvement in MCA awareness and training. Training sessions being delivered. to targeted areas in the UHB to improve awareness and therefore quality of care and safety. A Learning Event is planned to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation. No further steer on the implementation of LPS. Awaiting feedback in relation to the consultation on the code of practice. Update August 2022 - CTMUHB have received further WG funding of £184K. A further four BIA posts have recently gone out to advert. Two further Mental Capacity Practitioners will be advertised in September 2022. It is anticipated that the substantial increase in the teams resources will enable the BIA to address the current backlog and respond to the increase in DoLS requests. The appointment of two further MCA Practitioners will allow for increased capacity to deliver MCA training and prepare for further LPS training throughout CTMUHB. Sessions to highlight the issues in respect of capacity, the MCA and planned changes as a result of new legislation have commenced. Comments in respect of the proposed code of conduct have been submitted to WG by CTMUHB. Once all vacancies have been filled it is anticipated that the backlog of outstanding authorisations can be significantly reduced and the risk reviewed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	25.08.2022	21.10.2022
4152	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. 30.12.22: Cancer waits have reduced significantly and are getting towards the 10 day internal target with exception of CT. CTC pathway work has identified overuse of this test and pathway redesign will help realign the demand to optimal pathway reducing inappropriate testing. CTM Improvement team have undertaken a process mapping exercise showing variation and some opportunities for streamlining processes. Wales Cancer Network are supporting a demand and capacity exercise in Radiology as internal support is stretched and unable to support in a timely fashion. Consideration for additional sessions to reduce backlog quicker through Planned care recovery board have been declined. Further bids will be submitted for 2023-2024 as diagnostics are key to planned care recover pathways.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	05.01.2023	01.02.2023
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update – UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) – rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	Clinical Director of Allied Health Professionals - Therapies	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response. Update 16-9-21 Continuing with therapy business case as actions below. No other updates	Full engagement by AHP Leads with all Critical Care meetings and submission of all required therapy workforce info in line with GPICS standards but no confirmed investment in therapies for Critical Care across CTM. SLT and Dietetics are the most affected, with no cover in PoW and very limited cover in RGH and PCH. Recent Datix for PoW when team became aware that the 'emergency' enteral feeding regime was 10 years old, not written by a dietitian, and recommending a feed no longer stocked in PoW. Actions: Actions continue to try to improve safety at PoW, led by Head of Nutrition & Dietetics. Ongoing Therapy & ITU discussions with PoW and RGH regarding repurposing monies to fund SLT sessions. CD for AHPs met with PCH intensivist w/c 24/10/22. Meeting to be planned for upcoming weeks to review the AHP situation across CTM. Intensivist is engaging the Critical Care Network to seek support and advice. Risk remains high across all 3 sites. 21/12/22 update: - Recent formation of critical care project group with a remit to produce recommendations to the ELG end Jan/early Feb 23 in response to the Hackwell report 2022 regarding the future of critical care configuration in CTM. The CD for AHPs will be a key stakeholder in these weekly Jan 2023 meetings to ensure that the AHP requirements are fed in. We continue to not meet GPICS standards across all therapy professions. The current critical care AHP workforce situation as at 21 Dec 2022 is steady but limited Physio services across all 3 units. No OT service. Limited Dietetic service in PCH and RGH with no dietetic service in POW ITU. There is currently no critical care SLT service across CTM due to delays in future critical care planning. SLT have only 1 funded session which can give limited support to level 1 patients at ward level only. With no investment there will be no SLT critical care service in CTM causing continued delays in weaning, increased pressure on MDT, reduced pt experience and outcomes and potential disruption to repatriation pathway from UHW.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	21.2.2023	22.12.2022	21.02.2023
4906	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	The Health Board are developing a Learning Framework to ensure Learning is captured and shared across the organisation. Currently at consultation stage. The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023 Welsh Risk Pool have implemented a targeted improvement plan. Initial target was marginally missed, however, work continues to meet the overall deadline for 1st June. Update September 2022 - Work continues in this area, however this is still proving a challenging area of work. The new operational model has ensured that this area of work is included as part the Care Group Governance Team. Update October 2022 - A data reconciliation with WRP has demonstrated that the data held by CTM and WRP now correlate. This has been achieved through updating data and an in depth data validation. This will be invaluable going forward as service areas will have a clear position in relation to LFERs. The Governance teams continue to support service areas with the completion of LFERs. Guiding principles for the governance and accountability for quality and safety have been developed to support service areas through the transitional process to the new operating model. Update December 2022: - The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. LFER reports are now available per care group, ensuring better monitoring.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	19.12.2022	19.2.2023
4908	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in**: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	19.12.2022	19.02.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4940	Executive Director of Nursing	Central Support Function - Quality Governance (Patient Experience)	Assistant Director of Nursing & People Experience.	Improving Care	Quality, Complaints & Audit	Delay to full automated Implementation of Civica	**If:** the Information team are not be able to complete the necessary data extraction requirements, **Then:** there will be a delay to the roll out of the automated survey process within the Civica system, **Resulting in:** a lack of service user feedback and opportunity to areas of improvement as well a good practice.	The Health Board launched the electronic ""Have your Say"" and Generic Patient Experience Survey on the 13.02.22. Posters containing QR codes are displayed on notice boards in our hospital sites, KHHP and Dewi Sant. In addition links are available on our internal and external webpages, along promotion on available social media channels. A small card (like a business card) containing a QR code has been developed which will displayed in main thoroughfares such as Emergency Departments, Outpatients and community settings. Their will be made available to staff that are providing services in patients' homes. Exploration is taking place as to how the posters/cards can be promoted within he wider non-health board community settings. August 2022 Update: Value Based Health Care are working together with patient safety and quality to ensure the Health Board can align patient/peoples engagement / feedback. There is an objective in the new WG transformation strategy where we all have to work together and embed proms and prems. There is currently only one member of staff working on the Civica system (PT)and therefore resource is currently a major factor for the implementation and maintenance of the system. No change to the challenges relating to the full automation of Civica which remains an issue. Due to this CTM response rate to patient feedback is considerably lower when compared to other Health Boards e.g. SBUHB, HDUHB, ABUHB, BCUHB. Volunteers within POW are now actively engaging with patients in regards to the Have your say/ patient experience survey	Implementation of the Civica System. Information Team has completed provision of all data feeds (August 2022) Whilst the overall consequence and likelihood of the risk is not extremely high, the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. Reactive feedback continues be received and reported on via complaints, claims and compliments. August 2022 Update - SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. CIVICA system piloted in PoW in August using volunteers to capture feedback using the CIVICA system via IPADS. December 2022 Update- The information team have automated 8 patient experience surveys within Civica which is also aligned to the PROMs conducted as part of the VBHC portfolio. However the SMS component remains high as currently there is no target date for full implementation of the automated element of Civica which would increase real time response rates. The number of responses seen are low when compared to other HB who are actively using the SMS component. As a consequence of not having the automated SMS component up and running across CTM it has resulted in an increase of paper copies which require resource to manually input the responses into Civica- This resource currently does not exist as only 1x PM is working on the system part time. Update 5.1.2023 - Project Manager is exploring how the Health Board can slowly integrate within specialised surveys as this work is specific within the ask of IT, however the Health Board cannot implement the automatic SMS for all appointments/inpatient interaction with the Health Board at present.	Quality & Safety Committee	16	C4 x L4	12 (C4xL3)	↔	09.12.2021	5.1.2023	14.02.2023
5014	Chief Operating Officer	Children and Families Care Group	Children and Families Care Group Service Director and Clinical Services Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	IF patients continue to present at the ED at the RGH with obstetric and gynaecology related issues and if boundary changes and diverts at times of high demand lead to increased risks for this patient cohort . THEN they will need to transfer to the ED at PCH where the appropriate services are in place. RESULTING IN a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	Update October 2022 - the Assistant Director of Governance & Risk met with the Care Group Director and the Clinical Services Group Manager for the Children and Families Care Group regarding this risk and agreed that a review will be undertaken by the end of December to consider if the implementation of the On Call rota has mitigated this risk sufficiently to reduce the risk score. This will include engagement with the Executive Medical Director. Review by 31.12.2022	Quality & Safety Committee	16	C4 x L4	9 (C3xL3)	↔	15.02.2022	01.11.2022	31.12.2022
4722	Chief Operating Officer	Mental Health Care Group	Service Director - Mental Health and Learning Disability Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Senior Medical Workforce Shortfall	**If** the gaps in the senior medical workforce in RTE are not addressed (2wte vacancy OP, 1wte LTS, 1wte Non clinical duties plus paternity leave and isolation) **Then** routine work such as clinics will be cancelled, clinical decision making will be delayed and emergency escalation compromised along with the ability of the service to discharge the powers of the Mental Health Act. It is also possible that the training of junior doctors will be negatively affected. **Resulting in** poor quality and unsafe patient care, increasing concerns, risk of litigation, compromise of the UHB's reputation and removal of UHB from Psychiatry training programme.	Regular meetings with interim CSGD and Consultants to plan cover arrangements and support on weekly basis. Medical model change to functional inpatient at the RGH MHU covered by 3 Locum Inpatient consultants (22 sessions - 12/6/6) to cover 2 x Treatment Wards (28 beds) and 1 x PICU (6 beds). Recruitment - Vacancies out to advert for locum and substantive contracts. Exploring options for overseas recruitment. All staff being offered additional hours. In-patient team has been bolstered by an additional Registrar and 2 x SHOs ANP's covering appropriate PCMHSS AND CMHT clinics.	Update 06/06/22 - Vacant post in Rhondda Adult MH and been notified that Locum for Taff Ely who also covers in patient wards 1 day a week will be leaving the end of this weak. This leaves 2 vacancies in sectors for adult and an inpatient day short fall. Update Sept-22 - All adverts agreed to go in BMJ as part of wider recruitment drive. JDs have been reviewed and refreshed. Update November 2022 - Locum cover secured to mitigate partial risk pending substantive appointments. Recruitment exercise underway an interest has been received. Medical Director appointed into the Mental Health and Learning Disability Care Group to provide oversight and leadership on sustainable medical workforce activity.	People & Culture Committee Quality & Safety Committee	16	C4xL4	6 (C2xL3)	↔	28/06/2021	01.11.2022	31.12.2022
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Non-recurrent investment of the below posts have been given for 12 months, but Clinical Service Group has highlighted the requirement for these posts to be made permanent. *1.0 wte Psychiatrist (clinical lead role) *Uplift from 8a to 8b 0.6 wte Pharmacist *1.0 wte Band 3 admin *0.6 wte Band 3 HCSW Additional clinics are currently being held on weekends to address longest waiters. (WLI has been carried out in the service since 6 months of the service being set up) Meetings with National Lead for Values Based and Prudent Health Care arranged to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Within Bridgend the Directorate is reviewing the feasibility of repatriating the SLA from Swansea Bay so that a local service can be developed	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update – it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022. Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	03.1.2023	01.03.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022 from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward. Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	--	31.01.2020	31.12.2022	28.02.2023
4512	Chief Operating Officer	Mental Health Care Group	Deputy COO - Primary, Community and Mental Health	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	--	30/12/2020	02.11.2022	31.12.2022

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4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware o f issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (inc Pharmacy), also part of new CP plans to establish changes across CTM.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	20.12.2022	20.02.2023
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then:** If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update on actions December 2022 SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/03/2023. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. The 13 stage press is due to have the update to software data. Since the last review there have been constant breakdowns within the laundry which has kept putting the upgrade back. As a contingency the 13 stage press is being monitored and the Health Board hopes to complete the software upgrade before March 31st 2023. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed (DW 11/11/2022). Review Date: 28/02/2023	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	08.12.2022	28.02.2023
4920	Executive Director of Therapies & Health Sciences	Diagnostics, Therapies and Specialties Care Group	Deputy Head of Occupational Therapist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**If:** clinical capacity remains significantly reduced due to staff sickness and vacancies **Then:** clinical service delivery will be negatively compromised. **Resulting in:** increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	28.12.2022	31.3.2023
4971	Chief Operating Officer	Primary & Community Care Group	Assistant Director for Primary Care	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult Special Care Dentistry	**If** the Community Dental Service is unable to recruit a special care dentist, **then** there will be no dedicated specialist to undertake the appropriate assessment and dental treatment under GA for vulnerable adults in a timely manner, **resulting in** more patients waiting, longer waiting times, patients being in pain and some having to access secondary care dental services as an urgent or emergency care.	Patients can be seen within the CDS for advice and treatment under local anaesthesia where this can be tolerated by the patient. A Consultant advert has been placed 3 times alongside a Specialist level post to widen the opportunity for recruitment. No applications received. If either post is recruited in to the risk will be mitigated. Although it will take some time to clear the current waiting list. Patients will be contacted regularly as part of safety netting to check that their condition is not deteriorating and no one is left in pain.	All the patients on the list are being reviewed and contacted regularly to assess if their dental condition has deteriorated or if they are in pain . Consideration is being given as to whether treatment can be undertaken in a local routine dental practice as opposed to the community dental service (CDS). This is very much on an individual basis. Discussions are taking place with Medical Staffing, HEIW and Cardiff Dental School with regard to the possibility of recruiting from abroad. Especially in view this is a national recruitment problem and other Health Boards are in a similar position. September 2022 Update – Risk position discussed within Primary Care and rating being reviewed and will be updated once considered via the Primary Care processes. Update October 2022 - Recruitment stage to re-commence with interviews likely to take place in January with two potential candidates expressing an interest with continued dialogue and engagement with them. Risk likelihood reduced, rationale being sought prior to de-escalation from Organisational Risk Register.	Quality & Safety Committee	15	C3xL5	3 C1xL3	↔	04.01.2022	31.10.2022	31.01.2023
3337 Linked to RTE Risk 4813 and M&C 4817.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8.CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.10.2022	31.12.2022

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	The mitigating environment and staffing measures put in place last year are still in place. Anecdotally it is reported that the ward feels safer by night, the challenge for the ward team is to now use QI methodology to make a case for continuing with these staffing levels after the capital work is complete. No incidents involving suspended ligatures have been reported since these measures were implemented. This is reflected in Bridgend CSG risk register. Annual revisiting of all patient ligature risks progress Statement of Needs via capital process for any ligature risks assessed as needing resolution. RTE CG - RTE specific environmental risk mitigation plan in place and under regular review. RGH MHU are currently in the process of extensive anti-ligature upgrades as part of a capital work scheme, including all doors and ensuites on ward admissions/21/22 and PICU being upgraded. M&C CG - SRU/Pinewood – ligature work has been completed. Update 31.12.2022 Bridgend All works have been completed at: Ward 14 PICU Angelton. RTE Ward 21 - Completed Ward 22– Completed Admissions – Completed PICU – 1 Bedroom still to complete All wards scheduled to have returned to their home location and works fully completed by 13th January 2023	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A strategic case to be prepared and submitted to Welsh Government -COMPLETE Strategic Outline Document submitted and agreement to commence a Strategic Outline Business Case received. 3. If the strategic case conversation is supported by Welsh Government, develop a strategic outline business case. Timescale March 22 4. If the strategic outline business case is accepted, progress to the development of a full business case. 5. Full Business Case paused due to pandemic. Resource to be identified to progress full Business Case. 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. Updated - 31.12.2022 with no change to risk rating	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	31.12.2022	5.3.2023
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. Update December 2022 - Working with Care Inspectorate Wales (CIW) to understand how the Health Board can become a registered provider of care if appropriate.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	30.12.2022	28.02.2023
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A business case for additional resources for an IPC team for primary care to be developed. Due Date: 31.08.2021 07/10/2021 - Lead IPC Nurse is a member of an All Wales task and finish group looking at the IPC workforce across Wales. Report to IPCC once national work complete - Due to complete in December 2021. August 2022 Update: Risk score amended based on control measures in place. No additional measures implemented. Lead IPC Nurse to scope primary care services in next 4 weeks. reviewed by Lead IPC Nurse and Deputy Executive Nurse Director 06/09/2022, risk reduced from 20 (4x5) to 15 (3x5). Consequence score amended and reduced to 3 (from 4). Update 11/10/22 - scoping work delayed but plans to start in next 4 weeks. Update 6.1.2023 - The scoping work has been delayed due to the increased respiratory viruses circulating/ number of outbreaks which the IPC department have had to respond to. This will be reviewed at the end of January 2023.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	06.01.2023	31.1.2023
4721	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Fluoroscopy Room has become Obsolete	IF room 3 in POW is not replaced THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6) RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.	Utilising Room 6 to its full capacity Some Barium lists being performed at RGH when possible	Completion of SON to support replacement of Room3 - Timeframe 27.1.2023	Quality & Safety Committee	15	C5xL3	C5xL1	New risk escalated to the Org Risk Register in January 2023	23.12.2022	23.12.2022	01.02.2023

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
Nil assigned to this Committee											

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update May 2022 - Training to be provided to the CTM OH nurses from the CAV OH nurses via a 'train the trainer' approach. Dates being arranged for May 2022. All necessary paperwork in place. Update June 2022 - Training Ongoing. Risk reviewed and remains same. Update August 2022: training has been delayed due to staffing issues within OH department. New dates have been identified in September. New recruits continue to be risk assessed for active TB symptoms and where appropriate new staff from areas of high risk of TB are screened for latent TB. Update October 2022 - Risk reviewed and remains same. Trainer has been identified no date confirmed as yet to commence training the OH Nurses.	Quality & Safety Committee People & Culture Committee	Jan-23	Update Jan 2023 - Training is now arranged 16th and 18th January for Occupational Health Nurses and a support group via Cardiff & Vale is being implemented to provide peer support going forward. The likelihood score was reduced to a 2 as a result achieving the target score of 8. This risk can now be closed.
4253	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	**Bridgend Locality:** The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	**Bridgend Locality:** o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score.	Quality & Safety Committee Health, Safety & Fire Committee	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work.

AGENDA ITEM
5.2

QUALITY & SAFETY COMMITTEE

Update Report on progress following Internal Audit on Concerns & Welsh Risk Pool Review on Claims/Redress/Inquests

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Claims
Presented by	Stephanie Muir, Assistant Director of Concerns & Claims
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

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

ACRONYMS	
WRP	Welsh Risk Pool

1. SITUATION/BACKGROUND

1.1 The Health Board had experienced challenges in relation to the management of claims and redress cases over recent years, with the Welsh Risk Pool Creditor/Debtor level rising to an unacceptably high value and penalties applied by the Welsh Risk Pool Committee for deviation from the WRP Reimbursement Procedures.

1.2 With the challenges in respect of the management of claims and inquests, the Health Board commissioned a review by the Welsh Risk Pool.

1.3 At the same time, in line with the Internal Audit Plan for 2021/22, a review of processes for dealing with concerns was completed.

1.4 The Health Board underwent the following reviews in the latter half of 2021:

- The Management of Concerns – Internal Audit Review
- Review of procedures for the management of claims, redress cases and coronial investigations at CTM – Welsh Risk Pool

1.5 Reports were received at the end of last year.

1.6 The Health Board accepted the Welsh Risk Pool Review and Internal Audit Review findings and developed detailed action plans against the recommendations.

1.7 This report provides an update of progress against actions and any barriers/challenges facing achievement of actions

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

2.1 The Welsh Risk Pool review on the management of claims, redress cases and coronial investigations had 9 overarching recommendations, which had 28 assigned management actions to achieve the recommendations.

2.2 Good progress has been made to complete the Welsh Risk Pool actions, with only 7 actions remaining open and in progress.

2.3 There are no specific challenges in relation to implementation of actions.

2.4 The Internal Audit Review of Complaints management had 28 overarching recommendations with 35 assigned actions to achieve the recommendations.

2.5 Progress has been made on many actions, however 19 actions remain open, with progress delayed due to staff absence in the key complaints management role.

2.6 Whilst it is noted that more progress has been made in respect of the Welsh Risk Pool review and recommendations. The complaints manager has now commenced in post and has been progressing the outstanding actions from the internal audit.

2.7 It is envisaged that both action plans will be fully completed by the end of the financial year.

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

3.1 Progress continues on all actions, however, the new operating model and current organisational change process in respect of quality, safety and governance within CTM will have a bearing on some actions. Tracking delivery of these actions will take place through the clinical executive oversight group.

3.2 The operating model and the new arrangements for quality, safety and governance are being considered for all actions in progress and a review is currently underway in respect of any actions already completed to ensure that they are aligned to changes.

3.3 The 2022/2023 Internal Audit Plan includes a review of WRP concerns and claims and a follow up review of concerns management. These are scheduled to take place at the end of February 2023 and will be presented to the Audit and Risk Committee thereafter.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are quality and safety implications. If actions arising from WRP and IA reviews are not undertaken and improvements note made.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.

	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Resource realised through the operating model re-alignment will be required to take forward this work. An 'invest to save' case is also being progressed to cover immediate resources to tackle the high number of Redress Cases being managed by the HB.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee is asked to:

- **Note** progress made and any challenges highlighted.

AGENDA ITEM
5.2.1

QUALITY & SAFETY COMMITTEE

LEARNING FROM EVENTS REPORTS

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Claims
Presented by	Stephanie Muir, Assistant Director of Concerns & Claims
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

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

ACRONYMS	
LFERs	Learning from Events Reports

1. SITUATION/BACKGROUND

1.1 The Health Board are required to submit Learning from Events Reports (LFERs) to Welsh Risk Pool (WRP) in respect of learning information relating to claims and redress cases in order that costs can be reimbursed.

1.2 LFERs should be submitted to WRP along with evidence of learning as follows:

- Claims - 60 working days from decision to settle.
- Redress – 60 working days from admission of qualifying liability.

1.3 The Welsh Risk Pool Committee relaxed this deadline during the pandemic period.

1.4 The Welsh Risk Pool Committee reinstated this deadline with effect from 1st November 2021. This gave a deadline of 31st January 2022 for submission of cases.

1.5 The Health Board already had a previous backlog of learning from events reports and a list of permanent deferred cases. The completion of these was exacerbated by the reinstated targets.

1.6 In October 2022, the Health Board were notified of 4 outstanding cases that were going to be recommended at WRP committee for permanent deferral. Before the committee date the Health Board provided the WRP with satisfactory evidence to ensure that did not happen.

1.7 The new Once for Wales Concerns Management system was updated to allow the legal team to efficiently track outstanding and deferred LFER's.

1.8 A full reconciliation of Welsh Risk Pool and CTM LFER data fully reconciled for the first time in November 2022.

1.9 In November 2021, the Health Board received the outcome of the Welsh Risk Pool's review of the management of redress, claims and inquests. In relation to LFERs this found:

" We found that there is a lack of clarity regarding which teams are responsible for the development of actions in response to issues identified in legal cases and that the introduction of the Taskforce has accentuated this situation. The arrangements do not align to the current Health Board governance structure and there is a lack of oversight by leadership teams who are accountable for service design and provision. Evidence seen at the national Learning Advisory Panel highlights that effective Learning from Events can only be achieved by clinical and service teams who are close to the source of the issues identified in a case"

The Health Board accepted the Welsh Risk Pool Review and have developed an action plan against recommendations. Although the position in relation to the historic legacy cases has diminished, a backlog of newer cases is starting to build.

1.10 The new operating model and proposed new arrangements for quality, safety and governance has provided an opportunity to revisit how learning from events reports are managed within CTM.

1.11 Within the new arrangements it is proposed that the Patient Safety Improvement Managers who work more closely with care groups take a lead on facilitating completion of LFERs.

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

2.1 The Health Board have reviewed the current outstanding LFERs with an approximate figure of 124 outstanding LFERs that have not been submitted or approved by the WRP.

2.2 This equates to approximately £18,000,000

Claims
TOTAL - **82**

50 Red deferred (34 cases where blank LFER's were submitted to meet deadline)

15 Amber deferred (seen by panel, but requires some further evidence)

17 - LFER submitted and awaiting WRP decision (8 were submitted blank)

Redress

TOTAL - **42**

6 Red deferred (3 cases where blank LFER's were submitted to meet deadline)

14 Amber deferred (seen by panel, but requires some further evidence)

22- LFER submitted and awaiting WRP decision (6 were submitted blank)

Claims

Bridgend - £365,000

Merthyr Cynon - £11,096,115

Rhondda Taf Ely - £6,538,306

Corporate (facilities etc) £90,000

Redress

£150,000

Note: These figures change daily

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

3.1 Whilst these figures remain high, it should be noted that considerable progress has been made to reduce the number of outstanding LFERs. With costs associated reducing from £52 million to £18 million. With 3 LFERs with substantial costs associated being submitted and approved.

3.2 The Health Board still carries a risk that the non-submission of LFERs can result in the Welsh Risk Pool imposing financial penalties.

3.3 The Health Board needs to move to a position whereby learning is recorded/captured in a centralised way at point of incident/complaint/claim.

3.4 Actions taken:

- Reports/dashboards developed for the newly formed care groups.
- LFER drop in sessions undertaken over the past 6 months
- LFER how to guide developed and shared

- Learning Framework developed
- Shared Learning Event undertaken
- Learning Repository developed to capture learning
- Training undertaken on Datix, highlighting the need to complete actions and upload evidence of actions

Actions in progress:

- LFER facilitation moved to patient safety improvement managers who work more closely with care groups.
- A clear escalation process for missed deadlines needs to be formulated and agreed.
- Ensure accountability for learning is clear in the new care group set up.
- Additional training for the Patient Safety Improvement Managers

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are quality and safety implications. If learning from events does not occur, improvement actions and preventable measure will not be put in place and therefore incidents/complaints can reoccur.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications /	Yes (Include further detail below)

Impact	Resource will be required to take forward this work.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee are asked to:

- **NOTE** progress made.
- **SUPPORT** actions taken and in progress.

AGENDA ITEM
5.3

QUALITY & SAFETY COMMITTEE

DATIX CYMRU – INCIDENT REPORTING

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Presented by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DCIQ	Datix Cloud IQ

1. SITUATION/BACKGROUND

The Once for Wales programme was established in 2017 by the Welsh Government as part of the response to address the recommendations set out in Keith Evans "The Gift of Complaints" Report.

Aimed at bringing consistency across NHS Wales with regards to the use of electronic tools, the programme commenced development and implementation of DatixCymru (DatixCloudIQ). The new system has many of the features that people will be familiar with from our existing RLDatix system, with the added benefit of being a bespoke cloud-based tool that meets the needs of Putting Things Right, through the development of specific functionality such as the Redress Module and Mortality Review process.

A key objective of the system is to support the Health Board in providing real time data and information that can facilitate ward to board assurance leading to improvements in quality, safety and experience for patients and staff. Through successful embedding of the system, we can take proactive steps to demonstrate that we are a listening and learning organisation.

The Health Board implemented the Incident Management Functionality of Datix Cymru on the 1st April 2022. As part of the implementation of this functionality a new All Wales Coding Structure was adopted. This moved the coding from a two tier structure in the Health Board's Legacy System to a three tier structure in Datix Cymru. In addition to this, a further segregation of incidents has been introduced in relation to who was affected. As result staff are adjusting to both a new system and a new coding structure.

It was reported at the Health, Safety & Fire Sub-Committee that since the implementation of the Incident Management Functionality, there had been a decrease of 50% in the number of incidents reported relating to staff. A report provided to Quality & Safety Committee in November 2022, summarised the position and the mitigation actions being implemented within the Health Board.

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

2.1 Incident Reporting Data

A comparison of the incidents reported for the previous 4 years has been undertaken. The trend is provided in the chart below.

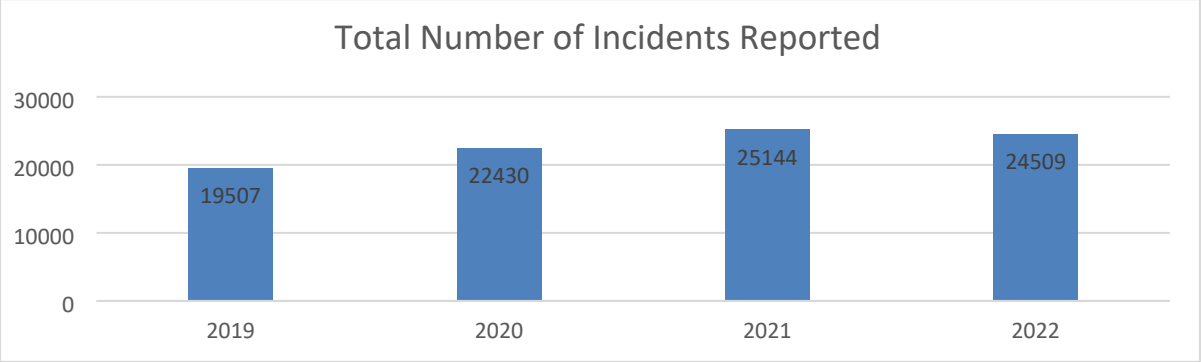


Chart 1: Total number of incidents reported

Whilst the overall number of incidents reported in 2022 has slightly decreased (by 635) compared to 2021, it remains higher than 2019 and 2020. The decrease in 2022 can be attributable to the increase in 2021 associated with the Covid Pandemic and the transition to a new system where a decrease in reported incidents would be expected.

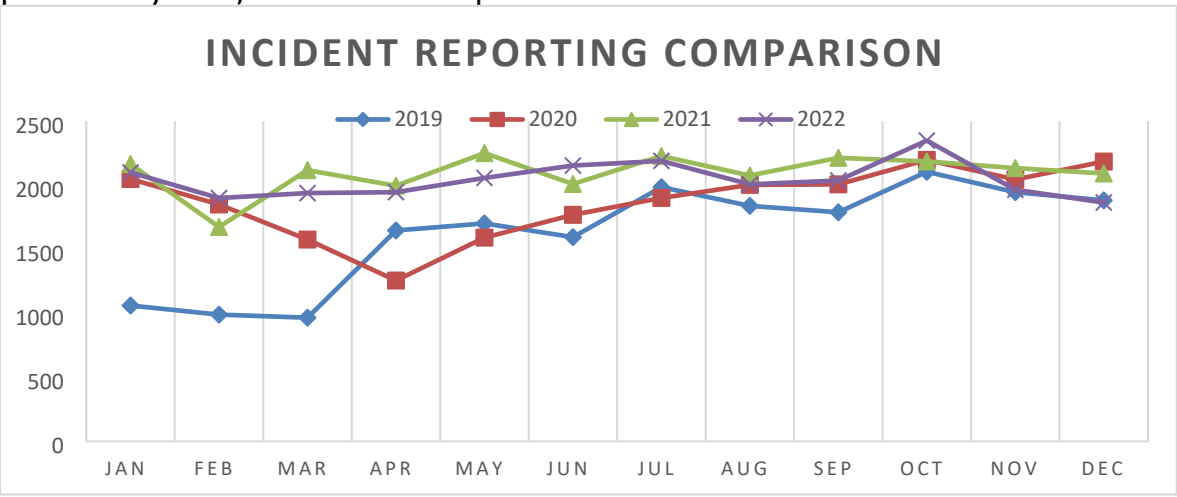
	Legacy System			Legacy /Datix Cymru*
Who was Affected	**2019**	**2020**	**2021**	**2022**
Patient	16,875	19,889	22,016	21,391
Non-Patient Safety	2,632	2,541	3,126	759
Organisational			2	940
Staff/Contractor				1,365
Public/Visitor				54
Totals	19,507	22,430	25,142	24,610

Table 1: Incidents by those affected

*Data for 01.04.22 to 31.03.22 is retrieved from the Legacy System. Data for the remaining year is retrieved from Datix Cymru.

The table above demonstrates that the Non-patient safety incidents have similar figures to the combined total of Organisational, Staff/Contractor and Public/Visitor incidents.

Further review of the data has identified that the number of incidents has continued to increase overall from April 2022. Whilst a reduction has been highlighted for November and December this is consistent with the trend in previous years, with the exception of 2020.



The previous report to Quality & Safety Committee advised that review of the Health & Safety specific codes had highlighted a decrease in the number of incidents being reported. A further review of those reported between 01.04.22 and 31.12.22 identifies that the number of incidents reported

under these specific codes remain lower than those pre 01.04.22 as demonstrated in the chart below.

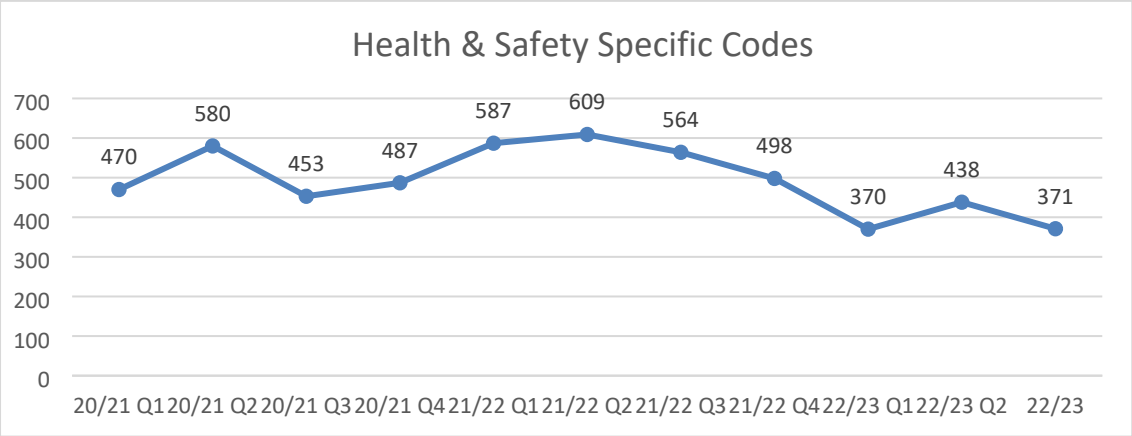


Chart 2: Health & Safety Specific Codes

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

Further scrutiny of the high level incident data provides an assurance that incidents continue to be reported but under different coding types. This is reflective of the introduction of the new All Wales Coding structure that differs from the Health Board's legacy system. With information spanning two systems it adds an additional challenge in providing robust trend data. It is therefore recommended that direct comparison at a granular level with incident data prior to 01.04.22 is not undertaken.

Additional challenges impacting the provision of high quality data and reports during the early stages of implementation of the new system relate to:

- The Health Board undertook a number of developments within the legacy system to reflect internal processes and board information requirements that are not currently available within Datix Cymru as this forms part of the system enhancement programme. Alternative options to support the processes are being identified. These options are more resource intensive, due to the increased manual intervention required in presenting information.
- The effective and efficient extraction of data from Datix Cymru at a locality, service group and Speciality level continue to be challenging.

Whilst there are system requirements that have been escalated to the National team, there are a number of local measures being implemented to improve the validity of data held within the system. These include:

- Corporate validation following initial reporting of the incident to be undertaken by the Patient Safety, Health & Safety and Business Intelligence Teams. To facilitate this, a quality assurance checklist is being developed to facilitate consistency, highlight key fields for review and act as a prompt for immediate action or escalation. This will ensure incidents are coded appropriately and enable identification for themes and trends.

- Development of detailed guidance for top reporting / high risk incidents impacted by the change, i.e. restraints, clinically challenging behavior, community acquired pressure damage, absconding.
- Commencement of an audit programme by the Business Intelligence Team of closed incidents to confirm data accuracy and completeness of all required fields.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The RLDatix system provides data to enable opportunities for improvement in safety and experience to be identified.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Relates to the implementation of an All Wales System.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the contents of the report.

AGENDA ITEM
5.4

QUALITY & SAFETY COMMITTEE

CTMUHB Quality and Safety Framework 2022-2025

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality, Safety & Safeguarding
Presented by	Lydia Thomas, Head of Quality & Patient Safety
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Director led weekly meeting	Dec 22-Jan 23	SUPPORTED

ACRONYMS	
	All explained within the report.

1. SITUATION/BACKGROUND

Welsh Government launched a Framework for NHS bodies **Quality and Safety Framework: Learning and Improving (gov.wales)** to reflect that learning and improving is at the heart of the NHS in Wales with quality and safety being highlighted as a priority above all else. The national Quality and Safety Framework emphasises that quality needs to be the central focus of any decision made with regards to the care of the population as well as the design of services. Our populations in Wales deserve to access a safe, effective service that provides an excellent user experience.

The Health and Social Care (Quality and Engagement) Act 2020 introduces a strengthened Duty of Quality and Duty of Candour for the NHS in Wales, as well as create a Citizen Voice Body to strengthen the voice of our population. This legislation, the need to learn from system failings, harmful incidents, positive practice and innovation, as well as recovery from the COVID-19 pandemic, are the principle drivers in the development of a National Quality and Safety Framework.

The National Framework states that organisations at every level should function as a *quality management system* to ensure that care meets the six domains of quality; care that is safe, effective, patient-centred, timely, efficient and equitable.

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

The National Framework sets out the need for a robust quality assurance system that brings all the information encompassing quality together so it is utilised to implement effective change and improvement in care, ensuring that we have a quality-driven organisation.

The CTMUHB Quality Governance & Patient Safety Framework, produced in June 2020 and revised in November 2020 has been reviewed in light of the national framework, and this paper presents the new CTMUHB Quality and Safety Framework: Learning and Improving, for endorsement for Board approval.

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

The Committee can be assured that the organisation has in place a comprehensive framework for a Quality Management System – an emphasis on quality with clear governance and safety at the centre of its functions.

The CTMUHB Quality & Safety Framework is aligned with national guidance and reflects the Health Boards unique organisational strategy and goals of CTM 2030: Our Health, Our Future. The Framework connects with other seminal CTMUHB Strategies and Frameworks to enhance its quality governance system and infrastructure as well as providing clarity and expectation of a strengthened point of service-to-board assurance.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	To support a comprehensive framework in line with national guidance.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	• Report for information for health board patient safety & patient experience activity • No service or staff impact in direct response from this report, this is considered through improvement work and other reports • Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The requirements to deliver safe, high quality care may impact on resources including workforce. The new Quality and Safety Framework and organisational operating model will support delivery of safe, high quality care.
Link to Strategic Goals	Improving Care

5. RECOMMENDATIONs

Members of the Quality & Safety Committee are asked to:

- **NOTE** the content of the report
- **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- **NOTE** the risks identified
- **ENDORSE for Board APPROVAL** the direction of travel for the organisational Quality and Safety Framework.

Cwm Taf Morgannwg University Health Board Quality & Safety Framework:

Learning & Improving

2022 - 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Foreword

We want to improve health and wellbeing, deliver better care, and better value across the diverse communities that we serve.

We want to sustain trust and confidence in our services and be seen as an organisation who is committed to improve and develop, working in partnership with our communities to ensure that local people can live happier, healthier lives for as long as possible.

This is what drives our commitment to put Quality and Safety at the heart of everything that we do. We recognise the primary importance of being able to deliver safe compassionate care that provides an excellent user experience.

An overarching goal of our NHS is to improve outcomes for people, whoever they are and wherever they live, by providing people with access to high-quality health and care, delivered through a sustainable culture of learning and improvement. We recognise in CTM that better outcomes can be achieved when we all work as one with our local people, our partners and the third sector towards one shared goal – *Building Healthier Communities Together.*

CTM 2030 Our Health, Our Future:

Our organisational strategy, **CTM 2030: Our Health, Our Future**, outlines how we will develop our services to meet the needs of our population as we look to 2030 and beyond.

We have identified four goals for developing our strategy; they set out the key things we want to achieve in CTM over the next few years and are:

- Creating Health
- Improving Care
- Inspiring People
- Sustaining our Future

Our organisational strategy goals are being discussed and planned through the lens of the five key stages that a person will go through during their lifetime; from first being born to dying with compassionate care.

There has been significant progress made in terms of establishing the Health Board as a quality-led system, such as our maternity and neonatal improvement work, but there is further work to do.

This Quality & Safety Framework does not sit in isolation. Quality is a 'golden thread' that runs through everything that we do, in order to deliver the ambitions of our Health Board. This Framework aligns with our vision and other key

infrastructure documents, namely our **Quality Strategy**, our **Incident Management & Investigation Framework, Risk Management Strategy** and our **Listening & Learning Framework** to evidence the commitment to continuous shared learning and improving outcomes for our patients, our employees and our communities.

Putting quality and safety above all else is the first NHS Wales core value. This focus has been strengthened through the Health and Social Care (Quality and Engagement) (Wales) Act (2020), the National Clinical Framework for Wales (2021), and the Quality and Safety Framework (2021). Collectively, these set out an aspiration for quality-led health and care services, underpinned by prudent healthcare principles, value based healthcare and the quadruple aim.

How we will deliver high quality care

Quality is at the heart of CTM and our aim is to improve outcomes for our people, whoever they are and wherever they live.

We are committed to making a real shift towards focussing on promoting health in our communities, by that we mean preventing ill health from happening rather than treating people when they get sick, whilst ensuring that we are able to provide the best care possible when people need our support.

Delivering high-quality care consistently across all our services is no easy task; it requires a strong commitment to working in partnership with all our key stakeholders.

Our organisational values and behaviours exist to make a positive difference to our employees, our organisation, our patients and our communities.

We want to empower our employees to be "At Our Best" to deliver high quality care to every person, every day, across all of our services.

By living up to our values at every opportunity, we can achieve our quality and safety vision and ambitions.

Introduction

Cwm Taf Morgannwg University Health Board, established in 2019, provides primary, community, inpatient, and mental health services to the 450,000 people living in three County Boroughs: Bridgend, Merthyr Tydfil, and Rhondda Cynon Taf.

We are situated between Wales' capital city, Cardiff, to the south, the beautiful coastal town of Porthcawl to the west, and the stunning scenery in the Brecon Beacons National Park to the north. We operate within a vibrant community, rich with history and heritage.

With almost 14,000 colleagues, **our workforce is the lifeblood** not only of our University Health Board, but also of the communities that we serve, as almost 85% of our colleagues live within our footprint.

The purpose of a Quality & Safety Framework

A new National Quality & Safety Framework introduced in 2021 (Welsh Government, 2021) requires that organisations at every level should function as a **quality management system** to ensure that care meets the six domains of quality; care that is **safe, effective, patient-centred, timely, efficient and equitable**.

It sets out the need for a robust quality assurance framework that is utilised to implement effective change and improvement in care delivery.

Reinforcing the approach for quality led services is **The Health and Social Care (Quality and Engagement) Act 2020,** which introduces a strengthened **Duty of Quality** and **Duty of Candour** for the NHS in Wales, as well as the creation of a **Citizen Voice Body** to strengthen the voice of our population. This legislation, together with the need to evidence learning and to recover from the challenges and harms of the COVID-19 pandemic are the principle drivers in developing this Quality and Safety Framework.

The Framework and the duties ensure the NHS in Wales has a **`relentless focus on quality and safety, as a priority above all else'**. It needs to be the central focus of any decision made with regards to the care of the population as well as the design of services.

Defining Quality

We describe quality using the framework outlined by the Institute for Healthcare Improvement. This model also describes how quality is driven by **'quality enablers'**; optimal organisational drivers which are required to ensure the best sustainable outcomes for our population

CTM is committed to supporting the vision articulated in *A Healthier Wales* (WG, 2018): that everyone in Wales should have longer, healthier and happier lives. **A clear and sustained focus on quality will help us to achieve this for the benefit of our Population.**

Defining quality alone does not guarantee success. We know that high quality, safe care does not happen by accident, but by design and from a commitment to working together. Key to the delivery of our plans is a *Quality Management System* approach in order to embed **a culture where people listen,**

think, feel and act 'quality' - promoting openness and learning, continuous improvement and service transformation. The *National Clinical Framework* (Welsh Government, 2021) provides a clinical interpretation of *A Healthier Wales* and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life journey approach.

When considering quality in CTM, our focus will be on our **people, patients, and place**.

The Quality Cycle

Quality is a concept commonly discussed in healthcare, but improvement needs to be part of a bigger process – a Quality Management System (QMS).

The Institute for Healthcare Improvement (IHI) has described a framework for effective quality governance. They found little evidence of education for Independent Members on effective quality management and, where it did exist, it was often focused on patient safety (just one of the six domains of healthcare quality) and in hospitals, as opposed to community and population health.

To ensure that quality has a focus in every part of the Health Board, the approach outlined comprises **quality planning, quality improvement and quality control.** Together these provide quality assurance. The three components form a key part of the Health Board's Quality and Governance Targeted Intervention maturity journey; tracking progress and embedding improvement against these three areas.

Everyone must understand the quality cycle and their role in the quality system. Our population must be able to contribute to each part of the cycle (through feedback and coproduction) to ensure that outcomes are meaningful to those who work within and use our services.

Continuous learning is central to the quality cycle, and so our **CTM Listening and Learning Framework** is a key enabler for our Quality and Safety Framework.

Our Quality Management System

The NHS (Wales) Act 2006 provides direction that Health Board's must agree Standing Orders in order to provide the regulatory framework for the business conduct of the Health Board and form the basis upon which the governance and accountability framework is developed.

This framework is integral to CTM's Governance and Accountability Framework, alongside other key frameworks such as the Board Assurance Framework (BAF).

Quality Governance is the combination of structures and processes at a Service to Board level to lead on Health Board-wide

quality performance. The functional elements include:

Compliance with legislation and regulation: e.g. Health & Care Standards, the Nurse Staffing Levels (Wales) Act, 2016, Putting Things Right including redress & clinical negligence, safeguarding & public protection, health and safety, external regulatory frameworks including Health Inspectorate Wales, regulatory notices issued by HM Coroner, recommendations made by the Public Services Ombudsman for Wales,

Quality planning e.g. via the Integrated Medium Term Plan, demonstrating learning and using a quality dashboard based on robust data analysis, through robust public engagement, value based health care and patient experience, based on understanding population health, principles of equality and diversity, workforce development and wellbeing.

Quality improvement: e.g. clinical effectiveness via research, audit, implementation of NICE guidelines professional and service specific standards, learning, education & training, embedding a culture of quality improvement, a shift to Safety II approaches, research & development, medicines management, organisation-wide and national sharing of learning.

