Quality & Safety Committee

Thu 16 March 2023, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:05
5 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*

09:05 - 09:45
40 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Gynaecology Services

Discussion   *Sarah Fox, Head of Midwifery & Gynaecology*

2.2. Care Group Spotlight Presentation - Mental Health & Learning Disabilities

Discussion   *Mental Health & Learning Disability Care Group*

📄 2.2a MHLD HIW Inspections QSC 16 March 2023.pdf (9 pages)
📄 2.2b Appendix 1 MH HIW Inspection Report QSC 16 March 2023.pdf (3 pages)

2.3. Care Group Spotlight Presentation - Unscheduled Care

Discussion   *Emma James, Care Group Nurse Director*

📄 2.3 USC Spotlight Report March 2023 QSC 16 March 2023.pdf (8 pages)

09:45 - 09:50
5 min

3. CONSENT AGENDA

3.1. FOR APPROVAL

3.1.1. Unconfirmed Minutes of the meeting held on 24 January 2023

Decision   *Jayne Sadgrove, Committee Chair*

📄 3.1.1 Unconfirmed Minutes QSC 24 January 2023 Final QSC 16 March 2023.pdf (14 pages)

3.1.2. Unconfirmed Minutes of the In Committee meeting held on 30 January 2023

Decision   *Jayne Sadgrove, Committee Chair*

📄 3.1.2 Unconfirmed Minutes In Committee QSC 30 January 2023 Final QSC 16 March 2023.pdf (2 pages)

3.1.3. Children & Young People 16-17 year's Acute Admission Policy

Decision   *Linda Prosser, Executive Director of Strategy & Transformation*

📄 3.1.3a CYP Acute Admission Policy QSC 16 March 2023.pdf (4 pages)
📄 3.1.3b Children and Young Person Hospital Admission Policy 2022 QSC 16 March 2023.pdf (8 pages)

3.1.4. Chairs Urgent Action - Policy Approvals

Decision   *Jayne Sadgrove, Committee Chair*

📄 3.1.4 Request for Ratification of UCA Policy Approval QSC 16 March 2023.pdf (3 pages)

3.1.5. Independent Member Walkround Protocols

Decision   *Greg Dix, Director of Nursing*

📄 3.1.5a Cover papers Exec IM Walkrounds QSC 16 March 2023.pdf (4 pages)
📄 3.1.5b App 1-Executive DirectorIndependent Members Walkround Framework-FINAL QSC 16 March 2023.pdf (15 pages)

3.2. FOR NOTING

3.2.1. Action Log

Information   *Jayne Sadgrove, Committee Chair*

📄 3.2.1 Action Log QSC 16 March 2023.pdf (10 pages)

3.2.2. Annual Cycle of Business

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

📄 3.2.2a Committee Cycle of Business - Cover Paper QSC 16 March 2023.pdf (2 pages)
📄 3.2.2b Quality Safety Committee Cycle of Business QSC 16 March 2023.pdf (4 pages)

3.2.3. Forward Work Programme

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

📄 3.2.3 Quality & Safety Committee Forward Work Programme QSC 16 March 2023.pdf (5 pages)

3.2.4. Quality Governance – Regulatory Review Recommendations and Progress Updates

Information   *Greg Dix, Director of Nursing*

📄 3.2.4 HIW regulatory report-March 23-FINAL QSC 16 March 2023.pdf (8 pages)

3.2.5. Clinical Audit Quarterly Report & Clinical Audit Annual Plan

Information   *Dom Hurford, Medical Director*

📄 3.2.5a National Clinical Audit Programme Update QSC 16 March 2023.pdf (6 pages)
📄 3.2.5b Appendix 1 National Clinical Audit Annual Plan 28022023 QSC 16 March 2023.pdf (12 pages)

3.2.6. Radiation Safety Committee Highlight Report

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

📄 3.2.6 Radiation Safety Committee Highlight Report QSC 16 March 2023.pdf (2 pages)

09:50 - 09:55
5 min

4. MAIN AGENDA

4.1. Matters Arising Not Contained within the Action Log

Discussion   *Jayne Sadgrove, Committee Chair*

5. GOVERNANCE

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

Cally Hamblyn, Assistant Director of Governance & Risk

📄 5.1a Organisational Risk Register QSC Cover Paper March 2023.pdf (4 pages)
📄 5.1b Appendix 1 - Master Organisational Risk Register - Final March 2023 - QSC 16.3.2023.pdf (10 pages)

5.2. Health, Safety & Fire Sub Committee Highlight Report

Discussion   Dilys Jouvenat, Independent Member/Sub Committee Chair

📄 5.2a HSF SubCmt Highlight Rpt QSC 16.3.23 (004).pdf (4 pages)
📄 5.2b Appendix 1 UPDATED TOR - FOR APPROVAL BY HSF SUB CMT QSC 16 March 2023.pdf (8 pages)

6. IMPROVING CARE

6.1. Maternity & Neonatal Improvement Programme Highlight Report

Discussion   Greg Dix Director of Nursing/Sallie Davies Deputy Medical Director

📄 6.1a MNIB Programme Highlight Report Jan 23 QSC 16 March 2023.pdf (8 pages)
📄 6.1b Maternity Metrics Feb 23 QSC 16 March 2023.pdf (23 pages)

6.2. Ty Llidiard Progress Report

Discussion   Lauren Edwards, Director of Therapies & Health Sciences

📄 6.2 Ty Llidiard QSC 16 March 2023.pdf (15 pages)

6.3. Quality Dashboard Report

Discussion   Greg Dix, Director of Nursing

📄 6.3a Quality Dashboard Report QSC 16 March 2023.pdf (25 pages)
📄 6.3b DU Dashboards Compliance summary Alerts QSC 16 March 2023.pdf (2 pages)
📄 6.3c DU Dashboards Compliance summary Notices QSC 16 March 2023.pdf (4 pages)
📄 6.3d Data Details_All Wales Dashboard QSC 16 March 2023.pdf (2 pages)
📄 6.3e Data Details_UHB Dashboards QSC 16 March 2023.pdf (2 pages)
📄 6.3f QPAR_All Wales_Summary Dashboard_Jan23 QSC 16 March 2023.pdf (1 pages)
📄 6.3g QPAR_CTM_Summary Dashboard_Jan23 QSC 16 March 2023.pdf (1 pages)

6.3.1. Thematic Spotlight Presentation - Falls and Pressure Ulcers

Discussion   Richard Hughes, Deputy Director of Nursing

A request has been made for this item to be deferred to the May meeting of the Committee

6.3.2. Care Group Highlight Reports

Discussion   Care Groups

- Planned Care
- Unscheduled Care
- Children & Families
- Diagnostics & Therapies
- Primary Care & Community
- Mental Health & Learning Disabilities

📄 6.3.2a Planned Care QSRE Highlight Report QSC 16 March 2023.pdf (3 pages)
📄 6.3.2b USC QSRE Highlight Report QSC 16 March 2023.pdf (5 pages)
📄 6.3.2c Children and Families Care Group Highlight Report QSC 16 March 2023.pdf (12 pages)
📄 6.3.2d DTPS QSRE Highlight Report QSC 16 March 2023 (002).pdf (3 pages)

- 6.3.2e PC and Communities Care Group Highlight Report QSC 16 March 2023.pdf (5 pages)
- 6.3.2f MHLD Highlight Report for QSC 16 March 2023.pdf (5 pages)

6.4. Report from the Chief Operating Officer

Discussion   *Gethin Hughes, Chief Operating Officer*

- 6.4 COO's Report on Overarching Issues for QS QSC 16 March 2023.pdf (9 pages)

6.5. Stroke Services Progress Report

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

- 6.5 Stroke Progress Report QSC 16 March 2023.pdf (20 pages)

6.6. Mortality Indicators and Mortality Reviews

Discussion   *Dom Hurford, Medical Director*

- 6.6 Mortality Indicators and Mortality Reviews QSC 16 March 2023.pdf (7 pages)

6.7. RADAR Committee Highlight Report - This item has now been deferred

Discussion   *Dom Hurford, Medical Director*

11:50 - 11:55
5 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*

11:55 - 12:00
5 min

8. DATE AND TIME OF NEXT MEETING - TUESDAY 16 MAY 2023 AT 9AM

12:00 - 12:00
0 min

9. CLOSE OF MEETING

	AGENDA ITEM
	2.2

QUALITY & SAFETY COMMITTEE

A FOCUS ON MENTAL HEALTH HIW INSPECTIONS

Date of meeting	16th March 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Ana Llewellyn, Nurse Director
Presented by	Ana Llewellyn, Nurse Director
Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR NOTING

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

ACRONYMS USED IN PAPER AND APPENDIX	
CIW	Care Inspectorate Wales
CMHT	Community Mental Health Team
HIW	Health Inspectorate Wales
ILG	Integrated Locality Group
MHLD	Mental Health and Learning Disabilities
PMVA	Prevention and Management of Violence and Aggression
QSRE	Quality Safety Risk and Experience Meeting

1. SITUATION/BACKGROUND

1.1   This report provides committee members with an overview of recent and legacy HIW inspections of mental health services in the Health Board.

1.2   There are two main inspections applicable to mental health services:
   - *Mental Health Service Inspections* – these are usually unannounced and consider the Health and Care Standards 2015 and compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards.
   - *Joint CIW and HIW Inspections of Community Mental Health Services* – these are usually planned and consider how services meet the Health and Care Standards 2015 and Social Services and Well-being Act (Wales) 2014 and how they comply with the Mental Health Act 1983 and Mental Capacity Act 2005. These inspections usually require multi-agency services to submit evidence in advance of a planned visit by inspectors.

1.3   In addition to these routine inspections HIW does also undertake national thematic reviews and bespoke inspections of services of concern.

1.4   This report will update committee on three recent inspections and will also provide an overview of legacy HIW action plans.

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

1.5   **HIW Discharge Review**

1.6   In February 2022 HIW wrote to the Health Board to advise that they would be undertaking a local review of the quality of discharge arrangements for adult patients from inpatient mental health services in CTM. This review was commissioned in response to serious incident intelligence.

1.7   The review included both fieldwork and a review of evidence, including a review of patient records. The proposed timescale for publication was August 2022, however HIW continued to seek evidence from the Health Board through to December 2022.

1.8　In June 2022 HIW identified a number of significant patient safety concerns relating to discharge governance, communication arrangements between teams (including the issue of the lack of a single electronic record), significant limitations in the involvement of patients and carers risk management and discharge arrangements.

1.9　This immediate assurance action plan was initially monitored by the Mental Health Head of Nursing based in Merthyr Cynon ILG and also within RTE ILG, due to the concerns being centred on discharge practices in Royal Glamorgan Hospital. From September 2022 the monitoring arrangements transferred to the MHLD Care Group and this immediate assurance action plan has continued to be monitored by the MHLD QSRE.

1.10　As the review is yet to be published by HIW, the latest version of the immediate assurance action plan is available upon request for the committee to scrutinise separately to this report. It was last updated in preparation for the MHLD QSRE on 1st February.

1.11　As part of their review of discharge arrangements HIW identified concerns relating to the discharge of a small number of patients. Independent reviews have been commissioned of these cases with investigating officers identified from outside the Health Board.

1.12　The discharge review is due to be published on 7th March and includes a further 40 recommendations. At this stage HIW have not requested an action plan for these recommendations although work has progressed within the care group to develop an action plan and to align these actions to the improvement programme workstreams.

1.13　**HIW Mental Health Service Inspection Glanrhyd Hospital: Angelton Clinic**

1.14　HIW undertook a three day unannounced Mental Health Service Inspection 14 -16 November 2022 and identified a number of immediate concerns. The Health Board was required to submit an immediate assurance action plan to address a number of concerns related to record keeping, ward environments, mandatory and statutory training and routine ward checks.

1.15　The Health Board was then provided with a draft report for factual accuracy with a requirement to submit a further improvement plan.

1.16 Both the immediate assurance improvement plan and the standard improvement plan were accepted by HIW and sent for publication.

1.17 At the time of writing the report has not yet been published by HIW. The immediate assurance action plan updated on 1st March 2023 is available on request for committee members for consideration ahead of publication by HIW.

1.18 **HIW Service of Concern Letter**

1.19 In 2021 Healthcare Inspectorate Wales introduced a Service of Concern process for the NHS, used when they identify significant singular service failures, or cumulative or systemic concerns regarding a service or setting. This process is used to identify and highlight any Service Requiring Significant Improvement (SRSI) with the aim to support improvement, ensuring rapid action is taken to ensure safe care. HIW wrote to the Health Board on 2nd February 2023 to advise that they had convened a Service of Concern meeting in response to the patient safety concerns identified in the Angelton Inspection and Discharge Review.

1.20 Having considered these two pieces of work and the concerns they highlighted about the mental health service, HIW determined that it was important to allow the health board the opportunity to respond to the findings and to demonstrate how it intends to drive the necessary improvements. Therefore, they decided not to escalate the service at that time but would continue to monitor the Health Board's response to these two reports.

1.21 **HIW and CIW Community Mental Health Team Review: Maesteg CMHT**

1.22 HIW and CIW completed an inspection of Maesteg Community Mental Health Team in December 2022. They provided verbal feedback on 14th December 2022.

1.23 Although the verbal feedback identified the consistent concern of the lack of a single patient record the regulators highlighted a number of issues of exemplary practice within the CMHT, including standards of care and treatment planning, partnership working and service user involvement. This learning is being shared across the other CMHTs in the care group.

1.24 A draft report has been shared for factual accuracy and a draft improvement plan has been completed by the Health Board. The Health Board is awaiting approval by HIW ahead of publication.

1.25 **Legacy Mental Health HIW action plans**

1.26 Prior to the implementation of the new operating model in September 2022 RTE ILG reviewed all mental health HIW inspection action plans dating back to 2016 and found that there were a number of actions that had not been completed.

Date of Inspection		Number of Recommendations	Updated status as of Feb 2023		
			Completed	Partially completed	Not complete
11/07/2016	RGH	27	26	0	1
22/01/2018	RGH adult inpatient	25	23	1	1
08/07/2019	RGH	44	39	1	3

1.27 This review of open actions was handed over to the new MHLD care group and has continued to be monitored by the care group QSRE. As of 1st February 2023 five legacy recommendations incomplete, with 2 other recommendations partially complete.

1.28 These seven recommendations (some of them repeated in each inspection from 2016 onwards) relate to the lack of a single electronic record, mandatory and statutory training and medical and nursing staffing levels.

1.29 In February 2023 a review of all MHLD care group HIW action plans dating back to 2020 were reviewed. There is a consistent theme of incomplete actions relating to the lack of a single electronic record, mandatory and statutory training compliance and out of date Health Board and mental health policies.

1.30 **Care Group Management, Oversight and Improvement**

1.31 A Quality, Safety, Risk and Experience governance framework (see Appendix One) led by the Nurse Director has been developed to ensure proactive oversight of issues previously outlined in this paper. The QRSE Board has a standing agenda item for external oversight, which includes HIW inspections. The recent and legacy action plans will be monitored via this board.

1.32 The care group has identified 4 main priorities: Ty Llidiard improvement, adult in-patient services, older adult in-patient falls and reducing restrictive interventions. Ty Llidiard improvement is monitored via a separate improvement board. The three other priorities will be monitored by a MHLD improvement board (again evidenced in Appendix One).

1.33 An initial virtual workshop was held in February (having been delayed by industrial action in December) to consider adult in-patient improvement. Leads were identified for all of the workstreams with HIW actions being aligned to each workstream.

1.34 A further in person in-patient improvement workshop is planned for 26th April to support and monitor the progress for all of the workstreams.

1.35 The key themes that are evident across the HIW inspections are also being monitored via QSRE: mandatory training, policies and clinical records.

1.36 *Mandatory and Statutory Training:* PMVA and Wales Applied Risk Research Network (WARRN) training is the responsibility of the care group to provide. A focus on PMVA training improvement, including securing external training sessions, will result in 100% compliance by June 2023.

PMVA Compliance
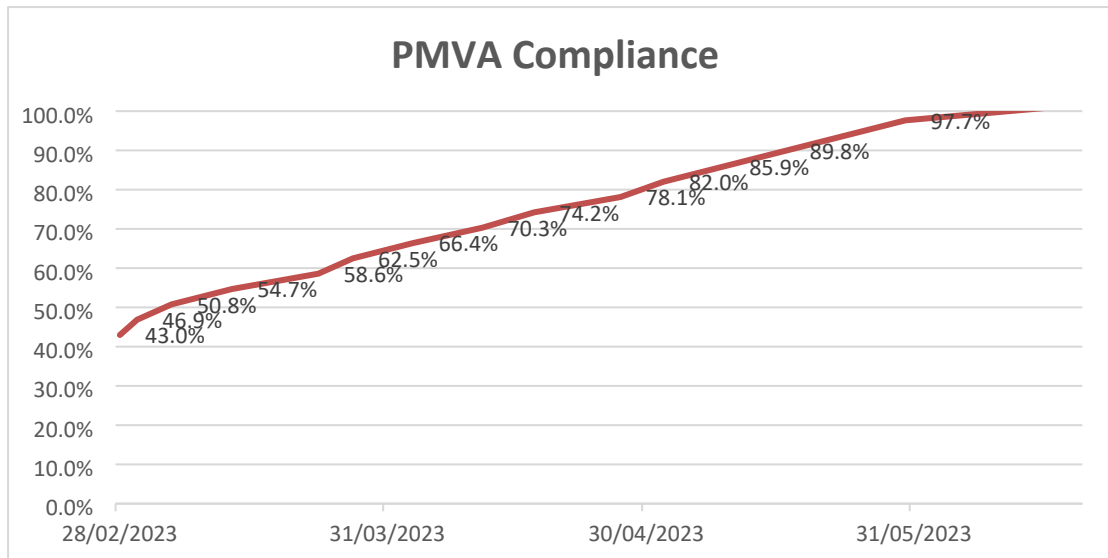
1.37 A multi-agency group is progressing WARRN training. To date 355 staff have been trained with a training team of 11 practitioners providing an ongoing monthly programme of initial and refresher courses.

1.38 In addition mental health specific training is being added to the Electronic Staff Record for completion by end of March 2023.

1.39 The limited availability of some face-to-face training, such as CPR, provided corporately will impact on compliance.

1.40 *Policies:* A care group policies group has been convened and is currently scoping all MH specific policies. A policy improvement plan will be reported to the QSRE in April 2023. The Health Board arrangements for ratification and management of clinical and operational policies is being reviewed by the Executive Medical Director and the Assistant Director of Corporate Governance.

1.41 *Clinical Records:* The executive team have considered a business case for the implementation of Welsh Community Care Information System (WCCIS) but to date no funding source has been secured.

1.42 Operational and clinical leads have been identified to process map the existing systems and will make recommendations for improvement in order to mitigate and manage the patient safety risks associated with the existing complex arrangements ahead of the implementation of a single electronic record.

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

3.1 The progress to implement WCCIS is being escalated to committee for further support. This risk is recorded on the organisational risk register with a Datix Risk ID of 3337. Committee members will also recall that the lack of a single electronic patient record was the subject of a Prevention of Future Deaths Notice from the Coroner in 2022.

3.2 The availability of some face to face training is also escalated to committee as this will continue to impact on mandatory and statutory training compliance.

3. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and safety of care for people in receipt of mental health services is central to this report.
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below: Safe Care Individual Care Timely Care Governance, Leadership and Accountability Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below)
	No new, changed or withdrawn policies or services outlined

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There are resource implications for the additional workforce proposed to underpin the internal oversight of mental health services. New posts are funded from recurrent the Mental Health Service Improvement Fund,
Link to Strategic Goals	Improving Care

4. RECOMMENDATION

3.3   Members of the Committee are asked to consider, discuss and note this initial assessment of CTM Mental Health Services set in the context of a developing Care Group.

3.4   Members are asked to note the priorities for improvement and the plans in place to address them.

Mental Health and Learning Disabilities Care Group

Quality and Safety Governance

ctmuhb.nhs.wales

Quality Improvement Board

CTM 2030
Ein Hiechyd
Ein Dyfodol
DATBLYGU CYMUNEDAU
IACHACH GYDA'N GILYDD

CTM 2030
Our Health
Our Future
BUILDING HEALTHIER
COMMUNITIES TOGETHER

CYNNAL EIN DYFODOL
SUSTAINING OUR FUTURE

YSBRYDOLI POBL
INSPIRING PEOPLE

GWELLA GOFAL
IMPROVING CARE

CREU IECHYD
CREATING HEALTH
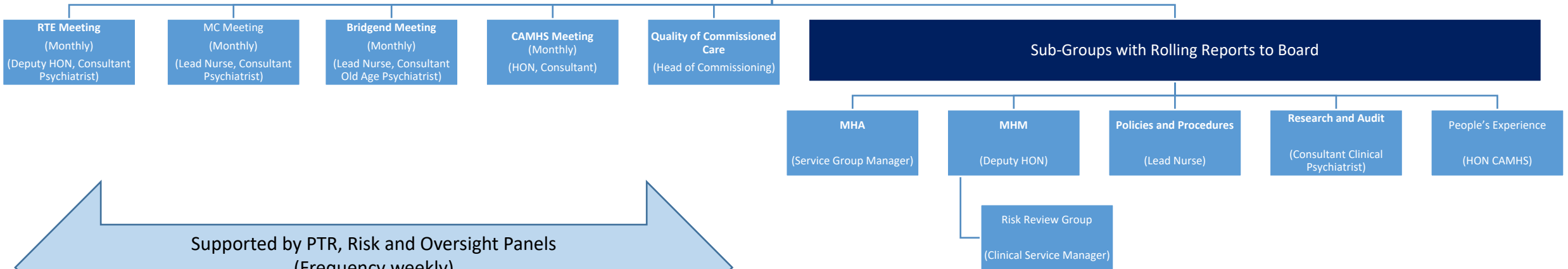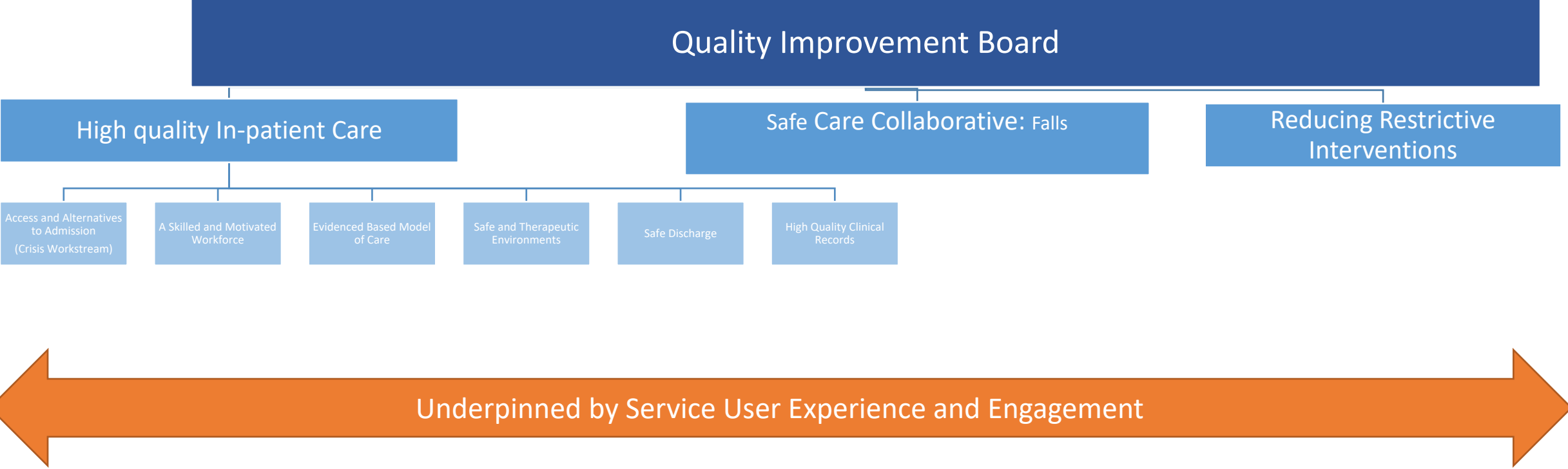
2.3	16th March 2023	Q&S Committee	Unscheduled Care Spotlight Review

Report Details:

FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable – Public Report
Prepared By:	Emma James - Unscheduled Care Nurse Director)
Presented By:	Emma James - Unscheduled Care Nurse Director
Approving Executive Sponsor:	Greg Dix - Executive Nurse Director
Report Purpose	For Noting
Engagement undertaken to date:	Discussed at USC QPSE – 26/01/23

Impact Assessment:

Indicate the Quality / Safety / Patient Experience Implications:	There are quality and safety implications related to the activity outlined in this report – subject to the findings and outcomes from the HIW inspection and the Audit Wales review of the MIU
Related Health and Care Standard	Safe Care
Has an EQIA been undertaken?	No – not required
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Improving Care

MAE EIN GWERTHOEDD YN EIN HELPU NI I FOD AR EIN GORAU
OUR VALUES HELP US BE AT OUR BEST

RYDYN NI'N GWRANDO, TRI DYSGU AC YN GWELLA
WE LISTEN, LEARN AND IMPROVE

RYDYN NI'N TRIN PAWB A PHARCH
WE TREAT EVERYONE WITH RESPECT

RYDYN NI I GYD YN CYDWEITHIO FEL UN TIM
WE ALL WORK TOGETHER AS ONE TEAM

STARTING WELL   GROWING WELL   LIVING WELL   AGEING WELL   DYING WELL

Spotlight Presentation Unscheduled Care

This spotlight report will cover the following areas of activity:

- Progress update on Minor Injury Unit at Ysbyty Cwm Cynon

- Ambulance Delays and Immediate Release Policy update

- Progress update on patients with a head injury leaving without being seen

- HIW visit to Princess of Wales Ward 5 - Stroke

- Response to health and safety concerns at Princess of Wales and fire evacuation simulation.

Minor Injury Unit -Ysbyty Cwm Cynon

Background - In September 2021, the Health Board decided to temporarily close the Minor Injuries Unit (MIU) at Ysbyty Cwm Cynon (YCC) due to concerns relating to the fragility of the service and competency-based training compliance.

Audit Review - In November 2021 Audit Wales performed a high level review to examine the issues around the temporary closure of the unit.

Key themes were identified around staff assessment, training and supervision and also support for the Emergency Nurse Practitioner (ENP) workforce.

It was felt that the closure led to increased attendances at Prince Charles Hospital without a robust assessment of patient experience and quality of care during the closure.

Positively it was found the communication strategy with all relevant stakeholders was effective as was the supported redeployment of MIU staff.

Despite the positive steps taken by the Health Board to address the situation, it is reasonable to conclude that the closure of MIU could have been avoided if action had to been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018/19 around staff training and qualifications.

Current Position - The MIU re-opened on a phased basis in May 2022 and is now open fully and seeing, treating and discharging up to 50 patients a day.
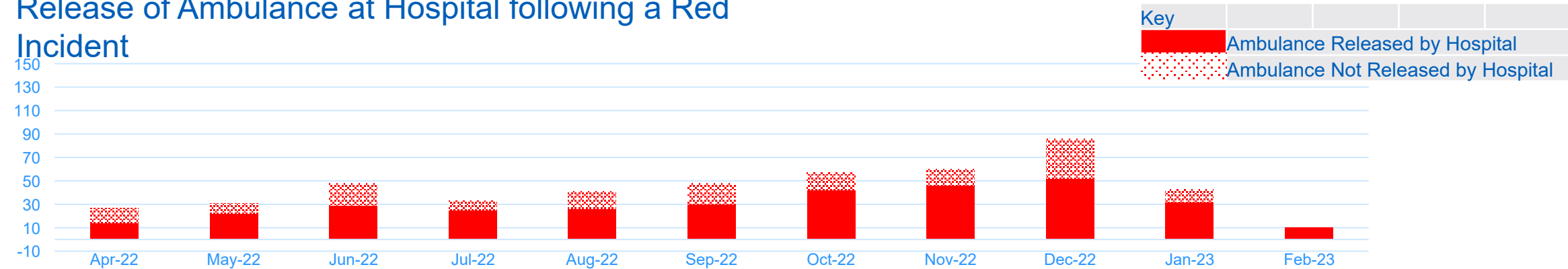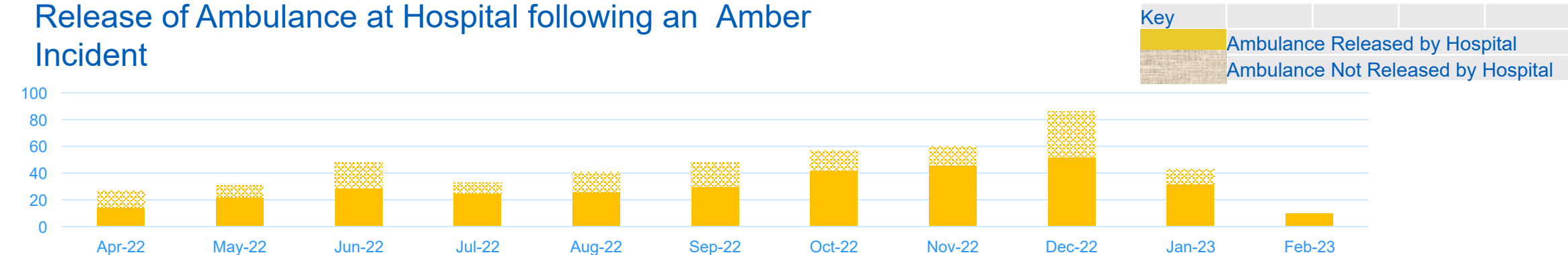
Adults Absconding and Did Not Wait Action Card

RGH Emergency Department
RGH ED Adult Absconding & Did Not Wait – Action Card

"ABSCONDING" is defined as a patient who has left the department unexpectedly, without the knowledge of clinical staff, and in whom there remains a potential risk of harm to self or others either through neglect or deliberate means.
Consider if the patient could be suffering from an impairment of, or a disturbance in the functioning of the mind or brain? eg mental health crisis, under influence of drugs or alcohol, head injury or cognitive impairment.

HIW visit to Ward 5 Princess of Wales

Immediate Assurance required –

To ensure that all cupboards and medication fridge within the Ward Treatment room have working locks.

To ensure that the mobile medication trollies on the stroke ward are secured to a wall when not in use to ensure unauthorised removal.

To ensure that the fire risk assessment for Wards 5 & 6 has been updated.

To increase provision for the stroke ward team to access mandatory training -

particular reference made to - resuscitation training, manual handling and IPC training.

Response to health and safety concerns

Following a letter received from Judith Paget, Chief Executive NHS Wales dated the 6th February 2023, regarding concerns relating to the management of boarded patients in fire evacuation routes being a breach of health and safety regulations.

There is an ongoing commitment to improve the standardisation of discharge processes working collaboratively with local authority colleagues, deployment of our Discharge to Recovery then Assess Hub, and extension of our 'Safe2Start' site-based meetings.

These approaches are part of our wider strategies under the USC 6 goals programme to ensure the utilisation of spaces such as fire routes is minimised to extremis conditions.

The fire and health and safety officers have been engaged in and advised on a fire evacuation exercise. This exercise was undertaken on the 8th February and has concluded boarded patients can be evacuated appropriately and demonstrated we can meet our obligations to ensure the safety of our patients and staff.

cwmtafmorgannwg.wales

Recommendation:	The Committee are asked to:
	NOTE the report

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 24 January 2023 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
Dilys Jouvenat	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Dom Hurford	Executive Medical Director
Lauren Edwards	Executive Director of Therapies & Health Sciences
Gethin Hughes	Chief Operating Officer
Greg Dix	Executive Director of Nursing
Lydia Thomas	Head of Quality & Patient Safety
Claire O'Keefe	Head of Safeguarding
Karen Wright	Assistant Director of Policy, Governance and Compliance
	Assistant Director of Governance & Risk
Cally Hamblyn	Assistant Director of Concerns & Claims
Stephanie Muir	Head of Midwifery & Gynaecology (In part)
Sarah Fox	Medical Lead, Children and Families Care Group
Mohamed Elnasharty	Primary Care, Community and Mental Health - Care Group
Ana Llewellyn	Nurse Director
	Medical Lead, Unscheduled Care Group
Owen Weeks	Clinical Advisory Group Chair
Sally Bolt	Planned Care - Care Group Nurse Director
Carole Tookey	Unscheduled Care – Care Group Nurse Director
Richard Hughes	
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Chris Beadle	Head of Operational Health, Safety & Fire
Sarah Morgan-Jones	Volunteer Manager (In part)
Jenny Oliver	Governance & Patient Experience Manager
Paul Dalton	NWSSP Internal Audit Services
Gaynor Jones	Royal College of Nursing (RCN) Convenor
Sara Utley	Audit Wales
Rowena Myles	Cwm Taf Morgannwg Community Health Council
Rhys Jones	Healthcare Inspectorate Wales
Lisa Love-Gould	Clinical Director of Allied Health Professionals
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Observing:

Sophie Bassett	Lead Nurse, Mental Health Care Group (Observing)

Unconfirmed Minutes of the CTMUHB
Quality & Safety Committee Meeting
held on the 24 January 2023

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Quality & Safety
Committee 16 March
2023

1/14

21/297

Agenda Item

1.0	**PRELIMINARY MATTERS**
1.1	**Welcome & Introductions**

In opening the meeting, J Sadgrove, Committee 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 Committee Chair.

1.2	**Apologies for Absence**

Apologies for absence were received from:
- Carolyn Donoghue, Independent Member;
- Sallie Davies, Deputy Medical Director;
- Julie Denley, Deputy Chief Operating Officer;
- David Miller, Medical Lead, Primary & Community Care Group

1.3	**Declarations of Interest**

No interests were declared

2.0	**SHARED LISTENING AND LEARING**

2.1	**Listening & Learning Story**

S Morgan-Jones shared a presentation and video with Members which related to the Cariad Pet Therapy project that was being undertaken within the Health Board.

The Chair welcomed the presentation which had outlined the wonderful contribution this new service was making.

G Hughes queried whether in recognising the importance of services such as this for both patients and staff, any support was required from the Health Board to enable the service to be expanded more widely. S Morgan-Jones advised that sharing experiences via forums such as the Quality & Safety Committee would help and added that positive working relationships were established with the Communications Team who were helping the team to cascade information in relation to the project. Members noted that Cariad Pet Therapy were also providing excellent support. S Morgan-Jones advised that it would be welcomed if Members of the Committee could undertake a visit to the unit on a day when pet therapy volunteers were present, this suggestion was supported by Committee members.

The Chair extended her thanks to S Morgan-Jones for sharing the story and welcomed the suggestion made by G Dix for S Morgan-Jones to attend a future meeting to discuss the wider piece of work being undertaken in relation to the Volunteer Service.

Resolution: The Listening & Learning Story was **NOTED.**

Action: Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.

3   CONSENT AGENDA

3.0   For Approval/Noting

3.1.1   Unconfirmed Minutes of the Meeting held on the 15 November 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 17 November 2022

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

3.1.3   Quality & Safety Committee Annual Cycle of Business

Resolution: The Quality & Safety Committee Annual Cycle of Business was **APPROVED.**

3.1.4   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   Quality & Safety Committee Forward Work Programme

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

3.2.3   Safeguarding Annual Report

Resolution: The Safeguarding Annual Report was **NOTED**.

3.2.4   Quality Governance – Regulatory Review Recommendations and Progress Updates

Resolution: The Report was **NOTED**.

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

Resolution: The report was **NOTED**.

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3.2.6   **CTMUHB Nosocomial Covid-19 Incident Management Programme**

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 that Care Group Directors had now assigned all of the risks escalated to the Organisational Risk Register to the new Care Group model, and added that a workshop had been held with the Executive Team to commence a programme of work to review all risks within their portfolio focussing on the risk description, mitigation and control measures to ensure there is a consistent approach to risk methodology and scoring.

N Milligan made reference to risk 4148 and advised that it would be helpful to have an update against this risk given the last update was provided in August 2022 and sought clarity as to when the posts were likely to be filled to assist in addressing the backlog. G Dix advised that a discussion had been held in relation to the Deprivation of Liberty Service (DOLs) and some of the court of protection challenges and provided assurance that the risk would be updated to reflect the current position.

P Roseblade made reference to Risk 5276 which related to the failure to deliver the LINC programme, drawing attention to the reference to an extension of the contract. P Roseblade queried if an extension with the current supplier was possible as she understood this not to be the case. C Hamblyn advised that she would seek to confirm the position outside the meeting.

In relation to a query raised by P Roseblade in relation to Risk 5214, which related to Critical Care, which had not been updated since September last year, D Hurford advised that he was planning on combining the critical care risks into one overarching risk and added that a discussion would be taking place in February as to how Critical Care Services would be delivered moving forwards. D Hurford agreed to keep the Committee updated on progress.

In response to a query raised by P Roseblade in relation to Risk 4071 and any impact on waiting times that may arise from the pausing of the 104+ day harm review panels on two sites, G Hughes advised that he would confirm the position

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on this outside the meeting as to whether the pausing of review panels would cause further delays.

In response to a comment made by P Roseblade in relation to risk 4013 which related to ophthalmology, G Hughes advised that as waiting times had not reduced as quickly as anticipated, additional funding had been secured from Welsh Government to enable the Health Board to undertake some further outsourcing by the end of March 2023. Members noted that this still remained the largest specialty in terms of long waits and noted that steps were being taken to source ongoing funding capacity for next year.

The Committee Chair made reference to Risk 3131 which related to the Mortuary service and noted that additional facilities were being provided. The Committee Chair sought clarity whether there was confidence that security and access control arrangements were in place. G Hughes confirmed that standardised processes were now in place. In relation to mortuary capacity, G Hughes confirmed that the new mortuary had recently opened at Prince Charles Hospital and added that significant support had been received from the Health Board's Funeral Director colleagues. Members noted that additional mortuary capacity had been purchased from Aneurin Bevan University Health Board between Christmas and New Year and it was hoped that the Health Board would no longer need to use this capacity from the 10 February. D Hurford also confirmed that the Coroner's office had reduced the number of post mortems the Health Board were required to undertake over the next year.

The Chair made reference to Risk 5254 which related to the Duty of Candour, and sought clarity as to how this would now be managed given the Invest to Save bid that was submitted being unsuccessful. G Dix advised that this would remain a risk and it was hoped that the recentralisation of the quality governance structure would help to support the mitigation of this risk moving forwards.

Resolution: The report was **NOTED**

Action: Responses to be sought from Executive Leads in relation to the queries raised in relation to Risks 4148; 5276; 5214; 4071 and 3131 and an update to be shared outside the meeting.

5.2 **Update Report on Progress following Internal Audit on Concerns and Welsh Risk Pool Review of Claims/Redress/Inquests**

S Muir presented the report which outlined the positive progress that had been made in relation to addressing the recommendations.

G Dix extended his thanks to S Muir and the Claims and Redress Team on the focus that had been placed on this piece of work and suggested that monitoring of progress would now be undertaken through local governance processes.

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In response to a question raised by J Hehir as to how sustainable was the progress that had been made to date, S Muir advised that she was confident that improvements made would be sustainable as a result of the new operating model structures that are being implemented to support the care group quality governance model.

The Chair extended her thanks to S Muir and G Dix for presenting the report and confirmed that Committee members were content with progress being monitored through operational processes moving forwards.

Resolution: The report was **NOTED.**

5.2.1   Learning From Events Reports

S Muir presented the report which provided Members with an update on the work being undertaken to improve timely submission of Learning From Events (LFER) reports to the Welsh Risk Pool.

P Roseblade welcomed the report which she had found to be self-explanatory and noted the significant amount of work that had been undertaken in this area. In response to a query raised by P Roseblade in relation to the escalation process, S Muir confirmed that an escalation process was now in place with clarity as to where concerns needed to be escalated if Learning From Events forms were not being received.

In response to a question raised by P Roseblade as to what the financial risk was in regards to the submission of blank Learning From Events forms to the Welsh Risk Pool, S Muir advised that it was difficult to answer this question in terms of financial risk given the fluctuating values associated with each LFER submission.

In response to a query raised by J Hehir as to whether there were any deadlines that needed to be met for the amber deferred cases, S Muir advised that amber deferred cases were given a further six months to action following presentation to the amber panel.

The Chair welcomed the progress that had been made to date and advised that she was pleased to see that the system was working more effectively. The Chair sought clarity as to whether Members felt there was sufficient assurance and confidence in place for this to be monitored through operational processes or whether further assurance was required by Committee Members.   G Dix suggested that it would be helpful if a further report could be presented to the Committee in three months for further oversight. Members received assurance that the position in relation to the submission of LFER's were also being monitored weekly at the Executive led patient safety meetings.

Resolution: The Report was **NOTED**.

Action: Progress report to be presented to the Committee in three months.

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5.3   **Datix Cymru Assurance Report**

K Jenkins-Forrester presented the report. Members noted that incidents continued to be reported and themes and trends continued to be identified via the system. Members noted that a robust corporate audit programme was in the process of being developed and noted that a significant improvement in the quality of data being reported should be seen over the next few months.

The Committee Chair extended her thanks to K Jenkins-Forrester for presenting the report and noted that a further report on progress would be presented to the Committee within the next six months.

Resolution: The report was **NOTED**.

Action: Report on progress to be presented to the Committee within the next six months.

5.4   **CTMUHB Quality & Safety Framework 2022-2025**

L Thomas presented the report.

The Committee Chair welcomed the framework which was a significant piece of work and advised that the Committee would fully support the standardisation of documents and templates.

N Milligan made reference to the statement made on page 3 of the cover report which stated that 'the Committee can be assured that the organisation has in place a comprehensive framework for a Quality Management System'. N Milligan added that it would need to be acknowledged that the framework was now in place and that it was having a positive impact.

D Jouvenat commented that the Framework itself, particularly on page 13, was not very accessible to read with some of the colours used behind the font making it difficult to read. This was noted by L Thomas.

In response to a question raised by J Hehir as to what success would look like in 12 months and how success would be measured, G Dix advised that the Quality Governance Framework was the vehicle for the delivery of the Quality Strategy. G Dix added that ongoing discussions were being held with Welsh Government as to what the Health Board needed to achieve to improve its escalation status. Members noted that there would be tangible outcomes and measures that would fall out of the Quality Strategy and noted that there would also be an implementation plan which would be thoroughly socialised across the Health Board.

The Committee Chair welcomed the progress being made in this area.

Resolution: The Quality & Safety Framework was **ENDORSED FOR BOARD APPROVAL**.

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6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

S Fox and M Elnasharty presented the report. The Committee Chair recognised the significant amount of information that had been included in the report.

N Milligan made reference to one of the questions used in the 'What we could have done Better? Section of the questionnaire and queried whether it would be more helpful to change one of the response options to 'Felt that they *sometimes* received sufficient info about unit facilities, visiting, support groups' to avoid confusion for those completing the questionnaire. S Fox agreed to feed this suggestion back to the team.

In response to a question raised by J Hehir as to whether there were any lessons that could be shared with the Committee today in relation to the severe incident that occurred in Prince Charles Hospital, S Fox advised that she was unable to share the exact make safes during this meeting but advised that she would be happy to provide feedback to the next Committee on any urgent make safes that have needed to be undertaken as a result of this incident. S Fox added that a robust review would be undertaken.

The Committee Chair advised that the report was discussed in detail at the Maternity & Neonatal Improvement Board and added that she was pleased to see that some of the areas discussed at that meeting would be taken forward. The Committee Chair advised that she was pleased to see that feedback being received was being considered and acted upon and formally congratulated the service for receiving their PROMPT training award.

Resolution: The report was **NOTED.**

Action: Feedback to be shared with the Team regarding the suggestion made by N Milligan to amend one of the response options within the questionnaire.

Action: Feedback to be provided to the next Committee in relation to the urgent make safes that had been put into place following the severe incident that occurred at Prince Charles Hospital.

6.2 Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

L Edwards presented the report and highlighted that the Welsh Health Specialised Services Committee had now formally de-escalated the Unit from Level 4 to Level 3 following a quality visit that was undertaken.

The Committee Chair welcomed the report and the progress that had been made and was pleased to see the connections with the Listening & Learning story that was shared earlier in the meeting.

D Jouvenat extended her congratulations to the service for achieving the de-escalation status and added that she recognised how hard the Unit had worked to achieve this position.

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The Committee Chair welcomed the reports that had been received on the two services that were in external escalation and added that she had been in discussions with G Dix in relation to the services that were in internal escalation and how updates against these areas could be presented to the Committee moving forwards.

Resolution: The report was **NOTED.**

6.3 Quality Dashboard

L Thomas presented the report and highlighted the key matters for the attention of the Committee.

G Dix advised that the Health Board had recently attended the performance meeting with Welsh Government and the Delivery Unit where the Health Board was thanked for the work that had been undertaken in relation to delivery of the Patient Safety Notices. Members noted that the Delivery Unit also provided feedback in relation to the Nasogastric tube misplacement patient safety notice and noted that the Delivery Unit were now taking a refreshed approach in relation to the actual requirements that medics need to declare in relation to level of compliance.

G Dix advised that work continues to refine the Quality Dashboard report in light of the new Duty of Candour and Quality Governance Framework and added that he would welcome feedback from Committee Members as to what they would like to see included within the Quality Dashboard report.

In response to a question raised by N Milligan as to how the monthly patient safety newsletter was disseminated, L Thomas advised that the newsletter was shared with Heads of Department who then cascade to their Teams. Members noted that the Team were also in the process of establishing a learning repository which would be housed within SharePoint and would include themes, trends, action plans and improvement projects.

J Hehir welcomed the comprehensive report and made reference to the pressure damage incidents update contained on page 4 of the report and sought clarity as to when the community acquired pressure ulcer project was likely to commence and where the project would report into. L Thomas confirmed that the project had commenced. A Llewellyn added that a discussion had been held as to which forum the group would report into and it was agreed that the group would report into the Primary Care & Community Care Group Quality & Safety meeting. Members noted that an update on progress would be presented to the Committee as part of the Deep Dive into Community Services report.

P Roseblade made reference to page 3 of the cover report which referred to patient safety incidents which reads that 28 people had died as a result of patient safety incidents. K Jenkins-Forrester advised that within Datix Cymru, there was a severe or death category which these incidents would have been reported against, even though a death had not occurred. Members noted that these

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incidents would undergo review to determine the level of harm that had occurred to the patient. D Hurford assured members that if the number of deaths had occurred as reported in this item then they would have been highlighted through the mortality review process which they were not and advised that he would highlight any areas of concerns with Members if they arose in future. Following discussion, it was agreed that a caveat would be included in the report to explain this moving forwards.

In response to a query raised by P Roseblade regarding the two falls referenced within the report being nationally reportable due to being unavoidable, L Thomas advised that this was a typographical error and advised that this should be avoidable as opposed to unavoidable.

P Roseblade advised that she could not reconcile the graphs to the narrative and asked for this to be addressed moving forwards. G Dix advised that as a result of the national policy changes, the content and format of the report would be reviewed moving forwards and added that he would be looking to test some data prototypes with Independent Members.

In response to a query raised by P Roseblade as to the potential reasons behind the reduction in patient falls, L Thomas advised that there had been an improvement made in the sharing of learning from patient falls.

R Hughes provided a verbal update in relation to the review that had been undertaken in relation to Emergency Care Incidents, particularly the incidents that had been deemed to be coded as severe and catastrophic incidents. Members noted that the review had identified that staff were concerned that pressures being seen within the department could result in death or injury of a patient and noted that some time had been spent with staff to work through alternatives for reporting of incidents. Members noted that the main areas of concern over the winter period related to falls and pressure sores and noted that the team had been asked to undertake a high level review of Quarter 3 data in order to gain an understanding of pressure ulcers and falls which would be classed as hospital acquired. Members agreed to receive a Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.

G Dix extended his thanks to R Hughes for commencing a review of the position and advised that whilst he had seen some fantastic compassionate care provided to patients, he still remained concerned in relation to the criticalness of the position and the lapses of care provided within the Emergency Departments. D Hurford advised that there were concerns in relation to the boarding of patients which was not the level of care that the Health Board wished to provide and added that an improvement had been seen in recent weeks in relation to ambulance red releases.

G Hughes advised Members that a letter had been written to the leaders of the three Local Authorities within Cwm Taf Morgannwg outlining the concerns in relation to the delays being experienced transferring patients out of hospital. Members noted that the response would be shared with Committee members

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once received. D Hurford also extended his thanks to O Weeks, S Follows and R Hughes for the significant amount of work they had undertaken in this area.

Resolution:	The report was **NOTED**
Action:	Caveat to be included within future reports in relation to the severe/death category for patient safety incidents to explain that an incident reported against this category had not necessarily resulted in the death of a patient.
Action:	Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.
Action:	Response from Local Authority Leaders to be shared with Committee members once received following the submission of a letter outlining the Health Board's concerns in relation to delays being experienced with the transfer of patients out of hospital.

6.4   Report from the Chief Operating Officer

G Hughes presented the report and highlighted the key matters for the attention of the Committee. Members noted that the 'go live' date of the navigation hub had recently been expedited which would enable Nursing Homes to contact the hub directly to identify whether there was a different response that could be provided to patients within the Community. Members noted that this was a significant development and noted that the Health Board were keen to encourage the ongoing uptake of this service.

P Roseblade made reference to the £3m investment that had been referred to for stroke services and sought clarity as to whether this was a bid or an investment. P Roseblade also sought clarity as to whether the action plan would be monitored through the Planning, Performance & Finance Committee or the Quality & Safety Committee. L Edwards confirmed that the Stroke Task & Finish Group had been tasked to scope out the gaps in services which would need further review and scrutiny in terms of risk stratification. L Edwards added that the resource currently in place was being utilised in different ways and the impact of this would be monitored. L Edwards advised that she would be happy to discuss this further with P Roseblade outside the meeting if it would be helpful. The Committee Chair advised that it was of her understanding that Stroke was an area that was overseen by the Quality & Safety Committee and in this respect would be happy for the Committee to monitor progress against the action plan.

P Roseblade advised that she was pleased to hear about the update provided that no red release of ambulances had been denied and added that she was disappointed to see that a six monthly update had been included in the report as opposed to a month by month summary. The Committee Chair also welcomed the positive improvement that had been made in relation to red release performance in January.

Resolution:	The report was **NOTED.**

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6.5 **Monitoring & Reporting of Continuing Healthcare and Funded Nursing Care Activity**

A Llewellyn presented the report and confirmed that she had met with P Roseblade following the last meeting to discuss the process further.

P Roseblade advised that she found the report to be very informative and welcomed the amendments that had been made to the report since the last meeting. P Roseblade clarified that whilst Audit & Risk Committee did monitor the action plan, this was undertaken by way of the Audit Recommendations Tracker.

Following discussion as to whether it would be helpful to receive further updates on this matter, it was agreed that it would be helpful if the Committee could be provided with an Annual Report, with regular reporting of any homes in escalation to be captured in the Quality Dashboard report.