Quality control and assurance: e.g. improvements using learning generated by internal and external scrutiny, including those undertaken by HIW, Community Health Council, and other regulatory, speciality, service specific and professional standards, mortality review, evidence based policies and protocols.

Managing risk e.g. assessing, understanding and articulating risk via risk registers, infection prevention and control, decontamination, clinical incident reporting and investigation, managing concerns, implementation of patient safety solutions alerts and notices applying learning.

As outlined above (Section 1) the Health Board has developed Strategic Goals, which support the delivery of quality. These are:

- Creating Health
- Improving Care
- Inspiring People
- Sustaining our Future

To ensure that planning is underpinned by quality, the **Quality Impact Assessment** (QIA) procedure has been revised to encompass any new plans, service change, programmes, projects or savings schemes. This is a fundamental process to ensure that **any** service changes or plans are thought through, understood and the potential consequences on quality are considered, with mitigating actions outlined in a comprehensive way. Any risk impact should be added to the relevant risk register. The QIA procedure is available on the intranet and there is an expectation that these will be submitted to the Q&S committee for further scrutiny.

Being able to measure quality with high reliability is a key element in a high quality, learning organisations. Building on the minimum dataset informed by national quality and performance indicators, robust data is required to be able to evidence quality outcomes.

Over the past two years, a **Quality Dashboard** has been implemented and refined, which is updated on a bi-monthly basis and presented to the Quality and Safety (Q&S) Committee through to Board. The metrics and indicators will be further developed to provide a greater breadth of measures, including primary care and commissioned services.

The Quality Dashboard was initially Health Board wide. In alignment with the Operating Model, there are Care Group based dashboards to provide more robust, detailed and specific assurance.

The Dashboard presents numerical information about key quality indicators and where possible Statistical Process Control (SPC) charts for a rolling 12 month period. Narrative analysis is also provided, however it is recognised that this is retrospective exercise. Additionally, quality narrative is included in the Integrated Performance Report at Management Board and Board. Further improvements include the setting of improvement trajectories. These have been set initially for pressure damage and falls but will be used along with improvement cycles to support purposeful change.

The Care Groups are supported by central functions such as: Patient Care and Safety, Planning, Workforce and Organisational Development, Finance, Procurement, Digital & Data and Performance. The Central element of the Chief Operating Officer also provides support.

Assurance is provided through Clinical Service Groups through to Care Groups, and to the Board through the Quality and Safety Committee. Where there are matters of immediate concern, a clear escalation pathway is in place from individuals through to the Board through the procedure of NHS Wales Staff to Raise Concerns Policy.

Corporate Assurance Process

The Board (Executives and Independent Members) are ultimately accountable for quality within the Health Board and are responsible for:

- ☑ Setting the organisation's strategic direction.
- ☑ Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour.
- ☑ Ensuring delivery of the organisation's aims and objectives though effective challenge and scrutiny of the Health Board's performance across all areas of activity.

Organisational governance and assurance of quality is scrutinised through Quality and Safety (Q&S)

Committee, a committee of the Board and an in-public meeting.

The Q&S Committee has an annual work programme, meets bi-monthly and is chaired by an Independent Member.

The Committee Chair is supported by the Clinical Executives though any Executive can be required to attend.

Recognising that quality is everybody's business, the Executive leadership of quality is shared by the four Clinical Executives, The Medical Director, The Director of Nursing and the Director of Therapies & Health Sciences

Enabling, monitoring and evaluating delivery

Our 3 year Quality & Safety Framework sits alongside our IMTP and annual plans.

Progression towards delivering our objectives will be monitored through our governance structures, inclusive of feedback and collaboration with our stakeholders, and will form part of our formal reporting structures. Through regular review, our Board and Quality and Safety Committee will ensure that our Quality Strategy and annual quality work plans continue to meet the needs of our organisation and our communities.

There are a number of ways in which we will measure our progress and iterate our objectives as necessary in order to achieve our ambitions. These include external reviews from HIW, feedback from CHC and other partners, internal reviews, and also our Quality Management System and quality governance structures.

Our Quality Strategy

Our Quality Vision

It is very important that our organisational vision for quality and safety be coherently reflected within our strategies, frameworks, policies and plans. We want to improve health and wellbeing, deliver better care, and better value across the diverse communities that we serve. We want to be considered an outstanding organisation by everyone – people who use our services, their families and carers, our colleagues, our communities, and our partners.

Our Quality Mission

For our excellent people to deliver high quality care to every person, every day, in every setting.

Our Quality Pledge

We will continuously improve by working in partnership and by placing people at the centre of what we do, so that we can consistently deliver high quality care for everyone.

Our Quality Ambitions

Safe Care	• everyone can be confident that our care will cause no harm
Timely Care	• people have timely access to care when they need it
Effective Care	• people receive care that is appropriate and based on evidence/research
Equitable Care	• everyone can be confident of positive health outcomes, regardless of geography or status
Efficient Care	• people will receive value -based healthcare, where waste is avoided
Person Centred Care	• people will be supported to be actively involved in their care as equal partners

Our Listening & Learning Framework

Healthcare systems and employers need to seek every opportunity to enhance safety and quality in a complex, changing environment.

Organisational learning can help to prevent and reduce risks, errors and harm that occur to patients during provision of care and the workforce in the course of their duties. A cornerstone of positive patient safety and workforce outcomes and experience is continuous improvement based on learning from errors and adverse events.

We are committed to promoting a culture which values and facilitates learning and in which the lessons learned are used to improve the quality of patient care, safety and experience, as well as the experience of our workforce.

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

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

Quality Improvement in CTM

Over recent years, CTM has experienced significant change, along with challenges relating to quality and the response to the COVID-19 pandemic. Our organisation recognises the ongoing challenges that we face. We are committed to improving quality and have a dedicated improvement directorate (iCTM).

The iCTM directorate builds capacity for change across our organisation, co-ordinates improvement and innovation activity, and engages with our colleagues, patients, communities and partners to drive the adoption and spread of the most impactful improvement and innovation options, all underpinned

by the principles of Prudent and Value Based Healthcare, and co-creation.

This commitment to provide ALL our people with the knowledge, skills and support to make changes will drive quality improvement initiatives throughout CTM.

We will implement a number of community of practice and community of interest groups to support our people to collaborate to drive high-quality care at every level. These communities will include:

- Change Community of Practice
- Improvement Community of Practice
- Value Based Healthcare Community of Interest.

Partners in Quality

We work closely with external partners such Improvement Cymru, Healthcare Inspectorate Wales (HIW), Audit Wales, higher and further education institutes, and many others. We will demonstrate an open culture and always seek out opportunities to learn and improve for the benefit of our people, our patients, and our communities. **We will develop, deliver and embed system-wide improvements** across health and social care in order to create a healthier Wales.

Duty of Quality and Candour

The duties of quality and candour come into force in April 2023 and supports us to actively consider whether our decisions improve quality and outcomes for our population, as well as being open and honest when things go wrong and harm has occurred.

When discharging the duties, we will take into account the Health and Care Standards: the national framework that helps us to demonstrate that we are doing the right thing, in the right way, in the right place. Current review of the *Putting Things Right* regulations will enable the duties to integrate with key patient safety NHS guidance.

The Quality and Safety Framework describes? our commitment to the delivery of our quality ambitions and will support people's understanding of the duty of quality. Our regular quality and performance reports will ensure **we are accountable to each other and to our stakeholders, providing service to board assurance of our services**.

Quality monitoring and reporting

Our Quality Strategy sets out our quality ambitions and our quality goals, structured around the six dimensions of quality for 2022-25. We have undertaken stakeholder engagement to ensure that these align with the views and priorities of our stakeholders.

Each year, we will devise an **Annual Quality Work Plan to focus our efforts on the delivery of SMART quality objectives**. Identification of these annual objectives will be data driven and risk-stratified to ensure a targeted approach to improving quality.

As an organisation, we will monitor and report our progress against the SMART quality objectives that we have committed to achieve. We will

do this at regular intervals and will adapt our plans based upon progress and learning.

Within CTM, we ensure that our **quality performance monitoring is 'always on'**. Our Quality Management System will ensure that quality performance data is readily available in order to ensure rapid identification and response to any early warning indicators.

The CTM Quality and Patient Safety Governance Framework defines responsibilities at service level through to the Executive Level. Our Incident Reporting and Management Framework offers clarity to ensure effective reporting and learning from incidents. Our Listening and Learning Framework ensures that we actively seek feedback, positive or negative, as we see this as an opportunity to learn and improve quality. Resources have been strengthened through the introduction of strategic roles to support quality and patient safety within the nursing management team and Allied Health Professions, as well as the office of the Medical Director.

A well-defined quality governance structure is established within CTM, with the Quality and Safety Committee receiving assurance and providing scrutiny on quality, patient safety and patient experience.

In addition to the Quality and Safety Committee, an Executive Director led Patient Safety meeting is held each week, where an 'At-A-Glance' dashboard of quality-related matrices is presented to facilitate a timely review of the previous week's quality performance. The Director of Improvement and Innovation attends this meeting so that any themes and trends are used to inform improvement interventions via iCTM.

Immediately following this weekly meeting, the clinical Executive Directors and the Director of Corporate Governance update the wider Executive Team on the key quality and safety concerns, ensuring that all Executive colleagues are sighted.

Each year we provide an overview of our quality achievements, reporting on issues identified through our quality management system, and setting specific annual quality improvement goals within the Health Boards Annual Report.

Our quality reporting structure provides a way for us to set progressive implementation plans; adapt plans based on experiences and learning, and monitor progress against our strategic goals.

Our Quality Journey

Managing risks and challenges to quality

We recognise the difficulties with delivering our quality ambitions in the challenging times we currently face. National and local plans for recovery from the impact of the COVID-19 pandemic, time frames, and resource pressures make it more difficult to deliver solutions for large- and small-scale system changes and complex issues. Re-energising our colleagues for transformation, changes to operational structures, and national workforce shortages add to the challenge.

We will aim to reduce the impact and risk of these by prioritising the wellbeing of our people and investing in the development of their skills and knowledge. Our continuing drive to innovate, increase integrated working, and engage regularly and effectively with our communities and partners will ensure that we understand each other's challenges and work together to find solutions and mitigations.

Our Quality Ambitions and Strategic Quality Goals

Our 6 inter-dependant quality ambitions are based on the 6 dimensions of quality and shape our strategic quality goals. These in turn provide the framework for our Annual Quality Work Plan, containing SMART objectives (Specific, Measurable, Achievable, Realistic, and Timed) against which we monitor and report our progress at regular intervals, adjusting our plans as required. Where appropriate, priorities have been mapped against NHS Wales Performance Framework & Guidance Document 2022-23.

OUR QUALITY AMBITIONS	OUR STRATEGIC QUALITY GOALS	CTM 2030 GOAL
SAFE CARE: everyone can be confident that our care will cause no harm	Develop and empower our colleagues to deliver outstanding care. Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Listening and Learning Framework.	• Inspiring People • Improving Care
TIMELY CARE: people have timely access to care when they need it	Improve access to urgent and emergency care. Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes.	• Creating Health • Improving Care • Inspiring People
EFFECTIVE CARE: people receive care that is appropriate and based on evidence	Develop evidence-based models of care with our partners, making the most effective use of skills and resources. Contribute to research in practice. Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't	• Improving Care • Inspiring People • Sustaining Our Future
EQUITABLE CARE: there are no avoidable, unfair or remediable differences in the care we give to people who have similar health needs	New models of care are designed using population health data and reflect local need. We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.	• Improving Care • Creating Health • Inspiring People
EFFICIENT CARE: we will focus on outcomes that matter to people and maximise those outcomes for every pound we spend on providing care	Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste. Support our colleagues to stay well and reduce agency use across CTM.	• Inspiring People • Improving Care • Sustaining our Future
PERSON-CENTERED CARE: people will be supported to be actively involved in their care as equal partners	Increase co-production across CTM, delivering care that is responsive to people's needs and wishes. Reduce variability in how well we engage and support patients, carers and families.	• Inspiring People • Improving Care • Sustaining our Future

The Care Group Operating Model

In March 2022, the Board made the decision to endorse the onward development of a proposed operating model based on a whole CTM Care Group structure and a move away from the geographic split of three integrated localities.

The following 6 Care Groups have been established to unite the Health Board and create equity of access across all services:

- Planned Care Group
- Unscheduled Care Group
- Children and Families Care Group
- Diagnostics, Therapies and Specialities Care Group
- Mental Health and Learning Disabilities Care Group
- Primary Care & Community Care Group

Each Care Group draws together all specialties and provision of services within that specific sphere of care. Each Care Group will be led by a Triumvirate/Leadership Team whom will have shared responsibility for quality and safety of services. They will use appropriate clinical governance and management structures to ensure that the service is safe, effective and efficient and of the highest quality, with routine audit and opportunities for the spread of learning. Improved quality, safety, outcomes and patient experience will be the primary drivers of each service.

Care Group Quality & Patient Safety Governance Model

Our population, who use our services, wherever they live, can expect no variation in approach to care and resources within our Health Board. To provide a consistent, equitable function across the Health Board in respect of Quality Governance, Patient Safety, People's Experience and Putting Things Right, current locality based Quality Governance roles and responsibilities will be re-aligned in order to provide a centrally managed team structure with a focus on effectiveness, performance and equitable distribution amongst the proposed care groups. The centralisation of the functions will provide greater flexibility and mobilisation to services where greater support is required in order to respond to acuity fluctuations and need.

The model will also support a central cohort of professional and technical expertise to support our services in responding to complex issues. The services within the '**Quality & Safety Central Team'** will work hand in glove with the Care Groups and Clinical Service Groups to ensure a quality service from the outset, but when things do go wrong, lessons are learnt and acted on swiftly and our patients and families are supported appropriately.

Each Care Group will benefit from an assurance, escalation and risk framework, clearly demonstrating how this links to the overarching governance framework for point of service to Board assurance. Similarly, a shared model of a multi-disciplinary panel to quality assure and recommend closure of all care group incident and complaint investigations will provide consistency of approach, robust analysis and drive quality and learning.

A Care Group Quality & Safety (Q&S) Fora, modelled on the current ILG function will enable each group to seek assurance from their clinical service groups and ensure that their services are safe, effective, efficient, equitable, timely and person centred.

Each Care Group Q&S Forum will upward report to a Health Board Wide Operational Services Management Board, which in turn will provide assurance to the Health Board via the Quality & Safety Committee as well as providing performance information to other committees, Executive and Leadership Groups.

There will be a focus on demonstrable improvement in effectiveness, performance and equity of service provision across the Care Groups.

The model proposes a Central Quality Governance Team which supports each of the care groups with a similar model to manage and optimise patient safety incident management and investigation, complaints, compliments, and Putting Things Right regulations work, patient experience, mortality and harm reviews, patient safety solutions, external action plan reviews, quality improvement and faculty advocates. Care Group Quality Governance teams will be centrally managed in order to maintain equity and consistency and strengthen resilience.

The executive and senior leadership team supported by the central patient safety team and the concerns and legal services team, will retain their core functions to provide pan-organisational strategic direction, leadership and oversight in compliance with legislation and regulation, quality planning, quality improvement, quality control and assurance, and in managing risk.

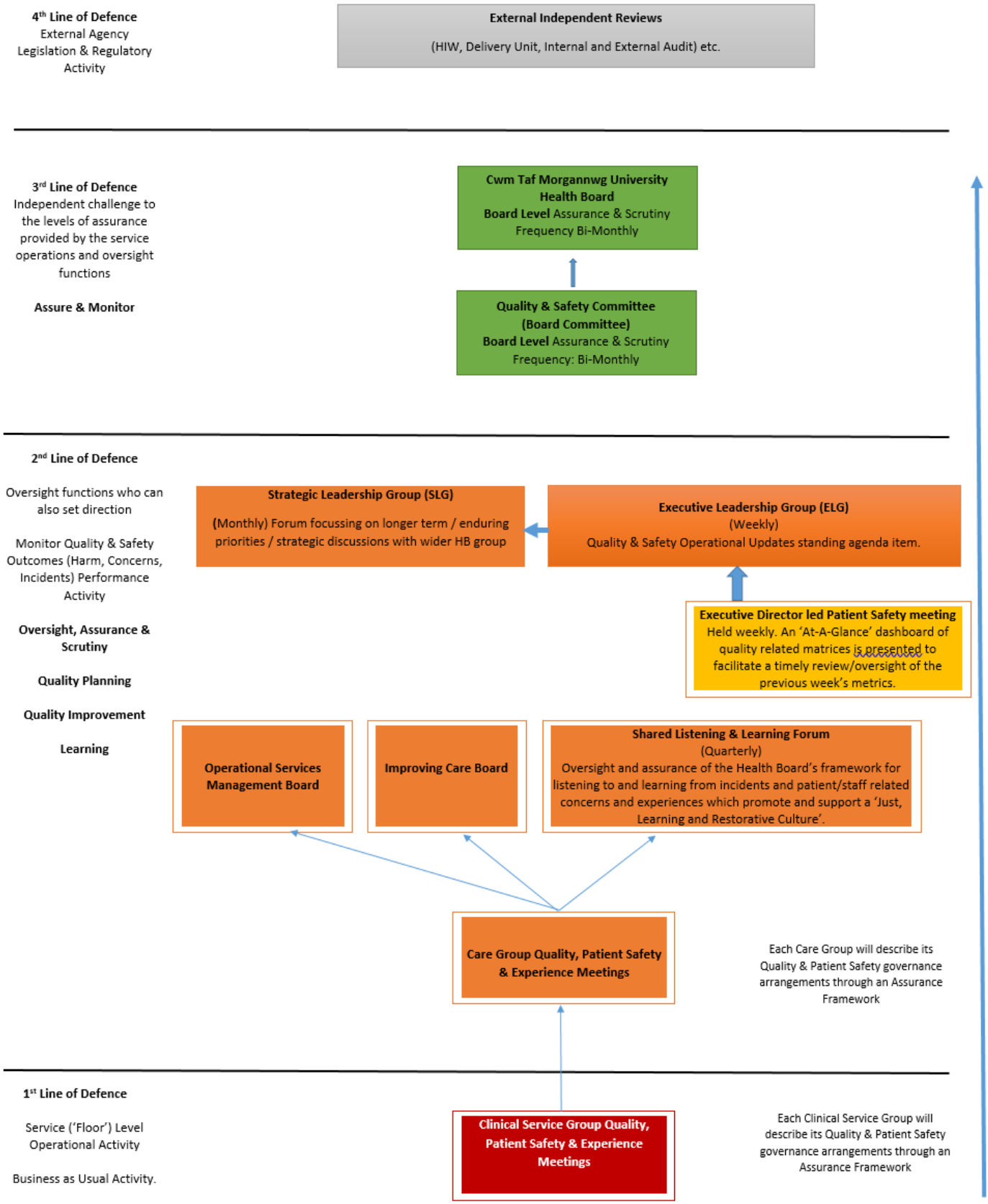
The central Business Intelligence function, which includes **Datix** management, will continue to support organisational assurance and data administration for all quality and safety information requirements.

References

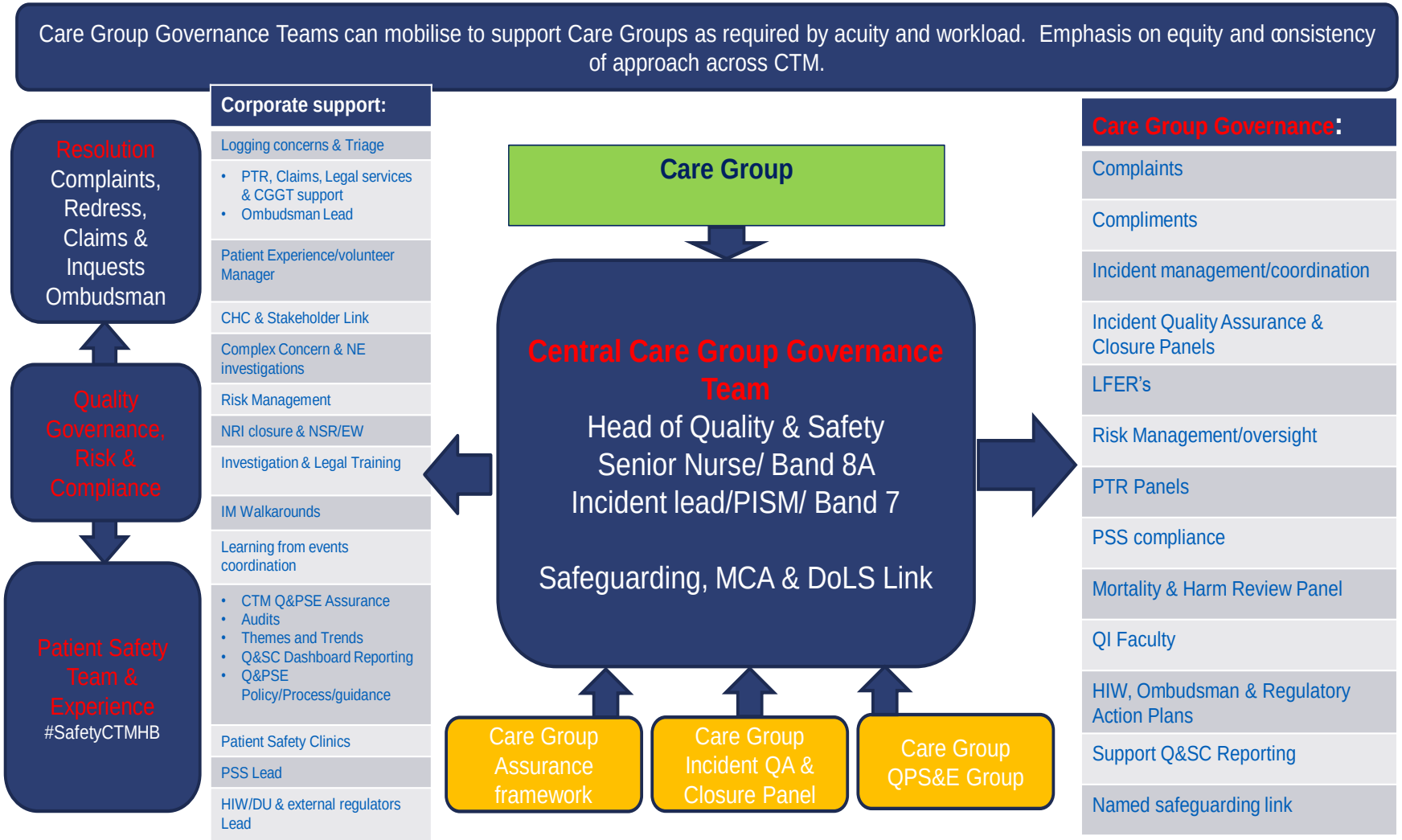
a. NHS Wales Performance Framework & Guidance Document 2022-23
b. Health and Social Care (Quality and Engagement) (Wales) Act (WG 2020)
c. National Clinical Framework for Wales (WG 2021)
d. National Quality and Safety Framework (WG 2021)
e. CTM 2030: Our Health, Our Future
f. A Healthier Wales (WG, 2018)

At Care Group level, the Group Service Director, Group Medical Director and Nurse Director are accountable for their Quality Management Systems. There is a shared responsibility for quality and the delivery of quality governance amongst the leadership team. Where Care Groups host a service, the host is accountable for upwardly reporting assurance, gaining that assurance from other relevant services or sites. Assurance of quality is through the Clinical Service Groups Quality, Safety and Patient Experience Group (QSPEG) to the overarching Care Group QSPEG, to the Q&S Committee. The Care Group QSPEG, a multi-professional group, will have an annual work programme. It will meet bi-monthly and is chaired by the Nurse Director. Each Care Group will have a centrally linked Head of Quality and Safety practitioner, supported by a small team to manage the quality and safety governance agenda. Concerns and *Putting Things Right* regulatory work will be managed centrally with close links to the Care Groups and clinical teams, patient advisory services and patient safety teams. The CTMUHB Listening and Learning Framework will ensure that organisational learning drives quality and continuous improvement of our services.

Quality and Patient Safety Framework – Governance System



Quality and Safety Governance and Assurance Standards and Templates



Quality Management System Tools

Risk Management Strategy (and Board Assurance Framework)

The Health Board is committed to developing and implementing a Risk Management Strategy (and Board Assurance Framework) that will identify, analyse, evaluate and control the risks that threaten the delivery of its strategic objectives and delivering against its Integrated Medium Term Plan (IMTP). The Board Assurance Framework (BAF) will be used by the Board to identify, monitor and evaluate risks which impact upon strategic objectives. It will be considered alongside other key management tools, such as workforce, performance, quality dashboards and financial reports, to give the Board a comprehensive picture of the organisational risk profile. This is further outlined in the Health Board's Risk Management Strategy available here: Health Board Policies and Procedures - Cwm Taf Morgannwg University Health Board (nhs.wales)

Quality Assurance, Governance and Risk Framework

Each Clinical Service Group and overarching Care Group are required to have a Framework in place that describes how they provide service to Board assurance in relation to Quality & Safety. The chosen model is based on the four lines of defence model which defines its internal systems and processes to control and govern quality, safety and risk, with a fourth line of defence being external/independent to the organisation.

An example of this Framework is from the Maternity and Neonatal Clinical Service Group, which can be found here.

Quality Patient Safety and Experience Groups (QPSEG) Toolkit

Each Clinical Service Group will require its own QPSEG as part of its governance and assurance business. Each QPSEG will have a **standard agenda, standard blue print of slides for CSG reporting,** including **quality indicators for services** and **Terms of Reference** for its operations. Each Care Group will have an overarching QPSEG utilising the same documents and tools for business. All Care Groups and Clinical Service Groups will have an **Annual Quality Work Plan** to focus on the delivery of SMART quality objectives as part of the **Quality Strategy** and **Quality Duty**. Identification of these annual objectives will be data driven and risk-prioritised to ensure a targeted approach to improving quality. We need to capture the information that is available to us across all aspects of quality management systems to measure the quality and outcomes of care. Central to this is person feedback, patients and staff; the use of Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMS) and staff survey measures can help us assess and meet patient needs, understand the lived experience of care and delivery, and to improve services. This can be used locally and nationally, and can inform a framework for measurement and benchmarking. Quality measures need to be on at least an equal footing with performance and finance measures.

Quality Dashboard Reporting

Intelligence is fundamental to improvement and assurance, and information should be consistent and widely available. Timely data is key to both understanding what is happening within our organisations at any point in time but also to look at outcomes, identify areas for improvement as well as for benchmarking. Over the past two years, a CTMUHB **Quality Dashboard** has been implemented and refined, which is updated on a bi-monthly basis and presented to the Quality and Safety (Q&S) Committee through to Board (template example). The metrics and indicators are under constant review and will be further developed to provide a greater breadth of measures, including primary care and commissioned services. Triangulation of data with workforce and Patient Experience measures are a key ambition to understand the lived experience of care and services in order to affect meaningful improvement.

The Quality Dashboard was initially Health Board wide. In alignment with the Operating Model, there are now Care Group and Clinical Service Group quality and safety dashboards to provide more robust, detailed and specific

assurance and benchmarking. The Central Business Intelligence Team work closely with Clinical Audit, Digital and Performance teams to support the requirement for valid quality and safety data and information. Highlight report example found here.

The Dashboard presents numerical information about key agreed quality indicators and, where possible, Statistical Process Control (SPC) charts for a rolling 12-month period. Narrative analysis is required, however it is recognised that this is retrospective exercise. Additionally, quality narrative is included in the Integrated Performance Report at Management Board and Board. Further improvements include incidents per bed days and the setting of improvement trajectories. These have been set initially for pressure damage and falls but will be used along with improvement cycles to support purposeful change.

Incident Management Framework and Toolkit

All incidents will be managed in accordance with the CTMUHB Incident Management Framework & Toolkit.

Incident Investigation Training

There is a comprehensive package of training for incident investigation at all levels delivered by the patient safety team on a bi-monthly basis. Training records are maintained on the Electronic Record System (ESR). Practitioners must have received health board training to lead an incident investigation. Bespoke training and Patient Safety Clinics are available by negotiation.

Quality Assurance and Closure Panels

The Health Board has developed a gold standard for scrutiny and quality assurance of its completed incidents. The Quality Assurance and Closure Panel process must be used by Clinical Service Groups to ensure robust application of this standard for all its Nationally Reportable Incidents. There is a common Terms of Reference and Quality Assurance Checklist available.

Quality Impact Assessment (QIA)

Our CTMUHB Quality Impact Assessment tool provides an opportunity for any service development, change or cessation to be considered in terms of its impact on patient safety, patient experience, workforce and clinical effectiveness. It is a tool to help develop service change. It should be used at the beginning of a change process ensuring that the dimensions of quality are reviewed and that the service is developed in a comprehensive way, based on rounded data and intelligence.

When a change to a service/care pathway is proposed, the Health Board must ensure that the proposal has only positive effects on patient safety and patient experience, and are evidence based, and demonstrate best practice. Only then can we be assured of high quality care. We also need to demonstrate that issues of workforce planning, and skills transfer, together with education and training have been appropriately considered. This tool will enable the Board to be assured that all essential factors are being considered and addressed through the development of service design and that we are compliant with our Duty of Quality. The QIA threshold result is designed to provide an assessment of the perceived impact that the service development will have on the quality of care delivered. Whatever the outcome of the threshold result, there may be individual indicators rated as having a negative impact on quality. In that case, due consideration should be given to all of these to establish how the service/plan could be changed to improve the quality impact or to ensure that on balance, the scheme is worth pursuing. In these cases, the reason for the decision to go ahead should be clearly documented. High risk service developments that result in a red risk score should be escalated through to Quality and Safety Committee for consideration.

Sign off processes

- ☑ All Care Group complaints responses will be signed off by the relevant Care Group Director.
- ☑ All MP or MS queries or concerns on behalf of constituents will be managed by the corporate team for consistency and will require CEO sign off. Awareness and copies of responses will be made available to the Care Group Directors and linked appropriately with any ongoing/parallel activity in relation to the concerns raised.
- ☑ Early Warning notifications will be authorised (watermarked) by the relevant Care Group Director prior to quality assurance within the central patient safety team CTHB_Patient_Safety@wales.nhs.uk before executive sign off and submission to Welsh Government.

- ☑ Notification of Nationally Reportable Incidents (NRIs) will be approved by the relevant Care Group Director prior to quality assurance within the central patient safety team CTHB_Patient_Safety@wales.nhs.uk before executive sign off and submission to the NHS Delivery Unit. NRI closures will be approved by the Quality Assurance Panel and relevant Care Group Director before submission to the central patient safety team CTHB_Patient_Safety@wales.nhs.uk for executive sign off and submission to the NHS Delivery Unit.
- ☑ Locally Reportable Incidents require relevant Director approval and sign off only.
- ☑ Risks will be reviewed and approved for escalation by the Care Group Director.

Listening & Learning Framework and Repository of Learning

Our Listening and Learning Framework and the Repository of Learning demonstrates how organisational learning will be identified, triangulated, stored, disseminated and implemented in practice to facilitate and embed a culture of appreciative enquiry and continually improving health care services and the experience of our workforce. The Framework facilitates a strategic approach to support the organisation to listen and learn lessons from a range of internal and external sources, to record, store and use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.

Quality Improvement – iCTM

The iCTM directorate builds capacity for change across our organisation, co-ordinates improvement and innovation activity, and engages with our colleagues, patients, communities and partners to drive the adoption and spread of the most impactful improvement and innovation options, all underpinned by the principles of Prudent and Value Based Healthcare, and co-creation.

This commitment to provide ALL our people with the knowledge, skills and support to make changes will drive learning and quality improvement initiatives throughout CTM.

AGENDA ITEM
6.1

QUALITY & SAFETY COMMITTEE

MATERNITY AND NEONATAL IMPROVEMENT PROGRAMME UPDATE

Date of meeting	24/01/2023

C=

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Shelina Jetha - MNIP Programme Manager
Presented by	Greg Dix - Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
MNIB Huddle – Greg Dix, Executive Nurse Director And Sallie Davies, Deputy Medical Director/Corporate Development	14/12/2022	SUPPORTED

ACRONYMS	
IMSOP	Independent Maternity Services Oversight Panel
MNIB	Maternity & Neonatal Improvement Board
MNIP	Maternity & Neonatal Improvement Programme
MIP	Maternity Improvement Programme

NNIP	Neonatal Improvement Programme
ESC.	Escalation (as per Neonatal Deep dive recommendations)
PCH	Prince Charles Hospital
BSOTS	Birmingham Symptom specific Obstetrics Triage system
PERIprem	Perinatal Excellence to Reduce Injury in Premature Birth
PMO	Project Management Office
datix	System for reporting incidents
AMAT	Audit management tracking
QLM	Quality of Leadership & Management
QWE	Quality of Women's Experience
RCOG	Royal College of Obstetricians & Gynaecologists
RCM	Royal College of Midwives
RGH	Royal Glamorgan Hospital
SEC	Safe & Effective Care
SBAR	Situation, background, assessment and recommendation
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

In April 2019, the Royal College of Obstetrics and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) published the findings of their joint Independent Review of Maternity Services at the former Cwm Taf University Health Board. The Welsh Government appointed an Independent Maternity Services Oversight Panel (IMSOP) that consisted of Obstetrics and Neonatal specialists to identify if the care provided at our Health Board was appropriate and, if not, what learning and improvements could be identified.

In 2020, the Health Board requested that an external review of its Neonatal Services at Prince Charles Hospital (PCH) be undertaken as part of the Panel's assurance processes for Maternity Services. This review was requested following routine reviews of care on the Neonatal Unit at PCH, and the former unit at the Royal Glamorgan Hospital (RGH), which senior

clinicians felt, in some cases, could be improved. A review of Neonatal Services termed a 'Deep Dive' started in May 2021.

In August 2021, the Panel escalated concerns to Welsh Government regarding some elements of care at the Neonatal Unit at PCH with some areas needing urgent action. Immediate action was taken to begin to address these concerns.

In February 2022, the Neonatal Deep Dive review was published. This consisted of 42 recommendations of which 5 were immediate plus a further 14 escalations, grouped into the following seven key themes:

1. Family engagement and support
2. Governance, Assurance and Accountability
3. Neonatal Service Workforce
4. Reporting
5. Neonatal Unit Functionality
6. Neonatal Unit Safety
7. Clinical Case Assessments

Note: The position of the progress on the Neonatal recommendations are detailed further in this paper.

In light of the NN deep dive recommendations, a Maternity and Neonatal improvement Programme (MNIP) was set-up to deliver the improvements. This included a robust programme structure with programme plans with deliverables; governance and accountability; highlight reports for both external and internal stakeholders; risks register with mitigating actions etc. Also plans for transition of the improvements into business-as-usual practices in service after the end of the programme. Furthermore, the health board worked with IMSOP to identify 'conditions for sustainability' to ensure progress on the delivery and sustainability of the improvements.

The key **overarching areas** of improvement for both Maternity and Neonatal are as follows:

- Quality of Leadership Management **(QLM)**
- Safe and Effective Care **(SEC)**
- Quality of Women and Families Experiences **(QWE)**

On 7th Nov 2022, Welsh Government announced Maternity services were removed from special measures *(for full details see link below)* and both Maternity and Neonatal services would be placed into targeted interventions. Key summary as follows:

- **Decision to de-escalate -** *the HBs maternity and neonatal services from special measures to targeted intervention. This transition recognises the clear progress made over the last three-and-a-half years'*

- **Continuous/sustainable improvements** met
- **Maternity and Neonatal improvement journey** can now be considered sustainable
- **IMSOP on-site visit 5/7th Sept 2022** - assurance on maternity service markedly different compared to 2019
- **Families** continue to ensure their experiences help shape service design and delivery
- **Culture change** - HB leadership committed to working collaboratively with staff on positive cultural changes
- **Neonatal service still has some way to go in its improvement journey -** The merger of maternity and neonates in one care group structure will help to deliver sustainable improvements in neonatal care. Also, learning from previous experience in maternity services will be an asset for the development of safe sustainable improvements in neonatal care.
- **IMSOP standing down the oversight panel at the end of the year 2022**
- **Oversight and support -** Welsh Government to advise
- **National programmes** of work underway on maternity and neonatal service provision across Wales. Identify any improvements collaboratively with all HBs.
- **Learning from Clinical reviews** - CTMs improvement journey to feed into these programmes.

Welsh Government notification on MNIP and standing down on special measures to targeted interventions 7/11/22 see link below for full details of published report:
written-statement IMSOP progress-report published 7th Nov 2022
BBC news Wales report 7th Nov 2022

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

This paper summarises the on-going improvement work led by the maternity and neonatal improvement board.

1. **Gynaecological pathway –** clinical guidelines
2. **Neonatal Improvement programme -** progress
3. **NNAP -** update
4. **Maternity Improvement Plan (MIP) 'wash up plan' -** progress
5. **Putting things Right (PTR) –** complaints; NRI's etc.
6. **Training compliance -** update
7. **National mat/neo safety programme -** update
8. **Workforce**
9. **Risks/mitigations**

Gynaecological pathway

Gynaecological emergencies can arise at any time of the day. The introduction of early pregnancy units (EPU) has led to an organised assessment of women with complications of early pregnancy, the most common cause of emergency assessment. Thus, most of these women are seen within working hours. However, some women have severe symptoms, which cannot wait until an EPU opens, and others have non pregnancy related conditions. The emergency gynaecology and early pregnancy service should be consultant led, with decision-making made in a timely manner, and at a sufficiently senior level. The service should be women centred, safe, effective, evidence based and multidisciplinary.

Emergency gynaecology is available at PCH 24/7 on ward 5 and from December 2022 an AESU (A&E surgical unit) available for 12hrs/day in POW.

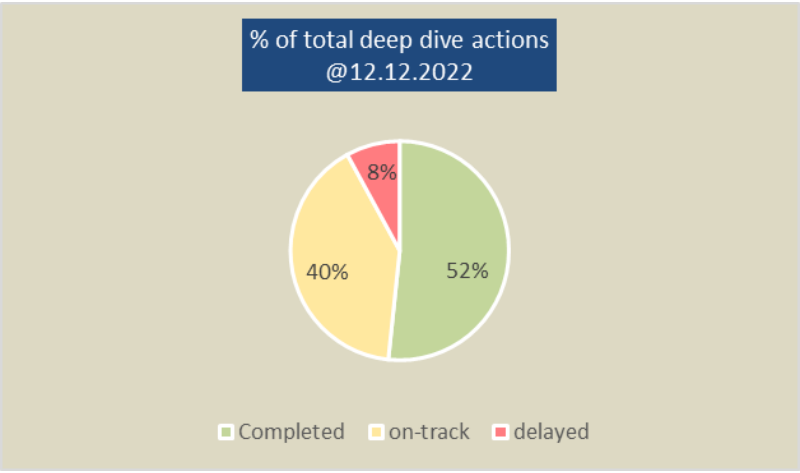
The following link is to the standards of service provision developed for the gynaecological pathway clinical guidelines and approved in April 2022:
Clinical guidelines emergency gynaecology and early pregnancy service April 2022

Neonatal Improvement programme (NNIP)

All of the 19 immediate actions from the deep dive recommendations had all been submitted to IMSOP by 30th September 2022 of which the following had not been verified:

- ***Esc 2*** *– IUT (intra uterine) pathway/close working between Maternity and Neonatal – pathway developed and to be implemented*
- ***Esc 5*** *– HIE (Hypoxic-ischaemic encephalopathy) cooling pathway and case example on improvements – awaiting a case.*
- ***Esc 7*** *– SI's (Serious incidents) renamed to NRI's/LRIs (National and local reportable incidents) – Trigger list audit completed; PMRT and NRI reports to be completed*

The following chart provides an overall summary on the progress on all deep dive actions as at 12.12.2022:



*Note: Delays are predominantly due to the outstanding immediate actions (as above, 2 **remaining** now on-track to be completed Jan 2023 and one pending on a HIE/cooling case) and 40% of remaining actions on-track i.e., short/medium with long-term delivery beyond Programme end 31/3/23.*

IMSOP stood down at the end of December 2022 hence, the following has been set-up to ensure all remaining deep dive actions are delivered, assured and improvements are embedded:

- **Please refer to Appendix 1 (attachment)** *'MATERNITY & NEONATES ASSURANCE, RISK & ESCALATION FRAMEWORK FINAL DECEMBER 2022 V5.0'*
- **Newly set-up 'Neonatal Operational Clinical Improvement Group' – first meeting to be held 9/1/2023 –** *multi disciplinary inclusive of Maternity where required to oversee implementation of improvements in BAU practices*
- **Revised NNIP plan** *(shared with Welsh Government 21.12.23)*
- **Using data for making service improvements –** *e.g. respiratory pathway, IUT pathway as QI projects; antibiotic stewardship; Normothermia – monitor temperature; golden drops – breastfeeding in collaboration Mat/Neo and reduce term admissions*
- **Programme led approach to delivery under review** *PMO ending 31/3/2023 (to be led by Clinical Improvement Lead)*

Maternity 'wash up plan'

This plan included outstanding items from the MIP and also those items that require collaborative working between Maternity and Neonatal services, as follows:

- **RCOG recommendation 7.3** – all women presented in A&E to be seen within 12hrs by a consultant. This target is the ambition for HBs across Wales and UK. It is not achievable within the current workforce model. However, a strategic workforce plan is being developed, inclusive of both Maternity and Neonatal in the new CTM governance structure. CTM HB is currently compliant with the 18 hours window. To date no safety incidents have been raised. **Action:** HB keep this under continuous review.
- **Transitional Care** – Data to be extracted from BadgerNet and pilot being scoped for POW as a trial.
- **Long term strategy** – formal launch to be arranged.
- **Culture survey** – to re-run and analyse results.
- **QI:**
    - **Maternity Data dashboard -** now live; staff provided with training; one process map across CTM; digital booking system to be tested Jan 2023/scale Feb 2023
    - **ATAIN** –QI training with Mat Neo Cohort 1 completed; Improvement in Practice training in October; Cohort 2 started November 22; MDT represented at training; engaging

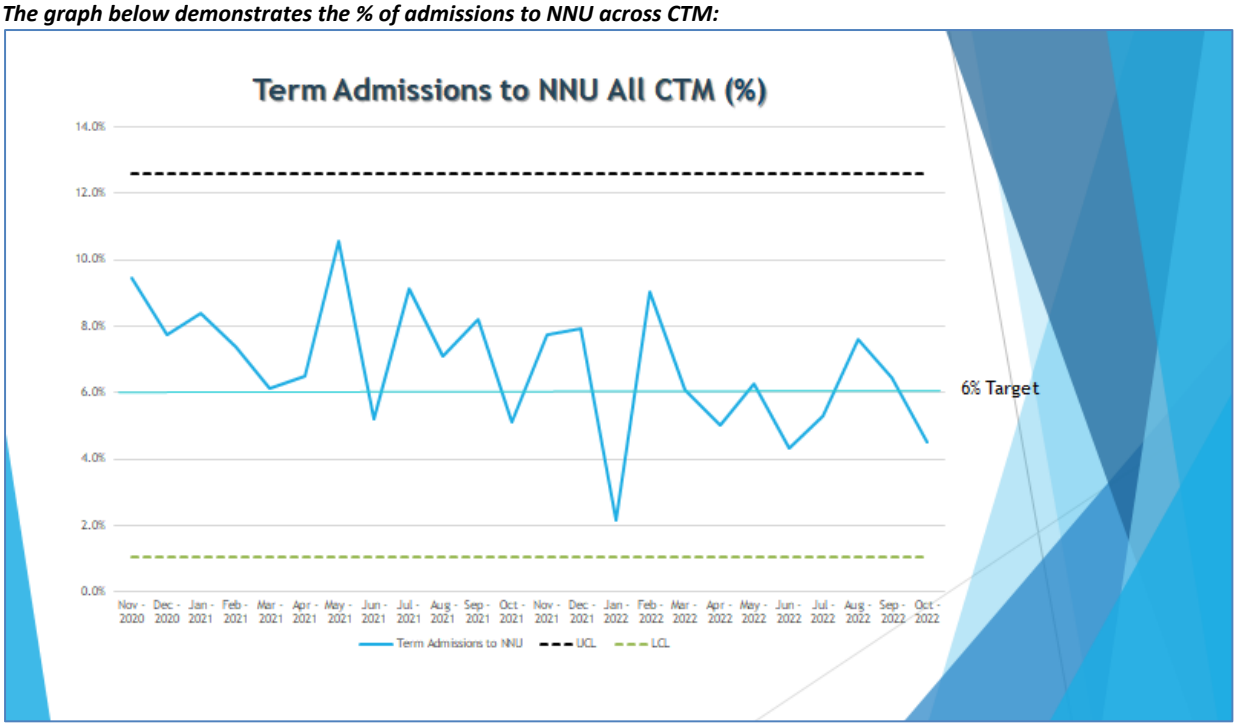
Obstetricians in QI training, with 1 booked in Cohort 3 to date in Nov 22; ATAIN dashboard developed; Mat/Neo team working collaboratively

- **BSOTS –** baseline data collected; good understanding of attendance; MDT at both sites; further engagement with staff and families; local adaptations; launch Feb 2023
- **PERIprem –** 11 QI projects identified and delivered in collaboration between maternity and Neonatal

*Note: **PERIprem** (Perinatal Excellence to Reduce Injury in Premature Birth) – this is a new care bundle developed in NHS England to improve outcomes for premature babies which CTM will be using for making improvements.*

Term admissions metrics

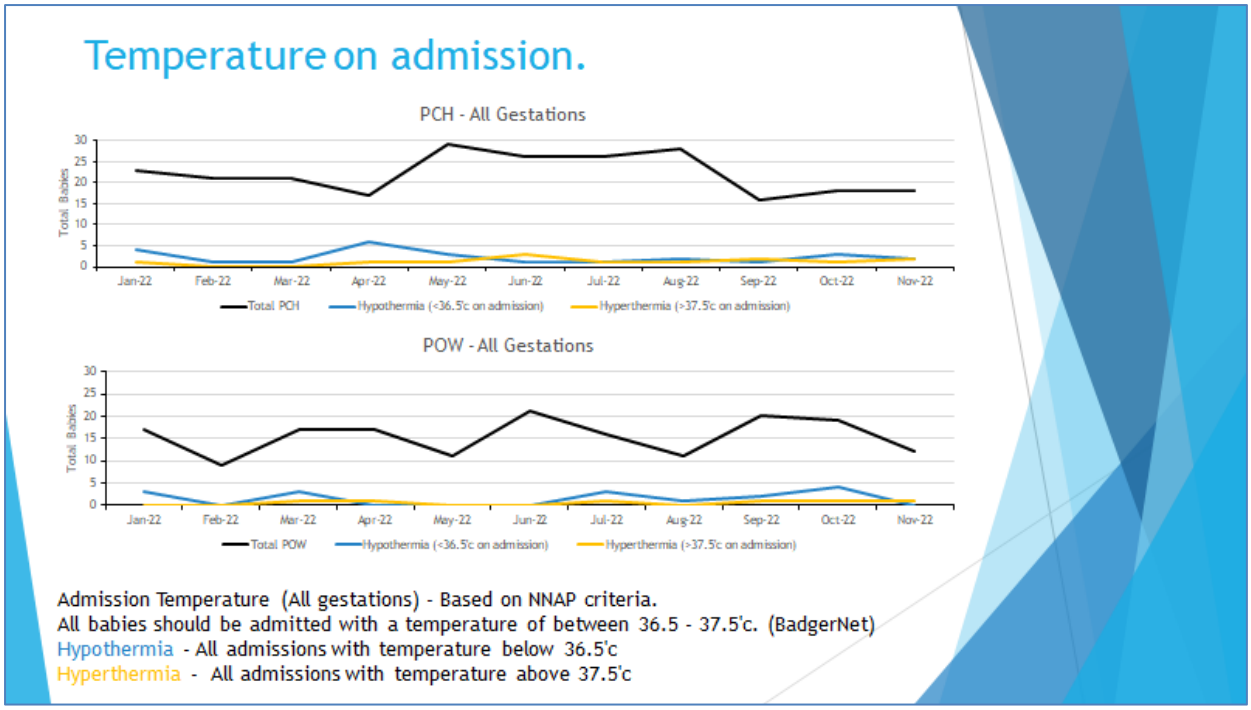
The graph below demonstrates the % of admissions to NNU across CTM:



*note: 6% target is a nationally set target. CTM - approx. 72% of term admissions are due to respiratory concerns. **Action:** Consultant led - respiratory pathway under review as part of QI project to be completed by 30th June 2023)*

Temperature on admission

The graph below demonstrates the infants temperature for PCH and POW:



*Note: **Action:** Consultant led - Normothermia QI project to improve processes for taking temperatures under review to be completed by 31st March 2023*

National Neonatal Audit Programme (NNAP) 2021 results

NNAP results for 2021 received; presentation to Mat/Neo clinicians 5th Dec and MNIB 14th Dec held. Mat/Neo collaboration to devise formal action plan from findings. **Actions for CTM**:

- **Data validation**
- **Peri prem QI project**
- **Thermoregulation QI project**
- **Staffing data analysis**
- **Maternity and Neonatal to develop formal approach to NNAP data/actions**

NNAP results can be found on this website: [NNAP Online (rcpch.ac.uk)]

Putting things Right (PTR)

Compliance against 30 working day target for Nov 2022

The following table presents the no. of complaints; resolved within the 30 day working day target; no. closed; total no. open and those that are >30days

Note: top 3 types of complaints relate to clinical treatment, appointments, and attitude & behavior.

No. of complaints 'closed'	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Number of complaints closed	10	8	19	11	8	5	9	8	1	5	2	6
Of the complaints closed, number responded to within 30 Working days	8	4	7	5	2	4	7	5	1	3	1	1
Complaints compliance response rate	80%	50%	37%	45%	25%	80%	78%	63%	100%	60%	50%	17%

Complaints 'open'	no. of complaints
Total no. of complaints open as at 8.12.22	30
Open complaints >30 days	17

All concerns are Quality Assured by the CD and HOM together: the process is lengthy and needs to be reviewed as women are waiting too long to have their concerns responded too. Please also note that some complaints also require an RCA investigation and therefore will breach the 30 day target. Note: The Health Board have recently transitioned from an Integrated Locality Model into a Care Group operating model and are also realigning the quality governance structure to support the new operating model. Therefore, reporting going forward will be aligned to the new Care Group model.

Maternity only clinical incidents by level of harm Nov 2022

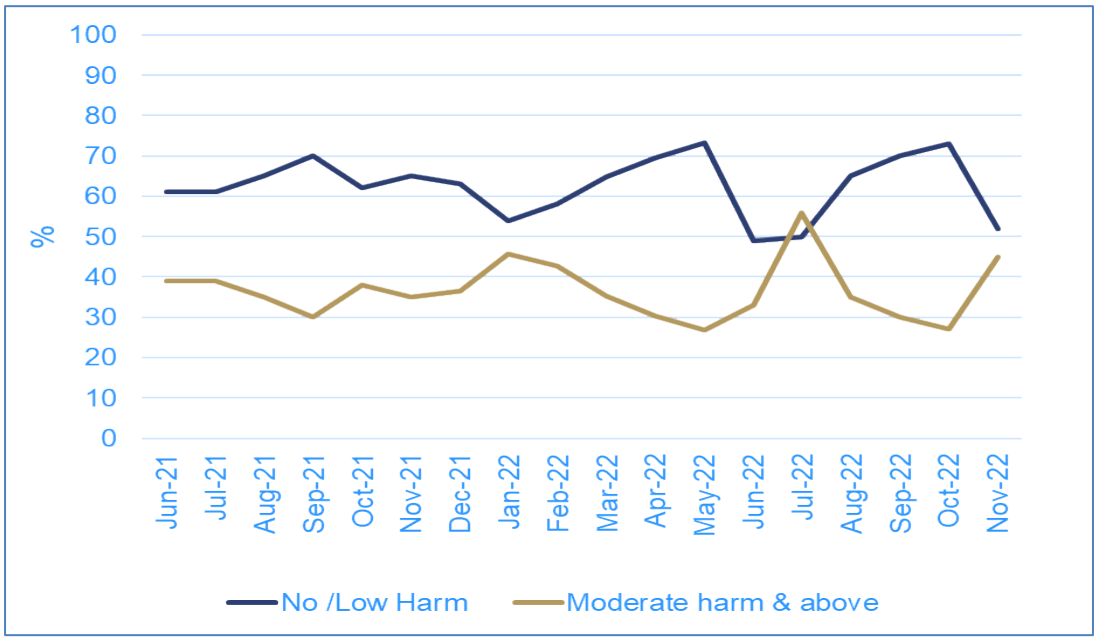
The following table presents the number of incidents by level of harm across CTM sites as at Nov 2022:

CTM site	None	Low	Moderate	Severe	Total
Community Sites	0	1	0	0	1
Other Sites	2	1	0	0	3
Prince Charles Hospital	22	22	25	1	70
Princess of Wales Hospital	24	23	19	0	66
Royal Glamorgan Hospital	4	3	0	0	7
Ysbyty Cwm Rhondda	0	2	0	0	2
Ysbyty Cwm Cynon	2	0	0	0	2
Total	**54**	**52**	**44**	**1**	**151**

The following table presents the type of incidents across CTM:

Type of incident	Total
Access, Admission	15
Accident, Injury	2
Assessment, Investigation, Diagnosis	10
Communication	12
Equipment, Devices	7
Information Technology	1
Infrastructure (including staffing, facilities, environment)	17
Maternity adverse occurrence	68
Medication, IV Fluids	4
Records, Information	2
Safeguarding	1
Transfer, Discharge	7
Treatment, Procedure	5
Total	**151**

The chart below shows the trend on % of clinical incidents by level of harm over a period between Jun 21 to Nov 22:

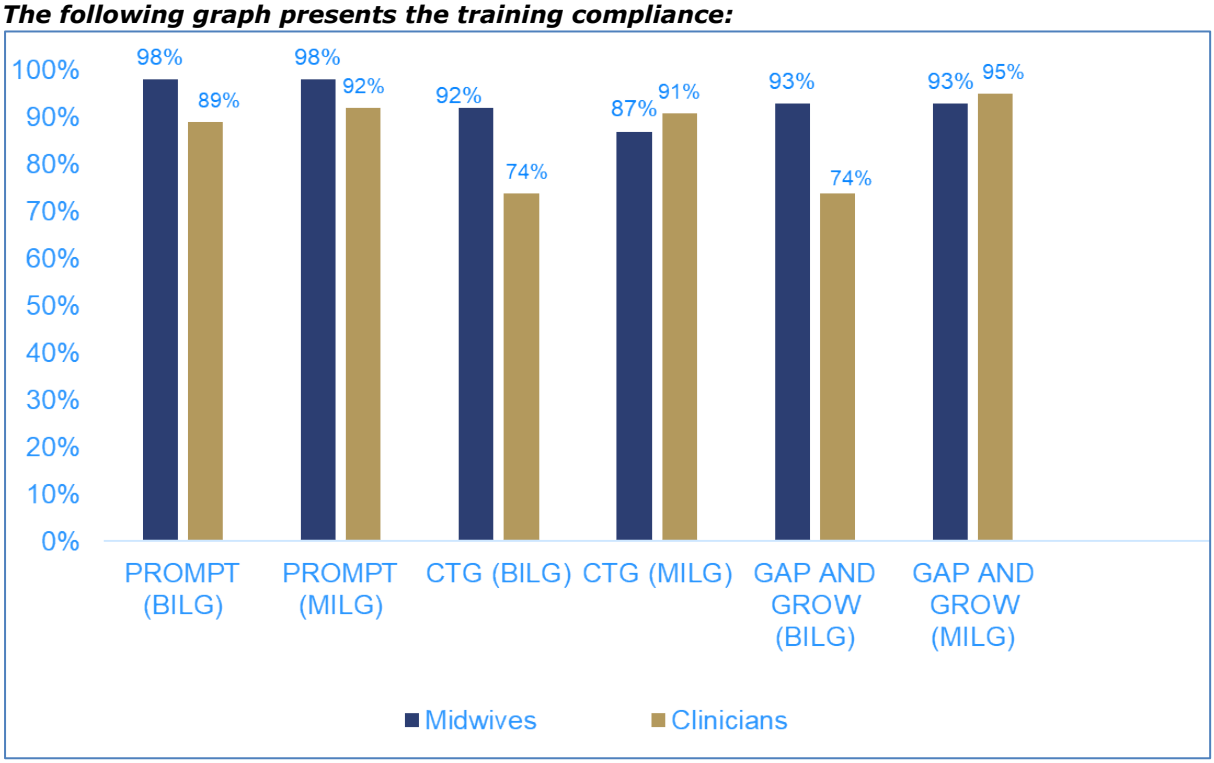


'low harm' showing a decrease and moderate harm and above a slight increase with one severe case at PCH. The process for handling cases is that an SBAR is raised; with a MDT review on a

Wednesday and further scrutiny on a Friday in the senior MDT. Actions are allocated on the Datix system and once complete the incidents are finally approved by the Senior Midwifery staff within the clinical area.

Training compliance – December 2022

The following graph presents the training compliance:



Note: A number of staff from PCH acute had been pulled clinically from M+S training scheduled for 2/12/22 which will inadvertently affect the compliance figures in the December report. Again, reasons for this are due to sickness levels and has been escalated to the senior team.
There has also been a significant number of staff sickness/shortages in all areas.
Compliance is reviewed/monitored on a monthly basis, staff who are not complaint are contacted by the training team to ensure their compliance. If still not compliant, this is escalated to the Care Group medical director to ensure all the staff are compliant with CTG and Gap and Grow training. Rota is adjusted to allow the medical staff to complete any required training.

National Maternity/Neonatal safety programme

This is a national short-term improvement programme across all HB's led by Improvement Cymru with the aim to report on findings by 31st March 2023; followed by a plan for improvements. The following is the progress to date:

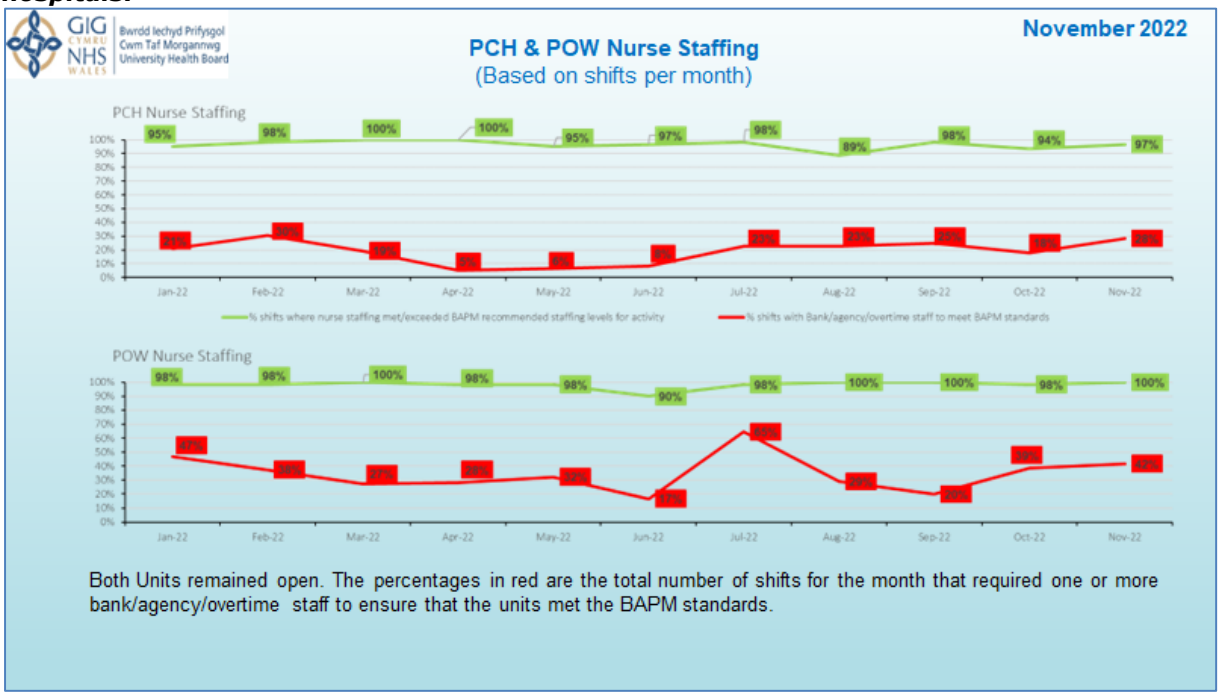
- **Mat/Neo safety officers** for CTM in post – collate thematic responses onto diagnostic tool
- **Phase 1** – collection of thematic responses in progress/interim report due 30/12/22
- **Phase 2** - collection of data/final report to be published 14/2/2023
- **Site visit** by senior leads from Improvement Cymru on 13/1/2023

Note: Series of meetings are in place between the Mat/Neo safety team and the team on shop floor. There is meeting in place between the Care group/Exec team and the Mat/Neo team to discuss the collaboration required to ensure delivery of the aims of the project.

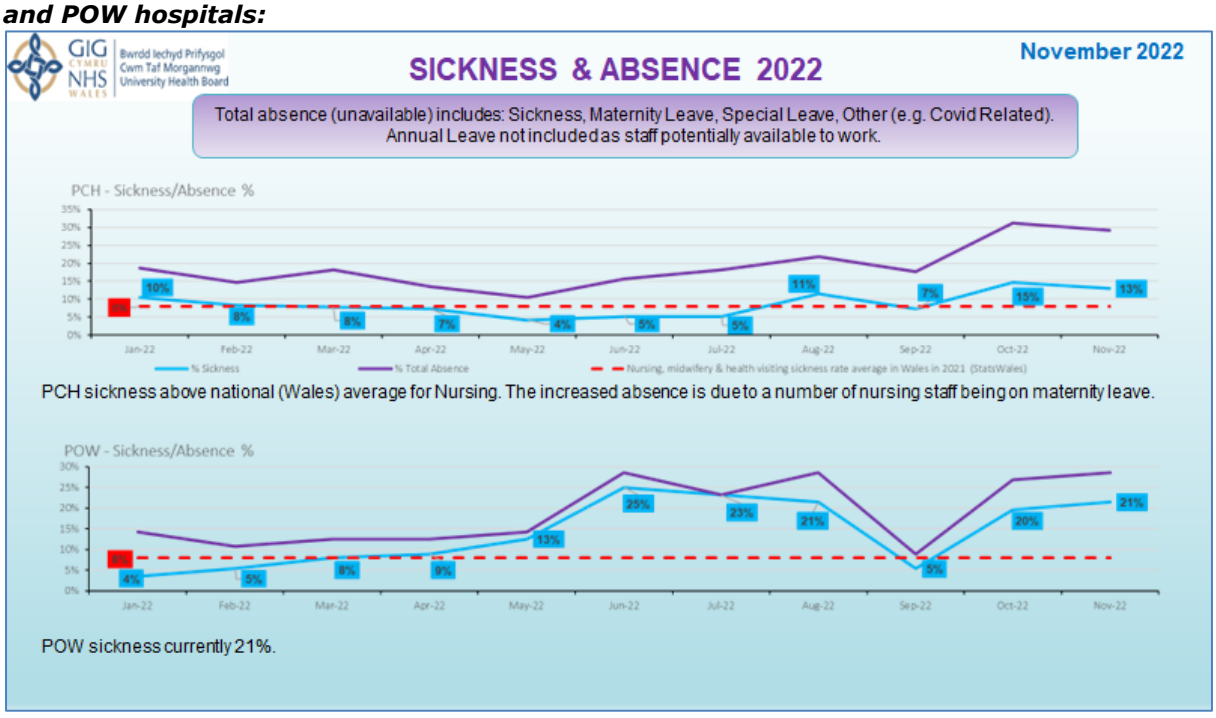
Workforce

Neonatal – November 2022

The following graph presents the Neonatal staffing levels and the bank/agency/overtime to meet BAPM standards in CTM across both PCH and POW hospitals:



The following graph shows the Neonatal sickness and absence levels in CTM across PCH and POW hospitals:



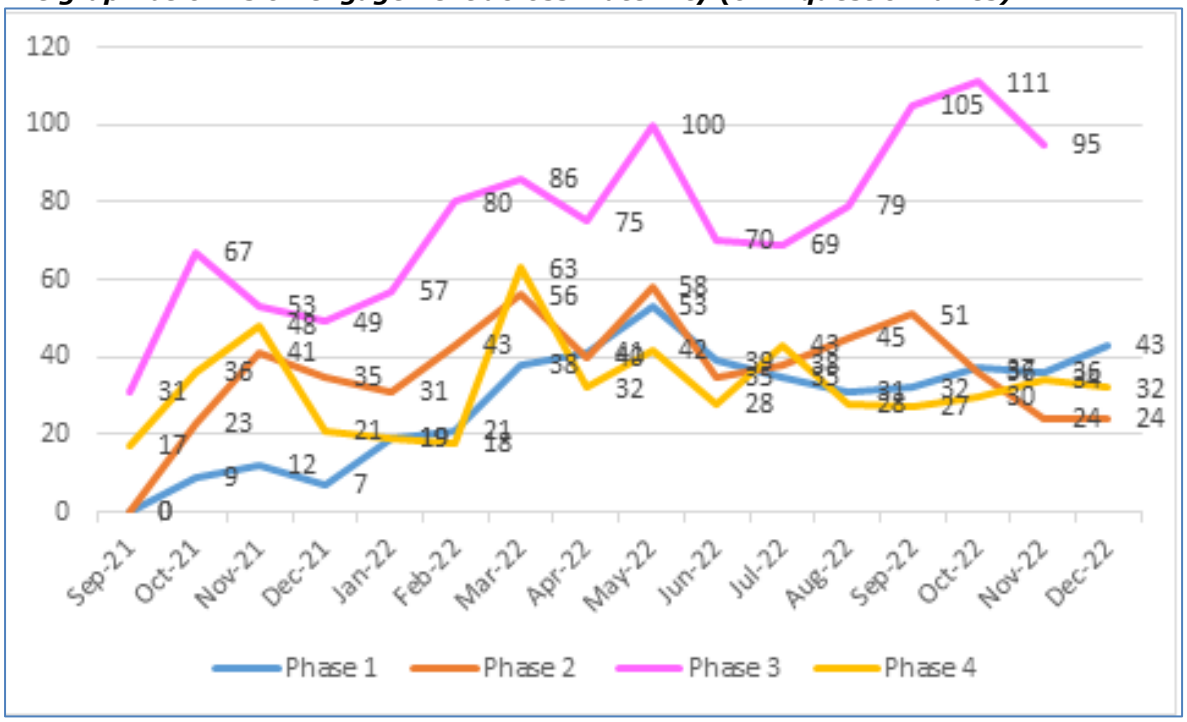
PREMS (patient recorded outcome measures) - Maternity

The following table provides no. of women/details on the different phases when questionnaires are sent out from 13th Sept to 31st Dec 22:

Phase	Type	No. of questionnaires sent
Phase 1	After anomaly USS	476
Phase 2	At 37 weeks	585
Phase 3	14 days post-birth	1193
Phase 4	12 weeks post-birth	521

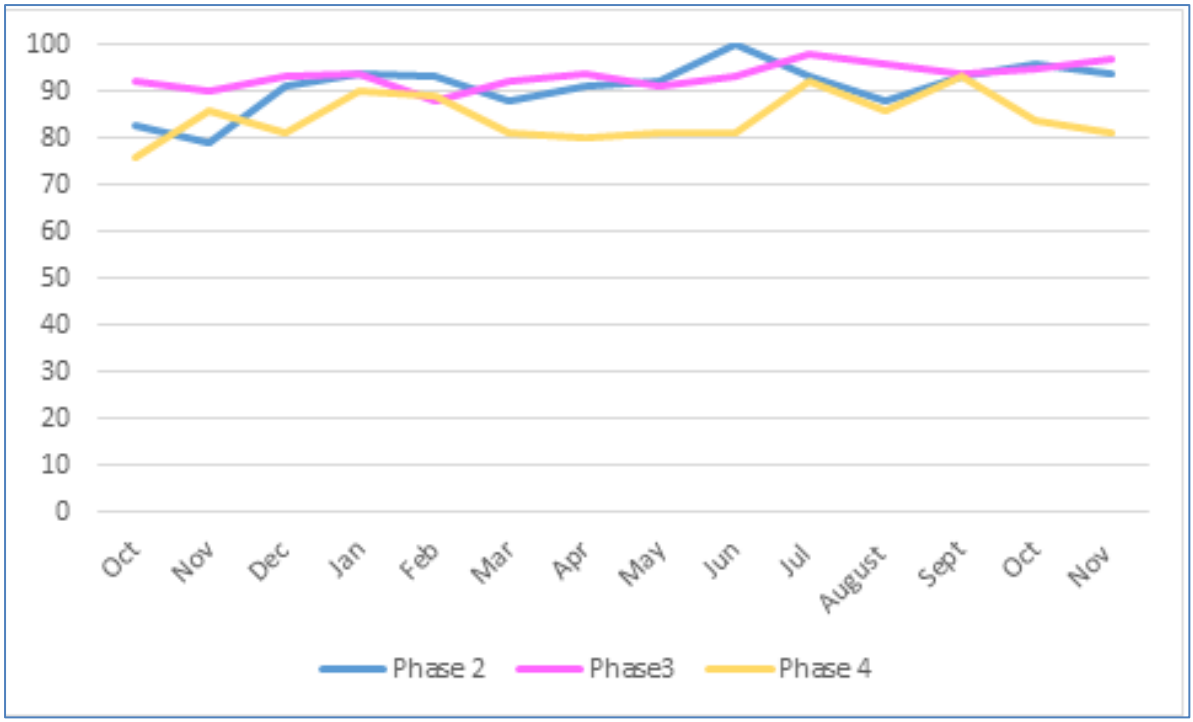
Overall, 25% response rate to Phase 2. Note: Phase 2 completed by those who have had their anomaly USS within the service; we continue to engage with our families to encourage completion of questionnaires.

The graph below is on engagement across maternity (on 4 questionnaires):



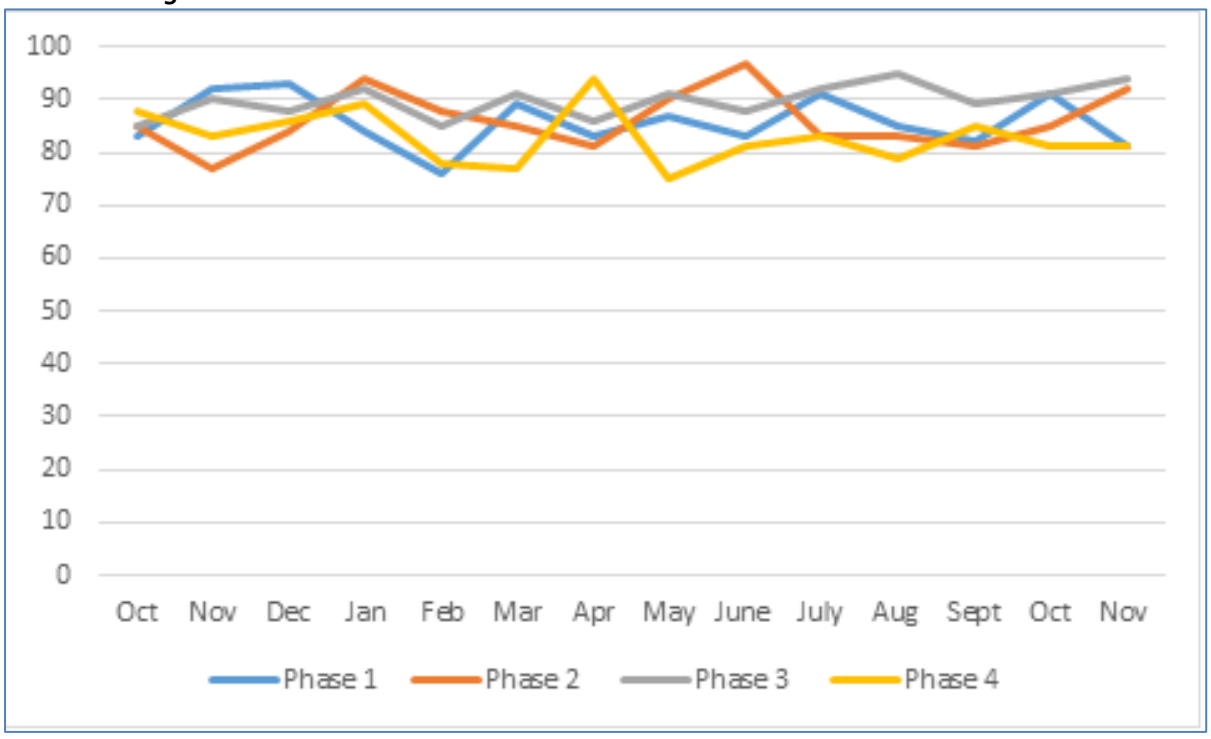
Note: For context, 4 questionnaires i.e. phases are sent out to women throughout pregnancy and post-birth (1st after anomaly scan, 2nd around 37 weeks, 3rd at 14 days post-birth and 4th at 12 weeks post-birth) and as presented above, there's good engagement.

The chart below is for the question 'Thinking about your care, have you been treated with dignity and respect'?:



Phase 4 asks specifically about pregnancy/post-birth experience as an overall so is likely why this is reflected a little lower.

The chart below is for the question 'Thinking about you care, were you treated with kindness and understanding'?:



Again, phase 4 picks up the pregnancy/post-birth as a whole, therefore is reflected lower.

Table below presents key themes (relating to areas of concern/requiring improvement) and how we've approached to make improvements:

Theme – requiring improvement	Improvement
Being able to contact community midwives	Implementation of community team phones, communication team supporting work to ensure all women have appropriate contact numbers, and the triage project for women contacting us with pregnancy concerns.
Partner visiting/involvement	Experience data has increased a lot with reducing visiting restrictions, but remains very low on ward areas, and we have discussed and considered further changes we can make safely in view of Covid/RSV and other IP&C restrictions
Women making choices which are right for them	Commissioning Birth Rights training for clinicians around choice and consent, and supporting individualised care planning.
Women making informed decisions/having appropriate information and explanations around induction of labour	An Improvement working group for all areas of induction of labour has been set up to consider strengthening the information we have available for women.

Neonatal engagement – progress update

With the appointment of an Engagement Lead in May 2022 and the Neonatal engagement strategy which was launched in July 2022, various methods of engagement are in place such as social media i.e. QR code questionnaire; Facebook; twitter; engagement forum which involved families and staff; awareness days; face to face; patient stories; you said we did etc. Also a monthly engagement forum and planned events such as Christmas party for families (30 attendees) and staff.

The following table provides an update on the Neonatal engagement social media reach:

Social media	No of members and response rates
Cwtch Facebook group	401 members (27 new members this quarter)
PCH SCBU Merthyr Facebook group	568 members (28 new)
Average post reach	300-400 views (increased from last quarter)
Average response	10- 30 likes or comments
Twitter	350 followers (37 new followers)

The following table presents the no. of compliments/complaints received:

Compliments	PCH	POW
Thank you, cards, received	25	20
Social Media compliments	101	60
Comments book on wards	0	1
Complaints		
On the spot	0	2
Formal	1	0

Neonatal are in the process of setting up an electronic questionnaire on CIVICA like Maternity services i.e., PREMS to be launched in February 2023 but in the meantime the department have designed a questionnaire via a Microsoft form accessible using a QR code and a paper copy on the wards.

The table below presents the no. of responses between July 22 to December 22:

Site	No. of responses
PCH	30
POW	46

Note: 98%of the respondents were white British and 7 were of the male gender

The following table demonstrates the 'fundamentals of care' and what we do well?

What we continue to do well?	% of responses
Felt they were always or usually fully informed about care	88%
Always or usually received an update from their doctor	90.5%
Felt that they were always or usually treated with dignity and respect	90.5%
Always or usually felt encouraged to participate in baby's care	92%
Felt they were always or usually fully informed about care	88%

The following table identifies 'what we could have done better':

What we could have done better?	% of responses
Felt that they sometimes or never received sufficient info about unit facilities, visiting, support groups	9.5%
Sometimes or never had unrestricted access to their baby	9.5%
Sometimes or never felt able to stay overnight with their baby	15%

Sometimes or never felt that they had access to an area to make drinks and meals or wash and shower	19.5%
Felt that they sometimes or never received sufficient info about unit facilities, visiting, support groups	9.5%

The following table presents re-occurring themes identified from the responses:

Re-occurring themes
• Stress and anxiety experienced during stay • Infant feeding • Access to well-being • Separation

Our aim to continuously improve on these themes

3.0 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- **MNIP improvement roles** – sustainability beyond March 2023.
- **A maternity and neonatal workforce** plan for 2023 and beyond is in development to ensure that improvement work is sustainable.
- **Remaining Neonatal deep dive actions -** delivery
- **Improvements** - are being embedded into business-as-usual practices.
- **Care group service risks as 'high'**: *Maternity Services* – manual handling training; *Neonates* – staffing establishment and infrastructure in POW

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The progress of the MNIP has demonstrated to Welsh Government the continued improvements in standards of services; resulting in removal of special measures for Maternity.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • **Safe care** • **Effective Care** • **Staff and Resources**

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There is a possibility that workforce plans will highlight a need for additional resource to achieve continuous improvement and embed all learning, conditions for sustainability as 'business as usual'.
Link to Strategic Goals	Improving Care

RECOMMENDATION

The Quality and Safety Committee are asked to **NOTE** the report

APPENDIX 1

MATERNITY & NEONATES ASSURANCE, RISK & ESCALATION FRAMEWORK FINAL

DECEMBER 2022 V5.0

CHILDREN & FAMILIES CARE GROUP MODEL

The following structure outlines the "Floor to Board" Escalation, however, it is important to note that there is two way communication which flows from Board to Floor. The Assurance Framework also outlines how it aligns to a 'Four' Lines of Defence Model including assurance framework for monitoring Conditions of Sustainability & Milestone Plan post IMSOP & once the Maternity Improvement Programme arrangements have ended.

4th Line of Defence
Independent challenge to the levels of assurance provided by the service operations and oversight functions
Assure & Monitor

Welsh Government

- **Joint Executive Team (JET)** Monthly
- **Quarterly Delivery Boards**
- **Integrated Quality & Performance Delivery (IQPD)** Monthly

External Independent Reviews (HIW, Internal and External Audit) etc.

Cwm Taf Morgannwg UHB Quality & Safety Committee

Board Level Assurance & Scrutiny
Frequency Bi-Monthly

Maternity & Neonatal Safety Board (MNSB)

Independent Member Representative attends

Board Level Assurance & Scrutiny

Frequency: Bi-monthly

3rd Line of Defence
Further oversight functions who can also set direction
Monitor Performance Activity
Assurance & Scrutiny

External Stakeholder

Engagement

Collaboration

Externality of Clinical Case Reviews

Sharing Best Practice

National Guideline Development

Welsh Government

Maternity Neonatal Safety Support Programme

Maternity & Neonatal Network

Improvement Cymru

Digital Healthcare Wales

Children & Families Care Group

Quality, Safety & Patient Experience Committee

Frequency: Bi-Monthly

Children & Families Care Group

Concerns Meeting -Maternity, Neonatal & ISH

Concerns Meeting – Children & Young People

Frequency: Monthly

Children & Families Care Group

Maternity & Neonatal Programme Board

Frequency: Monthly

Points to Note / Reference Documentation

Terms of Reference for all service meetings are available upon request from estelle.bish@wales.nhs.uk and are located in the Maternity Fileshare.
All Meetings have minutes and action logs. Exception Reports inform Service Group QSPE meetings.
Should risks or concerns be identified then the process adopted will be in accordance with the relevant Health Board Policies and Procedures.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

2nd Line of Defence
Care Group oversight functions who set direction, monitor performance and activity

Assurance & Scrutiny

1st Line of Defence

Service ('Floor') Level Operational Activity Quality &Performance monitored on a day-to-day basis

Business as Usual Activity Teams and Processes

Self-Assurance & creating a culture that supports psychological safety for colleagues

Quality Safety & Patient Experience Committee (formerly Service Wide Assurance Group SWAG)
(Maternity, Neonatal, Gynae & ISH)
Frequency: Monthly

Service Level (e.g. Ward, Tiers) Meetings

Week 1 – Workforce & Education,
Week 2 – Safety & Effectiveness
Week 3 - Experience & Engagement (WESEE)
Week 4 - Professional Governance

Multi Professional Forums
Antenatal Labour & Postnatal Ward Forums, MDT Risk, MDT Clinical audit,
MDT Clinical Governance
Frequency: Monthly

Service User Engagement Groups (e.g. My Maternity, My Way, Birth Partner Group, Breast Feeding Group)
Frequency: Monthly

Neonatal Clinical Improvement Group

Frequency: Bi-Weekly

Assurance and Closure Panel
Frequency: Weekly

Staff Engagement & Communication

Unit / ward meetings

Clinical Supervision, Caring for You Engagement Sessions

Senior Multi-Disciplinary Teams

Eg Rapid Review
Frequency: Weekly

Multi-Disciplinary Teams
Eg Risk, DATIX
Frequency: Weekly

AGENDA ITEM
6.2

QUALITY AND SAFETY COMMITTEE

Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Lauren Edwards, Director of Therapies and Health Science
Executive Lead	Director of Therapies & Health Sciences
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advice, Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person

HoN	Head of Nursing for CAMHS
iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
LSU	Low Secure Unit
NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression
PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
QI	Quality Improvement
SI NRI LRI	Serious Incident Nationally Reportable Incident Locally Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide committee members with an update on quality, safety and experience matters in Ty Llidiard (TL), the Tier 4 CAMHS Inpatient Unit within Cwm Taf Morgannwg University Health Board (CTMUHB).

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

2.1 TL is in enhanced monitoring arrangements with WHSSC. The focus of the monitoring relates to concerns regarding the service specification and culture/leadership. Positive feedback continues to be received from WHSSC regarding the visibility and oversight of improvements at TL, as well as the reporting standards and progress being made.

2.2 TL was de-escalated to Level 3 monitoring by WHSSC in December 2022, with a clear pathway for future further de-escalation awaited.

3. Quality Assurance

3.1 Patient Safety Incidents (Oct-Dec 2022)

3.1.1 There were 36 incidents reported during this reporting period: 15 in October, 12 in November, and 9 in December.

3.1.2 32 (89%) of these incidents were assessed as being low or no harm, with 4 being assessed as moderate harm. No incidents we assessed as being above moderate harm (i.e. Severe or Catastrophic).

3.1.3 During December, there were no incidents relating to NG feeding. These type of incidents have accounted for the majority of incidents reported at TL over the last 2 years. The TL team are analysing this trend in order to understand the ongoing reduction in NG related incidents and whether this can be attributed to the improvements made in the clinical management of this client group.

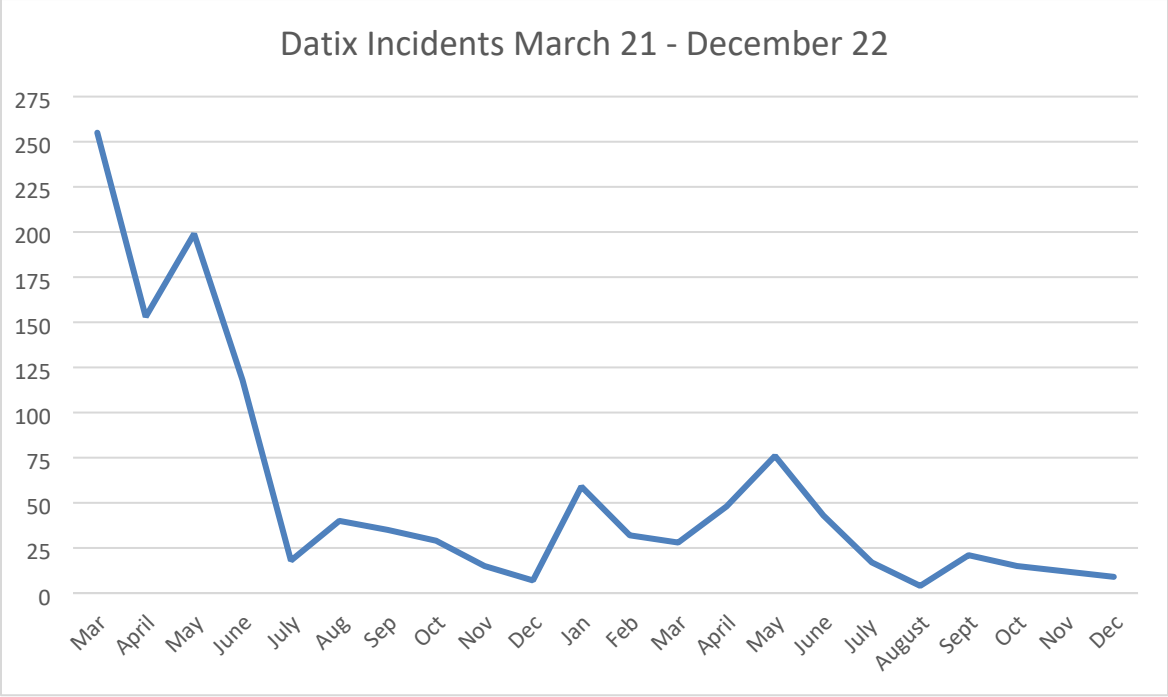


Table 1: Nine month summary of incidents by sub-type, grouped by severity and date reported

		Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Total
None	Absconding or missing patient/service user	1	2	1	0	0	1	0	1	0	6
	Aggressive/threatening behaviour	1	0	1	0	0	1	1	0	0	4
	Anti social behaviour	0	0	0	0	0	0	1	0	0	1
	Breach of patient / service user confidentiality	0	0	0	1	1	0	0	0	0	2
	Consent process for examination or treatment not / inadequately followed	1	0	0	0	0	0	0	0	0	1
	Inappropriate behaviour / attitude	2	1	0	0	0	0	0	0	0	3
	Mental Health Act Administration	0	0	0	0	0	0	1	0	1	2
	Non-medical equipment	0	0	1	0	0	0	0	1	0	2
	Patient clinically challenging behaviour	1	0	0	0	0	0	0	0	0	1
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	4	4	1	0	0	0	0	1	0	10
	Physical assault (physical contact)	0	0	0	0	0	0	1	0	0	1
	Provision of diet (enteral)	7	15	3	2	0	0	0	0	0	27
	Restrictive practices	13	39	21	6	0	19	5	5	0	108
	Safeguarding - Child	1	0	0	0	0	0	0	0	0	1
	Self-harm / self-injurious behaviour	8	0	5	0	0	0	0	1	1	15
	Staffing	0	1	0	0	0	0	1	0	0	2
	Treatment or procedure issues	0	2	0	0	0	0	0	0	0	2
	Total	39	64	33	9	1	21	10	9	2	188
Low	Absconding or missing patient/service user	0	0	0	1	0	0	0	0	0	1
	Aggressive/threatening behaviour	0	1	0	1	0	0	2	0	1	5
	Contact with object or animal	0	1	0	0	0	0	0	0	0	1
	Harassment	0	0	0	1	0	0	0	0	0	1
	Healthcare Acquired Infection (community, primary care or hospital)	0	0	1	0	0	0	0	0	0	1
	Healthcare record	0	0	0	1	0	0	0	0	0	1
	Inappropriate behaviour / attitude	1	0	1	1	0	0	0	0	0	2
	Patient/service user refuses / fails to take / discontinue the examination / treatment / medication.	1	0	0	2	0	1	0	1	0	5
	Physical assault (physical contact)	0	0	0	0	0	0	0	0	3	3
	Provision of diet (enteral)	0	1	0	0	0	0	1	0	0	2
	Restrictive practices	0	1	0	0	0	0	0	2	0	3
	Self-harm / self-injurious behaviour	7	8	7	0	0	0	0	0	1	23
	Struck against or by an object	0	0	0	0	1	0	0	0	0	1
	Total	9	12	9	7	1	1	3	3	4	49
Moderate	Absconding or missing patient/service user	0	0	1	0	0	0	0	0	0	1
	Aggressive/threatening behaviour	0	0	0	1	0	0	1	0	1	3
	Clinical assessment, clinical diagnosis	0	0	0	0	1	0	0	0	0	1
	Environmental hazards / issues	0	0	0	0	0	0	1	0	0	1
	Physical assault (physical contact)	0	0	0	0	0	0	0	0	1	1
	Safeguarding - Child	0	0	0	0	1	0	0	0	0	1
	Total	0	0	1	1	2	0	2	0	2	8
Total		48	76	43	17	4	22	15	12	9	246

3.2 Complaints

3.2.1 There were no open or new complaints during this reporting period.

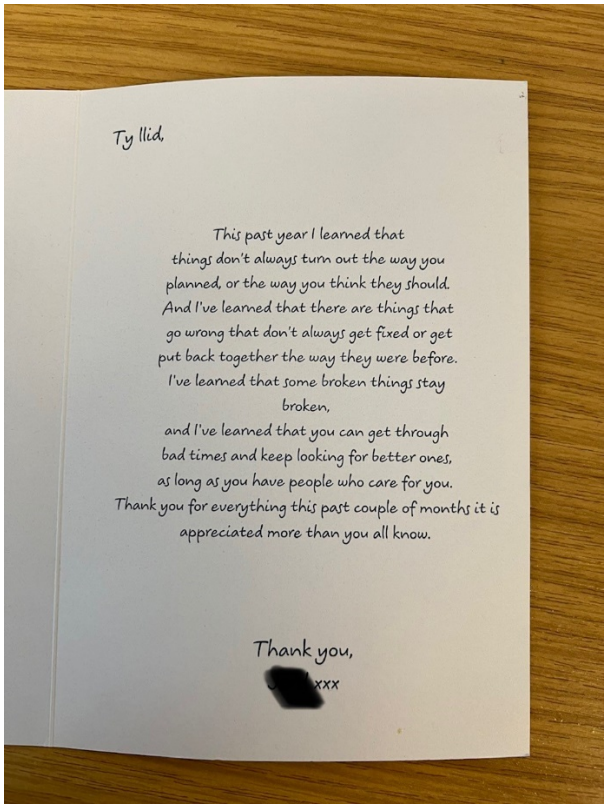
3.3 Compliments

3.3.1 Understanding the experiences of our YP and their families during their admission to TL is an important source of learning and the team are striving to increase feedback month on month.

Ty Llidiard Written Compliments

2022											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2	3	1	3	4	5	4	4	3	2	4	5

3.3.2 Below is a compliment received from a YP who was discharged from TL in December (shared with permission). All compliments are shared with the team at Ty Llidiard. There is a board in the staff room where compliments are shared and a monthly newsletter for colleagues is being developed, which will include a compliments section.



Ty llid,

This past year I learned that
things don't always turn out the way you
planned, or the way you think they should.
And I've learned that there are things that
go wrong that don't always get fixed or get
put back together the way they were before.
I've learned that some broken things stay
broken,
and I've learned that you can get through
bad times and keep looking for better ones,
as long as you have people who care for you.
Thank you for everything this past couple of months it is
appreciated more than you all know.

Thank you,
[redacted] xxx

3.4 **Current open SIs (NRI or LRI)**

3.4.1 There were no new or open LRIs or NRIs during this reporting period.

3.5 **Ombudsman complaints**

3.5.1 There were no new or open Ombudsman cases during this reporting period.

3.6 **Claims/redress cases**

3.6.1 There were no new or open claims/redress cases during this reporting period.

4. People's Experience/co-production

4.1 The HON has been engaging with *Parents Voices in Wales* to create a forum where past service users and their loved ones can provide feedback and contribute to co-produced improvement initiatives. Positive feedback has been received about the approach being taken across Ty Llidiard and the willingness to listen to, value, and work with people with lived experience.