Resolution: The report was **NOTED.**

Action: Annual Report to be presented to the Committee moving forwards with regular reporting of any homes in escalation to be captured in the Quality Dashboard report.

6.6 **Deep Dive into Children and Adolescent Mental Health Service (CAMHS)**

A Llewellyn presented Members with the report and highlighted the key matters for the attention of the Committee.

In response to a question raised by J Hehir as to whether the Committee should be concerned about anything contained within the report, A Llewellyn advised that she felt confident that oversight of any issues were being undertaken by the Team and advised that she would wish to highlight one risk which related to the Clinical Service Group Manager being successfully appointed into another role. Members noted that interim support had been secured whilst a substantive appointment was being made.

The Committee Chair expressed concern in relation to part 1 performance compared to performance within other Health Board's and also expressed concern in relation to care and treatment plan performance which was worsening and would inevitably affect the quality of care being provided. A Llewellyn advised that there were challenges across Wales in relation to Part 1 performance which was concerning. In relation to Care and Treatment Planning, A Llewelyn advised that an upward tick was being seen in this area and she anticipated the position would significantly improve by February/March 2023.

N Milligan commented that she was pleased to see the positive impact of the Schools In Reach Team. N Milligan expressed concern in relation to the 30% complaints response rate recorded for October 2022 and added that she was disappointed to read that further training to address this would not be undertaken until March 2023. A Llewellyn advised that this related to a small number of complaints and advised that whilst the Team were prioritising the

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waiting list backlog they had committed to undertake a training session in March 2023.

In response to a query raised by the Committee Chair as to whether any further updates on CAMHS were required by the Committee, Members noted that from March 2023 onwards the Care Groups would be reporting their Quality & Safety Care Highlight reports to the Committee and noted that any areas which were of concern would be highlighted in the alert/escalate section of the report for further discussion. Members noted that it had also been agreed that each Care Group would present a Deep Dive on a specific area twice yearly.

Resolution: The report was **NOTED.**

6.7   Liberty Protection Safeguards Preparation
C O'Keefe presented the report and highlighted to Members that the implementation date had now been delayed from October 2023 to April 2024. Members noted that the full impact this would have on colleagues would not be known until the Code of Practice was received and noted that the Team were trying to prepare for the implementation of the Liberty Protection Safeguards by addressing the backlog of Deprivation of Liberties Standards applications.

Members noted that as a result of Welsh Government funding, the Health Board had been able to appoint two Best Interest Assessors and two additional members of staff to undertake training and awareness on this matter, which had resulted in an increase in referrals being seen.

In response to a question raised by J Hehir as to whether the delays in the guidance being issued by Welsh Government would impact on the ability to deliver the training on time, C O-Keefe advised that the Team were undertaking a benchmarking exercise and were working with colleagues within other Health Board's to understand the impact of any delays. Members noted that it may be necessary to share a further report later in the year with Committee Members on the progress being made.

Resolution: The report was **NOTED.**

Action: Report to be shared with Committee Members later in the year on progress being made in this area.

6.8   Child T – Child Practice Review
C O'Keefe presented the report and highlighted the key matters for the attention of the Committee. Members noted that an improvement plan was in place which could be shared with Members if required.

In response to a question raised by N Milligan as to what steps would be taken to help support staff in challenging senior staff if they feel uncomfortable with any decisions being made, C O'Keefe advised that steps were being taken to ensure access to support and supervision was available to all staff with opportunities to contact other teams and services for support.

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D Hurford advised that in relation to Clinicians, communication had been issued reiterating their responsibilities and asking them to ensure they complete their training compliance.

J Hehir confirmed that this matter had been discussed at length at the Executive Safeguarding Board and added that he commended the work that had been undertaken to address the concerns highlighted within the report.

In response to a question raised by the Committee Chair as to whether the Committee needed to receive any further updates on this matter, D Hurford advised that assurances had been made through the Executive Safeguarding Board that the Committee would be regularly updated on this matter.

The Committee Chair advised that she agreed with the point made in relation to the difficulty for some staff in relation to raising concerns and advised of the importance of developing a culture that supports and enables staff to raise matters that were of concern.

Resolution: The report was **NOTED**.

7.   ANY OTHER BUSINESS

There was no other business to report.

7.1   HIGHLIGHT REPORT TO BOARD

7.2   HOW DID WE DO IN THIS MEETING TODAY?
The Committee Chair advised that she would be happy to receive comments outside the meeting as to how Members felt the meeting went today. The Chair advised that further reflection was required as to the number of items contained on the agenda to ensure that items receive adequate discussion.

8.   DATE AND TIME OF THE NEXT MEETING
The next meeting would take place at 9:00am on Thursday 16 March 2023. An In Committee session would also be held on Monday 30 January 2023 at 4:00pm.

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 30 January 2023 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
Dilys Jouvenat	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Lauren Edwards	Executive Director of Therapies & Health Sciences
Gethin Hughes	Chief Operating Officer
Greg Dix	Executive Director of Nursing
Dom Hurford	Executive Medical Director
Cally Hamblyn	Assistant Director of Governance & Risk
Luke Garthwaite	Medical Director Business Manager (Observing)
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:
- Carolyn Donoghue, Independent Member

1.3 Declarations of Interest

P Roseblade declared that she had previously been heavily involved in the development of a Controlled Drugs Policy for Swansea Bay University Health Board and added that she had also shared this declaration with the Medical Director.

2 MAIN AGENDA

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

Resolution: The Minutes were **NOTED**.

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2.2 Action Log

The action log was received and discussed.

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

2.3 Parc Prison, Controlled Drugs

D Hurford presented the report and outlined the key matters for the attention of the Committee, identifying the challenges faced and the actions being taken to mitigate any risks to the service.

Following discussion, Members noted that a further update on progress would be presented to the Committee in six weeks.

Resolution: The report was **NOTED**.

Action: Progress report to be presented to the Committee in six weeks.

3. ANY OTHER BUSINESS

There was no other business to report.

4. DATE AND TIME OF THE NEXT MEETING
The next In Committee meeting would take place on Monday 27 March 2023 at 2.00pm

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	AGENDA ITEM
	3.1.3

QUALITY & SAFETY COMMITTEE

CHILDREN AND YOUNG PERSON HOSPITAL ADMISSION POLICY

Date of meeting	16/03/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Sian Watkins -Strategic Planning & Commissioning Manager
Presented by	Charlotte Thomas – Head of Strategic Planning & Commissioning
Approving Executive Sponsor	Executive Director of Strategy & Transformation

Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Senior Nurse Meeting	31/01/2023	SUPPORTED
Sharepoint Consultation	06/02/2023	SUPPORTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
C&YP	Children and Young People

1. SITUATION/BACKGROUND

1.1　This paper presents a revised CTMUHB wide policy for the acute admissions of 16 and 17 year olds.

1.2 Welsh Government (WG) Admissions Guidance published in March 2019. The guidance needed to align with the new operating model, as well as with the practices followed by other health boards, C&YP 16-17 years are generally treated on adult wards in other health boards (with exceptions).

1.3 This policy aims to provide direction on the importance of effective support and treatment of C&YP 16-17 years. The policy details the pathways, processes and procedures that CTMUHB are expected to adhere to so that we can ensure the safety of the patient and ensure the appropriate provision of support and treatment.

1.4 The policy has been developed for C&YP 16-17 years admitted to all hospital sites across CTMUHB to ensure they receive high quality care in an appropriate environment/location whether this is a dedicated children's unit or an adult unit.

1.5 The policy outlines the criteria where C&YP 16-17 years should be admitted by age and provide exceptions to the criteria.
- The policy will incorporate the rights of the child and offer guidance to healthcare professionals caring for C&YP 16-17 years in an adult ward to ensure that there is appropriate risk management in place to safeguard those young people admitted to adult care settings.

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

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	**18/01/2023**
Informal Consultation with interested parties	**31/01/2023**
Formal Consultation	**06/02/2023**
Clinical Policy Approval Group – For approval	**27/02/2023**

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 Clinicians have been engaged in the consultation.

2.4 Organisational values and behaviours have been reflected within the policy.

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

3.1 In response to the consultation the policy required no amendments.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	Yes 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.
	Completed on 18/02/2023
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 are asked **APPROVE** the Children & Young Person Hospital Admission Policy.

5.2 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

CWM TAF MORGANNWG (CTM)
CHILDREN AND YOUNG PEOPLE AGED 16-17 ADMISSION POLICY

Policy Details:

Ref:	TBC
Policy Author:	Head of Strategic Planning and Commissioning Growing Well Systems Group
Executive Sponsor:	Executive Medical Director, Executive Director of Nursing, Midwifery, and Patient Care
Approval / Effective Date:	16/03/2023
Review Date:	30/03/2024
Version:	1

Target Audience:

People who need to know this document in detail	Quality, Safety and Risk Committee Executive Medical Director, Executive Director of Nursing, Midwifery, and Patient Care, Service Director, Children and Families Care Group, Service Director, Unscheduled Care Group Service Director, Primary & Community Care Group Senior Nurses Pediatrics and acute care
People who need to have a broad understanding of this document	Board Members
People who need to know that this document exists	All clinical staff within the relevant Care Groups.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: 18/01/2023
	Approved

Ref:
Policy Title: Children and Young Person Hospital Admission Policy
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Welsh Language Standard 82	N/A
Date of approval by Equality Team:	Date: 18/01/2023
Aligns to the following Wellbeing of Future Generation Act Objective	• Work with communities and partners to reduce inequality, • Provide high quality, evidenced based, and accessible care

Policy Approval Route:

Where	When	Why
Organisational wide consultation via SharePoint	6th February 2023	To ensure opportunity for comment from all staff
Clinical Policy Group	27th February 2023	Approval
Quality and Safety Committee	16th March 2023	Approval

Ref:
Policy Title: Children and Young Person Hospital Admission Policy
Page Number: 2

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APPENDICES

1. Equality Impact Assessment

2. Guidelines for accessing the CAMHS "designated bed" on the Admission Ward, Mental Health Unit, Royal Glamorgan Hospital.

3. All Wales Risk Assessment Tool and Action Plan for use in Wards/Areas that Admit Children/Young People 0-18 years.

Introduction

The purpose of this policy is to enable a standardised approach to the management of acute admissions of children and young people aged 16-17.

It serves to formalise the interim guidance for the management of acute admissions relating to 16 and 17 years olds that had been issued for Cwm Taf in October 2018, and enables an alignment of approach following changes to the Cwm Taf Morgannwg operating model.

It also serves to align Cwm Taf Morgannwg with the management of acute admissions of young people across other Health Boards in Wales.

This Policy will ensure that the care and treatment needs of young people are met in a way that minimises the risk of harm by being placed on an adult ward, and that they are appropriately cared for through their hospital admission. During any period that the young person is on the ward, appropriate safeguarding children arrangements must be in place.

This Policy <u>does not</u> apply to young people requiring acute admission in relation to Mental Health, for this please refer to Appendix 2, *Guidelines for accessing the CAMHS "designated bed" on the Admission Ward, Mental Health Unit, Royal Glamorgan Hospital.*

1. POLICY STATEMENT

1.1   Cwm Taf Morgannwg University Health Board (CTMUHB) recognises its fundamental duty to care and protect its patients at all times. All patients have the right to receive appropriate care in an environment most suited to their needs.

1.2   Under the Children Act, 1989, a child or young person is classified as a child until they reach the age of 18.

1.3   This Policy describes the processes that should be followed in order to ensure that all Children receive care in the most appropriate environment, when requiring acute admission to hospital.

2. SCOPE OF POLICY

2.1   This Policy applies to all Children and Young People. The decision where to admit lies with the Responsible Clinician. Staff responsible for making such decisions must be aware of the relevant safeguarding procedures, and their Level 3 Safeguarding Training must be up to date.

3. AIMS AND OBJECTIVES

3.1 The purpose of this Policy is to ensure that;

- All children (anyone up to the age of 18 years) receive high quality care in a safe, and appropriate environment, most suited to meet their healthcare needs.

- All patients, families, carers and staff are aware of the procedures in relation to admission.

- Healthcare staff take a Children's Rights Approach to meeting the needs of the young person (Children's Commissioner for Wales, 2017).

4. RESPONSIBILITIES

4.1 Staff are responsible for ensuring that they are aware of this Policy, and act in accordance.

4.2 Care Group management teams are responsible for implementing systems to ensure that staff are made aware of this Policy.

4.3 The Corporate Safeguarding Team are responsible for ensuring that this Policy is followed, and that appropriate risk assessment and safeguarding procedures are followed.

5. PROCEDURES

Children up to 16 years

5.1 All children up to 16 years (15 years and 364 days) must be cared for on a Paediatric ward except where only the adult facility has the expertise to provide safe care, e.g. Maternity, Gynaecological services. In these cases, a patient should still be allocated a Paediatric nurse.

Agreed exceptions:

- Patients who have been transitioned and are no longer under a named Paediatric Consultant.

5.2 Even if they are admitted to an adult facility, it must still be recognised that they are a child for whom there is someone with parental responsibility, and for whom protection is afforded under the Children Act 1989.

<u>Young People aged 16-17</u>

5.3   Almost all young people aged 16-17 will be accommodated on the adult wards under the appropriate specialty. A risk assessment of the adult environment/ward should be undertaken. Please see Appendix 3.

Agreed exceptions which include:

- A young person aged 16 – 17 years who is under a named Paediatrician and has not been formally transitioned. This includes young people with chronic health needs under paediatric follow up, such as complex needs, Diabetes, Cystic Fibrosis, Epilepsy, Inflammatory Bowel Disease.

- A young person that has care provided by a children's hospice/children's palliative care team.

5.4   The decision where to admit lies with the Doctor from which specialty the child is to be treated by.

5.5   Every admission of a young person aged 16-17 onto an adult ward should be risk assessed with the All Wales Risk Assessment Tool (Appendix 3), due to the potential safeguarding risks associated with a child being placed in an adult setting. A DATIX should also be completed.

5.6   The number, and status of any inpatients on adult wards aged 16-17 should be considered in line with the Safe to Start approach, with arrangements made for adult clinicians to attend and review their patients on the Paediatric ward.

5.7   The Outreach Team should be contacted to support a young person 16-17 years if acutely unwell whilst on the Paediatric ward.
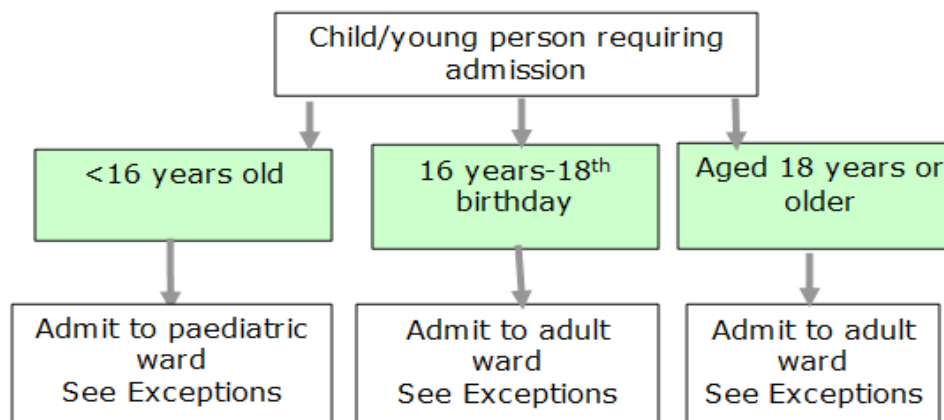
Figure 1. Visual process Map: 16/17 year old Admissions (Excluding Mental Health)

6. INFORMATION, INSTRUCTION AND TRAINING

6.1　All staff are expected to refer to this policy when caring for Children & Young People aged 16-17.

6.2　Managers are responsible for ensuring all staff are following this Policy, and that staff's Level three Safeguarding training is up to date.

7. MONITORING

7.1 All Patients are asked to share feedback through the Civica System. A specific questionnaire has been designed for children aged 16/17.

https://scanmail.trustwave.com/?c=261&d=4YbR4xsqSiIUNBWJ3szbaZ15rma0yAAHHurg4dnU7w&u=https%3a%2f%2fsecure%2emembra%2eco%2euk%2fExperienceCTM%2fm%2fpreliminarypage%2easpx%3fLang%3dEN%26%26ID%3d41

7.2 Ward Managers within the Adult wards will be responsible for recording the number of Children and young people aged 16-17, and confirming that a DATIX has been completed.

7.3 In cases of non-completion, the Senior Team is responsible for ensuring that the appropriate risk assessments are carried out.

8. CONSULTATION / APPROVAL PROCESS

8.1　The consultation/approval process is outline in the table below:

CONSULTATION PROCESS	DATE
Policy consultation via sharepoint	**06/02/2023**
APPROVAL PROCESS	
Clinical Policy Committee	**27/02/2023**
Quality & Safety Committee	**16/03/2023**

Ref:
Policy Title: Children & Young Person Hospital Admission Policy
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9. PUBLICATION AND DISSEMINATION

9.1   This policy will be available on Share point. The policy will also be shared with primary care colleagues.

10. REVIEW PROCESS

10.1   This policy will be reviewed annually. The following criteria will trigger the need for an earlier review:
- Regulatory/statutory changes
- Results/effects of critical incidents
- Any other relevant, compelling reasons.

APPENDICES

1. Equality Impact Assessment

Equality Impact
Assessment - Admissi

2. Guidelines for accessing the CAMHS "designated bed" on the Admission Ward, Mental Health Unit, Royal Glamorgan Hospital.

CTMUHB CAMHS
'designated bed' gu

3. All Wales Risk Assessment Tool and Action Plan for use in Wards/Areas that Admit Children/Young People 0-18 years.

ALL WALES RISK
ASSESSMENT TOOL

AGENDA ITEM
3.1.4

QUALITY & SAFETY COMMITTEE

RATIFICATION OF URGENT COMMITTEE CHAIR'S ACTION - POLICY APPROVAL

Date of meeting	16/03/2023

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 Operating Officer (COO, DPCMH)

Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	Date	Outcome
Urgent Chair's Action	Circulated 30/01/2023	SUPPORTED

ACRONYMS	
INNU	Interventions Not Normally Undertaken
DnD	Do not Dos
IPFR	Individual Patient Funding Request
PPMVB	Policy for The Recognition, Prevention and Therapeutic Management of Violence and Behaviours that Challenge

1. SITUATION/BACKGROUND

- The purpose of the report is to seek ratification of policies which were approved under Chair's Urgent Action outside the Quality & Safety Committee.

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

- The Policy on 'Interventions Not Normally Undertaken' (INNU) and 'Do not Dos' (DnD) is relevant to all practicing clinicians in primary and secondary care to ensure that referrals are managed appropriately. The INNU policy has been developed to support prioritising referrals and listing patients for surgery.

2.2 The policy for the Recognition, Prevention and Therapeutic Management of Violence and Behaviours that Challenge (PPMVB) relates to any person attending CTMUHB Mental Health in-patient services, either as a patient, visitor or member of staff. It aims to ensure care and treatment will be delivered in such a way that patient's rights are not compromised.

2.3 A request seeking urgent support for approval of the two policies was circulated on 30th January 2023 following agreement with the Quality & Safety Committee Chair. This resulted in the following responses indicating support from Committee IMs:
- Jayne Sadgrove, Vice Chair and Chair of the Quality & Safety Committee;
- Dilys Jouvenat, Independent Member;
- James Hehir, Independent Member.

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

3.1 Chairs Urgent Action was sought ahead of the Quality & Safety Committee due to the need to implement both policies as soon as possible.

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)	Effective Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below)
	Not relevant to the ratification of Urgent Chair's Action
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

- The Quality & Safety Committee is asked to ratify the approval of the request for urgent Chair's action in relation to policy approval for the following Policies:
  o Interventions Not Normally Undertaken' (INNU) and 'Do not Dos' (DnD);
  o Recognition, Prevention and Therapeutic Management of Violence and Behaviours that Challenge (PPMVB).

Ratification of Chairs Urgent Action Policy Approval

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Quality & Safety Committee
16 March 2023

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	AGENDA ITEM
	3.1.5

QUALITY & SAFETY COMMITTEE

EXECUTIVE DIRECTOR AND INDEPENDENT MEMBER WALKROUNDS FRAMEWORK REVISED FEBRUARY 2023

Date of meeting	16th March 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Allison Thomas, Patient Care & Safety Business Manager
Presented by	Greg Padmore-Dix, Executive Nurse Director
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

1. SITUATION/BACKGROUND

Executive Director and Independent Members Walkrounds have taken place across Cwm Taf Morgannwg for a number of years. There have been many different versions however, each version of the Executive Director & Independent Member Walkround process has as its main aim, receiving assurance of the high quality, safe and effective care delivered to our patients in a timely and patient centred manner by our staff.

1.1 As a Health Board, we aim to ensure that quality and patient safety is firmly at the heart of everything we do, with a culture that enables the active involvement of the population who receive care along with those who provide it, across every area of our organisation, in quality and patient safety, with a focus on learning, sharing and continuous improvement.

1.2 The Executive Director and Independent Member Walkrounds are focused on listening to patients, their relatives, carers, staff and any stakeholders, all of whom may have a strong interest in ensuring the Health Board is optimally positioned to provide high quality, safe and effective care to the right person at the right time.

1.3 Following recent feedback the Executive Director & Independent Member Walkrounds framework has been revised and is continuing to evolve whilst ensuring they remain as an integral part of our overall quality, assurance improvement and safety processes.

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

2.1 To date positive feedback on the Walkround process has been received from all involved including Executive Directors, Independent members and ward/area/site staff however, it is recognised that there is a need to move to a more dynamic and digital process for not only the process of completing a walkround but for the capturing the feedback and ensuring the actions agreed are closely monitored, reported on and completed in order to improve on the identified areas.

2.2 The revised framework (appendix 1) includes a range of prompts/suggested questions for all areas taking into account discussion with Patients, carers, relatives, staff and any other stakeholder who may be available at the time of the walkround.

| Executive Director and IM Walkround Framework Proposal | **Page 2 of 4** | **Quality & Safety Committee 16 March 2023** |

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2.3   The location for the walkrounds is agreed through triangulation of local soft intelligence and where there are areas of celebration and achievements as well as those areas which are facing exceptional challenging circumstances across all of Cwm Taf Morgannwg University Health Board whether this is in Primary, Community or secondary care services.

2.4   Work is progressing to ensure the feedback summary can be captured by the use of IPads in a digital format ensuring real-time feedback and preventing any delay in the reports being developed within the ten working days following the walkround. The process flowchart will be updated to reflect this change once this is in place.

2.5   Work to ensure the closing of the loop with local ward intelligence will be further developed with the intention to capture the findings on the Audit Management and Tracking tool joining up with the ward assurance findings. The Care Groups will ensure the feedback from each walkround is included as an agenda item on the Quality, Safety and Patient Experience groups for local monitoring and assurance that all actions are completed and shared where appropriate.

2.6   The development of a schedule of Walkrounds is in progress and an overarching report on the themes and trends will be developed for reporting to this Committee on a bi-monthly basis. This will be through the Quality Dashboard for acknowledgement and assurance of the work being undertaken.

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

3.1   No matters for escalation to this Committee or Board

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)	Governance, Leadership and Accountability
	Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Effective Care

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 / Impact	Yes (Include further detail below)
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1   The Quality & Safety Committee members are asked to **SUPPORT** this framework.

**Executive Director & Independent Member
Walkrounds Framework-revised February 2023**

1.0   Aim

Executive Director and Independent Member Patient Safety Walkrounds are embedded into Cwm Taf Morgannwg University Health Board (CTMUHB) and provide an opportunity to promote a culture of patient safety and commitment to ensure the quality of care being delivered to our patients is of a high standard and that in all we do the Values and Behaviours of CTM UHB are adhered to.

Staff are totally committed to ensuring that a high quality of safe and effective care is provided to all of our patients, resulting in good outcomes and experience for the people who receive care in all of our settings. The continuation of these walkrounds will allow for further assurance and first hand awareness, knowledge and understanding of the experience and outcomes for people receiving care and is a fundamental cornerstone of the Health Boards Quality and Safety Framework.

CTM UHB aims to ensure that quality and patient safety is firmly at the heart of everything it does, with a culture that enables the active involvement of the people who receive care along with those who provide it, in every part of the organisation, with a focus on learning and improvement.

This is predicated on listening to patients and their relatives, staff and stakeholders, all of whom have a strong interest in ensuring the health board is optimally positioned to provide high quality, safe, effective, timely, and patient centred care. The Executive Director and Independent Member Walkrounds form a part of this overall assurance process.

2.0   Purpose

Executive Director and Independent Member Patient Safety Walkrounds will provide an opportunity to enhance the patient safety culture by connecting senior leaders, clinical staff, support staff patients and carers. It will facilitate an opportunity to come together typically in a patient care setting to openly discuss patient safety, best practice, concerns, issues and determent actions for improvement in a continued and sustained manner. The objective will be to increase visibility of the senior Executive team and Independent members across the whole of CTM UHB, to provide an opportunity to celebrate success stories as well as identify patient safety related issues. The guidance of the

15 steps for Patient Safety will support the walkrounds along with the triangulation of local soft intelligence.

3.0 Process

- A 'Buddy Team' will consist of an Executive Director & Independent Member (detailed in Appendix B)

- The WalkRounds will take place across all Care Groups/sites/areas/wards/departments within CTM UHB including Primary Care and Community settings

- Walkrounds will comply with Health Board hospital visiting guidance

- Walkrounds should not be undertaken in an area of the Health Board which has been declared as an infection outbreak situation

- Walkrounds should not detract from the safe and effective provision of services

- Walkrounds will be pre-arranged and for the purpose of these walkrounds, there will be NO Unannounced Walkrounds however, should the need for an extraordinary unannounced walkround to be coordinated this will be actioned as directed via the Executive Director

- At the natural end of the Walkround, immediate findings will be verbally fed back to the clinical lead/manager who supported the walkround by and a discussion will take place to agree any required actions, with an agreed timescale and nominated lead for taking the action(s) forward. Any urgent matters will be escalated by the site/area/ward lead to the Care Group triumvirate as a matter of priority

- The Executive Director & Independent Member will complete and return the feedback summary template to the generic walkround email address, within 10 working days of the walkround CTM.PatientSafetyWalkrounds@wales.nhs.uk

- The Patient Care and Safety Business Manager will share the completed feedback summary with the leads and the Care Group Nurse Director/triumvirate who will be responsible for the continuous monitoring of the actions and reporting through their care group governance processes. The Patient Care and Safety Business Manager will prepare a bi-monthly overarching walkround report identifying any themes and trends

- The anticipated duration for a walkround is not prescriptive and is determined on the discussion and engagement at the time however, it is envisaged that the walkround process will take no more than 1.5 hours from start to immediate verbal feedback and end

- The Walkrounds will be conducted with openness and transparency and prior to the walkround and where available, data information for the site/area/ward will be shared with the buddy team 2 days prior to the date of the planned Walkround; the Patient Care and Safety Business Manager will request this data from the Quality Informatics team

3.1 Role and responsibilities:

- The WalkRound Buddy Team will be required to **arrive bare below the elbow** for the Walkround, when taking place in any of the clinical areas

- The Executive Director & Independent Member will ensure immediate feedback is provided to the lead/health professional for the site/area/ward and then reported on the feedback summary template in Appendix D and submitted via the generic email inbox CTM.PatientSafetyWalkrounds@wales.nhs.uk

3.2   Process Flow chart for Walkrounds:

Patient Care & Safety Business Manager will work with the Executive Assistants to develop an annual schedule of Walkrounds with a minimum of one per quarter for each buddy team (Executive Director & Independent Member)

Patient Care & Safety Business Manager will contact the Quality Informatics team for the previous 2 months of data for the Walkround site/area/ward and share the data summary with the Buddy Team 2 days prior to the Walkround taking place

The Executive Director & Independent Member will ensure immediate verbal feedback on the findings throughout the walkround are provided to the lead/health professional and any required actions are agreed at this point together with clearly identifying the lead responsible for each action(s) and a clear timeframe for completion

Executive Director and Independent Member complete the summary feedback template within 10 working days of the Walkround and return via the generic inbox address CTM.PatientSafetyWalkrounds@wales.nhs.uk for wider sharing with the Care Groups who will report through their Quality, Safety & Patient Experience meetings

Patient Care & Safety Business Manager collates all feedback summaries and prepares an overarching report on a bi-monthly basis reporting to the Quality & Safety Committee via the Quality Dashboard

Continuous monitoring and reporting is managed and monitored through the Care Group Quality, Safety and Patient Experience group meetings for completion and assurance of actions taken as identified through the walkround

Executive Director & Independent Members Walkround Framework-updated Feb 2023-FINAL
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*In exceptional circumstances if there is a late change to the Walkround site/area/ward the data summary will not be available

*Any Immediate concerns or Patient Safety risks/issues/concerns are to be immediately escalated to the Care Group Nurse Director/Triumvirate team by the Nurse in Charge/Lead person or other lead health professionals present at the walkround

Supporting documents for the Executive Director & Independent Member Walkrounds:

Appendix A - Walkround Buddy Team (Executive Director and Independent Member)
Appendix B - Site/area/ward summary proforma 2 previous months' data information
Appendix C - Feedback Summary Proforma 'buddy' partners to record findings and report findings via CTM.PatientSafetyWalkrounds@wales.nhs.uk
Appendix D – Suggested prompts and/or questions for engaging in conversation during the walkround process

Appendix A

Executive Director & Independent Member Walkround
'Buddy Teams'

	Executive Director	**Independent Member**
1.	Medical Director Dom Hurford	Dilys Jouvenat
2.	Executive Director Therapies & Health Sciences Lauren Edwards	Ian Wells
3.	Chief Operating Officer Gethin Hughes	Nicola Milligan
5.	Executive Nurse Director Greg Padmore-Dix	Patsy Roseblade
6.	Executive Director for People Hywel Daniel	Carolyn Donoghue
7.	Awaiting appointment of Director of Public Health	TBC
8.	Executive Director of Strategy & Transformation Linda Prosser	James Hehir
9.	Chief Executive Paul Mears	Lynda Thomas
10.	Director of Finance Sally May	Mel Jehu
11.	Director of Digital Stuart Morris	Jayne Sadgrove
12.	TBC (Health Board Chair)	TBC

Appendix B

Data information provided by the Quality Informatics team for the previous two (2) months, data ahead of the walkround will be requested and shared with the Executive Director & Independent Member (Buddy Team) at least 2 working days prior to the Walkround:

- Overview of the ward/area/site to be visited
- Number of Vacancies by profession
- Sickness percentage
- Compliance for Mandatory and Statutory Training
- Number of Nationally reported incidents (NRIs) and number of Locally reported incidents LRIs)
- Number of Compliments and Concerns
- Summary of compliance against Welsh Government Clinical Tier 1 performance targets:
    - Pressure ulcers
    - Falls
    - Medication errors
    - Infection rates (for example MRSA, MSSA, C.diff., Psudomonas, E Coli, Klebsiella)

Proforma for Ward/Area/Site Data Information where available and timings allow:

Executive Director & Independent Member Walkround
Data Summary Report:

		Additional Comments:
Data report for Care Group/Ward/Area/Site:		
Timeframe of data (2 *months prior to date of Walkround)*:		
Date & Time of Executive Director & Independent Member Walkround:		
Executive Director:		
Independent Member:		

	Data	**Comments**
Does the ward sit within the Nursing Staffing Levels (Wales) Act?		
Ward/Department funded Nursing Establishment		
Workforce		
Qualified vacancies		
Unqualified vacancies		
Sickness percentage		
Mandatory & Statuary compliance		
Incidents		
Number of Nationally reported incidents (NRIs)		
Number of Locally reported incidents (LRIs)		
Patient Experience		
Compliments and Concerns		
Tier 1 performance targets/Quality Metrics		
• Pressure Ulcers		

Executive Director & Independent Members Walkround Framework-updated Feb 2023-FINAL

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• Falls		
• Medication errors		
IP&C		
• MRSA		
• MSSA		
• E Coli		
• Klebsiella		
• Psudomonas		

Executive Director & Independent Member Walkround
Feedback/Summary Report

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

Date of Walkround	
Visited Ward/Area/Site	
Executive Director	
Independent Member	
Area Key Contact	
Additional comments/information	

Areas of Good Practice/ Achievements to Celebrate
Areas of Escalation/Concern/Safety Risks
Key Issues/Notable Practice
Any Other Matters

Agreed Actions		
Action:	**By Whom:**	**By When:**

*Once complete please forward to the generic inbox via email to CTM.PatientSafetyWalkrounds@wales.nhs.uk within 10 working days of the Walkround.

Appendix D

Prompts or suggested questions for consideration during the Walkround are listed below. Please consider these questions so that they support in making the most of the time together during the walkround.

Questions/prompts to consider as an Executive Director or Independent Member

1. Do the patients look comfortable and well cared for?

2. Is dignity and respect adhered to across the ward/area/site?

3. What are my senses telling me about the ward/area/site-what can I see, hear, smell, feel and touch?

4. How is the atmosphere on the ward/area/site? How does it make me feel?

5. Is the ward/area clear or cluttered?

6. Are there storage issues, any evidence of equipment stored in corridors/bays etc.?

7. Is there clear signage directing the patient /relative to:
    1) Reception
    2) Toilets
    3) Visiting times
    4) Meal Times

8. Is there appropriate signage such as:
    a) dementia friendly symbols for toilets, bathrooms, day rooms etc?

9. Are notices/ posters up to date and appropriate to the area?

10. Is there evidence of quality improvement initiatives on public display?

11. What could be done to improve patient experience on the ward?

Prompt/Questions for Patients:

1. What has been good about your stay on the ward?

2. Do you have any concerns regarding your stay on the ward?

3. What could be done to improve patient experience on the ward?

4. Does the patient wish to give consent to providing their name when feeding back to ward staff?
5. Do staff respond in a timely manner to patients (call bells, requests)?
6. During your stay, did you feel you were kept informed of any delays, for example, appointment times, tests, treatment, discharge?
7. Is there evidence of a culture of pride in the standards of care?
8. Are staff friendly and compassionate and do they welcome others with a smile?

9. Are patients addressed by their preferred name?

10. Are patients offered to communicate in their first language/language of choice, English, Welsh or any other language?

11. Do staff respond in a timely manner to patients (call bells, requests)?

12. What has been good about your stay on the ward?

13. Do you have any concerns regarding your stay on the ward?

14. Does the patient consent to providing their name when feeding back to ward staff whether relating to a positive or not so positive experience?

Patients and relatives
1. Tell us about what it's like to be a patient in this area please.

2. Is there anything that we could change to improve your experience or that of your family member, loved one, relative or friend?

3. Is there anything we should stop doing today?

4. How can we ensure you feel safe valued and cared for?

Staff:
Culture:
1. What are you most proud of?

2. Have you received recognition or praise for doing good work recently?

4. What can we do to make things right for patients and staff?

5.   What is it like to work here? What would make it better?

6.   Do we care for, respect and treat with kindness?

7.   Would you recommend the care in this area to your family and friends?

Safety:

1.   What is your biggest worry related to patient care? And why?

2.   What response was there when something untoward happened last? How were you supported?

3.   Were you able to care for your patients as safely as possible this week? If not, why not?

4.   Is there anything we can do to make things safer?

Thinking about Psychological Safety for staff

1. How do team members typically respond when someone makes a mistake or admits to not knowing something? Do they offer support and help or do they criticize and blame?

2. Are team members comfortable asking for help or feedback from their peers, or do they feel like they have to figure things out on their own?

3. What happens when team members raise concerns or bring up controversial topics? Are they listened to and respected, or are their ideas dismissed or ridiculed?

4. How does the team handle conflicts and disagreements? Are they resolved in a constructive and respectful manner, or do they escalate into personal attacks and blame?

5. Is it safe for team members to admit to feeling overwhelmed or stressed? Are there resources and support available to help team members manage their workload and mental health?

6. Are team members encouraged to share their ideas and opinions, even if they are different from the norm? Are diverse perspectives valued and considered?

7. Does the team have a culture of blame and punishment, or a culture of learning and improvement? Do team members feel comfortable taking risks and experimenting, even if they might fail?

8. How does the team handle mistakes and failures? Are they seen as opportunities

for growth and learning, or as reasons for punishment and shame?

9. Are team members able to be vulnerable and share personal experiences without fear of judgment or ridicule? Is there a culture of empathy and understanding within the team?

10. How does the team handle issues of diversity, equity, and inclusion? Are team members open to discussing and learning about these topics, or do they shy away from them?

11. Do you feel you are treated with dignity and respect in work?

12. Do you feel you work in a safe environment?

13. How are you encouraged to articulate current day to day risks or concerns and escalate issues beyond your control?

14. Do you feel you have a positive contribution to patient care?

15. Are you provided with feedback on the outcomes of any incidents/accidents that you report or that are reported within your clinical area?

16. Are you given the opportunity to identify and learn from good practice to bring about improvements in care?

17. Do you feel you are able to raise any concerns you may have?

18. Do you feel you are a valued member of your team and have a sense of belonging?

19. Do you feel you are given the knowledge and skills to deliver a consistent standard in the fundamental aspects of compassionate care?

20. What do you like about working here?

21. What would you do to improve patient experience?

22. What would you do to improve staff experience?

				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 March 2023)
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	Ongoing	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Medical Director to ensure interim timelines were put into place for the Task & Finish Groups referred to in relation to Risk 4080.	Medical Director	January 2023 **Revised target date for completion to be confirmed**	**In Progress** The Risk Register has not yet been formally updated as there are external factors that are effecting the timeline (All Wales Rate Card for Additional Duty Hours). At the recent Value & Effectiveness meeting it was decided that the work-

					streams would be reset. Each work-stream would have an agreed timeline, however, the overall target of each compliance would be March 2024. Risk 4080 will be updated when the targets are set as they will also be attached to a timeline of progress.
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 Now 16 May 2023	**In progress** Nurse Director for the Mental Health & Learning Disabilities Care Group has advised that this risk is for Acute Care Colleagues to address. An update will be sought for the next meeting in May 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	Nurse Director – Mental Health Care Group	16 March 2023	**On agenda** Update on progress being made in relation to the Welsh Community Care Information System has been included in the Mental Health & Learning Disabilities Care Group report.

		Community Care Information System.			
6.4	15 November 2022	**Report from the Chief Operating Officer** 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	Assistant Director of Governance & Risk	January 2023 Now March 2023 Now April 2023	**In Progress.** The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics in a timely fashion for openness and accountability.

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	**On agenda** Update has been included in the Quality Dashboard report.
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 Now April 2023	**In Progress.** The Health Board continues to work to improve the Integrated Performance Reporting to the Board. The lay out, content and specifically the narrative throughout the report to Board is constantly being refined and updated to ensure the Board has the right information at the right time. In addition steps have been taken to ensure that the Board Committees receive the performance information relevant to their remit. The Health Board is holding a workshop with Board Members in Spring 2023 to develop an approach that enables a greater visibility of the most important indicators whilst still presenting all other metrics

					in a timely fashion for openness and accountability.
2.1	24 January 2023	**Listening & Learning Story** Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Director of Nursing	To be agreed	**In progress** Date to be agreed
5.2.1	24 January 2023	**Learning From Events Reports** Progress report to be presented to the Committee in three months.	Assistant Director of Concerns & Claims	May 2023	**In progress** Forward work programme updated
5.3	24 January 2023	**Datix Cymru Assurance Report** Report on progress to be presented to the Committee in 3-6 months.	Head of Concerns & Business Intelligence	July 2023	**In progress** Forward work programme updated
6.3	24 January 2023	**Quality Dashboard** Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.	Deputy Director of Nursing	March 2023	**In progress** Added to the forward work programme
6.3	24 January 2023	**Quality Dashboard** Response from Local Authority Leaders to be shared with Committee members once received	Chief Operating Officer	March 2023	**In progress**

		following the submission of a letter outlining the Health Board's concerns in relation to delays being experienced with the transfer of patients out of hospital.			
6.7	24 January 2023	**Liberty Protection Safeguards** Report to be shared with Committee Members later in the year on progress being made in this area.	Head of Safeguarding	To be confirmed	**In progress** Date to be agreed

			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 March 2023)
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	**Completed and Ongoing** Agreed at the January meeting that the next Spotlight Report needs to focus on Emergency Care Incidents – Pressure Ulcers and Falls. Added to the forward work programme. Members will be asked at future meetings which spotlight area they would like to focus on at the next

					meeting during the Quality Dashboard discussions.
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 Gynaecology Pathway to be shared at the next meeting.	Director of Midwifery / Deputy Medical Director	November 2022 Now January 2023	**Completed** Report presented to the 24 January meeting included updates in relation to processes in place for women experiencing ectopic pregnancies and the Gynaecology Pathway
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	**Completed** Report received and discussed at the meeting held on 24 January 2023. Agreed that annual updates would be required moving forward which has been added to the annual cycle of business.
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	Assistant Director of Concerns and Claims	24 January 2023	**Completed and Ongoing** Report received and discussed at the meeting held on 24 January 2023. Agreed that a further report on progress would be presented to the May 2023 meeting. The forward work

		address the Learning From Events backlog.			programme has been updated to reflect this.
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	**Completed and Ongoing** Report received and discussed at the meeting held on 24 January 2023. Agreed that a further report on progress would be presented to the July 2023 meeting. The forward work programme has been updated to reflect this.
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	**Completed** Verbal update provided to the Committee at the meeting held on 24 January 2023 as part of the Quality Dashboard report. Agreed that a spotlight report would be presented to the March meeting on Emergency Care Incidents – Pressure Ulcers and Falls. This has been added to the forward work programme.
5.1	24 January 2023	**Organisational Risk Register** Responses to be sought from Executive Leads in relation to the queries raised in relation to Risks 4148; 5276; 5214; 4071 and 3131.	Assistant Director of Governance & Risk	March 2023	**Completed** Responses to the queries raised shared with Independent Members by email on 10 February 2023.

6.1	24 January 2023	**Maternity Services & Neonates Improvement Programme** Feedback to be provided to the next Committee in relation to the urgent make safes that had been put into place following the severe incident that occurred at Prince Charles Hospital.	Head of Midwifery & Gynaecology	March 2023	**Completed** Response received from the Head of Midwifery & Gynaecology and shared with Independent Members by email on 14 February 2023.
6.3	24 January 2023	**Quality Dashboard** Caveat to be included within future reports in relation to the severe/death category for patient safety incidents to explain that an incident reported against this category had not necessarily resulted in the death of a patient.	Head of Quality & Patient Safety	March 2023	**Completed** Report updated following the meeting and future reports will contain the caveat.
6.5	24 January 2023	**Monitoring & Reporting of Continuing Healthcare and Funded Nursing Care Activity** Annual Repot to be presented to the Committee moving forwards with regular reporting of any homes in escalation to be captured in the Quality Dashboard report.	Mental Health Care Group Nurse Director	January 2024	**Completed** Annual Cycle of Business updated.

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	**Completed** Report received at the meeting held on 24 January 2023. Regular updates will be received on this matter as part of Care Group reporting.
6.1	24 January 2023	**Maternity Services & Neonates Improvement Programme** Feedback to be shared with the Team regarding the suggestion made by N Milligan to amend one of the response options within the questionnaire.	Head of Midwifery & Gynaecology	March 2023	**Completed** Head of Midwifery & Gynaecology has confirmed that this will be broken down in separate elements going forward

	AGENDA ITEM
	3.2.2

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL CYCLE OF BUSINESS

Date of meeting	16 March 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 NOTING

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

ACRONYMS

1. SITUATION/BACKGROUND

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

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

1.3 Any changes made to the Annual Cycle of Business since the last meeting have been identified in red.

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 all new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

Quality & Safety Committee

Cycle of Business
(1st January 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	✓		✓ Deferred to May. Report will not be approved until 15/03/23		✓		✓		✓		✓	
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	✓				✓				✓			

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
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					✓ End of year update				✓ Annual Report		✓ Mid Year update	
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	✓		✓		✓		✓		✓		✓	
Healthcare Inspectorate Wales Action Plan Tracker	Director of Nursing	All regular meetings (from May 2023 onwards)					✓		✓		✓		✓	
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) – to include updates on Sepsis Compliance – Quality Improvement	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			✓ Deferred to May		✓				✓			
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 – Agreed at the January 2023 meeting that this can be removed from the	Director of Nursing	Quarterly	✓											

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
Annual Cycle of Business as progress will be monitored via operational processes.													
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	✓		✓		✓		✓		✓		✓	
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							✓					
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Director of Nursing	Annually	✓											

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
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	**In progress** Report received and discussed at the 24 January meeting. Agreed that a progress report would be presented to the Committee in **July 2023**.
Request from Strategic Planning & Commissioning Manager	Item deferred from November to January to allow for consultation period.	CYP 16-17 year's Acute Admission Policy – For Approval.	Strategic Planning & Commissioning Manager	Planned for January 2023 **–** Now deferred to March 2023 to allow for formal consultation to be undertaken on the policy. **On agenda**.
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Learning From Events Backlog – Progress Report	Assistant Director of Concerns & Claims	**In progress** Report received and discussed at the meeting held on 24 January 2023. Agreed that a further update on progress would be presented to the **May 2023 meeting.**
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 – Update included in the Quality Dashboard report. **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 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 – Update has been included as an appendix to the Quality Dashboard report. **On agenda**.
Email request received from the Head of Corporate Governance & Board Business	Additional Item	Independent Member Walkround Protocols	Director of Nursing	Planned for March 2023 – **On agenda**
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 – Update has been included in the Mental Health & Learning Disabilities Care Group Highlight Report. **On agenda**
Action agreed at the meeting held on the 24 January 2023	Additional Item	Spotlight Report on Emergency Care Incidents – Pressure Ulcers and Falls	Deputy Director of Nursing	Planned for March 2023 – The Deputy Director of Nursing has requested that this item is deferred to the May 2023 meeting.
Email Request received from the Chair of the Committee	Additional Item	NHS Wales Delivery Unit Review of Primary and Secondary Mental Health Services for Children and Young People	Director of Nursing	Planned for March 2023 – Update has been included in the Mental Health & Learning Disabilities Care Group Highlight Report. **On agenda**
Email request from the Assistant Director of Governance & Risk	Additional Item	Chairs Urgent Action – Policy Approvals	Assistant Director of Governance & Risk	Planned for March 2023 – **On agenda**

Email request from the Quality & Safety Committee Chair	Additional Item	Healthcare Inspectorate Wales Action Plan Tracker – Prototype	Deputy Director of Nursing	Planned for May 2023

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
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	**Completed** Received at the meeting held on 24 January 2023 and Endorsed for Board Approval.
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	**Completed and Ongoing** Report received and discussed at the meeting held on 24 January 2023. Agreement given to receive annual updates on this matter which has been added to the annual cycle of business. Regular reporting of homes in escalation to be captured in the Quality Dashboard report.
Action agreed at the May Quality & Safety Committee	Additional Item	Deep Dive into CAMHS	Chief Operating Officer	**Completed** Report received and discussed at the meeting held on 24 January 2023. Agreed that further updates in relation to CAMHS would be captured in the Care Group reports being presented to the Committee from March 2023. Also noted

				that Care Groups would be asked to present Deep Dives twice yearly.
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	**Completed** Information included in the report presented to the meeting held on 24 January 2023.
Request from the Chair following MHAMC Agenda Planning	Item Deferral as MHAM Committee only monitors the application of the MH Act.	Update on the new Liberty Protection Standards	Director of Nursing	**Completed** Report received and discussed at the meeting held on 24 January 2023.
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	**Completed** Verbal update provided as part of the Quality Dashboard discussion at the meeting held on 24 January 2023.
Email request received from the Committee Chair on 14 March 2022	Additional Item	Learning Disabilities Report: • addressing the recommendations of the 2020 report; • including the action plan developed by CTM as a result of that report; and • a progress report against the action plan.	Chief Operating Officer	**Completed** Report received at the meeting held on 24 January 2023. Future updates to be included in the Mental Health & Learning Disabilities report moving forwards.

On the Quality & Safety Committee Action Log from the February In Committee	Additional Item	Child Safeguarding	Director of Nursing	**Completed** Report received at the January 2023 meeting.

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	16th March 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Lydia Thomas, Head of Quality and Patient Safety
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing

Report purpose	FOR NOTING

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

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

CHC	Community Health Council
AMaT	Audit Management and Tracking

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales activity and correspondence since the last report for committee in January 2023. Due to the bi-monthly nature of these meetings, this report will cover the 8 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 includes updates and key messages from the Community Health Council (CHC) activity within the health board.

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

No visits by CHC have taken since the last report.

2.0 20th December 2022- 16th February 2023)
HIW activity across Cwm Taf Morgannwg University Health Board:

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 Live improvement plans submitted awaiting acceptance by HIW	**1**

2.1 **Unannounced Inspections:**

There has been 1 unannounced inspection during quarter 4.

Princess of Wales Ward 5 Stroke Ward:

An unannounced inspection took place to Ward 5 Stroke Ward in the Princess of Wales Hospital on 25th & 26th January 2023.

Following the visit conducted by HIW, assurance was requested and promptly provided by the Health Board. In line with HIW process an improvement plan has been developed in order to address the findings from

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the inspection and HIW have accepted this with the final report scheduled for publication on 28th April 2023.

2.2 **Update following unannounced Inspections:**

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

The final report was published by HIW 25th January 2023.

HIW found that all staff were working hard to provide patients with a positive experience and good levels of care despite extreme system pressures. Ongoing improvements are taking place to address the issues identified during the inspection.

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

An unannounced inspection took place within PCH maternity service. No immediate assurances were required. The final report was published 1st February 2023.

iii. Angelton Clinic: Glanrhyd Hospital 14th- 16th November 2022

An unannounced inspection took place 14th-16th November 2022. During this visit immediate assurances were sought in relation to the risk of patients with ligature. An improvement plan has been developed and submitted to HIW on 10th February 2023. A publication of the report is expected early March 2023.

Further correspondence has been received from HIW in early February discussing both the Angelton clinic and local review of inpatient adult mental health discharges. HIW have requested assurance and confidence that rapid action is being taken to make progress against the recommendations from these reviews, that all mental health services provided across the Health Board are addressing the learning and improvements in response to the issues identified by the inspections and reviews.

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2.3 <u>Announced Inspections:</u>

There has been 1 announced inspection within this reporting period which was to an Independent Contractor GP practice.

To note there has been one announced inspection at GP Practice Llynfi Surgery (Maesteg). This inspection will be reported separately within the Primary Care reporting papers to Quality & Safety Committee.

2.4 <u>Update following announced inspections.</u>

Community Mental Health Team (CMHT) - Maesteg Hospital

CMHT inspection visit by HIW and Care Inspectorate Wales (CIW) took place with both the Health Board and Bridgend County Council on 13th and 14th December 2022. The selected CMHT was 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. HIW is expected to publish the final report on their website on 16th March 2023.

2.4 <u>Future Planned HIW activity</u>

i. Governance Arrangements within Health Board

In February/March 2023, HIW and Audit Wales made the decision to support follow-up reviews by undertaking interviews and focus groups with key colleagues in the Health Board to ascertain the progress made in addressing and implementing the required actions in line with the recommendations.