4.2 The TL team facilitate weekly community meetings (open to all YP on the ward) to seek the views of our YP on what is done well and what can be improved. These meetings continue to be well-attended by the YP and have resulted in valuable insights, including their experience of ward rounds, suggestions for activities, and how access to mobile phones can be improved.

4.3 During these meetings, suggestions have been made by the YP about the type of therapeutic activities that they would like to see delivered

at TL. This has led to the development of a co-produced Activities Timetable. This timetable is delivered by the newly created Activity Coordination team and therapies team. The activity co-ordinators are now supernumerary and there is evening cover. This ensures that opportunities for meaningful activity are consistent and protected. The timetable changes regularly in response to individual needs and the requests of the YP.

4.4 The YP requested Pet Therapy sessions; in response the TL education and activity teams arranged visits from alpacas and Cody the therapy dog. These visits are primarily recreational activities, however important links have been made with the potential for some of our YP to undertake work-type placements on the farm in the future.

4.5 It is anticipated that positive experiences of engagement and co-production gained by the YP during their admission will result in them being more confident and willing to support future co-produced TL service projects and recruitment processes following their successful discharge.

4.6 The HON continues to invite the family members of the YP admitted to TL to share to their experiences, feedback and suggestions for improvement. Several family members have expressed an interest in joining a future group of people with lived experience to help with TL's improvement journey in a coproduced way. The feedback received was that they would prefer to be involved after their loved

ones have been discharged from TL. As a result, business cards with contact details have been developed as a means of supporting keeping in touch.

4.7 The above progress represents an important development in TL's culture of openness, engagement and co-production and the commitment to embed the philosophy of "Nothing about me, without me".

5. Quality Improvement

5.1 Since August 2022, a quality improvement group has been established to develop and monitor the various pieces of quality improvement work being undertaken in TL. The group meets every Monday to discuss and review the ongoing improvements and changes that have been made or are in progress.

5.2 Nurses on duty, the Ward Manager, the Quality Safety and Risk lead, Locality Manager, Specialist Social Worker, Consultant Psychiatrists and Therapists are encouraged to attend so that there is a multi-disciplinary approach to problem-solving and decision-making. It is through this group that many of the improvements now in place have been identified and implemented. The ideas and changes discussed in this group are shared with the young people in their community meeting to seek feedback and input.

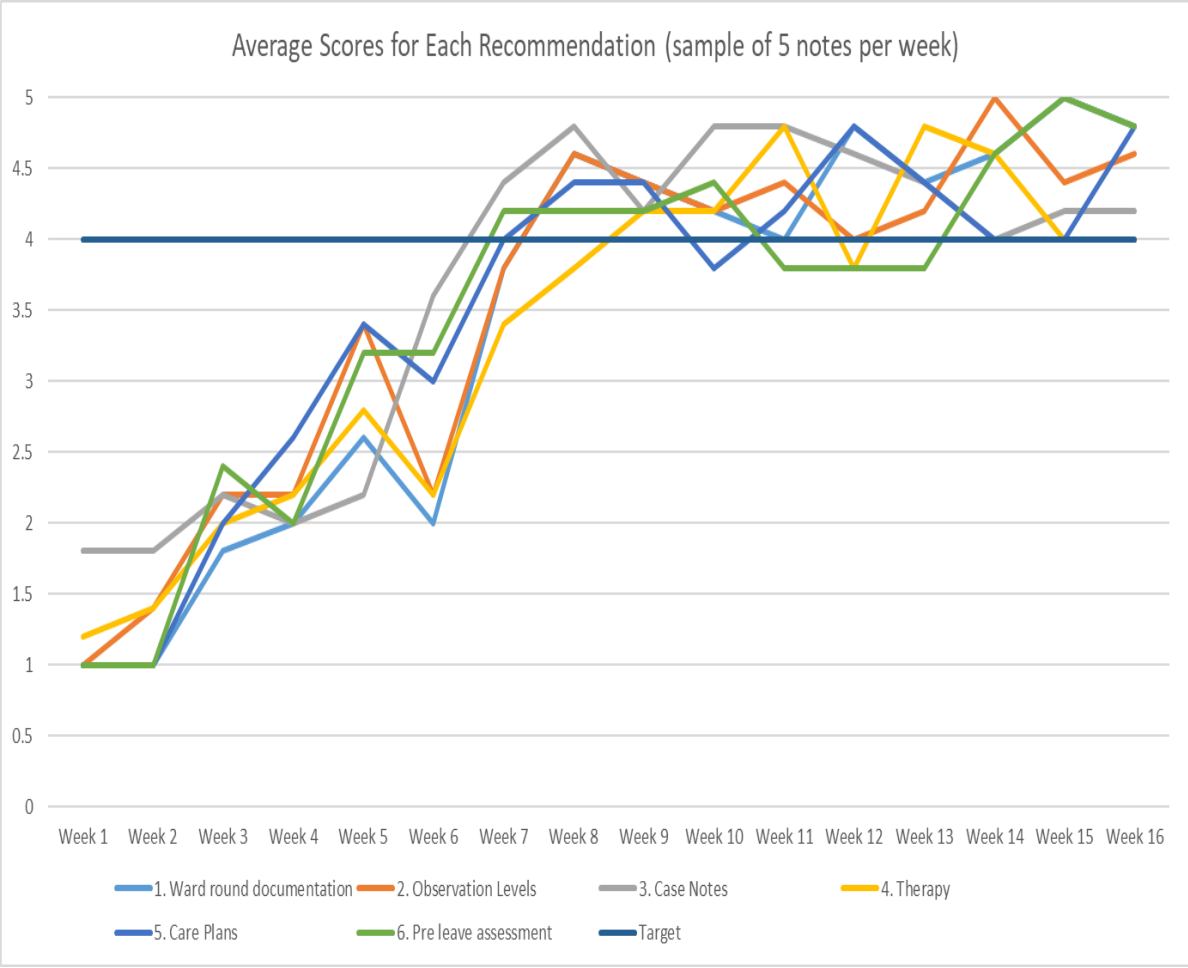
5.3 The improvements and initiatives that have been developed by the group are discussed and supported by the iCTM Team.

5.4 The TL quality improvement group has developed a QI measurement tool to monitor the 6 main areas covered in both the HIW and the QAIS Supportive Review in March 2022.

5.5 The QI measurement tool uses a 5 point Likert scale to assess the clinical documentation against the 6 recommendations. The target is to achieve an average score of 4 out of 5 for each of the 6 categories, and an average total score of 24 out of 30. A trajectory has been devised to achieve this by week 10 (currently in week 5). The audits will continue until there is adequate assurance that the improvements consistently are embedded in practice (minimum of 12 weeks after compliance).

5.6 The work has been well received by both WHSCC and NCCU. Members of QAIS attended TL in November 2022 for an unannounced visit. During the visit they checked the documentation improvements and were pleased with the progress, describing progress as "significant".

5.7 The average scores from the 5 sample sets of notes each week are outlined in the graph below. The TL team aimed to meet the improvement target by week 10, but actually met the target in week 7. The graph demonstrates that standards have been maintained.



6. Improvement Board

6.1 A monthly Improvement Board chaired by the Executive Director of Therapies and Health Science (DoTHS) continues to oversee the implementation of changes required to enable colleagues to

consistently deliver high quality care and the best outcomes and experiences for the YP and families we care for.

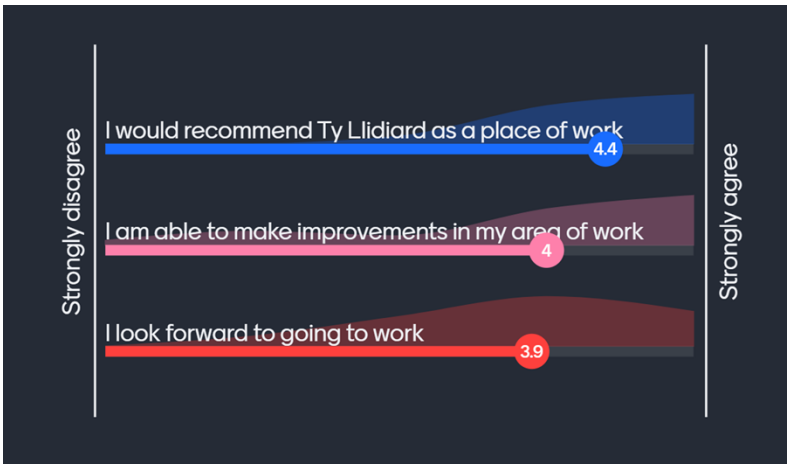
6.2 Monthly escalation meetings continue with colleagues from WHSSC, in addition to regular meetings between the CTMUHB and WHSSC executive leads for TL. Significant improvements have been made to the reporting format for the escalation meetings, resulting in ongoing positive feedback from WHSSC and de-escalation from level 4 to level 3 in December 2022.

6.3 Appendix 1 provides an overview of progress made against the Integrated Improvement Plan for Ty Llidiard. This improvement plan contains actions relating to the escalation status with WHSSC, along with wider improvements targets to ensure continuous service improvements for the benefit of our young people, their families, and our colleagues.

6.4 WHSSC have advised that they will provide a clear roadmap for further de-escalation for Ty Llidiard, until routine monitoring status is achieved. WHSSC have requested that QAIS undertake a piece of work to review referral and admission trends for Ty Llidiard. WHSSC colleagues felt that de-escalation to Level 3 was appropriate whilst this review was underway. The results of this review is expected in January 2023.

7. Colleague Experience

7.1 On 14th December 2022 the first of two "Team Ty Llidiard" away days were held, which included members of all staff groups from TL. The day included team information sharing and team building exercises. Colleagues were asked to complete a short online survey about working at TL. The results are below;



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

8.1 TL is in Level 3 escalation with WHSSC, who raised concerns in April 2022 regarding the Quality Assessment and Improvement Service (QAIS) report findings and progress in relation to the Escalation Action Plan. Although WHSSC remain assured by the progress being made, the scale and nature of changes required continue to require sustained support and focus within CTMUHB.

8.2 Changes to the clinical model within TL and improvements relating to leadership and culture within the unit have resulted in significant investment in clinical posts from a range of professional groups. Good progress continues against recruitment plans, but national shortages in some specialist areas pose an ongoing risk to recruitment.

8.3 As part of the improvement work within TL, changes to the layout of the unit have been suggested by the National Collaborative Commissioning Unit (NCCU). The senior leadership team have met with the Director of Quality and Mental Health/Learning Disabilities from the NCCU to explore what such changes could look like.

Phase 1 has been approved and will commence in January 2023. Phase 2 has been designed and costed at circa £700k, a SON has been completed and submitted but is as yet unapproved.

9. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)

Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required as no changes to service provision articulated
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Estates work suggested by WHSSC/QAIS will be associated with significant capital requirements
Link to Strategic Goals	Improving Care

10. RECOMMENDATION

10.1 Members are asked to **NOTE** the progress outlined in this report and the key risks identified

APPENDIX 1

Progress against Integrated Improvement Plan

Summary of progress and status of actions within the updated Integrated Improvement Plan est July

	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start	Total
Summary of all actions in Ty Llid plan December	19	12	13	0	5	49
Summary of all actions in Ty Llid plan October	13	18	12	0	6	49
Summary of all actions in Ty Llid plan September	8	28	4	0	7	47

Workstream theme: Caring and compassionate, safe and effective care					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To ensure there is a comprehensive and robust multi-disciplinary clinical leadership team who will lead a multi-disciplinary workforce to best meet the needs of the young people and to support good patient experience and outcomes	4	1			
To embed a whole system approach to care and treatment planning and risk assessment and ensure these are up to date, coproduced, individual and person centred and meet the best practice guidelines as set out in the Mental Health (Wales) Measure 2010.	1		5		2
To create an effective MDT infrastructure to support daily review of care and treatment planning and inform therapeutic interventions	2	1	2		1
To ensure there are appropriate processes and policies that support safe and effective care delivery	2	1	4		
To create a training strategy to support all colleague to provide safe and effective care delivery	1		1		2
Total	10	3	12	0	5

Work stream theme: Calm and Confident Leadership and Culture					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
To create a psychologically safe environment where colleague feel that their voices are heard	2	2			
To create an ethos of collective and calm leadership where everyone takes responsibility for delivering safe, reliable and effective care for patients	3	2			
To cultivate a culture of openness, transparency and confidence where our values and behaviours are a lived reality for everyone	3	2	1		
Total	8	6	1	0	0

Work stream theme: Environment fit for purpose					
	Number of actions green and complete	Number of actions in progress and on target	Number of actions in progress , timescales have slipped but action plan in place	Limited progress and timescales have slipped with concerns in completing the action	Actions to start
The environment is safe for colleague and young people and is conductive to therapeutic care	1	3			
Total	1	3	0	0	0

AGENDA ITEM
6.3

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	24th January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality, Safety & Safeguarding louise.mann@wales.nhs.uk Lydia Thomas Head of Quality & Safety, Central Patient Safety Team Lydia.thomas4@wales.nhs.uk Stephanie Muir, Assistant Director of Concerns & Claims Stephanie.Muir2@wales.nhs.uk
Presented by	Lydia Thomas Head of Quality & Safety, Central Patient Safety Team
Approving Executive Sponsor	Executive Director of Nursing Executive Medical Director Director of Public Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities	Various dates	Choose an item.

Joint working with Performance and Planning team		

ACRONYMS	
CA&QI	Clinical Audit & Quality Informatics
ILG	Integrated Locality Group
CAPU	Community Acquired Pressure Ulcer
NEWS	National Early Warning Score
LFER	Learning from Events Reports
DU	Delivery Unit
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
CMO	Chief Medical Officer
HCSW	Health Care Support Worker
YCC	Ysbyty'r Cwm Canon
YCR	Ysbyty's Cwm Rhondda
LOS	Length of stay
WAST	Welsh Ambulance Service NHS Trust

1. SITUATION/BACKGROUND

This presentation of the Quality Dashboard to Committee provides data from October 2022 to November 2022 taken from systems as on 1st December 2022. The Health Board is in the process of transitioning to a new operating model, which requires significant change to data alignment, in addition to introducing changes to the quality governance model and arrangements. As key senior leaders prepare and begin to adapt to new roles and responsibilities, the requirement for assurance from the previous Integrated Locality Groups during this interim period has been streamlined and brought together within this document.

Key areas to note in this reporting period are:

- The average number of complaints over the preceding 12-month period is 94, demonstrating a mean reduction in formal complaints received during October and November (81). Complaints have risen in the past 3 months, however, they remain on a decreasing trend over the 12 month period. Whilst there is an overall increase in early resolutions, data does still not represent a trend and there is no direct correlation with formal complaints. Once the new triage process is fully implemented with the new operating model with centralised complaints, a drive for early resolutions will continue with close monitoring of the impact of this on reduced formal complaints and improved patient satisfaction on timely issue resolution.
- For all complaints received in October and November 2022, the top three themes remain consistent with previous themes and relate to Clinical Treatment and Assessment (231), Communication Issues, including attitudes & behaviour (138) and Appointment issues (108). These reliable indicators must provide a focus for targeted intervention and improvement.
- CTMUHB Complaints response compliance 12-month average is 58% with a target ambition of 75%. Compliance in this reporting period is averaged as 56%. The impact of a changed operating and governance model as well as increased winter pressures may temporarily affect the ability of clinical teams to complete responses in a timely manner. Improving the quality and timeliness of complaint response is a priority for the central team.
- Between October 2022 and November 2022, there is a slight overall increase in reported patient safety incidents; 67 were reported with a severity of severe harm (39) or death (28), an increase of 12 when compared to the previous 2 months. It should be noted that following the introduction of Datix Cymru on

the 01.04.22, services are no longer able to update the harm field completed by the reporter on initial submission. As a result, the severity highlighted on reporting may not necessarily relate to the actual harm determined following investigation. Future reports to Committee will include information to reflect the nuances between these data sources. In addition to the All Wales work being undertaken to include links to the harm matrix in the reporter form, the Health Board is developing concise reporter guidance which includes level of harm information.

- Responsible Managers can link with the Central Business Intelligence Team to change incidents where the level of harm has been entered incorrectly at the initial input. This should facilitate a greater accuracy of reporting, especially in light of Duty of Candour requirements. Notably, an increase in severe incidents has been noted for the Princess of Wales Emergency Department due to an increase in Datix incidents reported in relation to non-patient specific capacity and flow concerns through the department.

- A total number of 505 inpatient falls were reported between October 2022 and November 2022, which represents a decrease of 8 in the number of falls reported in comparison to the previous two months. Of the falls reported, 91% were reported as no or low harm. The remaining incidents were reported as moderate and severe harm. No incidents relating to inpatient falls were reported as resulting in death.

- The highest number of inpatient falls occurred on the Acute Medical Unit (AMU) at Princess of Wales Hospital (24), Emergency Care Centre at Prince Charles Hospital (24), Clinical Decision Unit at Prince Charles Hospital (18), Ward 7 at Ysbyty Cwm Cynon (13) and Ward 10 at Princess of Wales Hospital (13). We have introduced falls per 1000 occupied bed days as an improved measure of benchmarking fall rates, with the next step to set reduction goals for numbers and severity of harm. This also facilitates flexibility in identifying areas of greatest risk and setting reduction targets accordingly. Inpatient falls per 1000 bed days for October was 4.92 and November 4.50 which represents a slight downward trajectory since recording began in August 2022.

- During October 2022 & November 2022, 2 falls were nationally reportable due to being deemed avoidable when presented to scrutiny at falls panel.

- During October 2022 and November 2022, a total of 961 pressure damage incidents were reported. There is no change in numbers of hospital acquired pressure damage incidents when compared to the previous 2 months. Work is in progress with WAST colleagues as an increase in pressure damage incidents is in relation to those patients who are awaiting offload from an ambulance and adequate turning and monitoring is difficult to achieve. This issue has been put forward to be included in the Community Acquired Pressure Ulcer (CAPU) project in the New Year. Pressure damage per 1000 days was 2.84 in October

2022 and 3.12 in November 2022. This represents a largely consistent picture of pressure damage incidents across CTM over time since the first recording in April 2022.

- A total of 223 medication incidents were reported during October 2022 and November 2022. 82% of the incidents were reported as resulting in no (141) or low (42) harm, with the remaining reported as resulting in moderate harm (17) and 2 severe harm. The severe cases relate to a prescribing error in Emergency Care Centre Prince Charles Hospital and a Medication storage, security and disposal in Mental Health Royal Glamorgan Hospital.

- The introduction of a specific Community Pharmacy form has impacted on data quality for medication incidents as a number of fields are not included for completion. Therefore, for incidents reported during October and November 2022, 21 incidents do not include the severity of the incident – this discrepancy is being addressed with the Head Pharmacist. Of the total number of medication incidents reported, the top three types of medication incidents relate to administration errors (75) Medication supply errors (73) and Medication prescribing errors (31).

- There has been a decrease in mortality during the months of September, 2.45% and October 2022, 2.65%. November 2022 data was not available at the time of this report.

- In relation to Patient Safety Solutions (PSS), it is very pleasing to report that further compliance has been achieved in Patient Safety Notice PSN063 since the last report to Committee. This leaves only 1 outstanding patient safety alert, which requires an all Wales solution for compliance. The Health Board now presents very favourably amongst other Welsh Health Boards in terms of PSS.

- Learning from Events reports, (LFER's) continue to be a challenge for the Health Board, with a historic backlog of overdue LFERs. This is included on the corporate risk register as a significant risk due to the potential reputational and financial impact. There remains much work to do in order to clear the backlog, and a shift being realised to ensure current incident management/investigation includes evidence provision on Datix for Learning from Events Reports (LFERs). The new operating model and proposed supporting quality, safety and governance arrangements, places responsibility within the Care Group Governance teams to facilitate the completion of the LFERs.

- **The CTM Listening and Learning Event took place on 23rd September 2022.** This was a significant opportunity to promote and nurture the learning culture supporting continuous improvement and patient safety across the Health Board. Another event is being arranged for 15th March 2023, which will

focus on sharing specific learning from across the health board, which at the time of reporting will encompass a recent high profile child practice review.

- The health board continues to hold quarterly shared listening and learning forums. This forum supports with learning being shared from across the health board along with sharing a patient story. The Learning Repository introduced at the launch of the Listening and Learning Framework, has a 3-month theme focus for those areas, which are the health board's main incident themes/trends. A presentation is set to be presented at the leadership forum in January to promote the listening and learning framework and repository and encourage more learning to be uploaded. SharePoint currently has its limitations, with the plan for an updated version of SharePoint in the near future, the repository is likely to become more intuitive and user friendly.

- A monthly patient safety newsletter is currently disseminated across the health board to highlight the main incident themes and trends for the month along with providing updates in relation to patient safety projects and developments.

    - The new Care Group Operating Model will mean changes will be required to the current CTMUHB Quality and Safety Framework, Putting Things Right (PTR) policies, with necessary changes to aligned systems and Audit processes to provide assurance of patient safety, learning and quality of care across the organisation.

    - Interim Arrangements for Quality Governance and Patient Safety have been in place since November 2022 with Governance teams continuing to work within the ILG framework for Governance until the Organisational Change Policy (OCP) consultation has been finalised.

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

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Number of formal complaints (managed through PTR)	102	94	95	87	84	87	57	84	82	88	75	**87**	
Number of formal complaints closed (managed under PTR)	107	67	117	100	77	83	81	70	81	69	67	**73**	
Number of Early Resolution complaints	117	174	183	229	180	206	168	175	234	208	181	**187**	
Number of compliments	51	71	59	25	60	182	196	99	24	80	80	**73**	
Number of Ombudsman Received	5	8	7	11	9	9	6	6	5	7	9	**4**	
Number of never events in month	0	1	0	0	0	1	0	0	0	1	0	**0**	
Number of Nationally Reportable Incidents New process from 14.06.21	4	4	7	8	4	5	6	2	9	2	7	**15**	
Number of Locally Reportable Incidents	18	9	17	13	10	5	5	6	7	17	5	**1**	

Data run on 01.12.22

Complaints:

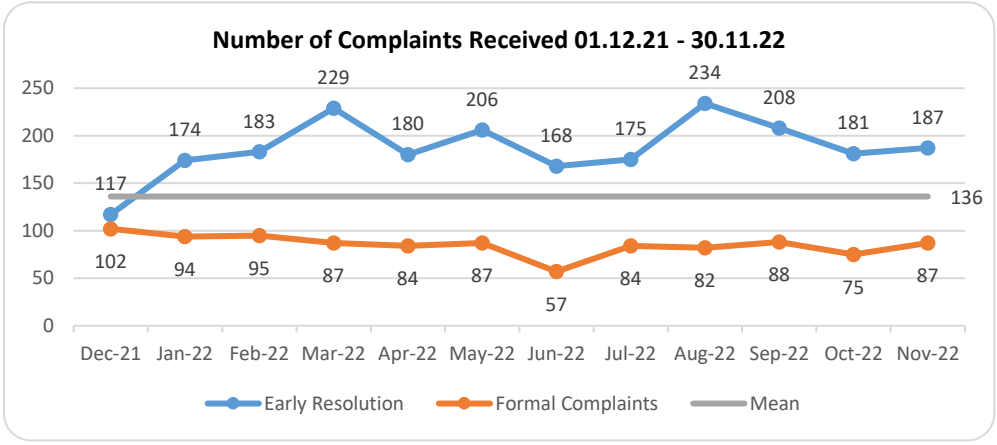
New Complaints Received

During October 2022 and November 2022, there were 162 formal complaints received within the Organisation which were managed in line with the Putting Things Right regulations. The number of formal Complaints managed through PTR has remained relatively consistent over the last 3 months. Within the same period (October and November 2022), the Health Board managed 368 complaints under Early Resolution, representing a decrease of 74 complaints when compared to the previous 2 months (442). The trend in relation to new complaints received is reflected in the chart below.

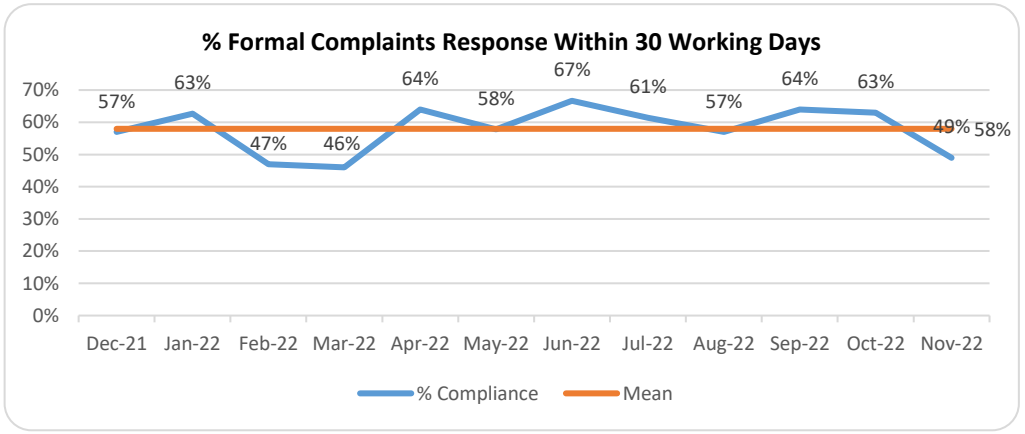
For all complaints received in October and November 2022, the top 3 themes relate to Clinical Treatment / Assessment (173), Communication Issues, including attitude & behaviour (126) and Appointments (108).

Closed Complaints

Between the 01.10.22 and 30.11.22, the Health Board closed 140 formal complaints (managed through PTR). Compliance with the 30 working day response rate decreased in November 2022 when compared to October, but the trend remains relatively the same with the mean average compliance for 12 months being 58%.



Data run on 01.12.22

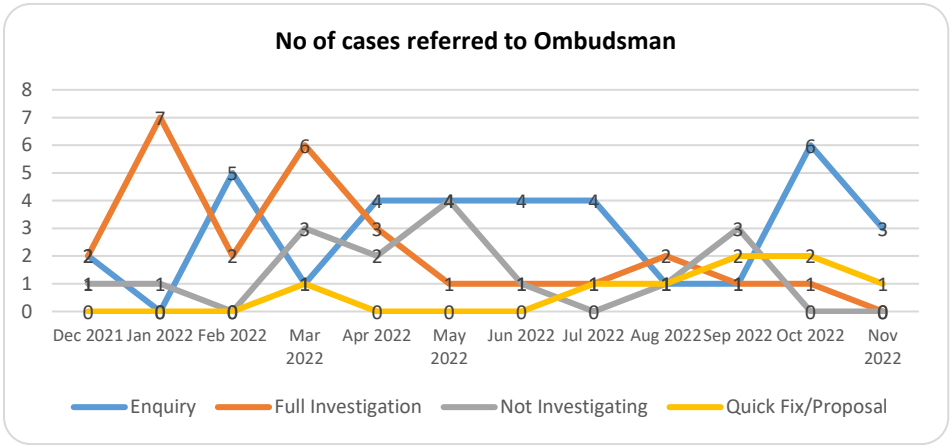


Data run on 01.12.22

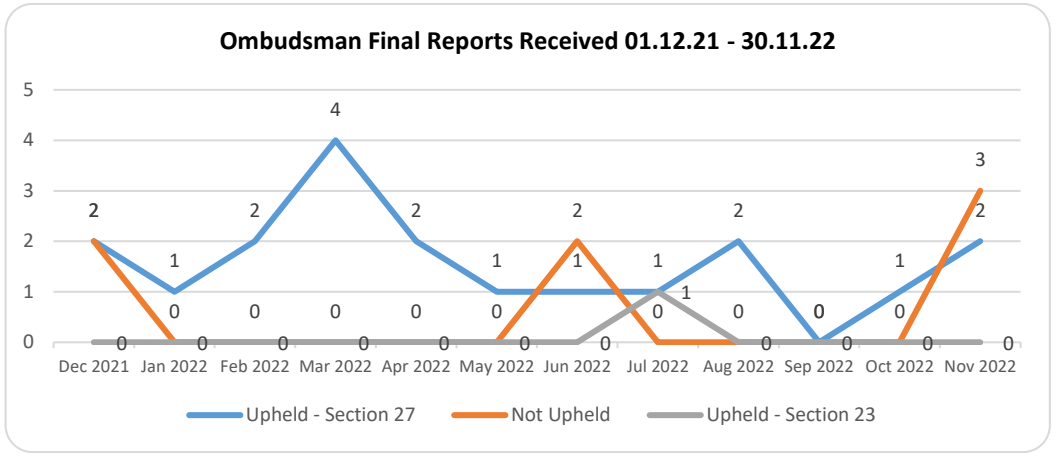
Public Services Ombudsman for Wales

During October 2022 and November 2022, the Health Board received notification of 13 Public Services Ombudsman for Wales (PSOW) referrals. The trend remains relatively the same when compared to the previous 2 months. Of the 13 referrals, 1 case was received as a full investigation, 3 were received as quick fixes/proposals with the remaining 9 managed as enquiries.

Between the 01.10.22 and 30.11.22, the Health board received 6 Final reports from the Public Services Ombudsman for Wales. Of the final reports received, 3 were Upheld (Section 27) and 3 were Not Upheld.



Data run on 01.12.22



Data run on 01.12.22

Compliments

During October 2022 and November 2022, there were 153 compliments recorded on the Datix Cymru system, which represents an increase of 49 when compared to the previous two months (104). The highest number of compliments recorded during October 2022 and November 2022 related to Maternity (49), Emergency Care (28) and Paediatrics (21) all within the Merthyr & Cynon Locality. Compliments are received into the Health Board via a number of mechanisms including social media, Patient experience Surveys as well as thank you cards and emails. This feedback is mainly recorded on the Datix Cymru and Civica user experience systems. Further work is being undertaken within the Health Board to improve the capturing, recording and reporting of the compliments received.

An all Wales Compliments Workstream has been established which will focus on the development of a comprehensive coding structure and system requirements for capturing positive feedback.

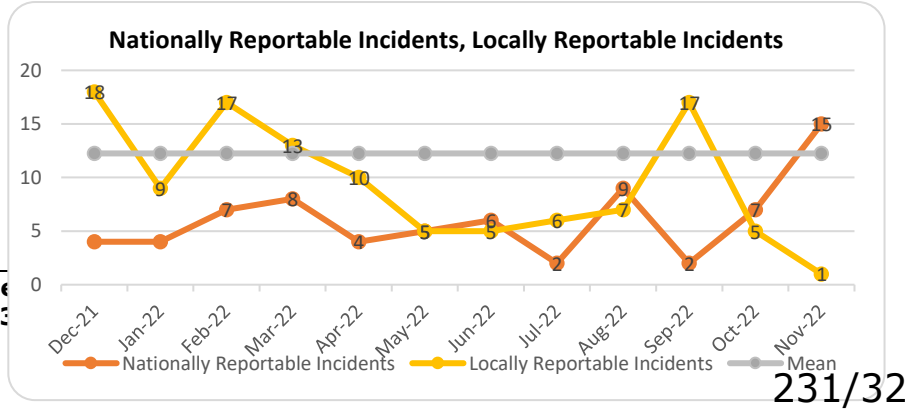
Patient Experience:
The latest patient experience data is attached at **Appendix 2**.

Patient Safety Incidents:
Between October 2022 and November 2022, a total of 4,400 incidents were reported across the Health Board. This is an increase of 347 when compared to the previous two months. Of these, 87% (3,807) were reported under the type of patient safety during the two month period. Of the patient safety incidents, 67 were reported with a severity of severe harm (39) or death (28), an increase of 12 when compared to the previous 2 months. This equates to 1.6% of the total number of patient safety incidents reported during the 2 month period. Caveats in relation to severe and death incidents are highlighted in the narrative above.

Nationally Reportable Incidents:
As highlighted in previous reports, following the introduction of the NHS Wales National Incident Reporting Policy on the 14.06.21, the Health Board distinguishes between Nationally Reportable Incidents and Locally Reportable Incidents (those previously classified as serious incidents). The trend for the last 12 months is reflected in the chart below.

During October 2022 and November 2022, 22 nationally reportable incident notifications were submitted to the Delivery Unit (DU) and 6 identified as Locally Reportable Incidents. During November 2022, it was required that historic Appendix B WAST cases would be reported to the DU prior to being investigated; therefore, this represents an increase of 11 nationally reportable incidents when compared to the previous 2 months. It is anticipated a number of these legacy Appendix B incidents will be downgraded following a full review at Multi-Disciplinary Team (MDT) panel.

Type of Nationally Reportable Incidents	Oct-22	Nov-22	Total
Transfer, Discharge	1	5	6
Access, Admission	1	3	4
Assessment, Investigation, Diagnosis	1	2	3
Patient/service user death	0	2	2
Slip, Trip or Fall	0	2	2
Treatment, Procedure	2	0	2



Pressure Damage	0	1	1
Maternity adverse occurrence	1	0	1
Safeguarding	1	0	1
Total	**7**	**15**	**22**

Patient Safety Solutions:

Summary

There have been no new patient safety notices or alerts issued since the previous Quality & Safety Committee meeting.

The Delivery Unit (DU) continue to facilitate the national working group for the review and management of Patient Safety Solutions (PSS). During this meeting health boards come together to share their progress and discuss barriers and solutions, which is supporting the ongoing internal work to achieve compliance.

The internal management, monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) is now operating in a structure of devolved responsibility to the relevant ILG teams, with the central Patient Care and Safety Team providing support, co-ordination and oversight, leading to reporting. This will be revised as we progress through the organisational structure changes with the oversight then being provided by the new role of compliance manager.

The Safety Alert Broadcasting System Policy is currently under review and is utilising the DU *All Wales Guidance for the Management of NHS Wales Patient Safety Solutions* published in July 2022 for reference. A national working group for safety alerts has been established in October which aims to support a more standardised approach of managing patient safety alerts/ solutions in health boards. This is going to focus on patient safety alerts and solutions in first instance and then focus on wider alerts such as MHRA's in the second phase of the working group.

Compliance:

In total, there is **1 alert** and **0 notices** in which CTMUHB are non-compliant. Non – compliance status for the alert is an ongoing issue which is currently being reviewed on an All Wales Level.

Since last report:

Compliance achieved: **PSN063**

Non-compliance

PSA008
Nasogastric tube misplacement
An all Wales Training package for NG Tube insertion is being established. The DU have fed back the first national meeting took place in September. The health board currently provides face to face training for nurses and F1 & F2 doctors. The assessment following the receipt of training is required to be strengthened. Face to face training was not provided during the pandemic, however confirmation has been received to state this has recently been re-established.

Safety Measure
Indicators

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Number of medication prescribing errors	21	10	13	19	14	15	8	8	21	13	14	17	
Number of medication administration errors	41	35	35	41	26	37	32	29	24	26	40	35	
Total number of inpatient falls	260	300	254	292	260	258	262	242	240	274	260	245	
Number of inpatient falls where harm has occurred (moderate, severe and death)	9	10	13	12	22	25	22	25	25	16	22	22	
Total number of instances of hospital acquired pressure ulcers	79	86	105	86	109	100	92	100	119	120	133	106	
Number of hospital acquired pressure ulcers grade 3 and 4	0	1	6	2	1	5	4	2	11	5	6	8	

Total number of instances of Community acquired pressure ulcers	168	170	147	163	105	104	112	116	96	105	118	**111**	
Number of Community acquired pressure ulcers grade 3 and 4	16	19	16	18	6	5	16	17	8	9	12	**14**	
Number of potential Hospital Acquired Thrombosis (HATs)	6	6	5	13	5	9	7	11	13	10	5	12	
% VTE risk assessments documented on the med. Chart	93	96	98	97	95	92	93	93	97	92	94	95	
Hospital Arrests (2222 calls) Adult	48	42	46	49	44	35	44	45	27	35	39	**N/A**	
% NEWS audit by site (RGH/YCR/PCH/YCC/PoWH/ Ysbyty'r Seren)	89.5	89.8	88.6	87.3	88.9	87.2	87.0	87.7	89.8	90.8	87.0	**90.4**	
C.difficile Rate/1000 admissions	2.87	1.91	2.66	3.54	1.89	1.14	1.55	2.10	2.87	2.83	2.02	**1.21**	
MRSA bacteraemia Rate/1000 admissions	0	0	0.22	0	0	0.19	0.39	0	0	0.20	0	**0**	
MSSA bacteraemia Rate/1000 admissions	2.10	2.12	1.33	2.42	3.15	2.66	1.75	3.05	2.87	2.42	1.61	**2.83**	
E. coli bacteraemia Rate/1000 admissions	5.74	5.09	5.21	4.47	6.10	5.69	6.22	4.77	7.16	8.48	7.87	**6.05**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge (Internal Measure by Arrival Date)	65	66	63	63	62	62	62	62	66	66			
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge (Internal Measure by Arrival Date)	91	88	87	88	87	88	88	88	88	88			
% turnaround of patients who spend less than 4 hours in A&E (based on discharges) (National Measure EDDS).											61	**63**	
% turnaround of patients who spend less than 12 hours in A&E (based on discharges) (National Measure EDDS).											87	**87**	

AvLOS overall mean (based on discharges only)	5.3	5.6	5.8	5.5	6.0	6.0	5.7	5.5	5.5	5.6	5.6	5.1	
Mortality Rate (CHKS)	3.82%	3.53%	2.76%	2.62%	3.44%	2.65%	2.82%	3.23%	2.81%	2.45%	2.65%	N/A	

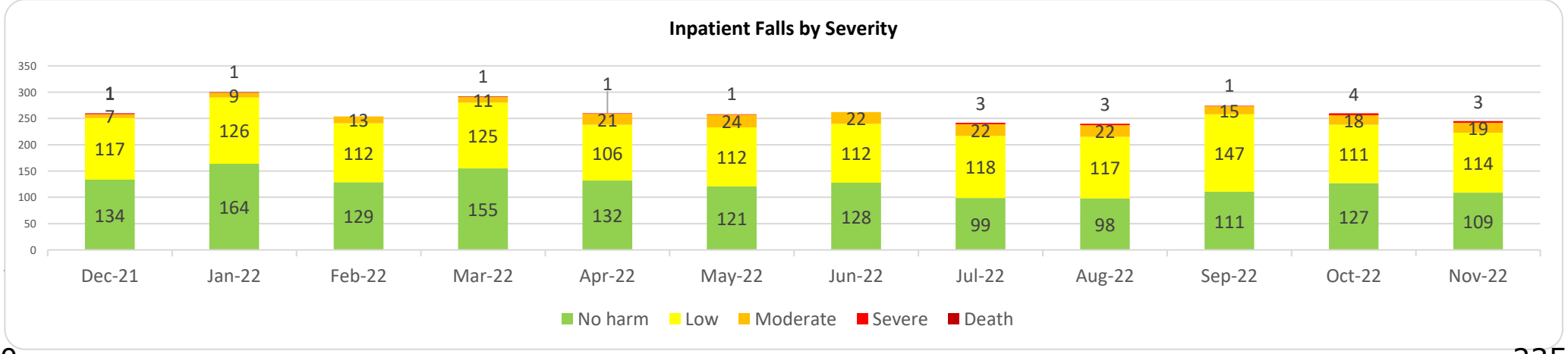
Data run on 01.12.22

Medication Incidents

A total of 223 medication incidents were reported during October 2022 and November 2022. 82% of the incidents were reported as resulting in no (141) or low (42) harm, with the remaining reported as resulting in moderate harm (17) and 2 severe harm. The severe cases relate to a prescribing error in Emergency Care Centre Prince Charles Hospital and a Medication storage, security and disposal in Mental Health Royal Glamorgan Hospital. The introduction of a specific Community Pharmacy form has impacted on data quality for medication incidents as a number of fields are not included for completion. Therefore, for incidents reported during October and November 2022 - 21 incidents do not include the severity of the incident. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (75) Medication supply errors (73) and Medication prescribing (31).

Inpatient Falls

A total number of 505 inpatient falls were reported between October 2022 and November 2022, which represents a decrease of 8 in the number of falls reported in comparison to the previous two months. Of the falls reported, 91% were reported as no (236) or low (225) harm. The remaining incidents were reported as moderate (37) and severe (7) harm. No incidents relating to inpatient falls were reported as resulting in death. During October 2022 and November 2022, the highest number of inpatient falls occurred on AMU at Princess of Wales Hospital (24), Emergency Care Centre at Prince Charles Hospital (24), Clinical Decision Unit at Prince Charles Hospital (18), Ward 7 at Ysbyty Cwm Cynon (13) and Ward 10 at Princess of Wales Hospital (13).

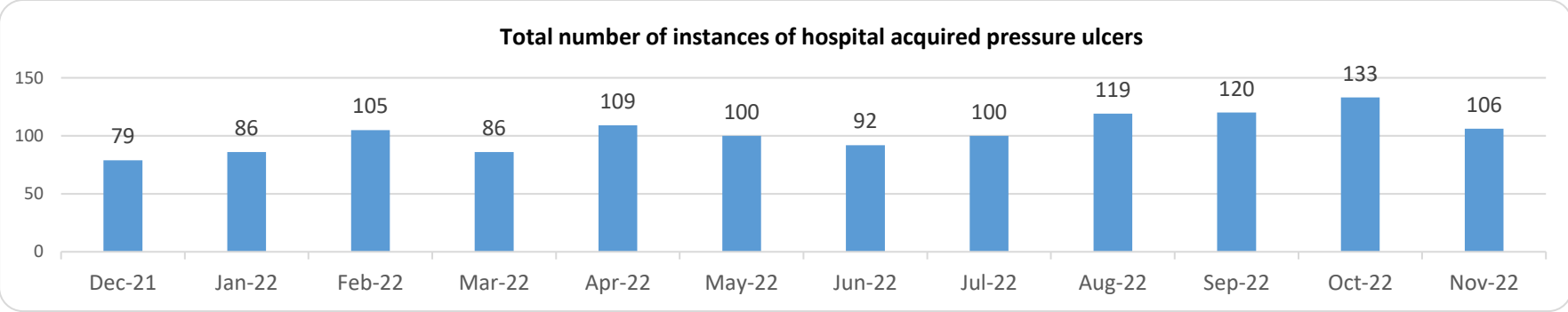


Data run on 01.12.22

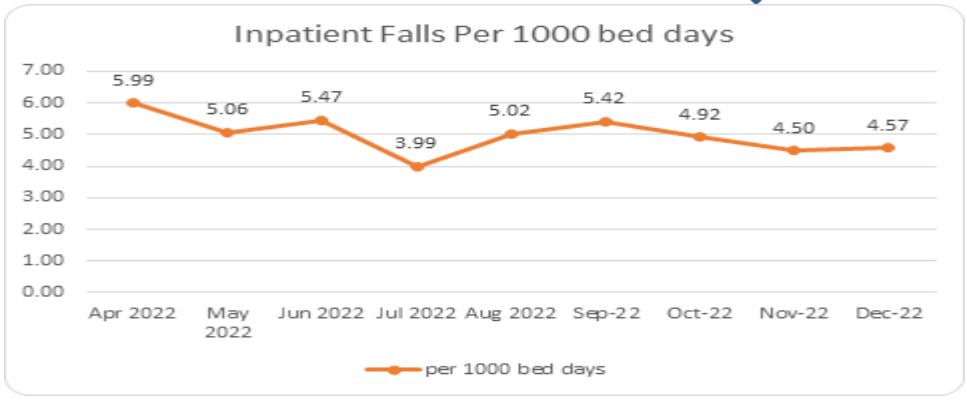
Pressure Damage Incidents

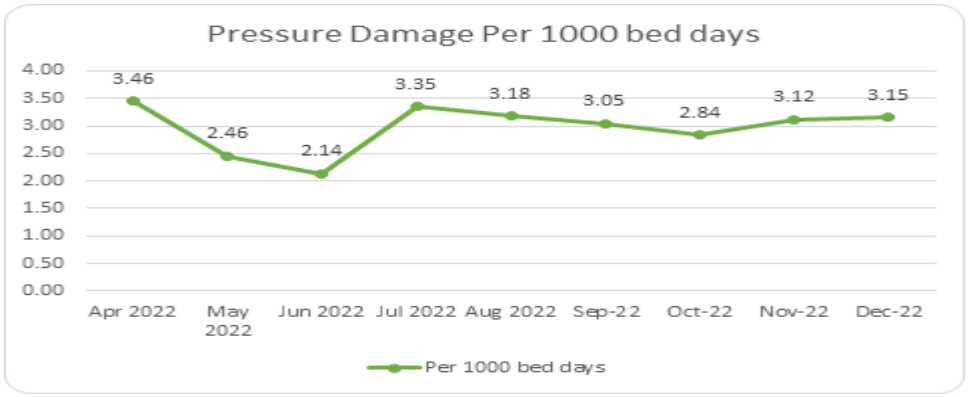
During October 2022 and November 2022, a total of 961 pressure damage incidents were reported, of which 466 were reported as occurring during the current case load. The remaining pressure damage incidents were reported as being present before admission to this clinical care area/caseload (495). Of the 466, 239 were identified as being hospital acquired and 227 as community acquired. This represents no change in hospital acquired pressure damage incidents when compared to the previous 2 months. The locations with the highest reported hospital acquired pressure damage incidents were the Emergency Department at Princess of Wales Hospital (19), Emergency Care Centre at Prince Charles Hospital (12), and Ward 5 at Prince Charles Hospital (12). There were 14 hospital acquired incidents reported as Grade 3 in October (6) and November (8) 2022. There were no hospital acquired Grade 4 incidents reported during the two month period.

Data run on 01.12.22



Falls and Pressure Damage per 1000 bed days





Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 17 potential HATs identified for October 2022 to November 2022 compared to 23 for the previous reporting period from August 2022 to September 2022. It is important to remind Committee that this measure is prior to the investigation of each case to identify if a HAT occurred or not. The ambition is to provide actual HAT's in relation to potential vs actual.

Hospital Cardiac Arrests and NEWS Training:
For October 2022, the number of calls taken were 39 compared to August 2022, 27 calls and September 2022, 35 calls. November 2022 data was not available at the time of this report. Hospital Cardiac Arrest Calls will remain an important metric, as the ultimate goal is for cardiac arrests only to occur in the Emergency Department. Strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our DNACPR processes, NEWS scoring, and training strategy, are integral to this goal.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities. NEWS training is also being recorded on the new Clinical Audit and NICE compliance monitoring system, so training figures are now available.

Infection Prevention and Control:
A rise in COVID and influenza cases along with other respiratory viruses has put additional pressures on the infection prevention and control team and clinical services. A rise in community prevalence and hospital cases has been reported across our acute and community hospital sites. Clinical pressures and outbreak management is discussed at the weekly IPC Cell meeting. Following a recent review of the testing guidance, all patients presenting with respiratory symptoms continue to be tested for a range of respiratory viruses in addition to COVID.

Mandatory surveillance continues nationally for five key organisms including C. difficile, Staphylococcus aureus bacteraemia and E.coli, Pseudomonas and Klebsiella bacteraemia. Local reduction expectations have been agreed with the Nurse Directors which has improved understanding and ownership of data. More than half of the bacteraemia reported since April 2022 are community acquired infections and a scoping exercise is planned to identify the infection prevention and control nurse resource required to provide a dedicated comprehensive service in primary care. Staff sickness and vacancies within the IPC team has delayed this work.

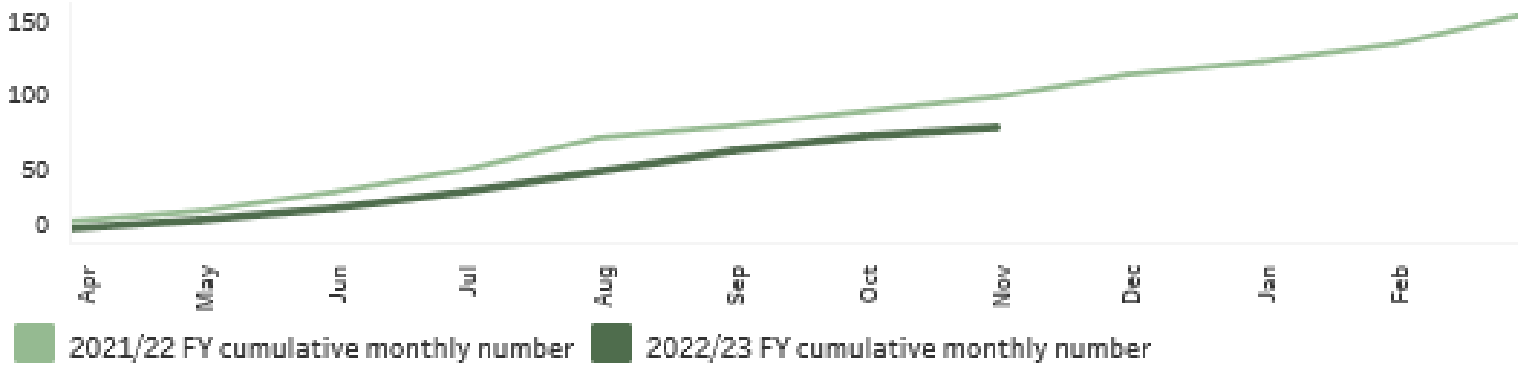
The infection prevention and control team continues to work collaboratively with the care groups to improve the investigation procedure and root cause analysis process for C. difficile infection and preventable bacteraemia. Learning is shared with clinical teams to inform and influence practice. Further engagement and support is required to introduce this in primary care.

Roll out of aseptic non-touch technique (ANTT) has commenced in Bridgend and sessions have been planned to increase the number of ANTT assessors across the Health Board. The infection prevention and control team is working with medical colleagues to improve compliance with infection prevention and control and ANTT training.

Infection prevention and control plan for the next 3 months –

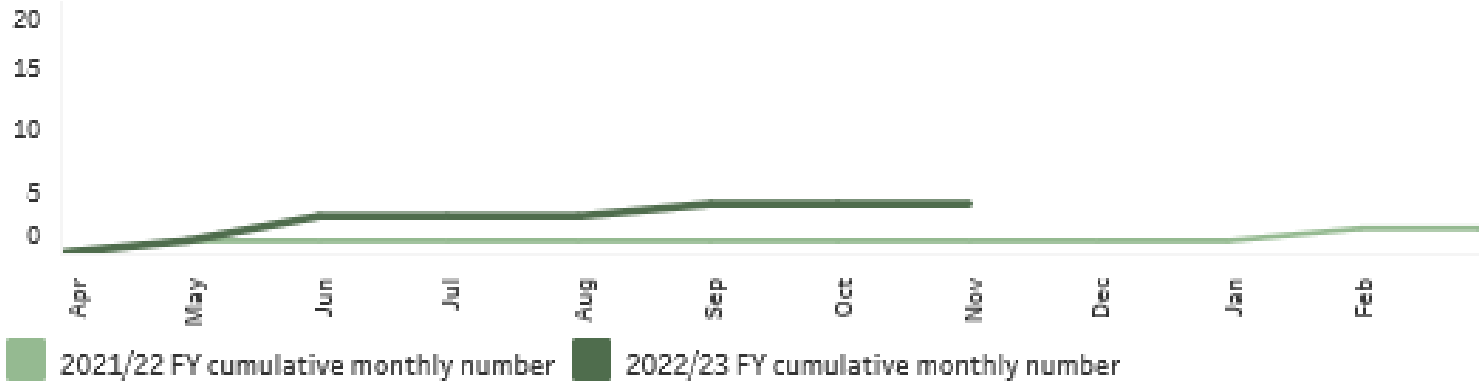
- Review current IPC establishment considering the need for a primary care resource and secure appointments into the IPC Nurse vacancies.
- Support newly appointed IPC Nurses.
- Support improvement work to reduce health care associated infections.
- Continue to support the respiratory/non-respiratory pathways, testing framework and COVID-19 response.
- Deliver an IPC service in line with the new organisational structure.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April 2022 to November 2022 against the equivalent period in 2021/22



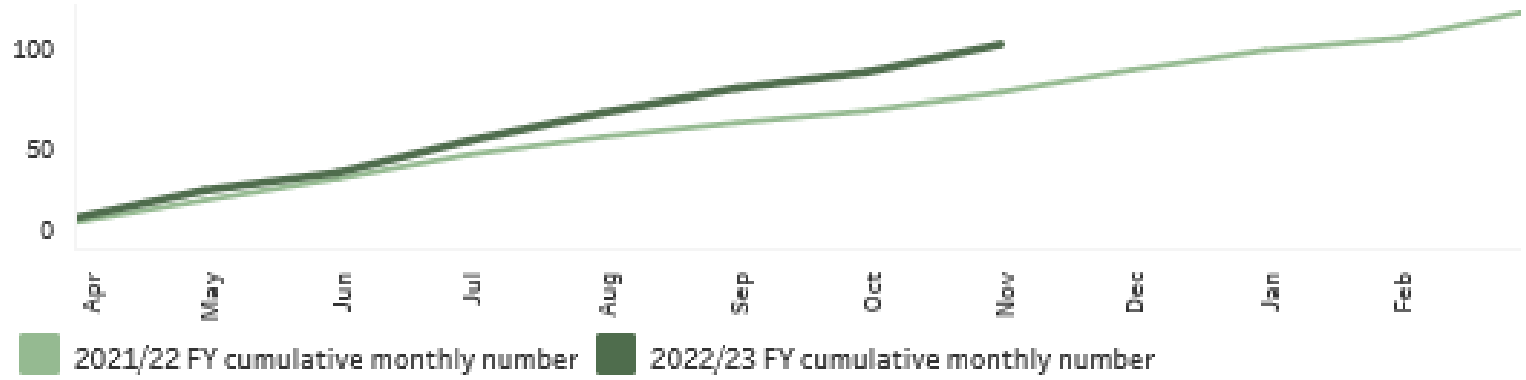
Data run on 7.12.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



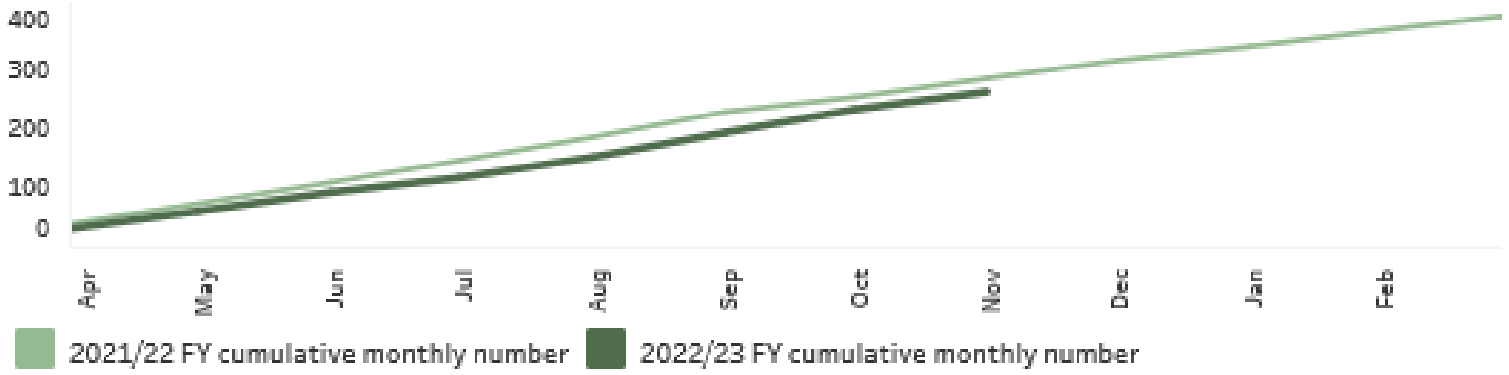
Data run on 7.12.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



Data run on 7.12.22

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April 2022 to November 2022 against the equivalent period in 2021/22



Data run on 7.12.22

Emergency Department 4 hour and 12-hour performance:
Compliance with the EDDS National Measure with the 4-hour target has increased to 63% in November 2022 compared to the previous reporting period 61% October 2022, as front door activity remains high. The 12-hour A&E performance remains comparable in October and November 2022 at 87%.

Average Length of Stay:
The ALoS has decreased to 5.1 days in November 2022 compared to 5.6 days in October 2022. A full review of COVID cases will be undertaken as part of the National COVID audit and as part of the COVID mortality review process to identify any common themes, trends and learning.

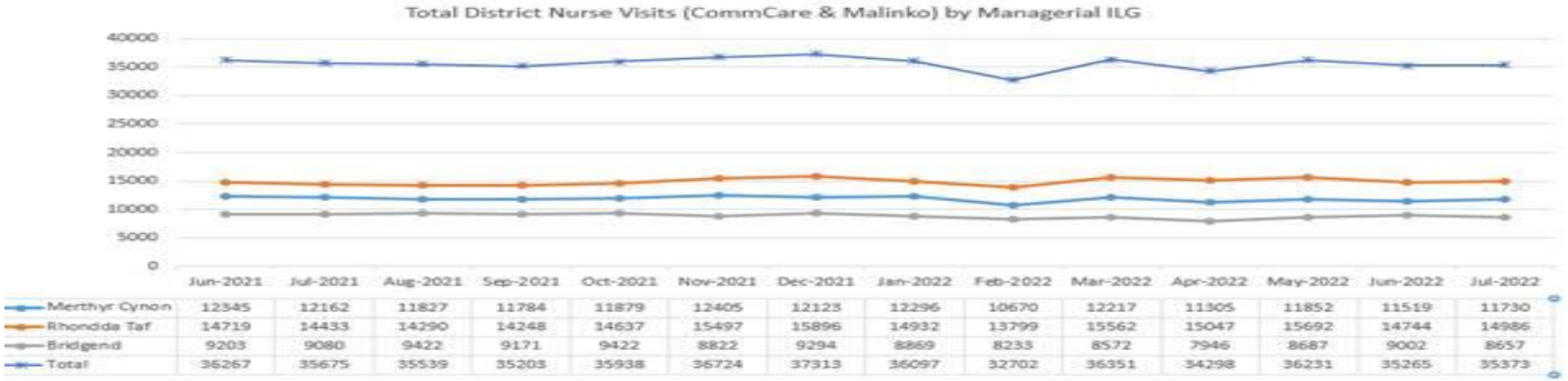
Mortality rate:
There has been a decrease in mortality during the months of September, 2.45% and October 2022, 2.65%. November 2022 data was not available at the time of this report.

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Community Care Metrics													
District Nurse treatments	37313	36097	32702	36351	34298	36231	35265	35376	36155	35404	36739		
Referral to At Home Services (All Referrals)	102	108	101	141	90	120	122	129	123	128	118	**120**	
Maesteg Hospital (ALOS)	0	0	0	0	0	0	0	0	0	0	0	**0**	
Ysbyty'r Seren (ALOS)	39	42	54	96	55	63	0*	0*	0*	0*	0*	**0***	
*Princess of Wales Hospital, Ward 21 (ALOS) (length of hospital spell where a patient's last episode was on this ward)	-	-	-	-	-	-	46	63	77	102			

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Community Care Metrics													
*Princess of Wales Hospital, Ward 21 (ALOS) (Patients that were transferred to this ward as opposed to being discharged and admitted there)							16	21	47	23	39	**50**	
Ysbyty Cwm Cynon (ALOS)	61	55	74	54	61	63	49	51	64	64	57	**56**	
Ysbyty Cwm Rhondda (ALOS)	58	82	69	75	67	70	56	67	55	62	80	**69**	
Palliative Medicine, Bridgend (ALOS)	13	25	27	14	19	14	20	9	10	24	19	**23**	
Palliative Medicine, Pontypridd/RGH (ALOS)	9	18	11	8	4	19	12	7	8	8	11	**7**	
Palliative Medicine, YCC (ALOS)	13	9	26	18	16	13	32	16	36	4	25	**28**	

Data run on 01.12.22

District Nurse Treatments and at Home Referrals:



	Jun-2021	Jul-2021	Aug-2021	Sep-2021	Oct-2021	Nov-2021	Dec-2021	Jan-2022	Feb-2022	Mar-2022	Apr-2022	May-2022	Jun-2022	Jul-2022
Merthyr Cynon	12345	12162	11827	11784	11879	12405	12123	12296	10670	12217	11305	11852	11519	11730
Rhondda Taf	14719	14433	14290	14248	14637	15497	15896	14932	13799	15562	15047	15692	14744	14986
Bridgend	9203	9080	9422	9171	9422	8822	9294	8869	8233	8572	7946	8687	9002	8657
Total	36267	35675	35539	35203	35938	36724	37313	36097	32702	36351	34298	36231	35265	35373

The data is currently collected at Health Board (HB) level.

District Nursing

This detail requires to be divided into localities to be able to provide qualitative information on. However, the Rhondda Taf Ely (RTE) District Nurse (DN) calls continue to increase and there are occasions with being unable to support timely hospital discharges.

The DN service as a whole see patients who are NOT housebound but this is due to other services not being available within the HB for the patients and the care falls to the DN teams.

RTE
There has been approximately 500 less visits during September. The ongoing demand continues to challenge the service's capacity. The main issue for the service is non-housebound patients on the caseload.

M&C
The number of palliative care visits continue to rise due to the ageing population we serve, palliative care, increased complexity, chronic health conditions and dementia adding increased pressure to an already overstretched service although the resources

remain the same. Maintaining the quality of care being delivered remains a challenge due to a combination of both an increase in demand and increasing patient acuity. Teams are mitigating against this through collaborative working, both within District Nursing and with supporting services, to share the risk and maintain a high quality service.

Community Hospitals Average Length of Stay (ALoS):

Bridgend
The Band 4 Health Care Support Worker (HCSW) development training is complete with staff completing competencies in practice. WLOC has been implemented in all district nursing teams across the locality; the professional judgment workbook has been completed for Health Education Improvement Wales (HEIW); Civica implemented across all teams plans for out of hours team now in January 2023 and CAPU project for all teams within District Nursing and ward 21. 8,667 patients were visited by a District Nurse during October 2022, November 8821. The service is currently carrying 5 WTE RN vacancy position.

GP
GP referrals continue to account for the majority of the activity, there continues to be some staffing deficits, however, the staff are still managing to provide a timely response to the patients referred to the service.

Ward 21 at Princess of Wales Hospital (POWH)
Representatives from the Ward Team engaged in CTM Community Pressure Ulcer Collaborative work. The ward have implemented *Safe to Start* and daily Multidisciplinary board round. Plan's in place to pilot the Discharge to Recovery Pathway (DTR). Pressure ulcer audit findings identified a need for training for bank and agency staff. Nurse staffing acuity completed daily on the ward. The service is currently carrying 3 WTE RN vacancies.

Ysbyty Cwm Rhondda (YCR)
Discharges have decreased by 2 in month, the issue remains with the lack of capacity of required support in the community for discharge. Length of Stay (LOS has increased.
Continues to have a significant number of patients awaiting appropriate discharge destinations. There are currently 39 'ready to leave' patients in YCR, either requiring a POC or care home bed.

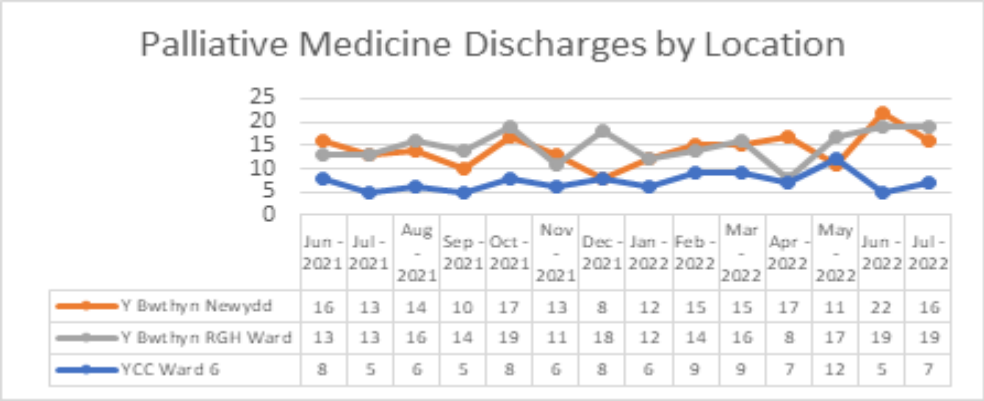
Ward 21 at POWH

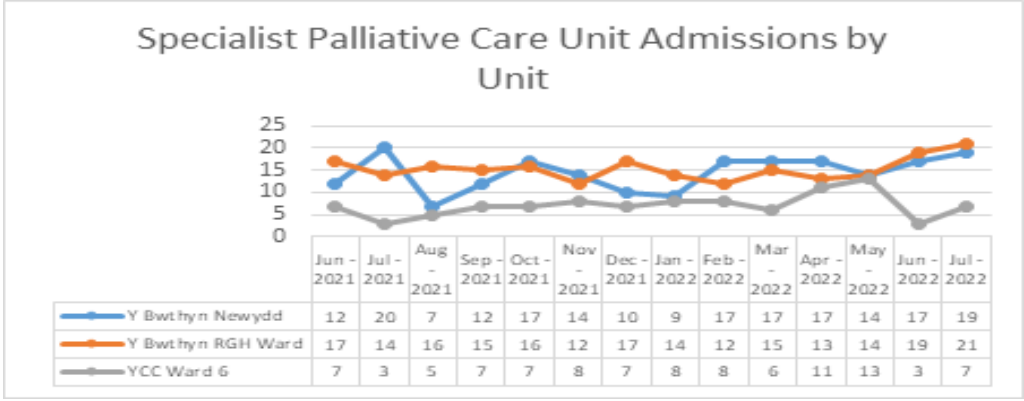
Representatives from the Ward Team engaged in CTM Community Pressure Ulcer Collaborative work. The ward have implemented Safe to Start and daily Multidisciplinary board round. Plans are in place to pilot the Discharge to Recovery Pathway. Dementia Awareness update training provided for the Ward Team. Pressure ulcer audit findings identified a need for training for bank and agency staff. Nurse Staffing acuity completed daily on the ward. The service is currently carrying 4WTE RN vacancies.

Palliative care inpatient units

The average LOS has increased, however LOS data does not reflect the accuracy against bed occupancy %.

Palliative Care inpatient admission data





Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Mental Health Care Metrics													
Number of 136 assessments in police cells	0	0	0	0	0	0	0	0	0	0	0	**0**	

Indicator Description	Dec-21	Jan-22	Feb-22	Mar-22	April-22	May-22	June-22	July-22	Aug-22	Sept-22	Oct-22	Nov 2022	Trend
Mental Health Care Metrics													
Restrictive Practices	6	9	1	0	3	0	16	22	12	32	46	**30**	
Number absconding from wards (overall not just detained) ****	21	18	23	25	22	22	21	24	25	18	23	**21**	

Data run on 01.12.22

Number of 136 Assessments in Police Cells:
This number remains 0 and is showing good compliance with the Crisis care Concordat ensuring that those who require mental health assessment are not detained in custody suites. (All Mental Health Localities included).

Restrictive Practices
Between October 2022 and November 2022, a total of 76 incidents using Restrictive Practices were reported within Mental Health. This is an increase of 32 incidents when compared to the previous two months. Of these, 68% (52) were reported as not care planned and 32% (24) were reported as care planned. Of the 76 incidents, 92% were reported as no (47) or Low (23) harm. The remaining incidents were reported as moderate (4) occurring on St David's Unit at Royal Glamorgan Hospital (2), Ward 21 at Royal Glamorgan Hospital (1) and Coity Clinic (PICU) at Princess of Wales Hospital (1). 2 severe incidents were reporting as occurring at Coity Clinic (PICU) at the Princess of Wales Hospital.

Absconding Incidents
During October 2022 and November 2022, a total of 44 Absconding incidents were reported. The highest number of incidents reported were for Ward 22 at Royal Glamorgan Hospital (7), and Emergency Care Centre at Prince Charles Hospital (7). 98% of the absconding incidents reported in October 2022 and November 2022 were recorded as No (28) or Low (15) harm, with the remaining incidents reported as moderate harm occurring in Emergency Care Centre Prince Charles Hospital.

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

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- The proposals in relation to a changed operating model presents significant challenges in ensuring the quality, patient safety and people's experience agenda remains well led and managed throughout. Significant leadership changes of key quality, nursing and quality governance roles are imminent and must be mitigated against. Quality governance arrangements during this time is operated within an interim position to ensure that robust oversight is maintained. The OCP in relation to Quality governance and patient safety is currently out for consultation until 19th January 2023.
- The CTMUHB Quality & Safety Framework is currently in draft and presented to Committee in a separate paper today; this will facilitate the direction of travel of national requirements and support the governance teams transitioning into the new care group structures.
- Post pandemic recovery, the impact of Industrial Action and increased demand and pressures of unscheduled care, patient flow and discharge difficulties for patients requiring ongoing support, continues to have considerable and ongoing consequences on the experience of patients and the ability of the HB to provide continuity around its core business. This is an unprecedented, considerably challenging time for health and social care services.
- The health board is working with the Welsh Ambulance Service Trust (WAST) to review how incidences such as patients being unable to receive an ambulance in the community can be reduced, and to mitigate the risk of harm to those waiting extended periods to be off loaded from ambulance in the meantime. The Unscheduled Care Nurse Director and acute sites Heads of Nursing are working through a set of care principles during delays in offloading to Emergency Departments. This will be co-produced with consultants and WAST.

- Ensuring robust implementation of the RLDatix system, which is aligned to the new operating model and progressing the ambition to develop an IT infrastructure to ensure up-to-date high quality data that is readily accessible enable triangulation and is meaningful to facilitate improvement objectives.
- Gaining health board wide assurance across the breadth of UHB services, especially during a period of significant change in its operations is a key requirement.
- Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas. Beyond this, the Health Board require ambitious pursuit of quality and safety in all it does to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines key areas of quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	This report applies to all Health and Care Standards.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	• Report for information for health board patient safety & patient experience activity • No service or staff impact in direct response from this report, this is considered through improvement work and other reports • Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.

Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) The requirements to deliver safe, high quality care impact on resources including workforce. The new operating model will support delivery of safe, high quality care.
Link to Strategic Goals	Improving Care

RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

4.1 **NOTE** the content of the report

4.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

4.3 **NOTE** the risks identified

4.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

APPENDIX 1:

Delivery Unit Dashboard Reports

APPENDIX 2

Patient Experience

Activity Period October 2022 – November 2022

A patient's voice is critical to enable us as healthcare providers to ensure the services we provide best help patients, families, carers and our communities in times of need. By engaging with our staff and communities, this enables the Health Board to build up an understanding of what is working well but also to drive service change and improvement.

The Health Board continues to engage via a number of different avenues to inform this via systems and services that sit within our acute settings but also those of third party stakeholders as well.

The Civica system continues to be developed and utilised across different specialities to explore how we can support patient feedback and look at the richness of information that this provides us with. There are currently 47 surveys on the system, the number of responses for each are detailed below:

Total Per Month	464	311	371	295	201	1642
Survey Name	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Total**
Maternity- Antenatal - Phase 1	35	31	32	36	29	**163**
Maternity- Antenatal - Phase 2	38	45	51	36	21	**191**
Maternity- Labour birth and postnatal care - Phase 3	69	79	105	109	54	**416**
Maternity- Postnatal community - Phase 4	43	28	27	30	30	**158**
Maternity- A vision for the future | CTM Maternity Services Survey						**0**
Maternity- Prem Questionnaire for Birth partners	0	1	0	2	1	**4**
Maternity- Staff Vision Questionnaire						
Have Your Say	56	4	5	6	2	**73**
Patient Experience	21	20	8	5	7	**61**
Heart Failure-PREM Survey	3	11	18	18	44	**94**
WREM Survey- PROMs/PREMs (Clinical/ Admin Staff)						**0**
WREM Survey- Support staff PREMs						**0**
WREM Survey- Support staff PROMs						**0**
WREM Survey- Platform Experience Outcome Measures	29					**29**
Paediatrics- Your Time in Hospital - Childrens Survey 11 years and upwards	5	2	1	0	0	**8**
Paediatrics- Your Time in Hospital - Children's survey aged 4-11 Years	14	8	3	0	0	**25**
Therapies	1	1	0	0	0	**2**
Pathology						**0**
Frailty Nurse Services	3	6	2	2	6	**19**
Emergency Department - Prince Charles Hospital	119	17	9	0	0	**145**
Integrated Cluster Survey	0	0	0	0	0	**0**
Visiting Survey - Patient	0	0	0	0	0	**0**
Visiting Survey- Staff	0	0	0	0	0	**0**
Wellness Survey	0	0	0	0	0	**0**
Quality of emergency admission patients' experience questionnaire (Infective)	0	0	0	0	0	**0**
Quality of emergency admission patients' experience questionnaire (Trauma)	0	0	0	0	0	**0**

Patient / Service User Experience Survey	0	0	0	0	0	**0**
Parents/Carers Questionnaire	19	11	15	0	0	**45**
YCC Staff Survey	0	0	0	0	0	**0**
Patient Safety Culture Snapshot Survey			20	1		**21**
HUMA Evaluation Phase 1- Oct 2021						**0**
HUMA Evaluation Phase 2- July 2022	9	1				**10**
LymPREM Questionnaire	0	0	0	1	1	**2**
Paediatrics- Evaluation Questionnaire (allergies)	0	0	0	0	0	**0**
RIW Digital Assessments (PREM)	0	41	73	45	2	**161**
Wellness Improvement Service (WISE) Questionnaire	0	5	2	4	2	**13**
Trauma and Orthopaedic (T&O) Patient Experience Questionnaire						**0**
Family Reported Outcome Measures (FROM-16)						**0**
CTM Inpatient Detox Patient Experience Survey						**0**
Staff Survey- Detox						**0**
Easy Read - Your NHS Care						**0**
Health Visitor PREM Survey - 27 Months						**0**
Health Visitor PREM Survey - 6 Months						**0**
Heart Failure Cardiac Rehabilitation						**0**
Homecare Service- Have Your Say						**0**
Patient Experience Survey - Endoscopy					2	**2**
Specialist Nurse – Homeless & Vulnerable Adults						0
Therapies patient experience survey						0

Please see below some of the comments that were left for our staff:

Although I was quite poorly, I had a great experience with the out of hours GP, A&E triage, and GP referral teams who treated me for a kidney infection. All of the staff I interacted with were both friendly and skilled in getting me treated and feeling better. Thank you very much!

From start to finish the service in this ultrasound dept is fantastic. The nurses are great and helpful. Anyone who complains about these services do not

appreciate how great this NHS service are. You all are a credit to the NHS. Have a great Xmas. All serve the world.

I want to thank nurse Miranda for taking time and interest in me to refer me for help because I was so scared I was going to lose the sight in my other eye. Because she was so kind, I saw a lady who has given me lots of support and referring me for help at home. Without her listening to me and understanding how upset I was, I wouldn't know there are people to help me, Thank you Miranda.

Fantastic staff at children ward and the care of DR Chandratreja – Thank you. Trauma coordinator need to be more understanding of patients and remember them when the planned operation is cancelled- this happened last week.

Came for an Xray this am. The radiographer was welsh speaking, it was a help and comfort to me. Would be lovely if all the staff could speak Welsh.

Lack of disabled car spaces at POW. Much worse now since Ambulances taking disabled car spaces. However this has been an ongoing problem before COVID.

This is the second appointment my husband has had at fracture clinic - Both have resulted in waiting over an hour past the appointed time. Staff friendly and helpful. But more staff is needed.

Couldn't fault the nurses or doctors but maybe a better variety of food for the kids.

Carers

As part of the hospital discharge project the Carer's Co-ordinator continues to have a weekly presence at Prince Charles and Royal Glamorgan Hospitals to support staff and carers alike, highlighting the support available within an acute setting and third sector organisations where needed. Due to capacity issues, we have been unable to secure space in Princess of Wales Hospital until December. As part of this process the Health Board has created a new Carers guide to Hospital Discharge which is now in circulation throughout CTM and available online to download. We have also updated our Carers web page (https://ctmuhb.nhs.wales/services/carers-support-services/) on the internet supplying more information to the public and the facility to download this as well.

Carers Co-ordinator has also supported the CAB4Carers advisor and information stands which have been successful in identifying and supporting

unpaid Carers with information across Prince Charles and Royal Glamorgan Hospital, it has also been an opportunity to identify staff Carers. There are plans to expand this across to Princess of Wales Hospital later in the year.

Our Staff carers meetings continue being led by the Carer's co-ordinator and the last staff Carers meeting was received with positive feedback and is gaining more attendees

'thank you for Friday, so enjoyed and found it so informative'

The content of this forum is led by the staff carers themselves to ensure the information provided is relevant to their circumstances and a number of representatives from Health and third party have been invited to present.

As part of the annual engagement plan for the Regional Partnership Board, the Carers coordinator attended the unpaid Carers hackathon engagement events, to help inform the development of the Regional Plan. The hackathons bring together users of services alongside service providers from both the statutory and voluntary sector in Cwm Taf Morgannwg, and key decision makers. This enables all involved to embark on a process of co-creating and co-designing creative conversation starters upon which further crucial operational and strategic conversations can be undertaken to inspire and inform positive service improvement and change.

Chaplaincy Services

Significant Spiritual and pastoral care

Patients	Relatives/Carers	Staff	Religious Rites	Out of hours requests
649	102	265	239	Total 31.50 hrs claimed. 15.5 hrs for the reporting period. 16 hrs were for the Roman Catholic priest from July to mid-October.

Three foetal collective cremation committal services were held. A private service was also held at Llwydcoed crematorium for a mum and dad.

Chaplaincy team continue to deliver classroom training to raise awareness of the department and what this entails, with a focus upon spirituality and how staff can discover their personal spirituality to help their own wellbeing and enable them to know how to look out for spiritual distress within our patients.

Chaplaincy offered support to staff members in two departments due to death in service, a condolence book was provided to each unit. The team also gave and continue to give support to two further departments where traumatic, unexpected death of patients had occurred.

The bereavement workshop was held in the Lighthouse project, with one of our chaplains leading, and was our first community based course. This was very well attended and received by the public. Positive feedback has been given and other agencies/centres have approached us to enquire about this and the 'At a loss café', we hope to be able to offer these widely across the UHB in 2023.

Our chaplaincy volunteers have joined us at Princess of Wales Hospital and are offering a great service/support mechanism to patients on this site. The role of the 'end of life companions' will now be referred to us through the support of the palliative care team in Princess of Wales Hospital rather than the three wards this was initially trialled on, as we did not receive any referrals through this route due to no patients meeting the criteria. As such, this role will now be trialled across the whole of Princess of Wales Hospital from January 2023.

Much preparation and planning has been undertaken for various December Christmas memorial and/or carol services that can now resume after a break due to covid restrictions. Some sites have held Remembrance Day services, one in the Outpatients department at Ysbyty Cwm Rhondda where 50 people attended.

Lead Chaplin has appointed two new chaplains to our vacant band 6 posts that were advertised recently and a further Band 5 vacancy is being progressed through the pre recruitment process within the Health Board. This will enable the team to explore how we can support patients, families, carers and staff alike through new projects in 2023.

Volunteer Service

Meet and Greet Volunteers

The meet and greet volunteer role provides a wayfinding service for those attending our sites across CTM. The following provides an overview of this service across the organisation.

- The meet and greet volunteers at Dewi Sant Health Park provide a Monday to Friday service and currently signpost those attending the Health Park which now includes wayfinding to the vaccination centre.
- The meet and greet service at Princess of Wales Hospital was reintroduced several months ago, both morning and afternoon shifts are covered Monday – Friday. This service provides wayfinding, signposting, information and distributing hearing aid batteries. In addition the volunteers encourage feedback from service users by handing out or filling in "Have Your Say" cards.
- The meet and greet service at Royal Glamorgan Hospital was reintroduced in September 2022 and provides an invaluable service with signposting, wayfinding and information. The volunteers also support the Macmillan Information Hub by ensuring the leaflets are in an orderly manner and stock up the holders if leaflets are running low. They also liaise with the porter service for those requiring a wheelchair. To date feedback has been very positive and the volunteers are very much appreciated by staff in the area, including switchboard who provide support for the volunteers on a daily basis.
- During November 2022 volunteer information sessions were held in order to recruit additional volunteers to support projects, one of which being the meet and greet service. The team will be introducing the service at Ysbyty Cwm Cynon in the New Year.

Vaccination Programme

Since 2020, our vaccination centre volunteers have supported the work stream across CTM and have been invaluable to the delivery of services. More recently the vaccination sites have moved to clinical venues and our volunteers continue to offer meet and greet support for those attending the centres at Bridgend, Llantrisant, Rhondda / Cynon Valley. In addition meet and greet volunteers are also promoting feedback from those attending the centres via the "Have Your Say" cards in order to collect details on their experience.

The End of Life Companion Volunteer Service – POW & YCC

The end of life companion volunteer project is a joint initiative between the volunteer service, chaplaincy and clinical staff and was launched on 1st August 2022. Monthly supervision sessions took place during November 2022 with Chaplains and volunteers. To date there has been a slow uptake for volunteer support, however, meetings were held between ward managers and Chaplain leading on the project, to review how this service could be promoted to increase referral uptake. Plans are in place to expand the service to other ward areas with the support of the Palliative Care Team and other clinicians to identify patients who would benefit from companionship whilst in hospital. During November several meetings were held between Chaplaincy Volunteers and Chaplains with the focus to reintroduce the service across CTMU HB. It is hoped that the volunteer presence will support the EOL companion project further, by promoting and informing staff of the benefits of patients having companionship during a difficult time and where patients may not have family or friends to visiting.

Wellness Improvement Service (WISE) Volunteers

The Wellness Improvement Service was officially launched on 5th September 2022. During October and November, classroom based sessions have taken place at various venues across CTMU HB's logistical remit. Volunteers have been instrumental in supporting Wellness Coaches with meeting and greeting participants, scribing, encouraging group discussions and helping those participants who may be upset or emotional during the sessions. The volunteers support sessions once a week for the first 6 weeks, then every other week for a further 6 weeks and then monthly up to a maximum of 9 months when the course ends. A meeting with WISE team including wellness coaches is planned for the end of December 2022, to review progress to date, discuss feedback and plan for courses throughout 2023. Furthermore, to explore additional duties and tasks that volunteers can get involved with to support the programme further.

Pets as Therapy Volunteers

The Pets as Therapy service is a positive and welcomed form of alternative therapy, which benefits patients, service users and staff. The volunteer service has been working jointly with Cariad Pet Therapy organisation based in Carmarthen to explore ways in which we could implement their service across CTMU HB. To date this has been an extremely positive working relationship and an agreement developed to identify and document responsibilities from both organisations is in progress, to ensure the recruitment of Cariad Pet Therapy Volunteers is robust, timely and streamlined.

In September 2022, we were pleased to recruit and start one of Cariad Pet Therapy Volunteers who visits Y Bwthyn Newydd at Princess of Wales Hospital and in October 2022 a second Cariad Pet Therapy volunteer started visiting the young people and staff at Ty Llidiard at the same hospital. Plans are in place to induct a further three Pet Therapy Volunteers during December 2022, for the Royal Glamorgan Hospital, one on the Dementia Ward, the second at Y Bwythyn Palliative Care Unit and the third for the mental health ward. Both Cariad Pet Therapy and the Volunteer Service are extremely keen to continue the working relationship and increase the number of volunteers, meetings are planned for the New Year to discuss and arrange information tables at several hospital sites with the hope to recruit volunteers from our local areas.

Breast Feeding Peer Support Volunteers

Breast Feeding Peer Support Volunteers in conjunction with the research team and infant leads continue to support new mothers, with virtual enhanced breast feeding peer support for pregnant ladies from 30 weeks to post-natal care up to 6 months. The BFPS volunteers are also active, offering information and support under the supervision of the infant leads. A further two volunteers are undertaking an induction session in November 2022 to join the Breast Feeding Peer Support initiative. The plan being to reintroduce our Breast Feeding Peer Support Volunteers onto maternity wards across CTMU HB.

Organ Donation Family Support Volunteer

Our organ donation family support volunteer continues to be on call for our 3 DGH sites across CTMU HB. This project was set up in conjunction with the Specialist nurse/Specialist Requester in Organ Donation and the Health Board's Lead Chaplain. In November 2022, our organ donation family support volunteer met with the new Specialist Nurse for Organ Donation and ITU ward manager at Prince Charles Hospital, which included meeting staff and a refresher/orientation session. Both ITU wards and Organ Donation Lead Nurse are keen to utilise the volunteer support whom will be contacted immediately should the opportunity arise. The Organ Donation Family Support Volunteer has also been supporting the End of Life Companion project and providing support for the memorial garden at Ysbyty Cwm Cynon.

Arts, Crafts, Good to Grow and Volunteer Drivers

The Arts and Crafts Group are keen to continue their workshops and plans will be made during 2023 with the aim to make items to donate to our wards and departments, with planned themes. Some of our arts and crafts volunteers also support other projects including WISE, meet & greet and digital support volunteers.

In October 2022, Y Bwythyn Newydd at Princess of Wales Hospital were pleased to reintroduce volunteer drivers, to enable service users to access the day unit by transporting them back and forth. The volunteer driver's information hand book was updated in November 2022, with additional information regarding pandemic situations and up to date checks, which is paramount to ensure both volunteers and service users are transported safely.

Patient Feedback Volunteers

Patient, service user public feedback is vital to any organisation as a tool to help improve services and capture positive experiences which can lift staff morale. In November 2022, the Volunteer Service was asked to support an all Wales one off survey concentrating on future visiting. Volunteers who were active in other roles were asked if they were interested in supporting the work stream and over the two week period undertook the survey on various wards across all DGH and Community Hospitals supported by the Volunteer Manager and Volunteer Coordinator. Due to some wards being closed the focus was to carry out the survey in green areas only. To date there are three patient feedback volunteers who will be supporting the work stream at Princess of Wales Hospital and during October / November 2022 undertook a local orientation with ward managers and were introduced to staff on identified wards. The plan is to arrange shifts during December 2022 and Ipads have been set up for volunteers to complete surveys directly via Civica, also encouraging patients and visitors to complete the "Have Your Say" cards.

Moving Forward

Over the past few weeks and months we have been privileged to be able to reintroduce a number of our existing volunteers in a variety of roles. To support further projects a recruitment information session was held the end of November 2022 with a themed approach concentrating on projects that are currently active and in green areas to ensure volunteers are safe. Moving forward we have a number of initiatives that we will be working on alongside supporting projects up and running which include:

- Meet and Greet Volunteers (Dewi Sant Health Park, Royal Glamorgan Hospital and Ysbyty Cwm Cynon
- Cariad Pet Therapy Volunteers (across CTMUHB)
- Wellness Improvement Service Volunteers (various sites across CTMUHB)
- Ward Befriender / Dementia Volunteers (Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon)
- Patient Feedback Volunteers (Various sites across CTMUHB)

Veterans

The new Armed Forces Covenant Duty came into force on 22nd November 2022. This places a legal obligation on Health Bodies to have due regard to the principles of the Armed Forces Covenant when exercising specific functions.

Patient Experience Manager has liaised with a number of third party stakeholders to look at how CTMU HB is able to promote this within the organisation via ESR training and is currently working with colleagues in Learning and Development to explore how we manage this going forward.

Patient Experience Manager also sits on the Armed Forces Steering Group to understand the needs of the armed forces/veterans community, and how we support with information/signposting around the Covenant and Health Board services.

Bereavement

The Health Board's new Clinical Bereavement Lead started on 17th October 2022 and has met with a number of staff/departments to understand the processes the Health Board has in place to ensure we meet the needs of our patients/families in line with the new Bereavement Framework.

The initial focus identified a gap in the service provided to families who suffered a pregnancy loss under 16 weeks and the amount of support being provided. As such, a process has been quickly established to ensure that when babies are going for communal cremation the Health Board is able to inform families and provide them with a choice as to whether they choose to attend or not. This has also provided the opportunity to ensure that signposting is offered should families require further support in their grief journey. A review of the bereavement booklet is also underway to ensure the information is updated and reflects the further support now available to families.

Review of processes is also underway across the Health Board to ensure that the Health Board has policies in place to support all those involved in supporting families in their hour of need. The Health Board's Bereavement Strategy Group allows representatives across all specialities to come together and drive service improvement in this area. The Clinical Bereavement Lead has also set up a Bereavement Champions network to allow information from the Strategy Group to be embedded across acute and community settings but also enables the input of staff who are working with these policies to advise how these translate into working practise.

Clinical Bereavement Lead also sits on the All Wales Bereavement Leads Group to share best practise and knowledge within this field of expertise.