2.5 <u>No Public Concerns raised via HIW</u>

2.6 <u>Local Reviews:</u>

    i.   Discharge Arrangements for Adult Mental Health Patients :

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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 has been returned to HIW. The Health Board are due to submit an action plan in early March. The current scheduled publication date by HIW is 16th February 2023. The Health Board are required to submit an action plan within 4 weeks of publication.

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 across Wales will be published by HIW. The health board will not receive an individual feedback report.

It was expected that the report will be published between January and February 2023. A date has not yet been confirmed or final report received.

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 HIW have recently asked for a further update in relation to progress against the recommendations.

An improvement plan was submitted mid-January and the Health Board are waiting to receive any feedback from HIW. Progress of the improvement plan is being monitored through the Planned Care Quality Safety Patient Experience Governance meeting.

iii.   *National Review of DNACPR Practices/ Processes*

HIW are undertaking a review to examine the use of DNACPR orders across Wales. They are reviewing the approach and practice of every Health Board and Trust and a selection of GPs in Wales in respect of this very important aspect of patient care. Their aim is to produce a Wales-wide report, highlighting areas of good practice and lessons learned, in an approach which apportions no blame but rather ensures nationwide learning and improvement. The Health Board have been asked to provide examples of recent audits in relation to this aspect; recent complaints and incident data as well as training provided for staff.

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Ongoing Work

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. A further meeting has taken place in February with the AMaT project team who provided a further overview of the functionalities within the inspection module. It is anticipated the Health Board will go live with this module early into the new financial year.

HIW inspection improvement plans are to be closely monitored as a standard agenda item through the care groups quality, safety & patient experience governance meetings going forward.

The Corporate Governance Team are in the process of putting together a presentation of useful information to support and share with staff on what they can expect when an announced and unannounced inspection takes place. This will be supported by the Health Board communications team.

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

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

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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 requested to **NOTE** the report.

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QUALITY & SAFETY COMMITTEE

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2022-2023

Date of meeting	16/03/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Mark Townsend – Head of CA&QI, Natalie Morgan - Thomas Deputy Head of CA&QI & Lead Nurse for Clinical Effectiveness & Lauren Dyton – Clinical Audit Manager
Presented by	Dr Dom Hurford – Executive Medical Director
Approving Executive Sponsor	Executive Medical Director

Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
NHFD	National Hip Fracture Database
CA&QI	Clinical Audit & Quality Informatics Department
NACEL	National Audit for Care at the End of Life
NAIF	National Audit of Inpatient Falls
NJR	National Joint Registry

PoWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
NEIAA	National Early Inflammatory Arthritis Audit
NICE	National Institute of Clinical Excellence
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
COPD	Chronic Obstructive Pulmonary Disease
PEDW	Patient Episode Dataset for Wales
HQIP	Healthcare Quality Improvement Partnership

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2022-2023 aligned to the National Clinical Audit and Outcome Review Plan for 2022/23, which is also available via the Welsh Government website: https://gov.wales/national-clinical-audit-and-outcome-review-plan-2022-2023, published June 2022.

1.2 **29** out of 35 national audits and 9 clinical outcome reviews (tier 1) are green fully compliant and **5** amber where the audits are delayed, a backlog exists but a plan is in place to comply with the national audit deadline. **1** clinical outcome review audit is red because the deadlines has passed, and we were only able to achieve limited participation (NCEPOD Epilepsy Study).

1.3 The DNACPR Tier 2 organisation priority audit has been completed, but all other planned tier 2 audits have been delayed due to a lack of available clinical audit resources diverted to underpin the prioritised COVID Mortality Review cases. The postponed tier 2 audits are currently under review for completion in 2023/24.

1.4 The AMaT ward and area module continues to develop with work in progress to include, the mental health unit and operating theatre department audits.

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

2.1 **Clinical Audit Forward Plan 2022-2023 Current Position**
The Royal College of Physicians acknowledged the HB data collection and entry performance for the national COPD audit, with 82% case ascertainment an improvement from 59% pre-Covid (% between number

of cases submitted compared to those reported to PEDW). Based on the organisation's significant achievement in improving case ascertainment compliance a case study has been submitted for inclusion in the Royal College of Physicians good practice repository, to share the learning across England and Wales, so that hospitals can use the steps taken to make improvements in their services.

Following release of the preliminary findings from the NACEL audit a potential outlier alert status was received, following a review of the identified data quality issues this has now been revised prior to publication of the report noting the organisation is no longer an outlier and therefore has no case to answer.

A clinical lead remains outstanding for the COPD National audit for PCH and a Health Board lead for the National Audit of Dementia (Round 5).

The NHFD amber compliance position for quarter 2, 2022/23 has been revised to green following considerable efforts from staff with overtime and the filling of a staff vacancy.

NJR is compliant for RGH and PCH, but amber compliance position reported for the PoWH due to clinical pressures and concerns that the end of February 2023 submission deadline would not be met, by the directorate. Therefore, the clinical audit department has agreed to commission overtime to maintain the HB Quality Data Provider status for this national audit activity put in place to provide a UK wide implantable medical device registry. The directorate is now looking at support arrangements to ensure full compliance for 2023. For PoWH this audit remains amber.

The NEIAA (Arthritis) audit is amber, but good progress is being made to achieve compliance. The current focus for the audit team in quarter 3 and 4, 2022-2023 is to recover the NAIF, TARN and Heart Failure non-compliance positions.

The following actions are being taken:
- Out to interview for Senior Clinical Audit Facilitator with responsibility for TARN, NHFD and NAIF.
- Commissioning overtime for staff to reduce backlogs, funding permitting.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2022-2023, by the end of March 2023.

2.2 Key clinical audit publications, findings and actions

National Early Inflammatory Arthritis Audit (NEIAA) Year 4 annual report
Based on data from 11,722 patients seen in England and Wales between 1 April 2021 and 31 March 2022.

The latest NEIAA annual report provides information on national and regional performance against seven key metrics of care and on outcomes. It found the first review by a specialist was achieved within three weeks of referral for 42% of patients (vs 48% in year two). Other key findings include:

- Conventional disease modifying anti-rheumatic drug (cDMARD) treatment delays remain stable with initiation within six weeks of referral in 65% of patients (vs 64% in year two).
- Early arthritis clinics were available in 76% of departments (vs 77% in year two).
- That disease remission was achieved in 34% of patients by three months after diagnosis (vs 37% in year two).

CTM Update – Findings from the report and NEIAA dashboards are being reviewed by the Rheumatology multidisciplinary team. Where required, a local improvement action plan will be developed.

Maternal, Newborn and Infant Clinical Outcome Review Programme: Saving Lives, Improving Mothers' Care Report 2022
The Maternal, Newborn and Infant Clinical Outcome Review Programme has published its ninth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, which includes surveillance data on 536 women who died during or up to one year after pregnancy between 2018 and 2020 in the UK. It also includes Confidential Enquiries into the care of women who died between 2018 and 2020 in the UK and Ireland from cardiovascular causes, hypertensive disorders, early pregnancy disorders and accidents and the care of women who died from mental-health related causes in 2020, and a Morbidity Confidential Enquiry into the care of 61 women with diabetic ketoacidosis in pregnancy.

CTM Update – The Clinical Audit Department is engaging with Maternity services to review the report findings and facilitate local action planning activity.

2.3 **Clinical Audit Training**
Bespoke clinical audit and effectiveness training was delivered to Pharmacy trainees and technicians from across the HB, designed to meet the needs of the staff and provide practical advice and resources to support good quality clinical audits.

Clinical Audit and AMaT training was also delivered to trainee doctors as part of the post graduate teaching programme. Feedback from the session

was positive with attendees rating the overall standard of the session either 'good' or 'excellent'.

2.4 **Clinical Audit & NICE Monitoring System (AMaT) Implementation**

With the implementation of AMaT the organisation is now able to monitor the CTMUHB Clinical Audit Forward Plan in real-time and compliance with NICE guidelines, standards and focus at present is on the ward and area audit module rollout.

The AMaT ward and area module rollout is progressing well with a health board wide focus on Mental Health and Theatre departments. Due to increasing service demands for support and rollout of this module work is ongoing to ensure suitable resources are in place for the long term management and support of this module.

2.5 **NICE Compliance Programme of work**

The CTMUHB NICE Reference Group (NRG) established in September 2021 and the centralised monitoring has currently been on hold whilst the team are focussing on other high priority areas.

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB will now remain with directorates and individual clinical leads.

A review of the Clinical Audit policy and Strategy is being undertaken to reflect this.

2.6 **CTMUHB Clinical Audit Forward Plan 2023-24**

Welsh Health Circular and NHS Wales National Clinical Audit and Outcome Review Plan is due to be published in June 2023. The CTMUHB Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by Welsh Government (WG) in June 2023. The CTMUHB Clinical Audit Forward Plan 2023-24 has been attached at Appendix 1.

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

3.1 Identifying appropriate colleagues to be involved in National tier 1 Audits has been challenging due to other commitments and availability of teams. SPA allocated time is being addressed in the recently approved Consultant SPA paper.

3.2 A lack of early detection of 'outlier status' or assurance around the monitoring of NICE clinical guidance and standards and risk of failure to comply with national audit programme tier 1 targets.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)		
Related Health and Care standard(s)	Effective Care		
	If more than one Healthcare Standard applies please list below:		
Equality Impact Assessment (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		
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   That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.
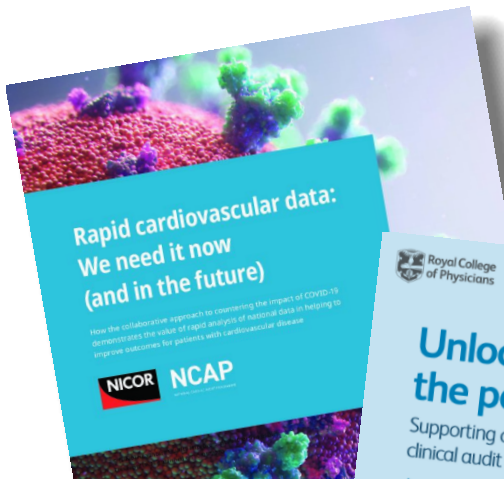
Knowing How Well We Are Doing

Clinical Audit Forward Plan 2023-24

Standard 3.1:
Safe and Clinically Effective Care
Effective Care

Version 1.0, 24 February 2023

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.

- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is due to be published in June 2023 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: **National audit** delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: **Organisation priority audit** delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2023 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

Due to COVID submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Acute						
National Joint Registry (NJR)	operates continuous data capture	**N/A**	September 2023	Trauma and Orthopaedics	Fully compliant RGH and PCH, PoWH compliance affected by clinical pressures, work ongoing to ensure full compliance	**AMBER**
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	**N/A**	November 2024	Surgery / Anaesthetics	Organisation wide compliance	**GREEN**
Case Mix Programme (CMP) ICNARC	operates continuous data capture	**Monthly**	March 2024	Anaesthetics	Organisation wide compliance	**GREEN**
Major Trauma Audit # (TARN)	operates continuous data capture	**Quarterly in line with dashboard publication**	Quarterly Dashboards From Apr 2023	Emergency Medicine	Support arrangements under review to ensure compliance by end of March 2023	**AMBER**
Long Term Conditions						
National Diabetes Audit * **Note this covers the following areas :** • National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	**N/A**	June 2023	Therapies	Organisation wide compliance	**GREEN**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
• National Diabetes Inpatient Audit (<u>NaDia</u>)	WG decided not to participate in year one of the harms collection	**TBC**		General medicine	Bedside audit discontinued / Harms audit England only	**N/A**
• National Pregnancy in Diabetes Audit (<u>NPID</u>)	operates continuous data capture	**N/A**	October 2023	Obstetrics and Gynaecology	Organisation wide compliance	**GREEN**
• National Core Diabetes Audit (<u>NCDA</u>)	Data capture from Primary Care at specific intervals	**N/A**	July 2023	Primary Care	Organisation wide compliance	**GREEN**
• National Diabetes Transition Audit (<u>NCDA</u>)	N/A	**Data will be collated from existing submissions**		Primary / Secondary Care	Organisation wide compliance	**GREEN**
National Diabetes Paediatric Audit (<u>NPDA</u>) * #	01/04/2022 – 31/03/2023	**N/A**	July 2023	Paediatrics	Organisation wide compliance	**GREEN**
National Asthma and COPD Audit Programme (<u>NACAP</u>)* # **Note this covers the following areas:** Adult Asthma	operates continuous data capture	**N/A**	March 2024	General medicine	Organisation wide compliance	**GREEN**
COPD	operates continuous data capture	**N/A**	March 2024	General medicine	Organisation wide compliance	**GREEN**
Children and Young People Asthma	operates continuous data capture	**N/A**	March 2024	Paediatrics	Organisation wide compliance	**GREEN**

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NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Pulmonary Rehabilitation	N/A	**N/A**	TBC	General medicine / Therapies	Service not operational	**N/A**
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	**N/A**	October 2023	Rheumatology	Action being taken to improve compliance	**AMBER**
All Wales Audiology Audit #	operates continuous data capture	**N/A**	TBC	Ears, Nose and Throat	Organisation wide compliance	**GREEN**
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	**N/A**	April 2023	General medicine / Therapies	Organisation wide compliance	**GREEN**
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NIFA)	operates continuous data capture	**N/A**	November 2023	General Medicine / Trauma & Orthopaedics	Support arrangements under review to ensure compliance by end of March 2023	**AMBER**
• National Hip Fracture Database (NHFD)	operates continuous data capture	**N/A**	November 2023	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	**GREEN**
National Dementia Audit * (NDA)	April – July 2023	**July 2023**	June 2023	Mental Health / Care of the Elderly	Organisation wide compliance	**GREEN**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
End of Life						
National Audit for Care at the End of Life (NACEL) *	N/A	**N/A**	July 2023 (Round 4)	Palliative Care / Medicine	Organisation wide compliance	**GREEN**
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	**June 2023**	June 2023	Cardiology	Action being taken to improve compliance	**AMBER**
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance. (excludes Bridgend)	**GREEN**
• Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	**June 2023**	June 2023	Cardiology	Action being taken to improve compliance	**AMBER**
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance	**GREEN**
Cancer						
National Bowel Cancer Audit * (NOGCA)	operates continuous data capture	**N/A**	January 2024	Surgery	Organisation wide compliance. Managed through cancer services.	**GREEN**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
National Oesophago-Gastric Cancer Audit * (NOGCA)	operates continuous data capture	N/A	August 2024	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Audit of Breast Cancer in Older People (NABCOP)	operates continuous data capture	N/A	May 2023	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Lung Cancer Audit * (NLCA)	operates continuous data capture	N/A	TBC	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	GREEN
National Prostate Cancer Audit * (NPCA)	operates continuous data capture	N/A	January 2024	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	N/A	November 2023	Paediatrics	Organisation wide compliance.	GREEN
National Maternity and Perinatal Audit *# (NMPA)	operates continuous data capture	N/A	June 2023	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool	operates continuous data capture	N/A	October 2023	Obstetrics / Midwifery	Organisation wide compliance.	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/23
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (<u>NASECYP</u>)	Series of data collection cohorts within the audit	Various deadlines for cohorts	July 2023	Paediatrics	Organisation wide compliance.	**GREEN**
National Clinical Audit of Psychosis * (<u>NCAP</u>) EIP Audit	TBC	**N/A**	TBC	Mental Health	Organisation wide compliance.	**GREEN**

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)

National Vascular Registry Audit (includes Carotid Endarterectomy Audit) * (<u>NVRA</u>) no longer included on the annual rolling programme due to vascular services moved to tertiary centre, combined outcomes now reported under Cardiff & Vale UHB.

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

Clinical Outcomes Review Programme (2022/23)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2022/23	RAG Status 2022/23
• National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	**N/A**	April 2023	Mental Health Programme	Organisation wide compliance.	**GREEN**
• NCEPOD – Transition from Child to Adult Services	01/04/2022 – 30/06/2022	**March 2023**	June 2023	Child Health Clinical Outcome Review Programme	Organisation wide compliance.	In progress at the time of publication
• NCEPOD – Crohn's Disease	2022	**March 2023**	TBC	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
• NCEPOD – Epilepsy	01/02/2022 – 30/06/2022	**June 2022**	December 2022	Medical & Surgical programme	**Incomplete**	**RED**
• NCEPOD – Testicular Torsion	2022	**March 2023**	February 2024	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
• NCEPOD – Community Acquired Pneumonia	2022	**March 2023**	TBC	Medical & Surgical programme	Organisation wide compliance.	In progress at the time of publication
• NCEPOD - Endometriosis	2022/23	**February 2024**	April 2023	Medical & Surgical programme	**N/A** (new for 2023/24)	**N/A**

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NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2023/24

Outcome Reviews in which all Welsh Health Boards and Trusts <u>must</u> participate (across sites where services are provided)

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2022/23	RAG Status 2022/23
• End of Life	2023/24	**TBC**	TBC	Medical & Surgical programme	**N/A** (new for 2023/24)	**N/A**
• Rehabilitation after Critical Illness	2023/24	**TBC**	TBC	Medical & Surgical programme	**N/A** (new for 2023/24)	**N/A**
• Juvenile Idiopathic Arthritis	2023/24	**TBC**	TBC	Child Health Clinical Outcome Review Programme	**N/A** (new for 2023/24)	**N/A**
• MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	**TBC**	October 2023	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**
• MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	**TBC**	November 2023	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2023/24

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/2023
Case Note Documentation Audits:	Revised methodology TBC				All tier 2 audits affected by requirement to divert resources to underpin priority COVID Mortality Review cases	
• Acute Hospital Documentation Audit		**TBC**	TBC	Acute inpatient activity	Compliance significantly affected by closure of department and demands on clinical audit staff December 2021 / February 2022	AMBER
• Community Hospital Documentation Audit		**TBC**	TBC	Community hospital inpatient activity	Compliance significantly affected by closure of department and demands on clinical audit staff December 2021 / February 2022	AMBER
• A&E Documentation Audit		**TBC**	TBC	Emergency Medicine	Organisation wide compliance.	GREEN
Consent to Treat Audit	Revised methodology TBC	**TBC**	**TBC**	Surgery	**N/A**	**N/A**
Do Not Attempt Cardiopulmonary Resuscitation Audit	Autumn / Winter 2022	**March 2023**	**March 2023**	Critical Care	Organisation wide compliance.	GREEN
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	Under Review	**TBC**	TBC	Ophthalmology	CTM agreed as an organisation priority audit, Bridgend inclusion delayed	AMBER

Cwm Taf Morgannwg University Health Board Organisation (Tier 2) Priority Annual Audit Programme 2023/24

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2022/23	RAG Status 2022/2023
Appendectomy Audit	Prospective audit methodology TBC	**TBC**	TBC	Surgery	Organisation wide compliance.	**GREEN**
Tracheostomy Care Audit	**TBC**	**TBC**	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance so audit rolled over to 2022/23	**RED**

Quality & Safety Committee	
HIGHLIGHT REPORT FROM THE RADIATION SAFETY COMMITTEE	
DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Paul Johnston, Superintendent Radiographer
PRESENTED BY	Melanie Barker, Assistant Director of Therapies and Health Science
EXECUTIVE SPONSOR APPROVED	Lauren Edwards, Director of Therapies and Health Science

REPORT PURPOSE	For noting

ACRONYMS	
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RPSC	Radiation Protection Service, Cardiff
RSC	Radiation Safety Committee

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key matters considered by the Radiation Safety Committee at its meeting on 19th January 2023. Minutes available on request.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items to report in this section.
ADVISE	There is concern around the lack of Laser Protection Advisor at POW due to limited, underfunded resource at CTM. There is a national shortage of Laser Protection Advisors. Discussions to be held with other UHBs to understand if there is any capacity for cover, which would help mitigate the risk in the short term. There is concern regarding the assurance of the management of radiation safety in the dental department in PCH. To date contact has been minimal with no representation at the Committee meeting, this has since been rectified. RPSC had also been unable to establish contact with the department to perform an audit under the regulations. The Committee will work with the relevant Directorate to review documentation and procedures. Outstanding action for RPSC to audit theatres in PCH. During HIW inspection (see below), there were concerns raised around the governance and use of the mini-c-arm, (mobile unit used to scan patient extremities e.g. hands, feet) in theatre in POW (no history of any safety incidents). Use of the mini-C-arm has been ceased so there is no current risk. All appropriate actions are being progressed to address this. A further update will be received at the next RSC meeting.
ASSURE	HIW inspection of IR(ME)R compliance took place on 27th and 28th September 2023. Feedback was very good with some limited recommendations that have subsequently been addressed. Several policies and procedures had been updated and were agreed at RSC and subsequently published to the Radiology SharePoint site and sent to applicable staff.
INFORM	There were no items to report in this section.
APPENDICES	**NOT APPLICABLE**

QUALITY & SAFETY COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	16th March 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	February / March 2023	RISKS REVIEWED
Executive Leadership Group	6th March 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.

Organisational Risk Register

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

2.1 Following discussion at the Operational Management Board in February 2023, Care Groups are undertaking to review all risks under their areas of responsibility, initial focus will be on the high level risks escalated to the Organisational Risk Register.

2.2 The Assistant Director of Governance & Risk and Chief Operating Officer held 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. Executive Leads agreed to undertake a robust review of risks assigned to them to ensure there is consistency and moderation in terms of risk scoring.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. **378** members of staff trained to date.

2.4 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**

People & Culture Portfolio
- Datix ID 4679 - Absence of a TB vaccination programme for staff. Risk re-escalated in March 2023. Risk score of 16.

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period
Nil this period.

b) Risks where the risk rating DECREASED during the period

- Datix ID 4722 - Senior Medical Workforce Shortfall - Adult Mental Health. Risk score decreased from a 16 to a 12.
- Datix ID 3131 – Mortuary Capacity. Risk score decreased from a 20 to a 16.
- Datix ID 5254 - Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour. Risk score decreased from a 20 to a 16.
- Datix ID 5036 - Pathology services unable to meet current workload demands. Risk score decreased from a 20 to a 16.
- Datix ID 2721 – Capacity to deliver POCT training to Health Board Nursing Staff. Risk score decreased from a 16 to an 8. De-escalated

from the Organisational Risk Register. Rationale captured in Appendix 1.

- Datix ID 4149 – Failure to sustain Child and Adolescent Mental Health Services. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.
- Datix ID 4908 - Failure to manage Legal cases efficiently and effectively. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.
- Datix ID 4940 - Delay to full automated Implementation of Civica. Risk score decreased from a 16 to a 12. De-escalated from the Organisational Risk Register. Rationale captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER
- Datix ID 4971 – Adult Special Care Dentistry. Risk Closed. Rationale captured in Appendix 1.

3.4 DICUSSION POINTS
- Updates to the following risks were received post ELG meeting on the 6th March, however, have been signed off by the Executive / Director lead:
  - Datix ID 4971 – Adult Special Care Dentistry
  - Datix ID 4632 - Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)
  - Datix ID 5214, Critical Care Medical Cover
  - Datix ID 4080, Failure to recruit sufficient medical and dental staff
  - Datix ID 3638, Pharmacy & Medicines Management - Training & Development Infrastructure
  - Datix ID 4590, Critical Care Pharmacist Resource

Organisational Risk Register

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

Consequence	CxL	1	2	3	4	5
5				3337 4772 5207 5323	4080 3826 4887 5214	4743
4					4458 4152 4148 3585 4798 3133 4906 1133 5014 4479 4679 3131 5036 5254	4491 4632 4071 4721 4103 4217 4907 4922 5267
3						4691 4512 4732 4590 4920 2808 3993
2						
1						
					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 all 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.

Organisational Risk Register (Risks Graded 15 and Above - Updated March 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
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. March 2023 - Currently awaiting further updates on the contractual arrangements. Board Members briefed at the Board Briefing on the 16th February 2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	1.3.2023	31.3.2023
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 of 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. Update March 2023 - risk score remains unchanged as the Health Board was unable to successfully recruit to the Covid-19 Information Project Manager role at the interviews in February 2023. The post has been re-advertised. Risk to be reviewed end of April 2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	3.3.2023	30.04.2023
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 into 10 years. Appoint Critical Care lead across CTM to establish one department - 3 sites approach (Care Group organisational change). Update 1.3.2023 - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore no change to this risk as at 1.3.2023. New Critical Care leadership team have taken on reconfiguration and will be involved in this risk review activity.	Quality & Safety Committee People & Culture Committee	20	C5xL4	10 (C5xL2)	↔	19.8.2022	1.3.2023	28.04.2023.
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	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. Update 02/03/2023 - Lead IPCN to speak to the Nurse Consultant for IPC (HARP TEAM) to determine if she could support the scoping work planned in primary care. IP&C team to continue to work through how community support can be delivered within the current resource, to be further discussed at the April 2023 IP&C. No change to risk score.	Digital & Data Committee & Quality & Safety Committee	20	C5xL4	10 C5xL2	↔	27.10.2021	02.03.2023	28.04.2023
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. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	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 sites 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 rigorous monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	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. Confirmation received 27.1.2023 from the Cancer Business Team that there are no additional delays to cancer patients as a result of the pausing of the harm review panels. Update for March; Overall cancer performance continues to decrease as the long waiting patients are treated. A deep dive into Urology pathways is underway. The breast cancer team are undertaking LEAN training to enable them to look to streamline pathways. A change from 104+ to 146+ day cancer harm reviews, in line with Welsh government guidance, has been approved.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	03.03.2023	31.3.2023

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
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. These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways – there is no one solution. The approaches include –recruitment, job planning (compliance and standardisation), establishment, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, sickness rates, all of these impact on the workforce and are part of the programme. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction.	Quality & Safety Committee / People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	09.03.2023	30.04.2023
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 / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	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. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	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 • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Regional and National Stroke Programme Boards established and progressing developments. • Unified, evidence-based pathway developed for thrombectomy • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update March 2023 - The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas: • Following the resignation of Consultant Stroke Physician at Prince Charles Hospital, recruitment process ongoing following recent job planning exercise. In the meantime, the CSG continue to work with medical staffing agencies with the recruitment of a Locum Consultant. • A CTM-wide stroke consultant rota, with joint working between PCH and POW consultants, in place enabling a more stable rota. Continued dialogue with C&VUHB to look at long term solutions, feeding into the South Central Wales Regional Programme Board. • Regional developments with C&VUHB continue, representatives from both UHBs attended a national programme workshop on Friday 13th January to inform the development of modelling, optimal stroke pathway and service specifications. Successful recruitment has been made to the role of Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network which will enable further progress to be made in response to national service specifications. • Board briefing in January 2023, with input from national stroke leads. • Prescribing nurse has been identified to support the initiation of the AF and BP project in Primary Care, with support of the GP with special interest and possibly additional pharmacists, commencing next month. The blood pressure element will be initially targeted at those patients previously identified through the Health Check programme where they will reviewed in terms of ensuring their management is optimised. The AF element will be initiated in 2 or 3 clusters in the Bridgend area and work again commenced next month. • Work ongoing to develop services in CTM UHB to respond to planned 24/7 access to thrombectomy in Bristol: - Awaiting final approval for radiographer approved CTA - Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy - Development of new stroke thrombolysis and thrombectomy pathway in anticipation of new stroke guidelines to be published in April 2023 - Task and Finish group to look at implementation of Brainomix, AI software for interpretation of CTA and CTP to help streamline thrombectomy. -Awaiting confirmation of date from alternative Hospital to commence 24/7 thrombectomy for patients in Wales	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	5.3.2023	30.04.2023
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
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

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
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 not 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 Update 1.3.2023 - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore, no change to this risk as at 1.3.2023.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022	1.3.2023	28.04.2023 (It should be noted that although the new reframed risk opened in October 2022 the previous iterations of this risk - Datix ID 4106 and 4157 were opened on the 01.06.2015 and 01.01.2016 respectively)
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. Update February 2023 - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Timeframe 28.4.2023. Review processes in conjunction with Funeral Directors - Timeframe 30.06.2023	Quality & Safety Committee	16 ↓ 20	C4xL4	C3xL2	↓ Risk score reduced from a 20 to a 16 in March 2023	05.03.2018	27.2.2023	15.05.2023
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 Due date 1.12.2022 Demand & capacity review Due Date 31.07.2023 Workforce redesign Due date 31.07.2023 Dedicated Pathology IT resource Due Date 31.7.2023 Accommodation review Due Date 31.07.2023 Novation of Equipment to the Managed Service Contract Due date 3.7.2023 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. Update 27.2.2023 - Outsourcing has affectively addressed much of the backlogs in Cell Path, however ongoing outsourcing will be required for the remainder of 22-23 and the whole of 23-24, unless significant changes are made within the HB and across the region. There is ongoing further work required more widely across Pathology to address the staffing and estates challenges. Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.	Quality & Safety Committee	16 ↓ 20	C4 x L4	6 (C3xL2)	↓ Risk Score reduced from a 20 to 16 in March 2023	02.03.2022	27.2.2023	30.04.2023
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	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. Update March 2023 - A plan has been developed for the implementation of Duty of Candour within CTM. The National Impact assessment is in progress. The new operating model is now at implementation phase, with any vacancies now being advertised. Focus will be to target the Redress backlog. The impact of the Duty of Candour is not yet fully known. Likelihood reduced to a 4.	Quality & Safety Committee	16 ↓ 20	C4xL4	8 (C4xL2)	↓ Risk score reduced from a 20 to a 16 in March 2023	07.10.2022	02.03.2023	30.04.2023

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
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\n\nImpact 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\n\n**Then:** there are a number of areas undertaking their own decontamination via automated/manual systems.\n\n**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.\nThe 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.\nAP(D)support available on site.\nMonthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting.\nSOPs is place\nWater testing carried out as per WHTM guidance\nMaintenance programme in place for decontamination equipment\n07/10/2021 - 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.\nEach 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.\n\nUpdate 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.\n\n17/08/22 - 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\n\nUpdate 6.1.2023 - actions as reported in August 2022 currently on track. Next review scheduled for January 2023.\n\nUpdate 28.2.2023 -Activity ongoing - Business case needs to be sent to Welsh Government by May 2023. No change to risk score.	Quality & Safety Committee	16	C4xL4	2\n\nC1xL1	↔	30.12.2020	2.3.2023	28.4.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety\n\nImpact 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;\n\n**Then:** the Health Board will be unable to deliver safe, high quality services for the local population;\n\n**Resulting In:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021).\n\nOption 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.\n\nSeptember 2022 Review by Nurse Director for Unscheduled Care:\nCurrently 6.3 wte ANPs in post with 3 new trainees commencing.\nAdvert for locum Consultant in progress\nAd-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021).\n\nReviewed no change as at 7th September 2021.\n\nReviewed 21.09.2021 - remains working progress.\n\nUpdate 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.\n\nMedium 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.\n\nPeople & Culture Committee - Workforce aspect	16	C4 x L4	12\n(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\n\nImpact 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 rescheduled.\n\n**Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen).\n\n**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.\nPosters developed and displayed in areas to encourage attendance.\nNew staff trained at induction.\nTNA has been undertaken.\nRefresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score.\nMedical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed\n\nTo 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\n\nMedical 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 from 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.\n\nMeeting 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\nMedical 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.\n\nThe 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).\n\nAction: Med Device Trainer to review with another UHB what can be delivered via e-learning to support some elements of this subject. Timescale: 31/05/2023.\n\nMedical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the UHB. As of Dec 22 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.\n\nNo significant increase in compliance. Attendance still poor for this subject matter, Med Device Trainer reviewing with another UHB what can be delivered via e-learning to support some elements of this subject, such as refresher training, however attendance would be required for initial training (WG 21/02/2023).\n\nThe 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	Quality & Safety Committee.	16	C4 x L4	8\n(C4xL2)	↔	01/05/2018	3.3.2023	31.05.2023
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational:\n• Core Business\n• Business Objectives\n• Environmental / Estates Impact\n• Projects\n\nIncluding 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.\n\n**Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department.\n\n**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.\n\nAdditional 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 –\n1. 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.\nPrior 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.\nPatient 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.\nJune 21 Update - Capital works for NIV room still ongoing and therefore no progress yet with the rest of the capital build. NIV room to be handed back mid June and patient toilet will be the next priority for completion. Update August 2021 - No Change.RCEM audit undertaken. Staffing remains ongoing issues- plans in place and frequently reviewed. ASCU staffing plan agreed at ILG level and ongoing. Surge trolleys in place to cope with additional capacity requirements. Building works progressing and some phases complete. X references to 1D445B & 1D3826.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.\n\nUpdate 3.11.2022 - WG funding secured to have works undertaken. CTM capital team progressing ASAP.\n\nUpdate February 2023 - Commencement of capital works in ED which will include a second, disabled access patient toilet. This will be situated within the main department and will be accessible for within the clinical area.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	06.02.2023	30.04.2023
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\n\nImpact 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.\n\n**Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation\n\n**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 2023 review of this risk the control measures have been revisited and streamlined.\n\n- 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.\n- An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog.\n- Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments.\n- The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised.\n- A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	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.\n- 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.\n- 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.\n\nUpdate February 2023 - WG have confirmed that further funding will be provided for 23/24 to continue to address the backlog of authorisations. Procurement are supporting the team to agree a contract with an agency to work with CTMUHB to address the backlog. WG have agreed to a change in use of funding to proceed with this action.	Quality & Safety Committee	16	C4 x L4	8\n(C4xL2)	↔	01/10/2014	10.2.2023	30.04.2023

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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
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 recovery pathways. / 30.01.2023 - Risk reviewed and score and mitigation remains unchanged.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	30.01.2023	08.05.2023
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 new 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	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. / Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted.	Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	21.2.2023	2.3.2023	31.5.2023
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 in 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. / Update March 2023: 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, with Patient Safety Improvement Managers taking a lead of facilitation. / 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. / Better LFER reports are available per care group to allow for better oversight by the Care Group triumvirate. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	27.2.2023	30.04.2023
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety / Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff / **Then:** Staff and patients are at risk of contracting TB / **Resulting in:** Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update Jan 2023 - Training is now arranged 16th and 18th Jan for OH Nurses and a support group via Cardiff & Vale is being implemented to provide peer support going forward. / Update March 2023 - Unfortunately the training did not take place as planned in Jan. The training and implementation of TB screening and vaccination within Occupational Health in CTM UHB has been delayed and is on hold due to a fundamental link in the chain which permits such screening and vaccination taking place. This is in the form of the signing of the Patient Specific Directives for Mantoux delivery and therefore a reform of our process must now be implemented prior to service training and delivery. This will need to be passed through Pharmacy. A meeting is arranged on 16th March to progress this. This risk has therefore increased in score and been re-escalated to the Organisational Risk Register.	Quality & Safety Committee / People & Culture Committee	16	C4xL4	8 C4xL2	Risk Re-escalated March 2023	09.06.2021	17.02.2023	30.04.2023
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
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, patients not being seen 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

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
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	Unscheduled Care Group	Care Group Director - Unscheduled Care	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	If: there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; Then: patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; Resulting in: incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO – Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	30/12/2020	02.11.2022	31.12.2022
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Chief Pharmacist	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	If: additional resource is not identified to increase the critical care clinical pharmacy service Then: there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. Resulting In: an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. 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 Ba specialist pharmacist for each critical care in RGH, POW and PCH 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. Update March 2023 - - Deputy Director of Nursing liaising with Medical and Workforce colleagues to lead the review of this risk and other risks in relation to Critical Care Workforce. Timescale for review April 2023. Therefore no change to this risk as at 1.3.2023. New Critical Care leadership team have taken on reconfiguration and will be involved in this risk review activity.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	05.04.2021	08.03.2023	28.04.2023
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 22/02/2023) We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023- beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract. 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 .	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	03.03.2023	31.05.2023
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 Update February 2023 - No change for this period, next planned review is due 31.3.2023.	Quality & Safety Committee	15	C3 x L5	12 (C3xL4)	↔	27.11.2021	23.2.2023	31.3.2023

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
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
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)	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 may 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. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority 21.2.2023 - no change in mitigation or scoring. Scheduled for a further review at the end of April 2023.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	21.2.2023	28.04.2023
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. Update 02/03/2023 - Lead IPCN to speak to the Nurse Consultant for IPC (HARP TEAM) to determine if she could support the scoping work planned in primary care. IP&C team to continue to work through how community support can be delivered within the current resource, to be further discussed at the April 2023 IP&C	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	02.03.2023	28.04.2023
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 30.1.23 RGH has list every other Friday SON submitted, initial agreement to fund new room	Quality & Safety Committee	15	C5xL3	C5xL1	↔	23.12.2022	30.01.2023	08.05.2023

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
4722	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Senior Medical Workforce Shortfall - Adult Mental Health	**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	12 (C4xL3) reduced from a risk score of 16.	6	The rationale for this score reduction is that the service area can now report that there is a Consultant Responsible Clinician for 3 areas, with CD Responsible Clinician for 1 area. Community Consultants are stable and set to improve with appointments in early February (Locum). Risk to be monitored by the MH and LD Care Group.
2721	Chief Operating Officer	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	8 (C4xL2) reduced from a risk score of 16.	C2xL2	Risk score reduced as POCT associate practitioner employed on a fixed term contract to progress training provision. Replacement of blood gas analyzers across the health board has provided the opportunity to re-train all operators on the new instrumentation. Over 700 operators were trained, competency assessed and validated for the next 2 years.
4149	Chief Operating Officer	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	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. o 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	Risk reviewed and updated the controls provement 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	12 (C4xL3) reduced from a risk score of 16.	C4xL3	Risk score decreased due to many mitigating factors/control measures. Enhanced Single Point of Access, Waiting List Imitative, close monitoring through fortnightly CTM Action Plan meetings, Performance Meetings, review of job plans, D&C plans and regular monitoring through a daily tracker.

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
4908	Executive Director of Nursing	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	12 (C4xL3) reduced from a risk score of 16.	8 (C4xL2)	Invest to save bid was unsuccessful, therefore alternative funding options being explored. The new operating model is now at implementation phase with any vacancies being advertised. Once in post, there will be some extra capacity. An action plan to prioritise older cases has been developed. Extra capacity will be used to focus on the backlog in readiness for the implementation of Duty of Candour. Risk score has been reduced as a result of the above mitigation.
4940	Executive Director of Nursing	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.	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	12 (C4xL3) reduced from a risk score of 16.	9 (C3xL3)	March 2023-VBHC Admin support temporarily helping to input have your say cards/ paper copies into the system within the POW area. Active discussions are being held with ED leads across CTM on automating a survey via SMS. Patient Feedback volunteer team are supporting collection of patient feedback in POW as a pilot at present. Due to changes in organisational structure the CTM Civica leads group is meeting in March to discuss how the system can be supported going forward and ensure reflection of representation across the care groups. Due to improvements and review of risk - risk score has been reduced in terms of likelihood.

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
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. **On Hold in closure section.** This will not be removed from the Organisational Risk Register whilst sufficient assurance is sought to the satisfaction of the Audit & Risk Committee. Confirmation received that the capital works have been completed. Consideration at the Audit & Risk Committee in April 2023.
4971	Chief Operating Officer	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. 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. Update March 2023 - Risk to be closed as Special Care Dentists appointed.	Quality & Safety Committee	Closed	The risk has now been closed as 1.6WTE Special Care dentists have now been appointed.

AGENDA ITEM 5.2

QUALITY & SAFETY COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE HEALTH, SAFETY & FIRE SUB COMMITTEE

DATE OF MEETING	16 March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Walters, Corporate Governance Manager
PRESENTED BY	Dilys Jouvenat, Independent Member
EXECUTIVE SPONSOR APPROVED	Hywel Daniel, Executive Director for People

REPORT PURPOSE	FOR NOTING

ACRONYMS	
	None Identified.

1.   INTRODUCTION

1.1   This report had been prepared to provide the Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 7 March 2023.

1.2   Key highlights from the meeting are reported in section 3.

2.   PURPOSE OF THE HEALTH, SAFETY & FIRE SUB COMMITTEE

2.1   The purpose of this Sub-Committee is to:

- Advise and assure the Board and the Accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the Health Board's health and safety policy, monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

- This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the committee will advise the Board (through the Quality & Safety Committee) and the accountable officer on where and how, its health and safety management may be strengthened and developed further.

3.   HIGHLIGHT REPORT

ALERT / ESCALATE	• The **Fire Safety Report** was received. Concerns were expressed regarding the low levels of compliance being achieved in relation to staff attending fire safety training sessions which presented a risk to the organisation.. Members noted that out of an available 4,290 spaces that had been made available between September 2022 – December 2022, only 1,100 of these spaces were taken up;
	• Under the 'Any Other Business' section of the agenda concerns were raised in relation to the **placement of patient beds in areas of wards not officially designated for patient care.** Such instances were understood to have arisen due to the very challenging bed capacity issues being faced by CTM hospitals. The need for assurances around the establishment of robust clinical and operational risk assessments and corresponding action plans to mitigate the issues these unofficial bed areas were creating was felt to be a key issue along with the ability of staff to maintain their safety and the safety and dignity of their patients under such circumstances. As a result the Chair of the Health Safety & Fire Sub Committee suggested

 ■ 	that these issues be escalated to the Quality & Safety Committee and this was agreed.
ADVISE	• The **Action Log** was received and discussed. Members noted that arrangements had now been put into place for Care Group representation at all future meetings. It was noted that both Deputy Chief Operating Officers would be representing Care Groups at meetings moving forwards; • The **Head of Health, Safety & Fire Report** was received. Members requested that further work was undertaken to strengthen responses provided against some of the risks identified in the report and noted that concerns remained in relation to Datix reporting issues and staff compliance against statutory and mandatory training requirements; • The **Health, Safety & Fire Performance** report was received. Discussion was held in relation to the difficulties some staff were experiencing in relation to updating their compliance against fire safety training on ESR which may be having a negative impact on compliance and it was noted that the Director for People would action the request to share a How To guide with Care Groups outlining how this task could be completed; • The **Organisational Risk Register report** was received. Members noted that in relation to Risk 3993 – Fire Enforcement Notice at Princess of Wales Hospital, the meeting to discuss options for decanting that was to have taken place in January 2023 had been postponed by Welsh Government. Whilst it was accepted that the content of the Risk Register update reflected the position to January 2023, some of the risks items required updates as the current status set out in the report predated January 2023. It was noted that the Risk Register was updated on a bi-monthly basis and risk owners would continue to be asked to ensure timely updates were submitted in a timely manner. • The **Health Surveillance Programme Background Report** was received. Members noted that the Maternity Services Team had been asked to undertake environmental monitoring in relation to the use of Nitrous Oxide and discussions were being held with the Medical Gas and Pharmacy Teams regarding reducing the usage of Nitrous Oxide where possible. Members noted no issues of concern had been highlighted to date.

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ASSURE	• A report on **Estates Safety & Compliance Report – Medical Gas Pipelines System Compliance** was received. Members welcomed the work that had been undertaken to address the recommendations which was borne out by the attainment of a 'reasonable assurance' rating.; • The **Internal Audit Follow Up Review – Fire Safety Arrangements** report was received. Members welcomed the progress that had been made to address the majority of recommendations and noted that a 'reasonable assurance' rating had been allocated to this area;
INFORM	• The **minutes of the meeting held on the 12 October 2022** were received and approved; • The **Forward Work Programme for 2023** was received and approved; • The **Health, Safety & Fire Sub Committee Terms of Reference** were ENDORSED for Quality & Safety Committee APPROVAL
APPENDICES	**NOT APPLICABLE**

4. RECOMMENDATION

4.1 The Quality & Safety Committee is asked to:

- **NOTE** the report;
- **APPROVE** the Terms of Reference for the Health, Safety & Fire Sub Committee.

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HEALTH, SAFETY & FIRE SUB COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

FINAL

Terms of Reference – Health, Safety and Fire Sub Committee
(Updates: inclusion of 'sub' designation to clarify this forum reports to a Board Committee and membership updates Feb 23)

INTRODUCTION

In accordance with CTMUHB the Quality & Safety 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:

1. Health, Safety and Fire Sub Committee

The detailed terms of reference and operating arrangements for the Health, Safety & Fire Sub Committee ('the sub-Committee') are outlined below.

Furthermore, the organisation has a 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".*

CONSTITUTION & PURPOSE

The purpose of the Health, Safety & Fire Sub Committee is to:

1. Advise and assure the Board and the accountable officer on whether effective arrangements are in place to ensure organisational wide compliance of the Health Board's health and safety policy, approve and monitor delivery against the health and safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

2. This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.

Where appropriate, the committee will advise the Board and the accountable officer on where and how, its health and safety management may be strengthened and developed further.

SCOPE AND DUTIES

The sub committee's programme of work will be designed to provide assurance that:

1. Objectives set out in the health and safety action plan are on target for delivery in line with agreed timescales;

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2.   Standards are set and monitored in accordance with the relevant standards for health services in Wales;

3.   Robust proactive and reactive health and safety plans are in place across the Health Board;

4.   Policy development and implementation is actively pursued and reviewed;

5.   Learning from health, safety or fire related incidents/events is shared across the CTMUHB;

6.   Where appropriate and proportionate health and safety incidents and ill health events are investigated and action taken to mitigate the risk of future harm;

7.   Reports and audits from enforcing agencies and internal sources are considered and acted upon;

8.   Employee health and wellbeing activities are in place in line with the CTMUHB commitment to be a public health practicing organisation and corporate health standards;

9.   Assurance can be taken in relation to mitigating health and safety risks;

10. Employee health and safety competence and participation is promoted;

11. Decisions are based upon valid, accurate, complete and timely data and information.

DELEGATED POWERS

With regard to its role in providing advice to the Board and Quality & Safety Committee, the sub-Committee will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective health and safety function encompassing:

1.   Staff health and safety
2.   Premises health and safety
3.   Violence and aggression
4.   Fire safety
5.   Health and safety risk assessment
6.   Manual handling
7.   Substances hazardous to health
8.   Patient health and safety
9.   Security

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10. Staff health and well-being including Staff healthy lifestyle / health promotion activities

The sub-Committee will support the Board /Quality & Safety Committee with regard to its responsibilities for health, safety and fire:

11. approve and monitor implementation of the annual health and safety action plan;
12. review the comprehensiveness of assurances in meeting the Board and the accountable officer's assurance needs across the whole of the Health Board's activities, both clinical and non-clinical;
13. the consideration of relevant UHB policies for approval by the Quality & Safety Committee.

AUTHORITY

The sub-Committee is authorised by the Board /Quality & Safety Committee to investigate or have investigated any activity within its terms of reference. In doing so, the sub-Committee shall have the right to inspect any books, records or documents of the Health Board relevant to the committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

1. Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
2. Other committee, sub-Committee or group set up by the Board to assist it in the delivery of its functions.

The sub-Committee is authorised by the Board to 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.

Task & Finish Groups

The sub-Committee may, subject to the approval of the Board/Quality & Safety Committee, establish task and finish groups to carry out on its behalf specific aspects of sub-Committee business.

If there are no formal task and finish groups, however, the sub-Committee will receive reports from the operational health and safety group as part of its assurance framework.

ACCESS

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

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The Executive Lead for health, safety and fire shall have unrestricted access to the chair of the Health, Safety and Fire sub-Committee.

MEMBERSHIP

The membership of the sub-Committee shall be determined by the Board/Quality & Safety Committee, based on the recommendation of the Health Board's chair - 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 Welsh Government.

Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the Health Board's Chair.

Members:

Chair: Independent member of the Board

Vice Chair: Independent member of the Board

Members: A minimum of one other Independent member of the Board

- Executive Director for People (Executive Lead)
- Executive Director of Therapies & Health Sciences
- Director of Governance / Board Secretary.
- Head of Health, Safety and Fire
- Deputy Chief Operating Officer (Care Group nominated lead in their absence)
- Chair of Staff-Side Health & Safety Committee
- Assistant Director of Strategy – Capital Planning
- Head of Estates

Deputies: In the event attendees are unable to attend the meeting every effort should be made to ensure their deputy attends and represents on their behalf.

Invitation
The sub-Committee chair may extend invitations to appropriate persons to attend committee meetings as required from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration at each meeting.

Secretariat
Secretary: as determined by the Director of Corporate Governance/Board Secretary.

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Support to Committee Members

The Director of Corporate Governance /Board Secretary, on behalf of the sub-Committee chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for committee members in conjunction with the Director for People.

Sub COMMITTEE MEETINGS

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

Frequency of Meetings
Meetings shall take place no less than 4 times a year, and otherwise as the Chair of the sub-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 sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

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

REPORTING AND ASSURANCE ARRANGEMENTS

The Sub Committee Chair shall:

1. Report formally, regularly and on a timely basis to the Quality & Safety Committee. This includes verbal updates on activity, the submission of highlight reports, as well as the presentation of an annual report;

2. Bring to the Board's specific attention any significant matters under consideration by the committee;

3. Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

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

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board through its delegation to the Quality & Safety Committee has provided delegated authority to the sub-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 sub-Committee is directly accountable to the Quality & Safety Committee and Board for its performance in exercising the functions set out in these Terms of Reference.

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

1. Joint planning and co-ordination of Board and Committee business; and;
2. Sharing of information

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

The sub-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 sub-Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which would normally be made by the sub-Committee need to be taken between scheduled meetings. In these circumstances, the sub-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 sub-Committee. The Director of

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Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the sub-Committee for consideration and ratification.

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

REVIEW

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

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	Maternity and Neonatal Improvement Programme Highlight Report January 2023
Date of Meeting	Maternity and Neonatal Programme Board to be held 13th February 2023
FOI Status	Open / Public
Prepared by	Shelina Jetha, Programme Manager MNIP
Presented by	As above
Approving Executive Sponsor	Suzanne Hardacre, Director of Midwifery
Report Purpose	Update the group on the progress of the Maternity and Neonatal Programme.

ACRONYMS

NN	Neonatal
NNIP	Neonatal Improvement programme
ATAIN	Avoiding Term Admissions into Neonatal Units
CNO	Chief Nursing Officer
DD	Deep Dive recommendations
ESC	Escalations (as per DD recommendations)
IMSOP	Independent Maternity Services Oversight Panel
IPAAF	Integrated Performance Assessment and Assurance Framework
MDT	Multi Disciplinary Team
MNISB	Maternity and Neonatal Improvement Safety Board
NNU	Neonatal Unit
QLM	Quality Leadership and Management (Maternity Workstream)
QWE	Quality Women's Experience (Maternity Workstream)
PCH	Prince Charles Hospital
PREM	Patient Reported Experience Measure
PTR	Putting Things Right
EIA	Equality Impact Assessment
SEC	Safe and Effective Care (Maternity Workstream)
QI	Quality Improvement
NNAP	National Neonatal Audit Programme
MNIP	Maternity and Neonatal Improvement programme
SOP	Standard Operating Procedure
DOM	Director of Midwifery
BAU	Business as usual

SITUATION/BACKGROUND

The purpose of this report is to provide an update on the progress of the Maternity and Neonatal Improvement Programme in the form of a highlight report.

SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

This section outlines an overview narrative describing some of the key matters within the Maternity and Neonatal Improvement Programme:

- NN Improvement programme risks
- Neonatal immediate recommendations progress
- Neonatal deep dive recommendations progress
- PTR
- Neonatal dashboard
- Maternity QI update
- NN Safety culture survey results summary

RECOMMENDATIONS
The Quality & Safety Committee are asked to note the report.

KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Please note the **"Programme Risks/Issues"** are captured on slide 3 of the highlight report.

Work to understand the extent of a new risk added in March 2022 is still underway. This relates to a number of recommendations in the Neonatal Deep Dive report specifically seeking additional investment in workforce. Costs have already been predicted to exceed £1m, so this will be significant.

IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below) Please refer to the highlight report for detail.
Related Health and Care standard(s)	Governance, Leadership and Accountability All Health and Care Standards apply.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) Not required for a progress report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below) Please refer to the highlight report for detail.
Link to Strategic Goals	Improving Care

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

TOP PROGRAMME RISKS AND ISSUES:

Risks/Issues	Details	Mitigating actions	Rating
Neonatal Deep Dive recommendations lead to increased operating costs	Work is underway to understand the operational cost consequences of a number of recommendations in the Neonatal Deep Dive report (3.3, 3.4, 3.5, 3.6, 3.7 & 3.8). The additional costs are greater than £1M but there are other posts that need scoped and costed.	Key improvement posts appointed; Risk/Governance Manager for neonatal services appointed 30.8.22; benchmarking of UK models of care and identify 3 potential models of care i.e. ANNP; PA, medical etc. discussed at a planned away day held in Sept.22; Supernumerary shift coordinators allocated – issues recorded on Datix; Also on-going workforce developmental meetings and workforce plan in line with BAPM regarding staffing model with draft business case developed. Business cases for other improvement roles to be developed: Psychotherapy; AHPs and ANNP with relevant departments.	High
MIP Sustainability of improvements	The improvements achieved through the MNIP needs to be embedded in business as usual practices and must be sustainable	Maternity and Neonatal safety champions in post as part of MATNEO SSP phase 1 (discovery). Preliminary report produced Improvement Cymru Dec 2022 to Minister and phase 2 March 2023; NN Operational Clinical Improvement Group (MDT includes Maternity) to drive BAU – meetings held: 9th Jan and 6th Feb 2023. Further support provided by Programme Management Office (PMO) team.	Moderate

Maternity and Neonatal Improvement Programme
SROs : Greg Dix and Sallie Davies

Focus on Neonatal improvement programme:

- **Total 56 NN deep dive recommendations which include 14 escalations and 5 immediate**
- **16 immediate/escalations verified by IMSOP**
- **Immediate escalation no.2 (IUT) and no. 5 (HIE)** *completed*
- *Total 18 out of 19 immediate actions delivered*
- **Immediate Esc 7 (SIs i.e. NRI's) –** *going through internal assurance*

Overall	%
Completed	69%
On-track	28%
Delays	5%

Delays overall: Immediate esc. 7 (SI's) and FIC care

<u>*Table and chart below demonstrate*</u> *the progress made in delivery of the deep dive actions, with Wales and national reporting i.e. data 100% - being embedded as BAU and dashboard being developed as per Maternity; QI projects identified through review of data.*

Workstream	delayed	on-track	completed
Family engagement	2%	24%	73%
Clinical case management	9%	2%	89%
Governance, assurance & accountability	0%	40%	60%
Neonatal Functionality	24%	44%	32%
Neonatal Unit safety	9%	64%	27%
Wales & National Reporting	0%	0%	100%
Workforce	9%	40%	51%

NN deep dive actions progress by workstream to date 7.2.23

delayed | on-track | completed

Workstream	delayed	on-track	completed
Workforce	9%	40%	51%
Wales & National Reporting		100%	
Neonatal Unit safety	9%	64%	27%
Neonatal Functionality	24%	44%	32%
Governance, assurance & accountability		40%	60%
Clinical case management	9% 2%		89%
Family engagement	2%	24%	73%
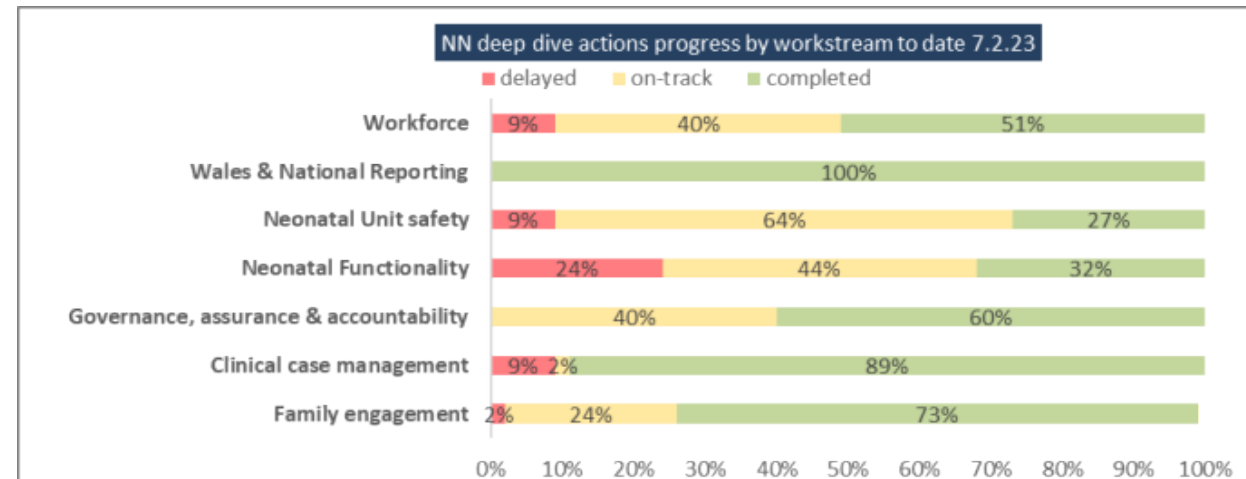
Things to know: PREMS live on CIVICA; Safety Culture survey completed and with Care group Managers

Rag status:

completed
on-track
delayed

Milestone	Due	Progress
Family engagement workstream – Lisa Baker		
PREMS now live on CIVICA	Feb 2023	PREMS questionnaire go-live 1/2/23
Family Integrated care (FICare) plan - in conjunction with BAPM standards	Dec 2022	Due to clinical demands and S/L progress has been delayed; however plan for scoping exercise with families who've used tertiary units on their experience on FICare to develop and action plan
Governance, Assurance & Accountability workstream - Gail Clack/Lee Evans		
Clinical Audits must be reviewed by service leaders developing improvement workplans in partnership with clinical teams which are then progressed reviewed and discussed as part of formal clinical governance mechanisms	Dec 2022	Clinical Audit esc. 14 presented evidence with actions/presentations etc; also part of annual cycle; newly appointed clinicians since Feb 23: at PCH and POW
Workforce – Gail Clack		
Explore financial remuneration to support staff rotation	Dec 2022	Financial remuneration to support staff included in the workforce paper
Training - named lead for each workforce group	Dec 2022	PDNs identified at PCH and POW
Annual local resus. Training provision and log e.g. Tier 1 level training	Dec 2022	All medical training comes under College Tutor (Local Programme Director); (LPD) and (Deputy LPDs)
Neonatal Unit Senior Nurse position who is in part Matron and part Improvement Lead Nurse to ensure there is a stable senior nursing leadership structure with the specialist ability and leadership experience to know and deliver 'what good looks like'.	Jan 2023	We have a Senior NN specialist nurse role in post across CTM since autumn 2022.
Opportunities for quality roles should be identified to all staff through mechanisms such as annual appraisal.	Jan 2023	Due to clinical demands due to S/L progress has been delayed
Ensure support for ongoing rotation of staff into quality roles to aid continuity of role provision.	Jan 2023	Due to clinical demands due to S/L progress has been delayed
Protected, allocated time job for quality roles.	Jan 2023	Due to clinical demands due to S/L progress has been delayed

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Things to know: Nursing staff Safety Culture survey results analysed; Esc. 2 (IUT) and Esc 5 (HIE) completed

Milestone	Due	Progress
Neonatal Unit Safety - Leanne Richards		
Safety culture survey - for MDT (to include both Maternity and Neonatal)	Dec 2022	Data extracted and analysed; next survey to include MDT; as only nurses included in Sept-Dec survey
Extract data analysis and review outcomes and improve safety culture/repeat at appropriate intervals	Feb 2023	Results analysed; to be shared and actioned
Neonatal Unit Functionality - Leanne Richards		
Culture survey (questionnaire development - as per previous survey - review baseline)/CIVICA	Dec 2022	Delayed due to lead for both Mat/Neo culture survey no longer employed by HB and SL. Plans to repeat maternity culture survey in March 2023. Leadership and culture development plan in place, supported by Caring for You Action plan. Second of two band 7 midwifery leaders away day held 27th February 2023 (first day 3rd October 2022).
Esc 2 (IUT) – immediate action not verified by IMSOP	Aug 2022	IUT pathway approved and cases reviewed by MDT (Mat/Neo) every Wednesday and tracker developed to log cases and learnings; Esc 2 re-submitted for internal assurance 8.2.23
Clinical Case Management - David Deekollu/Rebecca Pockett		
Esc 5 (HIE – cooling) – immediate action not verified by IMSOP	Jun 2022	Pathway in place case confirmed 28/12/22 now reviewed; submission being prepared for internal assurance
Esc 7 (SI's/NRI's) – immediate action not verified by IMSOP	Jul 2022	Going through internal assurance
Senior Medical oversight of discharge summaries	Dec 2022	Discharge before baby goes home is signed off by Registrars predominantly by using a checklist. However, agreed that there should be a senior oversight from a Consultant. Proposal to do a snapshot audit to review the quality and also to consider receptionist to bring discharge letter and checklist for Consultants to sign-off. Plan to report back at the Maternity and Neonatal Safety Board to be held 28.3.23.

Risks:1.0 sustainability of improvement roles post 31.3.23; 2.0 Embed improvements as business as usual across CTM

Maternity Improvement Programme (MIP) – 'wash-up plan' – remaining actions from RCOG recommendations on closure of the MIP

Things to know: QI (training sessions held and projects identified) and Maternity and Neonatal dashboard development on-track; Medical uptake to be improved; Transitional care pilot to commence 17th April 2023

Milestone	Due	Progress
Long-term strategy	March 2023	Staff and public consultation finalised; Comms dept. for launch
Re-run Culture Survey – Maternity and Neonatal	March 2023	
Quality Improvement (QI) – Maternity and Neonatal	March 2023	Several QI training sessions held; with further 'adhoc' as required; Medics to increase uptake; Neonatal first QI MDT meeting to be held 2.3.23; also All Wales PERIprem launched to be inclusive of NNAP/MDT approach
Transitional care	March 2023	Being scoped; presentation to Maternity and Neonatal safety board 19.1.23; MDT meeting to be held 27.2.23; 3 month pilot to commence at POW on 17.4.23; HOM to arrange visit Tertiary centre in Plymouth
Joint Maternity and Neonatal dashboard	March 2023	NN tab being developed for inclusion onto the Maternity dashboard live (Nov 22); *note: Neonatal dashboard developed*
Audit to be undertaken in 6 months time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level (CEPOD)	closed	Closed: change in iterations based on Welsh Gov./IMSOP advice; MD presented update to QSE 24.1.23; adhere to existing protocols 18hr window – fully compliant and no safety incidents

Cwm Taf Morgannwg

Maternity Metrics

February 2023.

Categories of Caesarean Section

•**Category 1** – **immediate** ("crash"): these are performed when there is an immediate threat to the life of the woman or fetus. Delivery should take place as soon as possible. The Royal College of Obstetricians and Gynaecologists recommends that a category 1 section should be performed within 30 minutes of making the decision for caesarean delivery.

•**Category 2 – urgent**: these are indicated when there is maternal or fetal compromise, which is not immediately life-threatening. To be performed as soon as possible, and within 75 minutes of decision for delivery.

•**Category 3 – scheduled**: this category of C-section is indicated where there is no maternal or fetal compromise, but early delivery is required.

•**Category 4 – elective**: the timing of this delivery is planned to suit the woman and staff.

Number of births by mode of delivery

Spontaneous Vaginal Births

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
221	252	229	246	259	229	223
60.5%	64.3%	55.9%	59.7%	60.1%	59.9%	60.6%

Instrumental Births

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
22	23	33	29	30	27	23
6.0%	5.9%	8.0%	7.0%	7.0%	7.1%	6.3%

Category 1 Caesarean Sections

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
6	6	17	8	7	8	7
1.7%	1.6%	4.2%	2.0%	1.6%	2.1%	1.9%

Category 2 Caesarean Sections

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
38	42	48	52	68	57	47
10.6%	10.9%	11.9%	12.8%	16.0%	15.1%	12.9%

Category 3 Caesarean Sections

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
20	15	19	20	17	12	13
5.6%	3.9%	4.7%	4.9%	4.0%	3.2%	3.6%

Category 4 Caesarean Sections

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
52	49	56	51	46	46	51
14.6%	12.7%	13.9%	12.6%	10.8%	12.2%	14.0%

Home birth rate

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
7	8	9	10	9	7	7
1.9%	2.0%	2.2%	2.4%	2.1%	1.8%	1.9%

3rd and 4th degree tears following instrumental birth

Month	3rd & 4th Degree Tears as a % of all instrumental births
Jun - 2022	4.5%
Jul - 2022	4.3%
Aug - 2022	6.3%
Sep - 2022	6.9%
Oct - 2022	3.3%
Nov - 2022	11.1%
Dec-2022	13.0%

Stillbirths and Neonatal Deaths per 1000 births

- During 2022, there were 15 Stillbirths, which equates to a crude rate of 3.17 per 1000 total births.

- During 2022, there were 9 Neonatal deaths (7 early (between day 0-7) and 2 late (between days 8-28), which equates to a rate of 1.9 per 1000 livebirths,
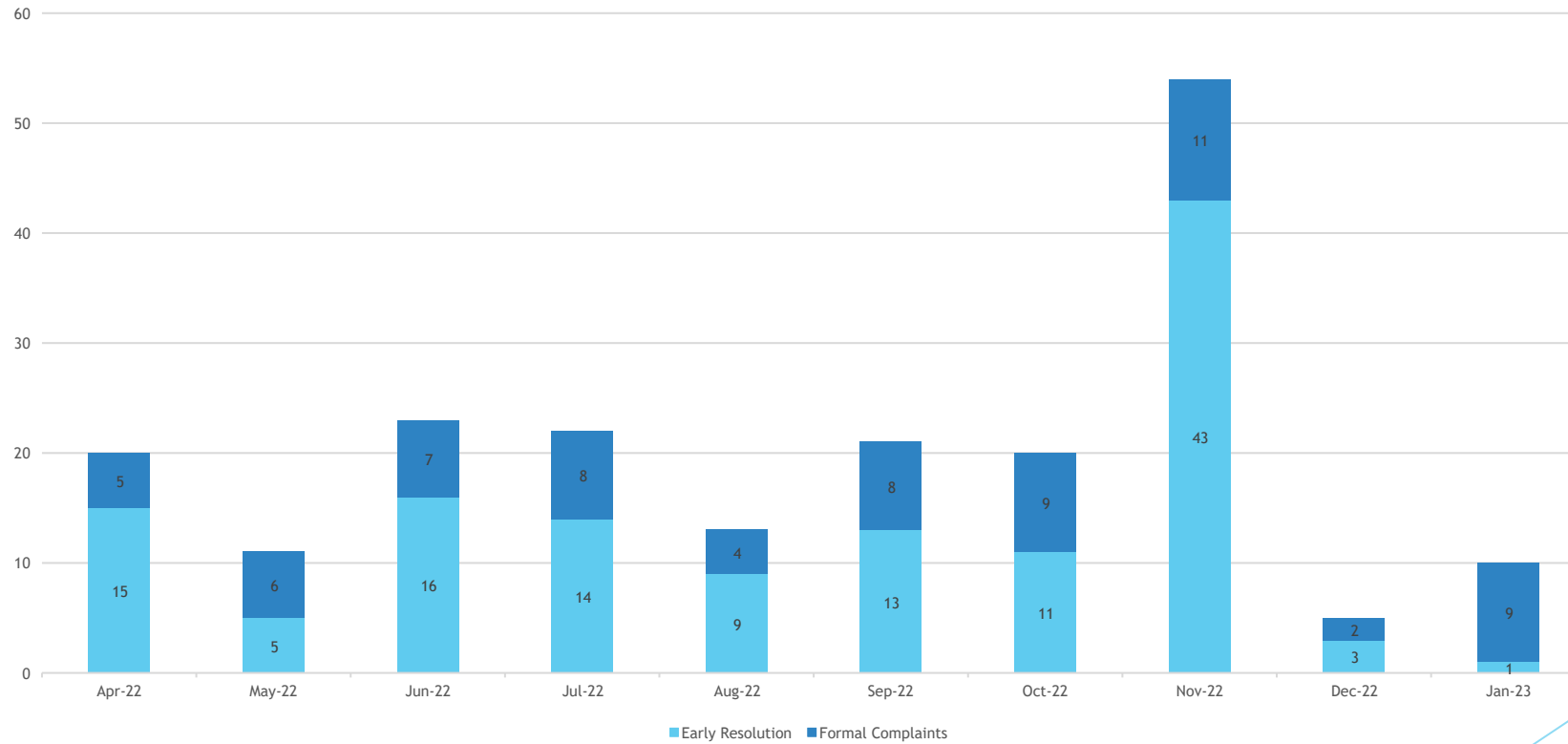
Concerns

Maternity New Complaints Received

Concerns

Maternity Complaints compliance response rate
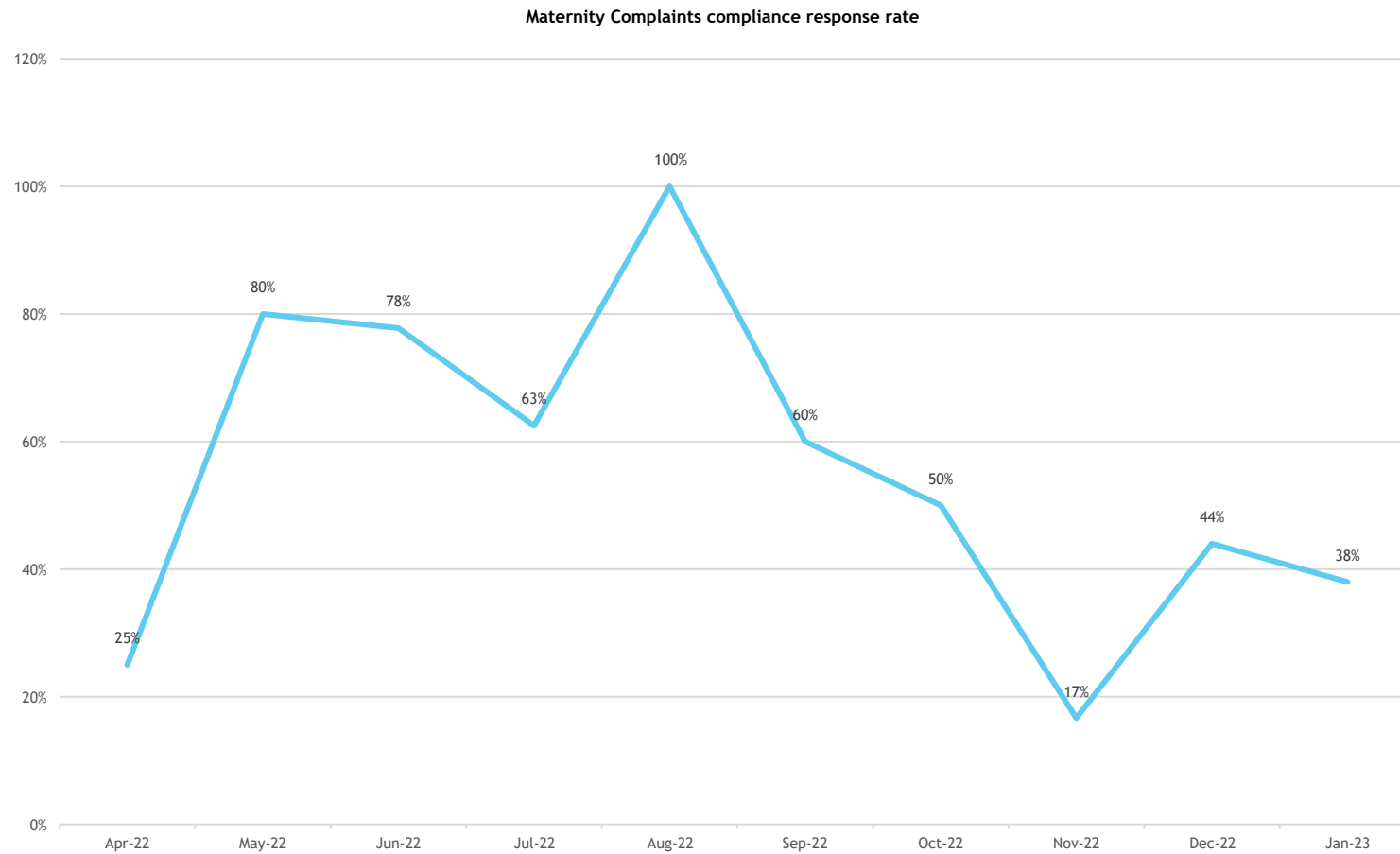
Unplanned term admissions to the neonatal unit, from consultant led and midwife led care

2022						
Jun - 2022	Jul - 2022	Aug - 2022	Sep - 2022	Oct - 2022	Nov - 2022	Dec - 2022
25	23	17	20	21	16	23
6.9%	5.9%	4.1%	4.9%	4.9%	4.2%	6.3%

Number and percentage of women who had an initial assessment carried out by 10 completed weeks of pregnancy

Jun - 2022	72.1%
Jul - 2022	71.8%
Aug - 2022	68.5%
Sep - 2022	72.8%
Oct - 2022	68.8%
Nov - 2022	74.8%

NB. Both of the above are subject to ongoing, multi-professional QI projects

Above clinical data source: MITS/ WPAS. Extracted via Maternity Dashboard

Quarterly review of thematic concerns

Thematic analysis of formal concerns June – August 2022

▶ 15 formal concern responses completed – 10 PCH site, 5 POW site.

7 minute briefings	One sent every month to ALL staff including midwives and doctors for personal reflection
Wider sharing commencing September 2022	One briefing a month will be chosen and this will be discussed in - Forums - Governance /audit meeting - WeSEE Meetings - SWAG meeting - Shared during supervision meeting.

Theme	Identified (how often)
Communication	8
Professional attitude	6
Not listening	3
Waiting times	1
Breach of confidentiality	1
Continuity of care	1
Documentation error	1
Incorrect advice	1

Action for Communication

1.	Birth rights training organised for improved knowledge in this area
1.	Video being produced (collaboration with Women's Experience and Communication's Team) regarding birth language
1.	Take briefing to each departmental meeting to understand the impact of the lack of communication on families in our care.

Actions for not listening

1.	Birth rights training organised for improved knowledge in this area
1.	Corporate induction includes values and behaviours
1.	The Service's Culture and Leadership Plan is being launched shortly

Actions for staff attitude

1.	Director of Midwives letter sent to maternity staff
1.	Discuss with Obstetric lead consultant to share similar letter with medical team
1.	Pilot values and behaviours session provided to GYM community team by OD team, further sessions viability being explored

Staffing levels compliant with BAPM and midwifery standards at the start of all shifts (POW)

Staffing levels compliant with BAPM and midwifery standards at the start of all shifts (PCH)

Staffing levels compliant with BAPM and midwifery standards at the start of all shifts cont..

Both Units remained open. The percentages in red are the total number of shifts for the month that required one or more bank/agency/overtime staff to ensure that the units met the BAPM standards.

Staff sickness levels, supported by evidence of timely reviews, referral to well-being, support

Children & Families Care Group Localities Sickness % compared to UHB Sickness %

	Value
110 Bridgend...	6.47%
Bridgend Paediatrics,...	7.23%
110 Children & Families...	4.00%
110 M&C/RTE...	6.21%
110 M&C/RTE Paediatrics,...	5.39%

UHB Sickness %: 6.20%

Legend: Sickness % Headcount — UHB Sickness %

Children & Families Care Group Localities Covid Sickness compared to UHB Covid Sickness

	Value
110 Bridgend...	0.59%
Bridgend Paediatrics, Acute &...	0.00%
110 Children & Families...	0.00%
110 M&C/RTE...	0.48%
110 M&C/RTE Paediatrics, Acute...	0.40%

UHB COVID Sickness %: 0.39%

Legend: COVID Sickness % Headcount — UHB COVID Sickness %

Children & Families Care Group Sickness compared to UHB Staff Group

	Sickness %	UHB Staff Group %
Add Prof Scientific and...	0.00%	5.48%
Additional Clinical...	6.07%	8.38%
Administrative and...	5.42%	4.81%
Medical and Dental	4.27%	2.88%
Nursing and Midwifery...	6.49%	5.66%
Students	0.00%	0.00%

Legend: % Sickness Headcount — % Sickness Headcount by UHB Staff Groups

Children & Families Care Group - All Covid Absence

	110 Bridgend...	110 Bridgend Paediatrics,...	110 Children & Families...	110 M&C/RTE...	110 M&C/RTE Paediatrics,...
COVID Sickness %	0.59%	0.00%	0.00%	0.48%	0.40%
COVID Suspension %	0.00%	0.00%	0.00%	0.24%	0.00%
Total COVID Absence %	0.59%	0.00%	0.00%	0.72%	0.40%

Staff sickness levels, supported by evidence of timely reviews, referral to well-being, support (cont..)

▶ All sickness is managed as per the All Wales Managing Attendance at Work policy

▶ Return to work meetings are held on the day of return following sickness

▶ Staff are offered support from the Health Board Well-Being Team

▶ Workforce colleagues working with senior management team to 'deep dive'

Staff undertaking mandatory (Specifically PROMPT and fetal surveillance).

▶ PROMPT compliance % (midwifery staff only)

Month	PCH	POW
June 2022	94	93
July 2022	95	98
August 2022	95	98
September 2022	99	97
October 2022	97	97
November 2022	97	95
December 2022	96	97

▶ Fetal Surveillance Training compliance % (midwifery staff only)

Month	PCH	POW
June 2022	97	96.0
July 2022	94	94.0
August 2022	95	95.0
September 2022	87	85.0
October 2022	87	87.0
November 2022	83	88.0
December 2022	89	92.0

Data source: maternity dashboard

POW Compliance

PCH Compliance

Overall Midwifery Compliance for POW
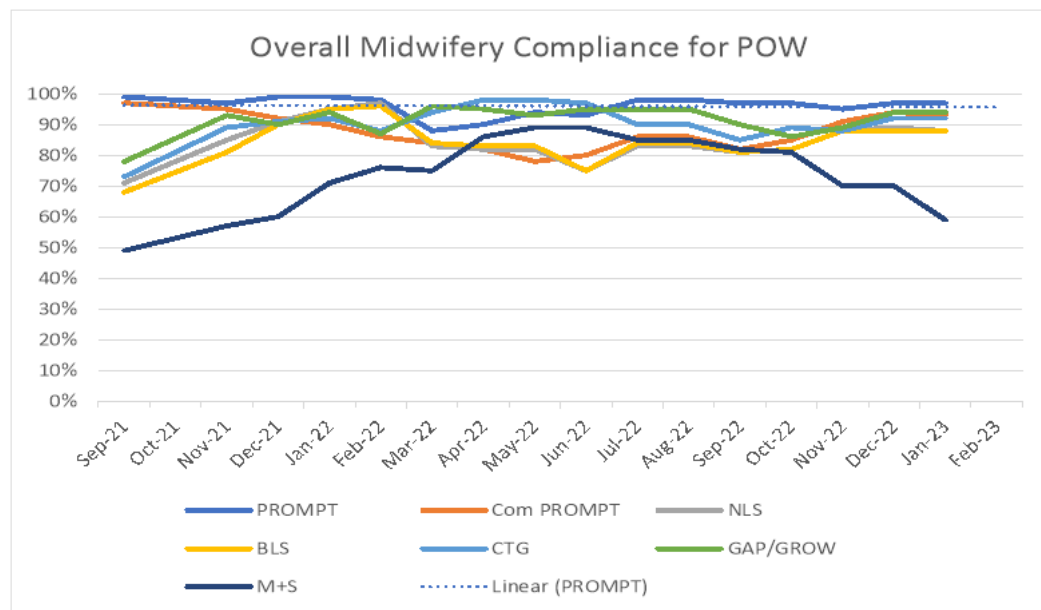
Overall Midwifery Training Compliance
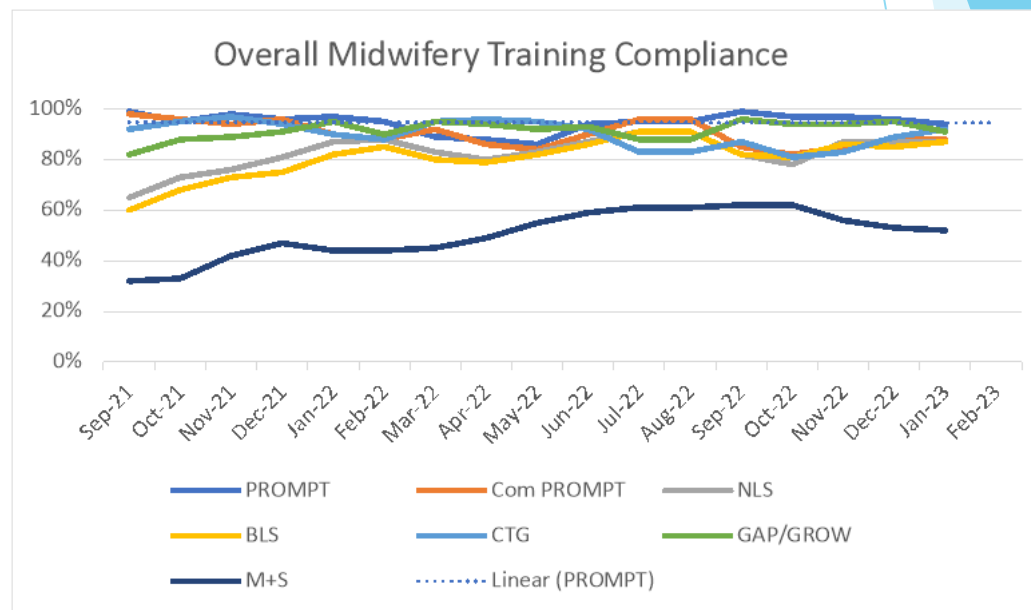
<mark>Overview and analysis of</mark> other training undertaken (6 monthly)

- Twenty Maternity and Neonatal members of staff have completed Improvement in Practice training in the second half of 2022. This is a 2 day course supported by iCTM and Improvement Cymru, with practical application of skills through QI projects.

- Twelve Midwives currently undertaking an MSc:

- Six Midwives and one Maternity Support Worker attending St Davids Day Conference (RCM)

- All MDT were given the opportunity to attend Birth Rights training in December 2022.

- Midwives supported to attend all other additional training (secondments to University of South Wales, Royal College of Midwives, shadowing opportunities)

- Band 7 midwifery leaders away day 3rd October 2022 and 27th February 2023.

- Seven midwives undertaking leadership opportunities

- One midwife seconded to HEIW part time to write a Labour Ward Coordinator Development / Induction programme

Maternity Patient Reported Experience Measure (PREM)
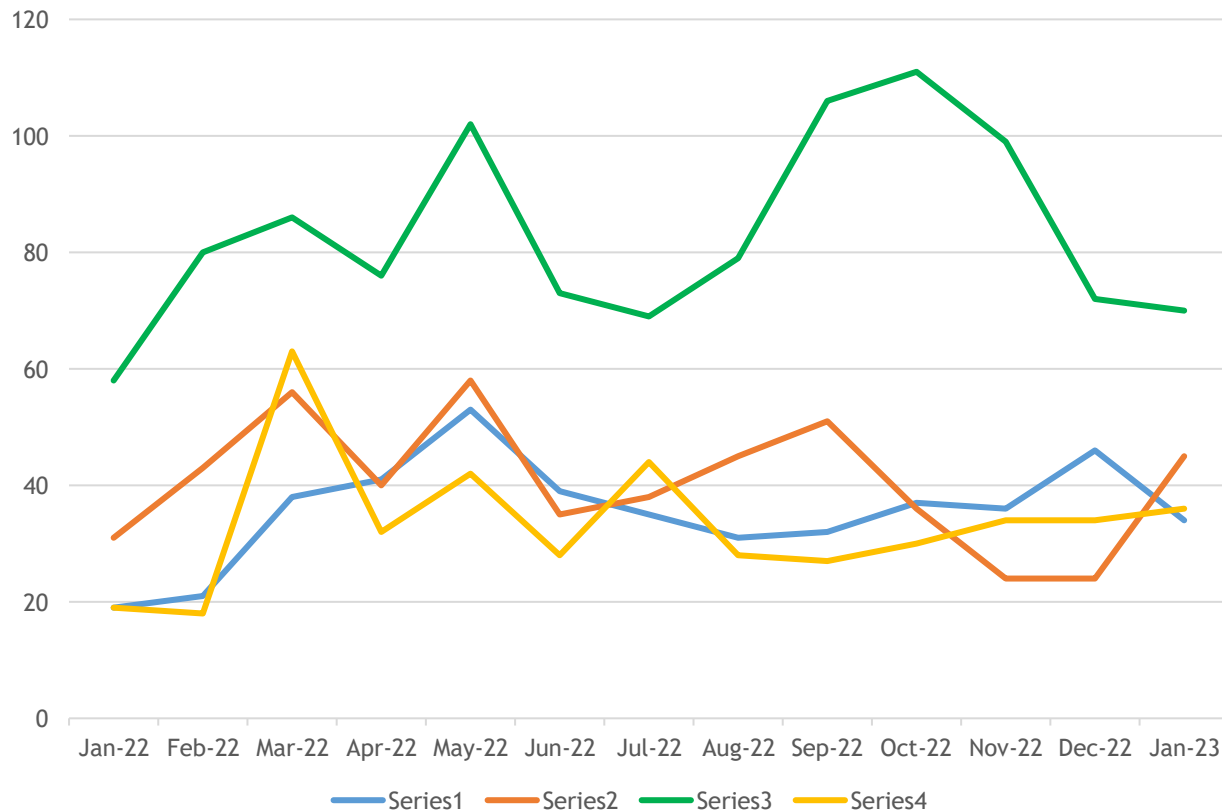
- The PREM is distributed as 4 questionnaires which are electronically distributed to women's mobile phones during pregnancy.

- Women will receive a questionnaire:

- Around 20 weeks (after completed anomaly scan) (Phase 1)

- Around 37 weeks of pregnancy (Phase 2)

- 14 days post livebirth (Phase 3)

- 12 weeks post livebirth (Phase 4)

During 2022, there were a total of **2306** responses to the maternity PREM.

- 428 responses to Phase 1,

- 481 responses to Phase 2,

- 1000 responses to Phase 3,

- 397 responses to Phase 4.

Maternity Patient Reported Experience Measure (PREM)

▶ Thinking about your antenatal care until now, were you treated with respect and dignity?

386 women (84.65%) responded that they had 'Always' been treated with dignity and respect. A further 61 women (13.38%) responded that they had 'Sometimes' been treated with dignity and respect. 8 women (1.75%) responded that they had not been treated with dignity and respect, and 1 women (0.22%) responded that she did not know/could not remember.

▶ Thinking about your care during labour and birth, were you treated with respect and dignity?

869 women (89.22%) responded that they had 'Always' been treated with dignity and respect during labour and birth. A further 83 women (8.52%) responded that they had 'Sometimes' been treated with dignity and respect during labour and birth. 22 women (2.26%) responded that they had not been treated with dignity and respect during labour and birth.

Maternity Patient Reported Experience Measure (PREM)

▶ Thinking about the care you have received during you pregnancy, have you been treated with kindness and understanding?

351 women (76.97%) responded that they had 'Always' been treated with kindness and understanding. A further 89 women (19.52%) responded that they had 'Sometimes' been treated with dignity and respect. 14 women (3.07%) responded that they had not been treated with kindness and understanding, and 2 women (0.44%) responded that they did not know/could not remember.

▶ Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

812 women (84.67%) responded that they had 'Always' been treated with kindness and understanding. A further 112 women (11.68%) responded that they had 'Sometimes' been treated with dignity and respect. 35 women (3.65%) responded that they had not been treated with kindness and understanding.

Choice: Place of Birth

▶ Women are asked at 37 weeks whether they were offered a number of choices about where to have their baby.

203 respondents (49.15%) indicated that they were offered a choice of hospitals or birthing environments. 44 (10.65%) were offered a consultant-led unit, 30 (7.26%) were offered a midwife-led unit/birth centre and 9 (2.18%) were offered a homebirth. A proportion of respondents indicated that they had not been offered any choices, 60 (14.53%). Some women responded that they felt they did not have any choice due to medical reasons, 59 (14.32%).

▶ Women are asked whether they feel they have received enough information from their midwife or doctor to help them decide where to have their baby.

241 women (58.64%) responded that they had 'Definitely' received enough information from their midwife or doctor to help them decide where to have their baby, and a further 100 women (24.33%) responded that they had 'Mostly' received enough information from their midwife or doctor to help them decide where to have their baby. 59 women (14.36%) responded that they had not received enough information from their midwife or doctor to help them decide where to have their baby, and a further 11 women (2.68%) did not know or could not remember.

When thinking about your overall experience of the maternity service at CTMUHB, how likely are you to recommend our service to others?

Extremely likely: 172 women (49.71%)
Likely: 115 women (33.24%)

Unlikely: 31 women (4.34%)
Extremely unlikely: 15 women (8.96%)

Don't know: 13 women (3.76%)

AGENDA ITEM
6.2

QUALITY AND SAFETY COMMITTEE

TY LLIDIARD TIER 4 CAMHS INPATIENT UNIT REPORT

Date of meeting	16/03/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Ana Llewellyn, Nurse Director PCCMH
Approving Executive Sponsor	Executive 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
PCCMH	Primary Care, Community & Mental Health
NWAS	North Wales Adolescent Service

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

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well as the reporting standards and progress being made. TL was de-escalated to Level 3 monitoring by WHSSC in December 2022.

2.2   There continues to be a national shortage of CAMHS LSU and PICU beds, which means that YP who are identified as needing a LSU or PICU by TL have to spend extended periods in TL on enhanced nursing observations. This can result in increases in patient safety incidents, adverse effects on the overall therapeutic environment of the ward, and staffing challenges.

2.3   Ultimately these issues can inhibit our ability to admit YP in a timely manner and can lead to YP either spending prolonged periods in adult mental health beds or being placed in private units which are inevitably outside of Wales.

3.   QUALITY ASSURANCE

3.1   **Patient Safety Incidents (Jan 2023)**

3.1.1 There were 8 incidents reported during January, compared to 9 in the previous month and 59 in the same period in 2022. One incident was initially assessed as moderate harm and relates to aggression towards staff. This was downgraded to no harm upon investigation. All other incidents were categorised as low or no harm.

Datix Incidents March 21 - January 23
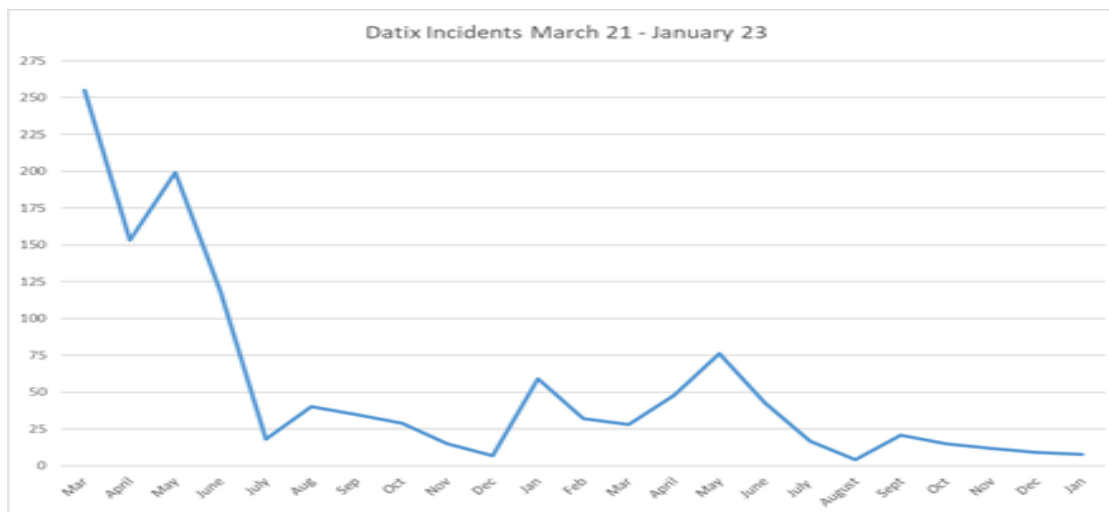
3.1.2 The sustained decrease in Datix reportable incidents in TL is not due to changes in reporting thresholds. The acuity within TL remains high, suggesting that the acuity is being managed more effectively. As with the reduction in NG related incidents, the team are exploring how best to evidence this.

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3.1.3 'Levels of Care' recordings have been introduced to map the acuity and occupancy levels within Ty Llidiard. The rating scale was recommended by NCCU for TL and NWAS in order to evaluate and compare the acuity and activity on the wards. Each YP is assessed and allocated a weekly level of between 0-5 (5 requiring the highest level of input) and the scores are then totalled to provide a picture of how the wards are running.

3.1.4 The higher levels of acuity reflect the Extra Care Area on Seren ward being in constant use from December to the present day, due to the ongoing national shortage of LSU beds.
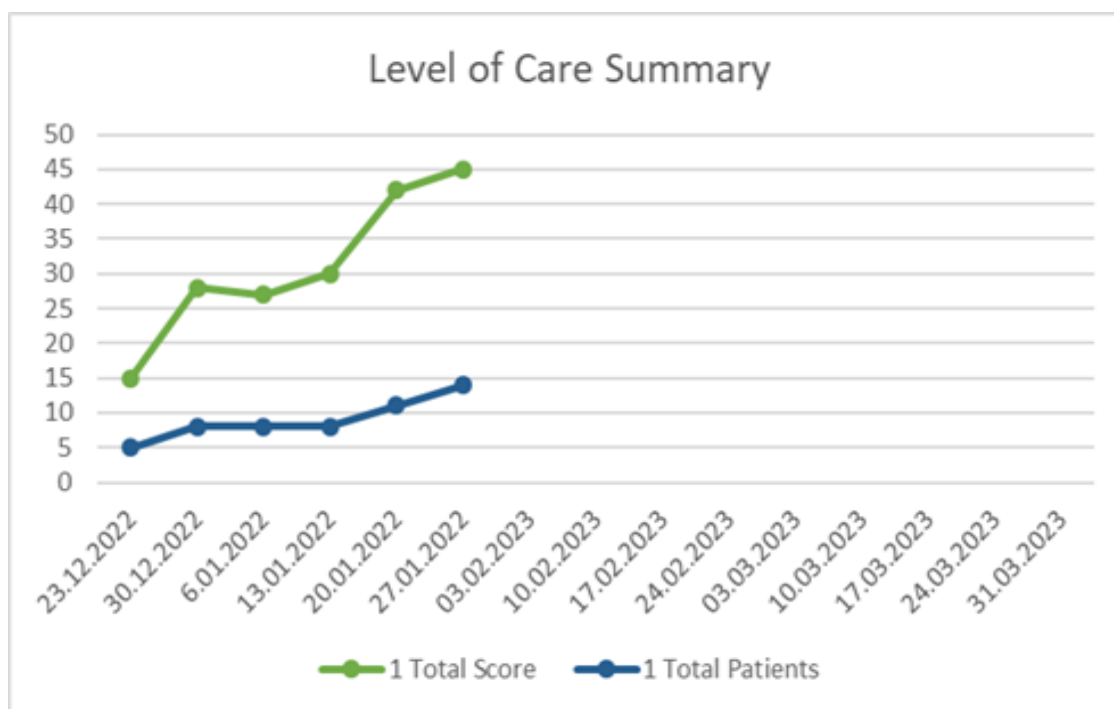
3.1.5 There were no incidents involving absconding from TL (actual or attempted).

3.1.6 There are no incidents which are overdue in terms of investigation or closure.

3.2 Complaints

3.2.1 There were no open or new complaints during this reporting period.

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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 recorded feedback month on month. The table below summarises the volume of written feedback received each month.

Ty Llidiard written compliments

2022-23												
Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan
2	3	1	3	4	5	4	4	3	2	4	5	3

3.3.2 All feedback is shared with the team at Ty Llidiard. The team are in the process of developing a monthly newsletter for colleagues, which will include a compliments section.

3.4 Current Open SIs (NRI or LRI)

3.4.1 There were no new or open LRIs or NRIs during this reporting period.

3.5 Ombudsman Complaints

3.5.1 There were no new or open Ombudsman cases during this reporting period.

3.6 Claims/Redress Cases

3.6.1 There were no new or open claims/redress cases during this reporting period.

4 PEOPLE'S EXPERIENCE/CO-PRODUCTION

4.1 The HON has been engaging with 'Parents Voices in Wales' to create a forum where past services users and their loved ones can provide feedback and support co-produced improvement initiatives. Positive feedback has been received about the approach being taken and the commitment to listen to and work with people with lived experience. A survey has been sent out through the Parents Voices in Wales network to gauge interest from prospective participants.

4.2 The TL team facilitate weekly community meetings (open to all YP on the ward) to seek the views of the YP on what is done well and what can

be improved. These meetings continue to be well-attended by the YP and result in valuable insights and improvements.

4.3   Over the last 4 months, our ST6 Psychiatry Trainee, with the support of our Quality Improvement group, has been working on a QI project to evaluate YP's experience of attending ward round. This has been done with a view to further increasing attendance, strengthening the voice of the YP, and improving their overall experience of attending ward rounds.

4.4   The project included the use of both Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS), as shown below.
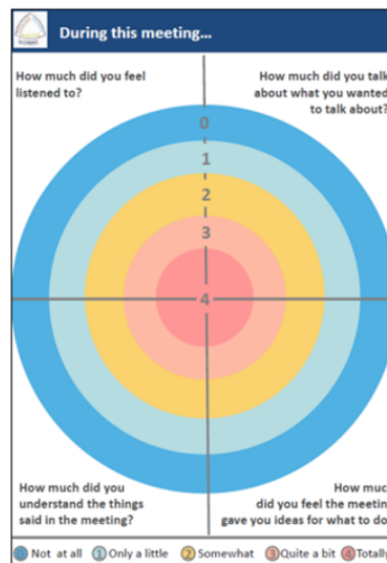
4.5   Attending a ward round with a large MDT can be a daunting prospect for a YP. The project was well received by the YP and the results will be used by the MDT and QI group as part of our continuous improvement journey.

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How do our YP feel about coming into WR?

Average overall scores for PREM
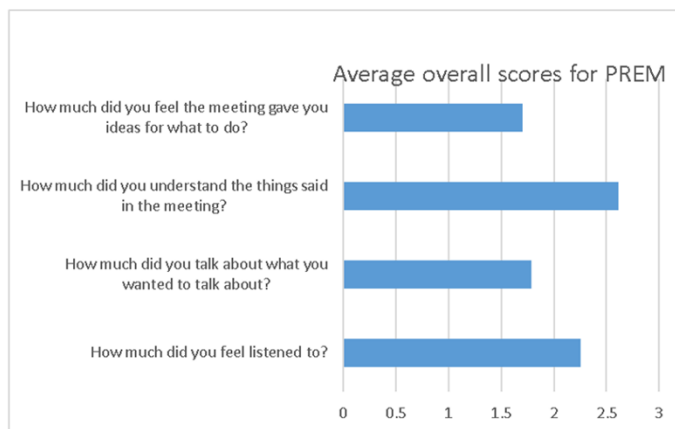
How consistent are these feelings?
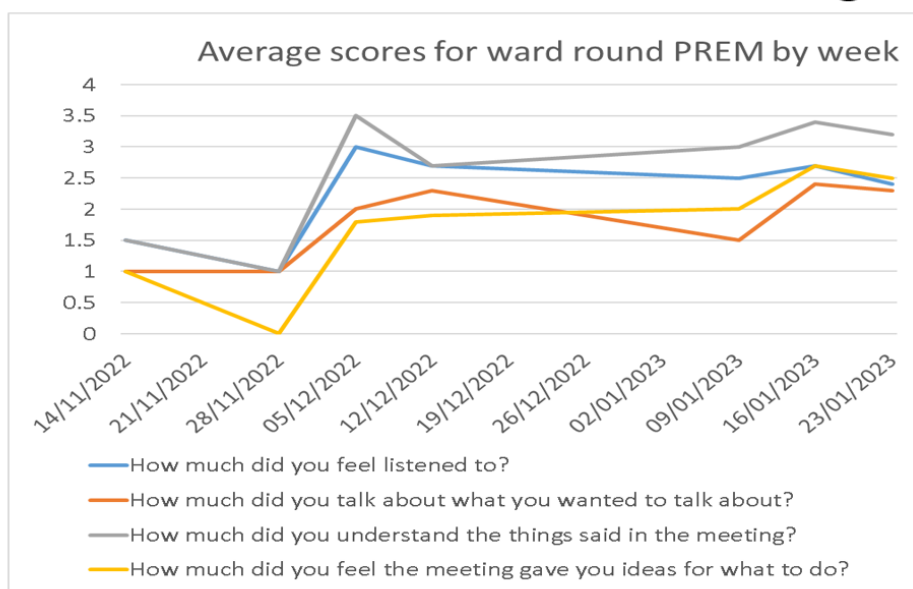
4.6   The HON continues to invite the family members of the YP currently within TL to listen to their experiences, feedback and suggestions for improvement. One piece of feedback from families was that there was no dedicated car parking for TL which often led to people being late for appointments, causing anxiety and adversely affecting their experience of TL. In our commitment to 'You said, we did', we worked with the Facilities Department to create the spaces shown below, which has been positively received by families and visiting professionals.

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5   **VISUAL IDENTITY**

5.1   The first phase of our new coproduced logo and 4Cs philosophy has been installed in the TL foyer and has been positively received by YP, families, staff and visitors.

5.2   Funding for the rest of the work has been secured through the CEO's charitable funds. The orders have been placed and the work will begin soon and will feature large co-produced artwork being installed throughout the unit.