TOGETHER

GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

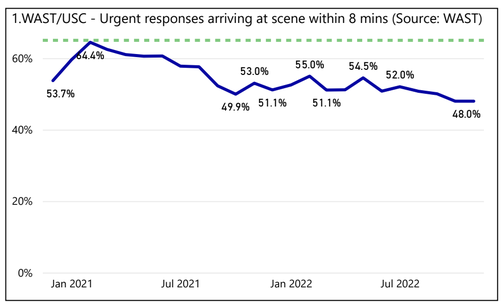
Wales

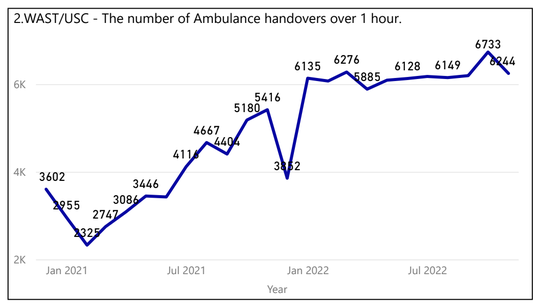
Summary UHB Level Monthly Performance Measures Dashboard (selected measures)

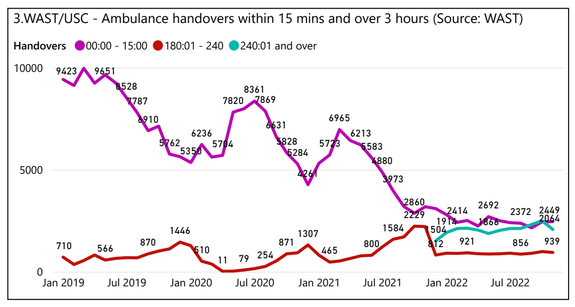
16/12/2022 11:11:40
Last Refreshed

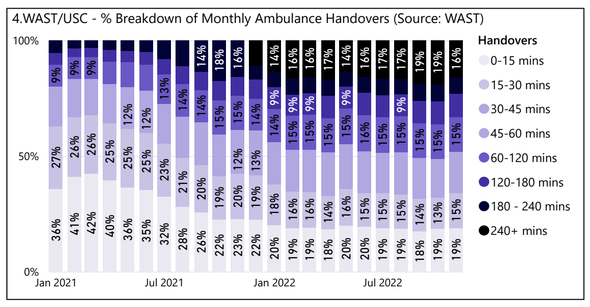
WAST

Site Level Data









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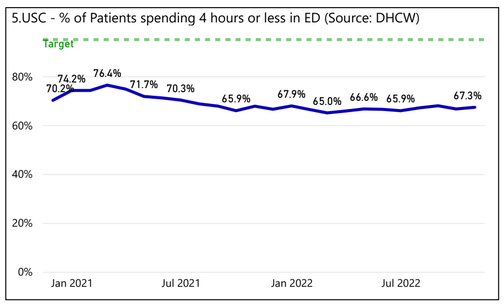
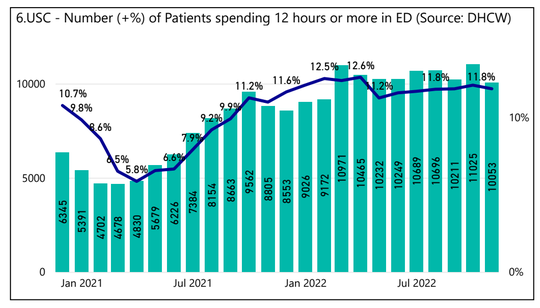
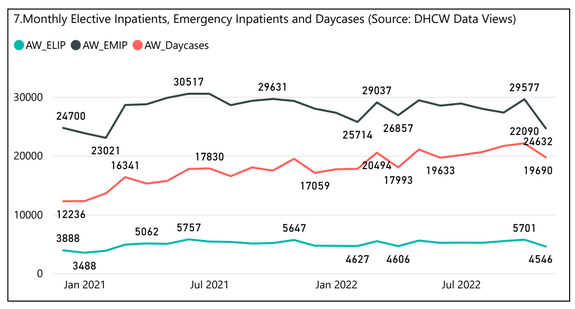
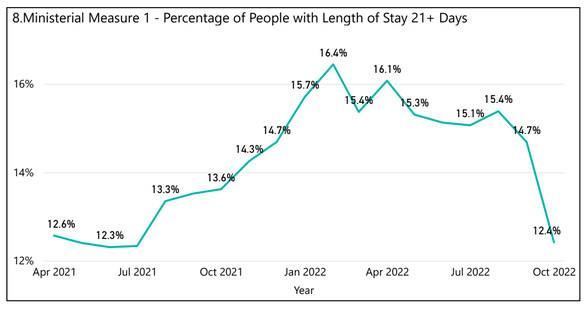
Site Level Data

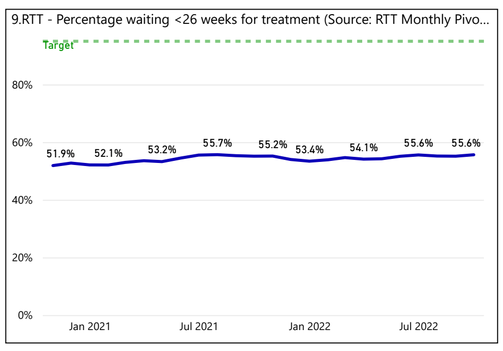


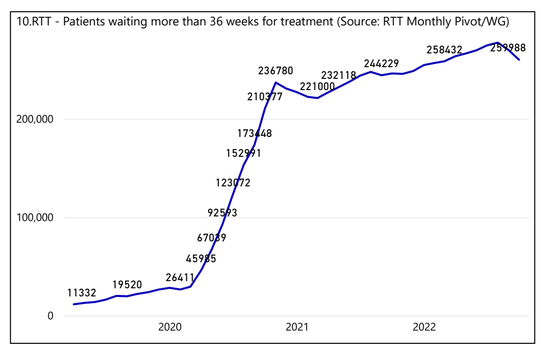


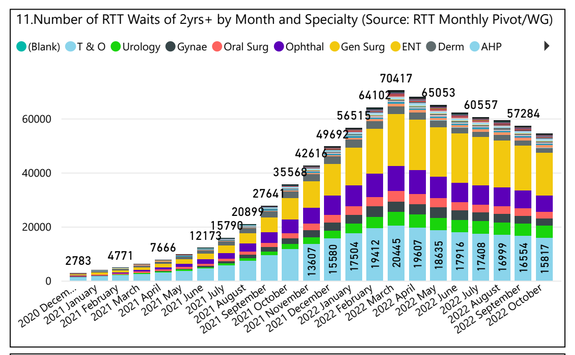


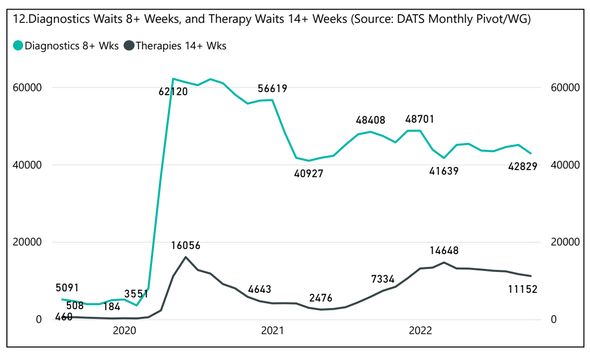


Planned Care

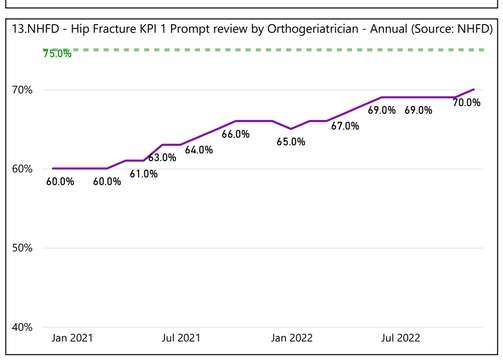


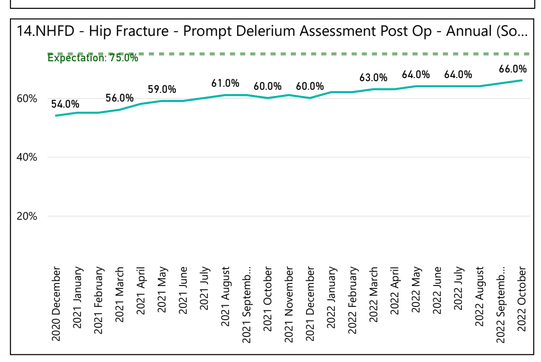


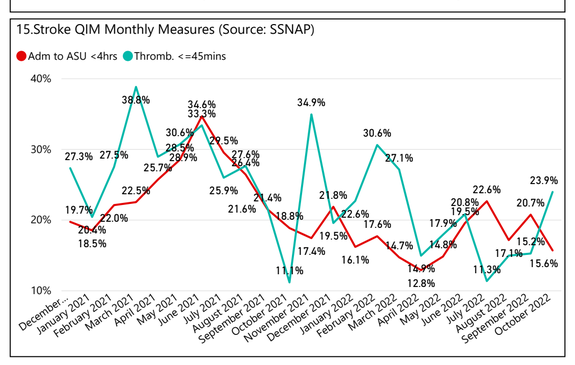




Major Conditions

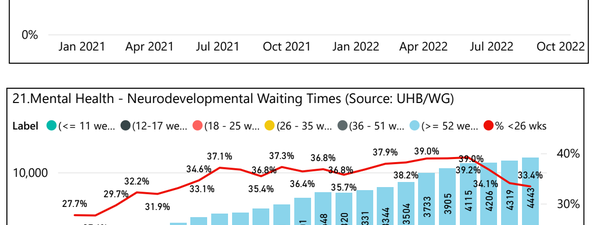




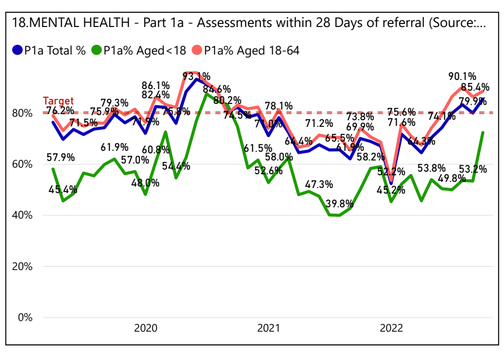


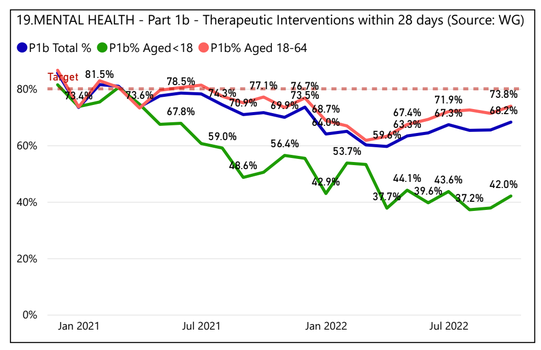
16. Total No. of Patients with a target date but no booked appointment

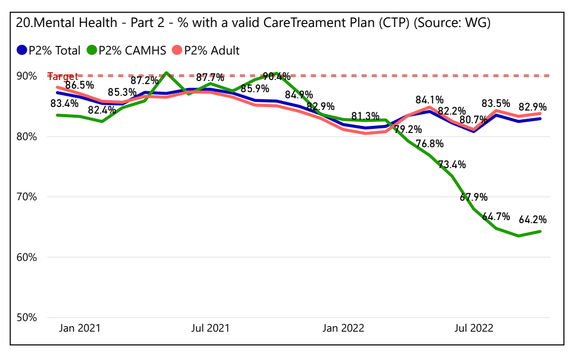
Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
30 June 2022	12435	17371	60056	31278	18985
31 July 2022	12874	17662	61370	32660	19351
31 August 2022	13020	18102	61821	33035	19621
30 September 2022	13132	18497	61114	33189	19422
31 October 2022	12726	18131	60524	32757	18886



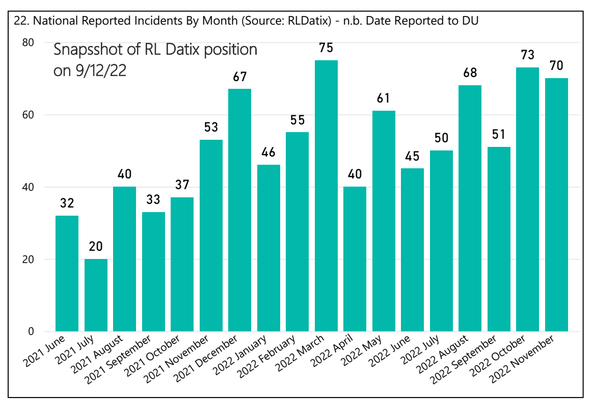
Mental Health

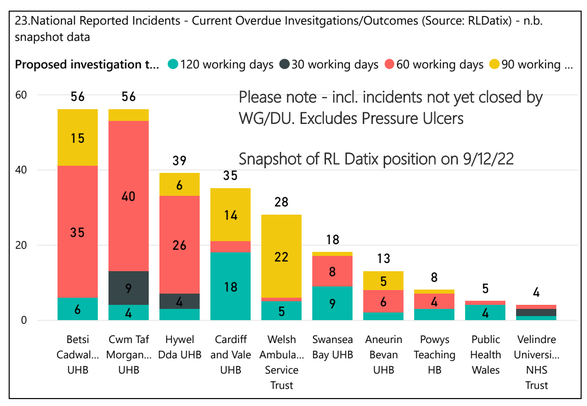






Patient Safety

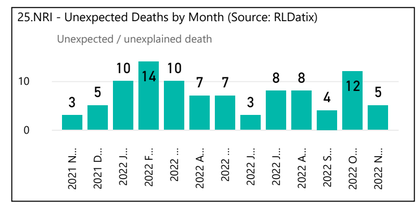


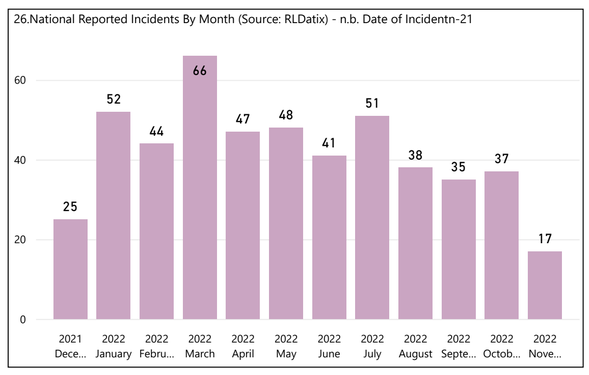


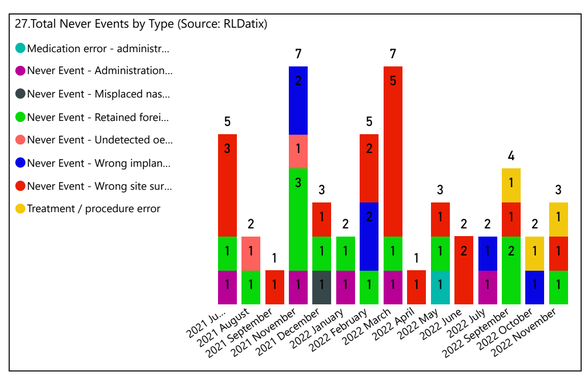
24.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)

Status	AB	BCU	CaV	CTM	SBU	Vel	Total
Non-compliant	1	1	2	2	1	1	8
Total	**1**	**1**	**2**	**2**	**1**	**1**	**8**

Snaphot of position on 12/12/22





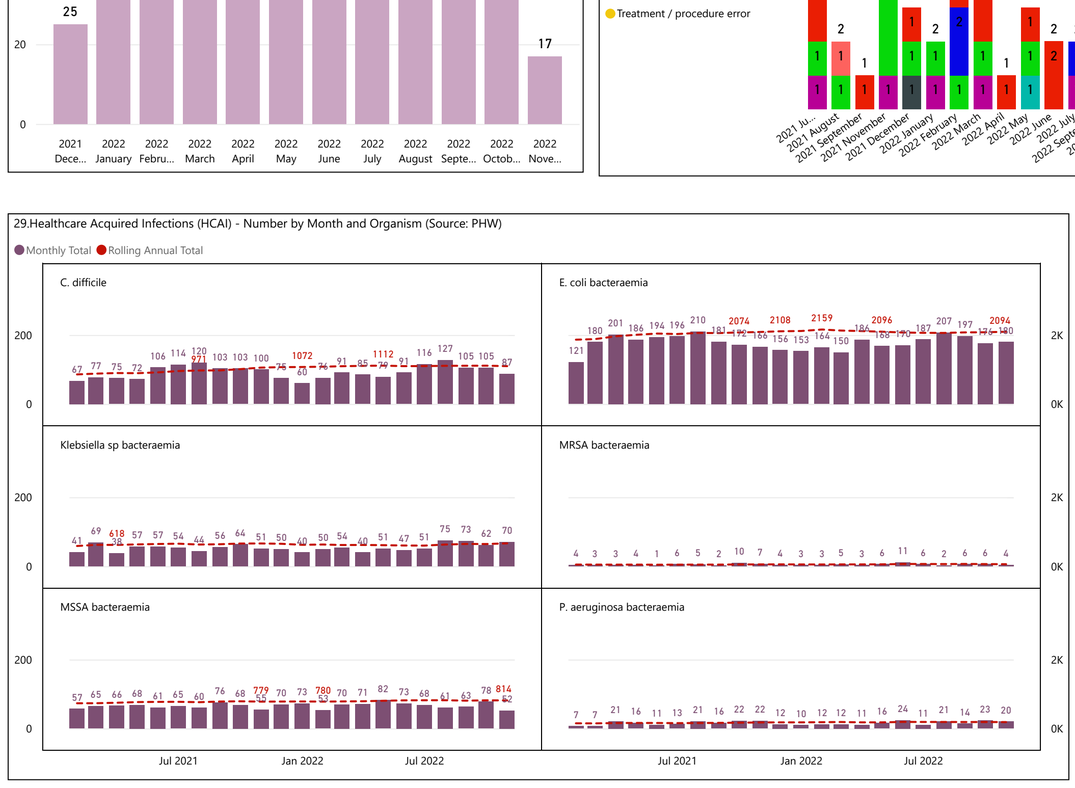


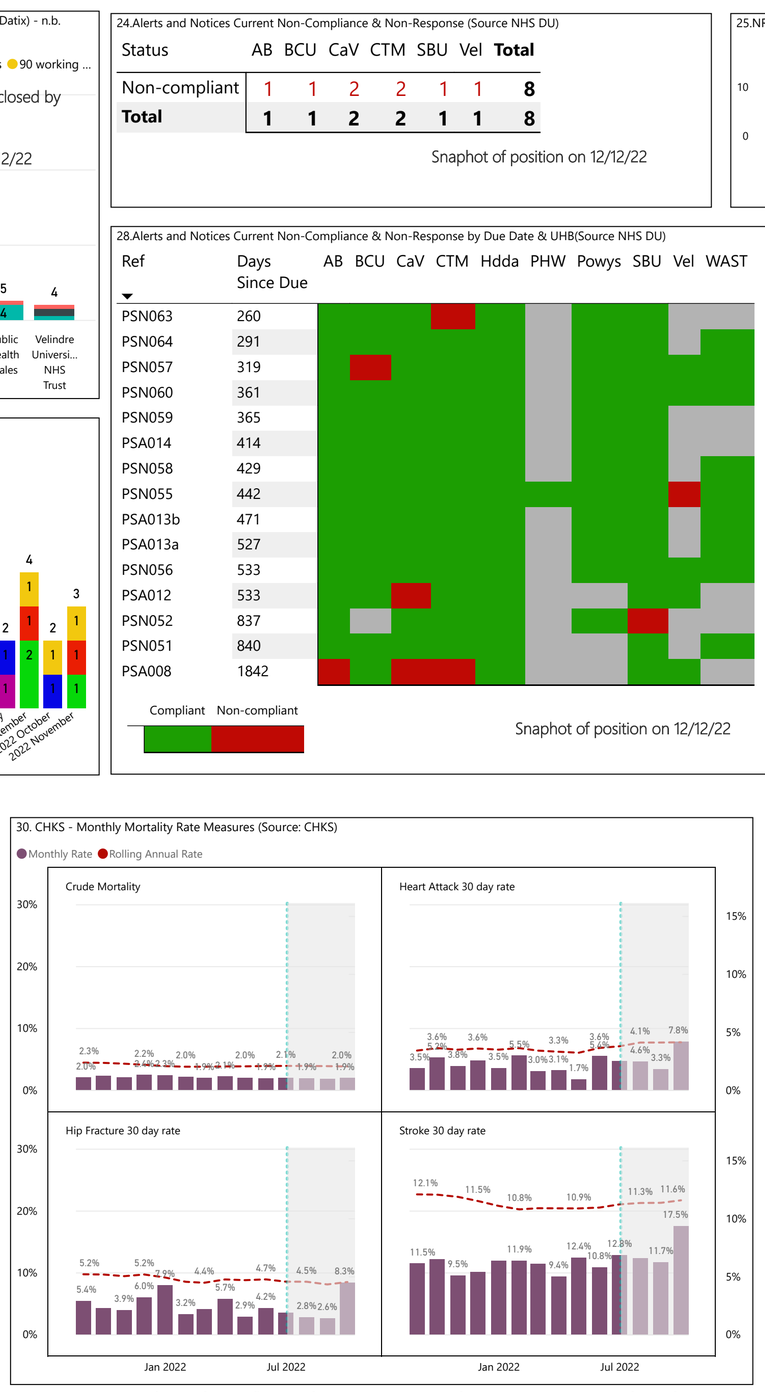
28.Alerts and Notices Current Non-Compliance & Non-Response by Due Date & UHB(Source NHS DU)

Ref	Days Since Due	AB	BCU	CaV	CTM	Hdda	PHW	Powys	SBU	Vel	WAST
PSN063	260										
PSN064	291										
PSN057	319										
PSN060	361										
PSN059	365										
PSA014	414										
PSN058	429										
PSN055	442										
PSA013b	471										
PSA013a	527										
PSN056	533										
PSA012	533										
PSN052	837										
PSN051	840										
PSA008	1842										

Compliant Non-compliant

Snaphot of position on 12/12/22





CHKS mortality data from latest 3 months is provisional only

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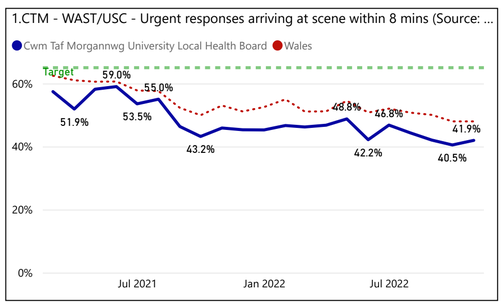
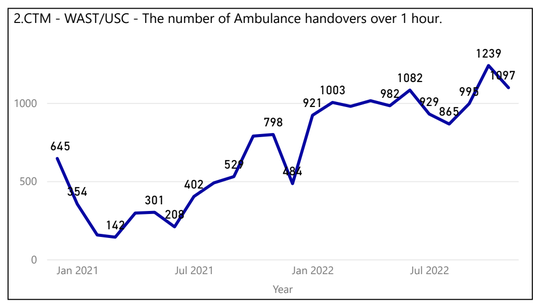
Cwm Taf Morgannwg UHB Summary UHB Level Monthly Performance Measures Dashboard (selected measures)

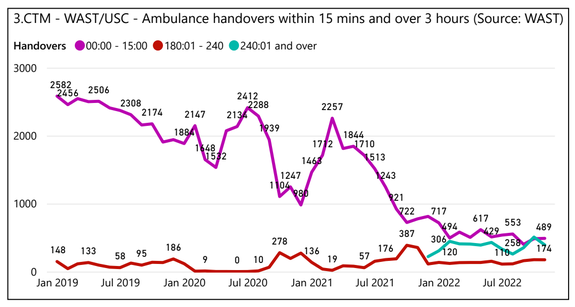
16/12/2022 11:11:40
Last Refreshed

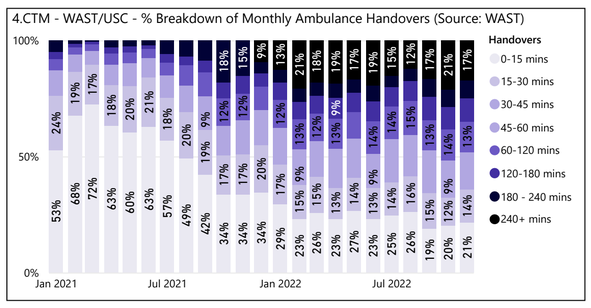
WAST

Site Level Data



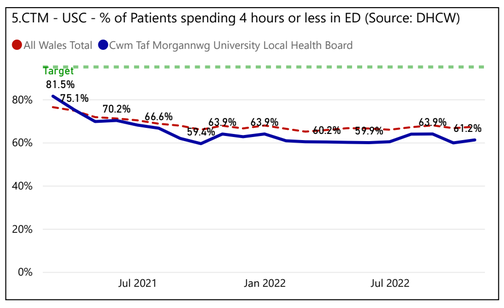


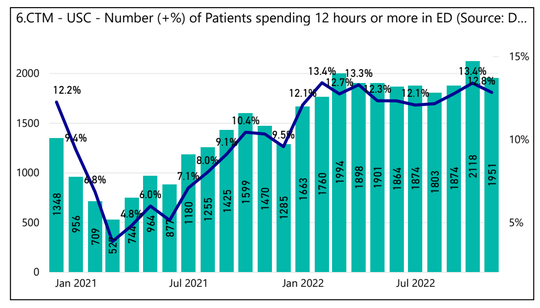


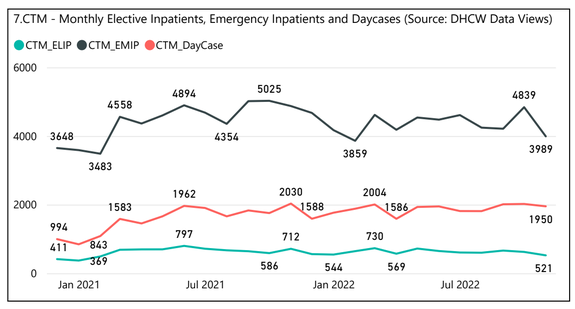


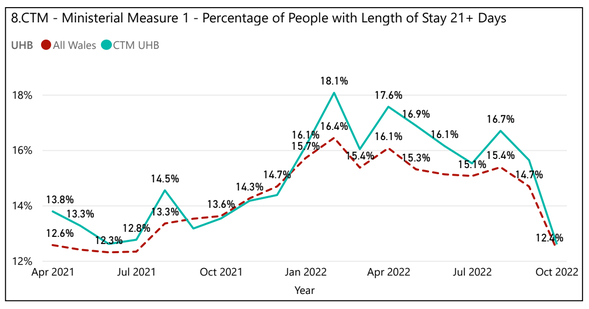
USC

Site Level Data

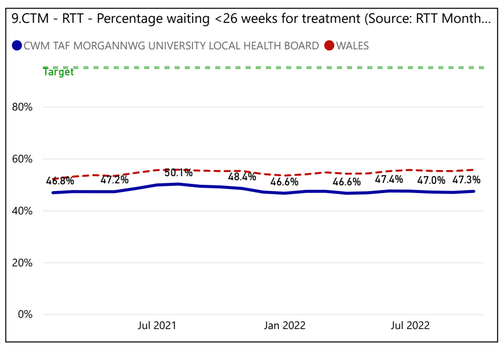


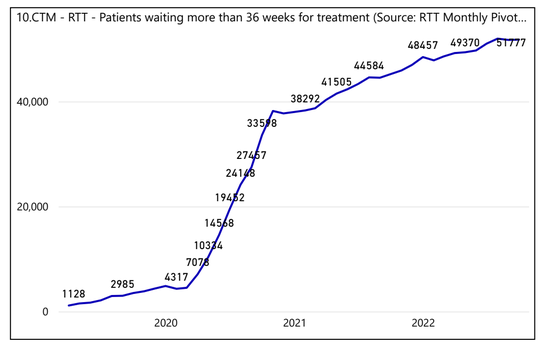


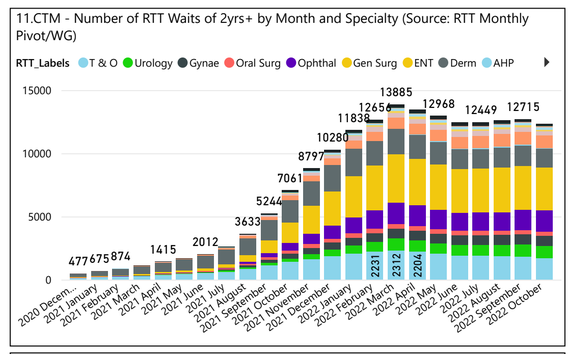


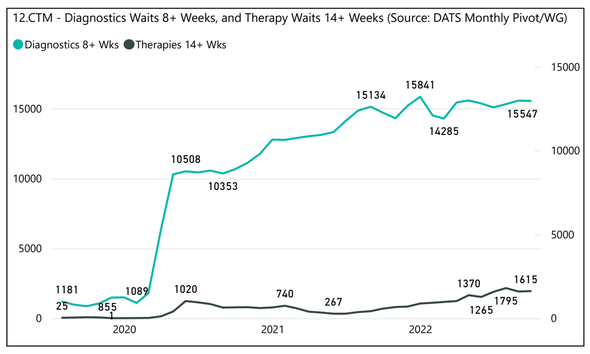


Planned Care

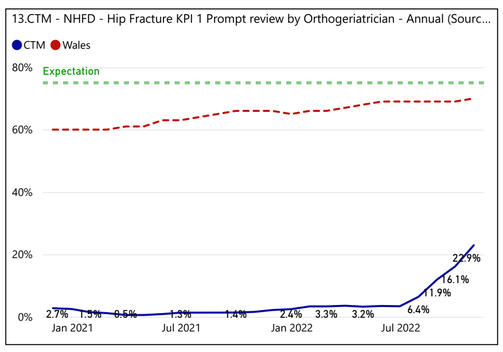


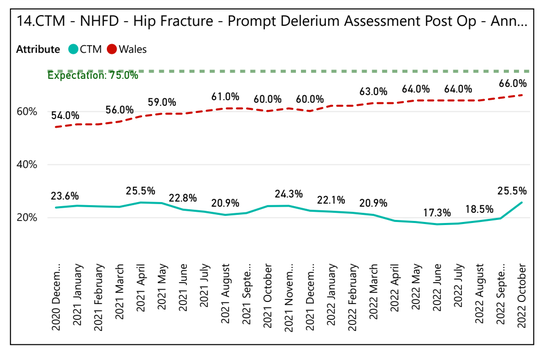


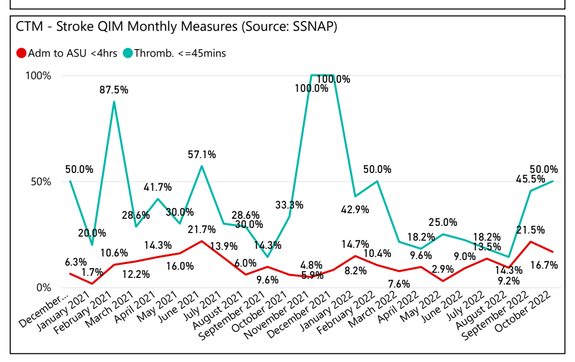




Major Conditions

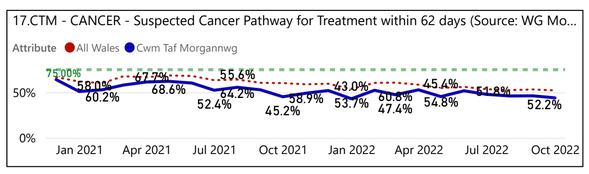




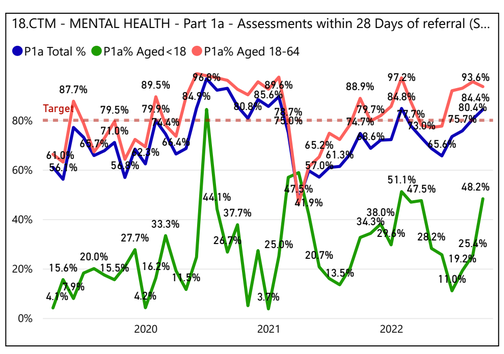


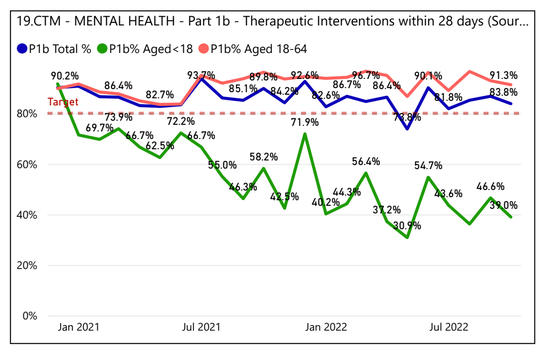
16. CTM - Total No. of Patients with a target date but no booked appointment

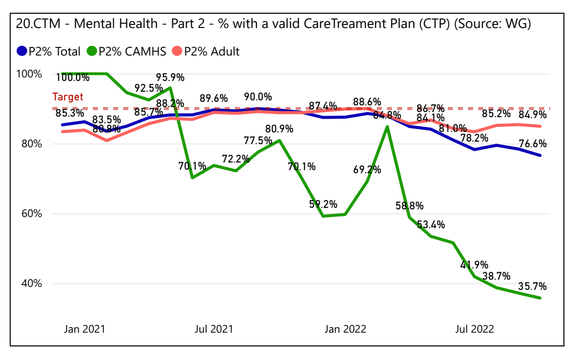
Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
30 June 2022	1241	2390	10772	7372	1649
31 July 2022	1282	2454	10941	7544	1669
31 August 2022	1272	2583	10852	7485	1765
30 September 2022	1307	2711	10480	7551	1860
31 October 2022	1080	2629	10477	7458	1864

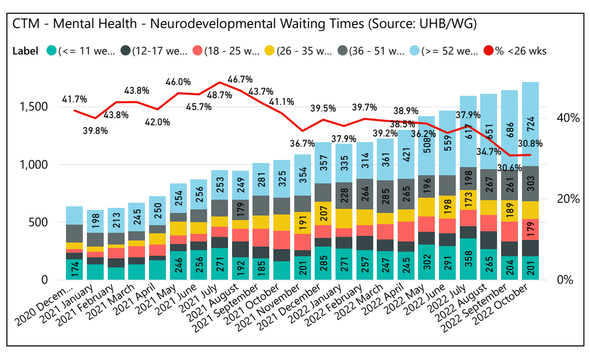


Mental Health

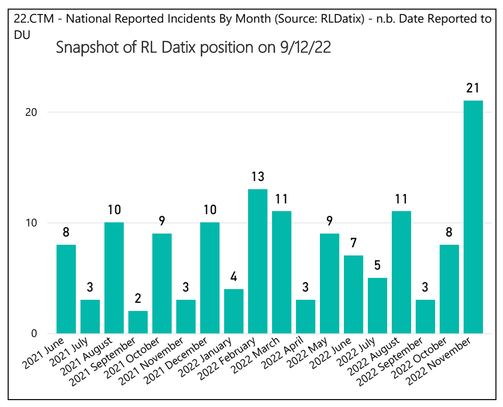


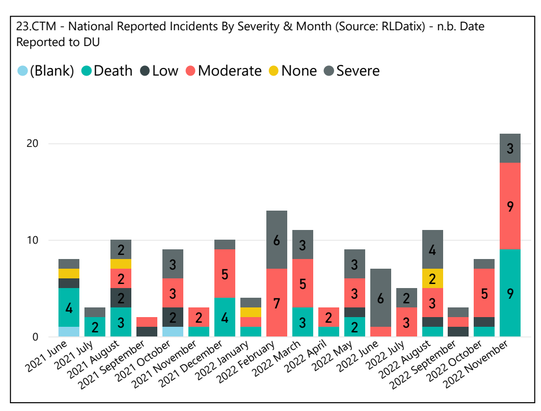


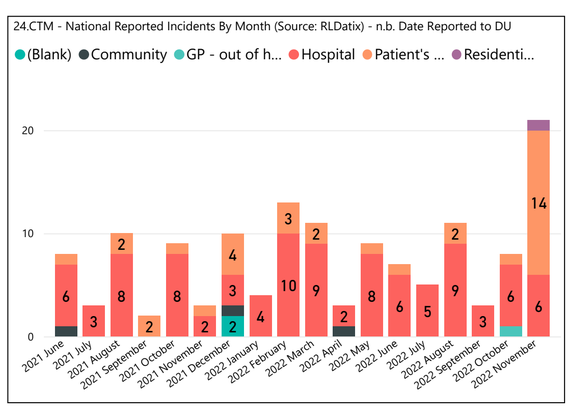




Patient Safety



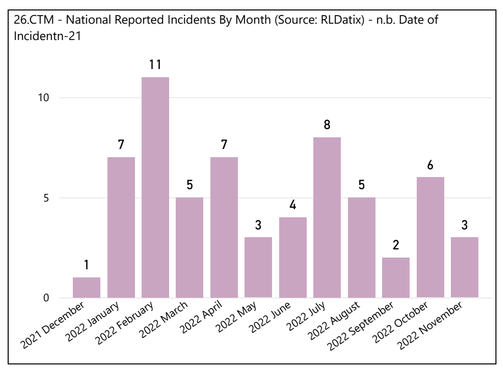


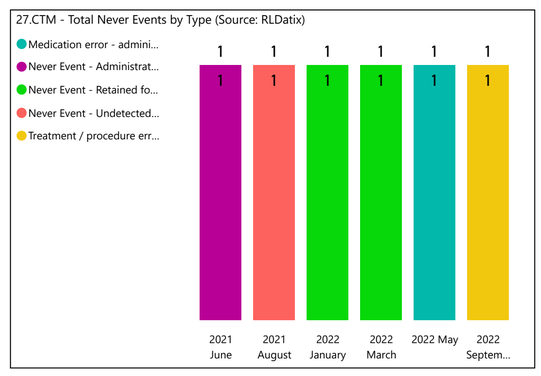


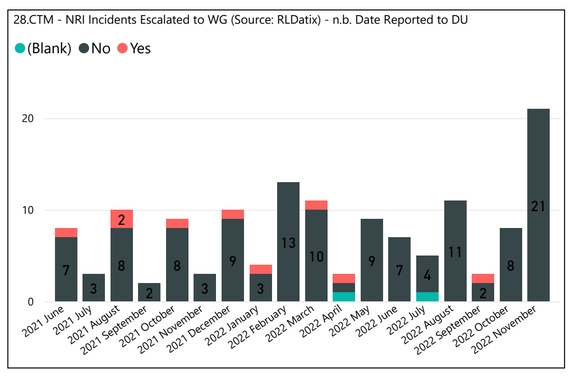
25.Alerts and Notices Current Non-Compliance & Non-Response by Due Date (Source NHS DU)

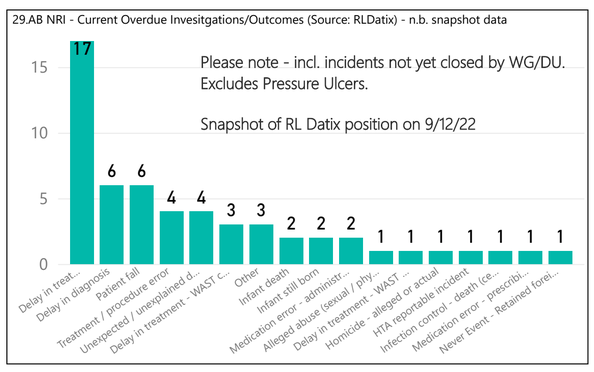
Status	Date Due	Ref	Title
Non-compliant	31 March 2022	PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)
Non-compliant	30 November 2017	PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm

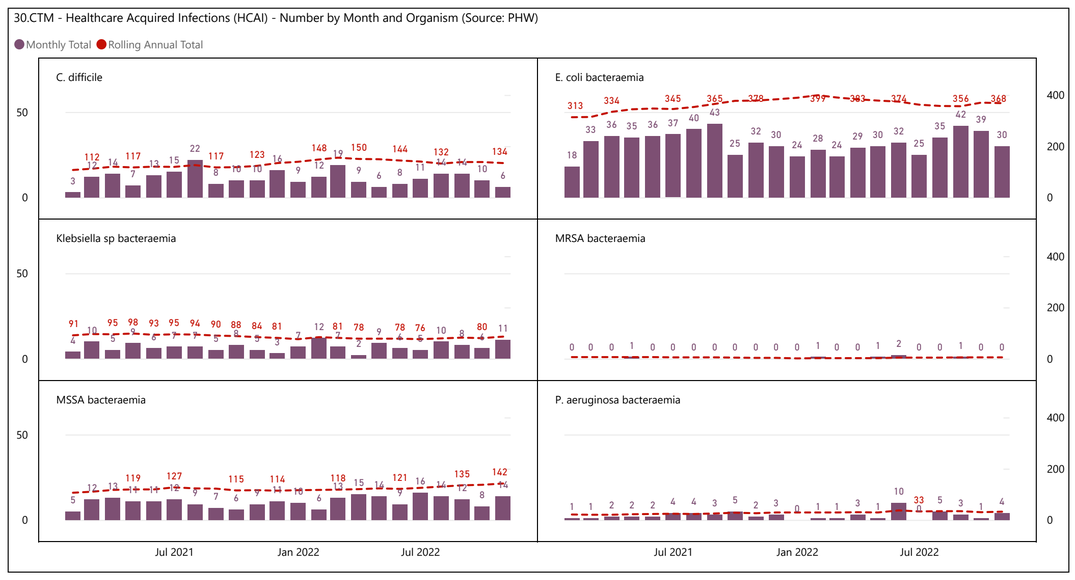
Snapshot of position on 12/12/22

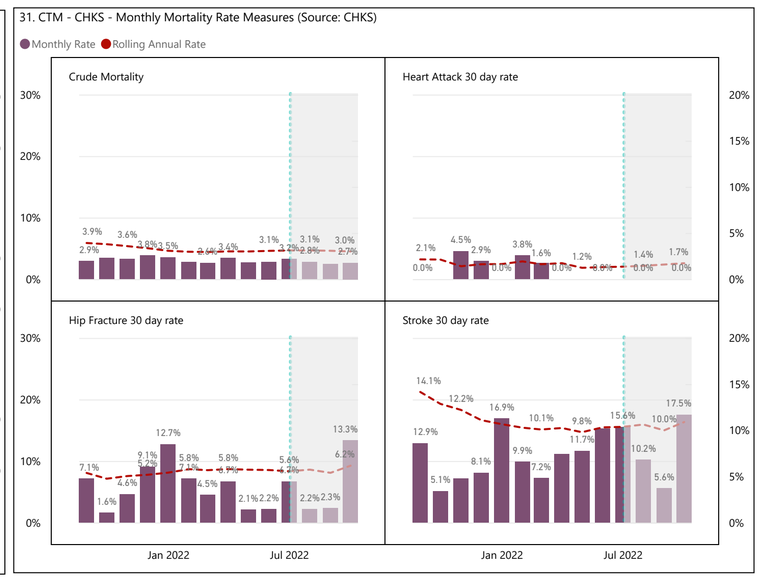




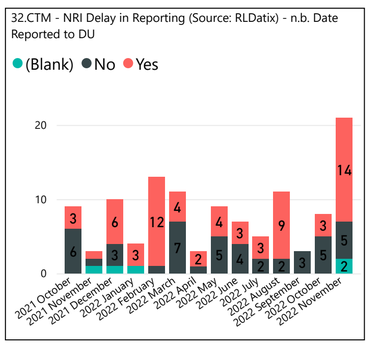


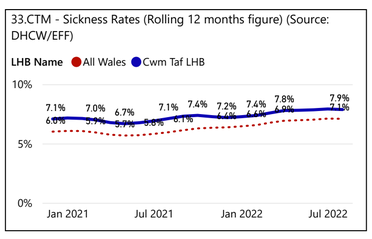






CHKS mortality data from latest 3 months is provisional only





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Monthly UHB Summary Dashboards - Further Details of Data Used (All Wales Dashboard)

Section	Chart Number	Title	Data Source	Further Details
WAST	1	1.WAST/USC - Urgent responses arriving at scene within 8 mins (Source: WAST)	WAST	Number of calls responded within 8 mins as % of total attendances Discrete monthly percentage figure Target 65% All Wales Figures also plotted on UHB charts
WAST	2	2.WAST/USC - The number of Ambulance handovers over 1 hour.	WAST	Number of ambulance handovers with a recorded delay of =>60 mins Discrete monthly absolute volume figure
WAST	3	3.WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)	WAST	Number of ambulance handovers with a recorded delay of <15 mins and those =>180 mins. Data plotted on dual y axis line chart. Discrete monthly absolute volume figure
WAST	4	4.WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)	WAST	A breakdown of the monthly percentage distribution of ambulance handover delays broken down into specific time categories: 0-15 mins 15-30 mins 30-45 mins 45-60 mins 60-120 mins 120-180 mins 180 mins+ Data plotted as 100% stacked monthly column chart.
USC	5	5.USC - % of Patients spending 4 hours or less in ED (Source: DHCW)	DHCW	Number of patients spending 4 hours or less in ED as % of total ED attendances. Discrete monthly percentage figure Target 95%. All Wales Figures also plotted on UHB charts.
USC	6	6.USC - Number of Patients spending 12 hours or more in ED (Source: DHCW)	DHCW	Number of patients spending 12 hours or more in ED. Discrete monthly absolute volume figure.
USC	7	7.Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)	DHCW	Number of elective inpatients, emergency inpatients and daycases. Discrete monthly absolute volume figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk).
USC	8	8.Emergency Avg Length of Stay - Monthly (Source: DHCW)	DHCW	Elective admission Average Length of Stay and Emergency admission Average Length of Stay (days). Discrete monthly figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk). Numerator / Denominator Numerator – sum of the duration of inpatient spells Denominator – number of inpatient spells
Planned Care	9	9.RTT - Percentage waiting <26 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting <26 weeks for treatment as a percentage of total waiting patients. Discrete monthly figure. Target 95%. All Wales Figures also plotted on UHB charts.
Planned Care	10	10.RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >36 week. Discrete monthly absolute figure.
Planned Care	11	11.Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >2 years broken down by specialty. Discrete monthly absolute figure.
Planned Care	12	12.Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)	WG	Diagnostics and Therapies waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Diagnostics: Numbers waiting 8+ weeks total volume. Therapies: Numbers waiting 14+ weeks total volume. Discrete monthly absolute figure.
Major Conditions	13	13.NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against KPI1 - Prompt review by orthogeriatrician. Monthly - Rolling Annual Figure. Target - 75%. All Wales Figures also plotted on UHB charts.
Major Conditions	14	14.NHFD - Hip Fracture 30 Day Mortality Rate - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against mortality measures. Data subject to review. Monthly - Rolling Annual Figure. All Wales Figures also plotted on UHB charts.
Major Conditions	15	15.Stroke QIM Monthly Measures (Source: SSNAP)	SSNAP	Source: SSNAP (Setinel Stroke Nationa Audit Programme) national programme data. Four key elements only listed: Admission to Acute Stroke Unit ,=4 hours (%). Thrombolyisis - Door to Needle in 45 mins (% of eligible patients). Attaining target level of mins with SLT (Speech Language Therapy). The percentage discharged with ESD/Community Therapy Multi-Disciplinary Team. Discrete monthly absolute figure.
Planned Care	16	16.Numbers Follow Up appointments booked or not booked past target date (Source: WG)	DHCW	Numbers Follow Up appointments booked or not booked past target date for specific specialties. Data source: WG
Major Conditions	17	17.CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pivot)	WG	% of Patients Treated within 62 days - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 75% All Wales Figures also plotted on UHB charts
Mental Health	18	18.MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:WG)	WG	% of Patients receiving mental health assessments within 28 days of a referral - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 80%

Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid are Treatment Plan (CTP) Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 90%
Mental Health	21	21.Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)	WG	Details of neurodevelopmental servces waiting times broken down into specific time categories: 0-11 weeks 12-17 weeks 18-25 weeks 26-35 weeks 36-51 weeks >52 weeks Data plotted as stacked discrete monthly volumes column chart - with % of those waitng 26 eeks or less overlayed as line series. Source: Welsh Government monthly pivot of data. Target 80%
Patient Safety	22	22.National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported ot the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	23	23.National Reported Incidents - Current Overdue Investigations/Outcomes (Source: RLDatix) - n.b. snapshot data	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported ot the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	24	24.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Table displays a numerical summary of the number where PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	25	25.National Reported Incidents by Month (Source: RLDatix)	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported on the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Suicide and Unexpected Incident Types ONLY.** Discrete monthly figure.
Patient Safety	26	26.National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidents	RL DATIX	National Reported Incidents as recorded on RLDatix. **Based on date the incident occurred.** Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	27	27.Total Never Events by Type (Source: RLDatix)	RL DATIX	Recorded National Reprted Incidents which resulted in a Never Event - by type. Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Based on Date Reported to NHSDU via RLDATIX
Patient Safety	28	28.Alerts and Notices Current Non-Compliance & Non-Response by Due Date & UHB(Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Breakdown by individual PSN and PSA. Table displays those PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	29	29.Healthcare Associated Infections (HCAI) - Number by Month and Organism (Source: PHW)	PHW	Number of HCAI (Health and Care Associated Infections) currently recorded by PHW - by organism. Discrete monthly figure overlayed with roling annual total for comparison (annual figure in red).
Patient Safety	30	30.CHKS - Monthly Mortality Rate Measures (Source: CHKS)	CHKS	Data taken from CHKS extract. Discrete monthly figure. Monthly mortality data for the four measured listed: Stroke, Hip Fracture, Heart Attack and a Crude overall Mortality rate. Snapshot of dynamic dataset and subject to revision. Latest three months (90 days) data to be treated as provisional only - subject to substantial revision pending lag in coding.
Patient Safety	31	31.Incidents Not Closed and Overdue - by UHB (incidents reported from 2020-21 and 21-22 up till Jun-21 only)	NHSDU/WG	Legacy records comprising Serious Incident records recorded in 2020-21 and 2021-22 (up until Jun-21). These represent Serious Incidents and were therefore recorded under a different framework to the National Reported Incidents recorded since Jun-21. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	32	32.Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)	DHCW	Data taken from EFF/DHCW extract. Discrete monthly figure. Subject to lag of several months in data becoming available.

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Monthly UHB Summary Dashboards - Further Details of Data Used (UHB Dashboards)

Section	Chart Number	Title	Data Source	Further Details
WAST	1	1.WAST/USC - Urgent responses arriving at scene within 8 mins (Source: WAST)	WAST	Number of calls responded within 8 mins as % of total attendances Discrete monthly percentage figure Target 65% All Wales Figures also plotted on UHB charts
WAST	2	2.WAST/USC - The number of Ambulance handovers over 1 hour.	WAST	Number of ambulance handovers with a recorded delay of =>60 mins Discrete monthly absolute volume figure
WAST	3	3.WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)	WAST	Number of ambulance handovers with a recorded delay of <15 mins and those =>180 mins. Data plotted on dual y axis line chart. Discrete monthly absolute volume figure
WAST	4	4.WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)	WAST	A breakdown of the monthly percentage distribution of ambulance handover delays broken down into specific time categories: 0-15 mins 15-30 mins 30-45 mins 45-60 mins 60-120 mins 120-180 mins 180 mins+ Data plotted as 100% stacked monthly column chart.
USC	5	5.USC - % of Patients spending 4 hours or less in ED (Source: DHCW)	DHCW	Number of patients spending 4 hours or less in ED as % of total ED attendances. Discrete monthly percentage figure Target 95%. All Wales Figures also plotted on UHB charts.
USC	6	6.USC - Number of Patients spending 12 hours or more in ED (Source: DHCW)	DHCW	Number of patients spending 12 hours or more in ED. Discrete monthly absolute volume figure.
USC	7	7.Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)	DHCW	Number of elective inpatients, emergency inpatients and daycases. Discrete monthly absolute volume figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk).
USC	8	8.Emergency Avg Length of Stay - Monthly (Source: DHCW)	DHCW	Elective admission Average Length of Stay and Emergency admission Average Length of Stay (days). Discrete monthly figure. Source DHCW data views (dw) - SQL script available upon request (email james.walford@Wales.nhs.uk). Numerator / Denominator Numerator – sum of the duration of inpatient spells Denominator – number of inpatient spells
Planned Care	9	9.RTT - Percentage waiting <26 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting <26 weeks for treatment as a percentage of total waiting patients. Discrete monthly figure. Target 95%. All Wales Figures also plotted on UHB charts.
Planned Care	10	10.RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >36 week. Discrete monthly absolute figure.
Planned Care	11	11.Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Monthly Pivot/WG)	WG	RTT Referral to Treatment waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Numbers waiting >2 years broken down by specialty. Discrete monthly absolute figure.
Planned Care	12	12.Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)	WG	Diagnostics and Therapies waiting list figures - provided in monthly pivot. Source: WG monthly pivot. Diagnostics: Numbers waiting 8+ weeks total volume. Therapies: Numbers waiting 14+ weeks total volume. Discrete monthly absolute figure.
Major Conditions	13	13.NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against KPI1 - Prompt review by orthogeriatrician. Monthly - Rolling Annual Figure. Target - 75%. All Wales Figures also plotted on UHB charts.
Major Conditions	14	14.NHFD - Hip Fracture 30 Day Mortality Rate - Annual (Source: NHFD)	NHFD	Source: National Hip Fracture Database (NHFD) - public domain website. Performance against mortality measures. Data subject to review. Monthly - Rolling Annual Figure. All Wales Figures also plotted on UHB charts.
Major Conditions	15	15.Stroke QIM Monthly Measures (Source: SSNAP)	SSNAP	Source: SSNAP (Setinel Stroke Nationa Audit Programme) national programme data. Four key elements only listed: Admission to Acute Stroke Unit ,=4 hours (%). Thrombolyisis - Door to Needle in 45 mins (% of eligible patients). Attaining target level of mins with SLT (Speech Language Therapy). The percentage discharged with ESD/Community Therapy Multi-Disciplinary Team. Discrete monthly absolute figure.
Planned Care	16	16.Numbers Follow Up appointments booked or not booked past target date (Source: WG)	DHCW	Numbers Follow Up appointments booked or not booked past target date for specific specialties. Data source: WG
Major Conditions	17	17.CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pivot)	WG	% of Patients Treated within 62 days - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 75% All Wales Figures also plotted on UHB charts
Mental Health	18	18.MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:WG)	WG	% of Patients receiving mental health assessments within 28 days of a referral - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 80%
Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid are Treatment Plan (CTP) Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 90%

Mental Health	21	21.Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)	WG	Details of neurodevelopmental servces waiting times broken down into specific time categories: 0-11 weeks 12-17 weeks 18-25 weeks 26-35 weeks 36-51 weeks >52 weeks Data plotted as stacked discrete monthly volumes column chart - with % of those waitng 26 eeks or less overlayed as line series. Source: Welsh Government monthly pivot of data. Target 80%
Patient Safety	22	22.National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	23	23.National Reported Incidents By Severity & Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded severity of the incident at the time of reporting.** Discrete monthly figure.
Patient Safety	24	24.National Reported Incidents By Month and Location (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded location of the incidents.** Discrete monthly figure.
Patient Safety	25	25.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Breakdown by individual PSN and PSA. Table displays those PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	26	26.National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidents	RL DATIX	National Reported Incidents as recorded on RLDatix. **Based on date the incident occurred.** Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	27	27.Total Never Events by Type (Source: RLDatix)	RL DATIX	Recorded National Reprted Incidents which resulted in a Never Event - by type. Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Based on Date Reported to NHSDU via RLDATIX
Patient Safety	28	28.National Reported Incidents Escalated to WG By Month (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown of those Escalated to WG for consideration.** Discrete monthly figure.
Patient Safety	29	29.NRI - Current Overdue Invesitgations/Outcomes (Source: RLDatix) - n.b. snapshot data	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	30	30.Incidents Not Closed and Overdue - by UHB (incidents reported from 2020-21 and 21-22 up till Jun-21 only)	NHSDU/WG	Legacy records comprising Serious Incident records recorded in 2020-21 and 2021-22 (up until Jun-21). These represent Serious Incidents and were therefore recorded under a different framework to the National Reported Incidents recorded since Jun-21. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	31	31.Healthcare Associated Infections (HCAI) - Number by Month and Organism (Source: PHW)	PHW	Number of HCAI (Health and Care Associated Infections) currently recorded by PHW - by organism. Discrete monthly figure overlayed with roling annual total for comparison (annual figure in red).
Patient Safety	32	32.CHKS - Monthly Mortality Rate Measures (Source: CHKS)	CHKS	Data taken from CHKS extract. Discrete monthly figure. Monthly mortality data for the four measured listed: Stroke, Hip Fracture, Heart Attack and a Crude overall Mortality rate. Snapshot of dynamic dataset and subject to revision. Latest three months (90 days) data to be treated as provisional only - subject to substantial revision pending lag in coding.
Patient Safety	33	33.NRI Delay in Reporting (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidetns (NRI) for each discrete month broken down by recorded nature of any delay noted in reporting. For further clarification contact NHSDU Quality and Safety team.
Patient Safety	34	34.Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)	DHCW	Data taken from EFF/DHCW extract. Discrete monthly figure. Subject to lag of several months in data becoming available.

Compliance against Patient Safety Solutions Wales - Alerts - Issued after April 2014

12/12/2022

	Alerts as at: 12/12/2022											
PSA No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSA001	Legionella and heated birthing pool filled in advance of labour in home settings.	**30/06/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA002	The prompt recognition and initiation of treatment for sepsis for all patients.	**28/11/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSA003	Update to the NPSA alert for safer spinal (intrathecal), epidural and regional devices	**01/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA004	Ensuring the Safe Administration of Insulin	**28/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA005	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	**14/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA006	Risk of death and severe harm from error with injectable phenytoin	**10/03/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA007	Restricted use of open systems for injectable medication	**01/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm	**30/11/2017**	Non-compliant	Compliant	Non-compliant	Non-compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA009	Wrong selection of orthopaedic fracture fixation plates	**15/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA010	Interruption of high flow nasal oxygen during transfer	**10/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA011	Blood control safety cannula & needle thoracostomy for tension pneumothorax	**15/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA012	Deterioration due to rapid offload of pleural effusion fluid from chest drains	**01/07/2021**	Compliant	Compliant	Non-compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA013a	Ligature and ligature point risk assessment tools and policies	**07/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA013b	Ligature and ligature point risk assessment tools and policies	**01/09/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA014	Inappropriate anticoagulation of patients with a mechanical heart valve	**28/10/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

Compliance against Patient Safety Solutions Wales - Notices - Issued after April 2014

12/12/2022

Notices as at: 12/12/2022												
PSN No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSN001	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women. NB not part of returns compliance.	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN002	The Surgical Management of Urinary Incontinence (UI) and Pelvic Organ Prolapse (POP)	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN003	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN004	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	**19/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN005	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN006	Risk of hypothermia for patients on continuous renal replacement therapy	**30/04/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN007	Risk of death or serious harm from accidental ingestion of potassium permanganate	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN008	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	**28/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN009	Awareness of NICE clinical guidelines on head injuries	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN010	Failure to act on known contraindications to Low Molecular Weight Heparins	**25/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN011	Risk of associating ECG records with wrong patients	**18/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN012	Adrenal insufficiency (addison's disease) in adults - information for general practitioners	**12/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN013	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	**13/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSN014	Residual anaesthetic drugs in cannulae and intravenous lines	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN015	The storage of medicines: Refrigerators	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN016	Risk of inadvertently cutting in-line (or closed) suction catheters	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN017	Risk of using vacuum and suction drains when not clinically indicated	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN018	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN019	Harm from delayed updates to ambulance dispatch and satellite navigation systems	**30/09/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN020	Minimising risks of omitted and delayed medicines for patients receiving homecare services	**27/11/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN021	Risk of death and serious harm from falling from hoists	**15/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN022	Risk of death from the inappropriate use and disposal of fentanyl patches	**31/01/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN023	The importance of vital signs during and after restrictive interventions/manual restraint	**12/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN024	Risk of using different airway humidification devices simultaneously	**01/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN025	Risk of death or severe harm due to inadvertent injection of skin preparation solution	**04/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN026	Positive patient identification	**13/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN027	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN028	Medicine Reconciliation - Reducing the risk of serious harm	**31/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN029	Standardising the early identification of acute kidney care	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN030	**THIS HAS BEEN REPLACED BY PSN055** **The safe storage of medicines: Cupboards**											
PSN031	Risk of Patient Safety Incidents resulting from errors in the British National Formulary for Children 2015-16 and British National Formulary 70	**31/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN032	Risk of Patient harm from an interaction between miconazole and coumarin anticoagulants	**10/06/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN033	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	**29/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN034	Supporting the introduction of the National Safety Standards for Invasive Procedures	**28/09/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A
PSN036	Reducing the risk of oxygen tubing being connected to airflow meters	**04/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN037	Resources to support the safety of girls and women who are being treated with Valproate	**06/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN035	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**16/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN038	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	**08/12/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN039	Safe Transfusion Practice - Use a bedside checklist	**15/02/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN040	Confirming removal or flushing of lines and cannulae after procedures	**12/09/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN041	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders harm	**23/04/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN042	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	**11/06/2018**	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN043	**THIS HAS BEEN REPLACED BY PSN049 Supporting the introduction of the Tracheostomy Guidelines for Wales**											
PSN044	Resources to support safer care for full-term babies	**21/10/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN045	Resources to support safer modification of food and fluid	**01/04/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN046	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN047	Management of life threatening bleeds from arteriovenous fistulae and grafts	**26/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN048	Risk of harm from inappropriate placement of pulse oximeter probes	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN049	**THIS NOTICE REPLACES PSN043 Supporting the introduction of the Tracheostomy Guidelines for Wales - Adults & Children**	**01/07/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN050	Assessment and management of babies who are accidentally dropped in hospital	**08/12/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN051	Depleted batteries in intraosseous injectors	**28/08/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN052	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**31/08/2020**	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Non-compliant	N/A	N/A
PSN053	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	**05/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN054	Risk of death from unintended administration of sodium nitrite	**12/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN055	THIS NOTICE REPLACES PSN030 Safe Storage of Medicines: Cupboards	**30/09/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Non-compliant	Compliant
PSN056	Foreign Body Aspiration during intubation, advanced airway management or ventilation	**01/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	**31/01/2022**	Compliant	Non-compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN058	Urgent assessment/treatment following ingestion of 'super strong' magnets	**13/10/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN059	Eliminating the risk of inadvertent connection to medical air via a flowmeter	**16/12/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN060	Reducing the risk of inadvertent administration of oral medication by the wrong route	**20/12/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN062	Elimination of bottles of liquefied phenol 80%	**25/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN061	Reducing the risk of patient harm - standardised strength of phenobarbital oral liquid	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN064	Handlebar injuries in the paediatric abdomen	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)	**31/03/2022**	Compliant	Compliant	Compliant	Non-compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

CHIEF OPERATING OFFICER'S REPORT ON OVERARCHING Q&S ISSUES WITHIN THE COO PORTFOLIO

Date of meeting	24 January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lucy Timlin, Head of Business Support
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Quality & Safety Meeting	September 2022	SUPPORTED
Quality & Safety Meeting	November 2022	SUPPORTED
Planned Care and Unscheduled Care Boards	Various	SUPPORTED

ACRONYMS	
HIW	Healthcare Inspectorate Wales
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POWH	Princess of Wales Hospital

YCC	Ysbyty Cwm Cynon
MIU	Minor Injuries Unit
SDEC	Same Day Emergency Care
ED	Emergency Department
WAST	Welsh Ambulance Service Trust

1. SITUATION / BACKGROUND

This brief paper provides an overarching update on a range of issues within the remit of the Chief Operating Officer.

In particular, committee members will recall that they have requested an update in the following areas due to their link to high scoring risks on the Risk Register. The areas include:

- Ophthalmology
- Stroke
- Planned Care – Waiting Times
- Unscheduled Care – ED, Ambulance Handovers Quality & Safety Impact
- Diagnostics
- Cancer
- LINC Programme Quality Update
- Red Release
- Internal Audit Follow Up Review – Patient Pathway Appointment Management Process report

These issues continue to provide a key focus for colleagues across the UHB. The full details of the matters outlined in this COO Report are covered in more depth within individual reports or available via the appropriate Department.

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

2.1 Ophthalmology Plan Update

Ophthalmology is a significant risk for the UHB and remains challenging. A range of actions are ongoing including:

- Super Saturday outpatient clinics, pre-assessment and operating lists for cataracts have been ongoing up to Christmas, aimed at clearing the number of patients currently waiting over 156 weeks on the inpatient and day case waiting list;
- Outsourcing of patients to the Nuffield Hospital continues, with further capacity being explored with two other providers;
- Validation work continues;
- The UHB has started using the Vanguard Theatre based at Cardiff and Vale – this will run until March 2003 with the UHB using 500 slots for cataract operations.
- In a major step forward, the additional Consultant with an interest in Glaucoma commenced in October and continues to settle in, with a second due to start early 2023.

Senior clinical and management colleagues met before Christmas with the aim of an open conversation around the challenges that continue within Ophthalmology. It is anticipated that steady progress will continue, though the targets remain difficult to achieve.

2.2 Stroke Plan

Committee members will be aware of the risk within Stroke Services, which highlights the potential for a prolonged wait for an appropriate bed if there is continued high demand for stroke beds across PCH and POWH sites. The risk register also highlights the resulting impact for patients in relation to a delay in appropriate treatment or therapy and also the fact that some stroke patients are also attending the Royal Glamorgan Hospital and then need to be transferred to one of the other sites.

In terms of update, a Stroke Task and Finish Group has been established under the management of the Urgent & Emergency Care (UEC) 6 Goals Programme. The Group has undertaken a further risk assessment of the pathway and ranked and rated the risks to prioritise the top risks, and then identified elements of the pathway that required further urgent investment in order to best mitigate the risk(s) and make the Stroke pathway safer and more resilient for patients, and optimize both short and longer term clinical outcomes.

It is anticipated that this assessment and the proposals will mitigate the risks in the longer term. In addition, meetings have taken place between colleagues from Cwm Taf Morgannwg and Cardiff and Vale University Health Boards to discuss the potential for regional working across the two Health Board areas, fitting in with the vision for stroke services across Wales, which is for the development of regional stroke centres functioning within regional stroke networks.

In the shorter term, the intention on both the POW and PCH sites to maintain a bed available within stroke units and to check on this through the 10am internal safety huddle, to ensure that flow of these patients is maintained – this has proved problematic at the time of current high demand.

2.3 Planned Care – Waiting Times

Planned Care waiting times remain a concern within CTM and other UHBs across Wales and are the subject of significant management focus.

Colleagues will be aware that there is a Planned Care Board that meets monthly to monitor the situation and ensure that all appropriate actions are taken as needed. The planned care programme is at present severely hampered by the number of admissions through the UHB's Emergency Departments – committee members will be aware of the efforts to maintain flow and thus protect elective capacity but this is a big challenge at present.

As described previously, it is anticipated that the length of time that patients are waiting will continue to reduce across all specialties, with patients being seen for first outpatients within two years within all specialties other than ENT, Urology, Ophthalmology and Dermatology. In each of these four specialties there are action plans to increase capacity, with actions including:

- Weekend clinics and theatre sessions in Ophthalmology and ENT;
- Recruitment of a Locum Consultant and additional pharmacy and primary care resource in Dermatology;
- Outsourcing. Since the start of the last financial year to date, CTM have sent 2,391 patients to be treated at Spire and Nuffield Hospitals;
- Validation in a range of areas commissioned by the National Planned Care recovery programme to provide administrative and telephone validation to all patients waiting over 52 weeks;
- Focus on waits currently showing in Rheumatology, Cardiology, Dermatology and Breast Surgery with transfer of patients across locality / consultant waiting lists;
- Additional clinics have been set up where possible – though staff are very fatigued and there is not always the appetite for additional working;
- Re-direction of Pain referrals to Wellness Improvement Service (WISE):
- Monitoring of general efficiencies;
- Additional inpatient and day case capacity will be in place between January and March through the insourcing of theatre staff enabling the centralisation of Orthopaedic inpatient activity and more concentrated DC capacity in PCH.

Further updates will be available in the next COO Report to colleagues on the committee.

2.4 Unscheduled Care and Six Goals Work

The work of the Programme Board for the Six Goals for Urgent and Emergency Care continues across a broad range of areas and projects. Key features include:

- The MIU has been successfully opened in YCC, which has been received well by the local population. Though successful, the anticipated effect on flow away from PCH has not been seen yet and the activity is in addition to what was being experienced there.

- Ward 16 has been opened as additional capacity at POWH, being used to support the Discharge 2 Recover and Assess pathway, where the UHB is currently seeing the largest number of "Ready to Leave" patients.

Work planned for implementation in January 2023 includes:

- Implementation of Discharge 2 Recover and Assess on 23 January.
- Launch of the new List View of the Electronic Whiteboard on 23 January
- Launch of Supported Discharge Notification/Electronic Transfer of Care Form on 23 January.
- Launch of the Optimal Hospital Patient Flow Framework.

Looking further ahead, there are plans to look at:

- Embedding Medical Same Day Emergency Care (SDEC) across the three acute sites.
- Launching Hot Clinics to support 'safety netting' of patients discharged from EDs.

Future progress will be reported at forthcoming meetings including the Quality & Safety Committee.

2.5 Ambulance Handover Delays

Following on from very significant issues around long waits for ambulances, an operational response plan has been developed which includes timescales and rigorous review on a regular basis.

Issues of note include:

- A Handover Delay plan has now been absorbed in to the Unscheduled Care Group for delivery and monitoring arrangements. There is an

expectation to deliver on no ambulances waiting in excess of four hours to hand over a patient;
- Expectations have been set that there will be a zero tolerance approach taken to immediate release declines;
- Work is ongoing through the ED Task and Finish Group to support clinical decision making – this includes standard principles for ED staff to follow;
- As part of the Six Goals Programme, a "Navigation Hub" has been set up through our Primary Care Leads. This allows WAST, Nursing Homes and other professionals direct access to a GP with the aim of 'safety netting' and keeping patients in the community;
- Pre-Emptive Boarding Standard Operating Procedures are now in draft to support the early conveyance of patients to wards and the subsequent decongestion of the Emergency Departments;
- Across the three acute sites, in excess of 80 additional surge spaces are currently open and utilised with the aim of supporting flow and minimising ambulance delays;
- Conversely, there are in excess of 150 patients across CTM who are ready to leave the organisation, waiting on either a care home placement or package of care. Work continues with Local Authority colleagues to mitigate this.

The work ongoing in this area is significant and this is a summary of the key areas – further information is available if needed.

2.6 Diagnostics

The highest scoring risk are within Pathology, where actions taken include:

- Mortuary Capacity – to address issues around insufficient capacity, an SBAR was given Executive approval at the end of November 2022. The approval involves a five year lease of additional space that will be Human Tissue Authority (HTA) compliant to be located at the Prince Charles Hospital site by the end of January 2023.

  In addition, colleagues within Pathology have negotiated with local funeral directors for additional space – which was used over the holiday period successfully. Aneurin Bevan UHB has also co-operated with CTM with additional requirements. It is likely that these actions will reduce the risks reported significantly by the end of January 2023.

- Pathology services unable to meet current workload demands – the backlog position in early 2022 was a significant risk to the organisation. To address this risk, the Directorate has undertaken the following:

- The Planned Care Recovery scheme agreed to outsource cell path backlog (non-Cancer to focus on cancer tests in house) has been successful and continues to bolster the shortfall in core capacity. A further bid will need to be approved to outsource in 2023 through planned care recovery to a similar level;

- The focus on achieving 10 days turnaround time has been largely successful (some samples that require additional testing / genomics will take a bit longer).

Until a regional solution is agreed, it is anticipated that further approvals as above will maintain the mitigations within this risk.

- Cellular Pathology & Mortuary staff resource, backlog and delays – a variety of actions have been taken or are in play. Vacant posts have been placed on TRAC and scrutiny panel approval is awaited, savings in drug spend will be considered as a saving for CRES and also bolstering a sustainable lab service, the job planning process will be concluded for consultants.

  In addition, consideration will be given to PA and dissection practitioner roles to modernise the workforce and a joint bid with Cardiff and Vale for Cancer Network allocation to support Cardiff 7 days working and providing some capacity for CTM is underway

  It is likely that these developments will reduce the risk by the end of March 2023, though further work will be needed.

2.7 Cancer

In line with the planned care position, cancer services and the achievement of targets are a considerable problem for the UHB and its patients - the breakdown by specialty is outlined below.

CTMUHB	SCP Cases 62-90 days	SCP Cases 91-104 days	SCP Cases >104 days
Head and neck	13	1	4
Upper GI	49	14	22
Lower GI	130	54	91
Lung	17	3	5
Sarcoma			2
Skin (exc BCC)	27	6	14
Breast	19	4	4
Gynaecological	41	9	16
Urological	91	31	72
Haematological	11	5	4
Other	4		1
Grand Total	402	127	235

In terms of actions being undertaken to improve the position and achieve the position, the main activities are as follows:

- Deep Dive analysis of each specialty / sub-specialty has commenced and action plans from each work-stream are being developed, there will be a specific focus on Endoscopy, GI, Urology and Breast
- Following the deep dive analysis a comprehensive Endoscopy action plan across the three sites is being developed for sign off with an Endoscopy working sub group with actions focused on equity of delivery across three sites;
- CTM has successfully tendered for £80K for additional Endoscopy activity for cancer pathways between January and March this year. Plans are now being developed.
- A separate Cancer Action Plan has been developed to support each specialty, to incorporate the actions from the Cancer Deep Dives and support discussion and collaborative working with NHS Wales Delivery Unit;
- A revised weekly Cancer Assurance cycle with an emphasis on recovery of trajectory and support for delivery of cancer pathways has been in place since November 2022. The focus is specifically on reducing backlog and patients with a confirmed cancer to ensure plans are in place and expedited to their treatment;
- The Health Board Executive for Cancer has prioritised resources for demand and capacity analysis for cancer pathway delivery to inform and support decision making and planning;
- Breast recovery plans continue to improve, with noted improvements in relation to total volumes. Additional theatre lists are required and mutual aid is being discussed;
- The breast unit launch is planned for this month;
- Development and agreed implementation of best practice Lower GI pathway and implementation of FiT prior to SCP referral;
- Outsourcing of Local Anaesthetic Perineal Biopsy (LAPB) procedures commenced 2nd December 2022;
- Merging of Urology MDTs and streamlining of processes and pathways;
- Outsourcing in pathology continues with improved waiting times noted at each cancer assurance meeting.

2.8 Pathology: LINC Quality Update

This, a failure to deliver a replacement Laboratory Information Management System (LINC), is an area where committee members sought particular assurance. Citadel Health was contracted in October 2021 to Design, Build and Operate a new LIMS Service for NHS Wales.

The Programme is currently in its second phase which will develop, test and validate the new Service. Local deployment projects (LDPs) have been set up to support this and prepare for deployment/rollout of the new LIMS during the third phase, currently contracted for completion at the end of 2024.

By way of mitigation, the following is noteable:

- CTM is part of the National programme group to input and advise on issues throughout the programme work.
- IT senior involvement has been maintained to consider IT risks with current different systems in CTM which will need to align. (IT changes linked to SLA with Swansea Bay)
- More involved local deployment workshops to be setup in Q1 of 2023.

The planned rollout for CTM is between September and October 2024. The risk will not reduce until plans are further defined.

2.9 Red Release

Summary data from 01 July 2022 to 31 December 2022 is as follows

Priority	Hospital Health Board	Hospital Name	Accepted	Not Accepted	Total
RED	Cwm Taf Morgannwg	Prince Charles Hospital Merthyr	108	10	**118**
		Princess Of Wales Hospital Bridgend	27	76	**103**
		Royal Glamorgan Hospital Pontyclun	91	20	**111**
		Total	**226**	**106**	**332**

Colleagues will be pleased to note the progress made recently:

- New red release Standard Operating Policies have been agreed and implemented across all three DGH sites. Though this has standardised practice, the UHB is yet to see the step change in performance anticipated, given the current acute exit block and poor flow;
- A Pre-Emptive Boarding Standard Operating procedure has been implemented to improve flow out of ED to allow for red release request;
- Further surge capacity opened across all three sites to improve flow and capacity to red release.
- Targeted work will start this month in POW with the aim of seeing where improvements can be made and rolled out across the UHB.

Further updates will be available – committee members will understand that the activity on site at present is a constraining factor.

2.10 Internal Audit Follow Up Review – Patient Pathway Appointment Management Process

The follow up of this audit remains a work in progress – given the operational pressures it has not had as high a profile as the UHB would wish.

Meetings have been held by the COO's Office with colleagues in Internal Audit, who have kindly provided some support. The Head of Business Support has isolated the three remaining recommendations where work is needed and it is anticipated that at the time of the next Quality & Safety Committee meeting there will be significant progress to report. The work needed is fairly straightforward and just requires the time for contacts to be made.

It has been agreed that given the operational pressures at present that the re-audit will be pushed forward.

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

A summary of the key areas of risk / matters for escalation for the COO's portfolio continue to be as follows:

- Planned Care Recovery;
- Cancer Services and the imperative to improve performance in all areas;
- The activity in and challenge for the Emergency Departments across the Health Board.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The paper considers a number of key quality, safety and patient experience issues
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet completed
Legal implications / impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential legal impact.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential financial impact.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

Members of the Committee are asked to **NOTE** the content of this review.

AGENDA ITEM
6.5

QUALITY AND SAFETY COMMITTEE

Monitoring and Reporting CHC FNC

Date of meeting	24th January 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Sian Lewis, Lead Nurse CHC FNC & Mark Abraham, Head of MHLD Commissioning
Presented by	Ana Llewellyn, Nurse Director
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
MH&LD QSRE	7.12.22	ENDORSED FOR APPROVAL
Primary Care Communities QSRE	9.12.22	ENDORSED FOR APPROVAL

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
SB UHB	Swansea Bay University Health Board
MH	Mental Health

LD	Learning Disabilities
ABI	Acquired Brain Injury
CHC	Continuing Health Care
DHCW	Digital Health and Care Wales
ED	Emergency Department
FNC	Funded Nursing Care
CQC	Care Quality Commission
AWF	All Wales Framework
MAOG	Multiagency Operational Group
SOP	Standard Operating Procedure
LRI	Locally Reportable Incident
NRI	Nationally Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide members with an update on quality, safety, risk and experience issues in Continuing Health Care services provided across Cwm Taf Morgannwg University Health Board.

1.2 This report reflects the QSRE issues for the period of September and October 2022. For the purpose of this report, the scope of Continuing Health Care (CHC) is inclusive of packages of care commissioned by the Health Board for individuals who are eligible for Continuing Health Care, Funded Nursing Care (FNC), S117 Aftercare and other joint health and social care packages.

1.3 CHC is provided across a range of settings including in hospitals, care homes and domiciliary care at home.

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

CHC Governance arrangements

2.1 Continuing Health Care services are delivered and monitored through the following areas, Adult, Children and Mental Health (MH) and Learning Disabilities (LD).

2.2 Adult and Children are responsible to the Primary Care and Communities Service Group and MH&LD through the MH&LD Service Group. Each service group has its respective QSRE meetings held every 2 months to report, discuss and seek assurance on matters relating to CHC in these areas. Each Service Group has a monthly cycle of Clinical Placement Panels whereby individual packages are scrutinised, approved and financed.

2.3 A revised structure for monthly Clinical Placement Panels to reflect the new operating model has been implemented. The Clinical Placement Panels monitor the Quality and Safety reviews which are completed 3 months after the care package commences and annual reviews thereafter. More focused reviews are completed in response to changes in individual needs or risk.

2.4 There is a regional approach to responding to concerns within the Care Homes and Domiciliary care providers in CTM UHB in line with the national guidance on managing 'Escalating Concerns', known locally as the Multi Agency Operational Group (MAOG). This is a collaboration between Local Authorities (LA), the Health Board, Safeguarding and Care Inspectorate Wales (CIW) established to review the governance of the providers operating in the region.

2.5 Services commissioned by CTM UHB that are located outside of CTM UHB will have similar arrangements for the same purpose. All regulated services in Wales and England including hospitals, care homes have a statutory duty to report and investigate concerns within their services. Notifications are required to both the regulatory bodies and commissioners of services to monitor. The All Wales Framework (AWF) for Mental Health and Learning Disabilities provides additional monitoring arrangements of all services commissioned via the AWF and is undertaken by the National Collaborative Commissioning Unit in NHS Wales.

2.6 The National Policy on Patient Safety Incident Reporting & Management has been published for consultation. This Policy includes a dedicated section on 'Incidents occurring to patients in receipt of commissioned services'. The Care Group Governance and CHC leads will meet with the CTM Head of Concerns in January 2023 to consider the application of the Policy and implementation of the Datix Cymru system in commissioned services.

Internal Quality Assurance

2.7 The table below provides an overview of the total volume and cost of CHC packages commissioned by area for September and October 2022. The monthly changes in volume articulated through death/discharges and new packages.
NB: These figures do not include FNC cases.

Care Group	2022/23 Forecast of Current Packages £	Number of Current Packages	D & D	New Packages
	September M6			
CYP	139,700	3	0	0
PC&C	13,706,677	222	15	14
MH&LD	36,448,452	570	17	21
Grand Total	**50,294,829**	**795**	**32**	**35**
	October M7			
CYP	139,700	3	0	0
PC&C	13,659,653	217	22	17
MH&LD	36,224,867	574	27	31
Grand Total	**50,024,220**	**794**	**49**	**48**

2.8 In the report period of September and October 2022 there were no new or open formal complaints under review by the CHC services.

2.9 There were no new LRI's or NRI's reported in the same period.
One NRI for MH&LD remains open subject to safeguarding proceedings.

2.10 There have been 5 compliments reported in CHC services during the report period. 3 in Adult CHC services and 2 in MH&LD. No formal complaints recorded in this period.

2.11 In response to the EdenField Hospital Panorama documentary which exposed significant failings in secure care NHS England, the CTM MH&LD commissioning team undertook a review of the inpatient population in Independent Hospitals, due to similarities in the provision commissioned by CTM UHB. This review found that there were a number of commissioning reviews that had not been completed within CTM's timescales. All outstanding commissioning reviews were completed by 1st December 2022. No clinical or safeguarding concerns were identified for CTM patients receiving commissioned inpatient care.

2.12 Welsh Government, in response to the national report 'Improving Care Improving Lives' (NCCU 2020) commissioned the Delivery Unit to undertake a quarterly review of the national and local population of people with LD receiving specialist MH inpatient care. The CTM audit return completed in September 2022 identified a continued reduction of inpatients in line with the Welsh Government and CTM strategic direction. All patients identified in the audit are receiving inpatient care either in SBUHB beds or in a single independent provider located in South Wales.

External Quality Assurance

2.13 **Escalating Concerns** (*multiagency response for commissioned services of concern)*

2.14 In the report period, there were 3 Care Homes within the CTM footprint subject to enhanced monitoring under MAOG arrangements, 2 in RCT and 1 in Bridgend. This enhanced monitoring resulted in a temporary embargo with admissions to 2 homes.

2.15 A Specialist MH Care Home in Preston resumed normal monitoring arrangements by CQC. CTM have one resident there and last site visit undertaken on 21st October 2022. There were no concerns identified during this visit.

2.16 One Nursing Care Home closed in RCT in September 2022 resulting in 31 residents requiring alternative care home provision at short notice. This is the second Nursing Care Home to close in RCT in 2022.

2.17 **All Wales Framework (AWF)** (*covers MH&LD hospitals and some care homes across Wales and England).*

2.18 In the report period, there are two female secure hospitals subject to enhanced monitoring through the AWF by NHS Wales. CTM currently commissions care for 6 female patients across the 2 sites, 1 in Wales and the other in England. Progress is monitored through weekly Commissioning Clinical Business Meetings and quarterly through intelligence sharing events coordinated by NHS Wales.

2.19 Female provision is limited to 1 hospital in Wales located in the CTM UHB footprint and thus alternative provision is very limited.

2.20 **Safeguarding** – (*referrals that have met threshold for investigation*)

2.21 Given the geographical spread of services across multiple safeguarding teams and joint commissioning arrangements there is no one single reporting method, therefore the total number of referrals is not centrally available.

2.22 When CHC services are notified of safeguarding concerns, they participate with its partners through the statutory arrangements. Referral themes in report period include patient safety incidents, staffing levels and allegations of abuse by staff employed by the providers. Individual incidents and themes are reported and monitored through existing MOAG arrangements.

2.23 **External Audit**

2.24 The last CTM UHB Audit of CHC was undertaken by NHS Wales Audit and Assurance services in 2021 and published in early 2022. CTM UHB Audit & Risk Committee monitors the action plan, which responds to the audit findings. There was 1 red action outstanding which relates to the 'Monitoring and Reporting of CHC' which this report seeks to address. The 4 remaining amber actions are scheduled for completion by February 2023.

Quality Planning and Improvement

2.25 A revised CHC Framework for Wales was published in 2022. CHC teams have undertaken a review of the existing documentation to support the new process. Updated documentation has been published via a dedicated SharePoint page to assist with implementation. A CHC training program has been devised and

following positive recruitment delivery has commenced and will be ongoing across the Health Board and Local Authorities.

2.26 The care home forums for matrons has been reinstated. This meets on a quarterly basis and is well attended, offering opportunities for guest speakers, sharing support, and good practice across all the homes with CTM.

2.27 An enhanced supported living project Elm Rd went live. This was a joint RCT, CTM & SB UHB development, benefiting five people with LD and complex needs. Residents took up tenancies throughout Sept and November 2022, reducing dependence on specialist residential services.

2.28 The new operating model provides further opportunities to strengthen existing CHC commissioning arrangements. One of the priority programmes in CTM2030's 'Sustaining Our Future' goals is Contracting and Commissioning. The Deputy COO for MHLD, Primary and Communities Care Group is leading on a number of strategic priorities relating to CHC. Some of the keys areas to be addressed through this work include:

- demand and capacity of CHC: packages of care and CTM team infrastructure
- review of existing and new provision
- review CHC information systems
- implementation of revised CHC framework
- joint commissioning arrangements under S117 Aftercare
- review of the financial scheme of delegation
- development of alternative approaches for women presenting with complex trauma

2.29 There are multiple and complex arrangements for the management of CHC information which impede the oversight of CHC quality, finance and performance and prevent effective future planning of services. A national system, which has significant limitations and is no longer supported by DHCW has resulted in Health Board teams relying on the development of multiple spreadsheets. Addressing this is a priority for CTM as it underpins all of the wider improvement work.

2.30 Although national solutions are being sought, in order to avoid further delay the Health Board has commenced work on process mapping the internal arrangements. This work will be completed by

1st March 2023 and will make recommendations on potential information system arrangements for CTM.

Quality Improvement and People's Experience

2.31 The CHC Teams in line with The Health and Social Care, (quality and engagement) Act 2020, are undertaking a review of available patient focused outcome measures, with the intention of embedding them into service reviews and the joint contract with the Local Authorities during 2023.

2.32 CHC 3 month and annual reviews will include a specific focus on people's experience in 2023, to be able to prove more robust experience data going forward.

2.33 Patient stories will be used to highlight areas of practice and learning in CHC services.

2.34 Other examples of more specific work to improve patient outcomes are underway including:

- Working with providers and families to develop crisis contingency plans for people receiving domiciliary care packages during adverse conditions.

- MHLD Commissioning Team working with RGH ED, Gastroenterology Consultants to review Acute hospital attendance by patients from local Independent Secure Hospital with the aim of devising an 'Attendance and Escalation Protocol' for those requiring emergency department interventions, in response to a 3-fold increase of attendance since 2019.

3. KEY RISKS/MATTERS FOR ESCALATION

3.1 There are two risks on the service risk register:

- the single record system for CHC, that has been detailed earlier in the report
- CHC team capacity

3.2 The capacity of the CHC teams has been challenged over the last two years due to competing demands: supporting patient flow, reviewing compliance and escalating concerns, as well as supporting the implementation of Delayed Pathways of Care and Discharge to

Recover and Assess. More recently additional CHC workload arising from the Court of Protection has affected service delivery and ability to maintain timely compliance with reviews. CHC services have engaged with the Health Board group reviewing the current arrangements. A review of team scope and infrastructure will be completed by the end of February 2023 and will be reported to the CTM2030 Sustaining Our Future Programme Board.

3.3 There is an additional risk on the organisational risk register that will be familiar to committee members: the quality and safety impact of national workforce issues and potential financial sustainability on the independent hospital and care home sector. This risk is titled 'Care Home Capacity' (Datix Risk ID 5207) on the organisational risk register and has a risk score of 15.

3.4 Committee members are asked to note the risks and the actions underway to address them.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report provides an overview of safeguarding issues and the management of escalating concerns in packages of care that are commissioned by the Health Board.
Related Health and Care standard(s)	Safe Care
	Safe and Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered required in the box below.
	There is no requirement for an EIA as there are no proposals for new, changed or withdrawn services
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.

	The workload associated with the Court of Protection is referenced in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	Commissioned services are resource intensive. There are no additional financial implications referenced in the report. There are workforce references in the report – the capacity of the CTM commissioning team and the workforce challenges in the independent sector.
Link to Strategic Goals	Sustaining our Future

5. RECOMMENDATION

5.1 Members are asked to **NOTE** this report.

AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

DEEP DIVE INTO CAMHS REPORT

Date of meeting	24/01/23
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing Lisa Davies, Clinical Service Group Manager, CAMHS
Presented by	Ana Llewellyn, Nurse Director – Primary Care, Community and Mental Health
Executive Lead	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CTMUHB	Cwm Taf Morgannwg University Health Board

EDOS	Eating Disorder Outreach Service
FACTS	Forensic Assessment and Consultation Team
HoN	Head of Nursing
ILG	Integrated Locality Group
LRI	Locally Reportable Incident
MHM	Mental Health Measure
NEST	Nuturing, Empowering, Safe and Trusted
NRI	Nationally Reportable Incident
PPF	Planning Performance and Finance Committee
SI	Serious Incident
SPOA	Single Point of Access
TL	Ty Llidiard, Tier 4 Inpatient Unit based in POW
WHSSC	Welsh Health Specialised Services Committee
WLI	Waiting List Initiative
YP	Young People/Person

1. SITUATION/BACKGROUND

1.1. The purpose of this report is to provide members with an update on quality, safety, risk and experience issues in CAMHS services within Cwm Taf Morgannwg University Health Board (CTMUHB).

1.2. The CAMH Clinical Service Group is made of up 3 main groups of services: Cwm Taf Morgannwg Community CAMHS; Swansea Bay Community CAMHS and Tier 4 National and Regional CAMH Services

1.3. The Cwm Taf Morgannwg Community CAMHS contains the following services:

- Single Point of Access team (SPOA)
- Primary CAMHS
- Secondary (Specialist) CAMHS
- Crisis Team
- CIIT (Community Intensive Interventions) Team
- Eating Disorder Team
- Schools In Reach Team
- Young Persons Drug and Alcohol Service (YPDAS)
- Learning Disability Service (Regional)

1.4. The Swansea Bay Community CAMHS contains the following services:

- Single Point of Access team (SPOA)
- MHM Part 1 Team – Assessment and Treatment Team
- MHM Part 2 Team which includes;
    - Secondary Specialist Team
    - Eating Disorder Team
    - Youth Offending and Forensic Team
- Crisis Team
- Schools In Reach Team

1.5. Tier 4 National/Regional Services contains the following services:

- The 15 bed Tier 4 General Admission Unit "Ty Llidiard" (TL) at Princess of Wales Hospital
- The All Wales FACTS team based in TL
- The South Wales EDOS team based at TL

1.6. Over the last year the CAMHS CSG has focused on implementing improvements in Ty Llidiard, Swansea Bay Community CAMHS and FACTS; as these services are now improving the leadership team focus is shifting to performance in CTM Community CAMHS. Performance against the MHM has been declining and this paper provides further information regarding the reasons for this but also the actions identified to support improvement.

1.7. This report to committee will provide an overview of progress for the key service areas but given that there is a separate report to committee on TL progress, that will not be covered in any detail in this report.

1.8. Committee members are reminded that MHM performance is reported via PPF committee. Given that access to services has potential consequences for quality, outcome and experience a detailed overview has been included in this report.

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

2.1. Internal Quality Assurance

2.1.1. CAMHS transitioned from Bridgend ILG to the Mental Health and Learning Disabilities Care Group in September 2022 as part of the CTM operating model changes. The ILG had been engaging in enhanced internal monitoring due to issues of culture, performance and quality across the service. Due to significant progress in Swansea CAMHS, TL and FACTS the service transitioned into the care group with routine internal monitoring.

2.1.2. The CAMHS leadership team attended their first care group integrated performance meeting on 4 January 2023.

2.2. Putting Things Right

2.2.1. Outside of the in-patient service, CAMHS report fewer than five incidents each month. There are no identifiable themes to note.

2.2.2. There were no LRI or NRIs reported during this period for community services. There is 1 open LRI, which is overdue but has been completed and awaiting final sign off.

2.2.3. The CAMH community services receive a small number of complaints ranging from none to 9 per month over the last year.

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Complaint response rate	100%	0%	0%	100%	67%	30%	30%
No of formal complaints open	3	0	3	5	8	4	2
Within 30 days	1	0	2	4	7	1	1
Over 30 days	2	0	1	1	1	3	1
Over 6 mths	0	0	0	0	0	0	0

Chart 1

2.2.4. Complaint response delays are either associated with the complexity of the concern or due to issues of quality assurance. The quality and safety team has identified a complaint response writing training need in CAMHS. This training has been delayed due to capacity within the quality and safety team but is planned to be delivered by the end of March 2023.

2.2.5. A small number of compliments are recorded on datix. However the leadership team have confidence that the number of compliments is much higher. In order to aid learning from what goes well, the CSG is working to promote all staff to share and report compliments.