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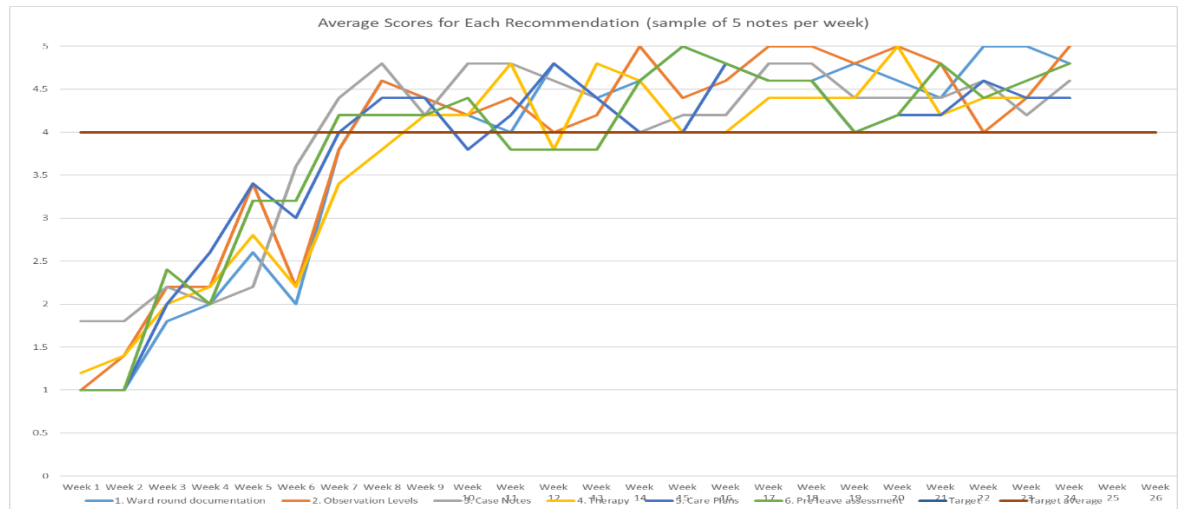5.3   All staff in TL have had the 4Cs logo and their name embroidered onto the uniform which again has been positively received by all.

6   QUALITY IMPROVEMENT

6.1   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 weekly to review the ongoing improvements and changes that have been made or are in progress. The improvements and initiatives are supported by the iCTM Team.

6.2   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. The tool uses a 5-point Likert scale to assess 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. We are currently in Week 24 and have seen a sustained improvement in all areas (see below). The improvement has been acknowledged and praised by both NCCU and WHSCC. The TL team are now confident that the improvements have been embedded into everyday practice and the monitoring of these areas will now move from weekly to monthly.

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Average Scores for Each Recommendation (sample of 5 notes per week)

7 IMPROVEMENT BOARD

7.1 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.

7.2 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.

7.3 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.

8 STAFF EXPERIENCE

8.1 Project Search is a supported internship programme. CTM proudly supports these 1-year work preparation programmes for young people with a learning difficulty, learning disability and/or autism.

8.2 Since January, TL has been privileged to have a Project Search Intern working alongside our excellent reception team. On 06/02/23, the Project Search Intern was awarded the 'Intern of the Week' award.

9 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES BENCHMARKING ANALYSIS FOR NHS WALES 2021/22

9.1 In January 2023, the 10th Annual Wales Mental Health National Benchmarking Conference was held and the Child and Adolescent Mental Health Services Benchmarking Analysis for NHS Wales 2021/22 was released.

9.2 Full reports are available here https://nccu.nhs.wales/qais/events/

9.3 Use of Restraint

9.3.1 In the UK there was a mean average of 1,188 (median = 626) uses of restraint per 10,000 bed days in 2021/22, an increase of 37% compared to 2020/2021.

9.3.2 Wales (TL and NWAS) had a lower rate of use of restraint, at a mean average of 592 per 10,000 bed days. This is a 45% reduction from 2020/2021. As highlighted throughout these reports, TL anticipates a further significant reduction in 2022/23.

General Admission CYPMHS: Number of incidents of use of restraint in 2021/22 per 10,000 OBDs (excluding leave)

All Orgs | WAL | Mean = 1,188 | Median = 626

General Admission CYPMHS: Number of incidents of use of restraint in 2021/22 per 10,000 OBDs (excluding leave)

Cwm Taf - Inpatient: 690
Betsi Cadwaladr: 493

WAL | Mean = 592 | Median = 592
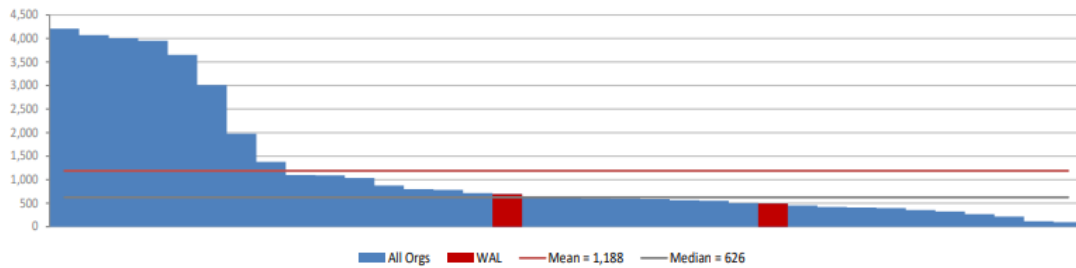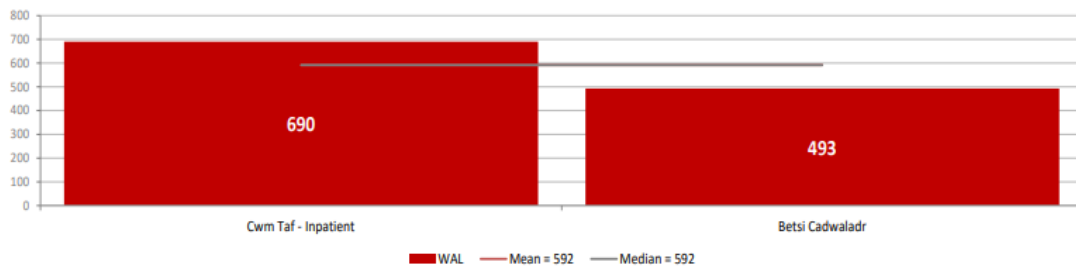
9.4 Length of Stay

9.4.1 In the UK, the average length of stay in Children & Young People (CYP) general admission beds was 90 days (increased from 71 days in 2020/21).

9.4.2 The average length of stay in NWAS was 73 days. In TL the average length of stay for 46 days. Overall the average was 60 days, a decrease from 65 days in 2020/21.

General Admission CYPMHS: Average Length of Stay (excluding leave)

All Orgs | WAL | Mean = 90 | Median = 84

General Admission CYPMHS: Average Length of Stay (excluding leave)

Betsi Cadwaladr: 73
Cwm Taf - Inpatient: 46

WAL | Mean = 60 | Median = 60
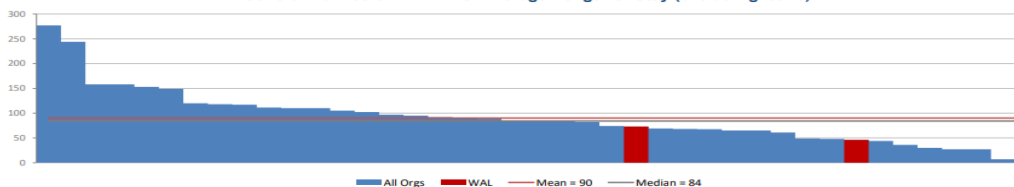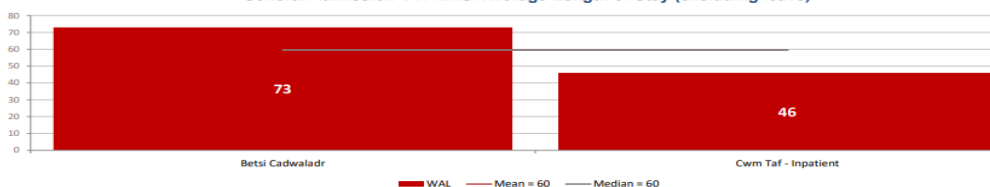
10 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/ COMMITTEE

10.1 TL is in Level 3 escalation with WHSSC. Although WHSSC remain assured by the progress being made and de-escalation has been seen, the scale and nature of changes required continue to require sustained support and focus within CTMUHB.

10.2 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.

10.3 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.

10.4 Phase 1 has commenced and is progressing well with the impact on the YP and staff being well mitigated, it is due to be completed at the end of March 2023. Phase 2 has been designed and costed at circa £700k, a SON has been completed and submitted but is as yet unapproved.

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11 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: 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

12 RECOMMENDATION

12.1 Members are asked to **NOTE** the progress outlined in this report and the key risks identified

Progress against Integrated Improvement Plan

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.	4		2		2
To create an effective MDT infrastructure to support daily review of care and treatment planning and inform therapeutic interventions	4	0	1		1
To ensure there are appropriate processes and policies that support safe and effective care delivery	5	1	1		
To create a training strategy to support all colleague to provide safe and effective care delivery	1		1		2
Total	**18**	**2**	**5**	**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	4	1	1		
Total	**9**	**5**	**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	2	2			
Total	**2**	**2**	**0**	**0**	**0**

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY & QUALITY DASHBOARD

Date of meeting	16th March 2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Presented by	Stephanie Muir, Assistant Director of Concerns & Claims
Approving Executive Sponsor	Executive Director of Nursing, Midwifery & People Services Executive Medical Director

Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities Joint working with Performance and Planning team	Various dates	Choose an item.

ACRONYMS	
ILG	Integrated Locality Group
CAPU	Community Acquired Pressure Ulcer
NEWS	National Early Warning Score

1. SITUATION/BACKGROUND

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.12.22 to 31.01.23 (where available information is provided to the 28.02.23) taken from systems as on 01.03.23, unless otherwise specified. 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.

This transition provides an opportunity to review and build upon the structure, format and information contained within the Quality & Safety Dashboard. As a result, this revised iteration will continue to be refined over the forthcoming months to improve data accuracy, enable robust monitoring and provide assurance.

Key areas to note in this reporting period are:

➢ Approval of CTMUHB Quality & Safety Framework
➢ Centralisation of Complaints Team with a focus on a robust triage and improving compliance with the 30 working target
➢ The number of incidents reported has continued the decrease from October 2022 onwards. This is consistent with previous years. The percentage ratio of severe and death incidents has decreased following a rise in November 2022.
➢ Medication incidents reported increased during January and February 2023
➢ Patient falls remains relatively consistent over the 12 month period
➢ Healthcare acquired pressure damage decreased during February 2023
➢ Number of absconding incidents decreased over the last 3 months
➢ Significant achievement in relation to compliance with Patient Safety Solutions

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

2.1 Patient / Service User Feedback

Complaints

New Complaints Received
Between the 01.12.22 and 28.02.23 the Health Board received a total of 694 complaints. Of these, 226 were categorised as formal and managed under the Putting Things Right Regulations. Whilst the chart below highlights a significant decrease in the number of complaints received in December 2022, followed by an increase in January 2023, there is no notable deviation from the trend as the number received in February 2023 remains consistent with previous months.
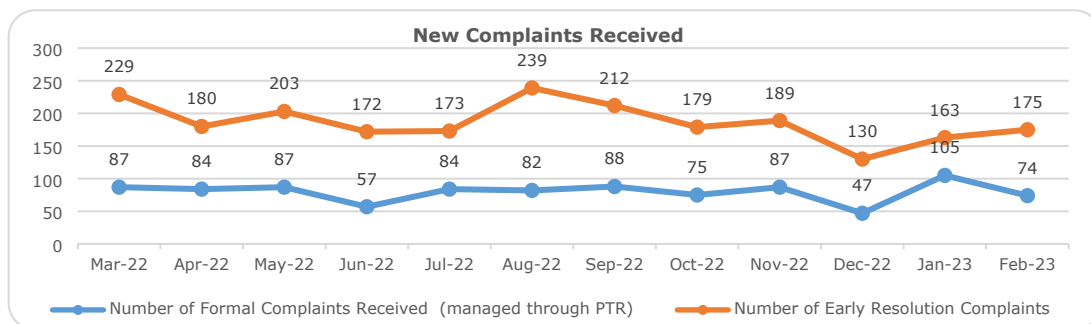
For <u>all</u> complaints received in December 2021, January and February 2023, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (273), Communication issues including attitude and Behaviour (103) and Appointments (98).

Closed Complaints
Within the period of 01.12.22 to 28.02.23, the Health Board closed a total of 199 formal complaints (managed under the Putting Things Right Regulations). Compliance with the 30 working day target decreased in December 2022 to 34%. Targeted improvement work has been undertaken which is reflected in the steady increase in compliance during January (39%) and February (54%) 2023.
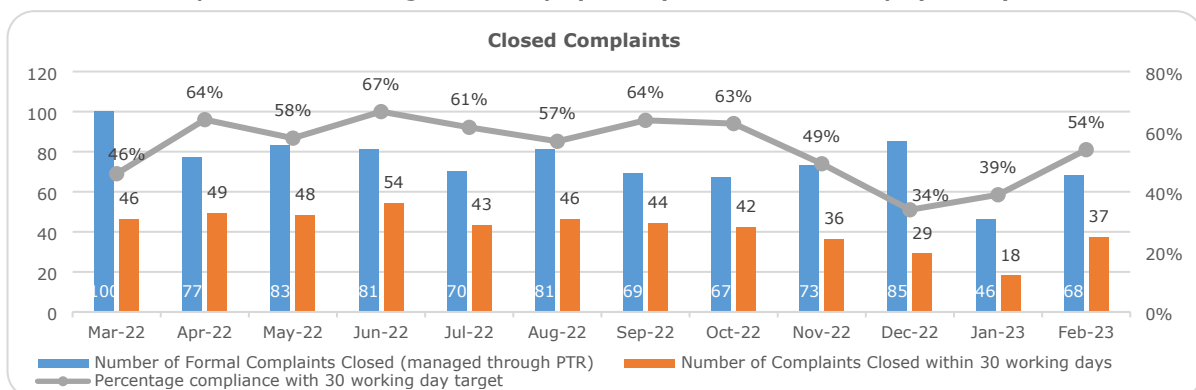
Following the organisational change process, the centralisation of the complaints process took affect from the 13.02.23. Aligned to this, a review of the systems and processes for the management of complaints is ongoing. This includes the standardisation of procedures and templates to ensure a consistent approach is adopted across the Health Board. In addition it is hoped the implementation of a robust triage process will result in a reduction in formal complaints and a rise in early resolutions, giving a better outcome for our patients and their families which directly impact on and further improve compliance with the 30 working day response rate.

Public Services Ombudsman for Wales

The Health Board received notification of 16 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.12.22 and 28.02.23. This represents a slight decrease when compared to the previous 3 month period. Of the 16 referrals, 4 were received as full investigations with the remaining 12 managed as enquiries.

New PSOW Referrals
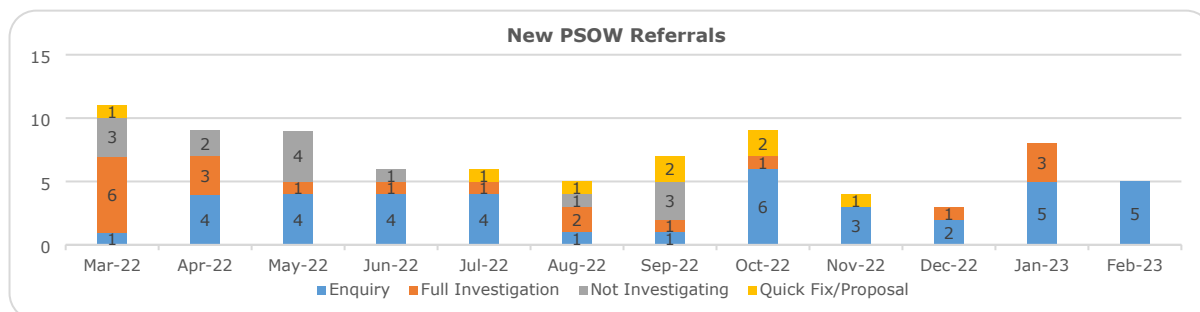
During the same period, the PSOW issued 8 final reports to the Health Board. Of these, 4 were not upheld and 4 were upheld. The upheld reports relate to services provided by Medicine (3) and Mental Health (1).

PSOW Final Reports Received
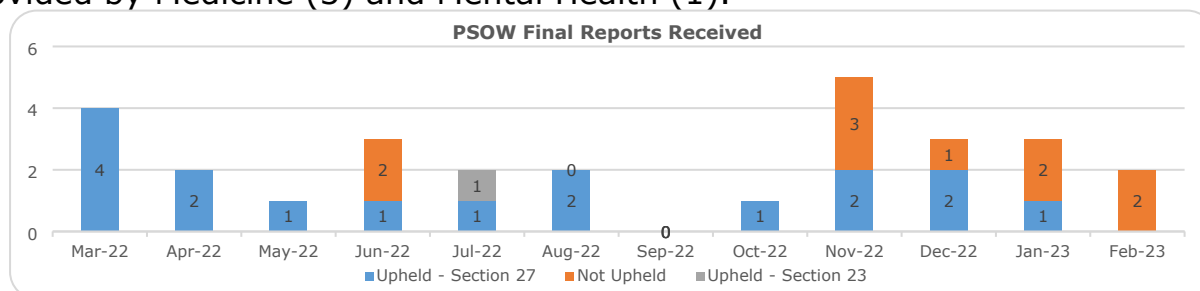
The Health Board currently has 57 Open PSOW cases, of these 44 are awaiting a response from the PSOW to instigate any further action required.

Compliments

Whilst compliments are received across the Health Board via a number of mechanisms the number of compliments recorded on Datix Cymru has continued to decrease over the 12 month period between 01.03.22 and 28.03.23, this is reflected in the chart below. A total of 59 compliments were recorded during December 2022, January and February 2023, a decrease of 174 when compared to the previous 3 months.

Number of Compliments recorded on Datix
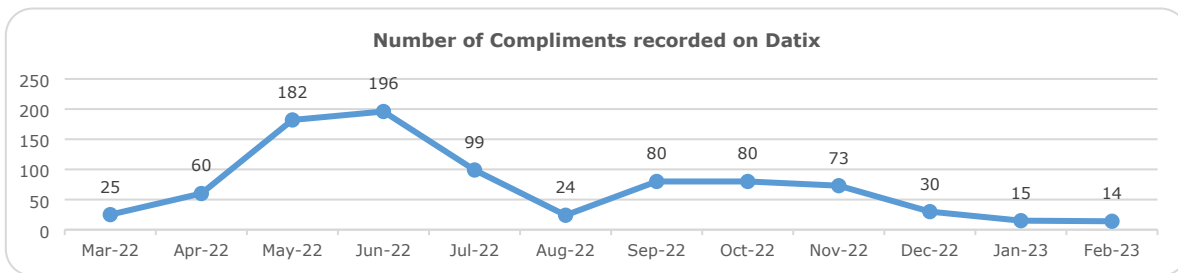
Work is ongoing to review the mechanisms and systems for capturing compliments to ensure a robust process is established to capture, record and report information relating to the compliments received.

Patient Experience Activity
A Patient Experience Activity Report can be found in appendix 1, going forward this information will be integrated into the main body of the report. In addition, a Welsh Cancer Patient Experience Summary in Appendix 2

2.2 Patient Safety Incidents

Total Patient Safety Incidents
A total of 5752 incidents were reported between 01.12.22 and 28.02.23, this represents a decrease of 698 when compared with the previous 3 months. The number of incidents reported where the patient is identified as the person affected has continued to decrease since October 2022. Of the 5752 incidents reported, 86% were reported as the patient affected. Of the patient safety incidents, 1.8% (91) were reported as resulting in severe harm (42) or catastrophic/ death (49). It should be noted that the harm is determined the reporter on initial submission of the incident and can be downgraded as further information is obtained and the investigation progresses. This is reflected in that of the 4528 incidents reported between 01.04.22 and 28.02.23, an investigation has been concluded for 2695 incidents and with an outcome severity of severe harm (18) or death (22) determined on 40 incidents. Work is being undertaken on an All Wales basis as part of the implementation of Duty of Candour to capture information in relation to the actual harm caused by incidents in a more robust manner within the Datix Cymru System. This will be reflected in future reports.

Nationally Reportable Incidents
Between 01.12.22 and 28.02.23, 26 nationally reportable incidents were submitted to the NHS delivery unit. No never events were identified in this period. The ratio of Nationally Reportable Incidents to the overall number of patient incidents is demonstrated in the chart below.

Patient Safety / Nationally Reportable Incidents
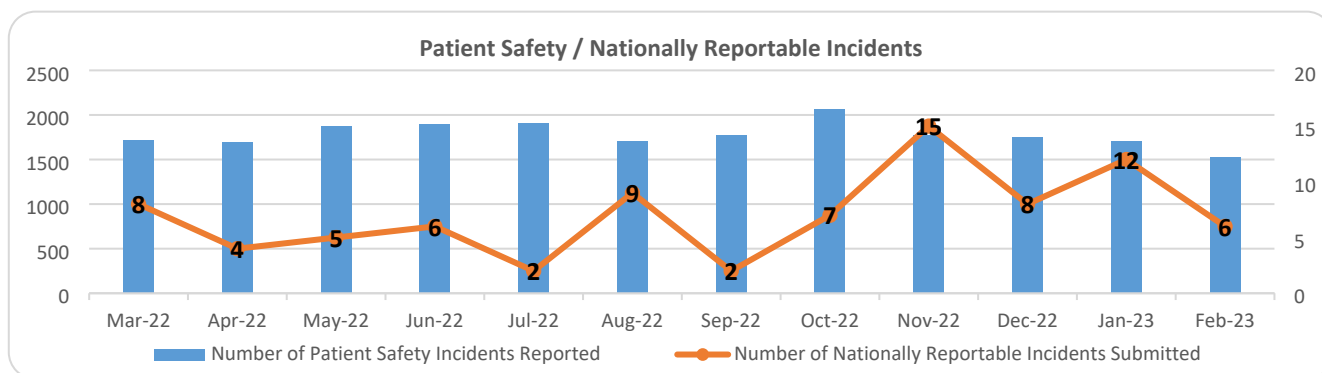
It should be noted that Nationally Reportable Incident is presented based on the date the notification was submitted to the Delivery Unit. As a result of this, the increase in both November and January is reflective of the submission of legacy ambulance delays that occurred prior to the reporting period. November 2022 submissions relate to delays that occurred between 28.06.21 and 28.10.22. January 2023 submission relates to delays that occurred between 08.09.22 and 21.09.22. It is anticipated that these incidents will be downgraded following the completion of the review by the Health Board's Multidisciplinary Panel.

Nationally Reportable Incident data is also impacted by the notification of Ophthalmology incidents following completion of the harm review process. As with Ambulance Delays, these cases relate to events prior to the current reporting period but are unlikely to be downgraded.

The type of Nationally Reportable Incident is highlighted in the table below:

	Dec 2022	Jan 2023	Feb 2023	Total
Access, Admission	1	5	0	6
Accident, Injury	0	0	1	1
Assessment, Investigation, Diagnosis	1	0	0	1
Maternity adverse occurrence	1	1	2	4
Medication, IV Fluids	1	0	0	1
Patient/service user death	0	0	1	1
Pressure Damage, Moisture Damage	2	2	2	6
Safeguarding	1	1	0	2
Treatment, Procedure	1	3	0	4
Total	8	12	6	26

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

Medication Incidents
A total of 299 medication incidents were reported as occurring between 01.12.22 and 28.02.23. This represents a small decrease of 11 when compared to the previous 3 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (96) Medication supply errors (93) and Medication prescribing (35).

Medication Incidents chart showing monthly data from Mar-22 to Feb 2023 with line values: 83, 83, 98, 88, 73, 92, 87, 99, 124, 76, 104, 119. Legend: Administration errors, Allergic reaction (unknown previously), Medication documentation errors, Medication prescribing, Medication prescribing error, Medication storage, security and disposal, Medication supply errors, Medicines advice errors, Monitoring errors, Preparation errors.

84% of the medication incidents were reported as resulting in no (175) or low (77) harm, with the remaining reported as resulting in moderate harm (26). It should be noted that the introduction of a specific Community Pharmacy form has impacted on the data quality for medication incidents as a number of fields are not included for completion, including the harm field. Therefore, for the 3 months identified above, the harm was not recorded for 21 incidents.

Controlled Drugs
The management of controlled drugs is outlined in the two procedures:
- Management of Controlled Drugs within Wards and Departments
- Management of Controlled Drugs in Theatres and Intensive Care Unit

Implementation of these procedures include the requirement of Nurses to complete a weekly controlled drug check, with areas of high usage (ITU, Theatres, A&E) completing a daily check. In addition, Pharmacy carry out a 3 monthly Controlled Drug audit which includes a full stock take and review of security arrangements which is fed back to the nurse in charge of the clinical area. This is in the process of being digitised, to provide a live document for interrogation to enable improved reporting at relevant Committees.

2.3.2 Patient Falls Incidents
A total number of 746 falls, where the person affected was a patient, were reported during December 2022, January and February 2023. This represents a decrease of 31 in the number of falls reported in comparison to the previous 3 month period. Of the falls reported, 92% were reported as no (349) or low (337) harm. The remaining

incidents were reported as moderate (58) and severe (2) harm. No incidents relating to patient falls were reported as resulting in death.
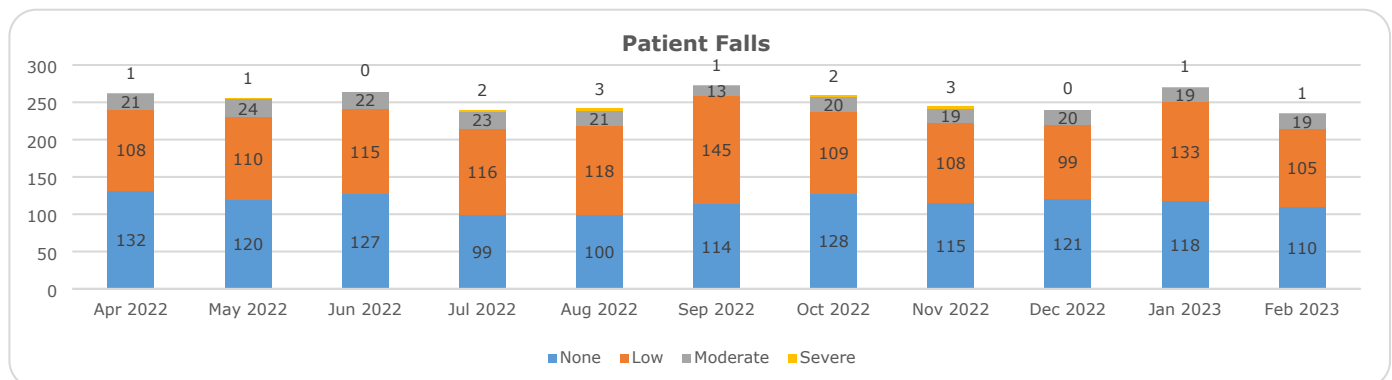
Patient Falls

During the time period, the highest number of inpatient falls occurred on AMU at Princess of Wales Hospital (30), Clinical Decision Unit at Prince Charles Hospital (28), and Ward 15 at Princess of Wales Hospital (23).

Work continues to develop and refine safety metrics for areas such as inpatient falls and pressure damage incidents per 1000 beds.
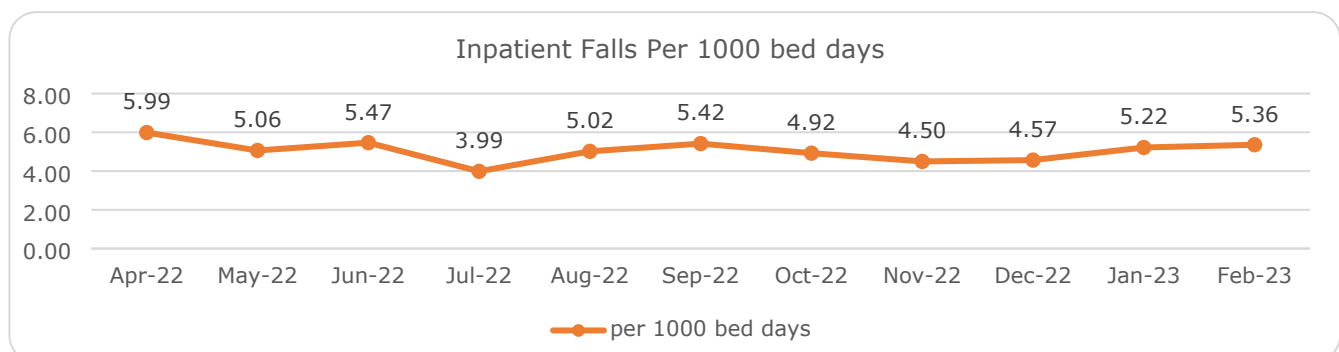
2.3.3 Pressure Damage

Between the 01.12.22 and 28.02.23, a total of 1,364 pressure damage incidents were reported, of which 614 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (750) were reported as being present before admission to this clinical care area/caseload.
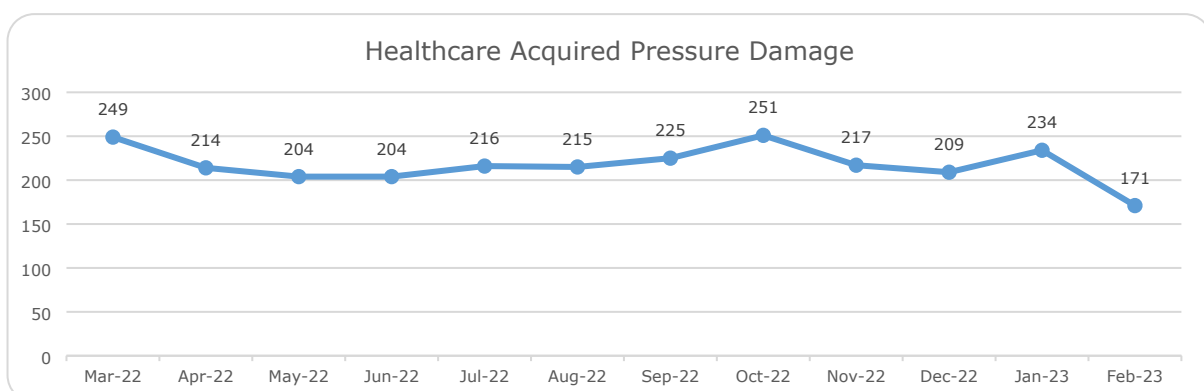
Of the 614, 365 were identified as being hospital acquired and 249 as community acquired. This demonstrates a decrease when compared with the previous 3 months.

The locations with the highest reported hospital acquired pressure damage incidents were reported within the Emergency Department at Princess of Wales Hospital (34), Acute Medical Unit at Princess of Wales Hospital (17), and Ward 4 at Royal Glamorgan Hospital (7). There were 32 hospital acquired grade 3 pressure damage incidents reported during December (15), January (13) and February (4). There were 4 hospital acquired Grade 4 incidents reported during the 3 month period.
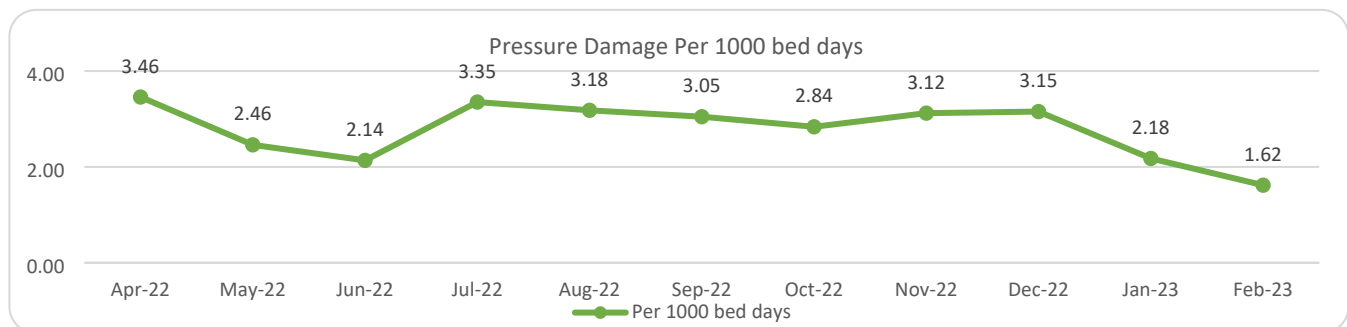
2.3.4 Mental Health Metrics

Number of 136 Assessments in police cells
The number of 136 assessment in police cells remains at 0 (Health Board wide), which demonstrates good compliance with the Crisis Care Concordat, ensuring that those who require mental health assessment are not detained in custody suites.

Restrictive Practices
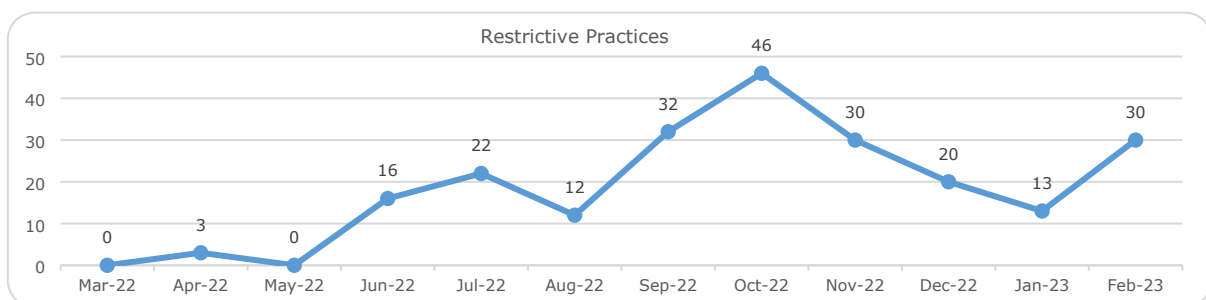
Between 01.12.22 and 28.02.23, a total of 63 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 45 incidents when compared to the previous three months. Of the 63 incidents, 86% (54) were reported as not care planned and 14% (8) were reported as care planned. Of the 76 incidents, 92% were reported as no (27) or Low (31) harm. The remaining incidents were reported as moderate (5) occurring on Coity Clinic (PICU) at Princess of Wales Hospital

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(3), Mental Health Admissions Unit at the Royal Glamorgan Hospital (2) and Ward 14 at Princess of wales Hospital.

Absconding incidents
During December 2022, January and February 2023, a total of 30 Absconding incidents were reported. 17 were recorded as actual absconding, with the remaining recorded as missing patient / service user (7) attempted (4), failure to return from authorised leave (1) and other (1).

Absconding incidents
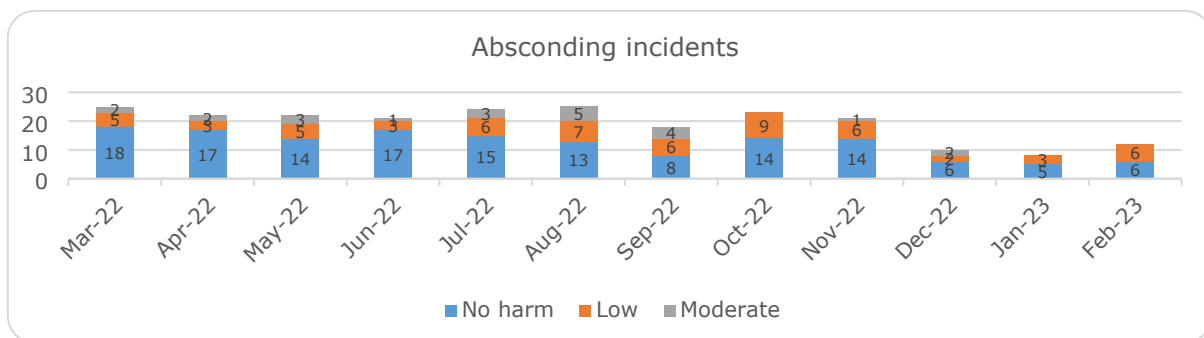
93% of the absconding incidents reported in the month time period (01.12.22 to 28.02.23) were recorded as No (17) or Low (11) harm, with the remaining incidents reported as moderate harm occurring in the Emergency Care Department and Ward 2 at Prince Charles Hospital.

The highest number of incidents reported were for Emergency Care Centre at Prince Charles Hospital (8) and Ward 22 at the Royal Glamorgan.

2.3.5 Mortality Rate

Mortality Rate (Crude CHKS)
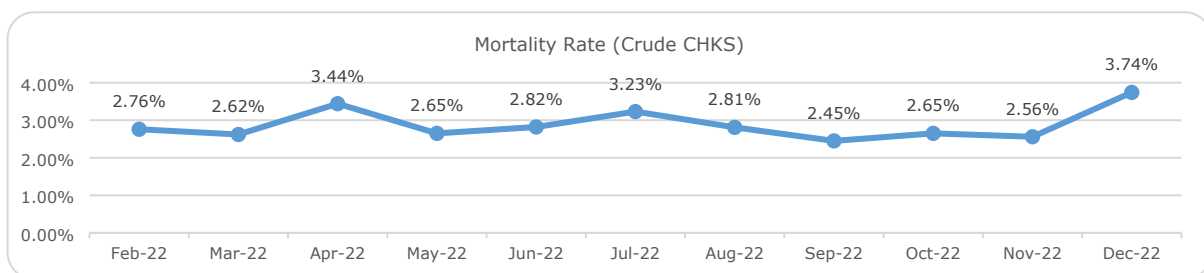
As highlighted in the chart above, there has been a significant increase in the crude mortality rate during the month of December 2022. At the time of preparing the report, the information was not available for January and February 2023.

It should be noted that the crude mortality rate is an in-month figure extracted from Welsh Patient Administration System (WPAS) based on the number of patients who have an outcome recorded as deceased. The figure is not adjusted for population, co-morbidities or expected deaths i.e. palliative care. Work is currently ongoing to develop and implement a data validation process for mortality information and address

the disassociation between CHKS and WPAS. Updates in relation to this work will be provided in future reports.

2.3.6 Infection Prevention & Control (IPC)

There was an increase in respiratory viruses which peaked during December 2022 and into January 2023 which caused extreme pressure on clinical services. The rise in respiratory infections across the Health Board mirrored the national position and it has been extremely challenging to isolate/cohort patients with the same respiratory virus together due to the increase in cases, demand for hospital beds and the hospital infrastructure with low availability of single rooms in the Royal Glamorgan Hospital and Princess of Wales Hospital.

There were fewer cases for 4 of the 5 surveillance organisms reported April – December 2022 compared to the same period last year (C. difficile, Staphylococcus aureus bacteraemia and E.coli and Pseudomonas 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. The COVID response, staff sickness and vacancies within the IPC team has delayed this work.

The infection prevention and control team continue to work collaboratively with the care groups to improve the investigation procedure and root cause analysis process for healthcare associated cases of 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) continues 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.

2.3.7 Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) Assessments

There were 7 potential HATs identified for December 2022 and January 2023 compared to 17 for the previous 2 month period. It is important to remind the 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 information that shows potential versus actual HATs.

Number of potential Hospital Acquired Thrombosis (HATs)
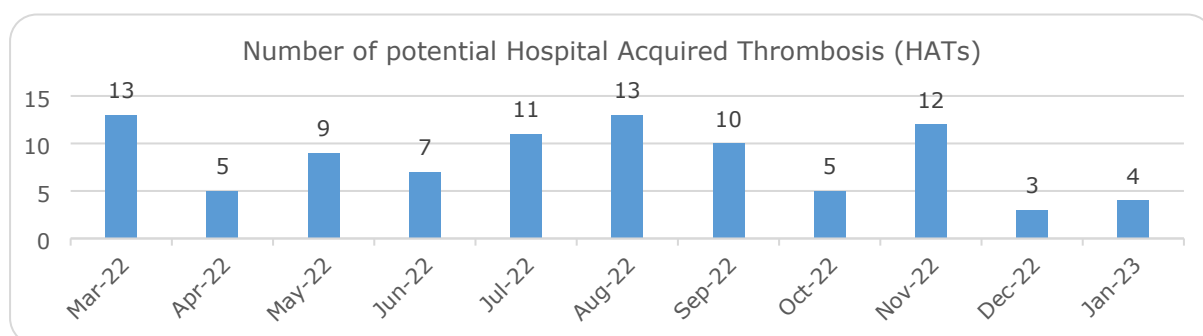
2.3.8 Hospital Cardiac Arrests and NEWS Training

Hospital Cardiac Arrest Calls (222)

Hospital Arrests (2222 calls) Adult
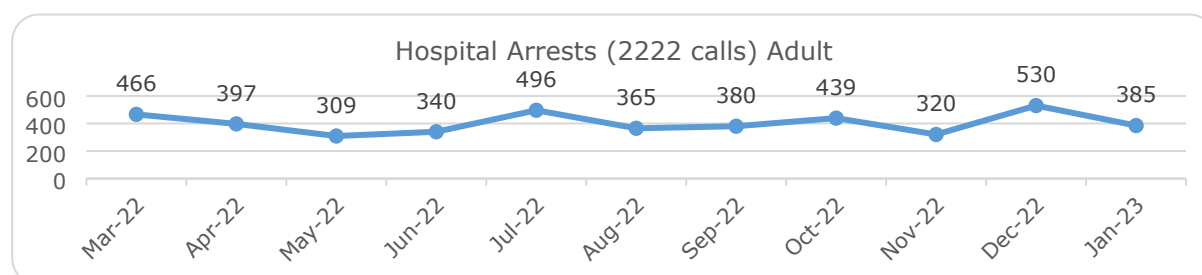
The number of calls taken rose significantly to 530 during December 2022 but decreased to a level consistent with the previous months.

Hospital Cardiac Arrest Calls will remain an important metric for inclusion in this report, as the objective 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 success in this area.

NEWS Audit
Following a dip during November 2022, compliance with NEWS has increased to above 90% from December 2022 onwards.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities in relation to NEWS.

% NEWS audit by site (RGH/YCR/PCH/YCC/PoWH/Ybyty'r Seren)

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
%	88.6%	87.3%	88.9%	87.2%	87.0%	87.7%	89.8%	90.8%	87.0%	90.4%	91.7%	90.7%
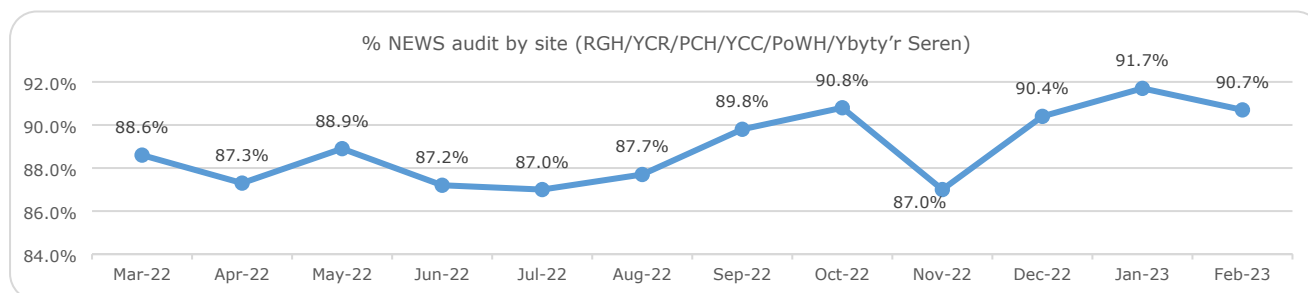
2.3.9 Community Metrics

A number of metrics (summarised in the table below) are measured in relation to Community Services including District Nursing treatments which has steadily increased over the 12 month treatment. Average length of stay has continued to rise in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, whilst remaining consistent with previous months on other Health Board sites. Further work is required to refine and validate this data.

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
District Nurse treatments	32702	36351	34298	36231	35265	35376	36155	35404	36739	36333	34494	35937
Referral to At Home Services (All Referrals)	101	141	90	120	122	129	123	128	119	125	138	121
Ysbyty'r Seren (ALOS)	54	96	55	63	0*	0*	0*	0*	0*	0*	0*	0*
*Princess of Wales Hospital, Ward 21 (ALOS)	-	-	-	-	16	22	47	22	39	48	33	23
Ysbyty Cwm Cynon (ALOS)	74	54	61	63	49	51	64	64	57	56	72	80
Ysbyty Cwm Rhondda (ALOS)	69	75	67	70	56	67	55	62	80	68	73	72
Palliative Medicine, Bridgend (ALOS)	27	14	19	14	20	9	10	24	19	23	18	16
Palliative Medicine, Pontypridd/RGH (ALOS)	11	8	4	19	12	7	8	8	11	7	6	10
Palliative Medicine, YCC (ALOS)	26	18	16	13	32	16	36	4	25	28	24	25

2.4 Patient Safety Solutions

There has been **1** new patient safety alert and **2** new patient safety notices issued since the previous Quality & Safety Committee meeting.

PSA015: *Safe use of oxygen cylinders in areas without medical gas pipeline systems:* Compliance required by 27th January 2023. Health boards received this compliance notice 20th January 2023. Risk assessments were completed on all sites and assurance provided by the Heads of Nursing to Unscheduled Care Nurse Director. Additional actions have been identified outside of the compliance of this notice, which are being monitored and supported by Pharmacy. Health Board submitted compliance 31st January 2023.

PSN065: *Safe Use of Ultrasound Gel: Compliance required by 28th March 2023.* An initial meeting has taken place with key leads. Procurement have reviewed the status of usage across the health board. An audit is currently being devised by the central team to establish the types of sterile and non-sterile gels used in clinical areas, to establish areas of compliance and non-compliance to support with the changeover.

PSN066: *Safer Temporary Identification Criteria for Unknown or Unidentified Patients*. Compliance required by 29th September 2023. This patient safety notice requires a number of actions from key IT personal & ED colleagues due to the number of patient systems which are currently in place. An initial meeting has taken place, however, further meetings are planned with Head of Information to establish a working group, this is predicted to be large scale project and there is a national working group to support.

Current Compliance
In total, there is **1 alert** and **0 notices** in which the Health Board are reporting non-compliance.

Non–compliance for alert **PSA008 Nasogastric tube** misplacement status is an ongoing issue which is currently being reviewed on an All Wales Level.
An all Wales Training package for NG Tube insertion is being established. The Delivery Unit have advised that the first national meeting took place in September 2022. 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.

Since the last report the Health Board has reported compliance with **PSA015** *Safe use of oxygen cylinders in areas without medical gas pipeline systems.*

Monitoring arrangements
The internal management, monitoring and reporting process for Patient Safety Alerts (PSAs) and Patient Safety Notices (PSNs) was 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 through to the Care Group structure with alerts and notices being a standard agenda item in governance meetings.

A national working group for the development of the safety alerts functionality within Datix Cymru has been established with an aim of in supporting a more standardised approach to the management of alerts in NHS Wales. The initial focus is on patient safety alerts and solutions in the first instance and before considering wider alerts such as MHRA's in the second phase of the working group.

2.5 UK Covid-19 Inquiry Update – Group Core Participant Status (Module 3)

The Health Board has been informed by the Inquiry team that the group application to be a Core Participant has been granted for Module 3. The 'Group' of Welsh NHS Bodies includes:

- Aneurin Bevan University Health Board;
- Betsi Cadwaladr University Health Board;
- Cwm Taf Morgannwg University Health Board;
- Hywel Dda University Local Health Board;
- Swansea Bay University Health Board; and
- Velindre University NHS Trust (excluding NHS Wales Shared Services Partnership)

The list of Module 3 Core Participants in the UK Covid-19 Inquiry is available here: List of Module 3 Core Participants - UK Covid-19 Inquiry (covid19.public-inquiry.uk)

Greg Dix, Executive Nurse Director is the Senior Responsible Officer (SRO) for the Health Boards preparedness response supported by the Assistant Director of Governance and Risk. Greg Dix as SRO is a member of the Steering Committee which has been established for the above Group of Welsh NHS Statutory Bodies, with the purpose of facilitating each member having the benefits of Core Participancy status in Module 3, at minimal cost to the public purse, by working together to ensure efficiency.

The Group will work together in preparing for the public hearings with the Module 3 legal team. Each member of the Group has, and will continue to have, a separate legal team which will continue to advise and support the individual member, respond to all requests made to it under Rule 9 of the Inquiry Rules 2006 for documents and witness evidence, whether these requests are made directly to the Group member or via the Group legal team.

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.

- ➢ Maintenance of robust quality governance arrangements during the transition to a centralised function is paramount. The implementation of OCP in relation to Quality and Governance arrangements is currently in the final stage.
- ➢ The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work is underway to align the Datix Cymru System to the Care Group Structure and ensure up to date information is accessible across the Health Board on a range of metrics.
- ➢ Learning from Events continues to be a challenge for the Health Board, with several deferred cases awaiting further information and submission.

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

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16 March 2023

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People's Experience Activity Report
(December 2022 – January 2023)

Patient centred care remains the focus of service delivery and improvement across the Health Board and the Patient Experience Team continue to engage with patients, families and carers alike to enable their voices to be heard within this.

This is undertaken through a variety of methods and in terms of receiving first hand qualitative data from patients, the Health Board utilises Civica – patient feedback system. The system continues to be embedded across services with more bespoke surveys being created as further departments come on board. The project team is currently working with the three acute ED departments to create a survey that meets the needs of the service. The SMS texting system requires improved IT infrastructure to enable activation of this service throughout CTM UHB.

Patient feedback received February 2023.

The nurses are very helpful and the food is very good.

My wife has terminal cancer and was brought in to control her pain medication. The ambiance was perfect for my wife. There was a calmness about the place and the staff were very welcoming and attentive. The nurses couldn't do enough for us. It is such a pleasant place. Well done for providing such a facility.

Liaison with family members began in an extremely open and warm hearted way. After months and months have worn on, this now seems to be at a premium and communications are somehow cooler, and the family feel held at arm's length with our very real grief around our relative's condition overlooked. We feel like inconvenient numbers rather than humans, with communication policies being inaccessible and no opportunity for meetings with the family and the key staff after the initial three months.

I want to thank all of the staff at the EPU for their service during such a difficult time. I was offered telephone support after attending A&E with vaginal bleeding. When the bleeding became worse I attended EPU who gave me an ultrasound. There was no heart beat. The staff were incredibly sensitive and understanding at such an awful time for me. I was treated with dignity, respect and was given time. Everything was explained to me in a sensitive way and I am truly grateful.

All staff have been very helpful and informative. Would be helpful if there was a shelf in the shower for belongings. Students were brilliant.

Many services manage to have lunch and keep the service running, I do not understand how you need to close the department for staff to have a lunch break while an eight-month pregnant patient is told to go for a walk. Terrible.

Carers

The Carer's co-ordinator continues to engage with carer's, patients, families and staff alike to raise awareness of the unpaid carer and the need to ensure their voice is heard within the discharge planning process to enable signposting where needed. The weekly information carer stands in the 3 acute hospitals continue to identify and support unpaid carers in a hospital setting. Posters have been displayed throughout the hospital, information booklets provided to emergency departments, discharge liaison services, outpatients departments and the acute wards.

Chaplaincy

Significant Spiritual and pastoral care provided (December 22- end Jan23)
- 663 Patients
- 204 Relatives/carer's
    364 Staff

The Bereavement and Loss Workshop was presented to CTMUHB 2030 Leaders and the response from community leaders was overwhelmingly positive, which has resulted in subsequent offers for venues to hold more workshops and 'At a loss Cafes' across the Health Board have been provided.

The annual memorial service, in collaboration with County Bereavement services, was held at Llwydcoed Crematorium and live streamed for those who could not and/or felt unable to attend. Carol services resumed at RGH, YGT and YCR and were very well attended, patients and families were pleased these had resumed. Comments below were provided by those attending POW service:

It was a lovely time together singing carols and sharing some of the Christmas readings from the New Testament. At the end one of the hospital volunteers asked to sing a Christmas song "It's the most Wonderful Time of the Year" and one of the patients from Angelton who had previously been a member of a male voice choir joined in with her.

Most people stayed for tea/ coffee and mince pies / biscuits. The hot drinks were especially welcome as it was very cold and as one of the patients with dementia remarked loudly "it's freezing in here!"

It was a joy to catch up with a patient from Caswell who chaplaincy had regular contact with prior to the HB transfer in 2019 and who now has accompanied leave from the ward. He hopes to be able to come to some of the Thursday morning services that are held in the chapel.

Volunteers

Meet and Greet Volunteers

The meet and greet volunteer role provides a wayfinding service for those attending our sites across CTM UHB. The following provides an overview of this service across the organisation.

- ➢ The meet and greet services at the Princess of Wales & Royal Glamorgan Hospitals were reintroduced several months ago providing wayfinding, signposting and information. In addition, the volunteers encourage feedback from service users by handing out or supporting the completion of the "Have Your Say" cards.
- ➢ In December 2022 recruitment for new volunteers was re-opened and promoted via our local community volunteer centres and the volunteer service intranet and internet sites, which included additional volunteers for YCC, DSHP and RGH.
- ➢ Since 2020, our vaccination centre volunteers have supported the work stream across the Health Board and have been invaluable to the delivery of services, during the busiest times with over 120 volunteers supporting with meet and greet, wayfinding and signposting.

Wellness Improvement Service (WISE) Volunteers

The Wellness Improvement Service was officially launched on 5th September 2022. During December and January wellness sessions have continued to take place with volunteers supporting wellness coaches and participants.

Pets as Therapy Volunteers

The Pets as Therapy service is a positive and a welcomed form of alternative therapy, which benefits patients, service users and staff. The volunteer service has been working jointly with the Cariad Pet Therapy Organisation to explore expanding their services more widely across CTMUHB.

To date we currently have the following volunteers and therapy pets at clinical sites which include:
- Palliative Care Unit (RGH) and Dementia wards (RGH)
- Y Palliative Care Unit (POW)

- CAMHS, Ty Llidaird (POW)

Cariad Pet Therapy has been instrumental in supporting CTM UHB with this initiative and has recently won an ITV Wales Wellness award. The Pet Therapy project was presented to the Quality and Safety Committee on the 24th January 2023, which was warmly received and hugely supported, the volunteer service has been invited back to the Quality and Safety Committee at a later date in 2023 to provide a presentation on volunteering from a broader aspect.

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. To date we have 2 volunteer drivers supporting with transporting participants to Y Bwythyn Newydd to enable them to get involved with the good to grow project which is also supported by volunteers under the guidance of the Occupational Therapist, with a volunteer driver handbook being developed and currently awaiting approval.

<u>Veterans</u>

Work continues to highlight the Armed Forces Covenant and how this affects the service we offer veterans/serving/territorial personnel who have associated medical conditions as a result of their time in service.
The ESR system has been updated to reflect a training package that staff can access to highlight the responsibilities of the NHS organisation.
The exploration of WPAS systems on an all Wales basis is still being undertaken to review how links can be inputted into the system to track patient referrals that can be expedited under the Armed Forces Covenant.

<u>Bereavement</u>

The Clinical Bereavement Lead continues to liaise with staff, third party stakeholders, patients to embed the Once for Wales Care of the Bereaved Framework across the Health Board. This involves a number of facets which are detailed below:
- The Care After Death policy and bereavement checklist has been updated.
- A new Pregnancy Loss under 16 weeks policy has been produced. This policy means that patients who experience pregnancy loss are supported and the procedure they encounter is sensitive and appropriate for their circumstances. A newly created Pregnancy loss

under 16 weeks information booklet produced has also been written to accompany this policy.

- Delivery of bereavement training to bereavement link nurses within clinical areas on pregnancy loss and care after death has commenced.
- Set up regular forums with contracted funeral directors within CTM UHB to share wider vision for bereavement services across the Health Board.

PALS service

The Head of People's Experience and the PALS team in POW are updating processes & procedures to ensure maximising engagement with patients/families/carers and staff.   As the service has recently transferred into the People's Experience portfolio this will support the planned expansion of the service across the Health Board enabling visible 'front of house' service supporting people's experience and feedback to support service improvements and shared learning. The Care to Share clinics have been reinstated across the wards in PoW to gain real time patient feedback.

Appendix 2

Welsh cancer patient experience summary

Background

The WCPES is designed to measure and understand patient experiences of cancer care and treatment in Wales to help drive improvement both nationally and locally.

This is the third Wales Cancer Patient Experience Survey (WCPES), it was conducted by IQVIA on behalf of Macmillan Cancer Support and the Wales Cancer Network. Whilst some of the responses are comparable to previous surveys, many questions have been changed. Responses were collected from October 2021 to February 2022.

COVID context

The WCPES includes the experiences of those who received treatment from 1st January to 31st December 2020, during the height of the COVID-19 pandemic. This significantly impacted on how care was delivered. Whilst this was done in order to comply with national guidance around infection prevention and control, this will have affected experiences.

Survey

There were 6259 responses across Wales, and over 800 responses from patients in CTM (a response rate of 60.5%). It is worth noting that overall, across Wales there is very little variation in results and this is a testament to how closely the Health boards worked together throughout the pandemic to deliver cancer services.

Despite the pandemic, there is very little difference in the overall satisfaction score compared to previous surveys. The overall rating of care for CTM was 8.76 slightly higher than the All Wales average 8.67.

CTM Strengths
- 85% of respondents had trust in all their health professionals, this was the highest in Wales.
- 83% of patients only saw their GP once or twice before being referred for cancer (a 4.5% improvement from previous surveys) and second highest in Wales. This is partly due to the implementation of the Rapid Diagnostic clinic.
- 92% of respondents said hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.
- 70% of patients were given information about how to get financial help, we were the highest performing HB and reflects that our Welfare benefits advice service is embedded within the HB.

- 97% of patients felt they always had privacy as an inpatient. This was the highest in Wales and an increase of 4%
- 94% of respondents said they were given all the information they needed about their operation

Areas for improvement
- 28% of respondents said after leaving hospital, they were definitely given enough care and help from their GP. A 24% reduction from the previous survey and worst in Wales. The pandemic is likely to have significantly affected this.
- 88% of patients said they had access to a CNS, a 5.4% improvement on previous surveys, but lower than nearly all the other HBs. As a HB we have a smaller CNS workforce than the other HBs.
- 55% of patients were able to easily contact other health professionals, poorest performing HB. As a HB we have a smaller AHP workforce than other HBs.
- As a HB we scored lower on several of the information provision questions. On further investigation this is because we have a larger number of people responding that they did not understand the information provided
- 40% of respondents said their family or someone else close to them definitely had enough opportunity to talk to a healthcare professional. However, this is likely to be as a result of COVID and the requirement to attend hospital alone.

We are waiting for the qualitative data to be released as this will be rich source of information and will allow us to understand the impact of COVID compared to the ongoing pathway challenges.

Actions
The Wales Cancer Network are writing a Wales wide action plan.
 Areas of focus locally will be;
- Reviewing information and support pathways; ensuring our information is simple, easy to understand and accessible. We are currently working on Cancer internet site.
- Continuing to work with cancer site teams on the provision of a point of contact, holistic needs assessment and signposting to support services.
- Supporting the Wales Cancer Network and Health Education Improvement Wales (HEIW) to review the CTM Nursing and AHP workforce to assess gaps and needs including the appropriate skill mix to support cancer patients.
- Improving secondary care communication with primary care through standardised pathways.

These actions will be led by the Macmillan Lead Cancer Nurse and the Macmillan AHP Lead for Cancer in conjunction with the appropriate service or care group. They will be monitored via the Cancer Steering Group.

Compliance against Patient Safety Solutions Wales - Alerts - Issued after April 2014

| | Alerts as at: 13/02/2023 | | NOTE: THERE IS AN ALL WALES ISSUE REGARDING PSA008 DUE TO NG TUBE COMPETENCY BASED TRAINING FOR MEDICAL STAFF. ALL ORGANISATIONS TO WHICH THIS ALERTS APPLIES ARE NON-COMPLIANT. | | | | | | | | | | |

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
PSA015	Safe use of oxygen cylinders in areas without medical gas pipeline	27/01/2023	Non-Compliant	Non-compliant	Compliant	Compliant	Non-Compliant	N/A	N/A	Non-compliant	N/A	Non-Compliant

Compliance against Patient Safety Solutions Wales - Notices - Issued after April 2014

Notices as at: 13/02/2023													
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	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A

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%

1/2

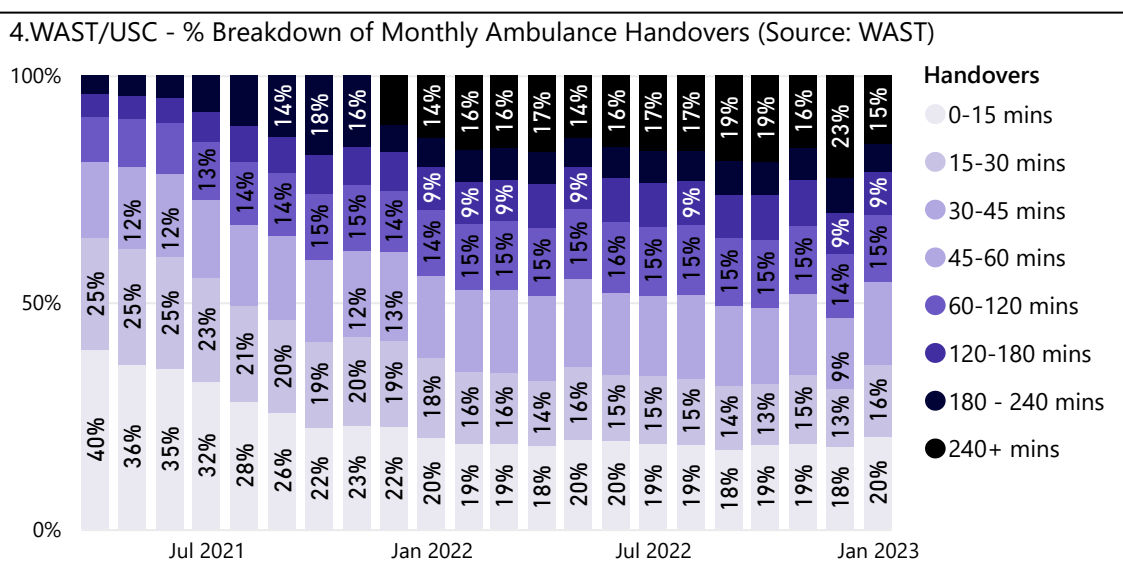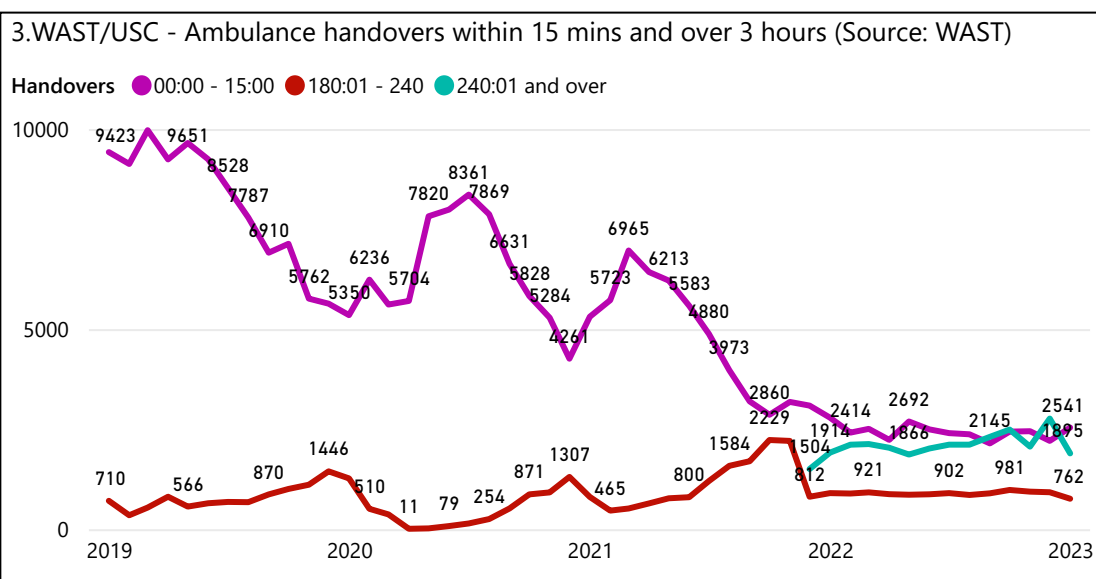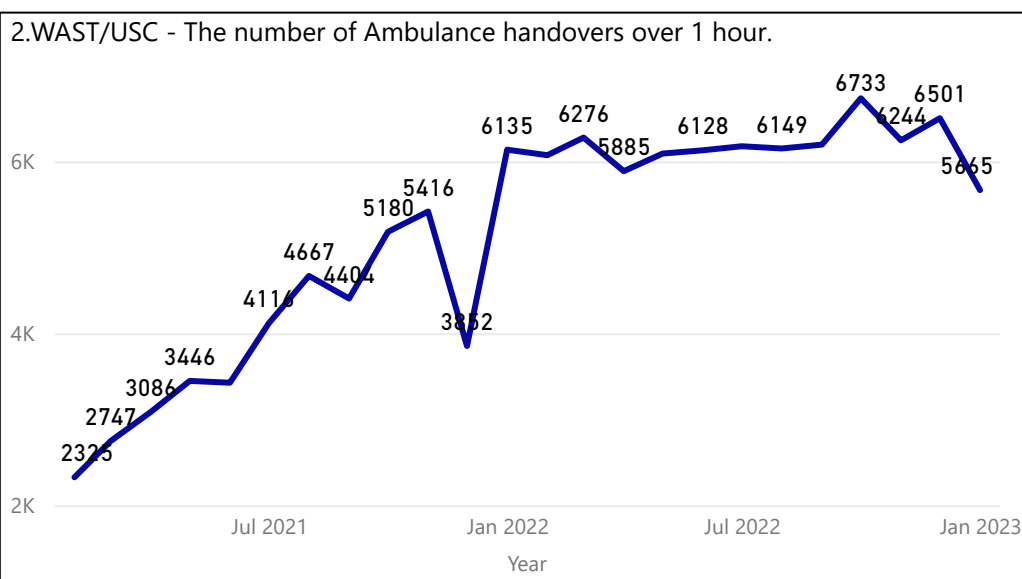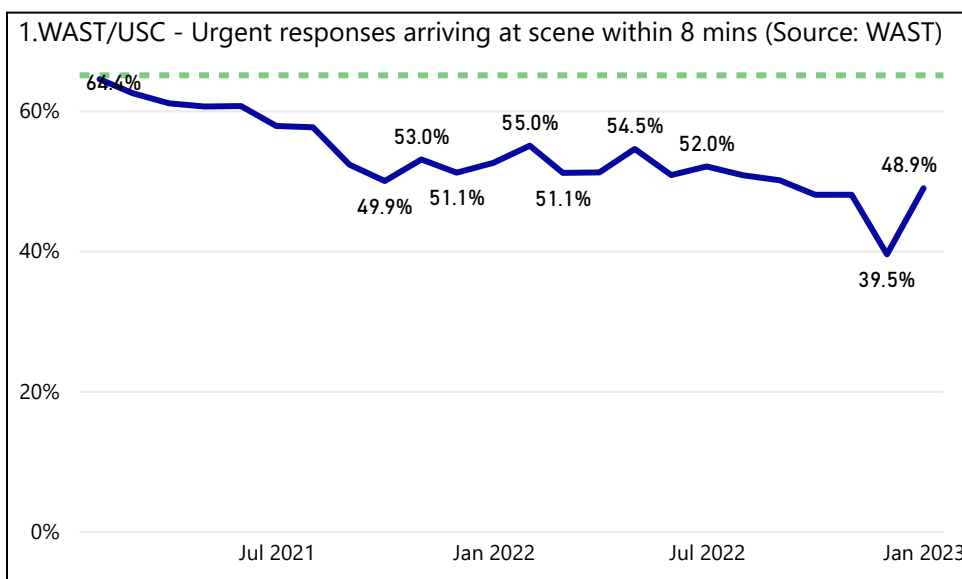|				
Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid 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.

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
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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.
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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.
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Major Conditions	15	15.Stroke QIM Monthly Measures (Source: SSNAP)	SSNAP	Source: SSNAP (Setinel Stroke Nationa Audit Programme) national programme data. Four key elements only listed: Admission to Acute Stroke Unit ,=4 hours (%). Thrombolyisis - Door to Needle in 45 mins (% of eligible patients). Attaining target level of mins with SLT (Speech Language Therapy). The percentage discharged with ESD/Community Therapy Multi-Disciplinary Team. Discrete monthly absolute figure.
Planned Care	16	16.Numbers Follow Up appointments booked or not booked past target date (Source: WG)	DHCW	Numbers Follow Up appointments booked or not booked past target date for specific specialties. Data source: WG
Major Conditions	17	17.CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pivot)	WG	% of Patients Treated within 62 days - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 75% All Wales Figures also plotted on UHB charts
Mental Health	18	18.MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:WG)	WG	% of Patients receiving mental health assessments within 28 days of a referral - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	19	19.MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)	WG	% of Patients receiving therapeutic interventions within 28 days of having an assessment - as per measure details. Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure. Target 80%
Mental Health	20	20.Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)	WG	% of Patients with a valid are Treatment Plan (CTP) Source: Welsh Government monthly pivot of data. Discrete monthly percentage figure Target 90%

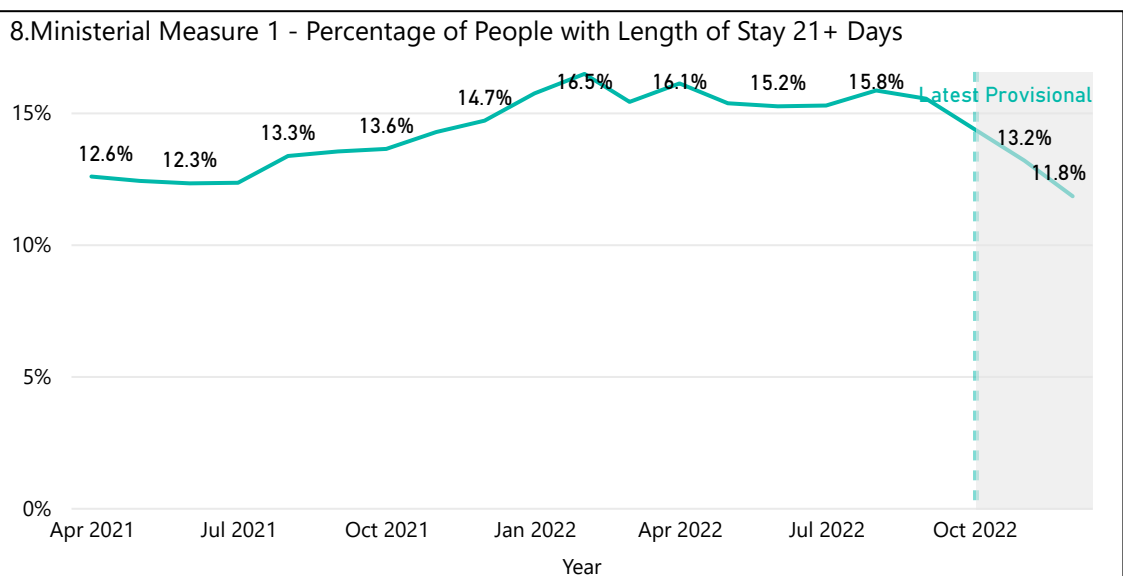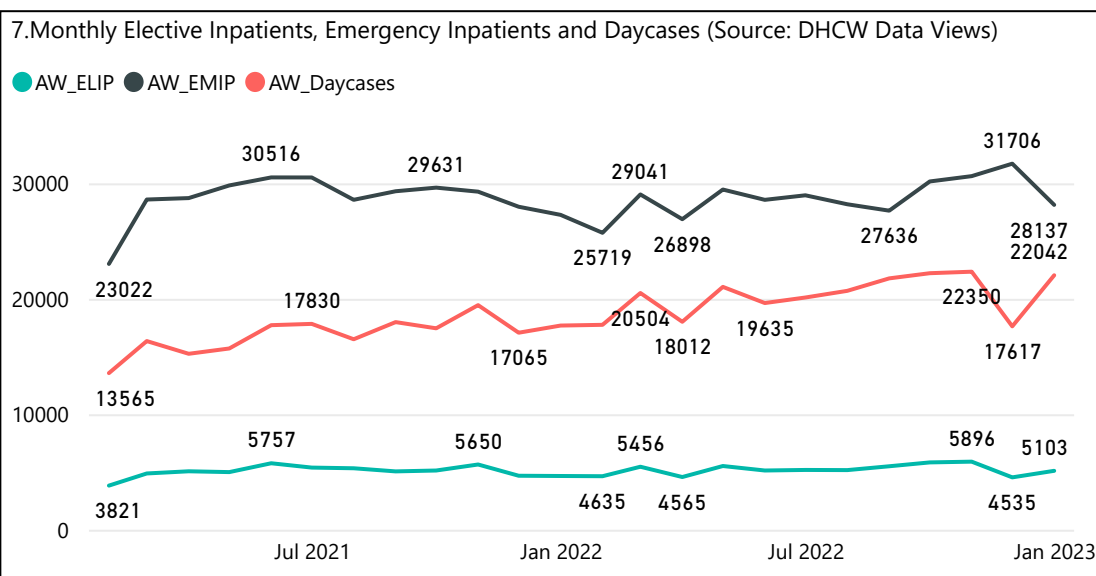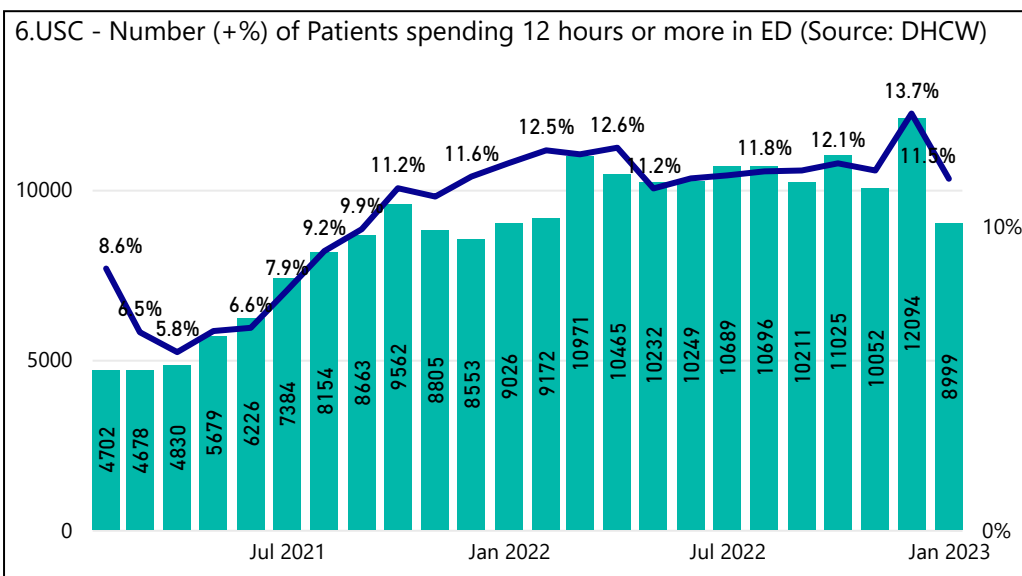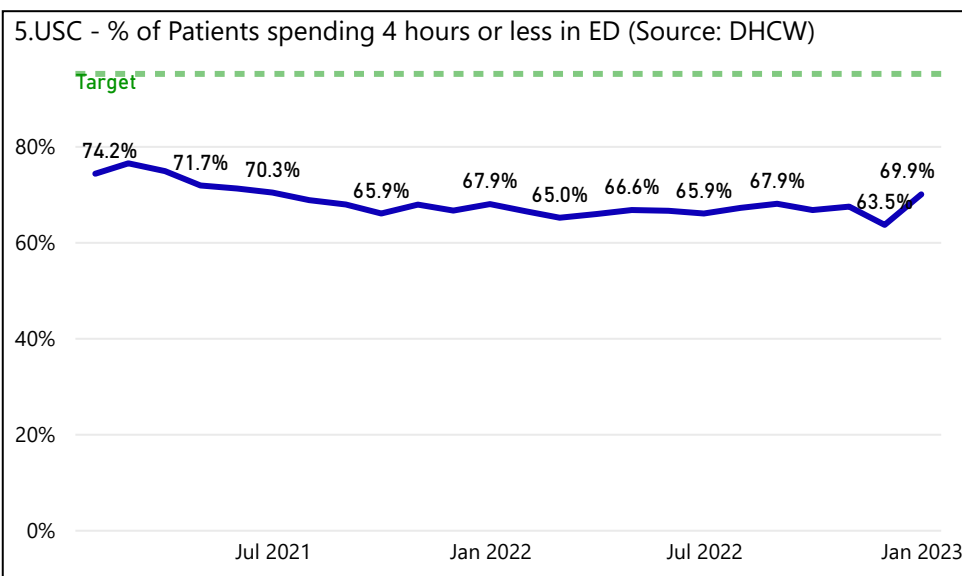|				
Mental Health	21	21.Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)	WG	Details of neurodevelopmental servces waiting times broken down into specific time categories: 0-11 weeks 12-17 weeks 18-25 weeks 26-35 weeks 36-51 weeks >52 weeks Data plotted as stacked discrete monthly volumes column chart - with % of those waitng 26 eeks or less overlayed as line series. Source: Welsh Government monthly pivot of data. Target 80%
Patient Safety	22	22.National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	23	23.National Reported Incidents By Severity & Month (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded severity of the incident at the time of reporting.** Discrete monthly figure.
Patient Safety	24	24.National Reported Incidents By Month and Location (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown by the recorded location of the incidents.** Discrete monthly figure.
Patient Safety	25	25.Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)	NHSDU/UHB	Breakdown of current snaphot of compliance with Patient Safety Alerts (PSA) and Patient Safety Notices (PSN). Breakdown by individual PSN and PSA. Table displays those PSN and PSA where UHB have recorded 'Not compliant', or where there has been 'No Response'.
Patient Safety	26	26.National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidents	RL DATIX	National Reported Incidents as recorded on RLDatix. **Based on date the incident occurred.** Snapshot of dynamic dataset and subject to revision. Discrete monthly figure.
Patient Safety	27	27.Total Never Events by Type (Source: RLDatix)	RL DATIX	Recorded National Reprted Incidents which resulted in a Never Event - by type. Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Based on Date Reported to NHSDU via RLDATIX
Patient Safety	28	28.National Reported Incidents Escalated to WG By Month (Source: RLDatix) - n.b. Date Reported to DU	NHSDU/UHB	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. **Breakdown of those Escalated to WG for consideration.** Discrete monthly figure.
Patient Safety	29	29.NRI - Current Overdue Invesitgations/Outcomes (Source: RLDatix) - n.b. snapshot data	RL DATIX	National Reported Incidents as recorded on RLDatix. Based on date the incidents has been reported to the NHS Wales Delivery Unit (via RLDatix). Snapshot of dynamic dataset and subject to revision. Discrete monthly figure. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	30	30.Incidents Not Closed and Overdue - by UHB (incidents reported from 2020-21 and 21-22 up till Jun-21 only)	NHSDU/WG	Legacy records comprising Serious Incident records recorded in 2020-21 and 2021-22 (up until Jun-21). These represent Serious Incidents and were therefore recorded under a different framework to the National Reported Incidents recorded since Jun-21. Records overdue - investigations not yet concluded by UHB beyond the recorded timescales.
Patient Safety	31	31.Healthcare Associated Infections (HCAI) - Number by Month and Organism (Source: PHW)	PHW	Number of HCAI (Health and Care Associated Infections) currently recorded by PHW - by organism. Discrete monthly figure overlayed with roling annual total for comparison (annual figure in red).
Patient Safety	32	32.CHKS - Monthly Mortality Rate Measures (Source: CHKS)	CHKS	Data taken from CHKS extract. Discrete monthly figure. Monthly mortality data for the four measured listed: Stroke, Hip Fracture, Heart Attack and a Crude overall Mortality rate. Snapshot of dynamic dataset and subject to revision. Latest three months (90 days) data to be treated as provisional only - subject to substantial revision pending lag in coding.
Patient Safety	33	33.NRI Delay in Reporting (Source: RLDatix) - n.b. Date Reported to DU	RL DATIX	National Reported Incidetns (NRI) for each discrete month broken down by recorded nature of any delay noted in reporting. For further clarification contact NHSDU Quality and Safety team.
Patient Safety	34	34.Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)	DHCW	Data taken from EFF/DHCW extract. Discrete monthly figure. Subject to lag of several months in data becoming available.

Delivery Unit / Uned Gyflawni — Wales

Summary UHB Level Monthly Performance Measures Dashboard (selected measures)

16/02/2023 14:58:27
Last Refreshed

WAST
Site Level Data

1. WAST/USC - Urgent responses arriving at scene within 8 mins (Source: WAST)
2. WAST/USC - The number of Ambulance handovers over 1 hour.
3. WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)
   Handovers: 00:00 - 15:00, 180:01 - 240, 240:01 and over
4. WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)
   Handovers: 0-15 mins, 15-30 mins, 30-45 mins, 45-60 mins, 60-120 mins, 120-180 mins, 180 - 240 mins, 240+ mins

USC
Site Level Data

5. USC - % of Patients spending 4 hours or less in ED (Source: DHCW)
6. USC - Number (+%) of Patients spending 12 hours or more in ED (Source: DHCW)
7. Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)
   AW_ELIP, AW_EMIP, AW_Daycases
8. Ministerial Measure 1 - Percentage of People with Length of Stay 21+ Days

Planned Care

9. RTT - Percentage waiting <26 weeks for treatment (Source: RTT Monthly Pivot...)
10. RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot/WG)
11. Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Monthly Pivot/WG)
    (Blank), T & O, Urology, Gynae, Oral Surg, Ophthal, Gen Surg, ENT, Derm, AHP
12. Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)
    Diagnostics 8+ Wks, Therapies 14+ Wks

Major Conditions

13. NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Source: NHFD)
14. NHFD - Hip Fracture - Prompt Delerium Assessment Post Op - Annual (So...)
15. Stroke QIM Monthly Measures (Source: SSNAP)
    Adm to ASU <4hrs, Thromb. <=45mins
16. Total No. of Patients with a target date but no booked appointment

Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
31 August 2022	13020	18102	61821	33035	19621
30 September 2022	13132	18497	61114	33189	19422
31 October 2022	12726	18131	60524	32757	18886
30 November 2022	12580	18246	60657	34037	18555
31 December 2022	13510	19926	63529	35537	18978

17. CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Monthly Pi...)

Mental Health

18. MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (Source:...)
    P1a Total %, P1a% Aged <18, P1a% Aged 18-64
19. MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Source: WG)
    P1b Total %, P1b% Aged <18, P1b% Aged 18-64
20. Mental Health - Part 2 - % with a valid CareTreament Plan (CTP) (Source: WG)
    P2% Total, P2% CAMHS, P2% Adult
21. Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)
    Label: (<= 11 w..., (12-17 w..., (18 - 25 w..., (26 - 35 w..., (36 - 51 w..., (>= 52 we..., % <26 wks

Patient Safety

22. National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU
    Snapshot of RL Datix position on 3/2/23

23. National Reported Incidents - Current Overdue Investigations/Outcomes (Source: RLDatix) - n.b. snapshot data
    Proposed investigation t... 120 working days, 30 working days, 60 working days, 90 working...
    Please note - incl. incidents not yet closed by WG/DU. Excludes Pressure Ulcers
    Snapshot of RL Datix position on 3/2/23

24. Alerts and Notices Current Non-Compliance & Non-Response (Source NHS DU)

Status	AB	BCU	CaV	CTM	Hdda	SBU	Vel	WAST	Total
No response	1				1				3
Non-compliant	1	2	2	1		2	1		9
Total	2	2	2	1	1	2	1	1	12

Snaphot of position on 13/2/23

25. NRI - Unexpected Deaths by Month (Source: RLDatix)
    Unexpected / unexplained death

26. National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidentn-21

27. Total Never Events by Type (Source: RLDatix)
    Medication error - administr..., Never Event - Administration..., Never Event - Misplaced nas..., Never Event - Retained forei..., Never Event - Undetected oe..., Never Event - Wrong implan..., Never Event - Wrong site sur..., Treatment / procedure error

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
PSA015	21										
PSN063	323										
PSN064	354										
PSN057	382										
PSN060	424										
PSN059	428										
PSA014	477										
PSN058	492										
PSN055	505										
PSA013b	534										
PSA013a	590										
PSN056	596										
PSA012	596										
PSN052	900										
PSN051	903										
PSA008	1905										

Compliant / Non-compliant
Snaphot of position on 13/2/23

29. Healthcare Acquired Infections (HCAI) - Number by Month and Organism (Source: PHW)
    Monthly Total, Rolling Annual Total
    C. difficile, E. coli bacteraemia, Klebsiella sp bacteraemia, MRSA bacteraemia, MSSA bacteraemia, P. aeruginosa bacteraemia

30. CHKS - Monthly Mortality Rate Measures (Source: CHKS)
    Monthly Rate, Rolling Annual Rate
    Crude Mortality, Heart Attack 30 day rate, Hip Fracture 30 day rate, Stroke 30 day rate

31. Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)

32. CHKS - Monthly RAMI - Risk Adjusted Mortality Index (Source: CHKS)

CHKS mortality data from latest 3 months is provisional only

GIG CYMRU NHS WALES | **Delivery** Unit **Uned Gyflawni**

WAST

Site Level Data

1.CTM - WAST/USC - Urgent responses arriving at scene within 8 mins (Source: ...)
2.CTM - WAST/USC - The number of Ambulance handovers over 1 hour.
3.CTM - WAST/USC - Ambulance handovers within 15 mins and over 3 hours (Source: WAST)
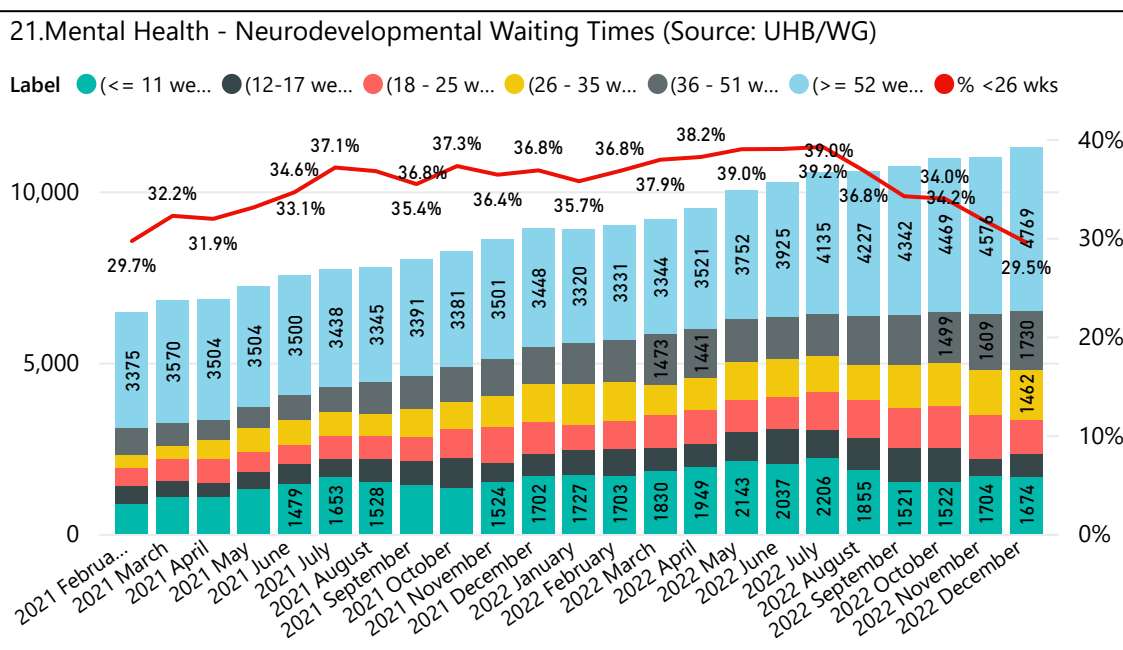4.CTM - WAST/USC - % Breakdown of Monthly Ambulance Handovers (Source: WAST)

USC

Site Level Data

5.CTM - USC - % of Patients spending 4 hours or less in ED (Source: DHCW)
6.CTM - USC - Number (+%) of Patients spending 12 hours or more in ED (Source: D...)
7.CTM - Monthly Elective Inpatients, Emergency Inpatients and Daycases (Source: DHCW Data Views)
8.CTM - Ministerial Measure 1 - Percentage of People with Length of Stay 21+ Days

Planned Care

9.CTM - RTT - Percentage waiting <26 weeks for treatment (Source: RTT Month...)
10.CTM - RTT - Patients waiting more than 36 weeks for treatment (Source: RTT Monthly Pivot...)
11.CTM - Number of RTT Waits of 2yrs+ by Month and Specialty (Source: RTT Pivot/WG)
12.CTM - Diagnostics Waits 8+ Weeks, and Therapy Waits 14+ Weeks (Source: DATS Monthly Pivot/WG)

Major Conditions

13.CTM - NHFD - Hip Fracture KPI 1 Prompt review by Orthogeriatrician - Annual (Sourc...)
14.CTM - NHFD - Hip Fracture - Prompt Delerium Assessment Post Op - Ann...
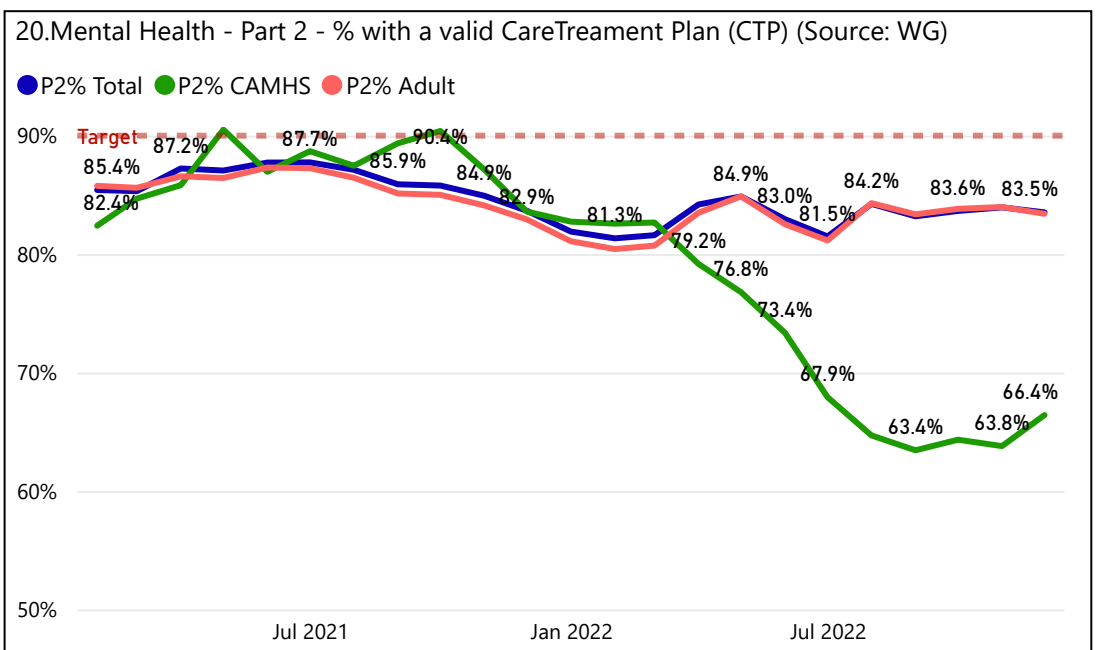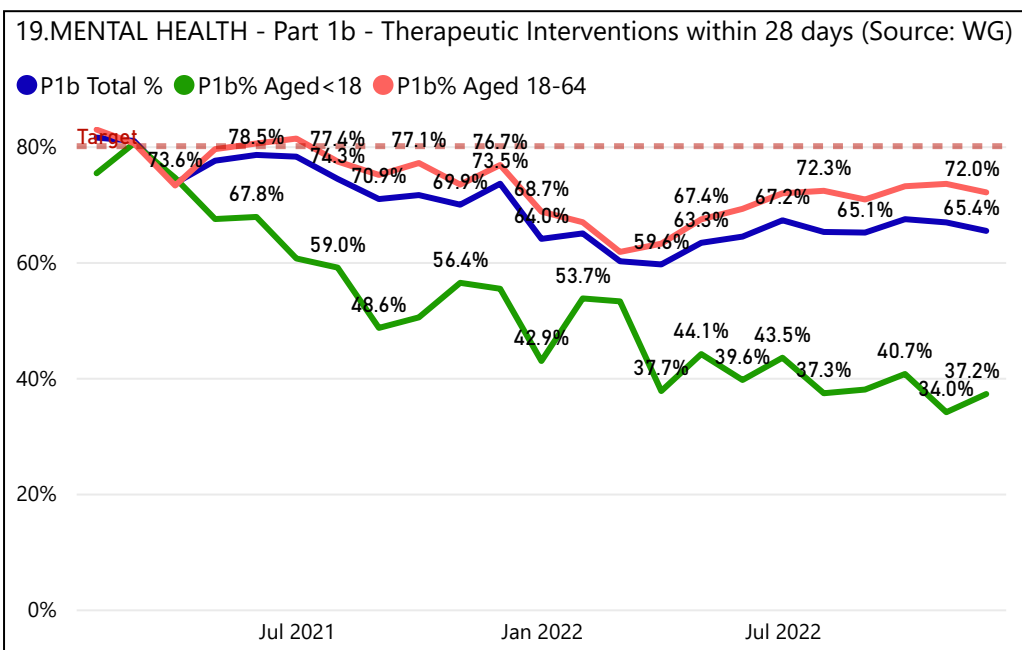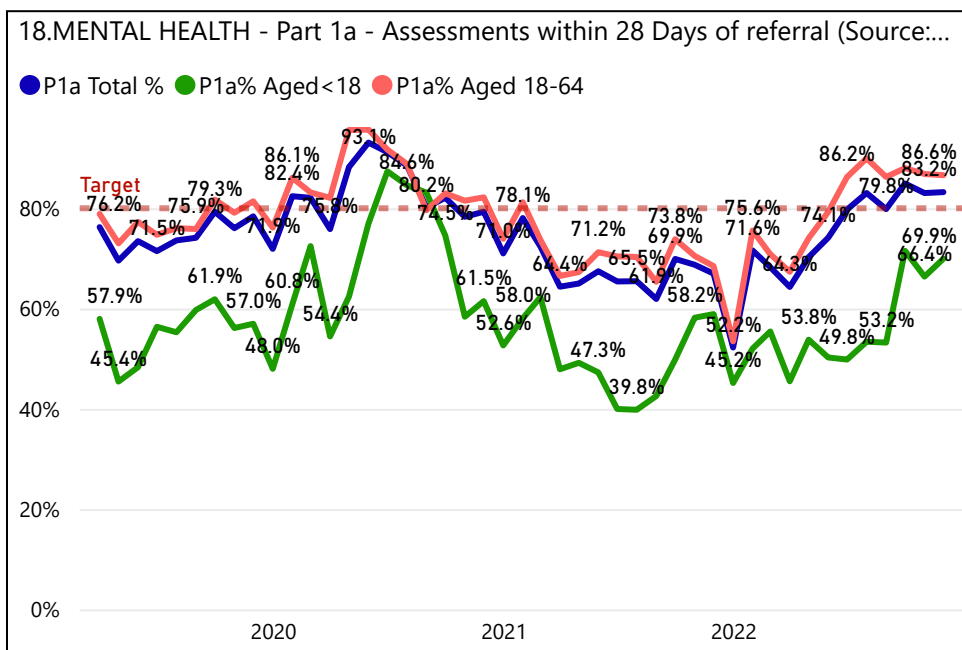CTM - Stroke QIM Monthly Measures (Source: SSNAP)
16. CTM - Total No. of Patients with a target date but no booked appointment

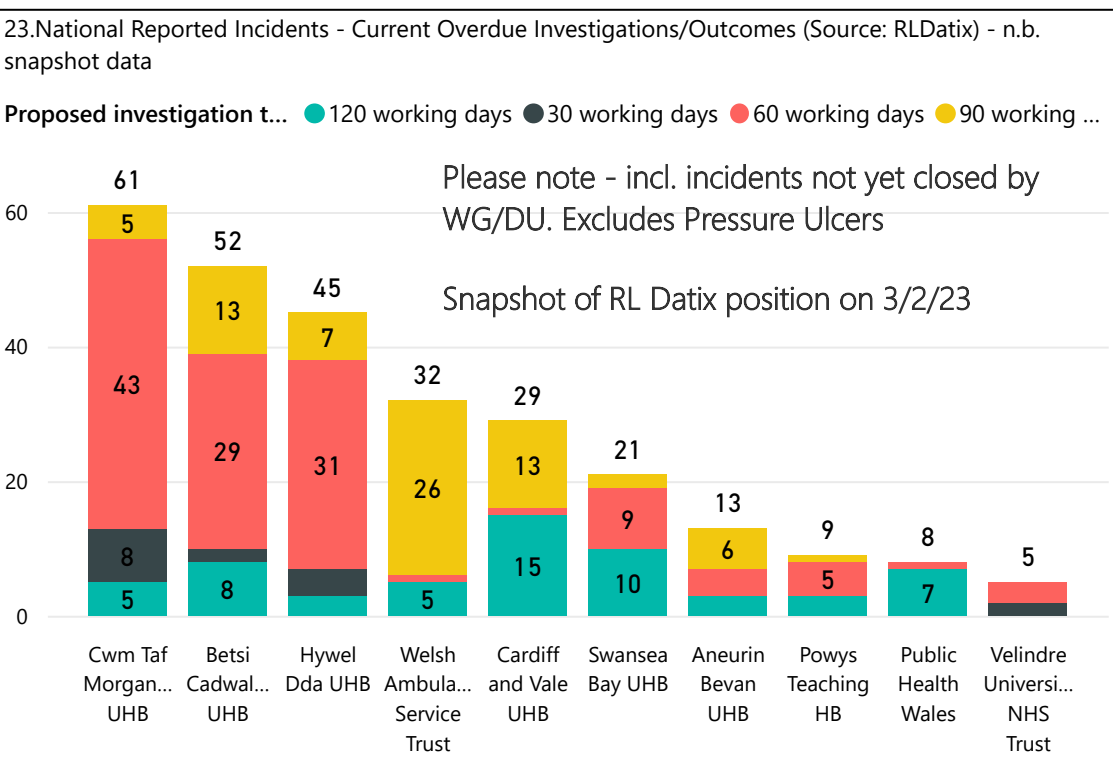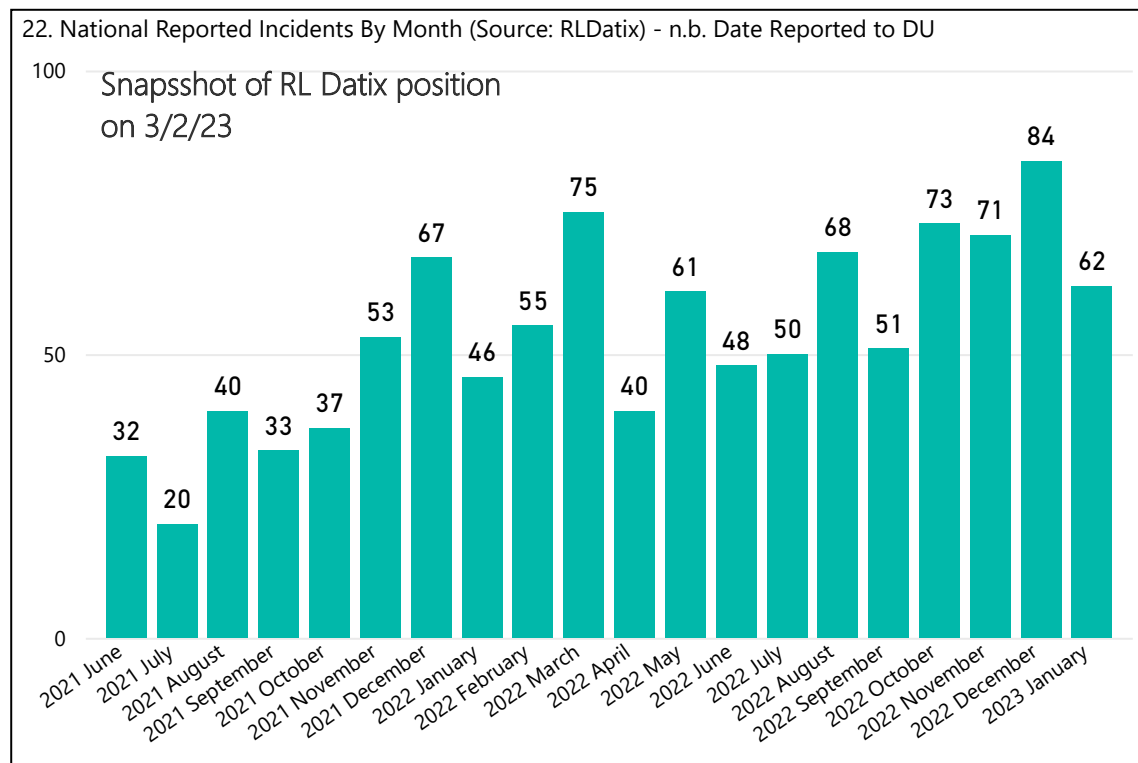| Date	Dermatology	ENT	Ophthalmology	Trauma & Orthopaedic	Urology
31 August 2022	1272	2583	10852	7485	1765
30 September 2022	1307	2711	10480	7551	1860
31 October 2022	1080	2629	10477	7458	1864
30 November 2022	1052	2628	10132	7511	1827
31 December 2022	1159	2858	10586	7739	1947

17.CTM - CANCER - Suspected Cancer Pathway for Treatment within 62 days (Source: WG Mo...)

Mental Health

18.CTM - MENTAL HEALTH - Part 1a - Assessments within 28 Days of referral (S...)
19.CTM - MENTAL HEALTH - Part 1b - Therapeutic Interventions within 28 days (Sour...)
20.CTM - Mental Health - Part 2 - % with a valid CareTreatment Plan (CTP) (Source: WG)
CTM - Mental Health - Neurodevelopmental Waiting Times (Source: UHB/WG)

Patient Safety

22.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU
Snapshot of RL Datix position on 3/2/23
23.CTM - National Reported Incidents By Severity & Month (Source: RLDatix) - n.b. Date Reported to DU
24.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date Reported to DU
25.Alerts and Notices Current Non-Compliance & Non-Response by Due Date (Source NHS DU)

Status	Date Due	Ref	Title
Non-compliant	30 November 2017	PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm

Snapshot of position on 13/2/23

26.CTM - National Reported Incidents By Month (Source: RLDatix) - n.b. Date of Incidentn-21
27.CTM - Total Never Events by Type (Source: RLDatix)
28.CTM - NRI Incidents Escalated to WG (Source: RLDatix) - n.b. Date Reported to DU
29.CTM NRI - Current Overdue Investigations/Outcomes (Source: RLDatix) - n.b. snapshot data
Please note - incl. incidents not yet closed by WG/DU. Excludes Pressure Ulcers.
Snapshot of RL Datix position on 3/2/23

30.CTM - Healthcare Acquired Infections (HCAI) - Number by Month and Organism (Source: PHW)
C. difficile
E. coli bacteraemia
Klebsiella sp bacteraemia
MRSA bacteraemia
MSSA bacteraemia
P. aeruginosa bacteraemia

31. CTM - CHKS - Monthly Mortality Rate Measures (Source: CHKS)
Crude Mortality
Heart Attack 30 day rate
Hip Fracture 30 day rate
Stroke 30 day rate

32.CTM - NRI Delay in Reporting (Source: RLDatix) - n.b. Date Reported to DU

33.CTM - Sickness Rates (Rolling 12 months figure) (Source: DHCW/EFF)

CHKS mortality data from latest 3 months is provisional only

AGENDA ITEM
6.3.2a

QUALITY & SAFETY COMMITTEE
HIGHLIGHT REPORT FROM THE PLANNED CARE QUALITY, SAFETY, RISK & EXPERIENCE (QSRE) MEETING

DATE OF MEETING	16 March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carole Tookey, Planned Care Nurse Director
PRESENTED BY	Carole Tookey, Planned Care Nurse Director
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	Noting

ACRONYMS	
HIW	Healthcare Inspectorate Wales
AW	Audit Wales
CSG	Clinical Service Group
POW	Princess of Wales
ITU	Intensive Treatment Unit
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital

1.   **PURPOSE**

1.1　This report had been prepared to provide the Committee with details of the key issues considered by the Planned Care Quality, Safety, Risk & Experience Group at its meeting on 09 February 2023.

1.2　Key highlights from the meeting are reported in section 2.

1.3　The Committee is requested to **NOTE** the report.

2.　HIGHLIGHT REPORT

ALERT / ESCALATE	• There were no items highlighted for escalation.
ADVISE	• Proposal awaiting for Cancer Board approval to move Cancer Harm review process to 146 days from 104 days to make the process more timely • HIW/AW Governance Review interviews scheduled for mid-March 2023. Good progress made in embedding new QSRE structure, still more work required to embed new operating model, risk management and learning. CSG Governance sub-structures in development • POW Surgery CSG now hosting Urology services and associated medical staffing issues • 4 Planned Care risks on the organisational risk register scoring 20: 　▪ 5214 Critical Care Medical Cover in POW - ITU resilience model for Health Board in development and being managed by Unscheduled Care (where ITU is moving to) 　▪ 4491 Demand for Planned Care services exceeds capacity – theatre insourcing in place at PCH & RGH to increase capacity and insourcing for 2 additional theatres at POW now approved 　▪ 4071 Failure to meet Cancer targets – some improvements noted but some service improvements linked to diagnostic capacity 　▪ 4103 Sustainability of a Safe and effective Ophthalmology service - Ophthalmology Harm review funding agreed for next 12 months and Ophthalmology outsourcing until end March 2023 to clear 104 week waits has commenced.
ASSURE	• Ongoing work to validate and update complete Planned Care Risk Register in progress as part of Governance re-structure • PCH ITU/Theatre Improvement programmes continue

INFORM	7 theatres in PCH now operational (includes insourcing team) - Positive feedback for theatre insourcing team on both sites (links into existing governance structure being progressed) - RGH Day Surgery model being reviewed ahead of Health Board developments - RGH elective Orthopaedic model now delivering care for 24 patients (from 15 beds) to reduce waiting lists (pooled lists for RGH & PCH from December 2022) 50% reduction in complaints across the Care Group (November 75 to December 31) with large numbers being resolved via early resolution – compliance with 30 day target remains poor but is a priority for the Care Group - Substantive appointments made to Planned Care Nurse Director and Planned Care Service Director commencing in post from 01 April 2023
APPENDICES	**NOT APPLICABLE**

Planned Care CSG QSRE Highlight Report	**Page 3 of 3**	**Quality & Safety Committee 16 March 2023**

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QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE UNSCHEDULED CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	16th March 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma James, Unscheduled Care Nurse Director Victoria Healey, Head Of Quality & Patient Safety
PRESENTED BY	Emma James, Unscheduled Care Nurse Director
EXECUTIVE SPONSOR APPROVED	Greg Dix Executive Nurse Director
REPORT PURPOSE	Noting

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ED	Emergency Department
HIW	Healthcare Inspectorate Wales
PCH	Prince Charles Hospital
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
DoN	Director of Nursing for Unscheduled Care
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon

MIU	Minor Injury's Unit
OCP	Organisational Change Policy
USC	Unscheduled Care Group
PTR	Putting Things Right
QPSE	Quality, Safety & Risk Experience
IPC	Infection, Prevention & Control
NRI	Nationally Reportable Incidents
WAST	Welsh Ambulance Services NHS Trust

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 26th January 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Change to 111 process YCR MIU - An options appraisal is being developed by the clinical team to be presented to the USC Senior Management Team with the preferred option and implementation plan to be agreed at QPSE and included in May highlight report.

| ADVISE | HIW made an announced inspection of stroke services at POW on the 25th January 2023, the initial feedback has been positive and official feedback will be received from HIW within the forthcoming weeks. 5 immediate actions were required with 3 completed the same day. Onsite training has been actioned and supported by the practice education team in POW. These sessions have been arranged and the two remaining actions will be completed by end of March 2023. Full details included in spotlight report.

In September 2021, the Health Board decided to temporarily close the Minor Injuries Unit (MIU) at Ysbyty Cwm Cynon (YCC) due to concerns relating to the fragility of the service and competency-based training compliance. Full details relating to this explored within USC spotlight report.

For noting MIU environment has been logged locally as a concern on risk register. Following this the Nurse Director for USC has commissioned an environmental review and options appraisal.

The ED Transformation Programme was developed and encompassed an action plan following the HIW inspection of the Emergency Department at Prince Charles Hospital in October 2021. Of the 74 actions that were recommended within the Programme, 72 have now been completed and the 2 remaining open actions are involving the capital redesign of the department and the Paediatric pathway which both require investment cases which are subsequently being refreshed to the new care group structure. As the Improvement Programme evolved a further 102 actions were generated from staff wellbeing, audit, policy development, medicines management and Workforce and OD. Of these actions, 30 remain outstanding however the short reinstatement of the ED transformation Programme meetings will now progress these actions to closure or to re-mitigate risk at pace under the direct supervision of the USC Nurse Director. |

	Following the OCP within the Quality Governance team and the new Care Group Operating Model, the USC Quality, Safety & Risk Experience meeting terms of reference have been approved by attendees as well as the interim governance reporting structures. These have been aligned to the planned care structure to provide a standardised and collaborative approach. As part of the OCP the complaints have been transferred to a central quality governance team within the organisation. This will ensure we maintain equity, consistency and strengthen resilience. Significant reduction in complaints (nearly 50%) from Dec 22-Jan 23. USC compliance with the 30 target remains poor however with the USC leadership team established they have provided a commitment to support to improve trajectories and a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This will be closely monitored by the USC Senior Leadership Team with a significant improvement trajectory expected. USC Risks on risks on the Organisational register over 20 highlighted for noting as updates received at committee. 4632 - Provision of an effective and comprehensive stroke service across CTM encompassing prevention, early intervention, acute care and rehabilitation. 3826 – Emergency Department (ED) Overcrowding
ASSURE	Following an incident within the ED, assurances were required in regards to processes in place when a patient reports to ED after sustaining a head injury and leaves the department without being seen. A standard operating procedure (SOP) for absconding and patient's that do not wait within the ED has been developed to be implemented within each ED CTM wide, this demonstrates cross hospital site working and provides assurances to the Director of Nursing and Senior Management Team (SMT) for USC that consistency is being achieved. As part of a collaborative pilot with planned care colleagues the previous monthly nurse education sessions that were developed at PCH will be expanded into a CTM wide learning, education and innovation sessions. These will be used to support transformation and improvement, wider learning from events and also to share patient experience, and staff ideas for

| | innovation. These will be implemented from April and will be shared widely for multiprofessional engagement.

Following the HIW inspection within the ED in POW on 17-19th October 2022, the previous DoN for USC commissioned a full IPC environmental review to be undertaken on each ED site, with the lead infection control nurse, this will include staff and public areas. This is to be completed early March and the audit results will be provided within the next Quality & Safety Committee highlight report for your reference.

The DoN for USC has been involved in the commissioning of joint investigation process regarding appendix B's, we have commenced weekly 'rapid' meetings from the 1st November 2022, for any new Appendix B's which are received by the Health Board to ensure we are determining if NRI reportable at a much quicker pace and notify the Delivery Unit (DU) within 5 working days of recognition. Our meetings have been positively received by WAST colleagues and have fed back that we were the first Health Board to have set up such meetings within this new process.

Following a letter received from Judith Paget, Chief Executive NHS Wales dated the 6th February 2023, regarding concerns relating to the management of boarded patients in fire evacuation routes. This issue has been addressed, through a comprehensive assessment of the wider hospital flow processes. There is an ongoing commitment to improve the standardisation of discharge processes working collaboratively with local authority colleagues, deployment of our Discharge to Recovery then Assess Hub, and extension of our 'Safe2Start' site-based meetings. The USC Senior Management Team is providing leadership and direction to the targeted actions required, to reduce risk and utilisation of space within the fire evacuation routes. The fire and health and safety officers have been engaged in and advised on a fire evacuation exercise. This exercise was undertaken on the 8th February and has concluded boarded patients can be evacuated appropriately and demonstrated we can meet our obligations to ensure the safety of our patients and staff. |
| **INFORM** | Head injury without being seen SOP – available on request
Health and Safety Report POW – evacuation exercise – available on request |
| **APPENDICES** | **NOT APPLICABLE** |

| | **AGENDA ITEM** |
| | 6.3.2c |

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE CHILDREN & FAMILIES CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	16th March 2023

| **PUBLIC OR PRIVATE REPORT** | Public |

| **IF PRIVATE PLEASE INDICATE REASON** | Not Applicable - Public Report |

PREPARED BY	Suzanne Hardacre, Director Of Midwifery & Nursing C&F Mohamed Elnasharty, Medical Director C&F Catherine Roberts, Director Of Operations C&F
PRESENTED BY	Suzanne Hardacre, Director Of Midwifery & Nursing C&F Mohamed Elnasharty, Medical Director C&F
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

| **REPORT PURPOSE** | NOTING |

ACRONYMS	
BFI	Baby Friendly Initiative
CSW	Cervical Screening Wales
CTMUHB	Cwm Taf Morgannwg University Health Board
CYP	Children and Young People
DHCW	Digital Healthcare Wales
DMC	Digital Maternity Cymru
EW	Early Warning

GIRFT	Getting It Right First Time
HDU	High Dependency Unit
HEIW	Health Education and Improvement Wales
HIW	Health Inspectorate Wales
IMSOP	Independent Maternity Services Oversight Panel
ISH	Integrated Sexual Health
ITU	Intensive Therapy Unit
LRI	Local Reportable Incident
LWC	Labour Ward Co-ordinator
MatNeoSSP	Maternity and Neonatal Safety Support Programme
MDT	Multi-Disciplinary Team
MenACWY	MeningococcalACWY Vaccination Programme.
MNSB	Maternity and Neonatal Safety Board
NRI	National Reportable Incident
NHS	National Health Service
PROMPT	PRactical Obstetric Multi-Professional Training
QR	Quick Response
QSE	Quality, Safety and Experience
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
UNICEF	United Nations International Children's Emergency Fund
WAST	Welsh Ambulance Service Trust
WG	Welsh Government

GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

WHSSC	Welsh Health Specialised Services Committee
WISE	Wellness Improvement Service

1. PURPOSE

1.1 This report has been prepared to provide the Committee with details of the key issues being considered by the Children & Families Care Group.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Maternity & Neonatal**
	Maternity and Neonatal Improvement Programme. The Maternity & Neonatal Improvement Programme is ending on 31st March 2023. The senior nurse / midwifery leadership structure has been reviewed to ensure that key strategic quality roles are permanently embedded. This will enable the medium to long term improvements to continue with assurance and oversight provided according to the Maternity and Neonatal Escalation Framework (Version 5.0 December 2023). The programme team are developing a 'wash up' and handover plans in preparation. Service leads and Care Group Directors are working to ensure that remaining quality roles as identified by RCOG/RCM and IMSOP Deep Dive Recommendations are maintained. ***Welsh Health Specialised Services Committee (WHSSC) Cot Configuration*** An initial options paper has been developed within WHSSC as part of a national review of ITU/HDU cots. The multi-professional team have reviewed the options and returned to WHSSC. A further financial impact assessment is awaited, escalated and discussed at Operational Management Board on 22.2.23. **Gynaecology & Integrated Sexual Health**

Children & Families Care
Group Highlight Report

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16 March 2023

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█	**Post-Menopausal Bleeding** Patients referred to Princess of Wales now reported to CTMUHB. Patients are still referred to Swansea Bay University Health Board for post-menopausal bleeding but there are delays (up to 71 days). The Care Group continues to review options for hysteroscopy services within the Health Board. A sustainable solution will be the completion of a hub and spoke model at Royal Glamorgan Hospital. Original works are planned to finish by the end of March 2023. Feasibility study underway for scoping of ventilation plant. Support being sought to progress with clinical service moves with infection prevention and control risk assessments in place. **Children and Young People** **School Entry Hearing Pathway** In other Health Boards in Wales, audiology colleagues carry out hearing testing. At CTMUHB this currently sits within the school nursing service. A Standard Operating Procedure has now been published by Welsh Government and recommends Agenda for Change Bands 2 & 3 colleagues carry out the screening within audiology services. The Children and Families Care Group remain committed to booking appointments within schools. Discussed at Operational Management Board in February 2023, plans requested from audiology to progress.
ADVISE	**Maternity & Neonatal** **Maternity & Neonatal Safety Support Programme (MatNeoSSP)** • Digital Maternity Cymru A letter was received into the Health Board on 10th January 2023 confirming progress is being made with the Digital Maternity Cymru (DMC) Programme. The Minister for Health and Social Care has approved funding to commence the implementation phase of DMC which will be hosted by Digital Healthcare Wales (DHCW). This will include an all Wales solution including women and pregnant people's access to their digital maternity records through the NHS App and website. An all Wales job description and person specification is being finalized, upon receipt of which CTMUHB will recruit a digital midwife for two years with financial support from the MatNeoSSP. • Peri Prem

Peri Prem Cymru will soon commence as part of the Mat Neo SSP. Funding letters have been received to support clinical time in introducing Perinatal Optimisation across maternity and neonatal services. This project will implement improvement concepts around a number of elements of perinatal optimization which when delivered as part of a 'care bundle' have been shown to significantly improve outcomes for the most vulnerable babies.

- National Review of Maternity and Neonatal Services

In 2022, Welsh Government formally requested Improvement Cymru to undertake the national discovery and diagnostic phase of the MatNeoSSP. In developing the report, safety champions were introduced across all Health Boards in Wales to support with visits, reviews and data collection. At CTMUHB this consists of 0.6wte Band 7 midwife and 0.6wte Band 7 Neonatal Nurse. Site visits by the national review team were carried out in January 2023. Using the Institute of Healthcare Improvement (IHI) Framework for safe, reliable and effective care, 'trigger tool' methodology was also used to quantify and measure instances of good, reliable practice as well as identify variation or deficits across Wales which could lead to harm. The draft report was received into the Health Board on 23rd February 2023 for comment. A further paper will be developed for Quality and Safety Committee once the final report and recommendations have been received.

Industrial action has had minimal impact on children and young people services however the Welsh Ambulance Service Trust (WAST) industrial action has given potential for reduced or delayed ambulance times impacting home birth services and the freestanding midwifery unit. There has been robust focus on communication for women, birthing people and their families during this time.

Gynaecology and Integrated Sexual Health

Getting it Right First Time (GIRFT) national programme ongoing. Monthly task and finish group with clinical representation.

Gynaecology theatre efficiency quality improvement project underway; Prince Charles Hospital teams have held their first session to explore initial pathway mapping.

Menopause services are developing via the Wellness Improvement Service (WISE). This programme will focus on lifestyle interventions for long waiting patients. Educational sessions for primary care underway, further meeting on 21st February 2023.
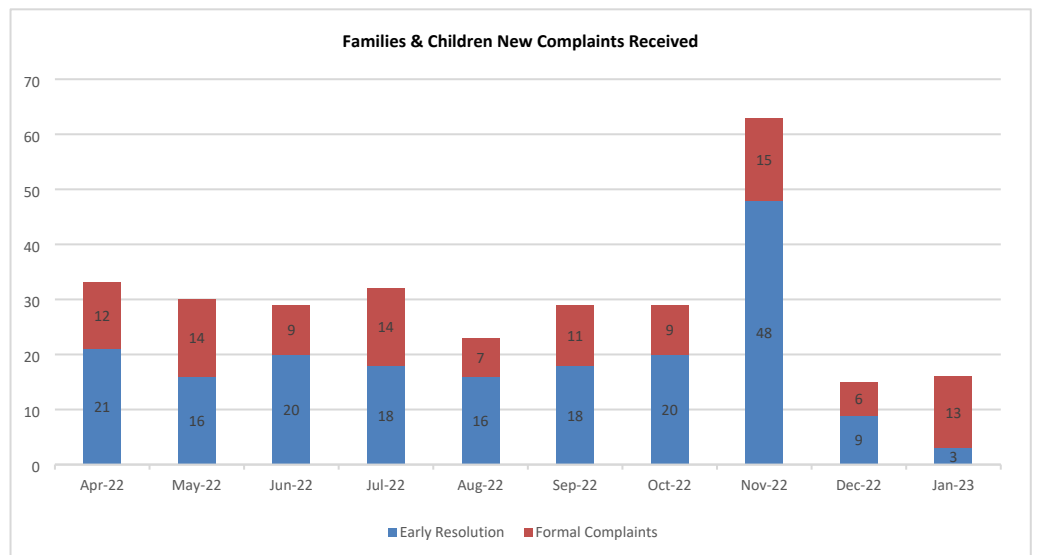
Children and Young People

Paediatric services are exploring the option of introducing a text reminder and electronic triage for paediatric outpatients across three sites.

Paediatric neurodevelopmental services are on track to deliver no waits over 104 weeks by the end of March 2023. This has been achieved through a combination of Planned Care Recovery funding and Regional Partnership Board money which has allowed short-term waiting list activity.

The first Safe Care Collaborative meeting was held on 31st January 2023. Paediatric diabetes is one of the ambulatory work-streams. Project group to be established and iCTM support has been confirmed. The next event is 7th and 8th March 2023. The Care Group has plans in place for paediatric virtual wards to be advanced via the programme.
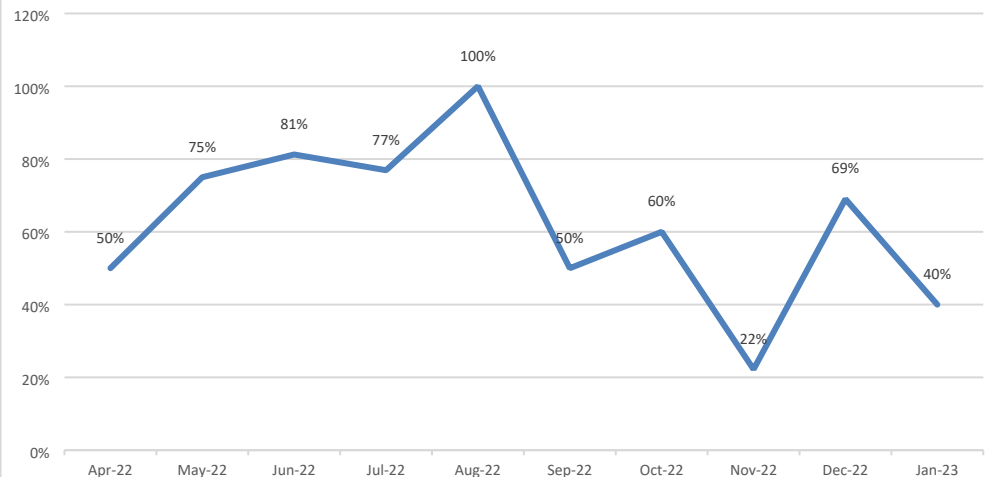
ASSURE

Concerns Management

Families & Children New Complaints Received

Month	Early Resolution	Formal Complaints
Apr-22	21	12
May-22	16	14
Jun-22	20	9
Jul-22	18	14
Aug-22	16	7
Sep-22	18	11
Oct-22	20	9
Nov-22	48	15
Dec-22	9	6
Jan-23	3	13

Legend: ■ Early Resolution ■ Formal Complaints

Families & Children Complaints compliance response rate

Incident Reporting

Families & Children Incidents Reported
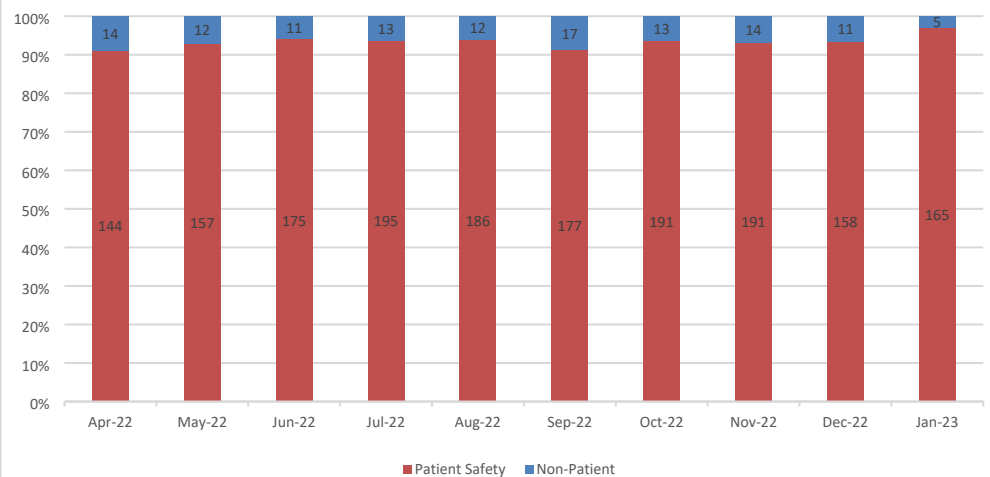
Open LRI & NRI Investigations			
Service Group	**NRI**	**LRI**	**Never Events**
Maternity	8	12	0
Neonatal	5	1	0
Gynae & ISH	0	6	0
CYP	10 including 3 legacy neonatal	5	1 report being finalized with

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Children & Families Care Group Highlight Report | **Page 7 of 12** | **Quality & Safety Committee 16 March 2023**

	patient safety team

- In January 2023, five Maternity Local Reportable Incidents (LRI) multi-disciplinary investigation reports were approved at Assurance and Closure Panel subject to minor comments and amendments.

Safeguarding

Work is progressing to increase the number of multi-disciplinary team members trained within the Care Group (Level 3). Additional sessions were held in December 2022 at Princess of Wales Hospital. Working closely with corporate safeguarding team to ensure training content is appropriate for all areas and staff groups.

Safe sleeping advice and information for families and professionals is developing at pace. Safe sleep week commencing 13th March 2023 working with partner agencies to hold events with increased communication / social media presence.

Ask and Act training implemented to maternity community and maternity support worker teams January 2023.

Safeguarding 'pilot' planned between health visiting and school nursing in Merthyr and Cynon to standardize models of practice.

Annual maternity safeguarding audit shows that 96% of women and pregnant people were asked about domestic abuse in pregnancy. This is an increase of 4% since 2021.

Maternity and Neonatal

The inaugural Maternity and Neonatal Safety Board (MNSB) took place on 19th January 2023. This replaces Maternity and Neonatal Improvement Board (and huddles) as per the Maternity and Neonatal Escalation Framework (December 2022). The MNSB will continue to provide assurance, challenge and oversight of continuous improvement since the de-escalation from special measures and the Independent Maternity Oversight Panel ending on 31st December 2022.

Maternity and Neonatal Quality Improvement (QI) capability is being embedded as business as usual. The first 'all share all learn' QI forum was held on 26th January 2023. There are now

ten staff initiated and led projects underway, three of which are linked to the MatNeoSSP Peri Prem initiative.

PROMPT Wales Quality Assurance visit took place on 10th November 2022. The team noted that the course was well constructed and facilitated and that previous recommendations had been considered and addressed.

Carbon monoxide testing in pregnancy has been reintroduced since May 2022. Currently 93% of community midwives are trained / retrained. Rates of monitoring are included and reviewed via the maternity dashboard and are 60% at booking.

Director of Midwifery and Head of Workforce presented an update of the latest Maternity and Neonatal Culture and Leadership work-stream at People and Culture Committee on 8th February 2023. Work continues at pace, highlights include:

- Labour Ward Coordinator (LWC) seconded to Health Education and Improvement Wales (HEIW) to develop a competency based development programme for aspiring LWCs in Wales / induction programme for newly appointed LWCs.
- Caring for You progressing across the multi-disciplinary team and Care Group. Next steering group meeting 30th March 2023.
- Learning needs analysis developed for all staff groups
- Maternity culture survey to be repeated March 2023.
- Second leadership day for Band 7 midwifery leaders on 27th February 2023.
- Plans in place for leadership away days for Band 8a and above & Band 2-4 workforce.
- Working with HEIW to develop the Band 2-4 workforce as part of MatNeoSSP.
- Heads of Midwifery drop-in sessions held monthly across sites.

Healthcare Inspectorate Wales (HIW) Unannounced Visit to Maternity Services 26-28th September 2022. The final report was received into the Health Board in December 2022. The improvement plan was submitted and accepted by HIW in January 2023. The service received NO immediate assurances. Most actions have been completed with three monthly monitoring arrangements in place through the Service Wide

Assurance Group (SWAG) and Care Group QSE Committee. Outstanding actions being progressed are:-

- Achieve UNICEF Baby Friendly accreditation by October 2023
- Develop a standard operating procedure for equipment repairs to avoid shortages / missing equipment
- Staff survey actions being progressed with well-being, trade union and workforce support through the Culture and Leadership plan / Caring for You initiative.

Gynaecology and Integrated Sexual Health
Cervical Screening Wales (CSW) site visit 29th and 30th March 2022. Outstanding actions are being progressed within the Care Group. Improvement plan updated February 2023 and monitored via the Care Group QSE Committee.

Planned care recovery: Care Group are working with colleagues via Operational Management Board to determine schemes to meet gynaecology recovery targets. An options appraisal is being developed to recover lost theatre sessions.

Children and Young People

St John's Immunisation incident: Letters were sent to all families and a meeting was held between parents and Health Board staff at the school on 8th February 2023. The school nursing team held a vaccination clinic on 13th February 2023 where 48% of children attended for re-vaccination. This incident has now been closed with monitoring arrangements in place.

'Pop up' clinics have been introduced on weekends (Saturday) to address outstanding continence assessments for five year olds. This has led to a reduction in assessments from 55 to 20 as of 23rd February 2023. Evaluation is currently being undertaken and will be presented at Care Group QSE Committee in June 2023.

Patient experience feedback mechanisms are progressing across Children and Young People services. A 'QR' code survey for health visiting services is soon to be available via CIVICA.

| INFORM | **Maternity and Neonatal** |
| | Maternity PROMPT (PRactical Obstetric Multi-professional Training) faculty recently won Wales Faculty of the Year for |

multi-disciplinary (MDT) obstetric emergency training along with six further individual awards.

Eleven nominations have been made to Royal College of Midwives (RCM) national awards.

UNICEF Baby Friendly stage 3 accreditation has been achieved at both Prince Charles and Princess of Wales Hospital neonatal units.

Baby boxes have been introduced for vulnerable families whose babies are being placed into foster care to aid comfort and attachment.

Royal College of Midwives Wales St Davids Day Conference 1st March 2023, six midwives and support workers being supported to attend.

Gynaecology and Integrated Sexual Health
Bereavement nurse working closely with the Care Group to improve the experience of women, pregnant people and families experiencing pregnancy loss <16 weeks gestation. Improvements include families being offered the opportunity to attend communal cremations, information for families and increased support to aid decision making. An update was received at Care Group Quality and Safety Committee on 23rd February 2023. Links are ongoing with charity CRADLE to promote privacy and dignity particularly in areas such as the Emergency Unit.

Patient Reported Experience Measures (PREMS) is due to go live via CIVICA for Gynaecology and Sexual Health services.

The transfer of healthcare responsibility for Parc Prison to CTMUHB is now complete.

Children and Young People
Senior nurse for Health Visiting has accepted an application to Bevan Exemplar (Cohort 8) for bringing the 5 'C's into every day conversation.

Two health visitors have had articles recently published within the Journal of Health Visiting.

| | Vaccination centre colleagues have been supporting school nursing services with the delivery of the Meningococcal ACWY (MenACWY) vaccination programme.

School nursing engagement events held 26th January 2023 and 9th February 2023 with the Group Manager and Deputy Head of Nursing.

Oxygen upgrade to the children's ward at Prince Charles Hospital approved

Patient bathroom on children's ward at Princess of Wales is progressing. This will provide full disability access. |
|---|---|
| **APPENDICES** | **NOT APPLICABLE** |

QUALITY & SAFETY COMMITTEE

HIGHLIGHT REPORT FROM THE DIAGNOSTICS, THERAPIES, PHARMACY AND SPECIALTIES QUALITY, SAFETY, RISK & EXPERIENCE (QSRE) MEETING

DATE OF MEETING	16 March 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carole Tookey, Diagnostics, Therapies, Pharmacy & Specialties Nurse Director
PRESENTED BY	Carole Tookey, Diagnostics, Therapies, Pharmacy & Specialties Nurse Director
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director
REPORT PURPOSE	Noting

ACRONYMS	
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
ITU	Intensive Treatment Unit
HTA	Human Tissue Authority
DTPS	Diagnostics, Therapies, Pharmacy & Specialties
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations

1.   **PURPOSE**

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Specialties Quality, Safety, Risk & Experience Group at its meeting on the 28th February 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	• Compliance with Home Office legislation on controlled drugs for Parc Prison has been met after a significant amount of work by the pharmacy team, and the licence provided. Further work needed to achieve compliance in other sites across CTM footprint including primary care/ community premises'.
ADVISE	• Concerns raised by staff regarding chaperoning for intimate radiological procedures – mitigations in place whilst longer term review is in progress • 7 DTPS risks on the corporate risk register scoring 16 or above: ➢ 3131 Mortuary Capacity remains a risk although reduced since new unit commissioned in mid-January. ➢ 5036 Pathology services unable to meet current workload demands – outsourcing has continued to help mitigate this. ➢ 2721 Capacity to deliver Point of Care (POC) test training. ➢ 4152 Backlog for imaging in all radiological modalities ➢ 4798 Unsafe therapy staffing in PCH/RGH/POW ITUs ➢ 4832 Paediatric pharmacy support RGH ➢ 5178 Staffing & capacity of Medicines management homecare service All risks being reviewed with progress updates for next committee.
ASSURE	• HTA virtual and face to face site inspection performed between 13th – 22nd February 2023. Really positive feedback showing significant improvements from 2018 inspection, HTA will be sharing the CTM model for the oversight and management of HTA regulated activities as an example of good practice

Diagnostics, Therapies, Pharmacy & Specialties Care Group Highlight Report

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	• Work underway to align Datix incidents reports for Care Group to the correct senior team in DTPS. Advised this is likely to conclude by April 2023.
INFORM	• Service Resilience issues in the Biochemistry service – discussions currently underway with provider of managed service contract, an equipment refresh has been identified • Cellular Pathology equipment & estate is limiting ability of the service to meet demand of planned care recovery/single cancer pathway – outsourcing in place at present to support • Serious Hazards of Transfusion (SHOT) gap analysis completed and submitted, for further discussion at Transfusion Committee next week • Positive presentation on the benefits of a Bevan funded Radiology Cancer Navigator role – permanent funding sources being explored • HIW IR(ME)R inspection at POW in September 2022 – most actions now closed and progress made on outstanding recommendations. • Some therapy incidents show an increase in human error e.g. Information Governance errors with reports being sent to wrong people/ included in envelopes. This is being addressed with training but also conscious of impact of staffing numbers and volume of work. Also impact of managing expectations (colleagues and service users) and the impact of verbal aggression is negatively impacting on teams. Well-being champions are in place and leaders share the HB well-being support resources • Air handling unit at RGH aseptics unit is 23 years old and has a likely working life of 3-5 years. Risk Assessment (RA) completed and mitigating actions taken while we prepare a statement of need and capital replacement programme.
APPENDICES	**NOT APPLICABLE**

Diagnostics, Therapies, Pharmacy & Specialties Care Group Highlight Report **Page 3 of 3** **Quality & Safety Committee 16 March 2023**

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AGENDA ITEM
6.3.2e

QUALITY AND SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM PRIMARY COMMUNITY CARE GROUP	
DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lucie Williams, Head of Nursing Primary Care and Communities Jane Armstrong, Clinical Director of Primary Care
PRESENTED BY	Ana Llewellyn, Nurse Director, Primary Community and Mental Health Care Groups
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	NOTING

ACRONYMS	
ED	Emergency Department
GDS	General Dental Services
GMS	General Medical Services
HIW	Health Inspectorate Wales
OOH	Out of Hours
POW	Princess of Wales Hospital
QSRE	Quality, Safety, Risk and Experience Meeting
RN	Registered nurse
ROLE	Recognition of Life Extinct
RTE	Rhondda Taff Ely

D2RA	Discharge to Recovery & Assess

1. INTRODUCTION

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Primary and Communities Care Group. The care group QSRE was cancelled in February due to the number of apologies, although community and primary care quality meetings all took place as planned.
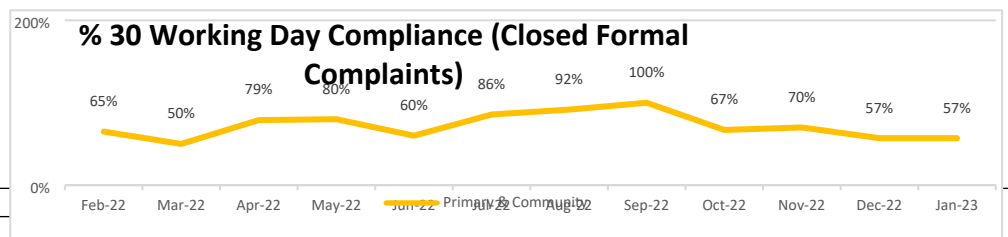
1.2 Key highlights from the care group are reported in section 2.

2. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	• **Quality data** provided by the central team does not currently provide details by locality only care group, which does not allow for full assurance to be provided.
ADVISE	• **Care group structure –** the delay in a confirmed structure is resulting in some uncertainty when managing governance across Communities. The aim is for implementation of new structures across the Health Board by June 2023. • Ongoing issue with access to **Mortality Review** module on **Datix Cymru** for Primary care concerns team. Dedicated central Primary Care inbox has been created for Medical Examiner (ME) Reports due to demand. Process still to be confirmed by central team especially in relation to feedback to family. Delay in putting in process has been raised with the ME Report Review meetings. • **Home Oxygen Financial Risk** - increased pressures in secondary care and need for emergency home oxygen to facilitate discharge will incur added costs. • There are a number of **RN vacancies** across Ysbyty Cwm Rhondda (YCR) and Ysbyty Cwm Cynon (YCC) hospitals. The nursing leadership team are exploring alternative options including overseas recruitment.
ASSURE	• **D2RA** has commenced across Community hospitals, however it is recognised this work is ongoing. • Ongoing work regarding the **District Nursing specification** and action plan. • **RTE community services** has developed a community equipment service model, which is being piloted.

- **RTE community services** has developed a new nebuliser service with governance measures in place.
- Review of **Ward 21, POW (Llynfi)** to be undertaken to align staffing model to Community Hospitals
- **Demand and Capacity** work has commenced for **District Nursing** with support from planning.
- All teams across communities are aware of the need to increase **mandatory training compliance.**
- All communities **concern responses** are undertaken within the timeframe, the only delays experienced are when medical teams have to provided responses.
- Excellent **Aamat compliance** across wards in Community Hospitals in RTE and MC
- **HIW Inspections Update**: Q3: 3 x inspection reports received for independent dental contractors and 2 x inspection reports for GMS contractors- no major actions required. 1 x rescheduled visit planned for 13/3/23.
- **100%** of CTM GMS practices are now using **electronic test requesting**. CTM average currently 88% (Wales 82%)
- All GMS practices have successfully achieved **Phase 1 access Standards** of the GMS contract.
- **GP OOH peer review** actions fully completed
- **Diabetic Retinopathy Pathway**- 100 patients sent to practices per month/316 patients seen to date seen from Aug. 75% do not need to attend HES. 1st app waiting times fallen from 50 wks in Oct'22 to 21 wks in Jan'23. Excellent patient feedback reported.
- The **Special Care Dentistry Consultant** post had been vacant for some time. Following a successful interview 2 individuals have been appointed (1.6 WTE) due to start June 2023.
- **Complaints Closure Compliance** is a priority for the Health Board. There are currently 60 open complaints in the care group with 28 of those complaints still open after 30 days. Complaint closure compliance is currently 57%

% 30 Working Day Compliance (Closed Formal Complaints)

200%

65%　50%　79%　80%　60%　86%　92%　100%　67%　70%　57%　57%

0%

Feb-22　Mar-22　Apr-22　May-22　Jun-22　Primary & Community　Aug-22　Sep-22　Oct-22　Nov-22　Dec-22　Jan-23

Primary and Community Highlight Report

Quality and Safety Committee 16th March 2023

	• Between 24/22/22-31/12/22 there have been **36 concerns** made to the Health Board in relation to Primary care services: 12 Formal complaints, 21 early resolutions and 3 enquiries (3 from MS/MP). There has been no significant increase in this reporting time. • There is one Locally Reportable Incident and two Nationally Reportable Incidents open and all 3 incidents are within timescales for completion.
INFORM	• Engagement process for the redevelopment of **Maesteg Hospital** commenced. • **Marie Curie contract** has been extended for 1 year but requires a review of the services provided. • **District Nursing night service** to be aligned to one service • **Bridgend Group Practice** have successfully been awarded the contract to provide GMS services following a successful tender process for Ogmore Vale. This will ensure that ongoing GMS services will be provided to the residents of this area following the planned retirement of the existing partner. • **Rhondda Urgent Primary Care** Service in present model to end 31/3/2023 with a clear exit plan in development. The new direction of work aligns with the 6 Goals - Navigation HUB project board set up to produce and implement a standardised Navigation Hub approach, inclusive of implementation, workforce and communication plans that reflects examples of good practice from models elsewhere in the UK. • **111 Press 2 – MH Practitioners** due to commence at Ty Elai with plan for team to be fully established by end of financial year. • **Navigation Hub pathways** launched – ROLE, Nursing Homes, ED Redirection • **GDS Contract Reform**: New measures released from WG to take effect from 1/04/23
APPENDICES	Choose an item.

3.   RECCOMENDATION

3.1   The Committee is requested to **NOTE** the report.

Primary and Community
Highlight Report

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QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE MENTAL HEALTH AND LEARNING DISABILITIES CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	16th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ana Llewellyn, Nurse Director, Primary Community and Mental Health Care Groups
PRESENTED BY	Ana Llewellyn, Nurse Director, Primary Community and Mental Health Care Groups
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Director of Nursing

REPORT PURPOSE	NOTING

ACRONYMS	
HIW	Health Inspectorate Wales
POW	Princess of Wales
SBAR	Situation Background Assessment Recommendations Report
SIF	Service Improvement Fund
WCCIS	Welsh Community Care Information System

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its meeting on 1st February 2023.

1.2 Key highlights from the meeting are reported in section 2.
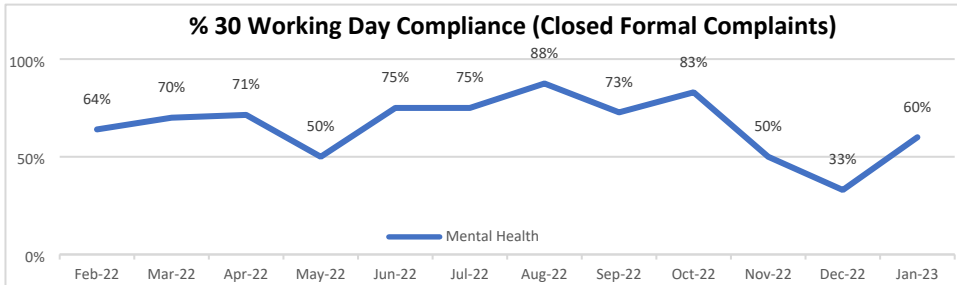
1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	• Committee is advised of limited progress towards a **Single Clinical Record System** *(Datix Risk Register ID 3337). A* full review of mitigations in place is being undertaken and linked to recommendations in HIW Discharge review. 22/23 new SIF funding enabled operational post and additional quality improvement lead to work on preparation for WCCIS when project of rollout commences. Business case developed and considered by Executive Team but no confirmation of funding source for the project to date. • The **limited availability of CPR and other face-to-face training** that is outside of the control of the care group is impacting on mandatory and statutory training compliance. • There continue to be **Datix Quality and Quality Governance Challenges** due to both the implementation of the new datix system and due to operating model changes. The Care Group have been working closely with the central quality and safety team who are progressing alignment of datix hierarchies to the Care Group. The central quality and safety governance team will be aligned to the care group from 1st April 2023. Inaccuracies in data will continue until all of this work is completed.

ADVISE	• **MHLD Commissioned Services Subject to Enhanced Monitoring**
	  o 2 Low Secure services; Cygnet Kewstoke Milton ward closing with 2 CTM patients with alternative placements identified, Heatherwood Court has Level 2 Performance Improvement Plan monitored by NHS Wales.
	  o 2 care homes within CTM; Caerlan Farm LD residential setting and Willows EMI Nursing Home subject to Joint Interagency Management Plan.
	  o 1 LD care home Cartref Mynydd residential setting in Cardiff and Vale subject to 'Notice of Improvement' by Care Inspectorate Wales.
	Progress on these services is monitored through increased site visits (announced and unannounced), participation statutory processes and regular intelligence sharing across professionals and organisations.

	• There is limited **Capacity in Low Secure Services for Female Patients** across the United Kingdom. This has resulted to the prolonged use of seclusion at the Psychiatric Intensive Care Unit at POW. The CSG have submitted an SBAR to Care Group Directors to provide assurance of actions taken to mitigate and manage patient risk. • The Delivery Unit completed a **Review of Primary and Secondary Care CAMHS** and submitted their report to the Health Board at the end of November 2022. Seven recommendations were made relating to the Part 1 scheme, the model; and demand and capacity issues. An action plan was developed in January 2023 and is monitored via the QSRE Board. • A short term solution provided for **Crisis Assessment Facilities at PCH** as part of the ongoing estates improvement at PCH is proving not to be suitable for all stakeholders. There has been delay in the provision of a medium term solution due to the cost of capital works. The MHLD Care Group have been working with the Deputy COO for Acute Services to approve the progression of a lower cost, risk assessed medium term arrangement.
ASSURE	• A **Quality Improvement Programme** has been developed for the care group with three main priorities: in-patient services, older adult in-patient falls (as part of the national IHI / Improvement Cymru Safe Care Collaborative) and Reducing Restrictive Practice. An initial virtual workshop was held on 14th February and leads identified for all of the in-patient improvement workstreams. An in-person workshop is planned for 26th April to monitor progress. • The Deputy COO has oversight of a full recovery plan for **Mental Health Measure Performance** with trajectories for improvement for CAMHS: **Part 1a Mental Health Measure CAMHS – Assessment** Over 28 days trajectory Performance – seen in 28 days • Q1 200 35% • Q2 100 40% • Q3 50 50% • Q4 10 70% **Part 1b Mental Health Measure CAMHS – Interventions**

Mental Health & Learning Disabilities Care Group Highlight Report   **Page 3 of 5**   **Quality & Safety Committee 16 March 2023**

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Over 28 days trajectory   Performance – intervention started in 28 days

- Q1   160   35%
- Q2   120   40%
- Q3   80   50%
- Q4   40   60%

Significant validation process work and the planning of additional sessions for care and treatment planning has been taking place and **Part 2 Mental Health Measure CAMHS** performance has improved from 37.4% December 2022 to 85.6% in January 2023 with the expectation of achieving and sustaining 90% by March 2023.

- **Complaint Closure Compliance** is a key priority for the Health Board. Compliance in the MHLD Care Group is currently at 60%. The low volume of formal complaints can artificially skew the reporting and as of 1st March 2023 there are only 2 formal complaints that have not been responded to within 30 days.

% 30 Working Day Compliance (Closed Formal Complaints)

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Mental Health	64%	70%	71%	50%	75%	75%	88%	73%	83%	50%	33%	60%

- There are 6 open **Nationally Reportable Incidents** with 4 of those overdue for completion. These cases are complex and are being actively managed. The data from the central governance team reports that there are 20 open **Locally Reportable Incidents.** There is further work to validate this figure and monitor the progress against these LRIs.

INFORM

- The **3rd cycle of the LD Inpatient Audit** has been completed with CTM returning 25 inpatients at time of the audit, which is an increase of 4 since the previous quarter. Increase is result of revised scope of the audit. Delivery Unit plan to undertake a deep dive into 40% of the patients with the longest delayed transfer of care.

Mental Health & Learning Disabilities Care Group Highlight Report   **Page 4 of 5**   **Quality & Safety Committee 16 March 2023**

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	• The **repatriation of Community CAMHS to Swansea Bay UHB** is progressing as planned and is on track for transfer at the end of March 2023. • The Delivery Unit are currently undertaking a **Review of Memory Assessment Services** as part of a wider national review. Any recommendations will be monitored via the Care Group QSRE meeting.
APPENDICES	Choose an item.

QUALITY & SAFETY COMMITTEE

CHIEF OPERATING OFFICER'S REPORT ON OVERARCHING Q&S ISSUES WITHIN THE COO PORTFOLIO

Date of meeting	16 March 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	Executive Director of Operations

Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
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
WISE	Wellness Improvement Service
NCCU	National Collaborative Commissioning Unit
FAST	Face, Arm, Speech, Time

1. SITUATION / BACKGROUND

This brief paper provides an overarching update on a range of issues within the remit of the Chief Operating Officer.

The areas include:

- An update on the risk register issues touched on in the last report including:

  - Diagnostics including LINC
  - Planned Care – Waiting Times
  - Cancer Services
  - Ambulance Handover and Red Release
  - Internal Audit Follow Up
  - Stroke Services

- A range of more diverse update matters across Care Groups

Colleagues will understand that 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 Diagnostics including LINC

There has been progress with the highest scoring risks as follows:

- Mortuary Capacity – to address issues around insufficient capacity, additional space has now been in use since mid January. This has reduced the risk to a score of 12;

- Pathology services unable to meet current workload demands – and action has been taken in the following areas:

  o The outsourcing of cell path backlog was successful and approval has been given to continue through Quarter 4. A further proposal has been submitted for 2023 – 2024 while the Care Group works through potential regional solutions.

- Cellular Pathology & Mortuary staff resource, backlog and delays – vacant posts were placed on TRAC, now the Care Group has progressed to awaiting advert and Royal College response to interview for the two consultant posts.

For the LINC process, feedback has now been provided to Digital Healthcare Wales (DHCW) with many concerns around traction and ability to deliver the programme and a revised plan has been sought by 8 March 2023. This will be reviewed at, and next steps identified at, the next LINC programme board on the 14 March 2023.

2.2 Planned Care – Waiting Times

Performance on Waiting Times remains fairly static, with small reductions across the UHB. Key matters of interest to committee members include:

- it is anticipated that the length of wait 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 actions being taken to increase capacity including extra clinics and theatre sessions in Ophthalmology and ENT, the recruitment of Locum Consultants and additional Pharmacy and Primary Care resource in Dermatology;

- There is additional focus on waits in Rheumatology, Cardiology, Dermatology and Breast Surgery with transfer of patients across locality / consultant waiting lists, additional clinics and re-direction of referrals to WISE are in place;

- Improvement programmes are in place to realise efficiencies in outpatient departments;

- Additional Inpatient/Day Case (IP / DC) capacity is in place running to the end of March in the first instance through the insourcing of theatre staff enabling the centralisation of Orthopaedic inpatient activity and more concentrated day case capacity in PCH. Insourcing in PCH theatres is anticipated to deliver additional cases each week;

- As per the charts below, the number of weekly elective treatments has been very slightly increasing, with the average number of treatments for February 2023 similar to that of January at 624 treatments per week. Despite this increase, elective cases are still around 24% fewer than pre-pandemic levels.

CTM Total Elective Activity
(week ending 10th May 2020 to 26th February 2023)
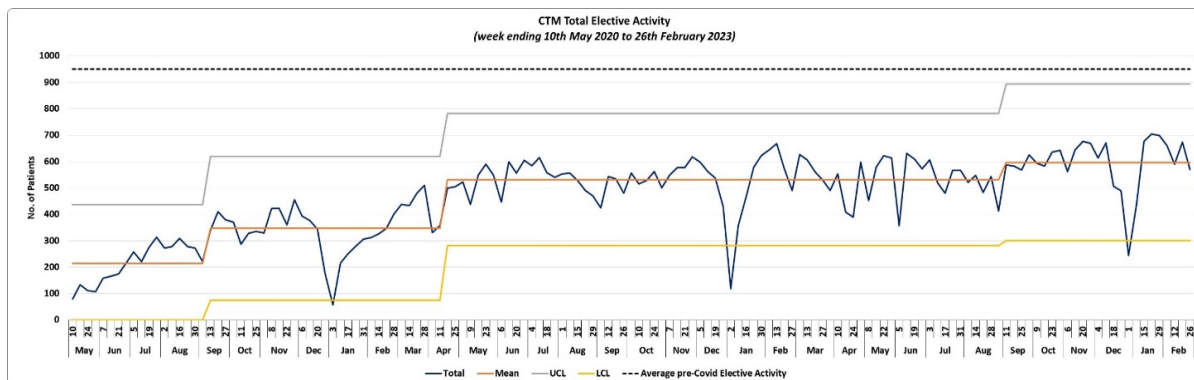
Further detailed information is available if required – committee members will be reassured to know that there are plans to mitigate activity issues wherever possible.

2.3   Cancer Services

Cancer performance remains subject to the highest level of concern and escalation at all levels internally. Weekly cancer assurance meetings continue, attended by all specialty leads, chaired by the Planned Care Director and reports and escalations made weekly to the COO and Medical Director as appropriate.

SCP target 75%	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb*
Total Treated	298	229	298	271	303	291	279	316	310	249	289	223
Total Treated in Target	135	119	134	135	145	134	129	139	145	97	110	103
Total Breached	163	110	164	136	158	157	150	177	165	152	179	120
Performance %	45.3	52.0	45.2	49.8	47.9	46.0	46.2	44.0	46.8	39.0	38.1	46.2
Retrospective performance %	46.5	52.1	44.9	52.3	48.5	45.9	47.2	43.3	47.8	40.3		

As has been the case hitherto, reduction of the backlog remains the focus, and the UHB has now demonstrated a sustained reduction in 62 day volumes consecutively for a five month period. The predicted performance for February 2023 currently is 46.2% which is an unvalidated position.

The biggest concern and the significant factor for not achieving targets continue to relate to the total number of active patients waiting at first outpatient (39%) and diagnostic stage (41%) of their pathway. This accounts for 80% of all active patients on the suspected cancer pathway, an improvement of 2% from last month.

Diagnostic delays in radiology, endoscopy and pathology and delays at tertiary sites for treatment are also significant contributors to under achievement.

The focus on treating the longest waiting patients and reducing backlog continues. Deterioration in performance is identified in Lung and Skin specialties whilst all other specialties showed improvement, committee members will be reassured to hear that plans for improvement are in place across the UHB and this remains.

2.4 Ambulance Delays and Red Release

The work around these important indicators continues, with the following of note:

- Colleagues will be aware that a "Navigation Hub" has been established through Primary Care Leads, allowing WAST, Nursing Homes and other professionals direct access to a GP with the aim of 'safety netting' and keeping patients in the community. Work has now moved to liaison with WAST and NCCU to increase the utilisation of the service;

- Work is ongoing constantly with colleagues in Local Authorities on a care home placement or package of care. This is a constant work in progress and the position has remained stable, with a marginal improvement from 150 to 142.

The work ongoing in this area is significant and this is a summary of the key areas – further information is available if needed.

In terms of Red Release, Colleagues will be pleased to note that progress continues as follows:

- The Immediate Release Standard Operating Procedure (SOP) and Pre Emptive Boarding SOP are under review by the Unscheduled Care Group, and will feature as part of the revised Escalation Framework being developed;

- Surge capacity opened across all three sites remains in place to improve flow and capacity to red release.

2.5 Internal Audit Follow Up

Detailed information has now been provided to Service Groups to enable them to comment on the way that closed pathways, watch lists and outcoming are managed, including a summary of the areas of concern where additional training may be needed.

It is anticipated that this assistance with the detail will result in further progress – and the Care Groups will be reminded about the importance of ensuring the audit is completed. Internal Audit colleagues have been consulted and kept updated.

2.6 Stroke Services

In January 2023, the Board received a briefing on the local, regional and national current position and plan for stroke services. Committee members are aware of challenges faced within the service at present, along with the performance against the Quality Indicator Measures (QIMs). Acute system pressures, inequity in service provision across CTM, a fragile workforce, and five day per week clinical workforce model all impact on the stroke service quality and performance.

Work has been recently completed to understand, risk assess and cost the additional resource that would be required to deliver a SSNAP (Sentinel Stroke National Audit Programme) A-rated service. It was initially anticipated that additional recurrent resource could be identified from within the Planned Care Recovery monies but this has not been possible and has been specifically brought to the attention of the Chief Executive of NHS Wales.

Prevention and early intervention – recruitment is underway following the successful bid for a project to identify and manage the two major clinical risk factors for stroke: hypertension and atrial fibrillation. Conversations are underway at a national level regarding a national re-run of the FAST campaign. Funding has been identified to run the FAST campaign locally.

Acute Care – a process is in place to ring-fence a stroke bed at both POW and PCH. This supports admission to a stroke bed within four hours, but is not possible during times of extreme pressures. Work is progressing for an aligned clinical pathway for stroke management. Unified criteria for thrombolysis is in place for both sites and significant progress has been made in anticipation of the thrombectomy service at Bristol being available 24/7. Updated guidance from the Royal College of Physicians is anticipated in April, with preparatory work underway to implement the new guidance. For some patients, this will result in an increased window of opportunity for certain specialist treatments.

SSNAP results for October-December 2022 result in PCH's overall rating increasing to a level B. It is the first time that this has been achieved since Covid. POW's rating remains at a level C. In November 2022 (latest benchmarking data), CTM demonstrated the best performance in Wales for thrombolysis within 45 minutes and was the third best performing Board for scans within one hour. We performed poorly in relation to admission to a stroke bed within four hours and assessment by a stroke consultant within 24 hours.

Regional developments – the South Central Wales Regional Stroke Programme continues to progress. A CTM Stroke Consultant has been appointed as the regional clinical lead.

2.7   Children & Families

Progress on a broad range of issues is included in the full report elsewhere but committee members will be pleased to hear about the following:

- The Maternity and Neonatal Improvement Programme ends on 31 March 2023, and all the planned changes have been embedded. A wash up meeting and handover arrangements are being planned;

- In Gynaecology, a Theatre Efficiency Quality Improvement Project is underway – with pathway mapping having occurred as a first step;

- In Paediatric Neurodevelopment, it is anticipated that there will be no waits over 104 weeks by the end of March 2023.

2.8   Planned Care

Progress continues and committee members will be interested in the following:

- The Human Tissue Authority (HTA) held a virtual and face to face site inspection in February 2023. Very positive feedback was received showing significant improvements from the 2018 inspection;

- Compliance with Home Office legislation on controlled drugs for Parc Prison has been met after significant work by the pharmacy team. Further work is needed to achieve compliance in other sites across CTM footprint.

2.9   Unscheduled Care

The Unscheduled Care Group has had another busy period, with areas of note including:

- Healthcare Inspectorate Wales (HIW) made an announced inspection of stroke services at the Princess of Wales Hospital (POW) on 25 January 2023. The initial feedback was positive, official feedback will be received from HIW within the forthcoming weeks;

- Following an OCP process, complaints have been transferred to a central quality governance team within the organisation, with the aim of maintaining equity, consistency and strengthen resilience. There has been a significant reduction in complaints (nearly 50%) between December 2022 and January 2023. Unscheduled Care compliance with the 30 day target remains poor however the leadership team has established an escalation mechanism which will be closely monitored by the team with a significant improvement trajectory expected

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 all 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 & SAFETY COMMITTEE

STROKE SERVICES – PROGRESS REPORT

Date of meeting	16/03/2023

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

Prepared by	Kevin Duff, Head of Strategic Planning and Commissioning Sarah Follows, Director of Operations – Urgent Care
Presented by	Lauren Edwards, Executive Director of Therapies and Health Science
Approving Executive Sponsor	Executive 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**

ACRONYMS	
	PCH – Prince Charles Hospital POWH – Princess of Wales Hospital YCRH – Ysbyty Cwm Rhondda Hospital ESD – Early Supported Discharge SSNAP – Stroke Sentinel National Audit Programme MDT - Multi-Disciplinary Team WAST –Welsh Ambulance Service Trust CTM UHB – Cwm Taf Morgannwg University Health Board QIMs – Quality Improvement Measures FAST – Face, Arm, Speech, Time

1. SITUATION/BACKGROUND

1.1 Stroke remains the fourth leading cause of death in Wales and can have significant long-term effects on survivors and their families. The prevalence of people living with the impacts of stroke is increasing due to a decrease in mortality from stroke and an ageing population.

1.2 In September 2022, the Quality and Safety Committee received a progress report on stroke services in CTMUHB which outlined a number of short, medium and long term measures being taken by the health board Stroke Planning Group to further improve the quality of care in CTMUHB's stroke services. It was agreed to have a six monthly cycle of progress reporting on stroke to the Quality and Safety Committee.

1.3 The stroke equity audit undertaken by Dr Hamilton-Kirkwood exposed inequities in stroke service provision and made numerous recommendations. The recommendations and actions were presented to the Senior Leadership Group in February 2022 and were acknowledged and accepted.

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

PROGRESS SINCE LAST UPDATE (SEPTEMBER 2022)

Stroke Task and Finish Group/Unscheduled Care Group

2.1 In August 2022, the CTM Urgent and Emergency Care (UEC) 6 Goals Programme established a Stroke Task and Finish Group to rapidly further develop and progress a robust and resilient stroke pathway within the acute hospital setting. This operationally-led and clinically-informed group progressed actions from the Stroke Equity Audit that did not require additional resource.

2.2 The Stroke Task and Finish Group undertook a further risk assessment of the pathway, rated and ranked the risks, and then identified and costed elements of the pathway that require further investment.

2.3 The significantly challenged financial picture and volume of competing priorities has resulted in no additional funding for stroke being identified in 2022/23 or 2023/24. Welsh Government has been advised of this in a letter regarding the 2023/26 IMTP, dated 28/02/23.

2.4 Some service developments have been achieved, but progress is limited without additional resource and due to sustained pressures across acute services.

South Central Wales Regional Stroke Network Programme

2.5 Cooperative working between Cwm Taf Morgannwg and Cardiff and Vale University Health Boards has enabled good progress in the development of regional working across the two Health Board areas. The work to develop a regional approach will fit with the vision for stroke services across Wales, which is for the development of comprehensive regional stroke centres (CRSC) functioning within regional stroke networks.

2.6 A governance and programme structure is in place, sitting as part of the South East Wales portfolio alongside diagnostics, ophthalmology and orthopaedics. The structure includes a programme board involving key stakeholders, including WAST, Public Health colleagues and the Third Sector. A small programme team, including a programme manager and clinical lead (a CTM Stroke Consultant) has also been established.

2.7 The national stroke programme is working with the Delivery Unit to undertake demand and capacity modelling. Colleagues from across both Cwm Taf Morgannwg and Cardiff and Vale UHBs have been invited to shape the model and its outputs. This work will inform the development of our new pathways and will underpin the national case for change and the development of regional and national business cases.

2.8 The service specifications, which will help determine our clinical model and pathways, will now be developed as part of the national stroke programme and we hope to bring colleagues back together in Spring 2023 to use the specifications to inform our regional model.

CTM UHB Stroke Strategy Group

2.9 A review of governance around the strategic development of stroke services in CTM UHB led to the establishment of the CTM UHB Stroke Strategy Group (replacing the previous Stroke Planning Group) in December 2022 to provide oversight on the development and improvement in provision of services across the breadth of the stroke pathway from prevention/early intervention, through to acute treatment and care and rehabilitation. Action plan is at **Appendix 1**.

2.10 The strategy group receives updates from three work streams:
- Acute care and rehabilitation

- Prevention and early intervention
- Regional and national developments.

Service developments and improvements

2.11 In May 2022, Public Health, Primary Care and Planning submitted a bid for funding to Welsh Government through the CTM Value Based Health Care team. The project is in the implementation phase, aiming to increase capacity in the current Health Check Programme team in CTM, including: a band 7 prescribing nurse; additional lifestyle advisors; project and analyst support; and sessional time for a GP with Special Interest/Clinical Lead.

2.12 Work has been progressed by colleagues in Public Health, working closely with the Stroke Association, to re-launch the FAST campaign locally across the CTM UHB area to promote early identification of stroke by members of the public and accessing services as early as possible.

2.13 Data collection has been completed and analysis is underway for stroke patients presenting at Royal Glamorgan Hospital (conveyed by WAST and self-presenting. This is due for completion by 27th February 2023 and will inform next steps.

2.14 Demand and capacity/bed modelling for CTM is in progress, to include predictive population risk and impact on increasing demand. This is due for completion by 10th March 2023.

2.15 An action taken forward from both the Stroke and Bed Management Task and Finish Groups is ring-fencing stroke capacity on a daily basis. A daily plan to create a ring-fenced stroke bed in PCH and POWH is confirmed through daily flow calls. Confirmation of stroke demand on all three sites (PCH, RGH and POWH) is communicated through daily flow calls. Protection of these ring-fenced beds is adversely affected at times of significant pressure in our acute sites.

2.16 Work continues to prepare CTM services for the planned 24/7 access to thrombectomy in Bristol and new Royal College of Physicians guidance that is anticipated in April 2023:
- Radiographer-approved CT Angiograms(CTA)
- Implementing CT perfusion (CTP) scanning to extend the window for thrombolysis and thrombectomy
- New unified thrombolysis and thrombectomy pathway
- Implementation of Brainomix, AI software for interpretation of CTA and CTP, to help streamline thrombectomy
- Awaiting date for 24/7 'go live'.

Quality Improvement Measure performance

2.17 The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides an overview to the Health Board against 4 national Quality Improvement Measures (QIMs) which are part of the suite of improvement measures in the SSNAP:

- direct admission to an acute stroke unit within 4 hours
- thrombolysis with a door to needle time within 45 minutes [1]
- CT scan within 1 hour
- assessment by a stroke consultant within 24 hours

2.18 The latest performance report against the four QIMs is attached at **Appendix 2**. Performance remains low against some key indicators, and this is a picture that is replicated across Wales. Some of the issues faced reflect the challenges faced in providing timely emergency care during a prolonged period of acute pressures. Overall, patient flow challenges on both the POWH and PCH sites have had a direct impact on the stroke pathway.

2.19 SSNAP quarterly results for October-December 2022 result in PCH's overall rating increasing to a level B. This is a significant achievement and is the first time that this has been achieved since Covid. POW's overall rating remains at a level E. Summary scores can be seen at **Appendix 3**.

2.20 In December 2022 (latest benchmarking data), CTM demonstrated the best performance in Wales for thrombolysis within 45 minutes and was the 2nd best performing HB for scans within 1 hour. We performed poorly in relation to admission to a stroke bed within 4 hours (ranked as performing 3rd in Wales) and assessment by a stroke consultant within 24 hours (ranked lowest in Wales).

Organisational Risk Register

2.21 Demand, capacity and performance challenges across the stroke pathway are recognised as a risk in the CTMUHB Organisational Risk Register. The risk is included at **Appendix 4**.

Next steps

2.22 Work is progressing through the Stroke Strategy Group to link with the Improvement CTM Team to support the transformational agenda around stroke services. This is accompanied by initial contact with the university sector to identify opportunities for partnership working to support the development of staff and services for stroke in the Health Board.

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[1] Drug Treatment known as Thrombolysis is used as soon as possible following the stroke to dissolve the blood clot.

2.23 Senior appointments within the Unscheduled Care Group have now been completed. A nominated senior operations lead will be given overarching responsibility for stroke services across CTM. The Service Director is pulling together key stakeholders in order to:

- Develop the overarching strategy for stroke patients
- Formalise the action plans to operationalise quality and safety improvements, including –
    - Pathway efficiency
    - Clinical outcomes
    - Sustainable stroke services
    - Trajectories for improvement
    - Further alignment of services across PCH and POW.

2.24 Based on feedback from discussions in both Quality and Safety Committee and also Planning, Performance and Finance Committee, the group described above will develop and action plan that incorporates current and newly-identified actions with clear action owners and delivery dates. Target trajectories for improvement will be set and reported against.

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

3.11 Significant pressures across all acute sites impact the ability to maintain ring-fenced stroke beds, affecting performance against the target to admit to a stroke unit within 4 hours of admission.

3.12 Performance challenges against the target for assessment by a stroke consultant within 24 hours reflects the current 5 day working clinical model of the stroke team. Additional resource would be required to address these challenges.

3.13 Significant discharge issues for stroke patients at the POWH site relate to the lack of ESD and community rehabilitation beds to improve flow through the stroke ward. Additional stroke rehab beds and extension of ESD to include Bridgend are both associated with significant cost.

3.14 The need to strive for continuous improvement to the stroke pathway in CTMUHB is recognised at Board level. Dedicated operational senior leadership will facilitate improved traction with implementing flow and discharge improvements across stroke services, within current resource.

3.15 Additional resource requirements for stroke service have been costed and ranked by the Stroke Task and Finish Group. This information is available should funds become available to the Health Board.

3.16 It is anticipated that internal service improvements coupled with regional developments and changes to national guidance will lead to improvements in the quality of the stroke pathway for CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Significant challenges delivering a consistent high-quality stroke pathway across CTM.
Related Health and Care standard(s)	Timely Care
	If more than one Healthcare Standard applies please list below: • Effective Care • Dignified Care • Safe Care • Staying Healthy • 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) EIA to be undertaken as part of further work if 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 Quality and Safety Committee are asked to:

- Note the significant challenges faced across CTM stroke services, reflected in the QIM performance data

- Note the inability to identify additional resource to support stroke service developments due to the challenged financial position across CTM

- Note the developments made in some aspects of the stroke pathway

- Note the focused work on the stroke pathway undertaken through the Stroke Task and Finish Group reporting to the Stroke Strategy Group.

- Note the plan for dedicated senior operational leadership to drive forward stroke service improvements.

- Note the regional and national work being undertaken to develop high quality prevention, identification and treatment for stroke.

Appendix 1

Stroke Action Plan

Key to RAG rating

Green = complete

Amber = work progressing with issues to address

Red = no progress

Short Term

	Action	Review Date	RAG Rating	Progress
1.	Review policy for transfer of acute stroke patients from RGH to PCH	April 2023		Draft being actively explored with operational leads at RGH and PCH, with a view to inclusion of an appropriate time period for awaiting transfer. Deep dive data/analysis expected March 2023.
2.	Check use of WAST/CTMUHB Pathway for Stroke	April 2023		Copy of WAST protocol/pathway received. Initial discussions with WAST suggest inability to tailor advice based on patient location. Ongoing.
3.	Use of electronic whiteboard to review therapy activity, caseload, numbers awaiting transfer in order to aid flow and transfer of care between PCH and YCR.	April 2023		Launched in January 2023.

4.	Provision of Therapy Space at POWH	June 2022		Complete - Handed over in May 2022.
5.	Provide ring-fenced beds on Stroke Wards	Ongoing		Action taken forward from Stroke and Bed Management Task and Finish Groups to re-start ring fencing stroke capacity on a daily basis. Daily plan to create a ring fenced bed for stroke in PCH and POWH to be confirmed through daily flow calls Complete – monitor use of plan on daily flow calls. Impacted by acute pressures.
6.	Development of single evidence-based care pathways across both sites	April 2023		Work progressing to develop a single operating procedure of how patients are handled from when they are assessed as having a stroke, from ambulance control or from home, and how handover is progressed to the stroke team. Continued work ongoing with clinicians across both acute hospital sites (PCH and POWH) to improve the stroke pathway looking at CT scanning, 7 day therapy and access to stroke unit (November 2022).
7.	Development of single evidence-based care pathway for thrombolysis	September 2022		Unified criteria for thrombolysis agreed across both sites.
8.	Review current pathway for Orthoptics and explore potential for unification of service across CTMUHB	April 2023		Attend anywhere video consultations and additional phone consultations have been put in progress to address W/L in North CTM. Training of staff in these localities has also commenced, which should lead to a more aligned service across localities. Head of Orthoptics post now vacant.
9.	Optimisation of medication and compliance for patients on Primary Care Atrial Fibrillation (AF) and Hypertension Registers. Case Detection of patients with AF and Hypertension.	April 2023		CTM UHB Value Based Health Care Business case successful as part of Regional Business Case. Work progressing on implementation.

Medium Term

1.	CTM UHB Stroke Task and Finish Group to scope clinical pathway across CTM UHB, develop workforce model and associated costs to include consideration of:	April 2023		Work completed by the Task and Finish Group but it has not possible to identify additional resource at this time, but information/plan ready should some become available.
	i. development of a single specialist bedded stroke rehabilitation unit for CTM to support flow from the acute sites and so increase acute stroke bed availability			Senior operational leads will work with clinical teams to develop improvement plan to ensure best use of current resource.
	ii. 7 day working of stroke teams (inc. medics, nurses and therapists) additional Junior Doctor hours, including 7day working			
	iii. provision of additional Advanced Nurse Practitioners to support the stroke pathway			
	iv. consider requirement for additional Stroke Consultant Capacity			
	v. provision of ESD service across CTMUHB footprint			
	vi. explore potential for increased inpatient stroke rehabilitation capacity in YCR			
	ii. appointment of a co-ordinator at YCR to improve communication with patients and families and free up medical, nursing and therapy time.			
2.	Develop ability to transfer patients with nasogastric tubes to YCR	September 2022		Protocol established and 2 recent admissions accepted. Complete.
3.	Explore reasons for delay in accessing help and arriving at PCH. In some cases this delay is a median time of 15 hours if travelling by own transport.	April 2023		Work has been undertaken to validate the data on the delays. It appears that delays have increased to both units but particularly in arriving at PCH when using own transport. Further work is being undertaken to understand reasons for the delay but likely multi-factorial (delay in recognition of symptoms, WAST waiting times, reluctance to seek health care, etc).Work on going but no clear reason for the delay(February 2023)

| | | | | Preliminary discussions are taking place on re-running the FAST campaign and there may be scope for targeting those with risk factors to proactively educate them in recognition of symptoms.

Stroke association felt that they could not undertake any audit without funding. (February 2023) |
|---|---|---|---|---|
| 4. | Improve access to thrombectomy at Bristol. | April 2023 | | Bristol thrombectomy service to go 24/7, improving access for both PCH and POWH.

Improvements being made to the pathway for CT scans and additional training for middle grade doctors planned in preparation for thrombectomy service going 24/7. |

Long Term

1.	Work with Cardiff and Vale UHB to explore potential for regional working and regional enhanced stroke unit	April 2023		A governance and programme structure is in place, sitting as part of the South East Wales portfolio alongside diagnostics, ophthalmology and orthopaedics. The structure includes a programme board involving key stakeholders, including WAST, Public Health colleagues and the Third Sector. A small programme team, including a programme manager and clinical lead has also been established.

Phase 1 of the programme has entailed scoping and discovery, and engagement with stakeholders has commenced both internally to each organisation and with key partners including WAST, Stroke Association and Community Health Councils. |

Appendix 2

Quality Improvement Measures across PCH and POWH

The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides the Health Board with an overview of 4 national Quality Improvement Measures (QIMs), which are part of the suite of improvement measures in the SSNAP:
• Direct admission to an acute stroke unit within 4 hours
• Thrombolysis with a door to needle time within 45 minutes
• CT scan within 1 hour
• Assessment by a stroke consultant within 24 hours.

Overall, patient flow challenges on both the POWH and PCH sites have had a direct impact upon the ability to admit people to a stroke ward within 4 hours. In addition, increased length of stay for stroke patients at the POWH site is linked to the lack of access to ESD and community rehabilitation beds to support flow.

Challenges in meeting the target for assessment by a stroke consultant within 24 hours, reflects the current 5 day working model of the stroke team. Challenges remain with numbers of stroke patients continuing to present at the Royal Glamorgan Hospital, leading to delays in accessing the stroke pathway at PCH.

% compliance with direct admission to an acute stroke unit within 4 hours

PCH - % of patients who have a direct admission to an acute stroke unit within 4 hours

POW - % of patients who have a direct admission to an acute stroke unit within 4 hours
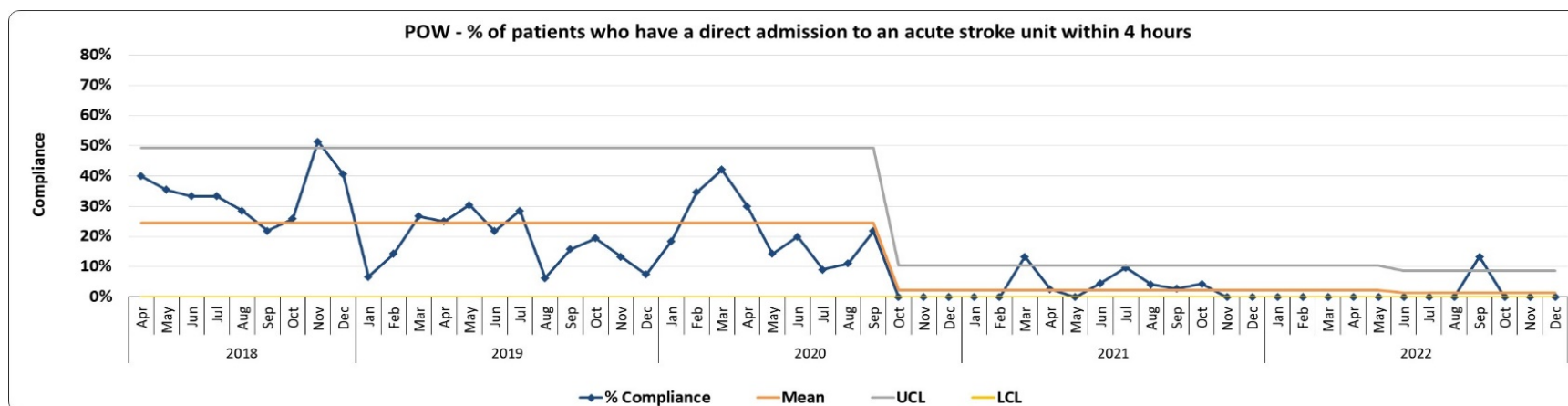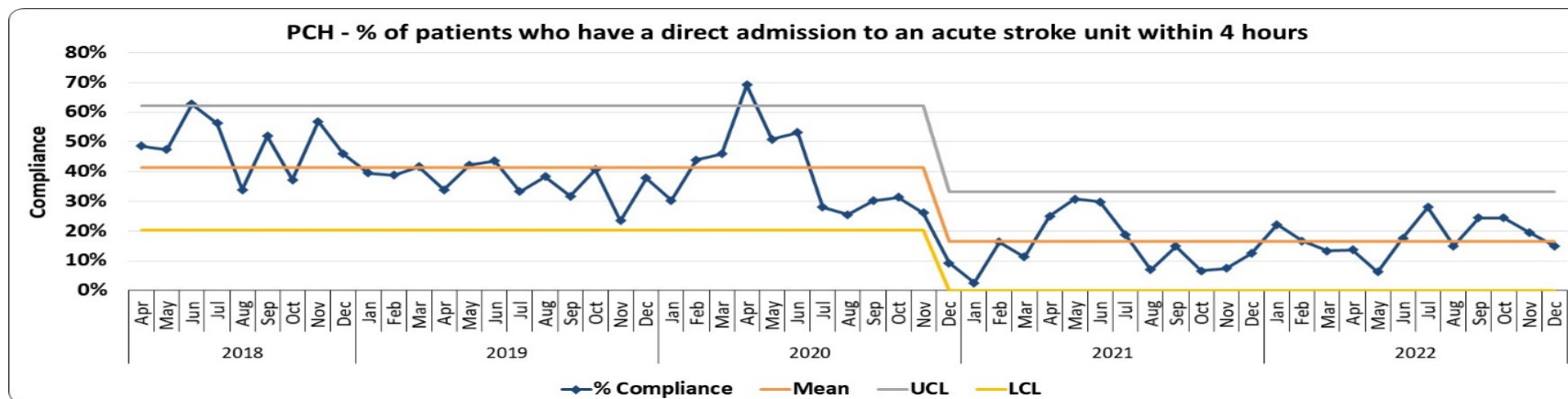
% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes

PCH - % of thrombolysed stroke patients with a door to needle time of <= 45 minutes

POW - % of thrombolysed stroke patients with a door to needle time of <= 45 minutes
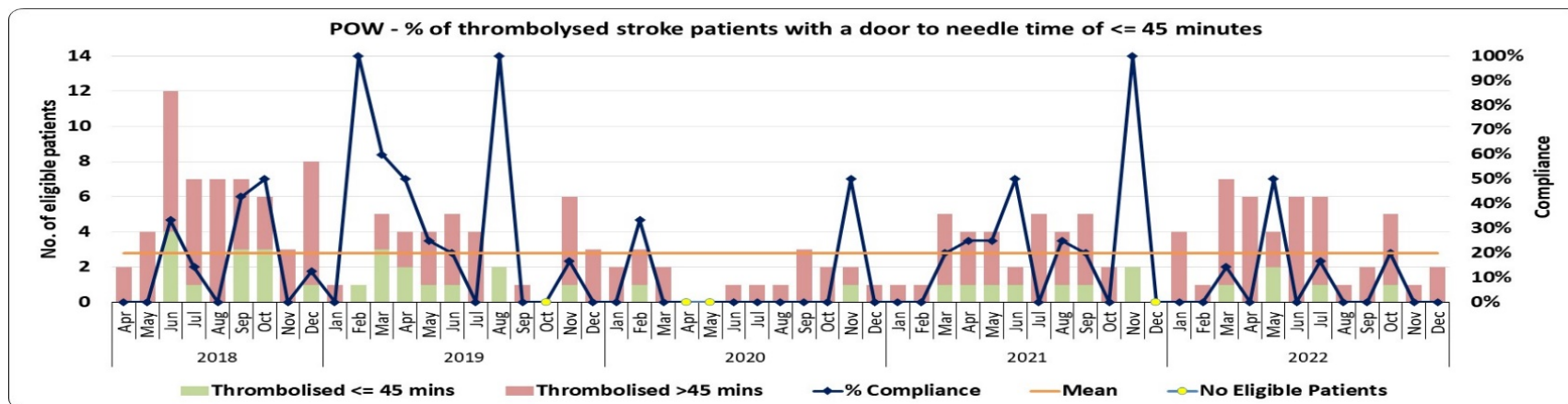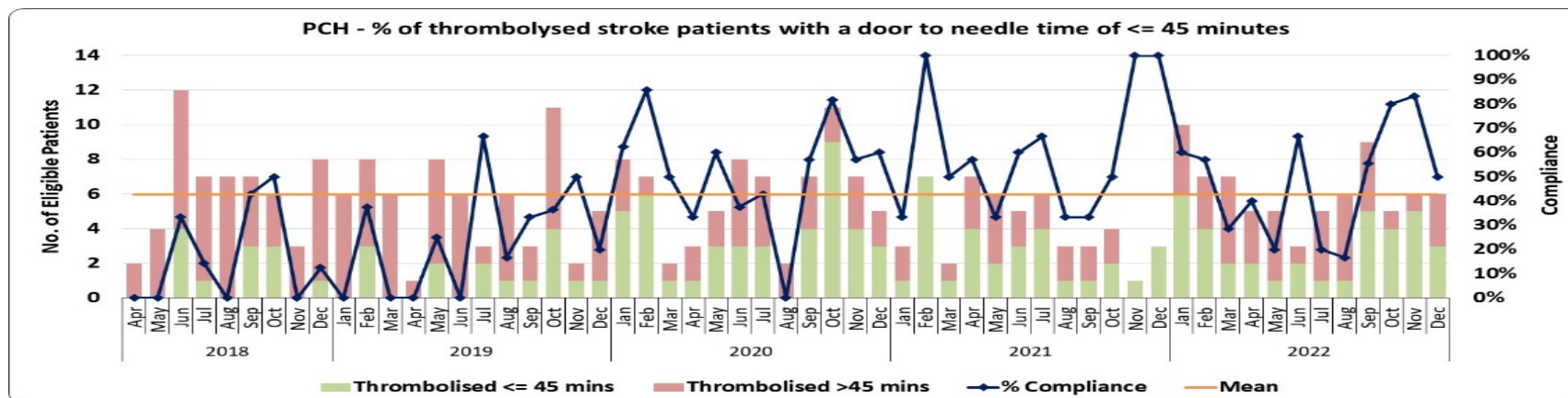
% compliance of patients diagnosed with stroke received a CT scan within 1 hour

PCH - % of patients who are diagnosed with a stroke who receive a CT scan within 1 hour

POW - % of patients who are diagnosed with a stroke who receive a CT scan within 1 hour

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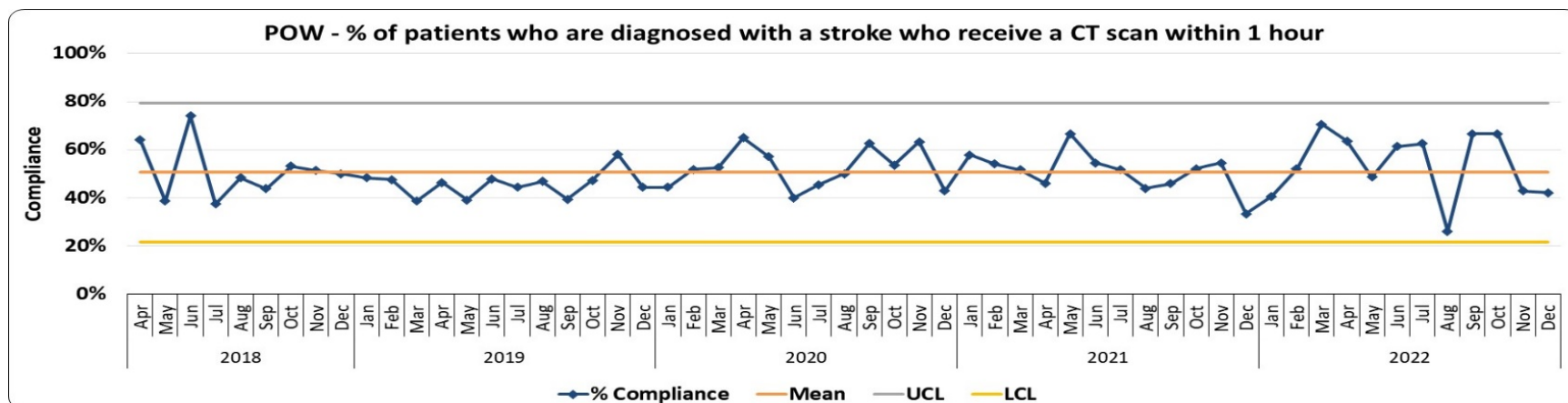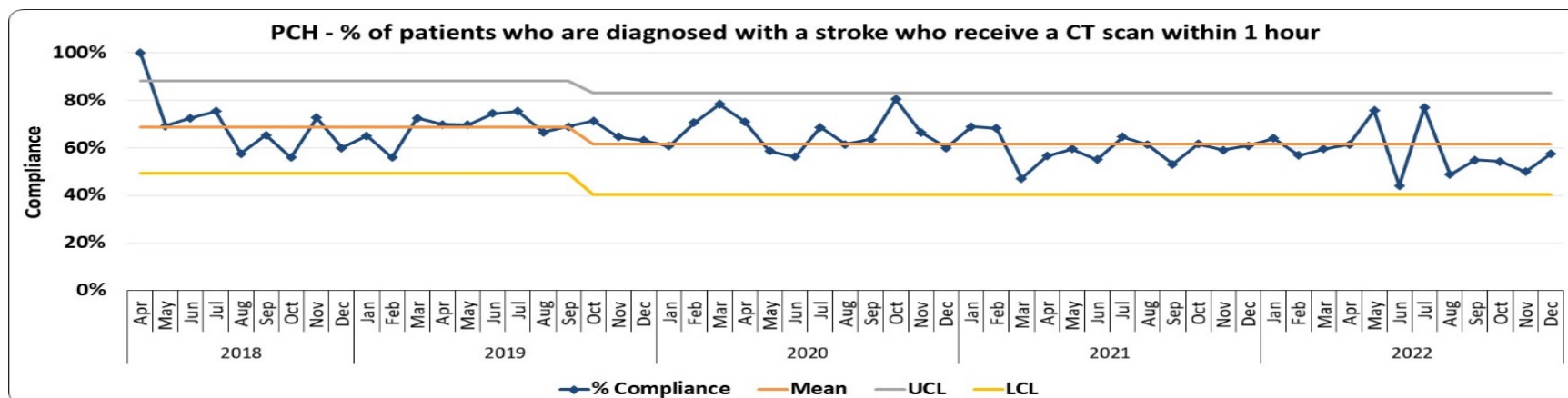
% compliance assessed by a stroke consultant within 24 hours

PCH - % of patients who are assessed by a stroke specialist consultant physician within 24 hours

POW - % of patients who are assessed by a stroke specialist consultant physician within 24 hours

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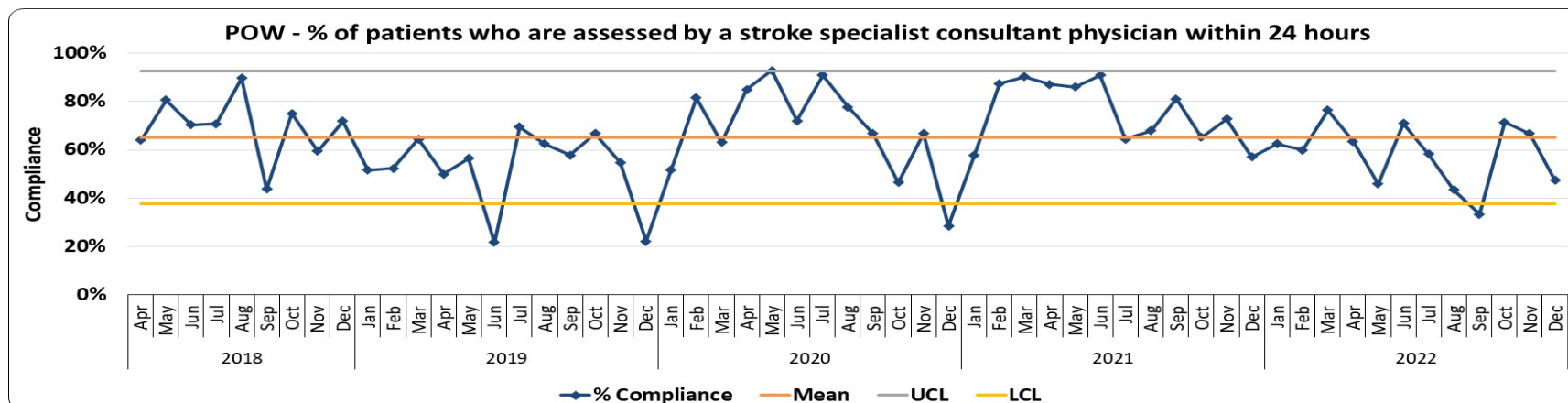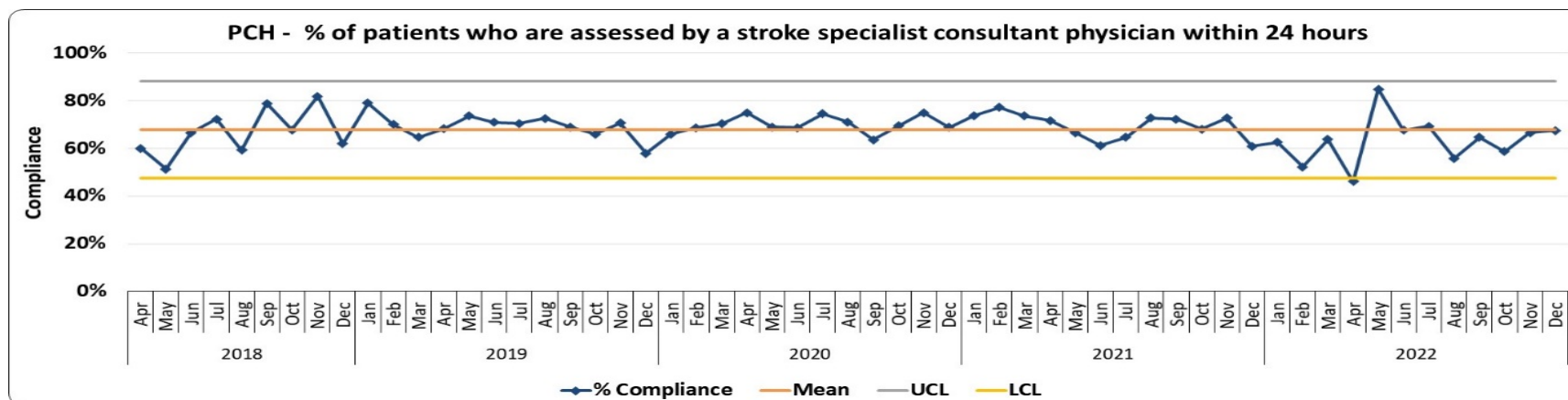
Appendix 3

Summary of quarterly SSNAP Scores PCH

Domain	April to June 2022	July to September 2022	October to December 2022
Overall	D	C	B
Scanning	A	A	B
Stroke Unit	E	E	E
Thrombolysis	D	C	C
Specialist Assessment	D	D	D
OT	C	A	A
Physio	B	B	B
SALT	B	B	B
MDT working	B	B	C
Standards by discharge	C	C	A
Discharge Process	C	B	B

Legend: A B C D E

Summary of quarterly SSNAP Scores POWH

Domain	SSNAP April to June 2022	SSNAP July to September 2022	October to December 2022
Overall	D	E	E
Scanning	A	A	B
Stroke Unit	E	E	E
Thrombolysis	D	D	E
Specialist Assessment	E	E	E
OT	C	D	D
Physio	E	D	D
SALT	E	E	E
MDT working	E	E	E
Standards by discharge	A	B	B
watermarDischarge Process	D	D	D

Legend: A | B | C | D | E

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Appendix 4 – Risk Register entry for Stroke

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 overseeing sub-group activity. ToR and membership updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Regional and National Stroke Programme Boards progressing developments. • Unified, evidence-based pathway developed for thrombectomy • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway

QUALITY & SAFETY COMMITTEE

MORTALITY INDICATORS AND MORTALITY REVIEWS

Date of meeting	16/03/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report

Prepared by	Mark Townsend - Head of Clinical Audit & Quality Informatics, Review, Natalie Morgan Thomas – Deputy Head & Lead Nurse for Clinical Effectiveness, and Matthew Smith – Interim Mortality Review & Learning Manager
Presented by	Dom Hurford, Executive Medical Director
Approving Executive Sponsor	Executive Medical Director

Report purpose	FOR NOTING

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

ACRONYMS	
MR	Mortality Review
ME	Medical Examiner
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
PoWH	Princess of Wales Hospital
HMR	Hospital Mortality Review (Previously Called Stage 2 Mortality Review)
SHMI	Summary Hospital-level Mortality Indicator

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to update the Quality and Safety Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All Wales Learning From Mortality Review Model Framework (September 2021) and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

1.2 The table below outlines the number of ME referrals received from 1st April 2022 (as of 17th February 2023), the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed Pending Feedback	Closed
CTMUHB	**1184**	**61 (5%)**	**307 (26%)**	**49 (4%)**	**767 (65%)**

1.3 Planned for 2023 are the introduction of biannual learning from MR events across CTM. In addition, the aim is for quarterly lunch and learn events to promote the newly released newsletter. In addition, the Development Unit have requested a thematic review is undertaken in quarter 1, 2023-2024.

Learning from Mortality Reviews

1.4 Medical Examiner Service is currently reviewing approximately 97% of all CTMUHB, in hospital deaths. Accident & Emergency Departments remain the final areas to fully utilise this service. Any deaths not reviewed by the Medical Examiner Service are still currently reviewed via the Universal Mortality Review (UMR) process, previously known as Stage 1 Mortality Review.

The table below outlines the number of deaths for each of the 3 localities from 1st April 2022 (as of 17th February 2023), the number where an initial review has been undertaken (either by ME or UMR), and the number and percentage outstanding.

	Total Deaths	Number Reviewed	Number Outstanding	Percentage Outstanding
Bridgend	876	841	35	4%
Merthyr Cynon	902	890	12	1%
Rhondda Taff Ely	963	943	20	2%

1.5 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. Alongside these reviews all HBs have been tasked with completing the outstanding backlog of Hospital Acquired Covid cases, Waves 1 & 3 (Nosocomial Covid Team (central funding) are responsible for Waves 2 & 4)

Including these COVID reviews has generated a backlog of HMR cases.

The table below shows the number of cases identified for HMR for each of the 3 localities from 1st April 2022 (as of 17th February 2023), the number where the review has been completed and the number and percentage outstanding.

	Number of HMR	Number Complete	Number Outstanding	Percentage Outstanding
Bridgend	155	65	90	58%
Merthyr	139	98	41	29%
Rhondda	189	66	123	65%

There are also a number of cases outstanding from:
- 2021-22 - Bridgend 86, Merthyr 96 & Rhondda 24. *83 of these cases relate to Hospital Acquired Covid-19 and will be completed by the Nosocomial Covid Reviews*
- 2020-21 - Bridgend 116, Merthyr 22 & Rhondda 7. *100 of these cases relate to Hospital Acquired Covid-19 and will be completed by the Nosocomial Covid Reviews*

1.6 Whilst Hospital Acquired Covid deaths are contained in the overall Mortality Review figures, data for waves 1 – 4 has also been collated separately. The table below shows the number of cases identified within each wave of the pandemic, the number where the review has been completed and the number and percentage outstanding.

	Number of Cases	Number Complete	Number Outstanding	Percentage Outstanding
Wave 1	154	151	3	2%
Wave 2	456	359	97	21%
Wave 3	78	48	30	38%
Wave 4	115	56	59	51%

1.7 Stage 3 Mortality Review panel was suspended during phase 1 & 2 of the Covid19 pandemic. Panels are now held on a monthly basis via Teams. There are currently 34 cases either waiting to be reviewed or in progress. Stage 3 functionality will be reviewed upon completion of the current backlog.

1.8 It is planned that with further development, a Mortality Review Dashboard can be created for easier access to learning from death and wider dissemination.

1.9 Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. Themes noted at Mortality Review and is shared via quarterly newsletter available on SharePoint.

1.10 Currently, learning opportunities are fed back to the clinical teams or to the heads of nursing directly. All actions will be routinely updated on the DATIX system to provide the required assurance for the organisation. When a case has not been resolved in the first two levels a proportionate investigation should be arranged. An MR will progress to level 3 when key issues and corrective actions have been identified, which could ultimately prevent or reduce the likelihood of the case recurring, providing assurance that risks have been reduced so far as is reasonably practicable, to ensure that appropriate control measures have been identified.

1.11 Work is in progress to link the findings from the MR process with the Health Board quality improvement programme of work.

Ongoing Development

1.12 CTMUHB wide MR Screening Panel live from April 2022. Feedback templates and procedures for next of kin feedback (where requested) is also currently under review.

1.13 Further recruitment of clinical reviewers across CTMUHB to attend mortality review sessions in order to undertake all hospital mortality reviews.

1.14 CTM is a field leader within Wales for the hospital MR Process.

1.15 From 1st April 2023 all deaths with the Community will be reviewed by the Medical Examiner Service. It is unclear at present the impact this will have on the current Mortality Review Service.

Baseline Population Numbers

1.16 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2021 for population of local areas to CTMUHB

Area	Estimated pop 2021	People/km 2021
Bridgend	145,500	580
RCT	237,700	560
Merthyr	58,800	528

1.17 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.

1.18 The following table shows the number of deaths per area for each month of 2022 for each local authority area. Again, the data sets are from the ONS using their 2022 dataset.

Deaths per region 2022(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	135	128	148	131	147	117	124	132	132	124	124	135
RCT	218	186	219	176	241	186	234	219	193	192	203	254
MCT	65	57	70	66	53	62	42	46	47	59	64	65

ONS data for deaths per month for Wales 2022

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3262	311	9.5
Feb	2730	196	7.2
March	3203	207	6.5
April	2894	255	8.8
May	2992	150	5.0
June	2740	62	2.3
July	2638	176	6.7
August	2931	144	4.9
September	2779	83	3.0
October	2975	147	4.9
November	3112	120	3.9
December	3432	128	3.7

General CTMUHB In-Hospital Mortality

1.19 The following table outlines the total number of in-hospital deaths per Locality for each month since April 2022 and up to end of January 2023

	Bridgend	Merthyr Cynon	Rhondda Taff Ely	CTMUHB
April 2022	91	99	90	280
May 2022	81	79	80	240
June 2022	76	83	87	246
July 2022	95	74	114	283
August 2022	73	82	86	241
September 2022	74	68	78	220
October 2022	83	96	90	269
November 2022	85	91	86	262
December 2022	119	117	131	367
January 2023	96	109	108	313

1.20 The table below outlines the total number of in-hospital deaths per specialty for each month since April 2022 and up to end of January 2023. (Specialties taken from Welsh PAS at time of death)

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Total
Total Deaths	280	240	246	283	241	220	269	262	367	313	2721
General Medicine	104	80	79	75	79	80	86	87	100	109	879 (32%)
Care of the Elderly	40	37	39	44	36	28	41	34	56	33	388 (14%)
Respiratory	23	11	22	25	18	14	25	30	42	36	246 (9%)
Cardiology	13	12	12	8	14	6	10	7	17	14	113 (4%)
Gastroenterology	14	11	11	10	7	5	6	9	15	11	99 (4%)
Diabetes/Endocrinology	1	-	3	6	3	2	3	2	2	-	22 (<1%)
Stroke Medicine	-	2	1	6	-	1	3	4	5	4	26 (1%)
Rheumatology	-	-	-	-	-	-	-	-	-	1	1 (<1%)
Emergency Medicine	30	20	22	28	21	26	37	34	52	32	302 (11%)
Palliative Medicine	23	26	25	30	24	25	28	35	41	31	288 (11%)
Haematology	-	-	-	1	-	-	-	-	-	-	1 (<1%)
Critical Care	-	5	-	2	3	-	2	2	1	5	20 (<1%)
General Surgery	15	15	14	18	15	19	12	11	16	13	148 (5%)
Trauma & Orthopaedics	12	9	6	23	14	9	10	3	15	17	118 (4%)
ENT	1	3	1	-	1	-	2	1	-	-	9 (<1%)
Urology	-	2	2	1	2	1	1	1	2	-	12 (<1%)
Gynaecology	-	-	-	-	1	-	1	-	-	1	3 (<1%)
Max Fax/Oral Surgery	-	-	-	-	-	-	2	-	-	-	2 (<1%)
Mental Health	3	4	9	4	3	4	-	2	1	3	33 (1%)
Rehabilitation	1	3	-	2	-	-	-	-	2	3	11 (<1%)

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

2.1 The Committee is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths

- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)

- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins

2.2 **Intrinsic:**

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues

- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD

3.1   Addressing the monthly MR caseload and backlog of COVID MR cases has been challenging with limited centralised resources to support the MR process. A review of centralised resources is currently being undertaken.

3.2   Limited clinical reviewers with appropriate MR experience has also contributed to the MR backlogs. SPA allocated time is being addressed in the recently approved Consultant SPA paper.

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: Safe Care, Effective Care, Dignified Care Timely Care, Staff and Resources
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all 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
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   That the Committee **NOTE** the contents of the paper.