Compliments	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Accum
Number received	1	1	3	4	2	2	4	17

Chart 2

2.2.6. An example of a compliments received by our CTM Schools In reach Emotional Wellbeing Service (Shine) is included here with consent from the school and the person receiving the compliment:

> *"When I arrived at ***** High school this week, the Headmaster and a member of the Board of Governors were awaiting my arrival at reception. The Head teacher shook my hand and thanked me for the service we have provided to his school thus far through our Schools In reach Service. We chatted about the good feedback he had received from staff in regards to staff training we had developed and delivered at their recent inset day. The Governor further mentioned that he had ring-fenced some money to put some cover staff in place so that other staff could also have the opportunity to be released from their teaching duties to undertake our training."*

2.2.7. There are no current open ombudsman cases.

2.2.8. There are no current open claims or redress cases.

2.3. Swansea Bay Community CAMHS Progress

2.3.1. In late 2020 concerns were raised about the culture of Swansea Bay Community CAMHS which subsequently led to recruitment and performance issues.

2.3.2. In April 2022 Swansea Bay University Health Board (UHB) commissioned an independent review of Swansea Bay CAMHS and the commissioning arrangements for the service. This included input from colleagues within the Swansea Bay CAMH service. The review resulted in an options appraisal around the potential future commissioning and provision of Swansea Bay CAMH service. Swansea Bay UHB supported the preferred option of repatriating Swansea Bay CAMHS to be provided within the organisational structure of Swansea Bay UHB. This proposal has been agreed with CTM UHB and the service will transfer from the 1st April 2023.

2.3.3. The review reflected that there had been improvement in the leadership of the service more recently. Swansea Bay CAMHS has also implemented a new clinical model based around the functions of the MHM. There has been an improvement in recruitment and retention of the service.

2.3.4. Alongside the improvement in leadership and recruitment to the workforce there has been a significant improvement in performance against the MHM. The waiting list for first assessment has reduced from approx. 460 patients waiting longer than 6 months for appointments to a sustained approximately 100 patients in last few months with over 80% waiting less than 4 weeks for assessment. This is demonstrated in the following graph:

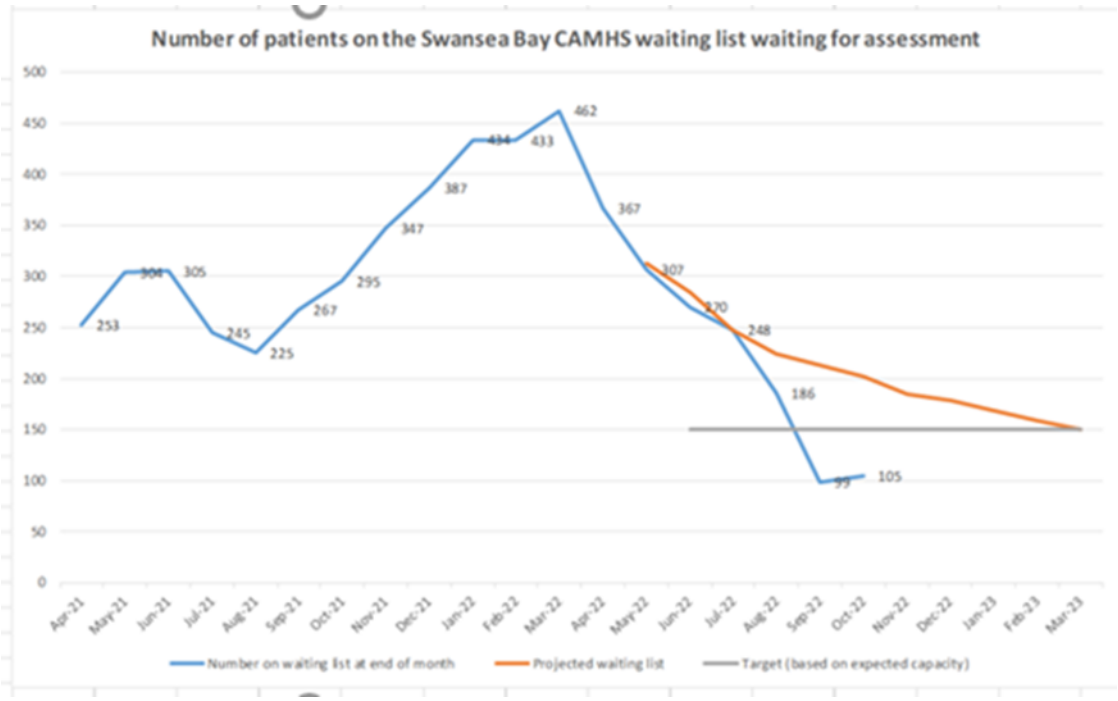


Chart 3

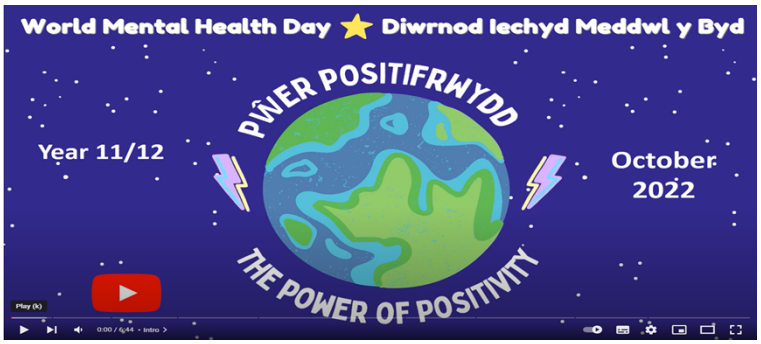
2.3.5. The CAMH service has implemented group therapy to support with those waiting for interventions, and this has used innovative approaches with art therapy as well as the development of parent courses. There has also been improved relationships and working with third sector organisations such as Platform. The service has implemented a referral system for those seen by the Crisis Team where they are automatically given an appointment within a week where appropriate for onward referral/support.

2.3.6. With the implementation of the new service model based around the functions of the MHM, there is a clear interface and approach for identifying patients that meet Part 2 of the measure. This has ensured that the service has maintained compliance with Part 2 of the MHM.

2.3.7. Swansea Bay CAMHS service are working collaboratively with their Primary Care stakeholders to develop the primary care liaison service. This will involve a CAMHS Practitioner working within the GP clusters to support GP's, families and YP with early intervention and appropriate signposting. It is anticipated this will help reduce the number of inappropriate referrals to SPOA. GP clusters are working closely with CAMHS to develop the pilot and the reporting systems.

2.3.8. Swansea Bay CAMHS has been working closely with Swansea Bay UHB and third sector services to develop a sanctuary service pilot to support YP in emotional crisis to aim to avoid admission to hospital. The aim for this is to be live around April 2023.

2.3.9. The Schools In-reach team produced a series of YouTube videos for World Mental Health day on "The Power of Positivity" and are planning to continue to use various social media channels to promote their service and offer help and advice to YP and their families.



The videos can be viewed here: https://www.youtube.com/channel/UCwBDb1VX80A0e91MNHT1MrA/videos

2.4. **Tier 4 National and Regional Services Progress**

2.4.1. **Ty Llidiard Update**

2.4.1.1. There is a TL specific paper also being presented at this meeting, therefore TL will not be discussed in detail in this paper.

2.4.2. **The All Wales FACTS Update**

2.4.2.1. The FACT service provides an all Wales, highly specialist consultation and treatment service to CAMHS, with the care and treatment of children and young people who, in the context of mental disorders or significant adversity/trauma and related severe psychological difficulties, present a serious risk to others.

2.4.2.2. The service was placed into formal escalation arrangements with WHSSC in October 2020 due to concerns of service sustainability with recruitment and retention issues and a reported lack of access to resources.

2.4.2.3. Since the service was placed into escalation with WHSSC, there has been successful recruitment into psychology posts and more recently into a substantive consultant position. The CAMHS leadership team have reviewed the funding of the service and agreed some new posts into the service including developing a new role to support with the implementation of Enhanced Case management

2.4.2.4. The FACT service has been working with the Youth Justice Blueprint Board in the development and implementation of Enhanced Case

Management. This has been received positively with demand increasing across local youth offending teams. Youth Justice Teams in England are now looking to implement a similar approach to Enhanced Case Management.

2.4.2.5. The CAMHS leadership team have worked closely with WHSSC to develop the service specification for FACT. This is currently out to consultation.

2.4.2.6. Due to improvement in both recruitment and retention and access to resources, WHSSC have confirmed that FACTS has been deescalated in December 2022 and will no longer be subject to any additional monitoring.

2.4.3. The South Wales EDOS team

2.4.3.1. Alongside the quality improvement taken place in Ty Llidiard, the EDOS team has developed improved working relationships with the inpatient unit. This has resulted in EDOS supporting multi-therapy groups for patients and their families in the unit. There are plans to explore the use of space in the unit to run some of the community multi-therapy groups.

2.4.3.2. The team are currently recruiting into some new posts due to vacancies from team members getting promotion and retirement. This is also giving the service the opportunity to review and adapt the service provided, particularly as there has been increased investment in community eating disorder services in recent years.

2.4.3.3. Working alongside the Clinical Director for CAMHS, EDOS are scoping a proposal and potential business case for establishing a day unit for patients with eating disorders. This is in line with WHSSC strategy.

2.4.3.4. EDOS is hosting a South Wales Eating Disorder away day in February 2023.

2.4.4. CTM Community CAMHS Progress

2.4.4.1. CTM Community CAMHS has been working closely with the Whole Schools Approach and has used the NEST model to design and implement the CAMHS Schools In-reach service from September 2022. This initial implementation has involved piloting the service in 40 schools across the CTM UHB footprint. The service is receiving

positive feedback from the initial schools and plans to roll out to the next cohort of schools in early 2023.

2.4.4.2. There has been successful recruitment into a couple of CAMHS consultant posts in the last couple of months, which is an area that regionally has been difficult to recruit into.

2.4.4.3. Alongside improvement in recruiting into consultant positions, the Welsh Child and Adolescent Specialist Training Scheme has also received exceptional high scoring responses and we have been reported as an exceptional 'above outlier' for training for specialist trainees. The service has also seen improvement in the number of training positions filled.

2.4.4.4. The crisis team in CTM Community CAMHS has extended its hours to provide 24 hour service offer 5 days a week. The remaining 2 days will go 24 hours once there is recruitment into the remaining vacancy in the service.

2.4.4.5. The Clinical Lead for CAMHS has been working collaboratively with adult mental health teams to develop a transition policy to support a seamless approach to transition between CAMHS and adult mental health services.

2.4.4.6. Following funding from the Mental Health Service Improvement Funding 2023/24, the CAMH service has recruited into new primary care liaison roles to support with managing demand and providing additional support and consultation to primary care colleagues. Roadshows have started and engagement with primary care clusters. A professional contact line will be implemented by March 2023 alongside the use of consultant connect.

2.4.5. Deep Dive into CTM CAMHS Performance against the Mental Health Measure (MHM)

2.4.5.1. Whilst the Clinical Service Group has made good improvements in a number of the services provided, it is acknowledged that performance against the MHM for CTM Community CAMHS has deteriorated over 2022. This is now the priority area for improvement for the service group.

2.4.5.2. In 2021 a SPOA was developed for CTM CAMHS to ensure oversight of all referrals into the service. Whilst this has streamlined access for referrers it has resulted in the smaller number of children and

young people requiring secondary care mental health services being included in Part 1 performance data. There is further work for the service to do to clearly delineate service provision for children and young people once they have been assessed.

2.4.5.3. CTM CAMHS Performance for Part 1a of the MHM in November 2022 was 29% which has reduced compared to the previous month. The following graph shows the performance since April 2020 and shows variation between 20% and 40% on a monthly basis falling short of the performance target of 80%:

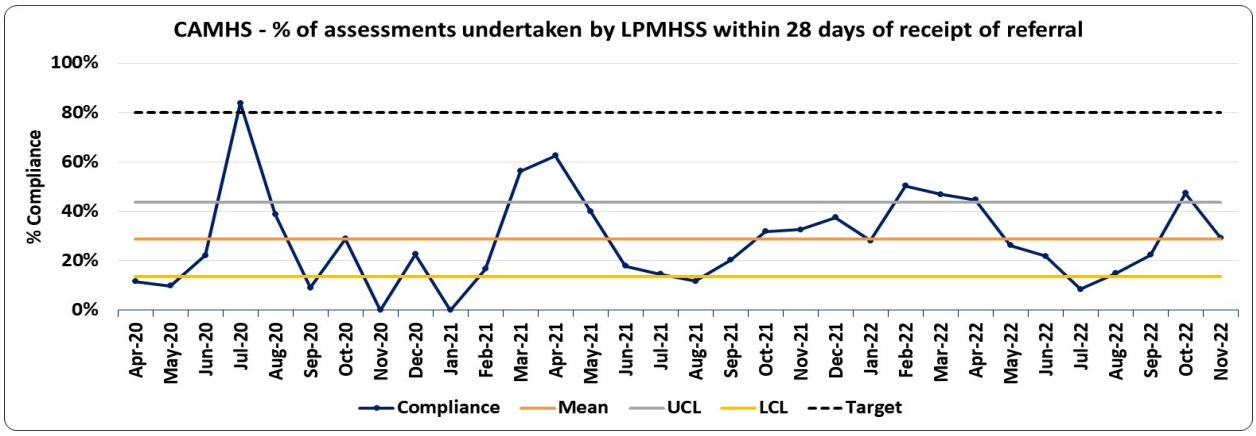


Chart 4

2.4.5.4. The poor compliance with Part 1a is linked to greater demand for CAMHS assessments compared to capacity and activity within the service. As a result there is a significant backlog of patients on the waiting list waiting longer than 28 days. All referrals received by the service are reported against Part 1 of the MHM.

2.4.5.5. The following graph shows the monthly referrals received against the assessment activity demonstrating the shortfall in capacity:

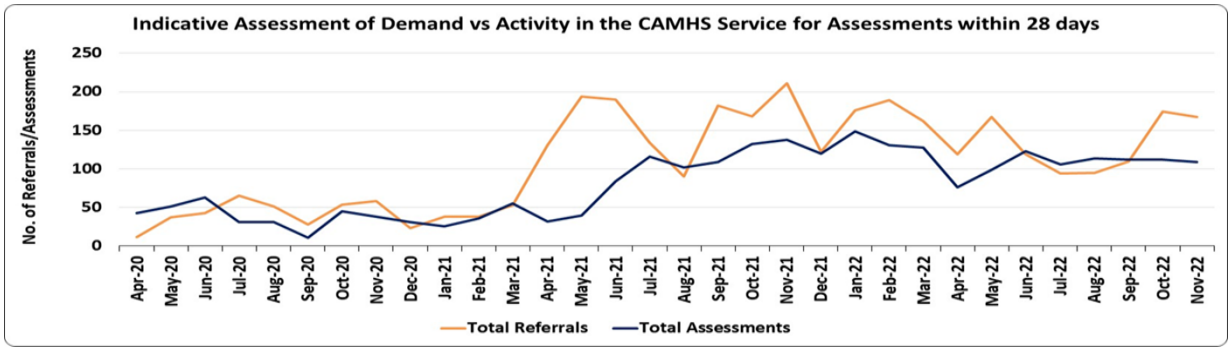


Chart 5

2.4.5.6. There was good progress over the summer period to provide more assessments than referrals received for the service, and the waiting list reduced to an average 3 week wait. However since the schools have started back there has been a sharp increase in referrals since October which has outstripped the capacity in the service and the overall waiting list has increased as a result as show in the following graph:

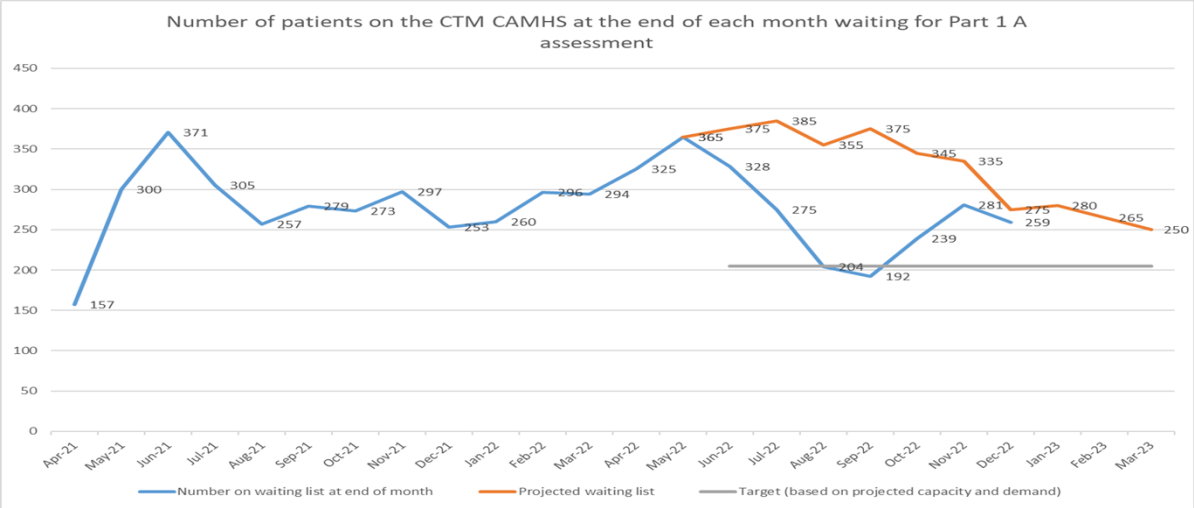


Chart 6

2.4.5.7. The longest wait for an assessment under Part 1A is 13 weeks.

2.4.5.8. It is anticipated that the implementation of the Whole School Approach and the Schools In-reach service will support the management of demand for CAMHS. As the service was only implemented in September 2022 and to a pilot of 40 schools it is recognised that it might be too early to benefit from this new service provision. Data is being collected to determine the impact of the service on wider CAMHS referrals and will continue to be monitored.

2.4.5.9. CTM CAMHS Performance for Part 1b of the MHM in November 2022 reduced to 22% which is the lowest reported performance over the last two years:

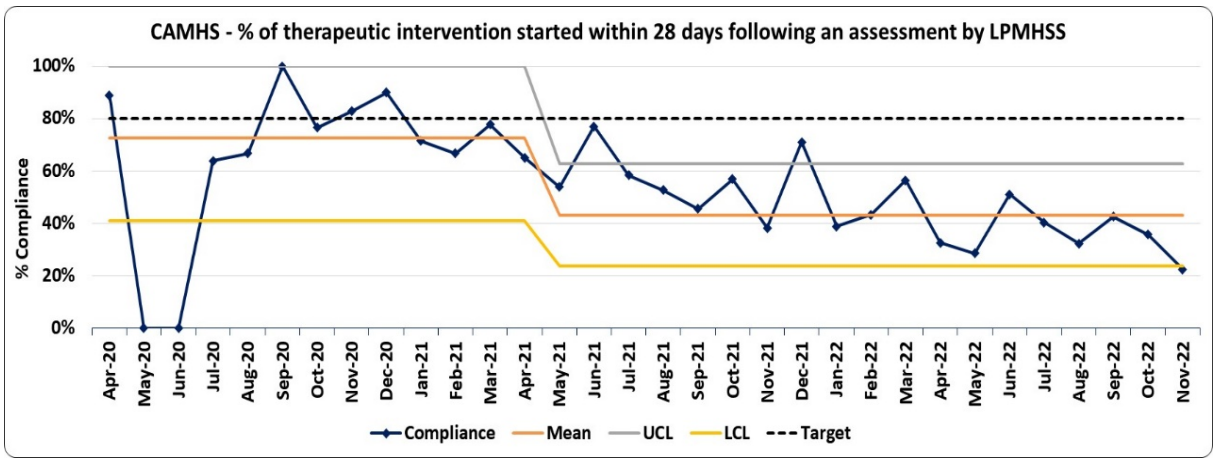


Chart 7

2.4.5.10. There has been a decline in Part 1b performance due to increasing complexity of children and young people in the service requiring more interventions and less capacity to start therapeutic interventions. There has also been vacancies and sickness within the service impacting on available capacity. As a result there has been an increase in patients waiting for interventions and the waiting times for interventions has exceeded 28 days.

2.4.5.11. The service has been focused on reducing the number of patients waiting for interventions in the last couple of months. The number of interventions started in November 2022 was slightly higher than previous months with a focus on increasing capacity to address overall waiting list for intervention and providing appointments for those waiting the longest. There has been a reduction in the number of patients waiting for intervention as a result from 225 in September 2022 to 188 at the end of November 2022.

2.4.5.12. The longest waiting time for intervention is 24 weeks. There are small numbers of young people waiting this length of time and these long waits will be addressed with the commencement of new group intervention and new staff commencing in post in one of the community teams.

2.4.5.13. An improvement action plan has been developed to support improvement in performance for both Part 1a and Part 1b and the service is currently reviewing the intended benefits of these actions to revise performance trajectories. The improvement action plan has been developed with the service team leads and senior nursing and therapy leads and is reviewed and discussed on a fortnightly basis.

2.4.5.14. The improvement action plan includes the following:

Action	Intended benefit	Timescale
Implement additional assessment capacity for Part 1a	Additional approx. 15 assessments available per month, reducing the gap between demand and capacity and overall backlog of patients waiting	From January-23
Additional assessment and intervention capacity for both Part 1a and Part 1b via WLIs	Confirmed additional approx. 9 additional assessments in January and February; additional WLIs being agreed to support interventions	In place and ongoing until Mar-23
Explore short term options for additional agency workers to provide additional assessment and intervention capacity	Provide additional capacity for assessments and interventions on a short term basis to address the backlog of patients waiting	In place and ongoing with agencies until Mar-23
Regular review of caseloads for all areas by senior nurse to support clinicians with discharge plans	Ensure balance of capacity for interventions	In place and ongoing
Demand and capacity training with the DU for team leads; senior nurses and admin leads	Provide the clinical team leads with the capacity	Jan-23
Implementation of text reminders to reduce DNAs and last minute cancellations for both assessments and interventions	Maximise the current capacity available to the service	To be confirmed by ICT timescales
Recruitment into new 3 x Band 5 and 3 x Band 3 posts from Service Improvement Funds 22/23 which will provide additional capacity to support roll out of courses/groups in each locality	Additional capacity to support implementation of new groups for interventions	Interviews taken place, awaiting start dates Re-advertising 2x Band 5 posts Expected timescale Apr-23
Review of current demand and capacity for therapies workforce	Understanding of any capacity gaps in the workforce and set capacity for each therapy intervention	Mar-23
Working with Mental Health Matters and Mind Cymru to implement group/courses to support with discharge pathways and primary mental health support	Additional capacity for interventions on a monthly basis. Each group could take approx. 8-12 patients and run for 6 weeks	Meetings taken place, awaiting confirmation from organisations on potential start dates expected by Feb 2023
Working with Silvercloud to refer patients waiting for intervention for online CBT programme	Additional capacity for interventions, currently scoping number of patients that could be referred on a monthly basis	Training being scheduled for Feb-23, aim for implementation in Mar-23

Action	Intended benefit	Timescale
Development of the new primary care liaison posts to provide consultation and advice to GPs to help manage demand into the service	Provide advice and consultation in primary care to reduce demand into the service	Work commencing in Jan-23 but impact of work is part of wider systemic work so benefit is anticipated into 23/24
Ongoing implementation of the Schools Inreach service rolling out to the next phase of schools across CTM UHB	Providing earlier intervention in schools and supporting the management of demand into CAMHS	Ongoing

Chart 8

2.4.5.15. Part 2 of the MHM ensures that people requiring secondary mental health services have a person-centred and outcome-focussed Care and Treatment Plan. CTM CAMHS Performance against Part 2 of the MHM continues to be below the target and declining, in November the performance dropped to 35%.

2.4.5.16. The decline in performance against Part 2 is linked to the significant increase in the number of patients identified for Part 2 since April 2022 from just over 200 to 460 in November 2022. This increase in patient numbers is as a result of quality improvement plan to providing education to improve awareness and understanding of the criteria for Part 2.

2.4.5.17. Whilst overall performance in Part 2 has declined the actual number of patients recorded as having a valid CTP has increased from 120 in April 2022 to 160 in November 2022.

2.4.5.18. The following graph shows the performance for Part 2:

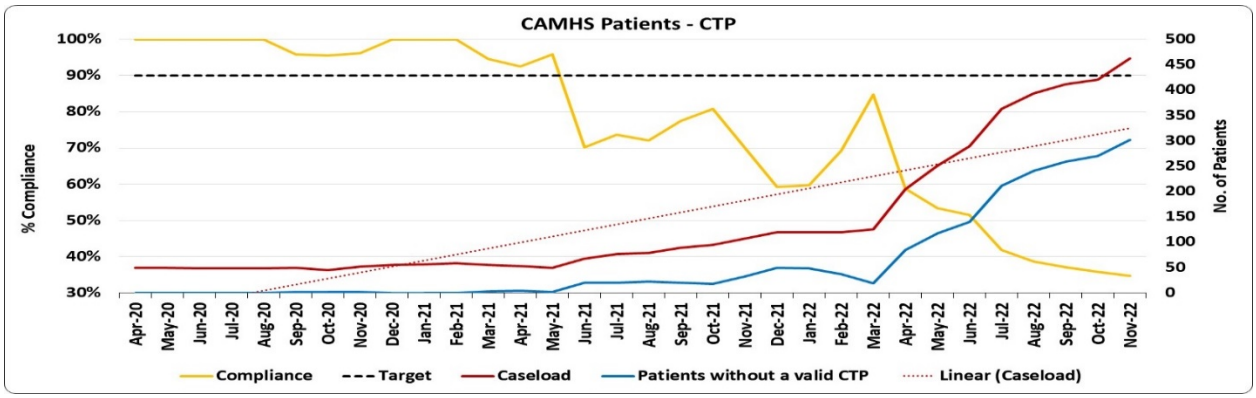


Chart 9

2.4.5.19. CTM CAMHS has implemented an improvement plan to support the improvement in performance with Part 2. This improvement plan initially focused on providing education to improve awareness and understanding of the criteria for Part 2. This work has led to the subsequent increase in patients being identified under Part 2. The improvement plans are now focused on ensuring the increased number of patients identified under Part 2 are reviewed as requiring Part 2 and have a valid CTP as well as ensuring the quality of the CTP.

2.4.5.20. Additional appointments have been identified during January, alongside a reduction in non-clinical meetings, in order to support the completion of CTPs for approximately 70 patients to support improvement in the compliance. It is anticipated with these appointments compliance should improve from 35% in November to approximately 65% in January 2023. There will be continued focus in February 2023 on the remaining patients to improve compliance by March 2023 to 90%.

3. KEY RISKS/MATTERS FOR ESCALATION

3.1. There has been poor performance against the Mental Health Measures for CTM CAMHS due to increasing demand outstripping capacity in the service. The waiting list for CAMHS is growing as a result and waiting times increasing. A detailed improvement action plan has been developed and there are regular fortnightly performance meetings with the clinical leads for the service to support improvement. It is anticipated due to the backlog of patients waiting and limited immediate additional capacity, improvement in performance for Part1a and Part 1b will take three to four months. Improvement in Part 2 is anticipated by the end of February 2023, with a clear focus in every area on ensuring patients CTPs are completed.

3.2. The CAMHS CSG Manager, who has overseen the improvements in performance in Swansea CAMHS has secured another position in the Health Board. This departure does pose some risk to the improvement plan for the CTM CAMHS Community service. The postholder will continue to work in the MHLD care group and in order to mitigate this risk will continue to provide support and coaching to the service.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report provides an overview of quality, safety and experience issues in CAMHS
Related Health and Care standard(s)	Choose an item.
	Governance, Leadership and Accountability Safe Care Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered required in the box below.
	The Swansea community service will be delivered by Swansea Bay UHB from 1st April 2023. The options appraisal and assessment of impact for their population has been undertaken by Swansea Bay UHB as the commissioner and reported to their Board.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The improvement plan for CTM Community CAMHS requires a review of workforce capacity and recruitment to new roles.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1. Members are asked to **NOTE** this progress outlined in this report and **DISCUSS** the matters for escalation.

AGENDA ITEM
6.7

QUALITY & SAFETY COMMITTEE

LIBERTY PROTECTION SAFEGUARDS PREPARATION

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire O'Keefe – Head of Safeguarding
Presented by	Greg Dix – Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Safeguarding Executive Group	(23/01/2023)	NOTED

ACRONYMS	
LPS	Liberty Protection Safeguards
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
BIA	Best Interest Assessors
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 Liberty Protection Safeguards, like Deprivation of Liberty Safeguards will protect the rights of people who use health and care services not to be deprived of their liberty without a proper legal process and

rights to challenge. People who might have a Liberty Protection Safeguards authorisation include those with dementia, autism and learning disabilities who lack the relevant capacity.

1.2 The LPS were introduced in the Mental Capacity Act (Amendment) Act 2019 and will replace the DoLS system. It is documented in Government Guidance that LPS will deliver improved outcomes for people who are or who need to be deprived of their liberty. The implementation of the Liberty Protection Safeguards have been repeatedly changed by the Government. The current date for implementation is now October 2023. However, it is envisaged that this may be delayed further, with Spring 2024 being the anticipated time for implementation. Despite no definitive date for LPS, CTMUHB continue to take measures to prepare for the changes this legislation will bring to practice.

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

2.1 Key changes introduced by the Liberty Protection Safeguards include;

1. Three assessments will form the basis of the authorisations of Liberty Protection Safeguards
2. Greater involvement for families
3. Targeted approach
4. Extending the scheme to 16 and 17 year olds
5. Extending the scheme to domestic settings
6. Clinical commissioning groups (CCGs), NHS trusts and local health boards as Responsible Bodies

(Department of Health and Social Care, 2021)

These changes are expected to affect current practice in relation to authorisations. In particular, the required three assessments, which include a capacity assessment, a medical assessment to determine whether the person has a mental disorder and a 'necessary and proportionate' assessment to determine if the arrangements are necessary to prevent harm to the person and proportionate to the likelihood and seriousness of that harm. Currently, the Best interest Assessors and section 12 approved Doctors carry out these assessments. However, in line with LPS, it is expected that General Practitioners, Medical and Nursing colleagues will be expected to undertake these assessments and the Best Interest Assessor will scrutinise and authorise these on behalf of the Health Board, replacing the current signatories. Specific details remain unknown due to the final Code of Practice not being published. During the

consultation period this aspect of the code was heavily criticised by the All Wales Group.

2.2 CTMUHB have approximately 4579 professional staff that will require specific training for the LPS safeguards. However, the Wales LPS training package has not yet been developed. Therefore, in preparation for LPS focus has been given to delivering MCA awareness and training. It is envisaged that this will assist colleagues in understanding the principles of LPS when it is implemented.

The different roles required by the LPS will require differing levels of competency in terms of knowledge and application of the new procedures. Figure 1 below shows the competency groups required to deliver the LPS.

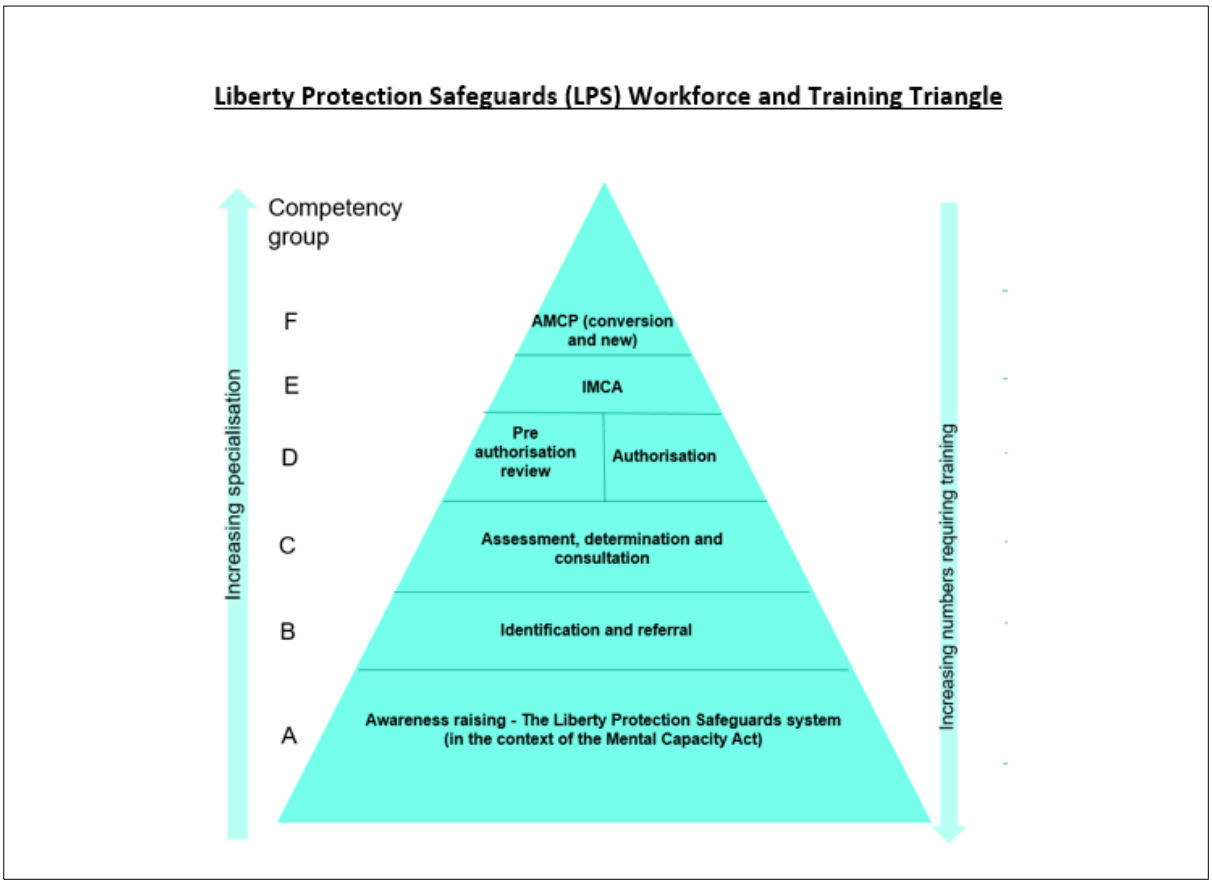


Figure 2 below provides a summary of roles that will be included in each competency group.

Competency Group	Description	Who
Competency Group A	Awareness raising	All stakeholders in health, care, education and other services, who may come across a person who might lack the capacity to consent to arrangements that may give rise to a deprivation of their liberty.
Competency Group B	Identification and referral	Supervisors and managers of staff and volunteers in Competency Group A
Competency Group C	Assessment, determination and consultation	All roles that under the regulations might undertake assessments, determinations and consultation
Competency Group D	Pre-authorisation Review and Authorisation	Managers in responsible bodies
Competency Group E	Independent Mental Capacity Advocate (IMCA)	Existing and new advocates
Competency Group F	Approved Mental Capacity Professional (AMCP)	People who meet the requirements set out in regulations, have undertaken full AMCP training or BIA to AMCP conversion training and have been approved by the relevant local authority in line with the relevant regulations.

A workforce planning estimate has been sent to Welsh Government identifying that 10,996 CTMUHB staff are in need of awareness training with 4,579 of those staff requiring more specialist training. To date 56% of the required workforce have completed MCA training online. Using Welsh Government funding, CTMUHB have recruited an MCA Practice Facilitator, who has developed face to face and virtual MCA training that is specifically aimed at embedding the Mental Capacity Act into everyday practice which will assist the implementation of LPS. The delivery of MCA training is already in progress across acute, community and Primary Care services.

CTMUHB have submitted a response to the Mental Capacity (Amendment) Act 2019 and also provided a response to the Consultation process for the LPS Code of Practice. The Code of Practice is currently being ratified by UK Government and publication is yet to be determined.

CTMUHB has been heavily involved and represented in an All Wales LPS Task and Finish Group which is led by Public Health Wales. DoLS colleagues also attend a National minimum dataset group, to develop a performance framework for reporting to the Education and Training Inspectorate for Wales (Estyn), Public Health Wales and Healthcare Inspectorate Wales. These groups continue to meet and share progress with each other.

CTMUHB was also represented in a Regional Response Group consisting of the three Local Authorities and the Health Board.

Participation at these groups allows colleagues to benchmark against other Health Boards and share ideas for improvements and progress.

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

3.1 In preparation for the implementation of LPS, CTMUHB are required to reduce or eliminate their backlog of assessments. The waiting list has increased following the delivery of bespoke training and awareness sessions within community hospitals. Urgent authorisations make up for 78% of the referrals received in quarter three. The backlog of authorisations has been on the Health Boards Risk Register for a considerable amount of time. The backlog is reviewed regularly, with urgent authorisations being prioritised.

Whilst additional funding has been provided by Welsh Government for the recruitment of further Best Interest Assessors (BIA), there has been significant difficulties in colleagues being released for secondments from their clinical areas while there are such significant pressures on the Health Board. Thus far a further 1 full time and 2 part time BIA posts remain vacant.

3.2 The delay in the publication of the final Code of Practice is resulting in uncertainty, the full impact is not yet clear for CTMUHB. Roles and responsibilities will undoubtedly change for the BIA and nursing colleagues. Sessions have commenced to set our current expectations and offer support to clinical areas ahead of the finalised Code of Practice.

3.3 The implementation of LPS may change the roles and job descriptions of the current BIA, as they will be required to undertake the role of an Approved Mental Capacity Professional. These roles will be required to scrutinise all assessments undertaken within the clinical settings.

3.4 Whilst it is anticipated that funding from Welsh Government will continue into the next financial year, this has yet to be confirmed by Welsh Government.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	Yes (Include further detail below)
	CTMUHB are required to comply with The LPS process within the Mental Capacity Act (Amendment) 2019 legislation once it is implemented.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Extra WG funding secured to increase resources, however not yet agreed for 2023/2024.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report

5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required.

5.3 **NOTE** risks in respect of the ability to clear the backlog of DoLS authorisations with current vacancies and uncertainty of reoccurring Welsh Government funding. Also, vast MCA training requirements that will need to be completed prior to the implementation of LPS.

AGENDA ITEM
6.8

QUALITY & SAFETY COMMITTEE

CHILD T – CHILD PRACTICE REVIEW

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire O'Keefe, Head of Safeguarding Louise Mann, Assistant Director. Quality Safety & Safeguarding.
Presented by	Greg Dix – Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Safeguarding Executive Group	(23/01/2023)	ENDORSED FOR APPROVAL

ACRONYMS	
MASH	Multi-Agency Safeguarding Hub
CTMUHB	Cwm Taf Morgannwg University Health Board
CTMSB	Cwm Taf Morgannwg Safeguarding Board
CPR	Child Practice Review

1. SITUATION/BACKGROUND

1.1 Following the tragic murder of a child from the Bridgend region, the Cwm Taf Morgannwg Safeguarding Board commissioned a Child

Practice Review to examine the involvement of various agencies across to inform learning and improvements required. The child is referred to as Child T within the report. This CPR was published by CTMSB on the 24th of November 2022.

1.2 As a result of this Child Practice Review, key learning for all agencies were identified. It was the Child Practice Review Panel perspective that these issues may be systemic, and not isolated instances of individual error or poor practice. The review identified learning for individual statutory agencies and for working together in partnership. For CTMUHB there were two specific recommendations. These included;

- Cwm Taf Morgannwg Health Board should commission an Independent Review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents. The Independent Review should make recommendations as to how the Health Board develops escalation and quality assurance systems that embed and maintain any practice learning.

- The Cwm Taf Morgannwg Health Board should ensure that practitioners who work directly with children and young people are aware of their roles in identifying safeguarding concerns and their duty to report. There needs to be a system in place to ensure compliance, including safeguarding training programmes across all health practice roles. Compliance should be reported on an annual basis to the Cwm Taf Morgannwg Safeguarding Board

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

2.1 On the 16th of August 2020, Child T presented to the emergency department of the Princess of Wales Hospital, who subsequently submitted a referral to the Children's Services Emergency Duty Team, reporting that Child T had an injury to his arm, bruises on his right cheek and a fractured humerus. The Child Protection referral made by Health Services raised concerns in relation to the delay in the mother taking him to receive medical attention for his injuries.

During this admission a Strategy Discussion was held between the Social Services Emergency Duty Team and Police. The purpose of a Strategy Discussion is to determine whether Child Protection Enquiries (Section 47) should be initiated, and how these enquiries should be undertaken. At this meeting, these agencies agreed that the threshold to undertake Child Protection Enquiries (Section 47)

had not been met at that stage, on the basis that there was limited medical information. There is no information recorded to confirm why a Health representative was not part of the strategy discussion as would be expected practice. Case file records stated that the Paediatric Consultant was reviewing Child T's case further.

Examination of Child T by a Paediatric Registrar and Consultant Orthopaedic Surgeon were not carried out under the framework of a child protection medical examination. During examination, multiple bruises were documented on the child's head and body; those on the face were clearly visible. Mother reported that Child T self-harms pinches and hurts himself when he is being sanctioned for his aggressive behaviour, and that this had been happening since the birth of her new baby. There was no evidence of professional curiosity or concern that a four-year-old child would physically harm themselves for any reason.

Medical photography and blood tests were requested and completed. Orthopaedic Consultant examination documented that given the whole history there was a clear suspicion of Non-Accidental Injury (NAI). The decision documented by the Lead Consultant Paediatrician when reviewing the investigations, (there is no documented evidence of discussion between orthopaedic and paediatric colleagues of their opinions on the cause of the injuries), and visiting the child on the ward is that the injury is consistent with the history given by the mother and the view is that the presentation is not suspicious of a NAI. There is no documentation that the incidence of bruising was reported to children services or police as a concern in addition to the late presentation of the shoulder injury. The conclusion of the Lead Consultant Paediatrician was shared with the local authority via a telephone call from the ward nursing staff.

Child T's attendance to hospital in August 2020 was considered by the CPR that information regarding the extent of his presenting bruising and injuries were not appropriately shared with other agencies and that if this information had been shared with police and local authority, this may have led to a decision to commence child protection enquiries and action. The information that was not shared included 31 medical photographs of the documented bruising that was observed during a medical on the paediatric ward at Princess of Wales Hospital. It is important to note that there was no safeguarding platform in which to share this information other than a new child protection referral as agencies were working outside the section 47 process.

In addition, there were concerns raised by CTMUHB at the CPR practitioners Learning Event. Some colleagues reported feeling their

value and voice in relation to concerns about children are not heard, with examples of safeguarding concerns not being reported to external agencies due to the dominant views of more senior practitioners. Colleagues shared a culture of not challenging those in a more senior, 'expert' position and their voice being heard is dependent upon the status of their role.

2.2 A CTMSB and CTMUHB action plan was developed following the initial independent rapid review of multi-agency safeguarding practice in Bridgend, commissioned by the safeguarding board in December 2021. The CTMUHB action plan addressed several areas of practice including training compliance. This action plan has been shared with the Lead Doctor for Safeguarding and Clinical Nurse Specialists for Safeguarding. The monitoring and progress of the actions are overseen through the Children's Safeguarding Operational Group, upwardly reported to the Safeguarding Executive Group, through to Quality and Safety Committee.

The CTMUHB safeguarding team undertook an internal audit of safeguarding referrals, involving children presented to the Princess of Wales Hospital with injuries. Partner agencies also conducted internal audits prior to completion of the CPR to ensure early learning was identified and acted upon. Following this, a multi-agency audit reviewed the same cases. In total 16 cases were reviewed, the remit included referrals made by the Emergency Department for children attending with injuries. The learning from the multi-agency audit was incorporated into agency improvement plans.

A Lessons Learnt event was delivered face to face and via Teams to Bridgend medical and nursing staff on the 27th of October 2022. In addition, three bespoke level 3 safeguarding training sessions were delivered. These events provided an opportunity to share the learning identified within the Bridgend multi-agency audit and from the CPR, the forum was used to promote confidence in safeguarding processes, improve information sharing, to enable colleagues to professionally challenge when cases do not follow the Wales Safeguarding Procedures.

A 7 minute briefing and NAI pathway has been developed in partnership with CTMSB, this has been disseminated through the Operational Safeguarding Groups and shared with leads for emergency care, acute and community paediatric teams. The Clinical Director within POW has shared these with medical colleagues; posters of the pathway are displayed on the wards and departments and discussed with all Consultants and Registrars.

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

3.1 In addition to the multi-agency recommendations and action plan from the Child Practice Review, a CTMUHB improvement plan has been developed in partnership with the Named Doctor for Safeguarding, Safeguarding leads and the Medical Director. The focus of this improvement plan is to ensure a robust system is in place to provide appropriate level 3 training to medical groups and monitor compliance of safeguarding training across all staff groups, including medical colleagues.

This plan will include the development of a CTMUHB training forum and strategy that will support a sustainable model of reviewing safeguarding training compliance.

3.2 Repeat audits will be required to evaluate the effectiveness of any changes to practice, implemented learning and subsequent training.

3.3 The learning from this review will be shared via the Operational and Safeguarding Executive Groups. In addition, the new organisational Listening and Learning Framework, Repository of Learning, and biannual Listening and Learning Event will support organisational values in using this learning to share knowledge, shape change and create opportunities to develop excellence in practice. The next Listening & Learning Event on the 28th March 2023 will focus on sharing the learning from the CPR and subsequent improvements to the quality and effectiveness of safeguarding services, as well as ensuring public trust and confidence.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The improvement plan is developed to improve safeguarding practice within the health board and amongst statutory partnerships in relation to safeguarding children.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The duty to report safeguarding concerns applies equally across the health board and to all children and adults at risk.
Legal implications / impact	Yes (Include further detail below)
	There is a statutory duty to report safeguarding concerns in relation to children and adults at risk.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report
5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
5.3 **NOTE** the risks identified
5.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports