Quality & Safety Committee

Tue 25 July 2023, 13:30 - 16:30

Agenda

13:30 - 13:35
5 min

1.
PRELIMINARY MATTERS

1.1.
Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2.
Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3.
Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

13:35 - 14:05
30 min

2.
SHARED LISTENING & LEARNING

2.1.
Listening & Learning Story - Speech & Language Therapy

For Discussion and Shared Learning *Natasha Bold, Highly Specialist Speech & Language Therapist*

2.2.
Care Group Spotlight Presentation - Diagnostic, Therapies, Pharmacies and Specialties

For Discussion and Shared Learning *Lisa Love-Gould, Clinical Director*

2.2 DTPS QSRE Highlight Report QSC 25 July 2023 - Final v3.pdf (10 pages)

14:05 - 14:05
0 min

3.
CONSENT AGENDA

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

The Chair will ask if there are any items from the Consent Agenda (Item 9) that Committee Members wish to bring forward to the Main agenda for discussion.

14:05 - 14:10
5 min

4.
MAIN AGENDA

4.1.

Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member Committee Chair*

14:10 - 14:30
20 min

5.
Setting the Scene - Service Delivery

5.1.
Report from the Chief Operating Officer

Discussion *Gethin Hughes, Chief Operating Officer*

- 5.1 Report from the COO for July 2023v2.pdf (9 pages)

5.2.
Care Group Highlight Reports

Discussion *Care Group Nurse Directors*

- Planned Care
- Unscheduled Care (to include an update on the detail contained within the WAST Patient Experience Report)
- Children & Families
- Mental Health & Learning Disabilities
- Primary Care & Community

- 5.2a Planned Care QSRE Highlight Report July 23 (final) QSC 25 July 2023.pdf (4 pages)
- 5.2a Appendix 1 Planned Care Ward Assurance Data QSC 25 July 2023.pdf (8 pages)
- 5.2b USC Highlight Report QSC 25 July 2023.pdf (8 pages)
- 5.2b Appendix 1 USC Care Group Highlight Report QSC 25 July 2023.pdf (1 pages)
- 5.2c Children Families Care Group Highlight Report QSC 25 July 2023.pdf (5 pages)
- 5.2d MHLD Highlight Report for QSC QSC 25 July 2023.pdf (4 pages)
- 5.2e PCC QSC highlight report QSC 25 July 2023.pdf (6 pages)

14:30 - 14:50
20 min

6.
DELIVERY OUR PLAN

6.1.
Quality Dashboard Report

Discussion *Nigel Downes, Assistant Director of Quality & Safety*

- 6.1a Quality Safety Dashboard Report QSC 25 July 2023.pdf (15 pages)
- 6.1b Apendix 1 Medication Supply Information 2023-07-23 QSC 25 July 2023.pdf (1 pages)
- 6.1c Delivery Unit Compliance summary Alerts QSC 25 July 2023.pdf (2 pages)
- 6.1d Delivery Unit Compliance summary Notices QSC 25 July 2023.pdf (4 pages)

14:50 - 15:30
40 min

7.
DELIVERING OUR IMPROVEMENT PROGRAMMES

7.1.
Maternity & Neonates Services Reports

7.1.1.
Maternity & Neonatal Metrics

Discussion *Suzanne Hardacre, Director of Midwifery*

- 7.1.1 Children Families Care Group Neonatal Maternity Metrics July 2023 QSC 25 July 2023.pdf (27 pages)

7.1.2.
Maternity Quality Improvement Annual Update 2022-2023

Discussion *Suzanne Hardacre, Director of Midwifery*

7.1.2 Children & Families Care Group QI Update MatNeo QSC 25 July 2023.pdf (4 pages)

7.2.
Ty Llidiard Progress Report

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

7.2 Ty Llidiard QSC 25 July 2023.pdf (13 pages)

7.3.
Mental Health In-Patient Improvement Progress Report

Discussion *Mary Self, Medical Director, Mental Health and Learning Disabilities*

7.3 MHLD HIW Inspections QSC 25 July 2023.pdf (10 pages)

7.4.
Stroke Services Progress Report

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

7.4 Stroke Progress Report QSC 25 July 2023.pdf (22 pages)

15:30 - 16:10
40 min

8.
GOVERNANCE, RISK & ASSURANCE

8.1.
Organisational Risk Register - Risks assigned to the Quality & Safety Committee

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

Members will have the opportunity at the circulation of agenda and papers to identify any risks where they would like further information or clarity.

8.1a Organisational Risk Register - July 2023 - QSCv2.pdf (5 pages)
8.1b App 1 - QSC Master Organisational Risk Register - July 2023.pdf (8 pages)

8.2.
Datix Cymru – Assurance Report

Discussion *Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence*

Report discussed at the January 2023 meeting. Agreed that a progress report would be presented to the July meeting

8.2 Datix Cymru Incident Reporting QSC 25 July 2023.pdf (4 pages)

8.3.
Mortality Assurance Report

Discussion *Dom Hurford, Medical Director*

8.3 Crude Mortality Report 2023-07-25 QSC 25 July 2023.pdf (3 pages)

8.4.
Healthcare Inspectorate Wales Action Plan Tracker

Discussion *Greg Dix, Director of Nursing*

8.4 HIW Tracker Inspection Improvement Plans QSC 25 July 2023.pdf (4 pages)

8.5.
Liberty Protection Safeguards Progress Report

Discussion *Greg Dix, Director of Nursing*

8.5 Liberty Protection Safeguards Progress Report QSC 25 July 2023.pdf (4 pages)

8.6.
Covid 19 Inquiry Preparedness

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

8.6. Covid 19 Public Inquiry Preparedness - QSC July 23.pdf (6 pages)

16:10 - 16:15
5 min

9.
Consent Agenda

9.1.
FOR APPROVAL

9.1.1.
Unconfirmed Minutes of the meeting held on 24 May 2023

Decision *Carolyn Donoghue, Independent Member / Committee Chair*

9.1.1 Unconfirmed Minutes QSC 24 May 2023 QSC 25 July 2023.pdf (20 pages)

9.1.2.
Unconfirmed Minutes of the In Committee held on 31 May 2023

Decision *Carolyn Donoghue, Independent Member / Committee Chair*

9.1.2 Unconfirmed In Committee Minutes QSCIC 31 May 2023 QSC 25 July 2023.pdf (2 pages)

9.1.3.
Volunteer Service Policy

Decision *Jenny Oliver, Head of People's Experience*

9.1.3a CTMUHB Volunteer Policy cover paper QSC 25 July 2023.pdf (3 pages)
9.1.3b Appendix 1 Volunteer Service Policy Final Approval Feb 23 QSC 25 July 2023.pdf (30 pages)

9.1.4.
Concerns Policy

Decision *Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence*

Please note that this item has now been deferred to the September meeting of the Committee

9.1.5.
Rapid Tranquilisation Policy

Decision *Dom Hurford, Medical Director*

9.1.5a Policy Approval Cover Paper Rapid Tranquilisation QSC 25 July 2023.pdf (4 pages)
9.1.5b Rapid Tranquilisation policy QSC 25 July 2023.pdf (17 pages)

9.1.6.
Cwm Taf Morgannwg Carers End of Year Progress Report 2022/23

Decision *Greg Dix, Executive Director of Nursing*

9.1.6a Carers End of Year Progress Report 2022 2023 QSC 25 July 2023.pdf (6 pages)

9.1.6b Appendix 1 Carers End of Year Report QSC 25 July 2023.pdf (13 pages)

9.1.7.
Health, Safety & Fire Sub Committee Highlight Reports

Decision *Dilys Jouvenat, Independent Member*

9.1.7a Health Safety Fire Sub Committee Highlight Report QSC 25 July 2023.pdf (4 pages)
9.1.7b HSF Sub-CMt Annual Report QSC 25 July 2023.pdf (8 pages)

9.2.
FOR NOTING

9.2.1.
Action Log

Information *Carolyn Donoghue, Independent Member / Committee Chair*

9.2.1 Action Log QSC 25 July 2023.pdf (12 pages)

9.2.2.
Committee Annual Cycle of Business

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

9.2.2a Committee Cycle of Business - Cover Paper QSC 25 July 2023.pdf (2 pages)
9.2.2b Quality Safety Committee Cycle of Business QSC 25 July 2023.pdf (4 pages)

9.2.3.
Forward Work Programme

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

9.2.3 Quality & Safety Committee Forward Work Programme QSC 25 July 2023.pdf (5 pages)

9.2.4.
WHSSC Quality & Patient Safety Committee Chairs Report

Information *Dilys Jouvenat, Independent Member*

9.2.4a Quality Patient Safety Committee Chairs Report v1 QSC 25 July 2023.pdf (5 pages)
9.2.4b Appendix 1 - Summary of Services in Escalation QSC 25 July 2023.pdf (10 pages)

9.2.5.
Putting Things Right Annual Report

Information *Nigel Downes, Assistant Director of Quality & Safety*

9.2.5a PTR Annual Report 2022-2023 QSC 25 July 2023.pdf (3 pages)
9.2.5b PTR Annual Report 2022-2023 Final Draft 2023-07-07 QSC 25 July 2023.pdf (10 pages)

9.2.6.
Quality Governance – Regulatory Review Recommendations and Progress Updates (to include an update on The Use of Controlled Drugs Home Office Controlled Drugs Licence Tracker)

Information *Greg Dix, Director of Nursing*

9.2.6a HIW regulatory report QSC 25 July 2023.pdf (4 pages)
9.2.6b The Use of Controlled Drugs Home Office Controlled Drugs Licence Tracker QSC 25 July 2023.pdf (3 pages)

9.2.7.
Clinical Audit Quarterly Report

Information *Dom Hurford, Medical Director*

9.2.7 Clinical Audit Quarterly Update Report QSC 25 July 2023.pdf (6 pages)

9.2.8.
Radiation Safety Committee Annual Update

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

9.2.8 Radiation Safety Committee Annual Report 2022-23 QSC 25 July 2023.pdf (4 pages)

9.2.9.
Nosocomial Investigation Update Report

Information *Nigel Downes, Assistant Director of Quality and Safety*

9.2.9 CTM Nosocomial COVID-19 Incident Management Programme QSC 25 July 2023.pdf (10 pages)

9.2.10.
Recovery Plan Hep B and Hep C

Information *Philip Daniels, Interim Director of Public Health*

9.2.10 Hep B&C Paper QSC 25 July 2023.pdf (5 pages)

9.2.11.
Welsh Risk Pool Claims Final Internal Audit Report and Action Plan

Information *Stephanie Muir, Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics*

9.2.11a QSC Cover Paper IA WRP Report QSC 25 July 2023.pdf (4 pages)
9.2.11b Copy of Internal Audit WRP Claims Action Plan updated 17-07-23 QSC 25 July 2023.pdf (2 pages)
9.2.11c CTMUHB 22.23 WRP Final Internal Audit Report QSC 25 July 2023.pdf (14 pages)

9.2.12.
Concerns Final Internal Audit Report and Action Plan

Information *Nigel Downes, Assistant Director of Quality & Safety*

9.2.12a Cover Paper Internal Audit Concerns Report 2023-07-25 QSC 25 July 2023.pdf (4 pages)
9.2.12b Internal Audit Concerns Management Action Plan 2023-07-10 QSC 25 July 2023.pdf (3 pages)
9.2.12c CTM Concerns Follow Up Final Internal Audit report QSC 25 July 2023.pdf (19 pages)

16:15 - 16:25
10 min

10.
ANY OTHER BUSINESS

10.1.
Highlight Report to Board - Verbal

Information *Carolyn Donoghue, Independent Member / Committee Chair*

10.2.
How did we do in this meeting - verbal

Discussion *Carolyn Donoghue, Independent Member / Committee Chair*

10.3.
Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Independent Member / Committee Chair*

The Chair will ask Members to consider any themes or discussion points that would support a targeted presentation or a focus at the Committee or the Shared Listening and Learning Committee.

10.4.
Items to be discussed at the In Committee Quality & Safety Committee

- Critical Care Reconfiguration

16:25 - 16:30
5 min

11.
DATE AND TIME OF NEXT MEETING - TUESDAY 19 SEPTEMBER 2023 AT 9:00AM

16:30 - 16:30
0 min

12.
CLOSE OF MEETING

AGENDA ITEM
2.2

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE DIAGNOSTICS, THERAPIES, PHARMACY AND SPECIALTIES QUALITY, SAFETY, RISK & EXPERIENCE (QSRE) MEETING	
DATE OF MEETING	25/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lisa Love-Gould- Clinical Director of AHPs DTPS
PRESENTED BY	Lisa Love-Gould- Clinical Director of AHPs, DTPS
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director
REPORT PURPOSE	Noting

ACRONYMS	
AHP	Allied Health Professionals
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
WMS	Weight Management Service

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 through June 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	**Pathology** **Outstanding Cancer Harm Review**: currently 14 outstanding harm reviews for Clinical Haematology, 4 outstanding harm reviews for Cellular Pathology. Recent discussions re how best to get Health Board oversight for harm review process. There had been some concern that the team are not always receiving feedback with regards to outcome. There had also been some harm reviews on Datix that pathology had not received breach reports for. This was raised as a concern in DTPS' most recent QSRE and following subsequent discussions with the coordinator for harm reviews, DTPS have now received the corresponding breach reports. Hoping that this is now resolved and will follow up in the next QSC meeting to provide assurance that all processes are working as they should. An ongoing concern is Haematology consultant time to complete the harm reviews.(see below) **Clinical Haematology consultant cover**: – This has occurred w/c 10/7/23 and will be escalated via OMB. reduced capacity due to sickness impacting on the ability to see all but the most acute patients which has occurred in the last week. There will only be one locum consultant for the next month, who has no notice period. There will be delays in responding to referrals and provision of advice across RGH and the waiting list will increase. There is also a small risk that Urgent Suspected Cancers (USC) may be missed in initial triage. There is a risk of the Consultant Haematology

service collapsing. (**Risk 4053)/ A locum has been sourced initially.**

Radiology
Lack of Professional Head of Radiology – Permanent Management Structure. We will be unable to afford this in phase 2 of the operating model change but is still in discussion for further developments such as expansion of Radiology facilities in Llantrisant Health park. At present we have 2 Superintendent Radiographers that are covering the main aspects of professional leadership.

Radiology Informatics System Procurement (RISP) Implementation
Concerns highlighted in terms of the scale of programme without dedicated project management support being identified as yet. Regular local meeting in progress and will be developing internal plan. New issue regarding the potential All Wales deployment order is being worked through at pace currently.

Therapies
Learning from Nationally Reportable Incident (NRI)
An incident related to management of a pressure area identified that a contributory factor was a delay in onwards referral to a specialist discipline.
The action plan includes ensuring accurate completion of vascular assessment, including documentation of clinical decision making. Learning identified in relation to newly qualified staff. Increased supervision put in place with new community lead role.

ADVISE	**Pharmacy and Medicines Management** • Homecare resource -The homecare service is currently running at half of the recommended staffing capacity. Demands on service continue to outstrip capacity for the funded establishment. Increase of 250 extra patients in 2022-23 compared with the previous year. Invest to save bid submitted December 2022 and approved July 2023. Recruitment is underway with staff expected to be in post September 2023, at which point new services can resume. • Medical gas cylinder storage security issues raised in POW theatres: recommended Statement of Need (SON) to upgrade area submitted. • Maternity services – PCH – no clinical pharmacy service provision ACTION TAKEN – from May 23. 0.5 WTE band 4 technician reallocated from core pharmacy team, and support from Women & Children (W&C) pharmacist team • GP admissions – no clinical pharmacy service provision ACTION TAKEN – from May 23. rotational posts added to admissions team • Medicines Policy not in place; undergoing final iteration and will be submitted to September Quality and Safety Committee for ratification. • Multiple changes of ownership in community pharmacies across the Health Board due to the withdrawal from the UK market of Lloyd Pharmacy. Only one notification of closure, Sainsbury's Sarn. Pharmaceutical Needs Assessment in date does not show community services will be seriously adversely affected. **Therapies** Dietetics service on acute sites Significant workforce pressures across the acute sites within Nutrition and Dietetics at present. This is due to workforce shortages and leave on top of a fragile workforce. Mitigation: moving staff across sites, standing down non-essential meetings and use of locums. Despite this, the service has been escalated to a pressured state. This will mean prioritisation of patients on enteral and parenteral nutrition. Instigation of an oral nutritional supplement pathway to be used across all ward areas, to enable teams to initiate oral nutritional supplements to

patients at high risk but who have been identified as safe from a re-feeding risk perspective by our Dietetics team.

Weight Management Service (WMS)
The demand for weight management service continues to outstrip capacity. Positive visit last month from the Minister for Health & Social Services and Jonathan Morgan, CTM Chair, who were very interested in the Public Health dietetics services across paediatrics and adult WMS. They were well aware of the national obesity concerns and demands on the services but this service will have a significant impact on the overall Therapies waiting list position.

Pathology

Blood Bank/Haematology Out of Hours (OOH) cover is an ongoing risk due to lack of suitably trained staff to undertake the overnight cover.

- Organisational Change Policy (OCP) process to review current working patterns and help provide more resilience to the out of hours period has caused concern amongst colleagues. Notification received that staff side have officially disputed the OCP and that the status quo must be maintained pending further discussions. Consequently there will be delays in the new rota which will add further risk to out of hours cover. Will be raised through Operational Management Board with Chief Operating Officer (COO).
- Ongoing issues with rotas at RGH. The result of not being able to cover would mean no service provision at RGH, this would result in significant delays to Haematology analysis and significant risk to patients requiring blood transfusion or Emergency Department / emergency theatre scenarios where blood is required at short notice. Various options are currently being considered.

Radiology
Waiting List Performance – All Modalities
Ongoing concerns around the lack of Support Staff which can reduce clinical activity, particularly in ultrasound.
Reporting Capacity across all modalities, though the Urgent Suspected Cancer (USC) work is appropriately prioritised and is being completed in a timely manner.
Increase in drug costs (Particularly CT contrast medium)

	CIVICA – No access to patient feedback which is being pursued in order to gain a better understanding of the service from a patient perspective.
ASSURE	The Clinical Director of AHPs has taken on the Governance lead for the DTPS care group to ensure accurate reporting and assurance. They will be linking in with the Care Group nurse directors weekly regarding Quality & Safety.
INFORM	**Pharmacy and medicines management** Regional Quality Assurance inspection of RGH aseptic unit 12th and 13th June showed unacceptable temperatures and the unit was forced to cease production. Estates organised a temporary rental chiller unit and production has now resumed. A paper was submitted to Executive Leadership Group (ELG) to inform, and the issue is now with Estates to ensure suitable environmental conditions are maintained. CTM's Chief Pharmacist is developing a regional contingency plan with the Chief Pharmacists of Velindre, Cardiff and Vale and Aneurin Bevan UHBs in order to plan for potential end of life of several aseptic units before the implementation of Welsh Government (WG) plans for the Transforming Access to Medicines project. (WG plan to centralize aseptic production services). **Pathology Services** Human Tissue Authority (HTA) update: 2 minor shortfalls raised during February inspection. Corrective Action and Preventative Action (CAPA) report submitted on time, actions accepted and closed by HTA. United Kingdom Accreditation Service (UKAS):

Follow up remote assessment Friday 14th July – review of Cellular Pathology and incident management

Annual assessment due early September – date to be confirmed

ISO 15189:2012 standards have been revised and updated in 2022 (ISO 15189:2022); more focus on communication with patients and risk management procedures. Gap analysis and development of action plan underway to meet compliance by deadline of 2024.

Therapies

Therapies SDEC (Same day Emergency Care) business case for Princess of Wales has been approved and posts will soon be out to advert.

Agreement reached to support a Speech & Language Therapist (SLT) specialist post for Critical Care so that there will be 0.5 WTE resource per critical care unit across CTM once recruited to. Allied Health Professions (AHP) resource across Critical Care in CTM remains significantly below Guidelines for the Provision of Intensive Care Services (GPICs) standards but this is a great step forward for patient safety, quality of care and Multi-Disciplinary Team (MDT) working. The impact of this will be closely monitored.

Therapies are committed to bi-lingual service provision and make a huge contribution to the Health Boards Welsh Language Standards annual performance report. Examples include:

- Offering an Introduction to Welsh Language session as part of multi-professional AHP induction,
- Completion of a gap analysis across **32** service areas to understand what is working well in relation to bi-lingual provision and areas for further improvement. This took 6 months to develop and implement. The results accounted for **65%** of activity across the whole HB; (32 out of 50 services/speciality locations across the HB were Therapy departments).

Patient story: A patient with dementia on an acute ward had regressed to a point in their childhood when they only spoke welsh. They were becoming increasingly agitated. The physio on the ward introduced themselves in Welsh. The patient became less agitated and explained that they wanted

to order their lunch but was frustrated that no one could understand. Communication in Welsh enabled their meal choices to be arranged and assisted in de-escalating their agitation/frustration.

Therapies are conducting a recruitment drive in July to support recruitment to newly funded posts.

Complaints compliance in DTPS for June:

Therapies – Complaints compliance in DTPS is currently **– June-100%**

No complaints were upheld. Concerns related to:

- Dissatisfaction with Podiatry service provision (the model is mapped to an All-Wales service provision)
- Dissatisfaction with provision of exercises to manage neck pain (clinical standards were adhered to)
- Dissatisfaction with decisions not to refer for Diagnostics for back pain in primary care (an MRI scan)

Early resolution- 6 cases

Radiology – See below for incidents and concerns table

Pathology – **Open concerns:**

MP enquiry (Pathology concerns) – response provided to concerns team

2x Early Resolution (Clinical Haematology appointments) – response provided to concerns team

	Medicines Management – team still awaiting regular reports on complaints and concerns - nil received as yet. Hopefully available for next report. **<u>Patient Safety Incidents with moderate or severe harm in month (June)</u>** **Therapies –** 5 incidents were reported as moderate harm; each underwent a review and all were downgraded to low harm. This trend has highlighted a need to support incident reporters in assessing the severity of harm. A moderate harm incident from May triggered Duty of Candour. The harm was caused by a lack of funded SLT service to a critical care unit. The SBAR and action plan are complete and funding of SLT critical care workforce has been agreed. 14 of the 28 incidents during this period related to difficulties in accessing specialist therapy assessment and treatment in line with SSNAP Quality standards. Moderate severity – delay in accessing PCH acute stroke unit and pressure damage (unavoidable) Severe – 1 reported within HB system but the incident related to care delivered within a private Nursing home

Radiology –

Reportable Incidents

	Total	Overdue
NRIs/SIs	2	1
LRIs (IRMER)	2	2

Datix web incidents

Holding area	In progress	Completed
34	39	315

LFERs

	Total	Overdue
New LFERs (>Dec 2021)	2	2

PSAs/PSNs

No. of non-compliant
0

There are no outstanding Datix Legacy incidents remaining.

Pathology – 1 x LRI – Submitted awaiting final feedback

1 x NRI – RCA completed, meeting arranged with Pathology and Obstetrics & Gynaecology (O&G) to finalise

14 x outstanding cancer harm review (Clinical Haematology)

4 x outstanding harm reviews for cellular pathology

Medicines management –All medicines related incidents are seen, from any clinical area which are potentially in the hundreds. Datix does not have a function to allow medicines management to report on incidents solely within the pharmacy department.

APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
5.1

QUALITY & SAFETY COMMITTEE

CHIEF OPERATING OFFICER'S REPORT ON OVERARCHING Q&S ISSUES WITHIN THE COO PORTFOLIO

Date of meeting	25 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lucy Timlin, Head of Business Support
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
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
T&F	Task and Finish
DU	Delivery Unit
Lower GI	Lower Gastro Intestine
HEIW	Healthcare Education and Improvement Wales
VTE	Venous Thrombo Embolism
ANP	Advanced Nurse Practitioners
LIMS	Laboratory Information Management System

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:

- Diagnostics including LINC
- Planned Care – Waiting Times
- Cancer Services
- Unscheduled Care
- Primary Care & Community
- Mental Health

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

For the **LINC process**, on 13 June 2023, NHS Wales and the software provider jointly agreed to end the contract for the implementation of a Laboratory Information Management System (LIMS). This decision was made on the basis of the current and future requirements of the Pathology service in Wales. Both parties remain committed to managing the transition out of this project in the best interests of patient outcomes in Wales.

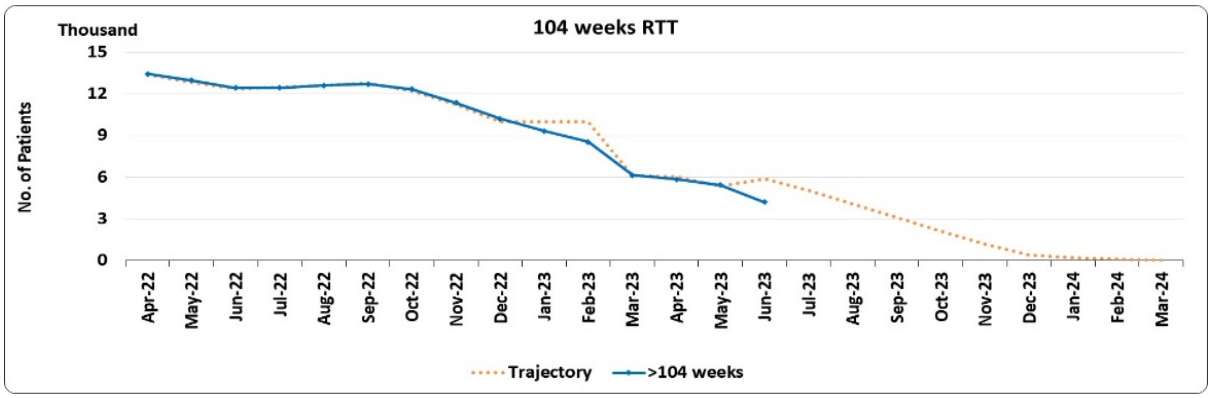
CTM Local Deployment Group met on 29 June 2023 to ensure adequate CTM representation on any newly formed work groups established to discuss forward plans for future All Wales LIMS.

2.2 Planned Care – Waiting Times

Committee members will be interested in continued progress within the Planned Care Group as follows:

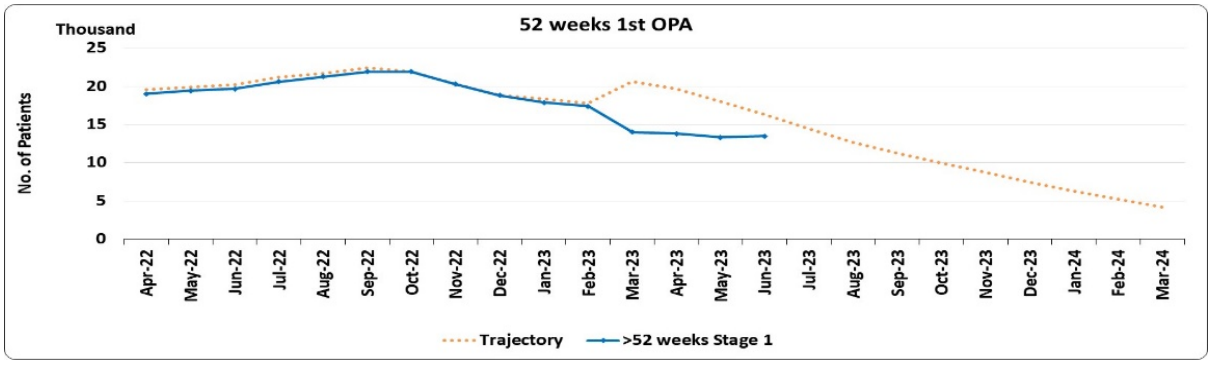
Waiting Times – the position continues to improve, with the main areas set out below. The approval of the Planned Care Recovery Bids will support delivery further – this is covered later in this section. The Care Group is also maintaining the weekly tracking meeting which is providing vital scrutiny. The number of weekly elective treatments has been gradually increasing, with the average number of elective admissions for June at 695 per week, an 8% increase over May.

104 Weeks



The 104 week position continues to be on the planned trajectory.

52 Week



The position has plateaued in this cohort, with the focus has been on work reducing the 104 / 156 position. The Care Group have started work with Primary Care to review the demand into secondary care, as this has increased enormously over the last 12 months compared to previous. Whilst this joint work is undertaken mitigations are in place to review and monitor with additional activity such as additional 'Super Saturdays', Outsourcing/Insourcing, 'Attend Anywhere' and Validation.

The process for the approval of **Planned Care Recovery bids** is being refined, with an agreed endorsement and authorisation procedure. It is anticipated that this will streamline the process and facilitate the approval of the most effective bids – the Care Group receives numerous additional cross cutting schemes. These have been collated and will be assessed against slippage on a quarterly basis.

With the de-escalation of Ward 16 at POW complete, the Care Group is now developing plans for temporary protected Orthopaedics in the Bridgend Clinic and general inpatient elective capacity on ward 16. These plans are an important factor in the plans to **increase elective activity** subject to financial approval.

Orthopaedics – Reconfiguration meetings continue on a fortnightly basis. Progress is being made however greater key stakeholder engagement is required and the development of acceptable pathways to support the reconfiguration. Work is ongoing to address the five key risks for delivery that have been identified, through joint working with all parties. Currently Orthopaedic follow up patients are being booked into all follow up clinics where there is spare capacity in order to ensure the FUNB holding lists are being reduced where possible.

Pre-Assessment – delays are being experienced across CTM and the Care Group is seeking mitigations to reduce the backlog. A separate workstream (part of the GIRFT Theatres pilot) has been developed to review the service across CTMUHB and provide some focus in this vital area. To note the Pre-assessment One Stop Clinic has been set up and is running well.

Ophthalmology – committee members will be pleased to hear that a significant piece of work is being undertaken to review the macular FUNB patients with a key focus as follows:

- Securing additional hours for a Consultant to review each individual case and prioritise clinic appointments accordingly;
- Additional weekend clinic appointments in July 2023;
- Additional nursing posts are being advertised as part of PCR funding to meet the demand for harm reviews and appoint a Family Liaison Officer to support the increased reporting and RCA investigations.
- The HIW action plan is being reviewed to ensure timely actions and reviews
- C & V Vanguard is re-starting – the UHB has 83 referrals per week until 21 July 2023.

2.3 Cancer Services

SCP target 75%	***Jun***	***July***	***Aug***	***Sept***	***Oct***	***Nov***	***Dec***	***Jan***	***Feb***	***Mar***	***Apr***	***May***	***Jun 23 ****
Total Treated	*271*	*303*	*291*	*279*	*316*	*310*	*249*	*289*	*241*	*304*	*280*	*281*	*311*
Total Treated in Target	*135*	*145*	*134*	*129*	*139*	*145*	*97*	*110*	*99*	*149*	*136*	*138*	*159*
Total Breached	*136*	*158*	*157*	*150*	*177*	*165*	*152*	*179*	*142*	*155*	*144*	*143*	*152*
Performance %	*49.8*	*47.9*	*46.0*	*46.2*	*44.0*	*46.8*	*39.0*	*38.1*	*41.1*	*49.0*	*48.6*	*49.1*	
Retrospective performance %	*52.3*	*48.5*	*45.9*	*47.2*	*43.3*	*47.8*	*40.3*	*40.0*	*41.3*	*50.0*	*49.1*		

* = unvalidated position

Cancer performance remains very high on the agenda for the UHB and is escalated at the highest level. Weekly cancer assurance meetings continue, attended by all specialty leads and chaired by the Planned Care Director, and a highlight report is provided weekly to the COO.

Key issues include:

- Removals at each pathway stage for each tumour site, to be in line with DU recommendations to clear backlog and provide sustainability.

- Backlog clearance **in line with submitted new trajectories**.

- Performance in May was achieved **in line with agreed original trajectory** but behind stretched trajectory.

- **Predicted June performance** is 51.9% but currently this is an unvalidated position.

- The biggest concern and the significant factor for not achieving targets continues to relate **to the total number of active patients waiting at first outpatient** (35%) and **diagnostic stage** (48%) of their pathway. This accounts for 83% of all active patients on the suspected cancer pathway, but is an improvement of 1% from last month.

- There are **variations in waiting times** and volumes across the main sites, which are multifactorial collectively with diagnostic delays predominantly in endoscopy and pathology. Delays at tertiary sites for diagnostics and treatment are significant contributors to under achievement.

The focus on treating the longest waiting patients and reducing backlog continues across Care Groups. Lower GI, Gynaecology and Urology account for 81% of entire backlog cohort. DU support is available for the three tumour sites, with action plans formulated and T&F groups established to work through and implement actions in both Lower GI and Urology.

2.4 Unscheduled Care

The Care Group has carried out sustained work in a range of areas – committee members will be interested in the following:

- **GP Assessment Unit PCH** – Significant work is ongoing surrounding the work force required to support patients that are attending the GPAU within Prince Charles Hospital.

- **The ED Transformation Programme** – the Unscheduled Care Highlight Report outlines actions from the HIW 2021 inspection as well as those which have been completed.

- Following the **transfer of complaints to the central quality governance team** the USC leadership team remain committed to support and improve trajectories and have developed an escalation mechanism. It is anticipated that this continued involvement will improve compliance.

- **Stroke Quality Improvement Measures** – direct admission to an acute stroke unit within four hours remains a challenge, however a recent T&F group has prioritised the acute stroke beds in both acute units and re-established ring fenced beds. The group will focus on ensuring a robust pathway for patients presenting to RGH to access stroke beds on a dedicated unit.

- **HEIW visited the General Medicine Department at PCH** in February 2023. An action plan was developed to address the expected improvement measures. There is an active action plan within the directorate, with oversight from the unscheduled care group and the medical education department.

- **Risk Register** – The USC Senior Management Team has recently undertaking a cleansing exercise to review the register, ensuring the review of mitigating actions and alignment of risk score matrices.

- The Care Group has made significant and sustained improvement in compliance with **Immediate Release** for both red priority and all priority calls.

- The South Wales **Trauma Network Model** – work has been initiated in collaboration with the planned care group to redesign the Repatriation Policy with the aim of providing a set of key principles to reduce ambiguity in where patients should go and under which team. This should be a significant driver for flow issues.

- POW recently made an application to be revalidated as a **VTE Exemplar Centre**. Validation was approved and CTM UHB will continue to be a VTE Exemplar Centre.

- **Red 2 Green engagement days** occurred across the three DGH sites on 20, 21 and 22 June 2023. These focused on patient time and value added care with the patient at the centre of all we do within CTM.

- Capital funding has been confirmed to enable the establishment of **an SDEC area at PCH**. Tenders are being sought for the design work with a target completion date of November 2023 in readiness for the winter months.

- **Medical Outlier Patients** – the CoT**E** team in RGH need to reduce consultant ward rounds to once weekly for the most well patients. These patients will remain under regular review with the junior doctors, with consultant board rounds and consultant review if there is any clinical deterioration.

2.5 Children & Families

- **Cancer Performance** – the provisional June performance is at 0%, pending results of four patients. A number of long waiting patients were treated in June (21 in total 12 malignant were over 62 – a further 4 are awaiting histology). All patients breached the 62 day SCP target, with long delays at NPTH significantly impacting on the number of long waiting patients. Additional slots have been created in the CTMUHB Women's Hub however any Bridgend patients who have been waiting for a service in SBUHB will have already breached if they need ongoing treatment. Any reduction in administration support would compromise progress further.

  Overall performance has fluctuated and there is now a pilot taking place of the cancer tracker sitting within the CSG team as well the development of a weekly CSG cancer monitoring meeting and processes for members of the CSG team to support monitoring of patients through the pathway. Meetings have been held with the medical secretaries so that the whole team are clear.

- **Insourced theatre sessions** – additional sessions are available at DSU POW, and, given the lack of administrative support, this has now been made available working with another Care Group. It is anticipated that this capacity will make a significant improvement.

- The Care Group has held MDT discussions around concerns expressed regarding **WHSCC cot configuration consultation**. A response has been formulated by the service and sent to planning. The Care Group Director will seek a meeting with executive colleagues to discuss further.

2.6 Primary Care & Community

- **RN staff deficit (primarily vacancies)** remains a significant and ongoing risk to patient safety and quality – mitigation is in place.

- **Neuropsychology support for Stroke patients –** there is no service provision for stroke patients in YCR, due to the withdrawal of funding. Stroke ESD team unable to support until June 2024 due to maternity leave. Patients who require neuropsychology support have longer lengths of stay at the District General Hospitals so that this can be provided.

- **HMP Parc Prison** – a review of Quality and safety governance processes has been undertaken with a training programme in place to embed systems and processes fully

- **Medical staffing** model – the challenges at YCC remain ongoing and are included in the risk register with a potential impact on to patient safety and quality. The risk is mitigated through a combination of ANP provision, Ward Doctors reviewing patients on Ward 2 (as and when requested), coupled with the provision of weekly "troubleshooting" sessions provided by an Associate Specialist.

2.7 Mental Health & Learning Disabilities

Issues in Mental Health include:

- Committee is advised of progress towards a **Single Clinical Record System**, which has been supported by colleagues in the Executive Team and Board. An Implementation Board was convened in May, chaired by the Director of Digital.

- The **limited availability of CPR and some other face-to-face training** that is outside of the control of the care group is impacting on mandatory and statutory training compliance.

- **Vacancies -** There are currently 15 band 5 staff nurse vacancies within the RGH MH Unit and seven staff nurse vacancies at Angelton Clinic in Bridgend. As part of the in-patient improvement programme, workforce colleagues are to commence a review of reasons for leaving so that appropriate action can be taken.

- **Homicide Safeguarding review** – the RGH Service Group has recently received the externally commissioned review into the circumstances around the tragic events in Pen y Graig in 2020. The Lead Nurse is developing an action plan with Local Authority for the shared learning of the Care Group.

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

A summary of the key areas of risk / matters for escalation for the COO's portfolio continue to be as follows:

- Planned Care Recovery;
- Cancer Services and the imperative to improve performance in all areas;

- The activity in and challenge for the Emergency Departments across the Health Board.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The paper considers a number of key quality, safety and patient experience issues
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	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
5.2a

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE PLANNED CARE QUALITY, SAFETY, RISK & EXPERIENCE (QSR&E) MEETING	
DATE OF MEETING	25th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sharon O'Brien, Director of Nursing, Planned Care
PRESENTED BY	Sharon O'Brien, Director of Nursing, Planned Care
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director

REPORT PURPOSE	Noting

ACRONYMS	
FUNB	Follow Up Outpatients Not Booked
PCR	Planned Care Recovery
RCA	Root Cause Analysis
HIW	Healthcare Inspectorate Wales
POW	Princess of Wales
PCH	Prince Charles Hospital
USC	Unscheduled Care
RGH	Royal Glamorgan Hospital

SOP	Standard Operating Procedure
ED	Emergency Department
SAU	Surgical Assessment Unit
ITU	Intensive Treatment Unit
WG	Welsh Government
GIRFT	Getting it Right First Time
ODP	Operating Department Practitioners

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 20th June 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	**Ophthalmology** Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 2023 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews

ADVISE	**Clinical Service Models**
	• Clinical Service Model being produced to improve the limited availability of 'elective bed capacity' across PoW and PCH. Early interventions include:
	  ○ Creation or 4 ring-fenced beds on a designated ward in PCH
	  ○ Opening of 16 additional beds in PoW to increase the elective capacity and the USC surgical patients.
	  ○ Surgical Assessment Unit in RGH operational since June 2023, pathways & SOPs in place to support patient flow from ED to SAU.
	
	• SAU in PoW to transfer over to Planned Care Group in August 2023 to support the emergency surgical flow of patients attending ED.
	• Critical Care Improvement Programme and work streams progressing to review Critical Care Services HB wide.
	• CTM Trauma & Orthopaedic reconfiguration programme commenced.
	
	Single Cancer Pathway – Highlight Report
	Weekly performance meetings for all Tumour sites and support services. A template has been developed to ensure that there is standardised reporting. This enables the Cancer Business Unit (CBU) to develop a weekly highlight report.
	
	Organisational Risk Register
	• 4 Planned Care risks on the corporate risk register scoring 20:
	  ○ 4491 Demand for Planned Care services exceeds capacity – theatre insourcing has increased in PoW to increase capacity
	  ○ 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 up until March 2024.

ASSURE	• Human Tissue Audit on Ward 5 in PCH achieved 100% compliance • As part of the WG, GIRFT, the Theatre Utilisation Project has commenced with initial focus on: • Reduction in cancellations

	• Standardisation of theatre utlilisation and start times • Standardising Pre-Assessment Clinics and processes across the 3 sites to limit variation and reduce cancellations • Productivity in relation to 'high volume, low complexity surgical procedures. • Theatre workforce planning progressing at pace to ensure standardisation of ODP and nursing workforce across CTM. **Monthly Ward Assurance** • Audit reports using AMaT fully embedded and presented at Planned Care QSR&E Committee. Monthly action plans are produced by Ward/Departmental Managers for areas that are highlighted as red. • Triangulation with incidents and concerns at the monthly Quality Reviews meeting attendance includes Heads of Nursing (HoNs), Head of Governance, Lead Nurses and Concerns lead. **May 2023 - Ward Assurance data (Appendix 1)**
INFORM	• Implementation of the E Whiteboard and "One View" Implementation of 'Staff Appreciation' awards in PCH • Critical Care Nurses in PCH have produced a pressure damage booklet-appropriate for staff, patients and families. Aim to roll out to Critical Care in RGH & PoW. • Pressure damage, falls and medication errors Scrutiny Panels are fully embedded across all 3 sites. • Quality Framework embedding successfully within the new Care Group structure.
APPENDICES	**NOT APPLICABLE**

	Documentation	Controlled Drug	environmental
PCH Day Surgical Unit	100 %	100 %	97 %
PCH Endoscopy Unit		93 %	100 %
PCH Theatre Department			
PCH Ward 05	73 %	87 %	91 %
PCH Ward 06	95 %	100 %	94 %
PCH Ward 07 (formerly ward 3)	76 %	97 %	88 %
PCH Ward 08	88 %	-	97 %
PWH Day Surgical Ward			
PWH Endoscopy Unit		97 %	83 %
PWH Theatre Department			
PWH Ward 07	-	-	-
PWH Ward 08	90 %	97 %	97 %
PWH Ward 09	92 %	93 %	91 %
RGH Day Surgical Unit	-	-	-
RGH Endoscopy Unit		-	-
RGH Theatre Department	-		
RGH Ward 02	-	100 %	94 %
RGH Ward 03	87 %	97 %	85 %
RGH Ward 08	90 %	91 %	88 %
RGH Ward 09	83 %	93 %	91 %
RGH Ward 10	91 %	100 %	97 %
RGH Ward 15	96 %	100 %	100 %

HH & BBE	Uniform	Glucose	PVC	Catheter	IP&C
100 %	100 %	100 %	95 %	100 %	100 %
-	100 %	-	100 %	-	
88 %	100 %				
100 %	100 %	100 %	100 %	100 %	74 %
90 %	100 %	80 %	91 %	95 %	90 %
100 %	100 %	100 %	93 %	96 %	87 %
95 %	100 %	-	97 %	92 %	97 %
100 %	88 %	-	96 %	-	
100 %	100 %	100 %	100 %		86 %
-	-	-	-	-	
-	-	-	-	-	
100 %	100 %	100 %	71 %	67 %	100 %
100 %	100 %	100 %	100 %	100 %	100 %
-	-	-	-	-	
-	-	-		-	
100 %	100 %	-	-	67 %	
85 %	100 %	100 %	97 %	100 %	92 %
95 %	100 %	100 %	100 %	83 %	95 %
85 %	100 %	100 %	88 %	94 %	89 %
100 %	100 %	100 %	98 %	96 %	89 %
100 %	100 %	100 %	96 %	95 %	95 %
100 %	100 %	100 %	100 %	100 %	97 %

N/A	= Site/Care group not assigr
	= Unable to complete CORE
-	= No audit submitted

wristband
100 %
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ned
audits

	Documentation	Controlled Drug	environmental
PCH Day Surgical Unit	100 %	88 %	100 %
PCH Endoscopy Unit		96 %	97 %
PCH Theatre Department			
PCH Ward 05	62 %	93 %	88 %
PCH Ward 06	92 %	97 %	97 %
PCH Ward 07 (formerly ward 3)	72 %	97 %	85 %
PCH Ward 08	95 %	90 %	91 %
PWH Day Surgical Ward			
PWH Endoscopy Unit		100 %	87 %
PWH Theatre Department			
PWH Ward 07	82 %	97 %	94 %
PWH Ward 08	95 %	-	94 %
PWH Ward 09	80 %	93 %	88 %
RGH Day Surgical Unit	-	-	-
RGH Endoscopy Unit		100 %	100 %
RGH Theatre Department	-		
RGH Ward 02	92 %	90 %	88 %
RGH Ward 03	91 %	97 %	91 %
RGH Ward 08	63 %	90 %	85 %
RGH Ward 09	76 %	100 %	94 %
RGH Ward 10	85 %	100 %	94 %
RGH Ward 15	97 %	97 %	97 %

HH & BBE	Uniform	Glucose	PVC	Catheter	IP&C
100 %	100 %	100 %	90 %	100 %	100 %
90 %	95 %	100 %	95 %	-	95 %
94 %	100 %		-	-	
95 %	100 %	100 %	97 %	100 %	89 %
90 %	100 %	100 %	100 %	88 %	95 %
100 %	100 %	100 %	93 %	88 %	90 %
100 %	100 %	100 %	96 %	88 %	97 %
100 %	95 %	100 %	100 %	100 %	
100 %	100 %	100 %	100 %		91 %
-	100 %	100 %	-	-	
95 %	100 %	100 %	87 %	33 %	-
100 %	100 %	100 %	62 %	100 %	97 %
100 %	100 %	100 %	43 %	91 %	84 %
-	-	-	-	-	-
100 %	100 %	100 %		-	100 %
100 %	100 %	-	75 %	67 %	
88 %	100 %	100 %	88 %	100 %	89 %
100 %	100 %	100 %	100 %	75 %	90 %
90 %	97 %	100 %	88 %	95 %	95 %
100 %	100 %	100 %	90 %	90 %	95 %
90 %	91 %	100 %	100 %	100 %	97 %
100 %	98 %	100 %	100 %	100 %	97 %

N/A	= Site/C
	= Unabl
-	= No au

wristband
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92 %
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100 %
100 %

Care group not assigned
le to complete CORE audits
udit submitted

RGH

WARD 2

CD 90% - CD book kept in a drawer of a locked treatment room but not secure.
Environmental – 89.2% Sinks dirty, stored equipment not labelled with green tape and general wear and tear
BBE – 100% but HH – 87.5% X1 nonmedical and X1 nurse
IPC – 89.2%

WARD 8

CD's - the fridge does not have a lock reported to estates still outstanding. fridge temperature check only done once daily audit asks if wards completing twice a day so will ask night staff to do a check
Hand Hygiene and Bare Below the Elbow - Both doctors, not BBE - spoken with staff at time of audit
Environment - Chipped door frames and awaiting floor renewal, some stock on floor when too big for shelves, no lock on fridge, new staff awaiting badges so ID on them, no hypo box on ward 8 we
VIP score - If cannulas not inserted here bundles not complete, VIP scores by night not being completed staff spoken to improve compliance
Documentation - common themes with regards to what is not being filled out appropriately or in a

Ward 10+11

Documentation- 84.7%
There have been some themes noticed. EDD Weight on admission What matters to me Weight on medication chart These will be discussed in the ward meeting and staff identified to ensure they are aware of what needs to be completed on the documentation. If needed further on the ward training will be
Hand Hygiene and BBE- 90%
On two occasions a doctor was observed not adhering to hand hygiene policy, the doctor on both occasions was spoken to and advised what is expected of them
Environmental- 90%
This is ongoing progress and jobs have been raised with estates- this has been re-done today
Uniform- 91.4%
Noticed jewellery and an id badge missing this was addressed at the time and will reiterate in the ward

PCH
More detailed action plan in place

AGENDA ITEM
5.2b

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE UNSCHEDULED CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	25th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma James, Unscheduled Care Nurse Director Alex Brown, Unscheduled care Medical 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
GPAU	General Practitioner Assessment Unit

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 28th June 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	**General Practitioner Assessment Unit PCH** Due to increasing numbers and length of stay of our patients, significant work is ongoing surrounding the work force required to support patients that are attending the GPAU within Prince Charles Hospital. This will be presented at the next improving care board as an invest to save proposal. To ensure that we have the right workforce with the correct skills and attributes to ensure that we deliver safe and effective care to our patients.

ADVISE	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 Organisational Development. Of these actions 2 remain outstanding but in progress to complete soon and will now move over to the Six Goals Programme to progress. Complaints have been transferred to a central quality governance team within the organisation. This will ensure we maintain equity, consistency and strengthen resilience. USC compliance with the 30 target has decreased from 36% in April to 32% in May. This has been a result from closing a large number of out of compliance complaints. Since February 2023 106 complaints have been closed, 62 have been closed which had been out of compliance and 44 within compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed 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. **Stroke Quality Improvement Measures – June 2023** During April, 14.7% (10 out of 68 admissions) of stroke patients were admitted directly to an acute stroke unit within 4 hours. Two of the twelve eligible patients were thrombolysed within 45 minutes (16.7%) and 46.4% of patients (32 out of 69 diagnosed patients) had a CT scan within an hour. There were also 32 out of the 69 stroke patients (46.4%) seen by a specialist stroke physician within 24 hours of arrival at the hospital. Direct admission to acute stroke unit within 4 hours has been a challenge, but a recent T&F group has prioritised the acute

stroke beds in both acute stroke unit sites and re-established ring fenced beds, we would expect to see significant improvement in future months.

STROKE TASK AND FINISH GROUP

A Stroke Task and Finish group has been established, the purpose is to rapidly further develop and implement a robust and resilient stroke pathway to ensure that there is equality of access to specialist stroke services across the UHB. The focus will be concentrated on ensuring a robust pathway for those patients presenting to RGH to access stroke beds on a dedicated unit.

Healthcare Education and Improvement Wales visited Prince Charles Hospital General Medicine department in February 2023. There was a list of expected improvement measures, which relate to:

- A need to increase the medical workforce (junior, including Advanced Nurse Practitioner/Physician Associate roles) and senior (consultant and specialist grade)
- Access to training
- Undue pressure on junior doctors to discharge patients
- Management of the medical rosters
- Information governance
- Corporate induction, including use of DATIX.

There is an active action plan within the directorate, with oversight from unscheduled care group and the medical education department.

Risk Register

The Unscheduled Care Senior Management Team have recently undertaken a cleansing exercise to review all risks currently located on the risk register. This is to assure that that the mitigating actions have been reviewed and risk score matrices have been correctly aligned.

AMaT

Audit Management and Tracking System (AMaT) is an innovative system designed to make auditing easier, faster, and more effective. AMaT is a user-friendly system created with NHS clinical audit teams it is designed to give users more

	control over audit activity and can provide real-time insight and reporting for clinicians, wards, audit departments and organisations. AMaT allows clinical teams to register audits, associate related guidance, complete audits online, manage action plans and the scheduling of audits and audit meetings. A high-level report has been produced which gives an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. Attached at appendix 1 is the compliance for all areas within the USC care group to highlight areas which require improvement.
ASSURE	**Wales Ambulance Services Trust (WAST) Immediate Release Review** Sustained improvement in the compliance against immediate releases for both red priority and all priority calls. Recent WAST Chief Executive Officer Briefing highlighted the improvements over the last 10 weeks with the average number of immediate release declines reduced from 11 (4 red) per week to 0.7 (0.4 red) per week. No immediate release request refused from within the organisation and we continue to work with WAST to ensure resources are available for our communities when required **WAST Quality and Safety Update** We continue to work in collaboration with WAST colleagues to ensure we strive to deliver a quality service to our patients. From their June Quality & Safety update – they currently have 4 Nationally Reportable Incidents (NRI's) open reported within CTM and 3 have been closed within the last 6 months. Cases referred to the Health Board under the Joint investigation framework are subject to a Joint Investigation Framework meeting with WAST. Decisions are made during those meetings regarding enacting Duty of Candour and the lead organisation will contact families where appropriate. We currently have 10 joint investigations in process and the Director of Nursing (DoN) meets with WAST colleagues on a weekly basis to review any new incidents.

	WAST currently have 74 open complaints (Since Dec 2022) within CTM with 46 of these being link to access to services. Within CTM our <15min handover has increased significantly, from Jan-May average 21% (500) this has increased to 45.2% (1,116)
INFORM	The South Wales Trauma Network model relies on an automatic acceptance policy for major trauma center (UHW) admissions and local repatriation. The current repatriation procedure often leads to confusion as to where patients should be repatriated and which medical team should be responsible for ongoing care. This results in a delay in patient transfer. Now that the major trauma service sits within the unscheduled care group portfolio, work has been initiated in collaboration with the planned care group, to redesign this repatriation policy with the aim of providing a set of key principles to reduce ambiguity in where patients should go and under which team. This should reduce delays in local major trauma repatriation. Recent application made by Princess of Wales Hospital to be revalidated as a Venous thromboembolism (VTE) Exemplar Centre. The portfolio of evidence was reviewed and they are delighted to confirm that our Health Board has been revalidated as a VTE Exemplar Centre. The Exemplar Centres Network remains central to the continued success of the National VTE Prevention Programme, to reduce avoidable harm and improve outcomes for patients. The VE Exemplar centre would like to thank us for the support that our organisation has shown for the National VTE Prevention Programme. This has been awarded to organisations who have demonstrated outstanding quality, innovation and leadership in the field. Red 2 Green engagement days occurred across the 3 sites with a focus on patients time and value added care with the patient at the center of all we do within CTM on 20th, 21st and 22nd of June 2023. Positive feedback has been received from staff, this will now be implemented within the six goals programme with a planned launch date to be shared in the next few weeks. Same Day Emergency Care (SDEC) at PCH Capital funds confirmed to enable the establishment of an SDEC area.

Tenders being sought for the design work with a target completion date of November 2023 in readiness for the winter months.

We are no longer boarding patients at Princess Of Wales Hospital (POW) in front of the fire exits due to concerns surrounding Health and safety.

POW ED Capital Works

ED capital work continues. Programme approximately four weeks behind schedule due to subcontractor issues. Potential for disruption when the flooring commences 27th June 2023

Medical Outlier Patients

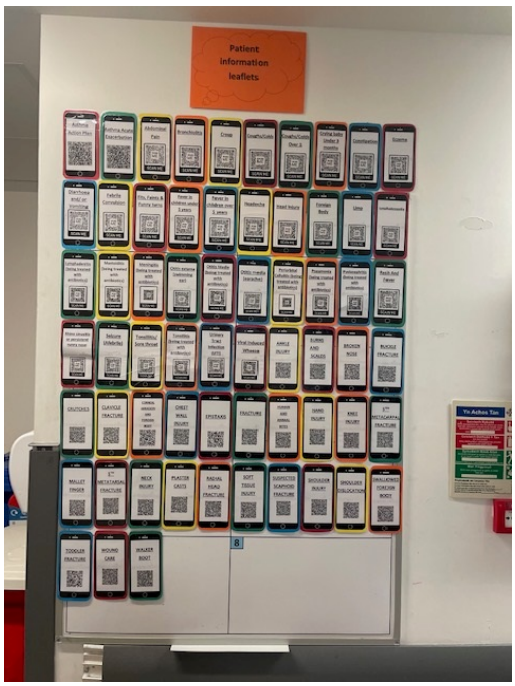
Across CTM, there is a 'core' of medical wards and medical inpatients which the medical teams look after. The actual number of patients in hospital under these teams is now consistently higher, leading to short staffing and reliance on locum staffing. In the short term, the Care of The Elderly (COTE) team in RGH are needing to reduce their consultant ward rounds to once weekly for the most well patients. These patients will remain under regular review with the junior doctors, with consultant board rounds and consultant review if there is any clinical deterioration.

In response to this, the Unscheduled Care team is writing a proposal for the medical workforce, which aims to:

- Increase and diversify the medical workforce
- Improve access to training and development
- Significantly reduce the agency overspend

This workforce proposal aims to be ready for escalation for approval (or otherwise) within a month.

Immediate release request Standard operating procedure (SOP) and pre-emptive patient transfer SOP has been finalized and sent for approval via the formal governance process.

	Positive patient outcome with an Emergency Department (ED) Paediatric Trauma Call at PCH where an infant sustained catastrophic injuries following Road Traffic Accident. The Paediatric ED has implemented a visual board within the department of QR codes for patient Information leaflets. These link with the national guidelines and are a great service development and quality improvement initiative within the department. We now hope to roll these out across CTM and also into the adult ambulatory areas. 
APPENDICES	**NOT APPLICABLE**

AREA	Apr-23	May-23
PCH Cardiac Day Case Unit	99%	98%
PCH Clinical Decision Unit	93%	95%
PCH Emergency Department	68%	58%
PCH ITU	94%	84%
PCH Medical Day Unit	100%	62%
PCH Outpatients Department - Main		94%
PCH Ward 01 CCU	98%	97%
PCH Ward 02	98%	99%
PCH Ward 03 (formerly ward 7)	75%	94%
PCH Ward 09	95%	96%
PCH Ward 10	99%	96%
PCH Ward 11	99%	99%
PCH Ward 12	89%	93%
PWH Acute Medical Unit	86%	89%
PWH Emergency Department	89%	77%
PWH ITU	95%	96%
PWH Outpatient Department	94%	95%
PWH Outpatients - Ophthalmology	96%	100%
PWH Outpatients ENT		
PWH Ward 04	91%	85%
PWH Ward 05	93%	87%
PWH Ward 06	96%	97%
PWH Ward 10	74%	95%
PWH Ward 15	92%	80%
PWH Ward 18	93%	96%
PWH Ward 19	67%	48%
PWH Ward 20	92%	88%
RGH Emergency Department	42%	28%
RGH ITU/HDU	77%	77%
RGH Outpatients - Ophthalmology		
RGH Ward 01 AMU / SAU	94%	39%
RGH Ward 04 AMU	93%	95%
RGH Ward 05	95%	98%
RGH Ward 06	82%	83%
RGH Ward 12	94%	98%
RGH Ward 14	96%	92%
RGH Ward 19	97%	99%
RGH Ward 20	96%	98%

AGENDA ITEM
5.2c

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE CHILDREN & FAMILIES CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	25th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Suzanne Hardacre, Director of Midwifery & Nursing, Catherine Roberts, Service Director, Mohamed Elnasharty, Medical Director,
PRESENTED BY	Suzanne Hardacre, Director of Midwifery & Nursing, Children & Families Care Group
EXECUTIVE SPONSOR APPROVED	Executive Director of Nursing

REPORT PURPOSE	FOR NOTING

ACRONYMS	
C&F	Children and Families
CAMHS	Children & Adolescent Mental Health Services
CCN	Children's Community Nursing
CTMUHB	Cwm Taf Morgannwg University Health Board
CYP	Children and Young People
DTP	Diphtheria, Tetanus & Polio
DU	Delivery Unit

IP&C	Infection Prevention & Control
Men C	Meningitis C
MRSA	Methicillin Resistant Staphylococcus Aureus
NICU	Neonatal Intensive Care Unit
PCH	Prince Charles Hospital
POW	Princess of Wales
PREM	Patient Reported Experience Measures
RCN	Royal College of Nursing
RCM	Royal College of Midwives
RGH	Royal Glamorgan Hospital
SBAR	Situation, Background, Assessment, Recommendation
SCPHN	Specialist Community Public Health Nursing
SEHS	School Entry Hearing Service
SRO	Senior Responsible Officer
TI	Targeted Intervention
USS	Ultrasound Scan
WG	Welsh Government
WLI	Waiting List Initiative

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children & Families Care Group at its meeting on 8th June 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	A number of colonisations of babies in the PoW NICU with MRSA have been identified. Public Health Wales experts supported with a visit and assessment of the unit with our health board infection prevention and control colleagues. Their report identified some environment and staff issues and an action plan was developed. The delivery of this plan has been managed through a task and finish group that has met daily. Support was sought from the executive team and capital monies identified. The closure, developed in partnership with internal and external teams, took place for 5 days from the 19th June to 24th June. The Delivery Unit, Welsh Government Targeted Intervention (TI) & Maternity Policy Teams visited Prince Charles Hospital on 5th June to review ongoing sustainability and assurance as part of TI oversight. Positive feedback received following the visit. A report will be prepared ready for the next Tripartite meeting in July.
ADVISE	Safeguarding - Joint inspection of child protection arrangements undertaken in Bridgend w/c 12th June. Level 3 safeguarding training increasing across the Care Group, will be part of maternity mandatory (in house) training from September 2023. Recent IP&C environmental audit undertaken within Women's Health Unit at PoW – report awaited. The Care Group is keen to progress initiatives to improve the long waiting times for children awaiting neurodevelopmental assessment. At the time of report a response is awaited from the strategy group. Head of Midwifery post for Prince Charles Hospital remains unfilled. Maternity services are reviewing Entonox training and awareness. Meetings are in place with the Health and Safety team to explore measurements within maternity settings.

	Access to timely ultrasound scan due to pressures within radiology team continue. Concerns that 72 hour target may not be achieved. No Datix reported. School Entry Hearing Pathway – update awaited from Audiology colleagues. Acute paediatric wards reporting increased CAMHS admissions.
ASSURE	The Children and Families Care Group formally review's risks once a month in our Operational Management Board. Information is shared on actions being taken to address, mitigate and manage. We currently have 6 risks scoring 15 or above and one additional new risk that we have submitted. We also update Children and Family elements or wider Health Board Risks e.g Cancer • ID 2808 -Waiting times for paediatric neurodevelopment services – investment through Regional Partnership will support service improvements but not fully mitigate the risk • ID 4650 - Delivering the BAPM staffing levels across our neonatal services – staffing options being explored • ID 3008 - Manual Handing training for labour ward staff – plans in place for bespoke training • ID 5413 - Replacement of obstetric theatre bed/table – awaiting capital funds • ID 4928 - POW neonatal unit infrastructure – Recent investment is being review and risk is being reassessed with infection control – likely to be reduced • ID 5364 - School nursing vacancies in Merthyr Local Authority Area – out to recruitment, likely to be reduced • New Risk - Safeguarding – work is underway to develop a single service for CTMUHB through the Safeguarding Hub in RGH with partners.
INFORM	Team members were invited to make a presentation on women's health activities and challenges to Health Board in June.

	First Multi-Professional, Multi-Agency 'Baby Shower' Engagement event at Orbit Centre, Merthyr Tydfil on 27th June. The event received over 40 families with plans to repeat across CTMUHB. Submissions are being prepared for the NHS Wales awards. A senior leader's away day was held (8a-8d) Care Group teams on 22nd June 2023. Royal College of Nursing, Nurse of the Year Wales Awards celebrated on June 29th:- • Chief Nursing Officer Award **Winner**: Midwife Sarah Morris • Improving Individual and Population Health Award **Winner**: Midwife Sharon Webber • Supporting Education & Learning in Practice **Runner - Up**: Midwife Laura Little Royal College of Midwives State of Maternity Services Wales Report launched 28th June 2023. The content of the report will be considered when reviewing Birthrate + midwifery workforce plans during summer 2023. Diversity Training session being arranged for care group senior management team. RCM Wales hosting diversity training for midwives and support workers across Wales. New toys acquired across all acute paediatric sites from endowment funding. SONY refurbishment of the paediatric ward scheduled for June/July. Baby Friendly (BFI) accreditation achieved across both PCH and POW neonatal units. Staff well-being event being planned for community children's nursing team on 16th August 2023.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
5.2d

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE MENTAL HEALTH AND LEARNING DISABILITIES CARE GROUP QUALITY & SAFETY COMMITTEE	
DATE OF MEETING	25th July 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	Dr Mary Self, Medical Director, Mental Health and Learning Disabilities
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Director of Nursing

REPORT PURPOSE	NOTING

ACRONYMS	
AMAT	Audit Management and Tracking
CTO	Community Treatment Order
CTP	Care and Treatment Plan
DU	Delivery Unit
LRI	Locally Reportable Incident
MHA	Mental Health Act
NRI	Nationally Reportable Incident
PCH	Prince Charles Hospital
QSRE	Quality Safety Risk and Experience Meeting
WCCIS	Welsh Community Care Information System

1. PURPOSE

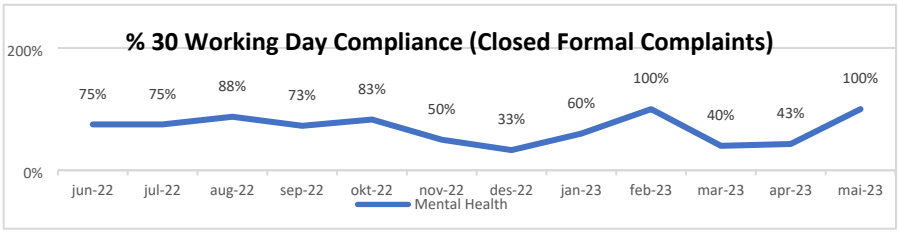
1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its QSRE meeting on 7th June 2023.

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 progress towards a **Single Clinical Record System** (Datix Risk Register ID 3337). The Executive Team and Board have supported the progression toward implementation of WCCIS and an Implementation Board will convene in May, chaired by the Director of Digital. • The **limited availability of Cardio-Pulmonary Resuscitation (CPR) and some other face-to-face training** that is outside of the control of the care group is impacting on mandatory and statutory training compliance.
ADVISE	• **Commissioned Services** *New services subject to enhanced monitoring:* Mountains Nursing Home Powys - 24th April 2023. 11 CTMUHB Patients at the site, all have received focused reviews since concerns identified. 2 patients need alternative placements and enhanced monitoring process remain in place. Next review meeting 30th June 2023. *Notice of closure:* Gellineudd Locked Rehabilitation Hospital closure on 31st May 2023. 1 CTMUHB patient transferred to Royal Glamorgan Hospital and commenced S17 leave to Nursing Home placement. *Existing services subject to enhanced monitoring:* Cwm Gelli Lodge Nursing Care Home in Gwent from 3rd April 2023. 4 CTM UHB patients at the site, all reviewed since concerns notice. Next escalating concerns review 12th June 2023. *Services resumed routine monitoring:* Heatherwood Court 3Q status from 5th May 2023. Willows EMI Nursing Home from 24th April 2023. Cartref Mynydd residential home in Cardiff from 24th May 2023. • **Vacancies** There are currently 15 band 5 staff nurse vacancies on RTE MH unit and 7 staff nurse vacancies at Angelton. As part of the in-patient improvement programme, workforce colleagues are to commence a review of reasons for leaving. A Care Group workforce group has been refreshed and will focus on mitigating actions for hotspot areas. • **Homicide Safeguarding review**

	RTE CSG has recently received the externally commissioned review into the circumstances around the tragic events in Pen y Craig in 2020. Lead nurse is developing an action plan with Local Authority for the shared learning of the Care Group. • **111#2** 24 hour "soft" roll out commenced in April. Initial outcomes have seen significant use of the service by Bridgend services users likely due to transition from SPOA arrangements. The 111 project team continues to develop governance and is building feedback and assurance processes with the wider MH service. National rollout is scheduled for June with ministerial launch and media campaign planned • **Smoke Free Environment** Care Group smoking cessation group is developing universal approach to managed/care planned smoking (timed and supported sessions) as interim measure while wider review of environments is underway. The smoking cessation work reports via Health and Safety but is included here for advisement as there are associated quality and safety risks. Staff have reported an increase in violence and aggression incidents – a review of incidents is underway to determine if there is any association.
ASSURE	• **Angleton Security** Following potential breaches to security on Ward 3 (that is believed to be a member of agency staff utilising the room) a desktop review of security was held. A number of actions were taken to increase security arrangements, including changing all locks. • **Complaint Closure Compliance** is a key priority for the Health Board. Compliance in the MHLD Care Group is currently at 100%. The low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.  • There are 10 open **Nationally Reportable Incidents** with 5 of those overdue for completion. These cases are complex, some are being externally reviewed and all are being actively managed.

INFORM	• **RCN Nurse of the Year Awards** – Two Learning Disability Acute Liaison Nurses were winners at the ceremony in June 2023. • Recent **Bed Pressures** across adult mental health services has resulted in the development of a pan-CTM weekend planning and bed escalation process • The **Older Adult Falls Safe Care Collaborative** is progressing its work. The improvement project commenced at Angelton and is now being progressed across the care group with an official launch for the wider care group project being planned for some time in August.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
5.2e

QUALITY AND SAFETY COMMITTEE

HIGHLIGHT REPORT FROM PRIMARY COMMUNITY CARE GROUP

DATE OF MEETING	25th July 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 (RTE & Bridgend) Fiona Wood, Head of Nursing, Primary Care and Communities (Merthyr/Cynon) Jane Armstrong, Clinical Director of Primary care
PRESENTED BY	Lucie Williams, Head of Nursing Primary Care and Communities (RTE & Bridgend)
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director
REPORT PURPOSE	NOTING

ACRONYMS	
YCR	Ysbyty Cwm Rhondda
AMaT	Audit Management and Tracking System
DN	District Nurse
ESD	Early Supported Discharge (Stroke team)
GMS	General Medical Services
GDS	General Dental Services
HMP	His Majesty's Prison
HoN	Head of Nursing
OGEP	On the Ground Education Programme
PCSU	Primary Care Support Unit
RN	Registered Nurse
SBRI	Small Business Research Initiative

TEPs	Treatment Escalation Plans
VBHC	Value Based Health Care
YCC	Ysbyty Cwm Cynon
YGT	Ysbyty George Thomas

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.

1.2 Key highlights from the care group are reported in section 2.

2. HIGHLIGHT REPORT FROM THE LAST COMMITTEE MEETING

ALERT / ESCALATE	**RN staff deficit (primarily vacancies)** remains a significant and ongoing risk to patient safety and quality. Action plan in place and daily senior nursing oversight to mitigate risk. On risk register, score = **16** (work is underway to align with the overarching clinical workforce risk on the Organisational Risk Register) **Neuropsychology support for Stroke patients** – there is no service provision for stroke patients in YCR, due to withdrawal of funding. Stroke ESD team unable to support until June 2024 due to maternity leave. Patients who require neuropsychology support have longer lengths of stay at the District General Hospitals so that this can be provided.
ADVISE	**HMP Parc Prison** – Quality and safety governance processes being reviewed with training programme in place to fully embed CTM systems and processes. **DN Night service** operational management has been aligned as one CTM wide service, to ensure that equitable services are evident for all. **Medical staffing** model YCC remains an ongoing challenge and a risk to patient safety and quality. The risk is mitigated through a combination of ANP provision, Ward Doctors reviewing patients on Ward 2 (as and when requested), coupled with the provision of weekly "troubleshooting" sessions provided by an Associate Specialist. A locum Specialty Doctor is due to commence w/c 10th July 2023 which will ensure all four wards have a designated Doctor. **Patient Transfers** between Prince Charles Hospital (PCH) and YCC, the required level of supervision is not always accurately reported prior to transfer resulting in a risk to patient safety. Formal concern received regarding avoidable fall. A new process has been piloted, bed allocation now coordinated by Flow Team Assistant, working well. **Unexpected Patient Exit, YCC** 7 reported cases throughout 2022 and 2 reported cases to date although this is thought to be higher. Whilst risk

	assessments and controls are in place to mitigate the risk, there is a need to install key codes to exit the wards – a meeting is scheduled for 6th July 2023 to agree/sign off required action. **Manual Handling compliance YCC** very low compliance which is in keeping with the organisational position of around 20%. This is due to the inability to release staff for 1 day training due to poor staffing levels. Action taken to date includes linking up with UHB's Manual Handling Coordinator to discuss feasibility of condensing training to half day. Additionally, the service group's Clinical Practice Educator has been upskilled to undertake the Patient Handling Key Trainer role with a view to providing site based training as opposed to staff having to travel to Tonteg hospital for training. A half day classroom session would have capacity to update 6 staff per session. **Management of Patients Community Hospital sites** increasing number of incidents are being signposted to site Senior Nursing & Management teams for a solution: ➢ Patients in Minor Injuries Unit (MIU) (after 6.30pm) awaiting transfer to the acute site. ➢ Patients in the Dental Unit (YCC only) who are unwell and require a clinical response. ➢ Members of the public who become unwell whilst visiting the site and/or present seeking medical support (out of hours). With reference to the above issues, a meeting is being held between site management team, HoNs, and Consultant Lead on 17th July 2023 to discuss and agree next steps. **District nursing medication charts** - Task and finish group to be set up to facilitate the safe prescribing and transcribing of medication for DN administration.
ASSURE	**<u>Community Hospitals</u>** **D2RA** – ETOC referral process embedded for transfers to YCR community Hospital. PCH commenced ETOC referral process for transfers to YCC 27th June 2023. **Recruitment** day planned for community hospitals in relation to RN vacancies. **YCR inpatient falls** a review has been undertaken by Head of Nursing and Lead Nurse for Governance for May 2022 to May 2023, to identify any themes and trends. Leaning identified for managers in relation to Datix investigation. **YCC inpatient falls between 1st April 2022 to 9th June 2023** Of the 12 incidents where staffing levels hadn't been maintained (in keeping with the planned roster), it was found that low staffing was a contributory factor in a total of 5 (41.6%) incidents. Lessons to be learned include:- ➢ The provision of accurate information in relation to enhanced supervision prior to the patient transferring from acute site to community hospital site.

- Robust risk assessment which serves to identify the patient's need for enhanced supervision.
- Timely specialist Mental Health assessment with a view to ensuring treatment plans are optimised for those patients with increased agitation.
- Provision of equipment (high/low bed) to maintain patient safety.
- Locating patients closer to the nurses station which allows for a quicker response when alerted by the wander guard alarm.
- Ensuring patients are nursed in a cohort bay which allows for enhanced supervision (as and when identified by the risk assessment and enhanced supervision documentation).
- Ensuring wander guard equipment is in full working order.
- Ensuring that all steps are taken to maintain planned staffing level in keeping with roster (cover from other wards/bank/agency).

Ward 21, POW deep dive planned to review current flow process to identify any delays in relation to discharge.
TEPS YCC HoN, AS and AMD met with YCC medical team, agreement reached regarding the need to strengthen the existing process which includes Advance Care Planning practice. ACP was also highlighted as a result of a recent **Level 2 Mortality Review.**
Safe2Start fully embedded, provides assurance that any risks are identified and mitigated as fully as possible early in the day.
ISO1401 Environmental Standard Audit external audit completed 7th June 2023 which included ward 2, YCC. No issues reported.

IP&C Environmental Audit – YCC completed 10th May 2023. Audit served to identify a range of estate related issues which are in the process of being addressed.

District Nursing

Community Nursing specification and action plan work ongoing.
Demand and Capacity work continuing with support from planning.
DN Principles return submitted end of March 2023. One area of non-compliance being 1 Community Navigator supporting 4 teams (M/C).

Specialist Services

Tissue Viability Community Acquired Pressure Ulcers (CAPU) task & finish group/steering group set up, honorary contracts for WWIC nursing staff in process of being drawn up. Annual PU Prevalence audit for community hospitals deferred until Autumn 2023.
Lymphoedema Service CTM UHB end of year report presented by national team 17th May 2023. Clinical Lead commended for her resilience in what has been an extremely challenging year. Recommendations & action plan in process of being implemented.

	Lymphoedema VBHC Improvement Project (OGEP) launched March 2023 to promote clinically effective and prompt management of Chronic Oedema. Steering group set up to monitor progress. **Primary Care** **GDS** Refurbishment of new practice commenced in Bridgend- anticipated to be completed in Oct 2023. First stage of grant to be awarded to support costs. **GDS**. Tender currently live to replace contract that closed at end of April. This will be for a 3 surgery practice. 12 parties have so far accessed this information on BRAVO. **GDS Internal Audit** Year End/Mid-Year- team asked to supply information/evidence of mid/year end processes **GMS** Access Standards – all practices have submitted evidence of achievement and these will be verified and approved at the Access Forum Group on 24th May 2023 **Dispensing Practices'** procedures and improvement plans have been reviewed with three joint visits undertaken with GMS/Pharmacy to review **Sustainability** PCSU currently supporting 2 x practices with GP/Management Support and meet regularly with practices where issues are identified.
INFORM	**DN team Bridgend North** received excellent patient feedback from a relative whom would like to nominate the team for a recognition award. **DN service** three month pilot of two new audits will be undertaken via AMaT (commencing July 2023) – nursing documentation audit and pressure ulcer documentation audit. **HCSW annual conference** DN service showcased a number of quality initiatives including community navigator role and assistant practitioner role. **Inaugural iCTM QI Showcase Event 2023** abstract submitted in relation to the safety huddle project within Merthyr/Cynon District Nursing service. **SBRI Challenge** both community hospitals are engaged in this new initiative to develop a web application that facilitates secure communications between staff, families and patients through voice–video memos and text exchanges. **Local Public Health Team/Senior Nurse Vac & Imms** presented Fluenz project to Vaccinations Project Team, Welsh Government. The project was also published in 'vaccine' Journal. **Specialist Immunisation service** Senior Nurse received a Lifetime Achievement award in recognition of services to individual and population health and setting up the Community Vaccination Centres (alongside colleagues). **Immunisation related incidents** a review of incidents by the specialist imms team has resulted in targeted training for A+E, Midwifery, and Sexual Health staff.

	GMS practice merger in Bridgend merger (clinical systems) will complete on 12.06.23 **Covid Autumn Booster** – 35 GP practices have expressed interest in participating in campaign pending further information. 25 of these would consider a network solution to delivering vaccine. **Complaints and concerns** Between 01/03/2023 and 30/04/2023 there have been 138 concerns made to the Health Board in relation to Primary Care Services. • 15 Formal Complaints • 116 Early Resolutions • 7 Enquiries (5 from MS/MP) (2 from Family/Carer) (1 from Service User) • There are currently 28 complaints over 30 working days **Incidents** in Primary Care services (36):- 11- No Harm 19- Low Harm 6- Moderate
APPENDICES	Choose an item.

3. RECCOMENDATION

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

AGENDA ITEM
6.1

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY & QUALITY DASHBOARD

Date of meeting	25th July 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	Nigel Downes, Assistant Director of Quality & Safety
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	
NEWS	National Early Warning Score
HMR	Hospital Mortality Review

1. SITUATION/BACKGROUND

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.05.23 to 30.06.23 taken from systems on 03.07.23, 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 changes to the quality governance model and arrangements are being embedded.

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:

- Increase in the number of early resolution complaints received. Implementation of a robust triage process along with improved recording of early resolution complaints.
- Compliance with the 30 working day target for responding to complaints increased to 56% in June 2023. A plan is in place to address the number of complaints open over 30 working days while maintaining the focus on the complaints due.
- Reduction in the number of Public Service Ombudsman for Wales referrals received.
- The number of compliments recorded on the Datix Cymru system has continued to decrease. A number of options for engaging with staff to ensure robust recording of compliments received are being explored.
- Continued increase in the number of medication incidents reported.
- Decrease in Patient falls incidents reported
- Increase in Pressure Damage Incidents reported
- Inclusion of Duty of Candour information

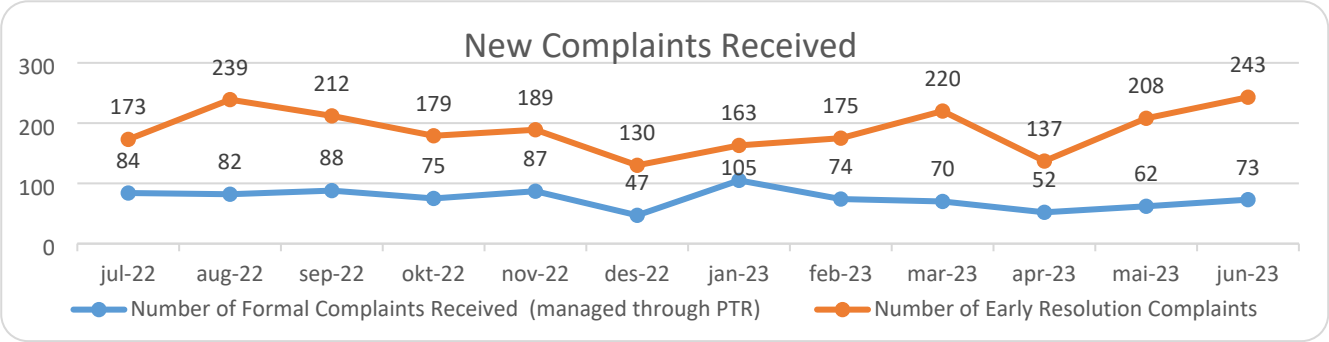
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Patient / Service User Feedback

Complaints

New Complaints Received

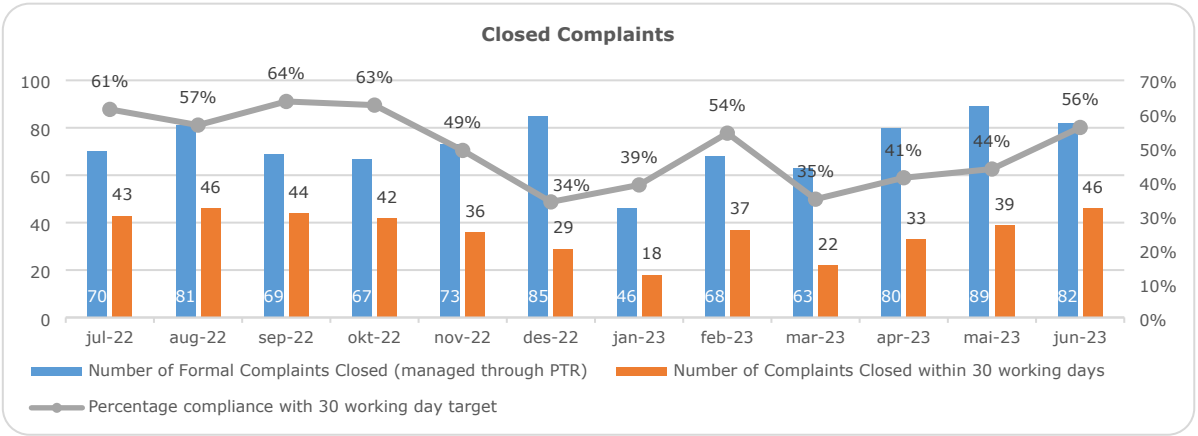
Between the 01.05.23 and 30.06.23 the Health Board received a total of 586 complaints. Of these, 135 were categorised as formal and managed under the Putting Things Right Regulations (PTR). Whilst complaints managed through PTR has remained relatively consistent since February 2023, the chart below highlights a steady increase in the total number of complaints received during May and June 2023. This may be partly attributed to an improved recording of early resolution complaints and embedding of the triage process to review complaints.



For all complaints received in March and April 2023, the top 2 types of complaints received remain consistent with previous months, with the addition of medication as a third top theme. These relate to Appointments (175), Clinical Treatment / Assessment (137) and Medication (60).

Closed Complaints

Within the period of 01.05.23 to 30.06.23, the Health Board closed a total of 171 formal complaints (managed through PTR). Following a decrease in compliance with the 30 working day target, compliance for June 2023 has increased to 56%.

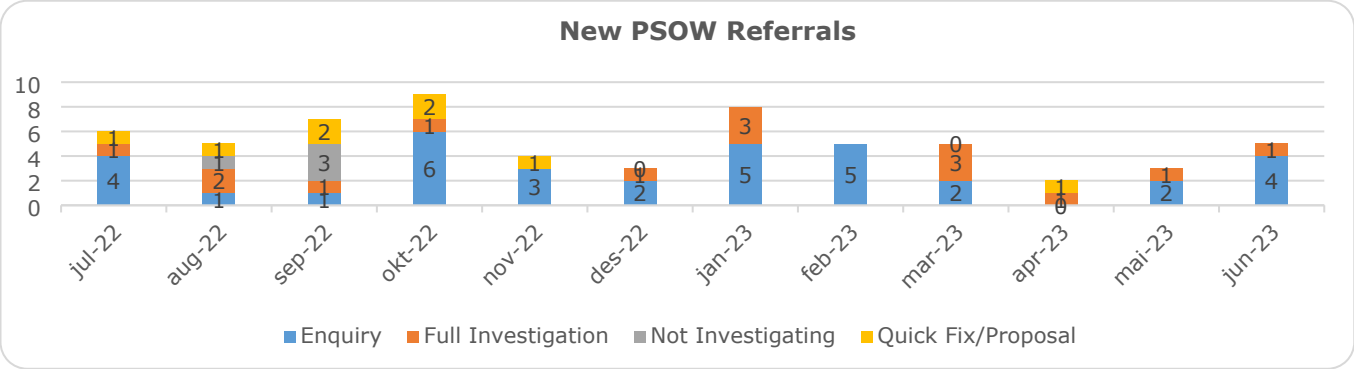


A plan is in place to continue to improve compliance with the 30 working day target to respond to complaints. Improvement actions are summarised below:

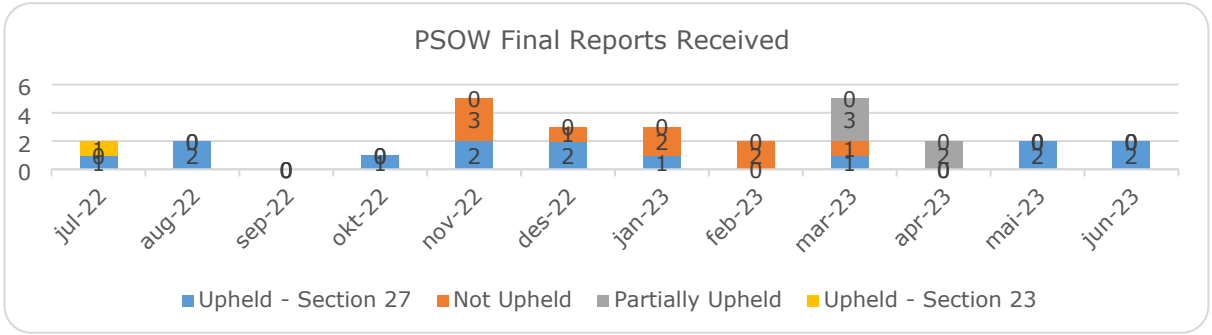
- Triaging of complaints to increase number of complaints managed via early resolution
- Revised process in place for management of Formal Complaints - early escalation requirements highlighted and being embedded
- Daily Complaint Team Huddles in place to review cases and support escalation process
- Trajectory plan in place to address complaints open over 30 working days. This has decreased by 50% from 160 on 01.04.23 to 80 on the 30.06.23.
- Monitoring in place to ensure that updates are provided to all complainants where cases have been open over 30 working days.
- A review of the service, by Internal Audit, provided reasonable assurance – action plan developed to address recommendations

Public Services Ombudsman for Wales

The Health Board received notification of 8 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.05.23 and 30.06.23. This remains consistent with the previous two month period. Of the 8 referrals, 2 were received as full investigations and 6 as enquires.



During the same period, the PSOW issued 4 final reports to the Health Board, all of which were upheld. The upheld reports relate to services provided by Unscheduled Care (1), Planned Care (1), Primary Care (1) and Diagnostics, Therapies and Specialities (1).



As at 30.06.23, the Health Board currently has 57 Open PSOW cases, of these 35 are awaiting a response from the PSOW to instigate any further action required. Compliance has been submitted and confirmation of closure is awaited on 4 of the 35 cases. 12 are at final report stage with actions being implemented by the Care Groups.

Compliments

Whilst compliments are received across the Health Board, via a number of mechanisms, there is a requirement to improve the system of recording to accurately reflect and analyse the information being received.

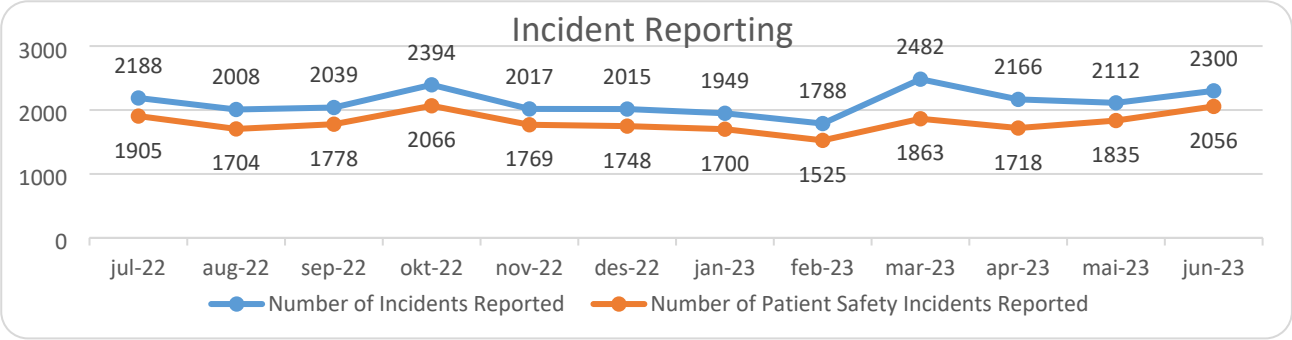
A plan to improve the recording of compliments has been established which includes:

- Development of a Standard Operating Procedure for management of compliments that outlines receipt, acknowledgement, feedback to staff and logging of compliments.
- Identify key individuals within Care Groups / Service areas who will log compliments on Datix Cymru. Discussions have commenced with Maternity and Primary & Community.
- Explore option of making available a compliments form that can be directly submitted to the system (akin to incident reporting form). A review process will be required to support this.
- Develop a communication and training plan to support roll out of Standard Operating Procedure.

2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4412 incidents were reported between 01.05.23 and 30.06.23, this represents a decrease of 236 when compared with the previous 2 months.

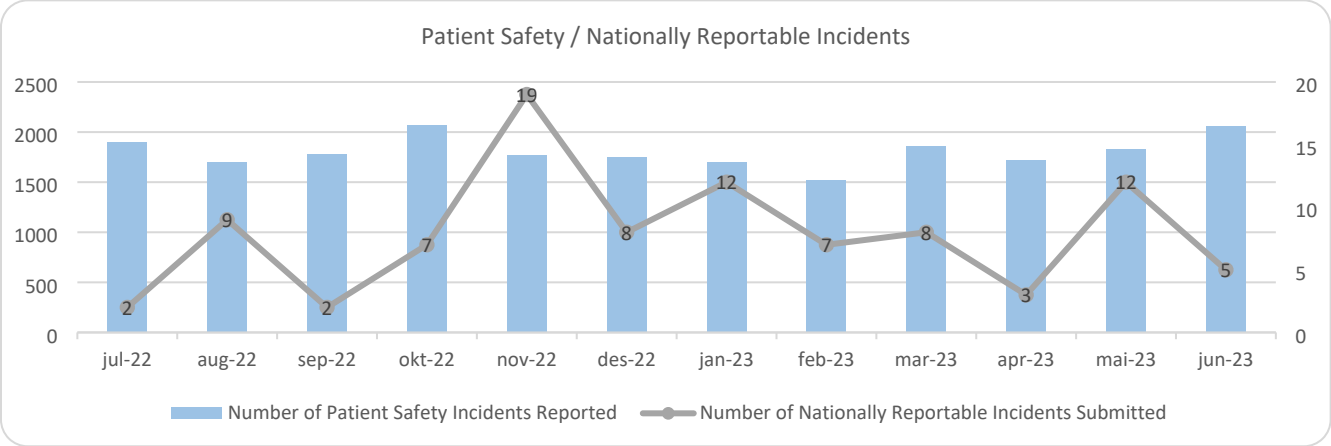


Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has continued to increase. Of the 4,412 incidents reported, 88% (3891) were reported as the patient affected.

The top 3 types of incidents reported for May and June 2023, linked to a patient affected are Pressure Damage /Moisture Lesion (1334), Infection, Prevention & Control (565) and Accident, Injury (535).

Nationally Reportable Incidents

Between 01.05.23 and 30.06.23, 17 Nationally Reportable Incidents were submitted to the NHS delivery unit. No never events were identified during this period. The ratio of Nationally Reportable Incidents to the overall number of patient incidents is demonstrated in the chart below.



As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive (formerly known as the "Delivery Unit"). This is reflected in the increase in both November 2022 and January 2023 totals above, which was as a result of the submission of legacy ambulance delays and notification of Ophthalmology incidents, following completion of the harm review process that occurred prior to the reporting period. In addition the increase in May 2023 is related to pressure damage deemed avoidable following review at scrutiny panel.

The Health Board currently has 81 open Nationally Reportable Incidents, of which 63 are overdue the timescale for completion. Of the outstanding Nationally Reportable Incidents, 40 remain open due to additional circumstances including Appendix Bs/ambulance delays (15), Ophthalmology (14) and other processes such as inquests or safeguarding (11).

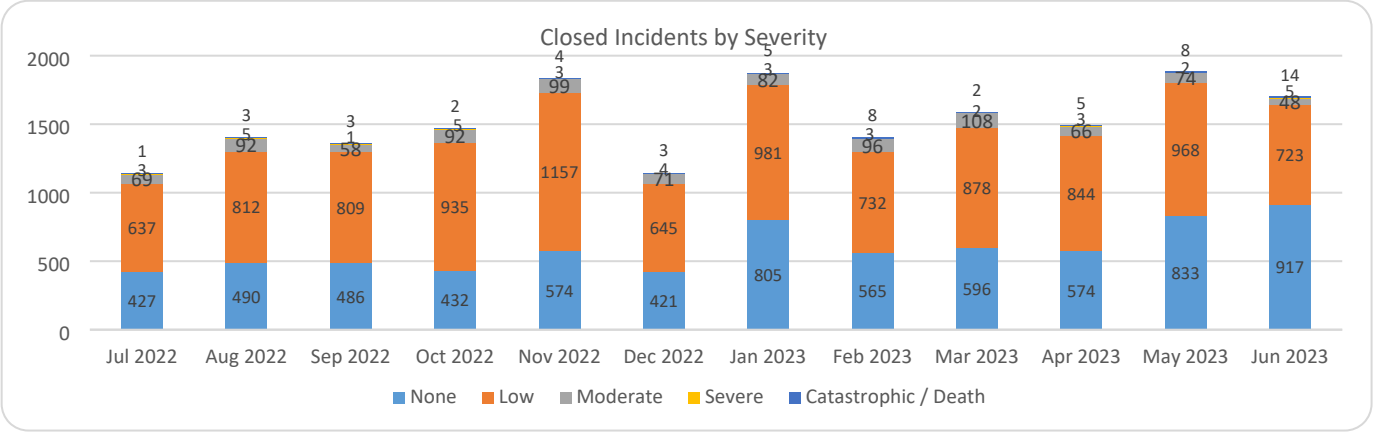
The type of Nationally Reportable Incident notifications submitted in May and June 2023 is highlighted in the table below:

	May 2023	Jun 2023	Total
Assessment, Investigation, Diagnosis	1	1	2
Equipment, Devices	1	0	1
Maternity adverse occurrence	2	0	2
Medication, IV Fluids	0	0	0

	May 2023	Jun 2023	Total
Patient/service user death	3	1	4
Pressure Damage, Moisture Damage	5	3	8
Treatment, Procedure	0	0	0
Total	12	5	17

Closed Patient Safety Incidents

Between the 01.05.23 and 30.06.23 a total of 3,592 patient safety incidents were closed. Of the 3592 patient safety incidents closed, 29 were closed with severity post investigation of severe harm (7) or catastrophic/ death (22). It should be noted, however, that an outcome of catastrophic / death may not be directly caused or attributable to an intervention (action/inaction) by the Health Board (e.g. an unexpected Mental Health death). The 12 month trend is reflected in the table below.



Duty of Candour

The Duty of Candour regulations where implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have ben devised, which are summarised in the table below. As the implementation of the Duty of Candour progresses, further analysis of the data can be undertaken and included within this report. A review of the 65 incidents where the Duty of Candour field within Datix Cymru has been completed is currently being undertaken to ensure the duty has been triggered appropriately and all requirements fulfilled.

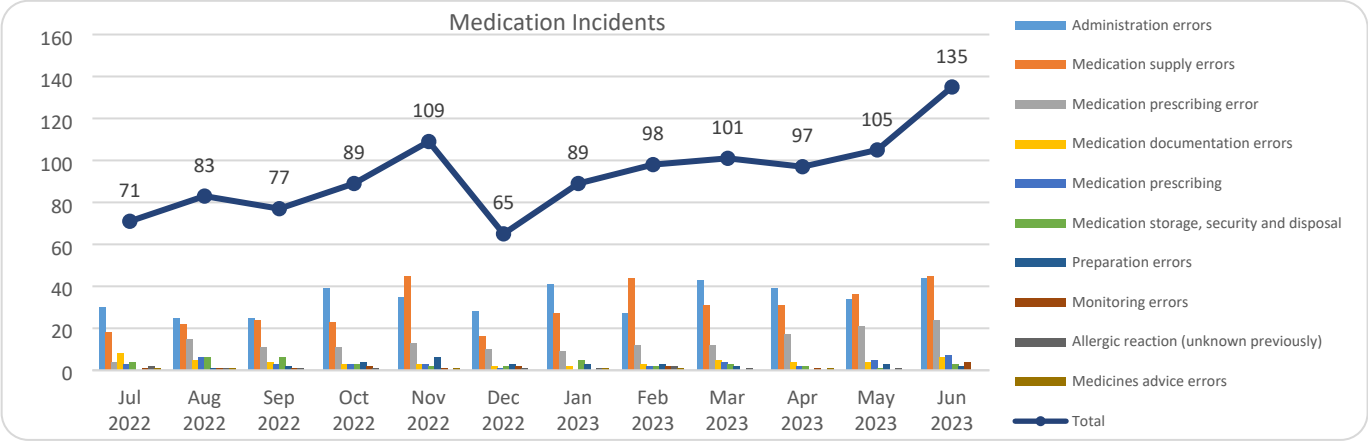
	Apr-23	**May-23**	**Jun-23**	**Total**
Number of Patient Safety Incidents occurring during the month	1718	1835	2056	5609
Number of incidents Initial Management Review Completed	1455	1317	1124	3896
Number of incidents identified as Moderate/Severe/Death following Management Review	56	50	65	171

	Apr-23	May-23	Jun-23	Total
Number of incidents where Duty of Candour Triggered	44	16	5	65
Number of incidents where In-person notification completed	9	9	2	20
Number of incidents where letter of notification sent	0	1	0	1

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

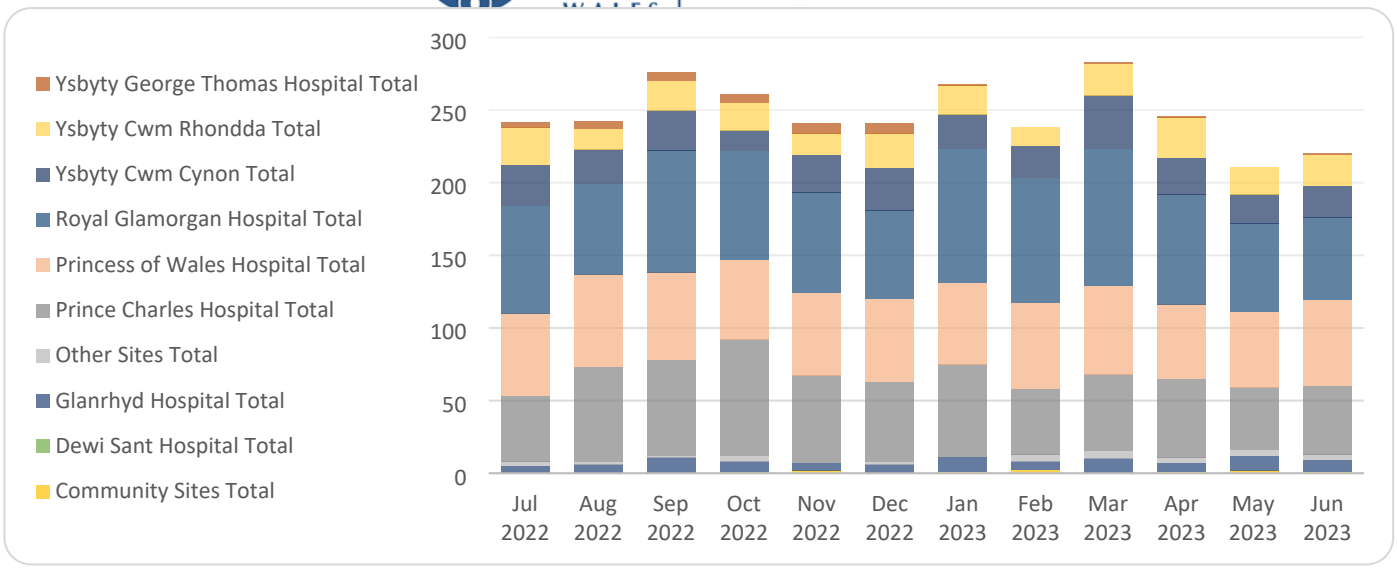
A total of 240 medication incidents were reported as occurring between 01.05.23 and 30.06.23. This is an increase of 42 when compared with the previous 2 month period and a continuation of the increase from January 2023. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to supply errors (81), administration errors (78) and prescribing (57).



85% of the medication incidents were reported as resulting in no (106) or low (99) harm, with the remaining reported as resulting in moderate harm (33) and severe (2) harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

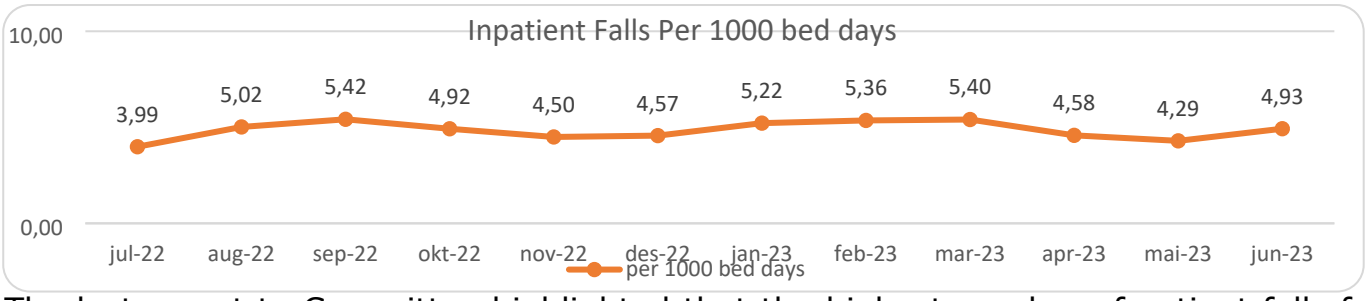
2.3.2 Patient Falls Incidents

A total number of 431 falls, where the person affected was a patient, were reported during May and June 2023. This represents a decrease of 98 in the number of falls reported in comparison to the previous 2 month period. Of the falls incidents within the time period, 92% were reported as no (126) or low (270) harm. The remaining incidents were reported as moderate (35) harm. No incidents relating to patient falls were reported as resulting in severe harm or death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

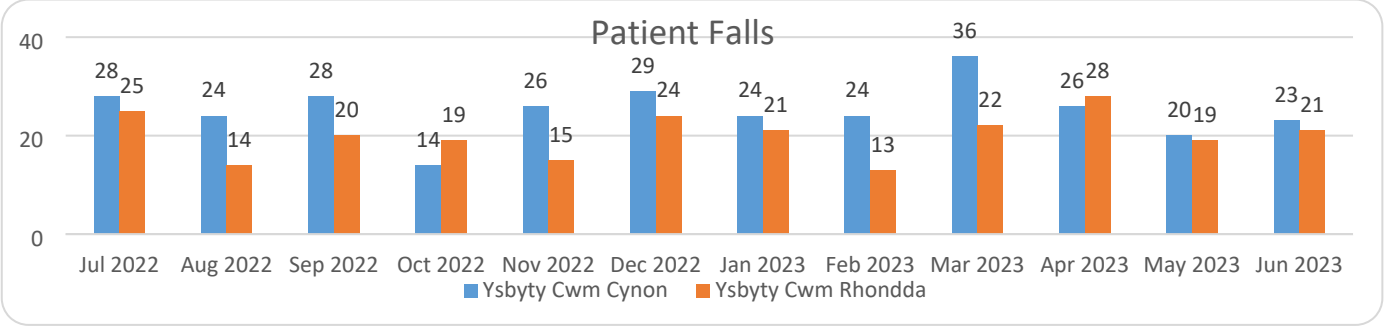


During the time period, the highest number of inpatient falls occurred on the Acute Admissions at Princess of Wales (111), Ward 15 at Princess of Wales Hospital (96) and the Emergency Care Department at Prince Charles Hospital (85).

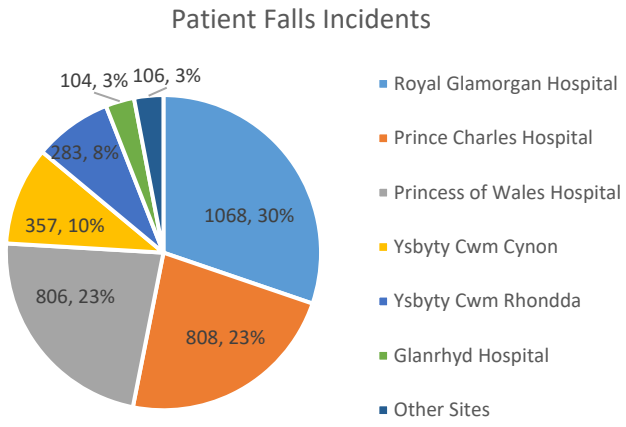
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.



The last report to Committee highlighted that the highest number of patient falls for March and April 2023 occurred on Ward 1 Ysbyty Cwm Cynon (YCC) and ward B2 Ysbyty Cwm Rhondda (YCR). Committee requested further information in relation to this. Review of patient falls incidents for the last 12 months in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda identifies that although there was an increase in March and April 2023, the number of incidents reported for May and June has returned to the monthly average: average for YCC across 12 months: 25; average for YCR across 12 months: 20.

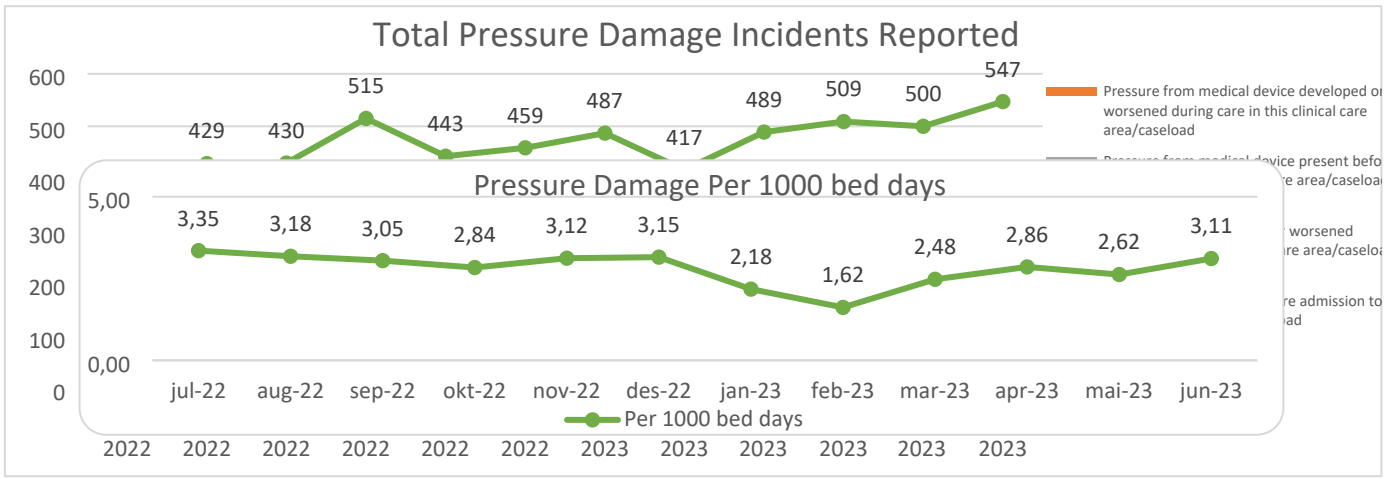


Within the period 01.07.22 to 30.06.2023, the number of patient falls incidents for Ysbyty Cwm Cynon (357) and Ysbyty Cwm Rhondda (283) account for 18% (640) of the total number reported. As reflected in the chart below this remains significantly lower than the 3 acute hospital sites.



2.3.3 Pressure Damage

Between the 01.05.23 and 30.06.23, a total of 1,047 pressure damage incidents were reported, of which 507 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (540) were reported as being present before admission to this clinical care area/caseload.



Of the 507, identified as developing or worsening during current caseload, 283 were identified as occurring within the community. This represents an increase when compared with the previous two months.

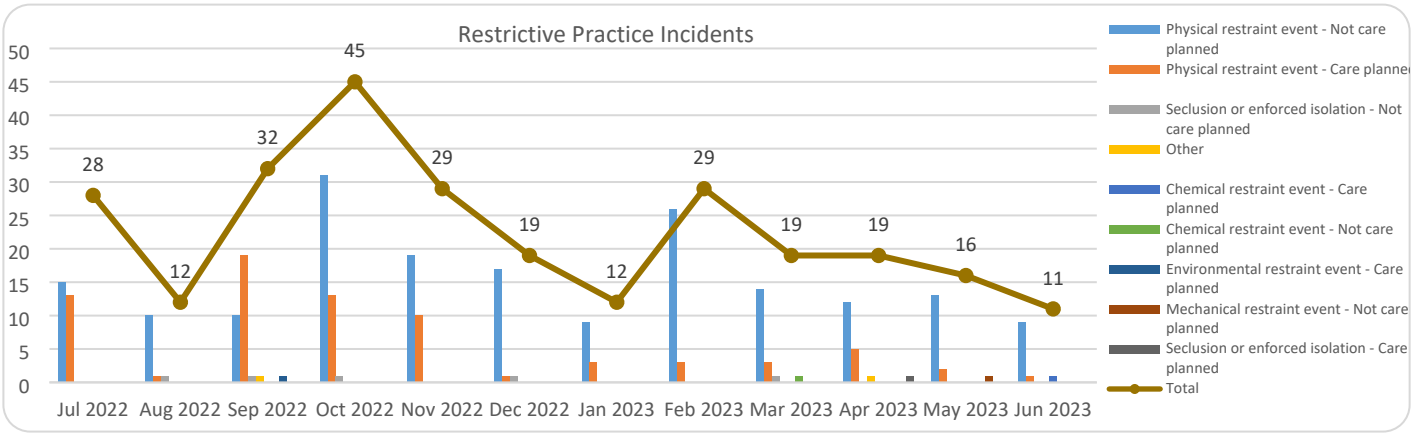
The pressure damage improvement continue to progress with a particular focus on grading on grading of pressure damage and completion of required documentation.

2.3.4 Mental Health Metrics

<u>Number of Section 136 (Mental Health Act 1983) Assessments in police cells</u>

The number of Section 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.

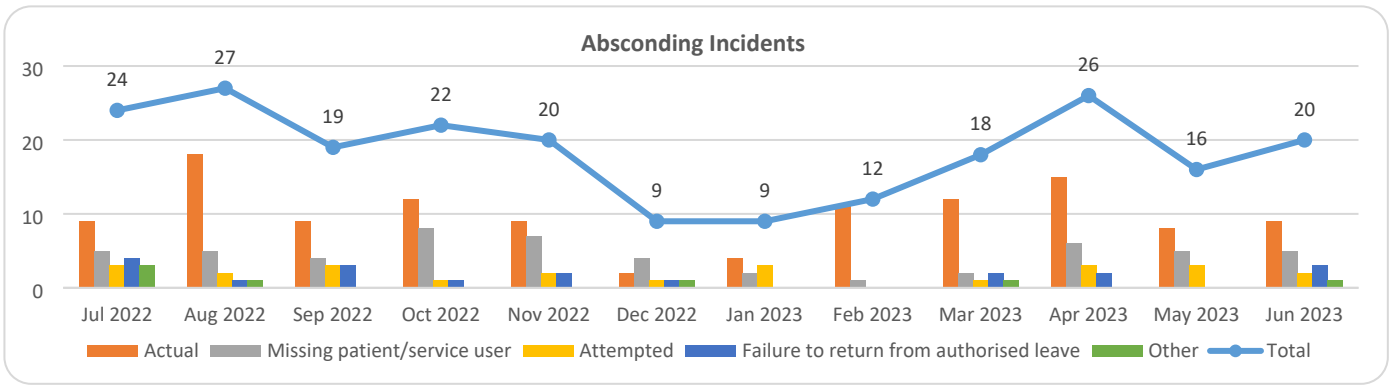
Restrictive Practices



Between 01.05.23 and 30.06.23, a total of 27 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 11 incidents when compared to the previous two months. Of the 27 incidents, 23 were reported as not care planned and 4 were reported as care planned. The highest number of incidents were reported as occurring at the Adult Mental Health Acute Admissions Unit (8).

Absconding incidents

During May and June 2023, a total of 36 Absconding incidents were reported, a decrease of 8 when compared with the previous 2 month period. 17 were recorded as actual absconding, with the remaining recorded as missing patient / service user (10) attempted (5), failure to return from authorised leave (3) and other (1). The highest number of incidents were reported as occurring in the emergency Care Department at Prince Charles Hospital (5).



2.3.5 Community Metrics

A number of metrics (summarised in the table below) are measured in relation to Community Services. Average length of stay increased during June 2023 in Ysbyty

Cwm Rhondda and Palliative Medicine in Pontypridd / Royal Glamorgan Hospital, decreased in Palliative Medicine in Bridgend whilst remaining relatively consistent with previous months on other Health Board sites.

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Referral to At Home Services (All Referrals)	129	123	128	119	125	138	121	145	182	127	177	165
Princess of Wales Hospital, Ward 21 (ALOS)	22	47	22	39	48	33	23	21	20	55	45	44
Ysbyty Cwm Cynon (ALOS)	51	64	64	57	56	72	80	74	50	64	56	51
Ysbyty Cwm Rhondda (ALOS)	67	55	62	80	68	73	72	79	62	76	69	74
Palliative Medicine, Bridgend (ALOS)	9	10	24	19	23	18	16	18	11	30	17	13
Palliative Medicine, Pontypridd/RGH (ALOS)	7	8	8	11	7	6	10	7	9	5	10	10
Palliative Medicine, YCC (ALOS)	16	36	4	25	28	24	25	18	23	38	37	10

2.5 Patient Experience Initiatives

2.5.1 Carers

Following the creation of a leaflet to support carers through the hospital discharge process, the team is being supported to undertake a scoping exercise across CTM, to understand how this is being embedded/utilised within the patient's pathway. This will also encompass a discussion to understand the barriers staff are facing to support the conversations with carers around any difficulties they may be facing in supporting the cared for.

Due to the change in distribution of the carers funding via the RIF (Regional Integrated Fund), Head of People's Experience, local authority leads and colleagues within the RIF team have met and populated an action plan to support a more strategic plan across CTM. This action plan has been signed off within the RPB (Regional Partnership Board) and a further meeting to discuss the draft is planned in June with all members of the CTM Carers Stakeholder Group to agree the actions as to how this is taken forward.

The team also continue to engage with the Short Breaks Team to review how this funding is supporting carers across CTM.

2.5.2 Chaplaincy Support

The team held three foetal collective cremation funeral services at Coychurch, Glyntaf and Llwydcoed, these were well attended by parents on each site. This enables the Health Board through one element to demonstrate how they can support/signpost families through their grief journey.

Delivering training sessions to student nurses and midwives as part of their induction programmes, and for newly registered nurses continues. The department is currently

writing competencies for spiritual care champions in line with the Welsh Universities EPICC project and spiritual care competencies for nurse and midwifery degrees. Recently we have had an increase in interest in our roles with students asking if they can 'shadow' a chaplain to learn more about the spirituality of patients and how to implement spiritual care in their daily practice.

In May the Health Board facilitated a request for an emergency wedding for a patient in Prince Charles Hospital. As the patient was going to be discharged, the registrar was unable to perform the ceremony on site, we were able to ensure all the correct documentation was completed and the registrar married the couple at home on the afternoon of the patient's discharge. (Please note the wedding blessings we officiate are not legal, only a registrar can do the legalities. However, as a department, we are involved in liaising with ward staff, patients, their families and our local registrars on the occasion they request us to arrange emergency weddings on site for a patient).

2.5.3 Bereavement

Work continues to ensure the gaps identified within the Bereavement Framework are being progressed. Documentation to support families in the form of bereavement booklets for adults has been updated and shared with the Bereavement Steering Group for comments. Booklets specifically supporting loss within our Maternity and Gynaecology departments have been updated /created and have been distributed across CTM.

A directory of bereavement support to aid staff in signposting families is now available on share point. Collaboration with Aching Arms Charity has also enabled distribution of teddy bears across all ED, EPAU, Gynae and maternity units to support families**.** Four training sessions have been provided on PLR (Pregnancy Loss Remains) to staff on Ward 11, POW.

Bereavement Clinical Lead has supported two families and remained their single point of contact for a one-week old baby who suddenly passed away and a young girl who passed following a stay in hospital, family needed extra support as well, liaising with 2wish and the coroner on their behalf.

Through examination of the Health Board's process surrounding hospital contract funerals the Bereavement Lead has identified cost savings by transferring these to Cefn y Parc. A booklet to support the process of establishing the circumstances leading to contact funerals has been created for families to understand the process and also to ensure the Health Board has supported the family to explore all avenues to fund these themselves. This has been sent to the senior team for review initially.

2.5.4 Patient Feedback Volunteers

There are a number of services that have become a mainstay of the volunteer department across the Health Board, involving meet and greet services, ward befriender/ activity co-ordinator and digital co-ordinators to name a few.

However, during April the team were asked if they could support a new project with the Emergency Department (ED), Princess of Wales Hospital, to look at piloting a scheme where volunteers can support patients, families and carers alike, whilst attending the department. The ED Volunteer pilot project commenced on 20th April 2023, with the aim of volunteers providing support initially Monday to Friday 9am to 5pm, dependant on availability. The volunteers will provide support in a number of different areas:

- Provide support and companionship for patients
- Support patients to contact relatives and loved ones either using patient's personal device, CISCO phone or tablet where appropriate
- Provide feedback to staff, transfer messages and run errands to other departments within the hospital
- Provide refreshments for patients (under staff guidance)
- Help at meal times to give out food and drinks, check cutlery and utensils are suitable for patients, clear away after mealtimes
- Check in on patients and visitors in waiting areas and alert staff with any concerns they may have
- Replenish stock on trolleys, in bays and information leaflet stands
- Provide signposting and directions for patients and relatives/companions
- Direct, and accompany where appropriate, patients/visitors to other areas of the hospital
- Encourage and assist patients, family, carers and friends to complete feedback survey's

The ED Volunteer project will initially run as a pilot to understand the impact of volunteer support, and how this service can be embedded within the department moving forward. Once in place the Volunteer Service in conjunction with other ED's will be looking to replicate and roll the volunteer support across other sites including Royal Glamorgan and Prince Charles Hospital.

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

The following issues/risks have been identified in relation to quality reporting within the Health Board.

- The 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.
- Work is required to ensure data from the range of Health Board systems included in this report are consistently captured and appropriately validated.
- Improving and maintaining compliance with the 30 working days complaints response rate.
- Robust reporting of Duty of Candour Metrics.

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 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

Medication Supply Information

There were 362 medication supply incidents reported in the last 12 months. Of these 242 were reported within the Community. Breakdown of the type of incidents reported is provided in the table below:

Row Labels	Count of Reported Date
Delay in medication supply	41
Drug content errors - Expired medication	8
Drug content errors - Incorrect form	20
Drug content errors - Incorrect medication	60
Drug content errors - Incorrect patient/service user information leaflet	5
Drug content errors - Incorrect quantity	40
Drug content errors - Incorrect strength	69
Drug content errors - Omitted patient/service user information leaflet	1
Issue errors - Ancillaries not supplied when necessary	1
Issue errors - Inappropriately stored mediation supplied	1
Issue errors - Medication not delivered	24
Issue errors - Medication not supplied against prescription/order	15
Issue errors - Medication supplied that was not prescribed	9
Issue errors - Supplied to wrong patient/ward	27
Issue errors - Supply against illegal prescription	4
Issue errors - Supply of a defective product	5
Labelling errors - Incorrect directions	16
Labelling errors - Incorrect medication	9
Labelling errors - Incorrect strength	2
Labelling errors - Incorrect/incomplete patient/service user name	3
Labelling errors - Incorrect/omitted warnings/cautionary labels	1
Labelling errors - Omitted directions	1
Grand Total	**362**

Compliance against Patient Safety Solutions Wales - Alerts - Issued after April 2014

12/06/2023

	Alerts as at: 12/06/2023	NOTE: THERE IS AN ALL WALES ISSUE REGARDING PSA008 DUE TO NG TUBE COMPETENCY BASED TRAINING FOR MEDICAL STAFF. SOME ORGANISATIONS TO WHICH THIS ALERTS APPLIES ARE NON-COMPLIANT. All Wales approach to support organisations to meet the requirements of PSA008, Compliance date extended to the 29/09/2023										
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**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Non-compliant

Compliance against Patient Safety Solutions Wales - Notices - Issued after April 2014

12/06/2023

Notices as at: 12/06/2023												
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	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	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	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
PSN065	The safe use of ultrasound gel to reduce infection risk	**28/02/2022**	Compliant	Compliant	Compliant	Non-compliant	Non-Compliant	Compliant	Compliant	Compliant	Compliant	N/A

(7.1.1)	25th July 2023	Quality & Safety Committee	Maternity & Neonatal Metrics

Report Details:

FOI Status:	Please select: Open
If closed please indicate reason:	Not applicable- Open report
Prepared By:	• Suzanne Hardacre - Director of Midwifery & Nursing, Children & Families Care Group • Catherine Roberts – Service Director, Children & Families Care Group • Mohamed Elnasharty – Medical Director Children & Families Care Group
Presented By:	Suzanne Hardacre - Director of Midwifery & Nursing Children and Families Care Group
Approving Executive Sponsor:	Greg Dix – Executive Nurse Director
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	Maternity & Neonatal Programme Board 10.7.23 To be presented at Maternity & Neonatal Safety Board 20.7.23

Impact Assessment:

Indicate the Quality / Safety / Patient Experience Implications:	There are quality and safety implications related to the activity outlined in this report in accordance with those identified within the RCOG/RCM Review of Maternity Services at former Cwm Taf (2018) and IMSOP Neonatal Deep Dive (2022).
Related Health and Care Standard	Safe Care Individualised Care Governance Leadership and Accountability Timely Care
Has an EQIA been undertaken?	No – Not a policy or guideline
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Sustaining Our Future Inspiring People Improving Care Creating Health

Acronyms

ABUHB	Aneurin Bevan University Health Board
ATAIN	Avoiding Term Admissions in Neonates
BAPM	British Association of Perinatal Medicine
BSOTS	Birmingham Symptom Specific Obstetric Triage System
CaVUHB	Cardiff and Vale University Health Board
CS	Caesarean Section
CTG	Cardiotocography
CTMUHB	Cwm Taf Morgannwg University Health Board
HDUHB	Hywel Dda University Health Board
IOL	Induction of Labour
MatNeoSSP	Maternity and Neonatal Safety Support Programme
NICU	Neonatal Intensive Care Unit
NNAG	Neonatal Assurance and Action Group
NNAP	National Neonatal Audit Programme
PCH	Prince Charles Hospital
PeriPrem	Perinatal Excellence to Reduce Injury in Premature Birth
POW	Princess of Wales Hospital
PROMPT	PRactical Obstetric Multi-Professional Training
QI	Quality Improvement
ROP	Retinopathy of Prematurity
SCBU	Special Care Baby Unit
SVD	Spontaneous Vertex Delivery
WHSCC	Welsh Health Specialised Services Committee

Neonatal Improvement – June 2023

Things You Need To Know:

- Neonatal Deep Dive actions 52 actions have been completed out of 56.
- NHS Executive Delivery Unit and Welsh Government visit to 5.6.23. Report being drafted in preparation for Tripartite meeting July 2023.
- Continued development of Maternity and Neonatal Dashboard anticipated launch early autumn 2023
- Neonatal Forward Audit plan 23/24 is in final draft.
- The Quality improvement work that has been completed in medicines management and safe prescribing has been presented on a national level (to be presented at (MNSB July 2023)
- Nursery Nurse posts for POW remain in scrutiny panel due to ongoing WHSCC cot reconfiguration.
- There continue to be delays in neonatal nursing rotation being addressed by Head of Nursing.
- Changes in radiology service need to be addressed, to ensure sustainability of the improvements made.

Next steps:

- Continuation of psychology provision agreement maintained.
- Clinical Improvement group refresh 'Neonatal assurance and actions group' NAAG. June 2023.
- To agree future monitoring arrangements. i.e Neonatal KPI's, working with MatNeoSSP.
- Response being finalised to WHSCC cot reconfiguration.
- Preparation of Neonatal Wash up plan underway.
- Remaining long term workforce actions monitored via Risk Register

Neonatal Improvement – June 2023

Focus on Neonatal improvement programme:

- **Total 56 NN deep dive recommendations which include 14 escalations and 5 immediate**
- **All 19 immediate** actions completed
- **15** of the 19 **Medium term** actions completed
- **16** of the 16 **short-term** actions completed
- **2** of the 2 **long-term** actions completed
- Overall **4 remaining actions** to be completed

Timescale	Completion within
Immediate	**3 months**
Short-term	**6 months**
Medium	**12 months**
Long-term	**24 months**

Tables demonstrating by timescale and workstreams completed/remaining actions:

Timescale	Total no.	Actions completed	Remaining actions
Immediate	19	19	0
Medium	19	15	4
Short-term	16	16	0
Long-term	2	1	0
Total	56	52	4

Neonatal Metrics – June 2023

- The neonatal dashboard remains in development phase.
- Informatics are currently developing an auto population of the neonatal monthly dashboard.
- Combined dashboard will be available to all staff on SharePoint and utilised for quality, safety and improvement purposes anticipated launch early autumn
- Neonatal data is manually collected from BadgerNet and input into Excel to create time series data.
- Currently there are no examples of this available nationally.

Month/year	Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Total
Livebirths		1 unknown so included			1 unknown so included			2 unknown so included	1 unknown so included	1 unknown so included	2 unknown so included	2 unknown so included	1 unknown so included	2 unknown so included	
Term =>37 weeks		204	166	202	191	185	171	202	198	212	210	194	158	191	2484
Preterm =<36+6 weeks		9	8	22	13	25	15	24	21	13	16	13	20	19	218
Total		213	174	224	204	210	186	226	219	225	226	207	178	210	2492
Admissions		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Total
Total		23	21	21	17	29	26	26	28	16	18	18	27	25	295
Term =>37 weeks		17	14	13	11	14	14	14	11	6	13	9	18	12	166
Late Preterm =32-36.6 weeks		4	6	8	5	15	10	10	17	8	4	8	8	13	116
Preterm =<31.6 weeks		2	1	0	1	0	2	2	0	2	1	1	1	0	13
% All gestations admitted NNU	<12%	11%	12%	9%	8%	14%	14%	12%	13%	7%	8%	9%	15%	12%	12%
% Term Admissions NNU	<6%	8%	8%	6%	5%	7%	8%	6%	5%	3%	6%	4%	10%	6%	7%
PCH annual average all admissions admitted NNU %		12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%	12%
Annual UK average all gestations admitted NNU %		14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%
Wales national target term admissions to NNU %		6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%
Reason for Term Admissions		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Total
Respiratory		13	11	9	6	7	8	8	9	6	9	6	15	7	114
% of admissions that are Respiratory		76.5%	78.6%	69.2%	54.5%	50.0%	57.1%	57.1%	81.8%	100.0%	69.2%	66.7%	83.3%	58.3%	68.7%
Hypoglycaemia		1	0	0	3	0	0	2	2	0	0	1	0	0	9
% of admissions that are Hypoglycaemia		5.9%	0.0%	0.0%	27.3%	0.0%	0.0%	14.3%	18.2%	0.0%	0.0%	11.1%	0.0%	0.0%	5.4%
Suspected Infection		2	1	2	1	5	2	0	0	0	0	0	2	3	18
% of admissions that are suspected infection		11.8%	7.1%	15.4%	9.1%	35.7%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	25.0%	10.8%
Other		1	2	2	1	2	4	4	0	0	4	2	1	2	25
% of all other admissions		5.9%	14.3%	15.4%	9.1%	14.3%	28.6%	28.6%	0.0%	0.0%	30.8%	22.2%	5.6%	16.7%	15.1%
Exceptions		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Total
<32/40 (singletons)	0	3	1	0	1	0	3	2	0	0	1	1	1	0	13
<34/40 (multiples)	0	1	1	1	1	4	1	1	0	1	0	0	1	0	12

Neonatal Metrics – June 2023

What Went Well..

- Metrics remain stable no exceptions to report.
- There were no babies born outside of gestational criteria in CTM 100% of shifts maintained BAPM standards.

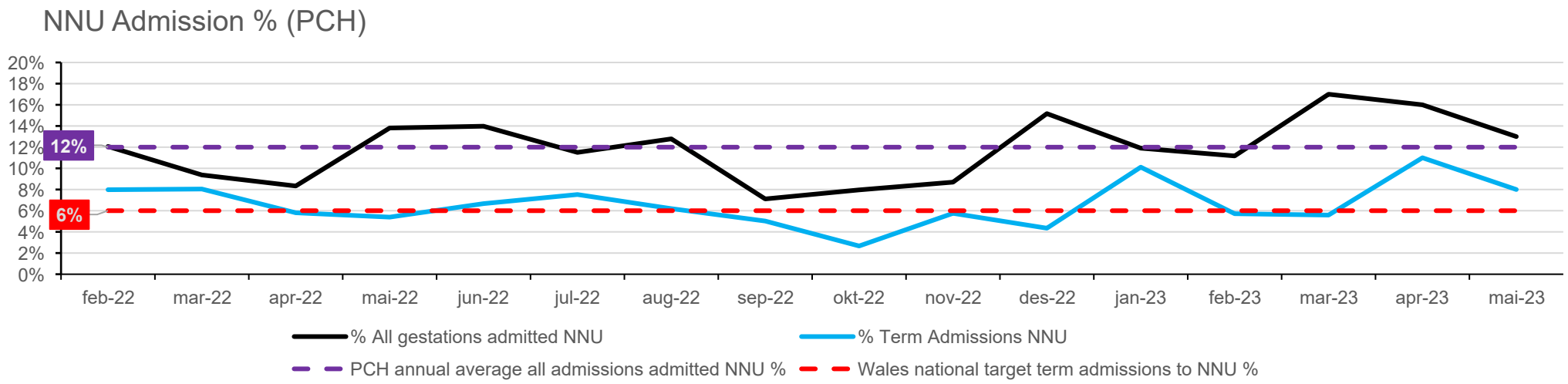
What needs to improve..

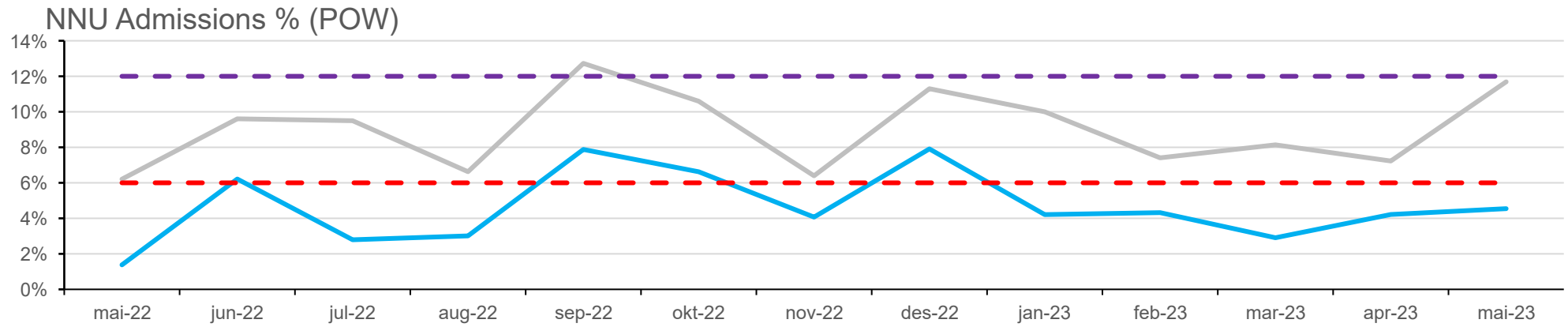
- ROP data entry
- NNAP data field
- Badgernet entry, particularly first consultation with senior clinician. Development of NNAP form for medical notes to be signed by senior clinician. This will also provide another assurance check for data entry.

Further information

- Normal variation noted through metrics- decision to monitor quarterly due to small numbers, individual cases will be reviewed and reported through normal governance processes.
- **PCH** have seen an increase in normothermia (babies admitted with a temperature within normal range) from 85% to 96% steady increase to watch and wait. QINT QI project.
- 3 babies in **PCH** ROP not on time (Team to review this as repatriations of Quads) **POW** 2 babies ROP late. To look at data entry of infants (**POW)** 15% admission coming from labour ward are admitted cold this is a significant increase?
- **POW** to watch and wait second month with large increase in term admissions.

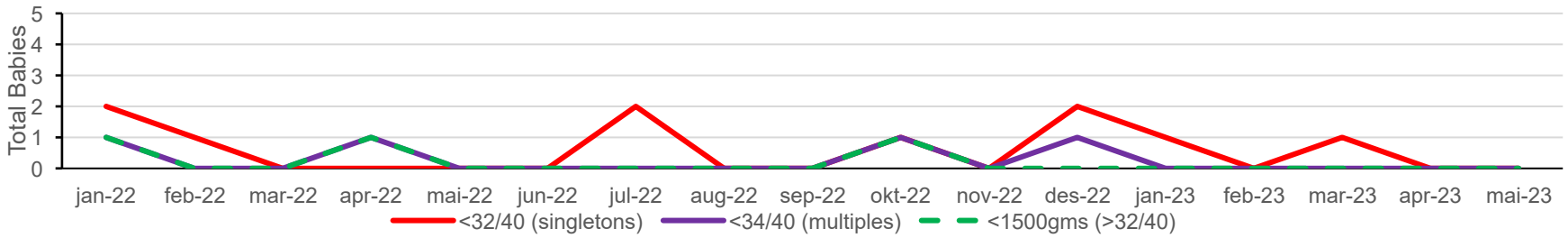
Neonatal Metrics: Admissions – June 2023





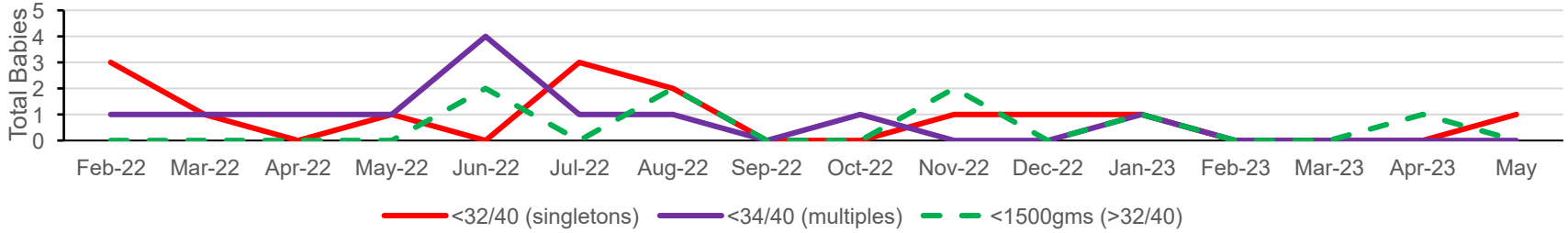
Neonatal Metrics: Right Place of Birth – June 2023

POW



No babies born outside of gestational criteria for May 2023 (POW)

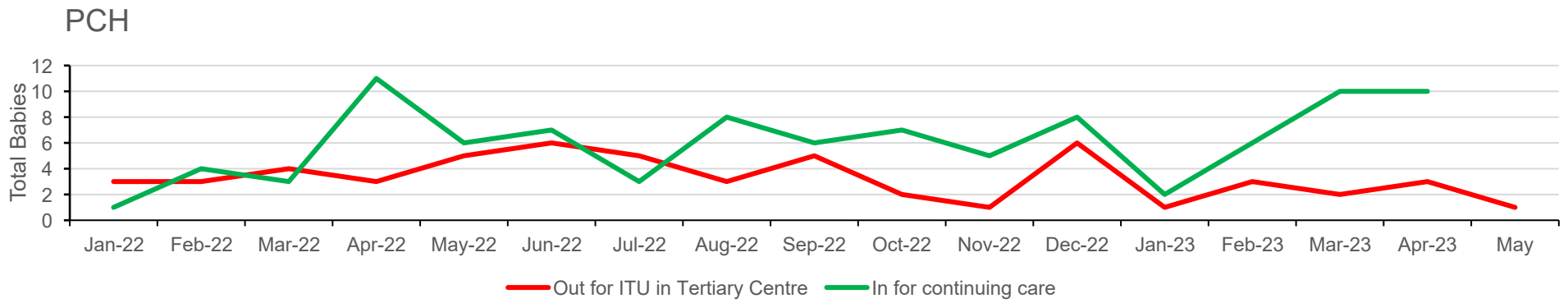
PCH

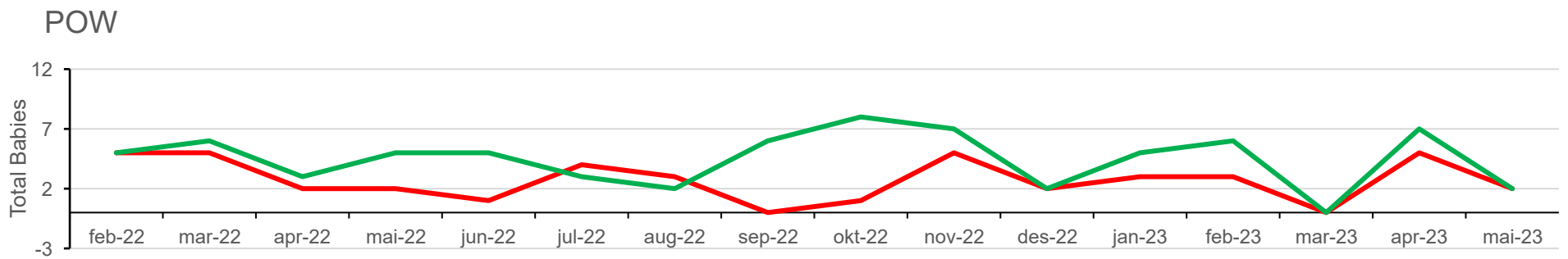


One baby was born in PCH outside of gestational criteria, case has received full reviewed and was unavoidable

Neonatal Metrics: Ex Utero Transfers – June 2023

- Transfers out- All babies requiring an increased level of care- transferred to NICU facility.
- Transfers in- repatriation to 'booking' unit having been born or received care at another hospital.





Neonatal Metrics: Family Engagement – June 2023

The following table provides an update on the Neonatal engagement social media reach:

Social media	No of members and response rates
Cwtch Facebook group	430 members (6 new members this quarter)
PCH SCBU Merthyr Facebook group	604 members (10 new)
Average post reach	200 views
Average response	15-20 likes or comments
Twitter	406 followers (14 new followers)

The following table presents the no. of compliments/concerns received:

Compliments	PCH	POW
Thank you, cards, received	5	3
Social Media compliments	45	38
Comments book on wards	Tbc	3
Complaints	2	3
On the spot	tbc	1
Formal	2	2

Neonatal Metrics: Family Engagement – June 2023

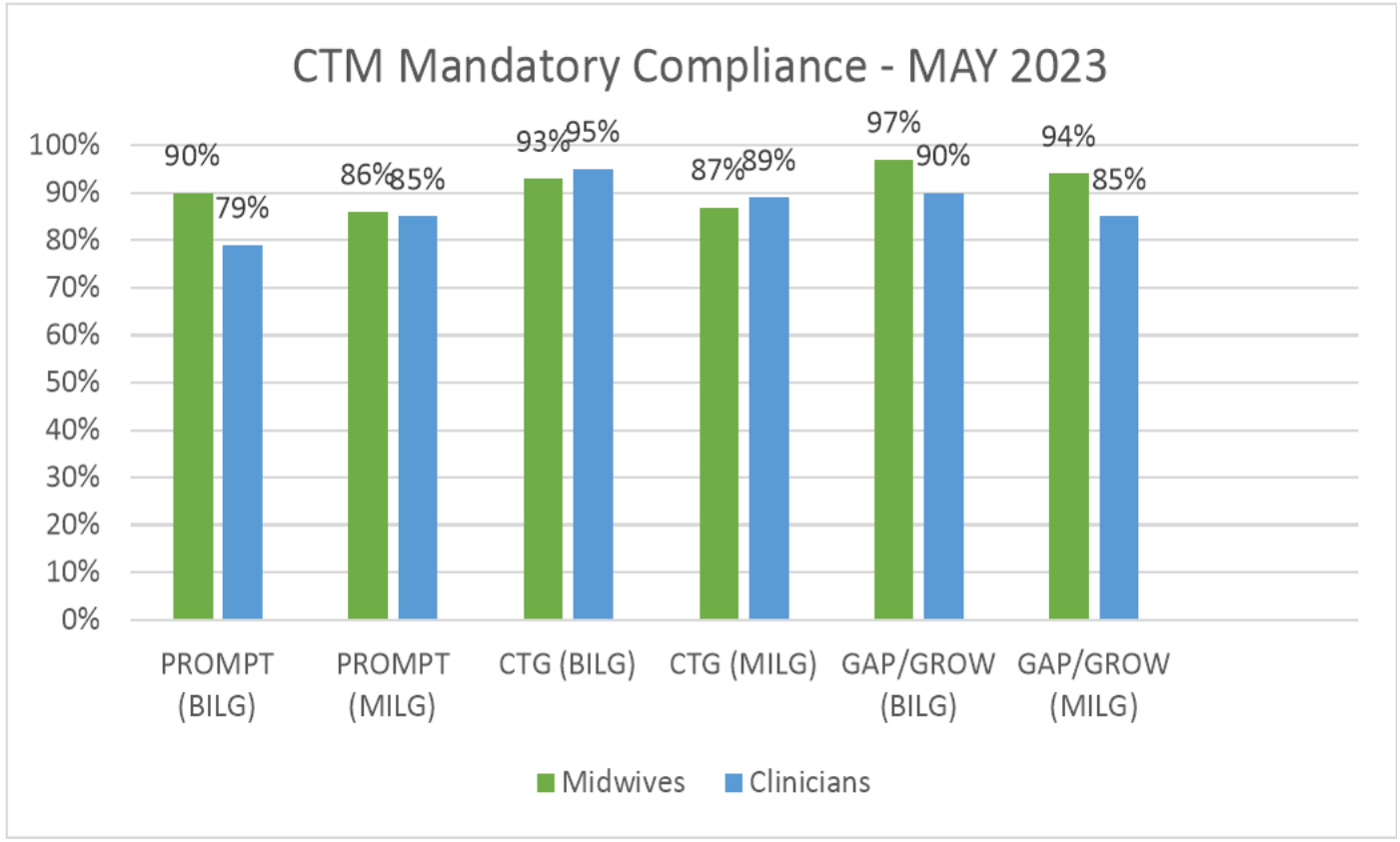
What we continue to do well?	% of responses
Felt they were always or usually fully informed about care	92.3
Felt they had always had unrestricted access to their baby	91.3
Felt that they were always or usually treated with dignity and respect	96
Always or usually felt encouraged to participate in baby's care	100
Felt they were able to do everything they wanted for their baby	100

What we could have done better?	% of responses
Felt that they always or usually received sufficient info about unit facilities, visiting, support groups	78
Always or usually received an update from their doctor	78%
Always or usually felt able to stay overnight with their baby	78
Sometimes felt or weren't that they had access to an area to make drinks and meals or wash and shower	13

Learning

- Postive feedback about how supportive staff are.
- More space needed at cotside
- Inconsistent information from Doctors

Maternity Metrics: Training Compliance



Maternity Metrics: Dashboard Signals – June 2023

Signals from the Maternity Dashboard

How dashboard data are presented and reviewed

The dashboard is reviewed monthly through reporting forums, including the senior midwives WESEE (Workforce, Education, Safety, Effectiveness and Experience) weekly meeting, with specific areas for improvement discussed as indicated by the data.

Exceptions are reported through QPSE, SWAG and up to Board Quality and Safety.

All colleagues are encouraged to access the dashboard regularly as an integral part of their roles.

Time series data- a quick reminder...

Rule 1

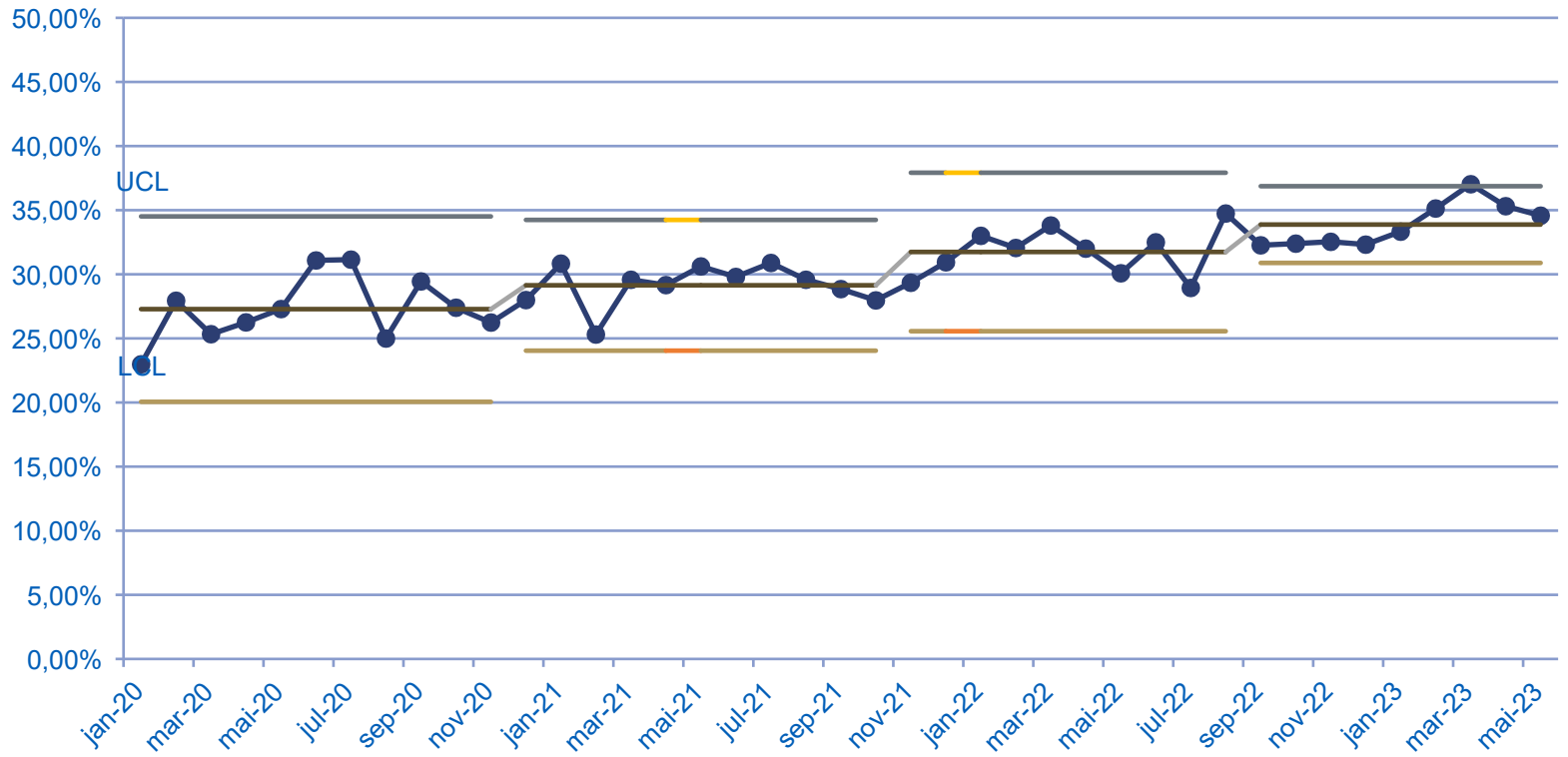
- A shift in the process or too many data points in a run (6 or more consecutive points above or below the median)

Rule 2

- A trend (5 or more consecutive points all increasing or decreasing)

Maternity Metrics: Caesarean Section – June 2023

Caesarean Section CTM as a % of all births



The median CS rate has shifted from 27% in January 2020, to 34% in November 2022.

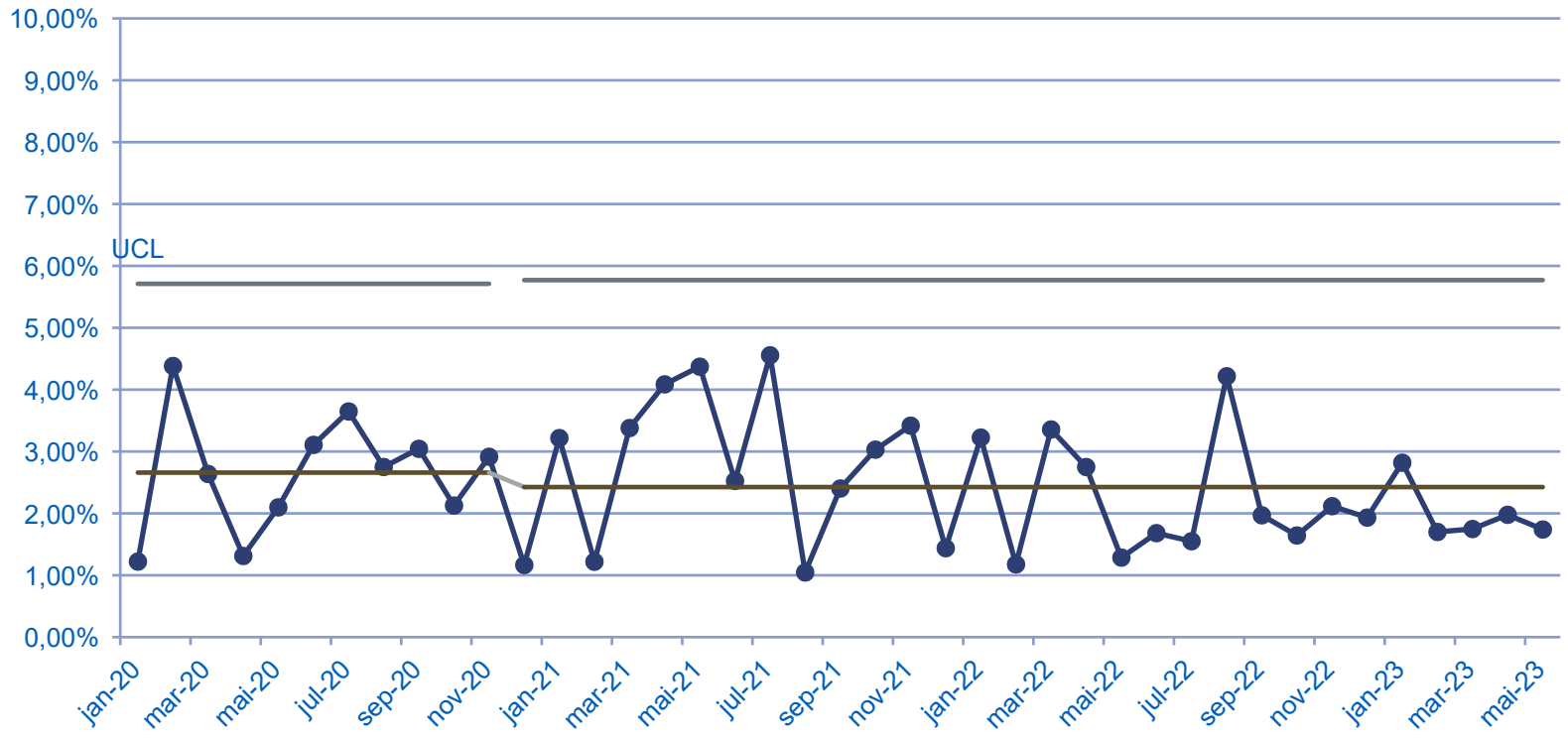
This is a picture that is emerging nationally in Wales. ABUHB have seen a shift from 26%-40% in the past 4 years.

We have linked with colleagues in CaV, ABUHB and HD to work together on understanding the reasons.

The following slides will break this down by category

Maternity Metrics: Caesarean Section – June 2023

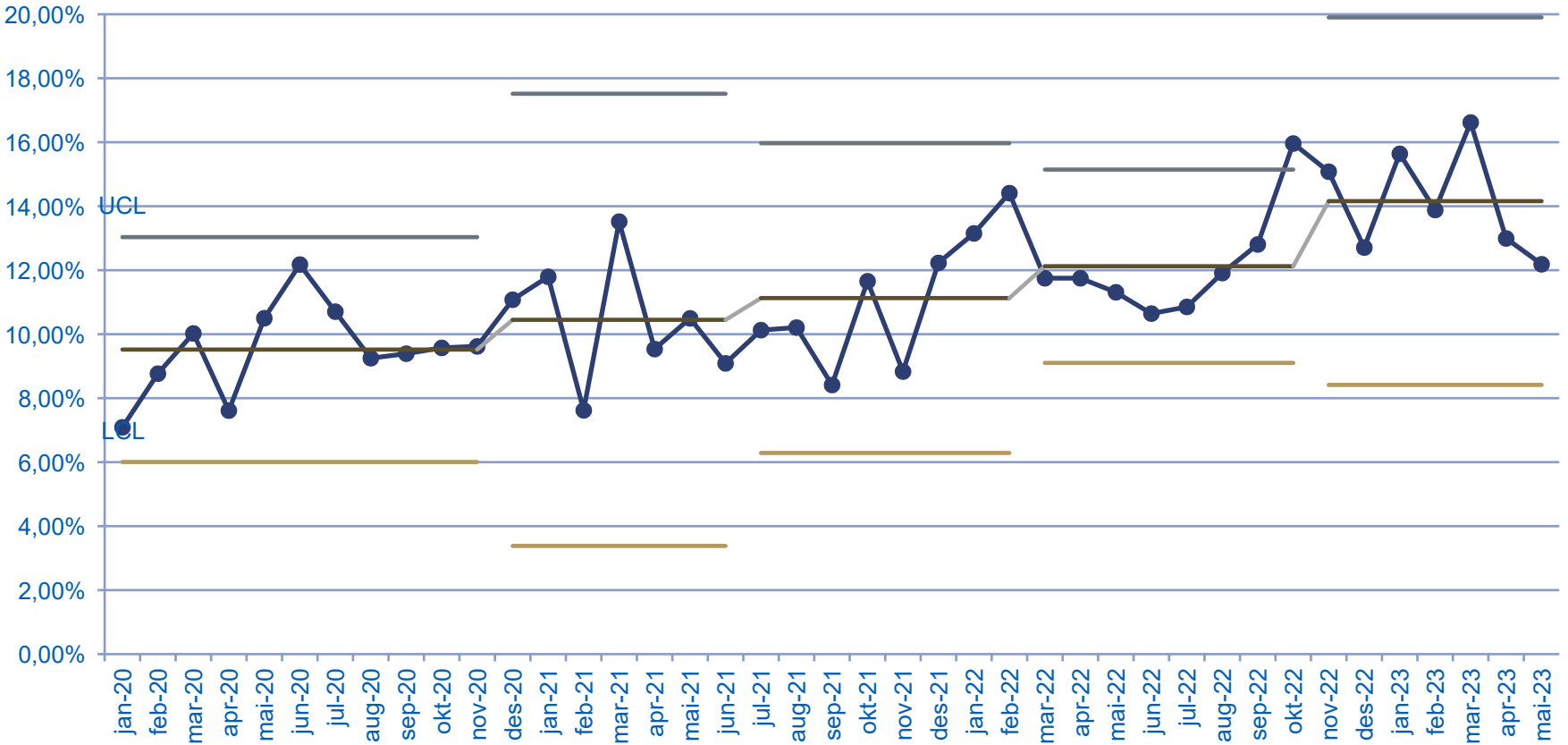
Category 1 Caesarean Section CTM as a % of all births



Category 1 CS rates have remained stable for the past 3 years. Normal variation can be seen, but no shift or trend.

Maternity Metrics: Caesarean Section – June 2023

Category 2 Caesarean Section all CTM as a % of all births



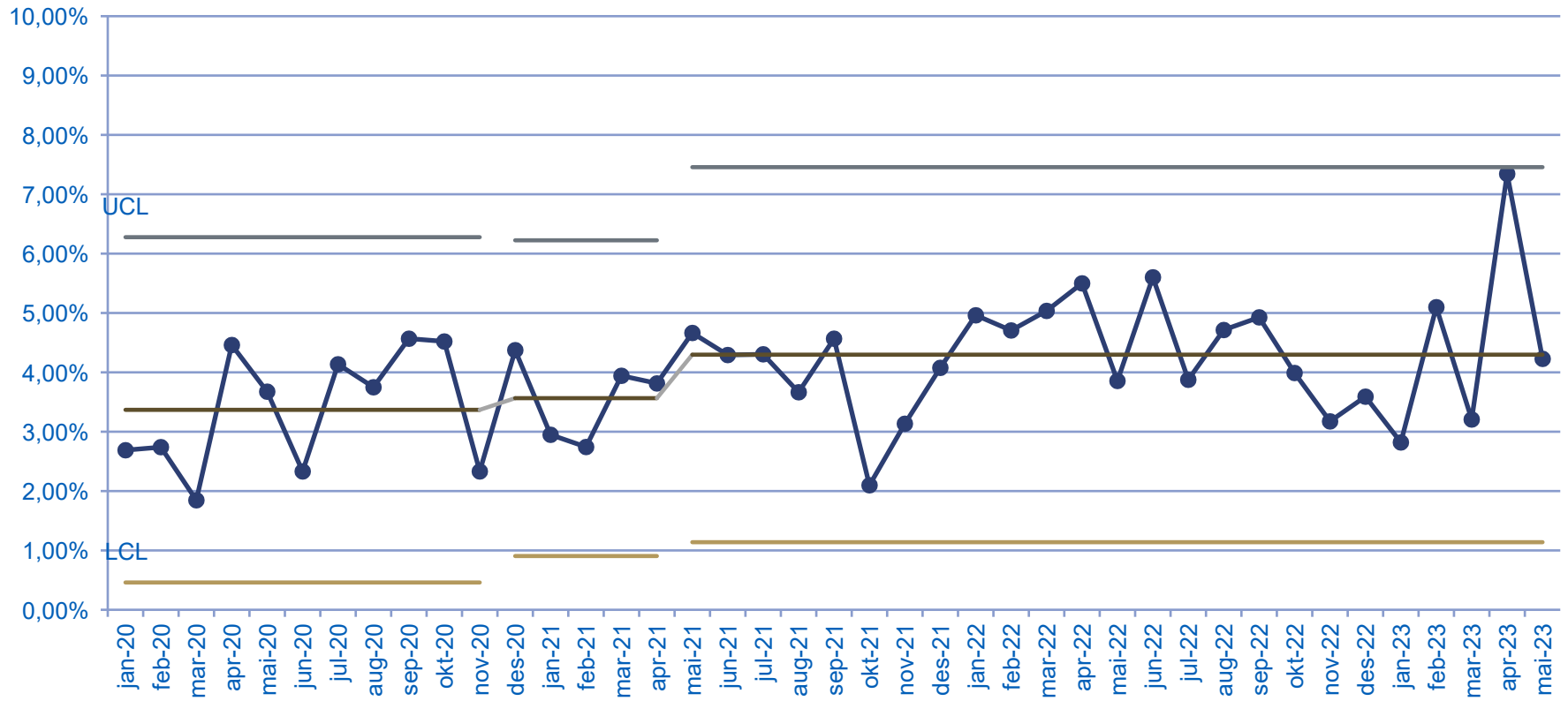
The median Category 2 CS rate has shifted from 9% in Jan 2020, to 14% in November 2022.

A deep dive has begun to understand reasons for the change.

Other Health Boards are experiencing a similar increase.

Maternity Metrics: Caesarean Section – June 2023

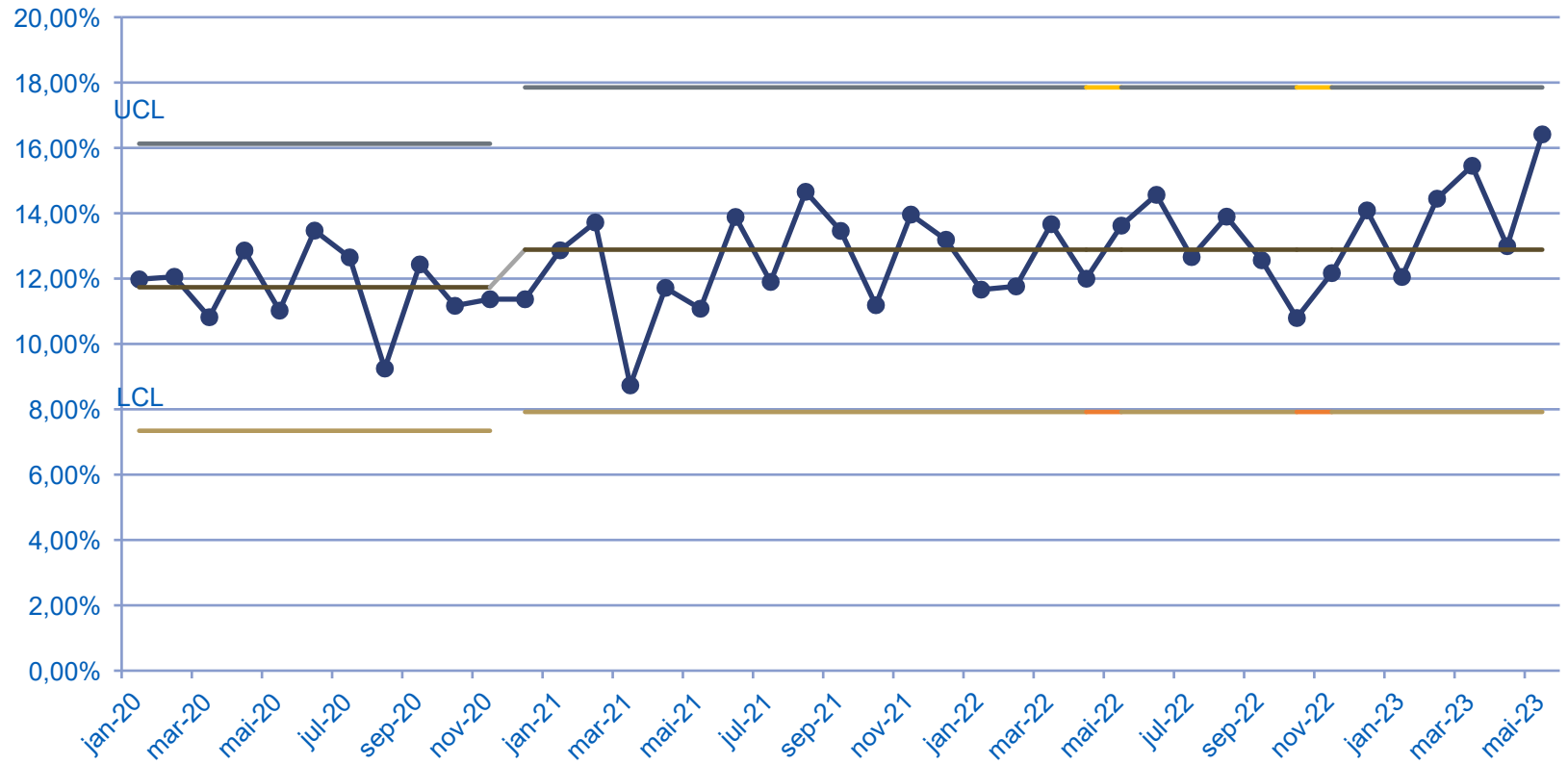
Category 3 Caesarean Section all CTM as a % of all births



The median Category 3 CS rate has shifted slightly from 3.3% in Jan 2020, to 4.2 % in July 2021. April 2023 saw a particularly high Category 3 CS rate (7.4%).

Maternity Metrics: Caesarean Section – June 2023

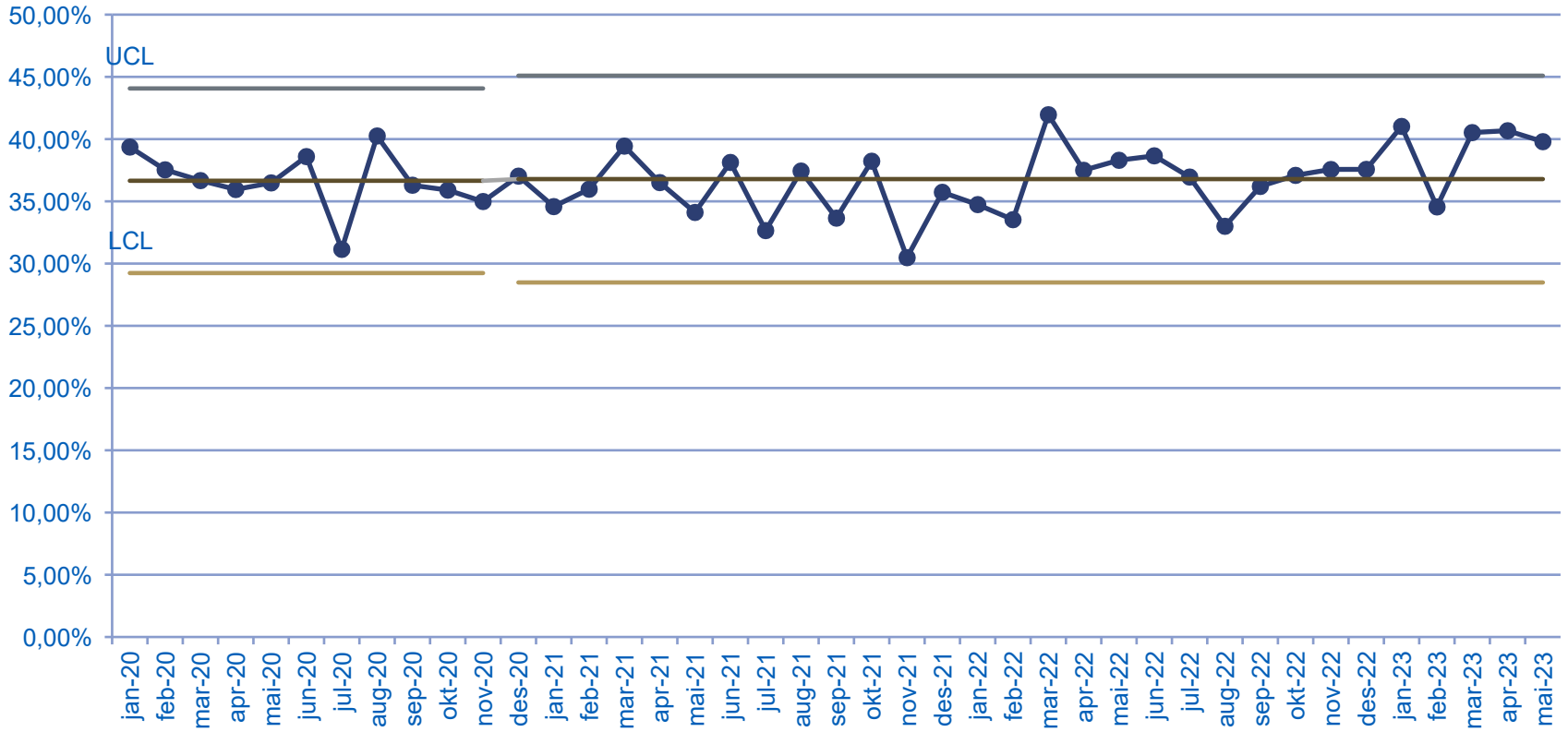
Category 4 Caesarean Section all CTM as a % of all births



The median Category 4 CS rate increased slightly in January 2021 from 11.9% to 12.8%. There has been no significant change since. However, there are 4 points above the median in the past 4 months. If this continues through June and July, this would signify another significant increase. May 2023 saw the highest rate to date at 16%.

Maternity Metrics: Induction of Labour (IOL) – June 2023

IOL as a % of all Births

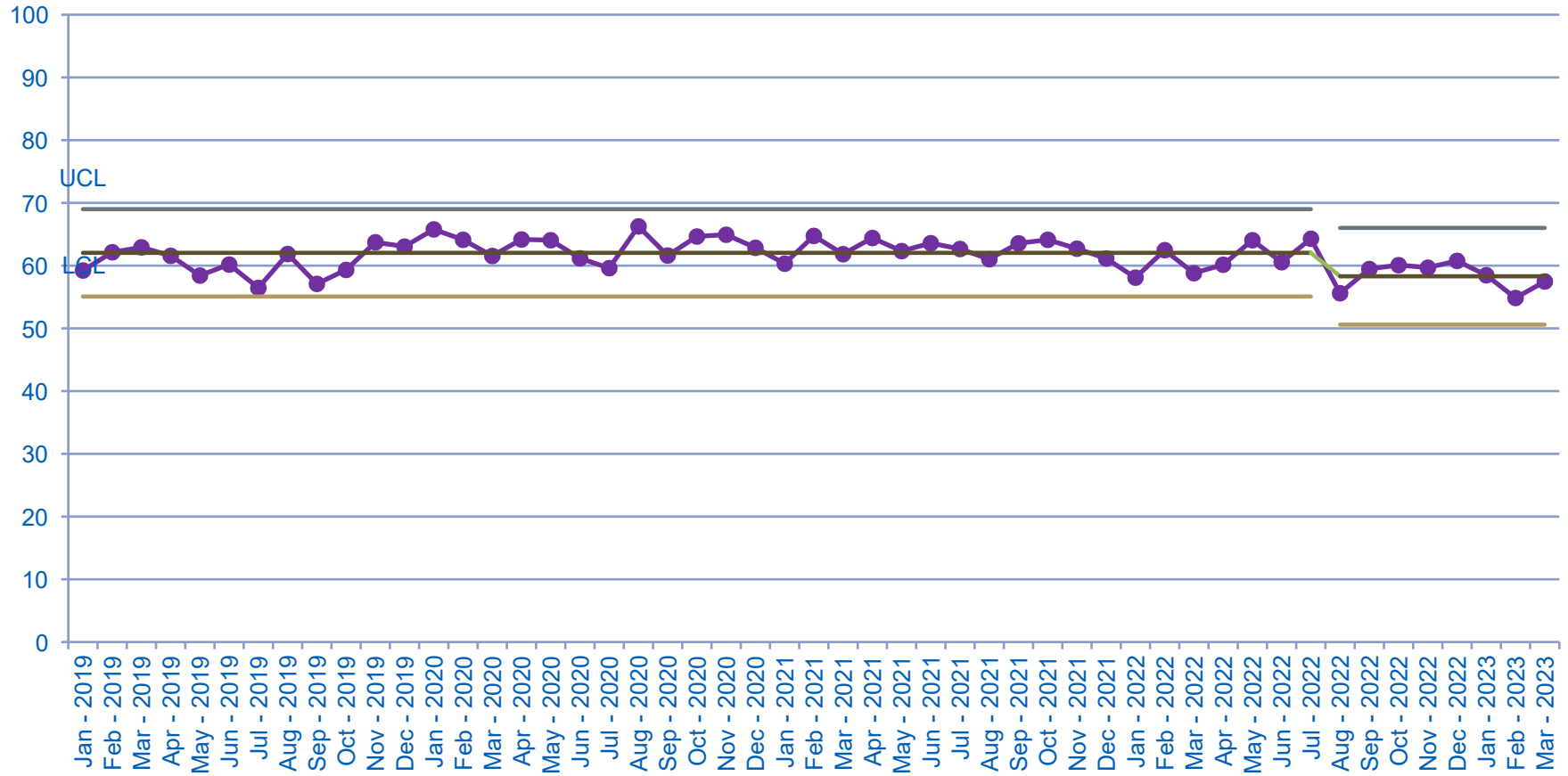


Induction of labour rates have remained stable for the past 3.5 years. There is normal monthly variation, but no significant changes. The median has remained at 37%.

The rates are broadly the same across sites.

Maternity Metrics: Spontaneous Vaginal Delivery (SVD) – June 2023

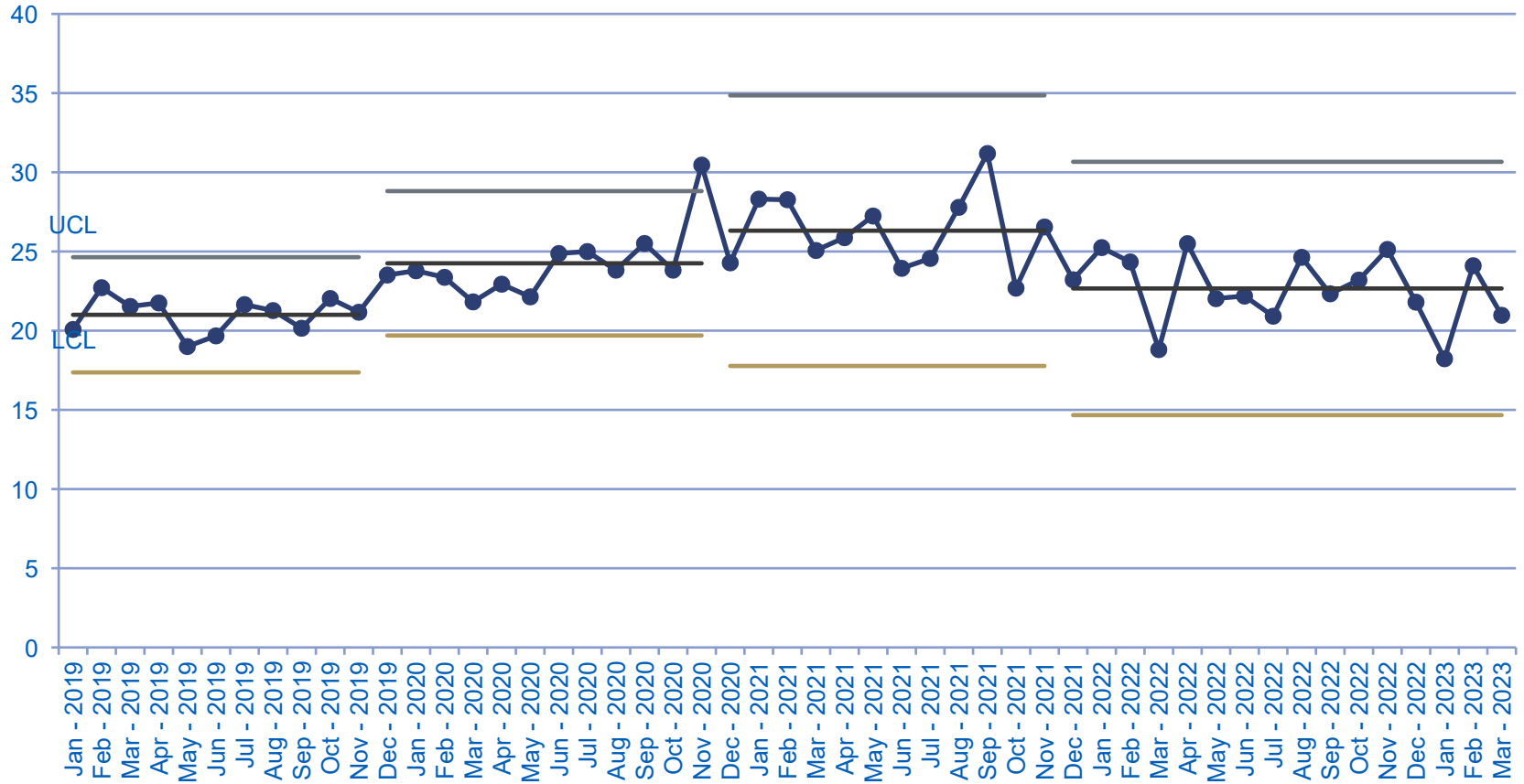
SVD as a % of all birth for all CTM



Rates of women having a spontaneous vaginal birth decreased in July 2022 from a median of 62% to 58%. This is the first significant change in over 5 years and along with other birth data indicates a significant change in the types of birth women are experiencing.

Maternity Metrics – June 2023

Women commencing the normal labour pathway



The median rate of women commencing on the normal labour pathway has gone from 21% in 2019, to 24% in 2020, then 26%. Since November 2021, the rate has fallen to 22%.

In May 2023, the rate was 18%.

This is another indication of increasing rates of birth with intervention.

Maternity Metrics: Birth & Women's Experience – June 2023

Women are asked whether they were given enough time to ask questions or discuss their wishes and concerns during labour and birth.

- 755 women (77.59%) were 'always' given enough time to ask questions or discuss their wishes and concerns
- 140 women (14.38%) were 'sometimes' given enough time to ask questions or discuss their wishes and concerns
- 78 women (8.01%) were not been given enough time to ask questions or discuss their wishes and concerns.

19 women did not know or could not remember.

Women are asked whether they feel they have received enough information from their midwife or doctor to help them make decisions about their care during labour and birth.

- 713 women (73.05%) responded that they had 'definitely' received enough information
- 193 women (19.77%) responded that they had 'mostly' received enough information
- 31 women (3.17%) responded that they had 'rarely' received enough information
- 39 women (3.99%) had not received enough information

10 women did not know or could not remember.

Women are asked whether they were given information and explanations during labour and birth that they could were able to understand.

- 795 women (82.12%) responded that they were 'always' given information and explanations that they could understand
- 143 women (14.77%) were 'sometimes' given information and explanations that they could understand
- 30 women (3.09%) responded that they were not given information and explanations that they could understand

9 women did not know or could not remember.

Women are asked whether their midwife and/or doctor listened to and respected their birth plans and preferences during labour and birth.

- 710 women (72.89%) said that their midwife or doctor had always respected their birth plans and preferences
- 156 women (16.01%) said that their midwife or doctor had mostly respected their birth plans and preferences
- 60 women (6.16%) said that their midwife or doctor had respected their birth plans and preferences a little
- 48 women (4.92%) responded that their midwife or doctor had not respected their birth plans and preferences.

18 women did not know or could not remember.

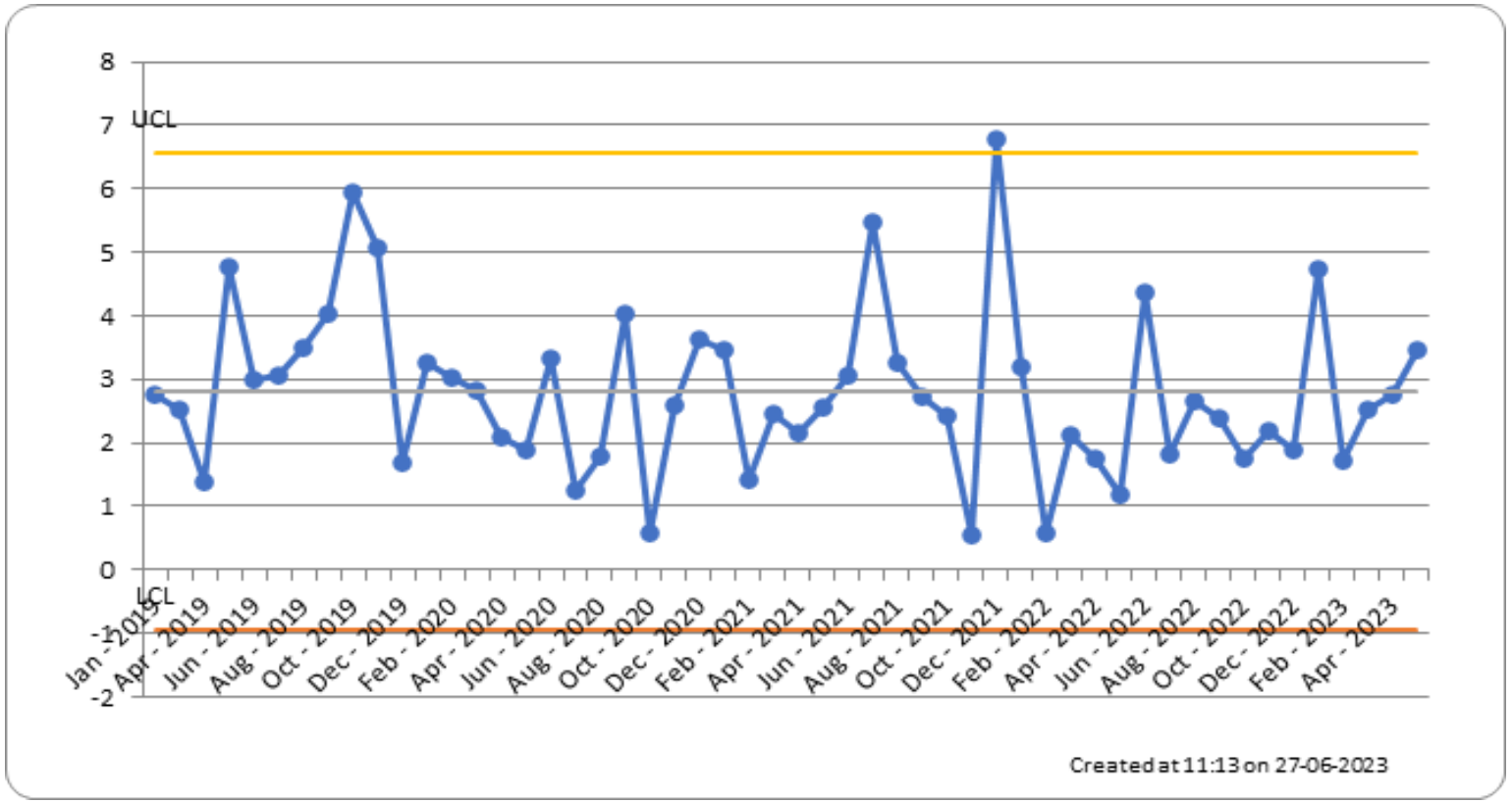
Women are again asked during labour and birth, whether they have been supported to make choices which were right for them:

- 778 women (80.53%) had 'always' been supported to make choices which were right for them
- 138 women (14.28%) had 'sometimes' been supported to make choices which were right for them
- 50 women (5.17%) had not been supported to make choices which were right for them

10 women did not know or could not remember.

Maternity Metrics – June 2023

% of Babies with an Apgar of less than 7 at 5 minutes

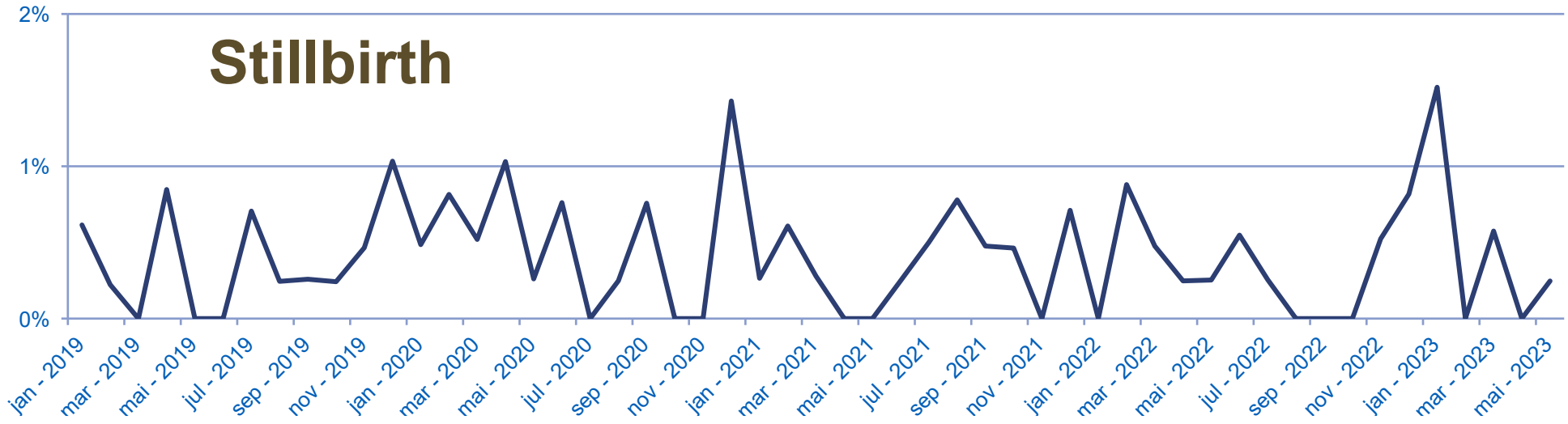


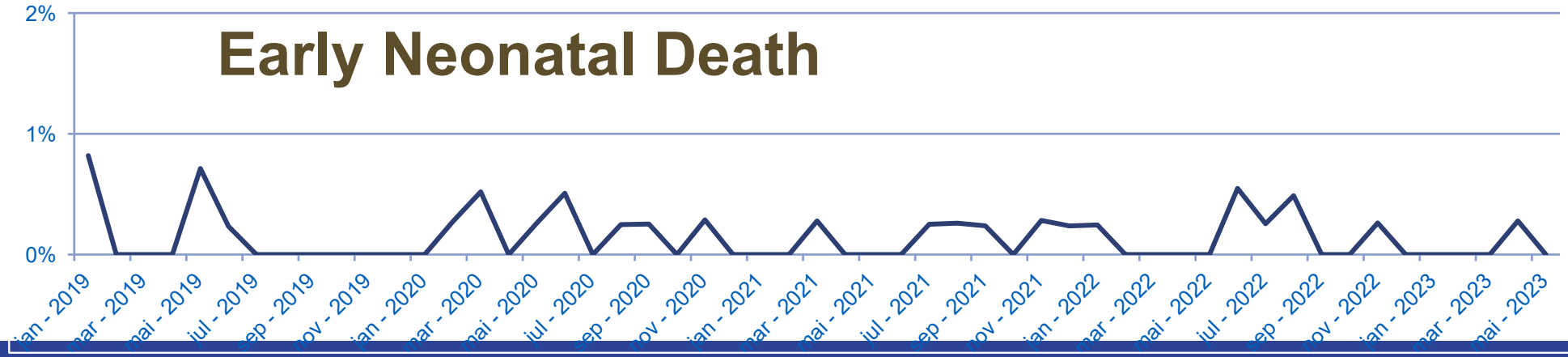
Neonatal Data: Are the increasing interventions improving outcomes?

The rate of babies with an Apgar of less than 7 at 5 minutes has not changed in 4 years.

Note: in December 2021, the rate was outside normal variation.

Maternity Metrics – June 2023





Stillbirth and early neonatal death rates have not seen any significant change.

Note: due to very small numbers, variation can appear high.

Maternity Metrics – June 2023

What we know

- Intervention rates are increasing within CTMUHB and across the UK
- Caesarean section rates are rising across Wales
- In CTMUHB, rising intervention does not appear to be associated with an improvement in perinatal outcomes

Work in Progress

- Birth plan QI to help women make informed choices about labour and birth
- Work to increase the uptake of the normal labour pathway & continuity of carer
- Category 2 CS deep dive to understand our local data and find areas for potential improvements
- National Intrapartum Fetal Surveillance work underway with CTMUHB multi-disciplinary representation (hosted by Welsh Risk Pool).
- Working collaboratively with our colleagues in other Health Boards to understand why intervention rates are increasing nationally
- Engaging with MatNeoSSP

Maternity Metrics: Quality Improvement (QI) – June 2023

Progress against the 2022-2023 QI Plan Milestones for Maternity

All milestones for 2022-23 have been met

Milestone	Achieved?
Develop an understanding of the current quality improvement capability and capacity with the service	Yes- on time
Scope any ongoing improvement projects	Yes- on time
Identify key improvement priorities for Maternity and Neonatal Services	Yes- on time
Develop a QI dashboard	Yes- on time
identify local leads for priority projects	Yes- on time
Identify priority team members for IiP level QI training..	Yes- on time

Milestone	Achieved?
Developing and starting QI projects as identified in section 3.1 of the QI framework	Yes- on time
Training for multi-professional team members	Yes- training plan developed in collaboration with iCTM
Staff encouraged to share their improvement ideas via various mechanisms, including Engagement and Experience sessions, service forums, and QI clinics.	QI Clinics launched in August 2022. Communication also sent out via monthly service newsletter. Staff Voices launched September 2022

Milestone	Achieved?
Significant progress should have been made in the initial QI projects being undertaken, demonstrated by the attendant measurement plans.	Yes. See section 2.1- 2.3
Cohort one of Multi-professional Maternity and Neonatal team completed IiP course.	Yes. 3 MatNeo cohorts completed IiP training by December 2022.

Maternity Metrics – June 2023

Other QI Work in Progress

- **Drymester-** supporting women to have alcohol free pregnancies
- **Birth planning-** supporting women in making choices for birth and increasing health professional's confidence in making clinical recommendations
- **Booking by 10 weeks.** The digital self-referral system was launched on 26th June.
- **BSOTS-** launched on 17th April, the system continues to embed. Data shows the median time for women to be initially assessed has improved since implementation.
- **PERIPrem-** led by 2 quad teams, work is ongoing to implement 10 interventions to improve outcomes for babies born below 32 weeks gestation
- **Transitional Care in POW-** the test phase continues
- **Postnatal contraception-** improving access to contraception in the immediate postnatal period

Increasing Capability

- Perinatal Cohort 4 of Improvement in Practice begins in July 2023. Support and coaching will continue to be provided by the maternity QI Lead.
- Improvement fundamentals training will be provided to all midwives through group supervision from September 2023- August 2024.
- QI trained team members have been invited to present our QI story at the iCTM showcase in July to demonstrate how we have developed our QI programme of work and embedded QI as business as usual.

AGENDA ITEM
7.1.2

QUALITY & SAFETY COMMITTEE

MATERNITY QUALITY IMPROVEMENT ANNUAL UPDATE 2022-2023

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elinore Magillivray – QI Lead Midwife
Presented by	Suzanne Hardacre Director of Midwifery & Nursing, Children & Families Care Group
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	
ATAIN	Avoidable Term Admissions In Neonates
BSOTS	Birmingham Symptom Specific Obstetric Triage System
CTMUHB	Cwm Taf Morgannwg University Health Board
DAU	Day Assessment Unit
ESR	Electronic Staff Record

IOL	Induction of Labour
PeriPrem	Perinatal Excellence to Reduce Injury in Premature Birth
QI	Quality Improvement
MEOWS	Modified Early Obstetric Warning Score
PDSA	Plan, Do, Study, Act

1. SITUATION/BACKGROUND

1.1 This report is intended to provide an update on progress made against the key improvement priorities and milestones as outlined in the Maternity and Neonatal Quality Improvement (QI) Framework published in July 2022.

1.2 This progress report has a particular focus on maternity improvement. For 2023-2024, it is expected that the QI plan will have more of a focus on collaborative Perinatal QI as neonatal services move into continuous improvement and sustainability.

1.3 Three key priorities for 2022-2023 were identified from the clinical dashboard for improvement:-

- BSOTS (Birmingham Symptom Specific Obstetric Triage System).
- ATAIN (Avoiding Term Admissions in Neonates).
- Antenatal Bookings by 10 completed weeks.

1.4 Many other QI projects were started during the period July 2022-June 2023, based on what the data from the service was indicating as being required as well as staff suggestions for improvement including:

- Induction of Labour (IOL) QI Collaborative, with a focus on improving quality, safety and experience of IOL
- Obstetric Anal Sphincter Injury, with a focus on care before and following birth
- Improving women's choice in fetal monitoring, initially focused on DAU
- Postnatal contraception
- Smoking Cessation
- Golden Drops- ensuring premature babies receive early colostrum
- Improving the Golden Hour in Obstetric Theatre in PCH
- PERIPrem- an All Wales QI Project aiming to improve outcomes for babies born below 32 weeks gestation (or 34 weeks for multiple pregnancies)
- Improving compliance with MEOWS outside maternity settings

- Birth planning compliance
- Drymester, to reduce alcohol consumption during pregnancy
- Transitional Care

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

2.1 Each project is monitored by the QI lead, with coaching and support given as required.

2.2 The lead for each QI project is asked to submit a monthly project progress score. The purpose of the score is to highlight where projects do not appear to be making progress as expected, support can be provided as needed.

2.3 All identified projects are achieving their milestones.

2.4 All staff are expected to have completed Improvement Fundamentals - an online 45-minute module on ESR - as a part of their core competencies

2.5 Three cohorts of perinatal team members completed improvement in practice training between September and December 2022. Twenty members of staff in total are now trained to IiP level.

2.6 Although training numbers are measurable, some intangible significant improvement has also happened. The language being used to describe change has become more improvement focused, with phrases such as 'test of change' and 'PDSA' becoming more commonplace. This signals a changing attitude to and understanding of QI.

2.7 The maternity improvement lead is trained to Improvement Advisor level and remains in a seconded post.

2.8 A Neonatal Clinical Improvement Nurse was also appointed to lead on QI in neonates.

2.9 Both the Lead Midwife and Lead Nurse for QI work collaboratively to ensure all projects are aligned with joint priorities where appropriate. ATAIN is an example of this.

2.10 An "All Share, All Learn QI Collaborative Forum" was launched in January 2023. The purpose of the meetings is to provide a forum for those who are trained and/or actively engaged in QI to share the progress of projects and to seek peer support. This has proved to be a valuable resource for the team

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

3.1 None identified.

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
	Safe Care Timely Care Effective Care Dignified Care Staff and Resources Staying Healthy
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 a policy or a guideline
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee is asked to **RECEIVE** and **NOTE** the report and progress made by the Maternity and Neonatal Improvement projects.

AGENDA ITEM
7.2

QUALITY AND SAFETY COMMITTEE

TY LLIDIARD TIER 4 CAMHS INPATIENT UNIT REPORT

Date of meeting	24/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Lauren Edwards, Director of Therapies and Health Science
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 and Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person
HoN	Head of Nursing for CAMHS

iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
LSU	Low Secure Unit
NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression
PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
QI	Quality Improvement
SI NRI LRI	Serious Incident Nationally Reportable Incident Locally Reportable Incident

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide committee members with an update on quality, safety and experience matters in Ty Llidiard (TL), the Tier 4 CAMHS Inpatient Unit within Cwm Taf Morgannwg University Health Board (CTMUHB).

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

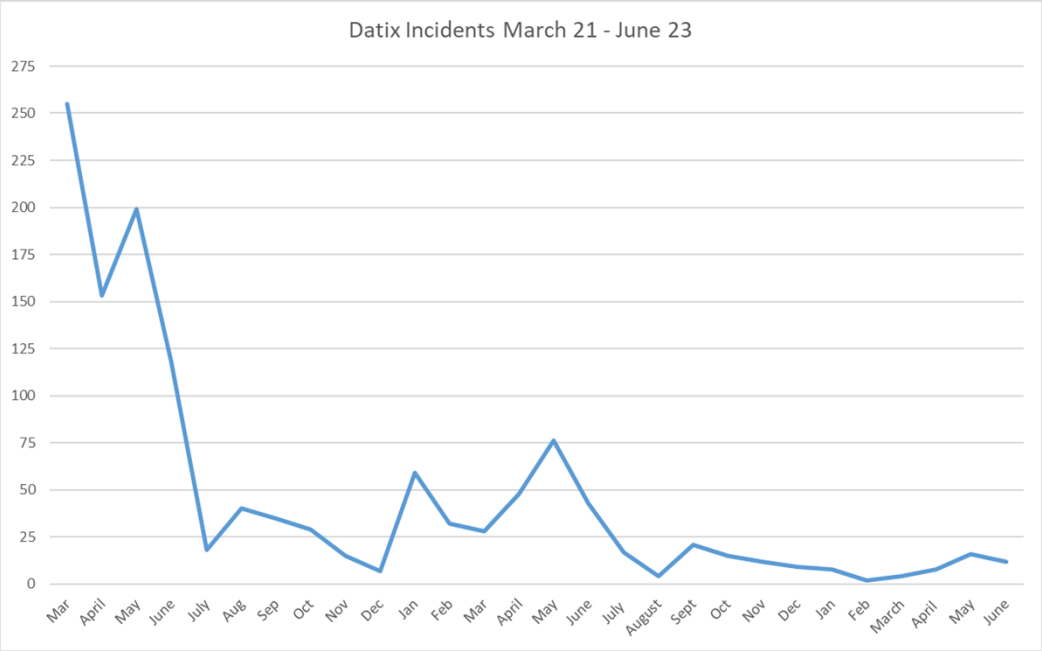
2.1 TL is in Level 2 Escalation with WHSSC. The focus of the monitoring relates to previous concerns regarding the service specification and culture/leadership. Positive feedback continues to be received from WHSSC regarding the visibility and oversight of improvements at TL, as well as the reporting standards and progress being made and sustained.

TL was de-escalated to Level 2 monitoring by WHSSC in June 2023 and given a clear route and actions to achieve full de-escalation by August 2023.

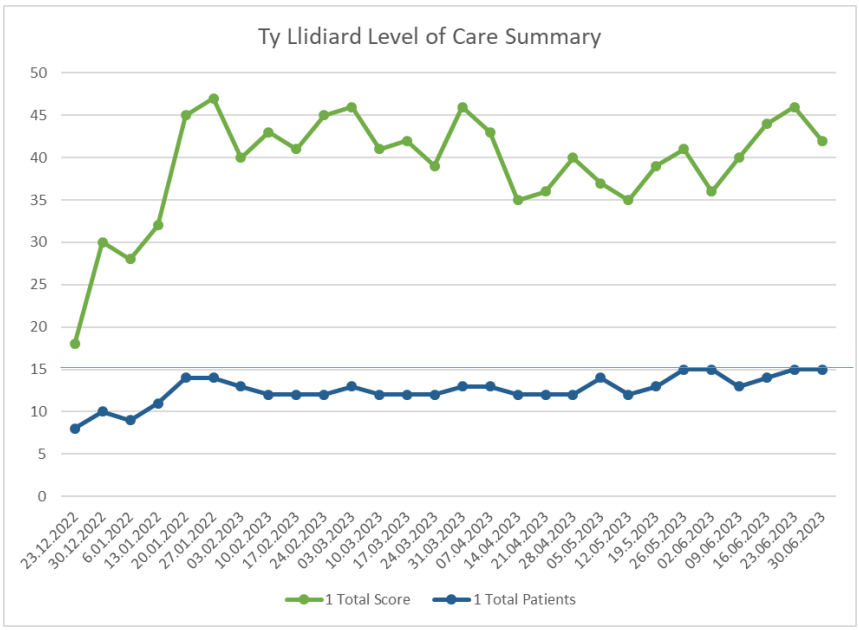
3. Quality Assurance

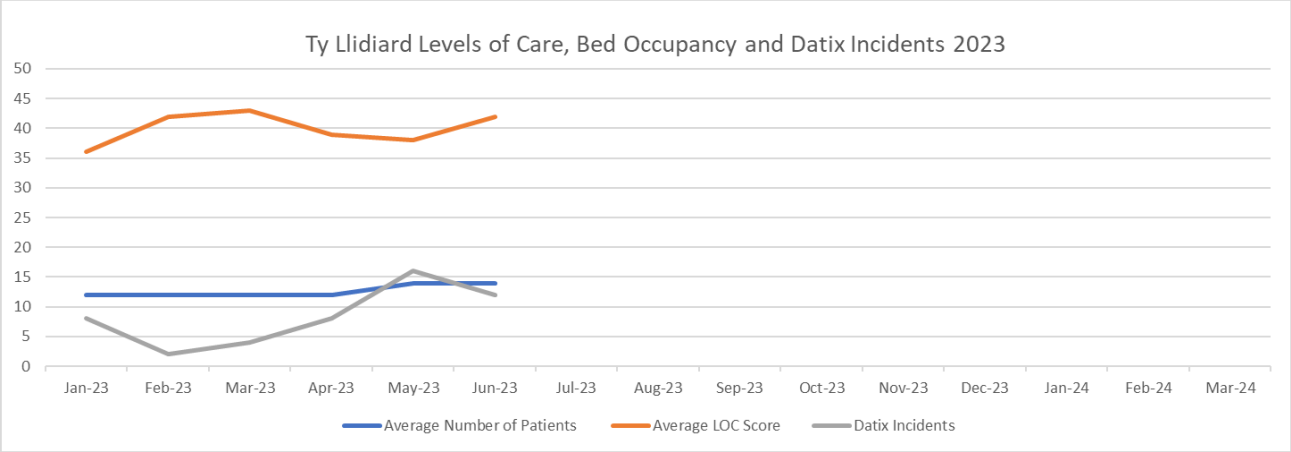
3.1 Patient Safety Incidents (May and June 2023)

There were 28 incidents reported during this period, compared to 118 in the same period in 2022. There were 3 incidents assessed as moderate harm relating to aggression. All other incidents were classified as low or no harm.



The acuity and occupancy levels are demonstrated by the graph below which is a summary of the *Level of Care* results. Level of Care is a rating scale recommended by NCCU, which TL and NWAS use to evaluate and compare the acuity and activity on the wards. Every week, each YP is assessed and allocated a level of between 0-5 (5 needing the highest input) the scores are then totalled to give a picture of how the ward is running. The report shows consistently high acuity levels combined with high occupancy levels.



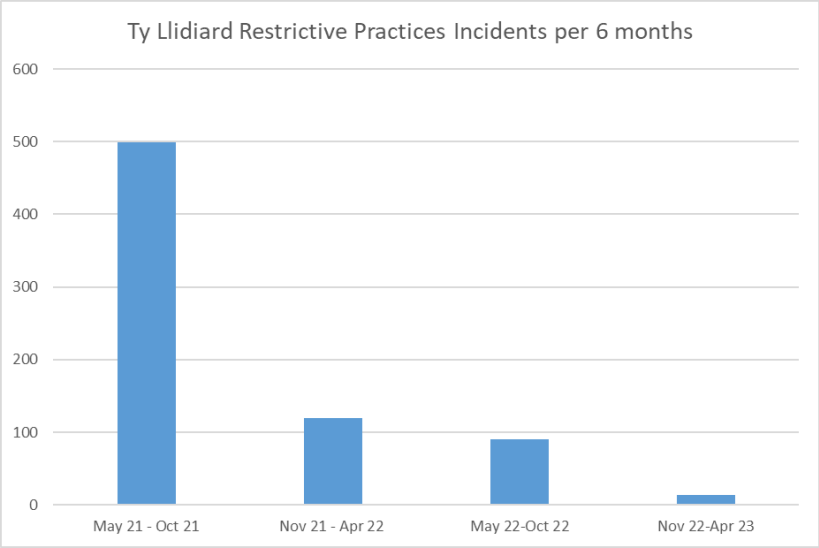


3.2 **Reducing Restrictive Practices**

One of the most discussed topics of the TL Quality Improvement meeting is reducing restrictive practices, particularly naso-gastric feeding under restraint, which historically has been a very challenging area.

Further analysis of restrictive interventions has been completed to show the impact of the improvement work. In the past 6 months, there have been 13 datix incidents involving restrictive practices. This is a significant decrease compared to 90 incidents in the previous 6 months and significantly higher historical levels.

This has been achieved through changes in clinical practice, supported by a Multi-Disciplinary Team (MDT) who are committed to reflect, learn and improve the quality of care and support provided to YP.



During this reporting period there were 2 incidents involving restrictive interventions, both classified as low harm. 1 of these incidents related to NG feeding under restraint.

3.3 Complaints

3.3.1 There were no formal complaints received during this reporting period and there are no open complaints.

3.4 Compliments

3.4.1 Understanding the experiences of YP and their families during their admission to TL is an important source of learning and the team are striving to increase feedback month on month.

Ty Llidiard Written Compliments

2022											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
2	3	1	3	4	5	4	4	3	2	4	4
2023											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
3	5	6	4	5	4						

3.4.2 All compliments are shared with the team at Ty Llidiard. There is a board in the staff room where compliments are shared. The team are in the process of developing a monthly newsletter for colleagues, which will include a compliments section.

3.5 Current open SIs (NRI or LRI)

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

3.6 Ombudsman complaints

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

3.7 Claims/redress cases

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

4. People's Experience/co-production

4.1 The TL team facilitate weekly community meetings (open to all YP on the ward) to seek the views of the YP on what is done well and what can be improved. These meetings continue to be well-attended and have resulted in valuable insights.

4.2 On 16/06/2023, the Children's Commissioner for Wales visited TL and spent time meeting the YP. She made positive comments about the improvements made and the care the YP were receiving.

4.3 The TL Music Therapist and Art Therapist have introduced group Art and Music Therapy in conjunction with 'Music in Hospitals'.

The group was well attended and positively received by the YP, it aims to;

- To be creative and make a creative response to the live music performed by 'Music in hospitals'
- To experience the anxiety reducing qualities of art and music
- To consider how music and art might support emotional regulation
- To reflect on how the music made us feel
- To experience working together as a group with a shared task

- To reflect on how we coexist as a group with our individual needs for space and boundaries
- To build a sense of community

4.4 TL continues to engage with people with lived experience to help on the improvement journey.

4.5 This month, a lived experience survey run by Parent's Voices for Wales has been launched aimed at getting feedback from carers with lived experience of contact with TL.

4.6 The TL team were recently approached by someone with lived experience of TL after they saw a post on Twitter about the improvements. This person has become a healthcare professional and offered to assist with the improvement work as an expert by experience. Their views were sought on some areas of focus in TL: reducing restrictive practices, mobile phone use, and meal support training for Healthcare Support Workers (HCSWs). This was their feedback after a meeting (shared with consent)

"Thank you so much for meeting with me today, it honestly means so much to hear my experiences are valued and I am incredibly grateful for all the hard work you have put in. Ty Llid certainly seems like a very different pace to when I was there. Please let me know if there is anything I can do to help"

5. Capital Works /Visual Identity

5.1 Phase 1 of the capital improvement scheme is now complete. This phase has included the creation of a new ward office in the heart of the ward, improving visibility, observation and staff/young people interaction. It features more of TL's 4Cs visual identity graphics.

New Ward Office

5.2 We have also invested in TL outdoor spaces with the internal courtyard being pressure washed, painted and replanted with new furniture added. The TL Occupational Therapy and activity staff will be working with the YP to plant vegetables and salads in the raised beds as a therapeutic activity.

5.3 The final stages of the TL visual identity work will be completed soon and will see a large external sign installed, staff locker name plates, and bedroom door signs that the YP can customise.

6. Quality Improvement

6.1 The TL quality improvement group is well established and meets weekly. This group is highly valued and well attended by all members of the Team Ty Llidiard. The improvements and initiatives that have been developed by the group are discussed and supported by the iCTM Team.

6.2 The iCTM team have recently delivered a 2 day QI training course to new staff at TL.

6.3 Through the iCTM and IT teams we are going to be a pilot site for the introduction of digital whiteboards on mental health wards. The TL team are working with the IT team to process map the admission procedures to digitalise and use on the digital whiteboards.

7. Improvement Board

7.1 An 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.

8. Open Day

8.1 On 28/06/2023 an open day was held as a follow up to the engagement event that was held in April 2022 to show the progress that has been made in TL.

8.2 The day was attended by over 40 stakeholders, including representatives from WH, NCCU and WHSSC. Feedback from the day was overwhelmingly positive with people enjoying having the opportunity to discuss the improvements with the TL MDT.

8.3 See Appendix 1 for the leaflet produced for the day.

9. Staff Experience

9.1 In June, the first edition of the Ty Llidiard newsletter was published and distributed - designed to improve communication, celebrate achievements and further embed the "Team Ty Llid" philosophy.

9.2 On 21st June a "Pride Picnic" was held in the reception area which was well attended. Colleagues prepared a healthy picnic and wore colourful clothes to celebrate Pride week. All monies raised are being put to summer activities for the YP.

9.3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/ COMMITTEE

9.4 TL is in Level 2 escalation with WHSSC, following a recent de-escalation. Although WHSSC remain assured by the progress being made, the improvements continue to receive sustained support and senior oversight within CTMUHB.

9.5 As part of the improvement work within TL, changes to the layout of the unit have been suggested. Phase 1 is now complete. Phase 2 has been designed and costed at circa £700k. A Statement of Need (SON) has been completed and submitted. Phase 2 mainly consists of the creation of an Extra Care Area and Disability Discrimination Act friendly bedroom, ensuring Ty Llidiard meets the WHSSC service specification.

10. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If 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

11. RECOMMENDATION

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

Appendix 1


Our 4Cs are at the heart of everything we do to support our young people & staff to thrive.
CARING
CALM
COMPASSIONATE
CONFIDENT
LISTENING AND ACTING ON FEEDBACK TO IMPROVE WHAT WE DO
"Involve young people in self evaluation, contributing to their own records/reviews etc. Promotes shared understanding." Staff Member
"Opportunities for young people to practice self care and caring for others and one another." Young Person
"Staff welcoming to family and happy to receive phone calls." Family/Carer
"Encourage exercise and laughter... the best medicine." Family/Carer
"The sensory room is great! ... A great addition to the ward." Young person/Family/Carer
"Staff have a very caring approach. Young people feel valued !! " Young Person
"They didn't give up - Saved my life." Young Person
"Staff very compassionate as they demonstrate a true understanding of the illness." Family/Carer
"Having a named nurse for each patient is a positive." Staff Member
FOR MORE INFORMATION PLEASE CONTACT US AT: LLOYD.GRIFFITHS@WALES.NHS.UK
TŶ LLIDIARD LITCHARD HOUSE
"Thank you to the young people and their families and carers, our staff and stakeholders for helping us to make improvements that really make a difference to everyone's daily lives, and are creating a caring, calm, compassionate, and confident culture at Tŷ Llidiard."


APRIL 2022 – JUNE 2023: OUR IMPROVEMENT JOURNEY SO FAR...
Tŷ Llidiard (TL) Listening and Consultation drop-in event attended by 75 people – People shared their ideas for how to improve TL and voted for their TL logo/graphics design choice.
With parents/carers and young people who'd previously been at TL; young people currently at TL; staff and stakeholders.
Consultation display with feedback forms in TL reception for 5 weeks, plus online forms. 300+ responses received and used to inform our 4Cs strategy.
The 4 Cs philosophy embedded in our improvement plan, and the chosen logo/graphics start being used to share the philosophy.
Staff uniforms with the new TL logo
Our young people and staff's activity suggestions implemented throughout.
Sports day
Restrictive Practice incidents reduced from 059 in May 21 – Oct 21 to 13 in Nov 22 – Apr 23.
Phase 2 TL 4Cs visual philosophy interior graphics. Staff room updated with wall graphics and furniture
Animal Therapy with therapy dog Cody, a dog competition and visiting animals, including Alpaca and reptiles.
TL de-escalated from level 4 to 3 by Welsh Health Specialist Services Committee (WHSSC), then from 3 to 2, a clear de-escalation pathway to 0.
Phase 1 exterior/interior graphics
In response to parent/carer feedback, dedicated car parking places set up to reduce stress when visiting TL.
Outdoor areas renovated, with new furniture, games & plants.
Visits by CTMHB staff and leaders, and stakeholders throughout, including CTMHB CEO & Children's Commissioner for Wales.
New ward team office built in the centre of the unit.
Phase 3 graphics including a graffiti chalk board wall all the request of the young people.
Tŷ Llidiard Open Day Drop-in Event 28.06.23, sharing our improvement journey over the 14 months, with young people and staff involved at each stage, co-producing our improvements together.

AGENDA ITEM
7.3

QUALITY & SAFETY COMMITTEE

A FOCUS ON MENTAL HEALTH IN-PATIENT IMPROVEMENT AND HIW INSPECTIONS

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ana Llewellyn, Nurse Director
Presented by	Dr Mary Self, Medical Director, Mental Health and Learning Disabilities
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	
BLS	Basic Life Support
CIW	Care Inspectorate Wales
CMHT	Community Mental Health Team
HIW	Health Inspectorate Wales
ILG	Integrated Locality Group
ILS	Immediate Life Support
MHLD	Mental Health and Learning Disabilities

PMVA	Prevention and Management of Violence and Aggression
QSRE	Quality Safety Risk and Experience Meeting
RTE	Rhondda Taff Ely

1. SITUATION/BACKGROUND

1.1 This report provides committee members with an overview of progress against 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 and local thematic reviews and bespoke inspections of services of concern. The Mental Health Discharge Review is an example of a Local Review.

1.4 This report will update committee on updates, to the recent in-patient inspections, the discharge local review and the legacy HIW in-patient action plans, provided to the Mental Health Quality Safety Risk and Experience Board on 7th June 2023.

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 2023 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 HIW identified 4 areas for immediate assurance, which have been further broken down into 53 sub-actions.

Total Completed Actions	Completed since last report	Number of actions due for completion by next QSRE (Aug)	Number of actions with later timescales	Number of actions with slipped timescales
45	2	6	2	8

1.11 Two actions have been completed since the last committee – these relate to the work of the clinical records monitoring group. The evidence was reviewed at the MHLD QSRE meeting and these actions were determined to be completed.

1.12 The areas of slippage are in 4 main areas:

- Investigation of two identified cases – see update below
- Clinical Records
- Training related to Clinical Records
- Care and Treatment Planning Training

1.13 As part of their review of discharge arrangements HIW identified concerns relating to the discharge of two patients who subsequently died. Independent reviews have been commissioned of these cases with investigating officers identified from outside the Health Board. It is not anticipated that these reviews will be completed before September 2023.

1.14 The other areas of slippage are being addressed through the Mental Health In-patient Improvement Programme priorities and are on track for completion by the next QSRE in early August.

1.15 The discharge review was published on 7th March and includes a further 40 recommendations: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (hiw.org.uk)

1.16 HIW asked the Health Board to submit an improvement plan by 7th April 2023. HIW wrote to the Health Board on 31st May 2023 to advise that the improvement plan had not been accepted. A revised improvement programme was submitted on 14th June 2023. At the time of writing the Health Board is yet to have confirmation from HIW that this revised improvement plan has been approved.

1.17 All 40 recommendations and associated actions in the table below have been aligned to workstreams and are in progress as part of the In-patient Improvement Programme, which is discussed further on in this report.

1.18 All but one of the actions are on track to meet the planned timescales; there has been a revision to one timescale which relates to a review of the therapy workforce. Therapy leads have considered that a much broader review than originally planned will be required and this therefore requires more time to complete.

Total Completed Actions	Completed since last meeting	Number of actions due for completion by next QSRE (August)	Number of actions with later timescales	Number of remaining actions with slipped timescales
2	1 (0 overdue)	14	24	1

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

1.20 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.

1.21 HIW identified 7 areas for immediate assurance, which the Health Board has further broken down into 31 sub-actions.

Completed Actions	Completed since last meeting	Number of actions due for completion by next QSRE (August)	Number of actions with later timescales	Number of actions with slipped timescales
26	1 (1 overdue)	3	1	4

1.22 The action completed since the last committee meeting relates to the national mental health outcome measure training. All of the remaining actions relate to training, which all had earlier completion dates that have subsequently been revised. All of these training requirements relate to face-to-face training where there is limited training availability. In addition the service has to balance the release of staff for training with the requirement to maintain safe staffing levels.

1.23 Revised completion dates for the 4 slipped actions are as follows:

- Dysphagia training – end of July
- PMVA – end of August
- ILS and BLS – end of July
- Evacuation – end of July

1.24 The risks are mitigated by ensuring that there are trained staff rostered for each shift.

1.25 The final report was published on 15th March: 20230315AngeltonClinicGlanrhydEN_0.pdf (hiw.org.uk)

1.26 The Health Board was noted for doing the following areas well: physical health monitoring; staff, patient and family experience and engagement; and falls quality improvement.

1.27 In addition to the areas of immediate assurance HIW identified 8 additional areas for improvement, which have been further broken down into 33 sub-actions. The table below provides an overview of progress against those actions:

Completed Actions	Completed since last meeting	Number of actions due for completion by next QSRE (Aug)	Number of actions with later timescales	Number of remaining actions with slipped timescales
30	8	3 (1 overdue)	0	1

1.28 Eight actions were due for completion by June 2023 and these were completed as planned. The action with a revised timescale is due to an operational requirement to reschedule medicines management training. This will be completed by the next meeting.

1.29 **Legacy Mental Health HIW action plans**

1.30 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 May 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	40	4	0

1.31 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.

1.32 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 nurse staffing levels.

1.33 There is a dedicated action plan for the legacy HIW actions that is monitored at every MHLD QSRE meeting. The In-patient Improvement Programme, which is discussed later in this report, also includes the oversight of the outstanding actions.

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

1.35 A Quality, Safety, Risk and Experience governance framework led by the Nurse Director is in place 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 HIW action plans are on the agenda for every meeting and are actively monitored via this board.

1.36 The key themes that are evident across all HIW inspections are:

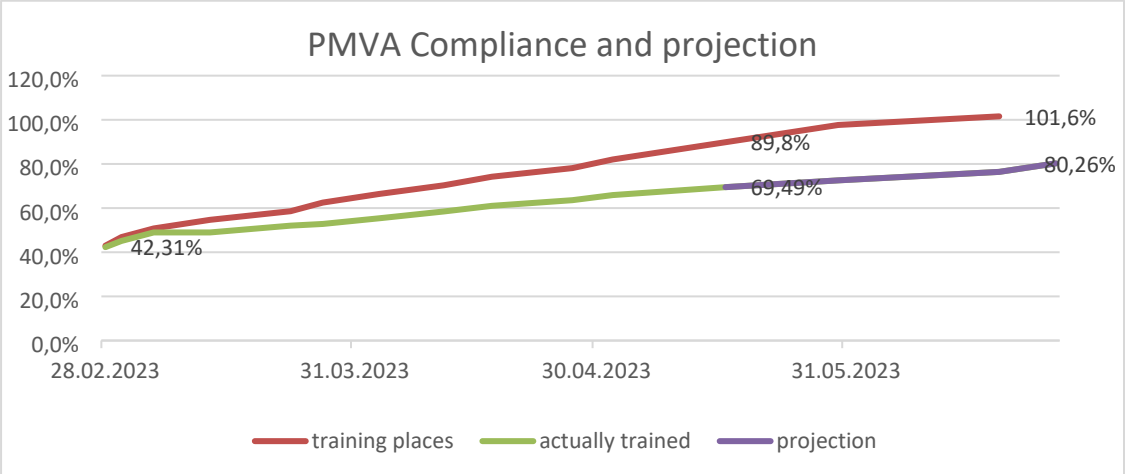
- Clinical records
- Statutory and mandatory training
- Policies
- Ward assurance

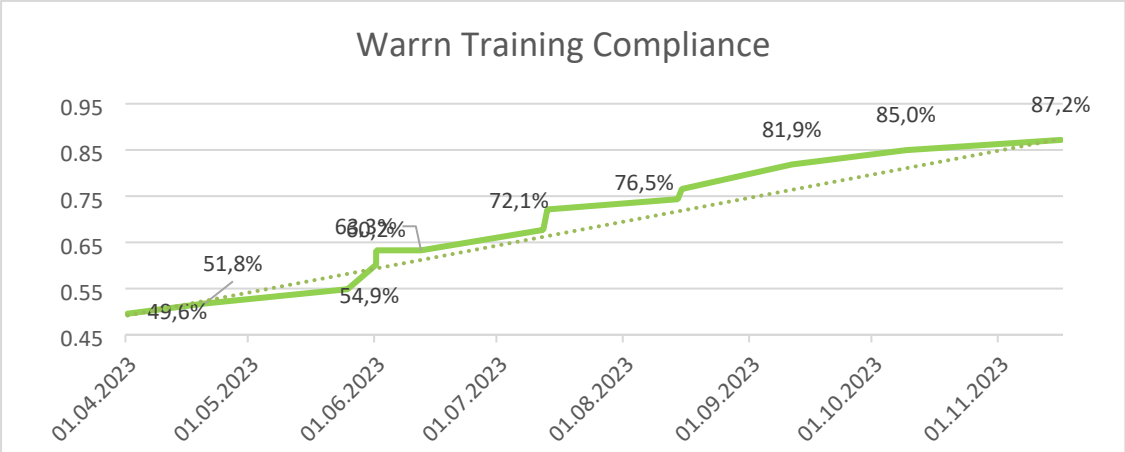
1.37 These four improvement themes are monitored via QSRE but also through the monthly integrated performance meetings with Clinical Service Groups and an update is provided below:

1.38 ***Clinical Records:*** The executive team and board have given approval to progress the implementation of WCCIS during 2023 / 2024. The Director of Digital and Deputy COO will co-chair an Implementation Board.

1.39 In the interim, operational and clinical leads have process mapped the existing systems and have introduced a number of actions to mitigate the current risk. 'High Quality Clinical Records' is also a priority workstream in the In-patient Improvement Programme.

1.40 ***Statutory and Mandatory Training:*** A Pan CTM review of ESR competencies has been undertaken, with support from the Learning and Development team. A working excel document will be used for all wards as an interim assurance measure for reporting and maintaining compliance. This will enable the development of robust trajectories. Trajectories are in place for PMVA and WARRN training.





1.41 There are however significant challenges with corporately provided resuscitation and manual handling training. There are limitations in the availability of face to face training.

1.42 ***Policies:*** A care group policies group has been convened and has completed a scoping exercise of all MH specific policies.

Review underway	4
In date and approved	13
Expired	32

1.43 The in-patient policies will be prioritised for updating. A plan is in place to have completed the 32 expired policies by June 2024. 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.

1.44 **Ward Assurance:** A working group has identified an initial core of specialist MH audits and is working on a further shortlist for inclusion in the Health Board electronic audit system. Once this is complete the group aim to develop a programme of peer review. A programme of director level visits is also being developed.

1.45 A Mental Health In-patient Improvement Programme has been developed with a number of workstreams. The HIW actions and the four improvement themes referenced above are aligned to these workstreams.

1.46 The Executive Director of Therapies and Health Sciences has recently been identified as the executive lead for the In-patient Improvement Programme and will chair the Programme Board on 11th July. A maturity matrix and Integrated Performance Assessment and Assurance Framework (IPAAF) has also been developed for ratification by the Improvement Board for onward endorsement by Welsh Government and the Performance and Assurance Division of NHS Wales Executive.

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

3.1 The progress to implement WCCIS is a priority for the Health Board. This risk is recorded on the organisational risk register with a Datix Risk ID of 3337. Members will note the updates on the development of an Implementation Board.

3.2 The committee are asked to note that availability of some face to face training and the ability to release staff will continue to impact on mandatory and statutory training compliance.

2. IMPACT ASSESSMENT –

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and safety of care for people in receipt of mental health services is central to this report.
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below: Safe Care Individual Care Timely Care Governance, Leadership and Accountability Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No new, changed or withdrawn policies or services outlined
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There are resource implications for the additional workforce proposed to underpin the internal oversight of mental health services. New posts are funded from recurrent the Mental Health Service Improvement Fund,
Link to Strategic Goals	Improving Care

3. RECOMMENDATION

3.3 Members of the Committee are to **note** the progress on HIW inspection action plans and the mitigating actions in place for areas of slippage against timescales.

3.4 Members are asked also ask to **note** the ongoing progress of the In-patient Improvement Programme.

AGENDA ITEM
7.4

QUALITY & SAFETY COMMITTEE

STROKE SERVICES – PROGRESS REPORT

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kevin Duff, Head of Strategic Planning and Commissioning
Presented by	Sarah Follows, Service Director Unscheduled Care Group
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 RGH – Royal Glamorgan Hospital POWH – Princess of Wales Hospital ESD – Early Supported Discharge SSNAP – Stroke Sentinel National Audit Programme WAST –Welsh Ambulance Service Trust CTM UHB – Cwm Taf Morgannwg University Health Board QIMs – Quality Improvement Measures FAST – Face, Arm, Speech, Time AI – Artificial Intelligence EDI – Equality, Diversity and Inclusion

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 The Quality and Safety Committee has received regular progress reports on stroke services in CTMUHB which outlined a number of short, medium and long term measures being taken by the health board to further improve the quality of care in CTMUHB's stroke services. It was agreed to move from a six monthly to a quarterly cycle of progress reporting on stroke to the Quality and Safety Committee.

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

PROGRESS SINCE LAST UPDATE (March 2022)

2.1 The significantly challenged financial picture and volume of competing priorities resulted in no funding for stroke being identified in 2022/23. Investment of £500,000 has been confirmed for 2023/24, but Regional Integration Funding for the existing Early Supported Discharge team will cease from September, resulting in additionality of just £130,000. Whilst some investment has been identified for 2023/2024, it is not possible to allocate the volume of resource required to fully mobilise our plans.

2.2 Some service developments have been achieved, but progress is limited due to scale of investment.

South Central Wales Regional Stroke Network Programme

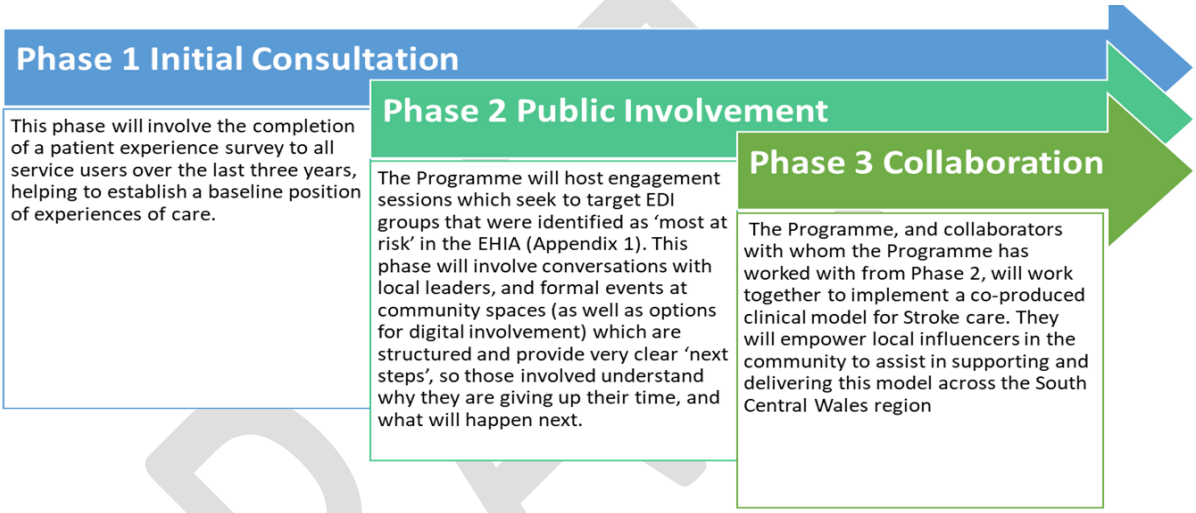
2.3 In the areas served by Cardiff and Vale and Cwm Taf Morgannwg University Health Boards, approximately 1,800 strokes occur annually. Welsh Government's Quality Statement for Stroke, published in September 2021, emphasises the importance of collaborative work to address all aspects of the stroke care pathway.

2.4 To address challenges faced by our current services, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards, along with key stakeholders, have established the South-Central Wales Stroke Delivery Network. A governance and programme structure is in place as well as a small programme team, including a programme manager and clinical lead (a CTM Stroke Consultant). The structure includes a

programme board involving key stakeholders, including WAST, Public Health colleagues and the Third Sector.

2.5 To achieve our goals of sustainable and effective services, it is crucial to understand the perspectives of stroke patients who have received care from us. This summer, we will be inviting all stroke patients from the past year, approximately 1,800 patients across both health boards, to provide feedback on their care, establishing a baseline understanding of our current services. The survey is available in English, Welsh and Easy Read format.

To achieve our ambitions, the programme will undertake three engagement phases as set out below:



2.6 The National Stroke Programme, part of the NHS Executive, seeks to work in partnership with patients, their families, those who provide services and the wider community to develop stroke services that better serve the population of Wales, both now and in the future. A number of key milestones have been met by the national programme:

- First draft of the case for change has been generated and circulated for comments and further iteration. This case for change will need to be informed by engagement activities.
- The Programme Definition document, an iterative document that will develop over the life of the programme, has been circulated for comment and approval.
- The Terms of Reference for the programme have been drafted and updated.
- The 2023 version of the National Clinical Guideline for Stroke for the United Kingdom and Ireland (April 2023) has been published.

2.7 The service specifications, which will help determine our clinical model and pathways, will be developed as part of the national stroke programme and it is anticipated these will be available in September 2023. In the South Central Wales Programme, we plan to bring colleagues back together in Autumn 2023 to use the specifications to inform our regional model.

CTM UHB Stroke Strategy Group

2.8 The Stroke Strategy Group was developed to provide oversight on the development and improvement in provision of services across the breadth of the stroke pathway and receives updates from three work streams:

- Acute care and rehabilitation
- Prevention and early intervention
- Regional and national developments.

Service developments and improvements

2.9 The CTM UHB Service Director Unscheduled Care is pulling together key stakeholders in a stroke programme board in order to further develop the action plans to operationalise quality and safety improvements. The first meeting of the board is scheduled for 27th July 2023 (a June meeting was deferred due to availability of key stakeholders).

2.10 The Unscheduled Care Group is undertaking a number of actions to improve stroke services in CTM UHB:

- Direct admission to acute stroke unit within 4 hours has been a challenge, although some progress has been made in improving the availability of the beds, with a second stroke bed identified on the PCH site to accommodate the stroke pathway from RGH.
- Referrals to Bristol for thrombectomy are predominantly limited by Bristol's opening hours, although the Bristol service is persevering with its plans to become a 24/7 thrombectomy service by late Autumn 2023. From a CTM perspective, timely referral to the service will be a challenge whilst the one 1 in 4 Stroke Consultant rota remains in place.
- The Care Group have recently implemented radiographer approved CT and CT angiograms, to minimise delays in getting CT angiograms in patients presenting with acute strokes.
- There is an upcoming project to implement artificial intelligence software reporting for CTs and CT angiograms, which would minimise delays in referral for thrombectomy. £20k slippage funding in 2023/24 has been identified and a further £40k for 24/25 and 25/26 respectively needs to be identified to secure the 3 year contract.

2.11 In May 2022, Public Health, Primary Care and Planning submitted a successful bid for funding to Welsh Government through the CTM Value Based Health Care team to support primary care in the optimal management and targeted case detection of atrial fibrillation (AF) and hypertension. The project is in the implementation phase and progress has been made attaching a pharmacist to the project in addition to the prescribing nurse. The hypertension element has started and is being picked up in practices, through the Health Check clinics and there are three practices identified that will be starting the AF work on 1 July.

2.12 Work has been progressed by colleagues in Public Health, working closely with the Stroke Association, and the FAST campaign was re-launched over April to promote early identification of stroke by members of the public and accessing services as early as possible.

Quality Improvement Measure performance

2.13 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

2.14 The latest performance report against the four QIMs is attached at **Appendix 1**. Performance remains low against some key indicators, and this is a picture that is replicated across Wales. The following key factors continue to impact on performance against stroke care standards:

- 5-day/week service model for medical and therapy provision. No funding is available to address this during 2023/24.
- Lack of access to an Early Supported Discharge (ESD) team and adequate bedded rehabilitation unit impact on length of stay and flow of stroke patients through the Princess of Wales hospital. The additional resource allocated in 2023/24 will be used to establish an ESD service for the whole CTM footprint. Recruitment processes are underway.
- Ongoing demand for acute beds and the challenges maintaining a ring-fenced stroke bed impact on the ability to admit to the stroke wards within 4 hours across the whole hospital site.
- Pressures within adult social care, which result in delayed discharges and increased pressure across all inpatient areas.

[1] Drug Treatment known as Thrombolysis is used as soon as possible following the stroke to dissolve the blood clot.

- Continued self-presentations to the Royal Glamorgan Hospital (RGH), instead of specialist stroke sites. Demand for acute beds results in delays in subsequent transfer to acute stroke sites and access to specialist stroke services. Progress being made with WAST regarding telephone advice provided to patients who will self-convey following a suspected stroke.

2.15 In March 2023 (latest benchmarking data), CTM demonstrated the second best performance in Wales for scans within 1 hour. We performed poorly in relation to admission to a stroke bed within 4 hours (ranked as performing 5th in Wales), 45 minute door to needle time for thrombolysis (5th in Wales) and assessment by a stroke consultant within 24 hours (ranked lowest in Wales).

Organisational Risk Register

2.16 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 2**.

Next steps

2.17 Based on feedback from discussions in both Quality and Safety Committee and also Planning, Performance and Finance Committee, the Stroke Strategy Group will continue to oversee progress against the stroke action plan **(Appendix 3)**, informed by updates from the Stroke Programme Board**.** The group will regularly assess performance and progress, and review the plan to ensure it incorporates current and newly-identified actions with clear action Owners and delivery dates.

2.18 Extreme system pressures have resulted in an All-Wales picture of delays in getting patients to the right place to start the pathway of care (specialist stroke teams via emergency departments). The NHS Wales Executive Delivery Unit has identified that patients are self-presenting to emergency departments in units who are both specialist stroke centres and emergency departments in hospitals that do not specialise in stroke. The Delivery Unit has, therefore, established an All-Wales review of self-presenters in stroke care, which aims to establish whether the practices and processes in each Health Board are appropriate for timely stroke care and to make quality improvement recommendations.

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

3.11 The intended impact of the short, medium and long term actions, along with the regional and national stroke programmes, is to improve the quality, safety and experience of care for patients, their families and our workforce. CTM will develop an improvement plan, with ambitions to achieve a SSNAP rating of 'A'.

3.12 Specific risks arise from the lack of funding for implementation of the AI solution, which would minimise delays in referral for thrombectomy. In addition the current position of only 2 stroke consultants on each site (POWH and PCH), with the difficulties faced in recruiting to the one vacant consultant post places pressures upon the stroke pathway. The pressure is compounded by the current establishment of only 2 Clinical Nurse Specialists in stroke at PCH which impacts on the ability to provide a 7 day a week service. Consistency of systems and processes across PCH and POW is a key issue for the care group and colleagues are exploring an opportunity to expand Stroke Services Admin Co-ordinator to cover POWH as well, which is dependent on additional funding.

3.13 The main risks to achieving this rating are resource challenges and the wider patient flow challenges experienced in ED and throughout the hospital, which make it difficult to ring fence stroke beds, particularly affecting the 4-hour target. Bed pressures also impact the ability to transfer stroke patients from RGH in a timely manner in order to access specialist stroke care. This is part of the wider unscheduled care improvement programme and the wider performance management of the system.

3.14 In order for the national stroke care ambitions to be achieved, local services are required to deliver effective and efficient acute care and rehabilitation post-72 hours. Whilst some investment has been identified for 2023/24, it is not possible to allocate the volume of resource required to fully mobilise our plans.

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 identification of a small amount of additional resource to support stroke service developments. It has not been possible to identify the large-scale funding required to deliver improvement across all 4 QIMs 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 Strategy Group.
- **Note** the regional and national work being undertaken to develop high quality prevention, identification and treatment for stroke.

Appendix 1

Quality Improvement Measures across PCH and POWH

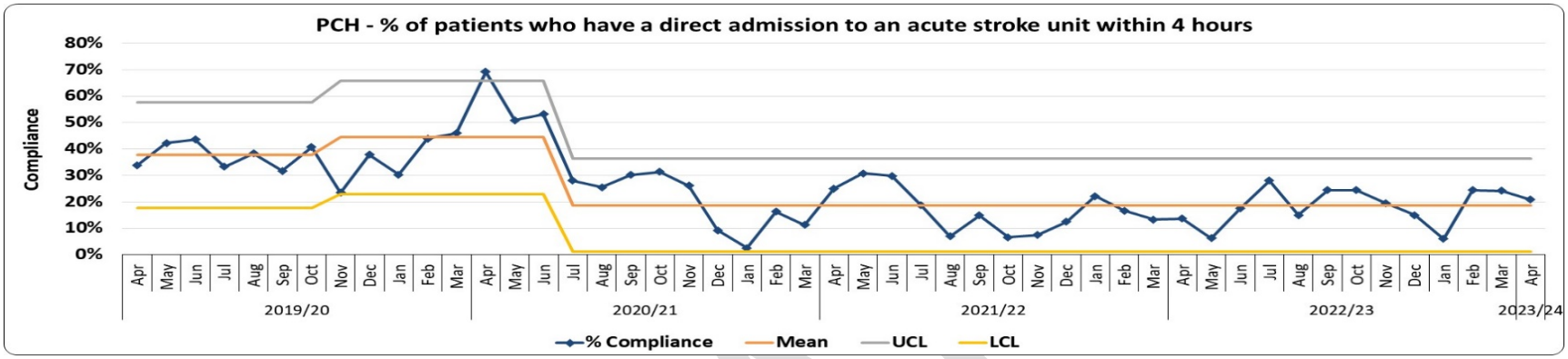
The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides the Health Board with an overview of 4 national Quality Improvement Measures (QIMs), which are part of the suite of improvement measures in the SSNAP:

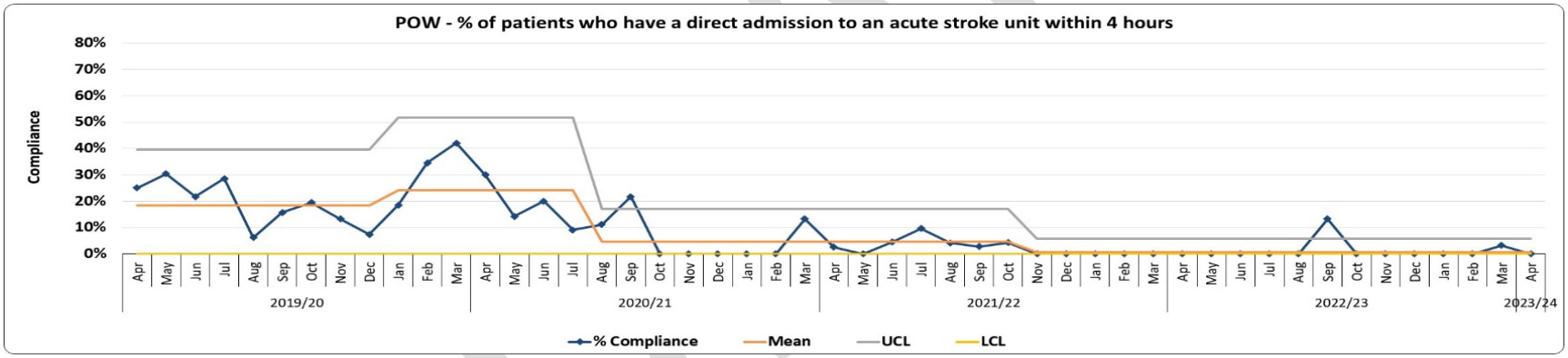
- Direct admission to an acute stroke unit within 4 hours
- Thrombolysis with a door to needle time within 45 minutes
- CT scan within 1 hour
- Assessment by a stroke consultant within 24 hours.

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.

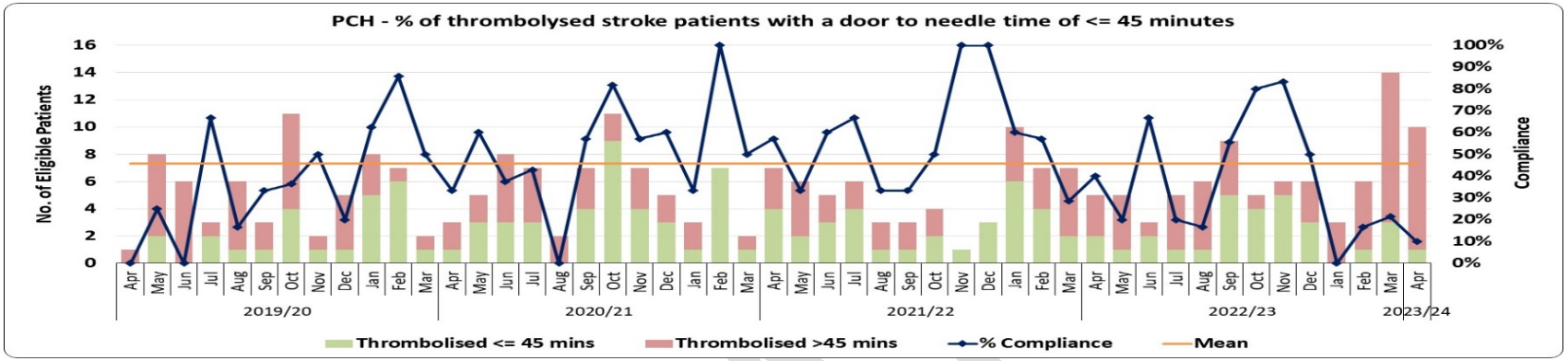
Challenges in meeting the target for assessment by a stroke consultant within 24 hours, reflects the current 5 day working model of the stroke team. Challenges remain with numbers of stroke patients continuing to present at the Royal Glamorgan Hospital, leading to delays in accessing the stroke pathway at PCH.

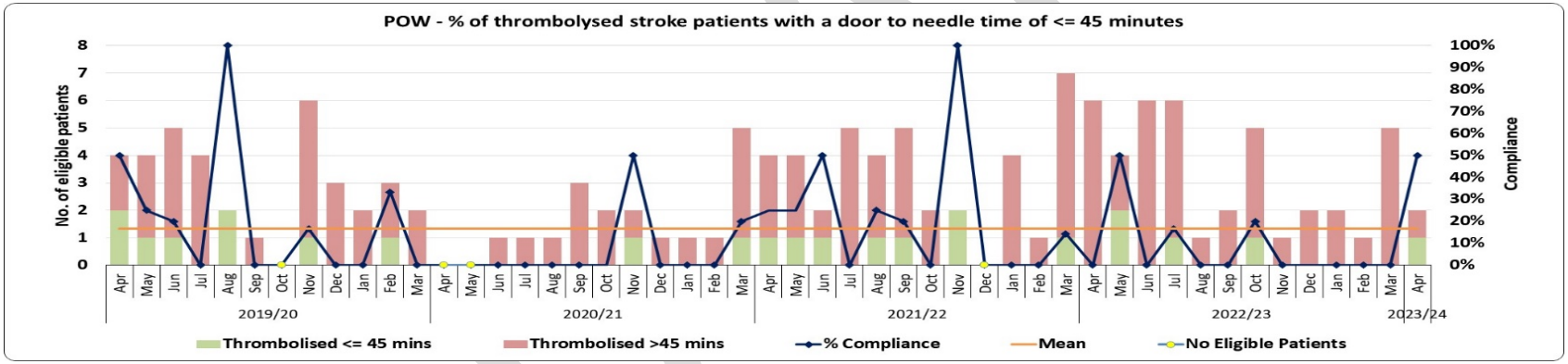
% compliance with direct admission to an acute stroke unit within 4 hours



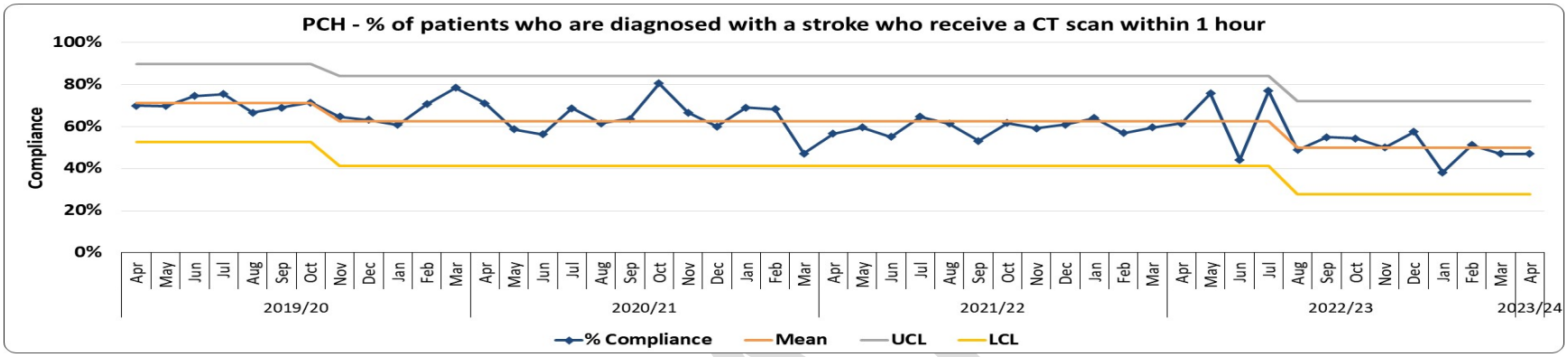


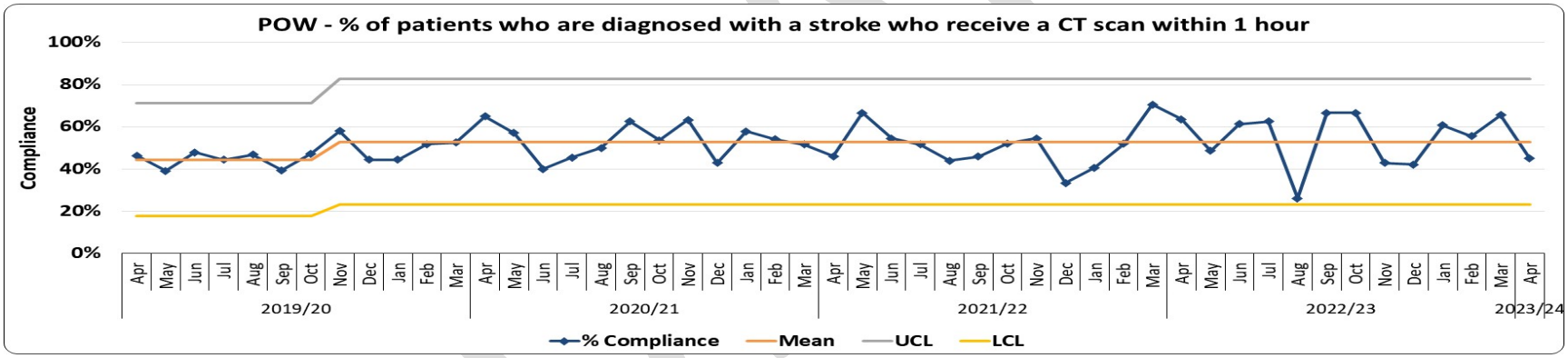
% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes



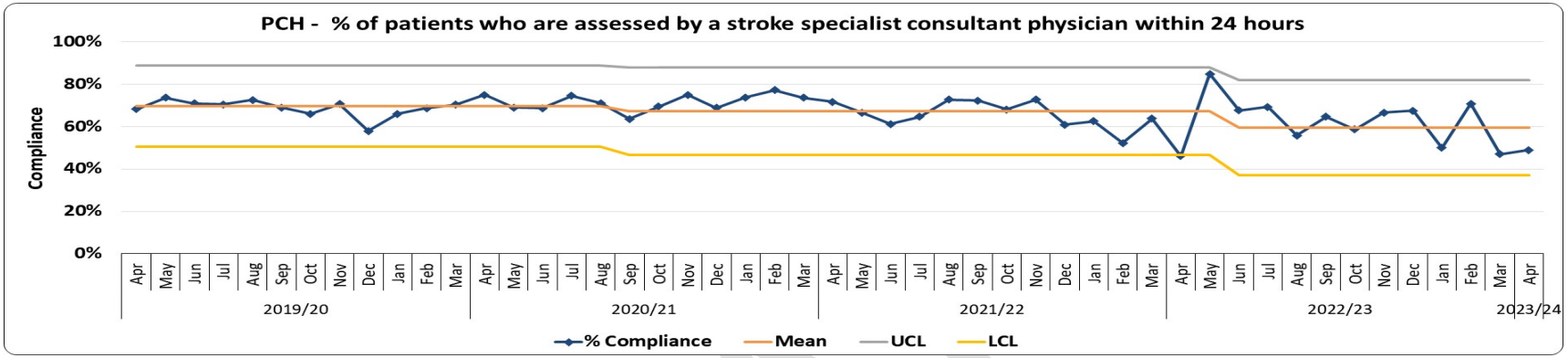


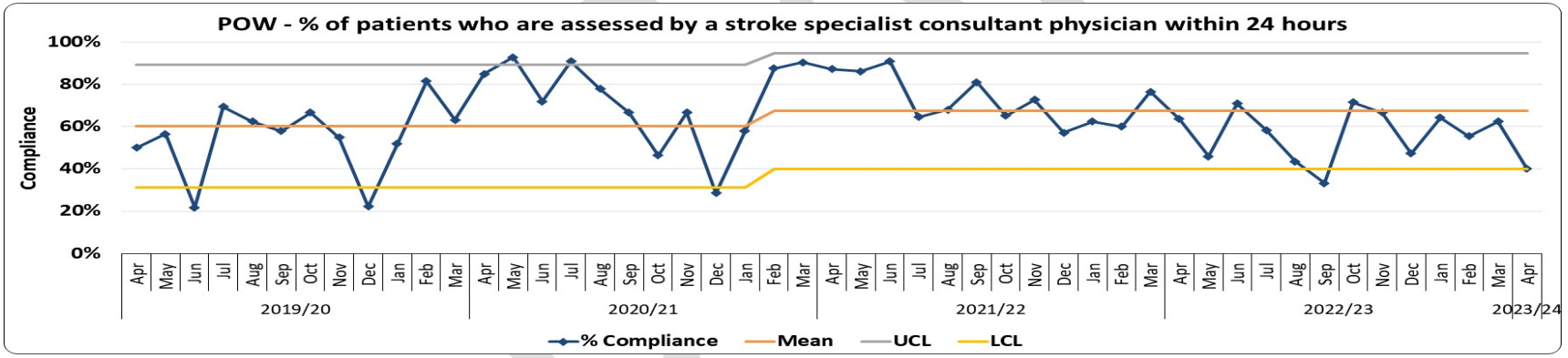
% compliance of patients diagnosed with stroke received a CT scan within 1 hour





% compliance assessed by a stroke consultant within 24 hours





Appendix 2

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.	Update June 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: - SOP and patient pathway developed for stroke patients presenting at RGH which has been imp - WAST agreement to advise patients on acute stroke site locations - Ring-fencing of stroke beds ongoing - Continued CTM-wide stroke consultant rota - Ongoing regional developments with C&VUHB continue. CTM consultant in post as Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network. Developments underway to capture patient outcomes and experience data. - Prescribing nurse and specialist pharmacist have been identified to support the initiation of the AF and BP project in Primary Care. Work is progressing on implementation. A primary care nurse will work locally with those at risk to raise awareness of the signs and symptoms of stroke. - Radiographer approved CTAs now operating on all 3 acute sites, reducing delays in thrombectomy - Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy - Development of new stroke thrombolysis and thrombectomy pathway underway in response to new stroke guidelines, published in April 2023 - WHSSC commissioned thrombectomy service hours extended from 08:00-00:00 from 2nd May 2023. Awaiting confirmation of date for 24/7 service - Discussions between CTM, Stroke Association and Public Health Wales resulted in agreement to run FAST campaign in Wales from 27th April 2023 - Social media campaign funded by CTM Public Health for local FAST campaign - Stroke Operational Group Meeting established with first meeting at the end of July with the intention to establish specific workstreams for

		improvement of services and approaches. - The pathway between RGH and PCH with the ring-fencing of an additional bed has been implemented. It is the expectation that there will be improvement over the coming months as this is embedded.

APPENDIX 3

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	~~November 2022~~ ~~May 2023~~ July 2023		Fortnightly Task & Finish Group developed proposal to ring fence acute stroke beds on both sites unless under Business Continuity. Daily reviews by Head of Flow to improve stroke transfers. Design of a formal protocol and Standard Operating Procedure for transfers of acute stroke patients presenting at RGH. WAST to review recommendation regarding presenting to nearest acute stroke unit vs nearest ED. SOP to be formalised and go to the Board before sharing with care groups for implementation.
2.	Check use of WAST/CTMUHB Pathway for Stroke	~~November 2022~~ ~~May 2023~~ July 2023		Copy of WAST protocol/pathway received. Currently under review.

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.	August 2023		In January 2023, Cwm Taf Morgannwg University Health Board launched a new digital enabler known as the E Whiteboard List View. As staff embed and increase the usage of this digital enabler, there is an aspiration that we will see a median reduction in the length of stay on our acute sites and we will be able to demonstrate the patients experience as a measure of value rather than time as we move forward.
4.	Provision of Therapy Space at POWH	July 2023		Covered via a risk assessment submitted to the previous pathways task and finish group. There has not been any change in the risk since then, and accommodation for therapy at PCH and POW is still significantly limited.
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 POW to be confirmed through daily flow calls. Complete – monitor use of plan on daily flow calls.
6.	Development of single evidence-based care pathways across both sites	~~November 2023~~ July 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). Radiographer approved CTAs are now operating on all 3 acute sites, to minimise delays in thrombectomy. Following publication of new stroke guidelines in April will need to develop new thrombolysis pathways and CT perfusion scanning.
7.	Development of single evidence-based care pathway for thrombolysis	September 2022		Unified criteria for thrombolysis agreed across both sites. As above.
8.	Review current pathway for Orthoptics and explore potential for unification of service across CTMUHB	~~November 2022~~ July 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 remains 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.	~~November 2022~~ July 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 Business Case / Investment Plan to include consideration of:			These actions are complete but the additional resource required is not available for these developments other than for point *v. provision of ESD service across the CTMUHB footprint*. The Stroke Task & Finish Group, using previous Stroke information from other forums, undertook a further risk assessment of the pathway. The T&F Group ranked and rated the risks to prioritise the top risks and then identify elements of the pathway that require further investment in order to best mitigate the risk(s), make the stroke pathway safer and more resilient for patients, and optimise both short and longer term clinical outcomes.
	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			
	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 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.			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. Despite efforts to understand the reasons for protracted delay in attendance at PCH with stroke, there does not appear to a single reason for this. It is most likely to be multifactorial ranging from a lack of recognitions of symptoms and signs of stroke, particularly in waking strokes to an intrinsic stoicism to not trouble acute services. Funding was agreed to run the F.A.S.T. campaign in Wales, commencing 27th April 2023 In addition, a social media campaign has been funded by public health to run locally. Furthermore, as part of the AF/BP prevention work, a primary care nurse will work with

				those at risk to raise awareness of the signs and symptoms of stroke locally.
4.	Improve access to thrombectomy at Bristol.	~~November 2022~~ Awaiting go-live date from Bristol		Bristol thrombectomy service to go 24/7, improving access for both PCH and POWH. No definitive date on Bristol providing 24/7 thrombectomy service for South Wales. However, CTM UHB continue to develop structures that will enable this to be delivered when able, including radiographer approved CTAs, urgent Everlight reporting of CTs and implementation of AI software.

Long Term

1.	Work with Cardiff and Vale UHB to explore potential for regional working and regional enhanced stroke unit	Q1 2024		South Central Stroke Delivery Network (SCSDN) Programme Board now in place. Phase one of the programme, scoping and discovery, is now drawing to a conclusion as we prepare to work with key stakeholders to develop a new model for the delivery of our services. There are ongoing delays in the ability to initiate phase two fully, as capacity constraints within the National Stroke Team are leading to delays in the development of required service specifications, optimal pathways and demand/capacity modelling. It

				is envisaged that the business case for the new clinical model will be completed by the end of Q1 2024. A meeting is being arranged between CTM and C&V therapy staff - to get to know each other, roles and how current services are run.

AGENDA ITEM
8.1

QUALITY & SAFETY COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	25th July 2023
FOI Status	Open
If closed please indicate reason	Not Applicable
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

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	June/July	RISKS REVIEWED
Operational Management Board	12.7.2023	ENDORSED FOR ELG
Executive Leadership Group	17.7.2023	REVIEWED AND EXECUTIVE SIGN OFF RECEIVED

ACRONYMS	

1. SITUATION/BACKGROUND

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

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

2.1 Care Groups and Central leads are continuing to review and update their assigned risks taking into account feedback received from Members in relation to scoring, actions with associated timeframes and ensuring timely reviews. This will be a continuous improvement area that Members will hopefully note will evolve over the next 12 months.

2.2 The Operational Management Board now signs off the Organisational Risk Register in terms of Care Group risks prior to submission to the ELG.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **424** members of staff trained to date. Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

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**

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- Datix Risk ID 4798 - Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. Risk reinstated and scored as a 16. Rationale for reinstating is captured in Appendix 1.

- Datix Risk ID 5462 - Adult weight management service - Insufficient capacity to meet demand. Risk scored as a 20.

- Datix Risk ID 5404 - Post Mortem Backlogs in Mortuary. Risk scored as a 16.

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite. Risk scored as a 16.

Children and Families Care Group

- Datix Risk ID 4928 - Special care baby unit infrastructure does not comply with recommendations. Risk scored as a 15.

- Datix Risk ID 4650 - Ensuring correct establishment for Special Care Baby Unit (SCBU). Risk scored as a 15.

- Datix Risk ID 5364 - Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage. Risk scored as a 16.

3.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period

Central Function - Patient, Care and Safety

- Datix Risk ID 4908 - Failure to manage Legal cases efficiently and effectively. Risk re-escalated as risk score increased from a 12 to a 16.

b) Risks where the risk rating DECREASED during the period

Central Function Risks – Medical Directorate

- Datix Risk ID – 4080 - Failure to recruit sufficient medical and dental staff. Risk score reduced from a 20 to a 15.

Central Function Risks – Strategy and Planning

- Datix Risk ID – 5207 - Care Home Capacity. Risk score reduced from a 15 to a 10.

Central Function Risks – Facilities

- Datix Risk ID 4772 - Replacement of press software on the 13 & 10 stage CBW presses. Risk score reduced from a 15 to a 12.

Central Function Risks – People Services

- Datix Risk ID – 4679 - Absence of a TB vaccination programme for staff. Risk score reduced from a 16 to an 8.

Unscheduled Care Group

- Datix Risk ID – 3826 - Emergency Department (ED) Overcrowding. Risk score reduced from a 20 to a 16.

Rationale for changes captured in Appendix 1.

3.3 **CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER**

Unscheduled Care Group

- Datix Risk ID 4458- Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches). Risk Closed.

- Datix Risk ID – 3585 - Princess of Wales Emergency Department Hygiene Facilities. Risk Closed.

- Datix Risk ID - 4721 - Shift of the boundary for attendances at the ED. Risk Closed.

All Care Groups

- Datix Risk ID - 4743 - Failure of appropriate security measures / Safety Fencing. Risk Closed.

Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 3638 - Pharmacy & Medicines Management - Training & Development Infrastructure. Risk Closed.

Rationale for closure captured in Appendix 1.

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

Consequence						
	5			3337 3993 4080	5276	
	4				4148 4906 3131 5364 4908 5462 4798 3826 5404 4152 3133 1133 4922 4479 5254 5036 5304	4491 4632 4071 4103 4907 5267
	3					4691 4732 4928 2808 4217 4650
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Committee are asked to:

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

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** 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. On the 13th June 2023, NHS Wales and the software company jointly agreed to end the contract for the implementation of a Laboratory information management system. This decision was made on the basis of the current and future requirements of the pathology service in Wales. Both parties remain committed to managing the transition out of this project in the best interests of patient outcomes in Wales. CTM Local Deployment Group met on the 29th June 2023 to ensure that there is adequate CTM representation on any newly formed work groups established to discuss forward plans for future ALL Wales LIMS. Review 31.08.2023.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	05.07.2023	31.08.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update June 2023 - The Health Board has successfully appointed to the Covid-19 Information Manager position who commenced on the 30th May 2023. The priority activity will be the development of a Timeline and starting the archiving of information to a central repository. The likelihood of this risk will be revisited once the new post holder is embedded an initial assessment of the Health Boards preparedness has been undertaken. Review 31.8.2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	04.07.2023	31.08.2023
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	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.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. The risk will be further reviewed on the 31.8.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	16.6.2023	31.8.2023
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 rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update June 2023 - Action plan in response to Welsh cancer patient experience survey finalised. Roll out of Canisc replacement piloting with the Breast MDT. Implementation of weekly performance meetings with highlight report to COO weekly. Action plans developed for high risk challenged areas - Gynaecology, Lower GI, & endoscopy with support from the DU to implement required changes.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	19.06.2023	31.08.2023
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.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Next review 31.8.2023	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	13.7.2023	31.08.2023
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. Membership updated to reflect senior Ops changes. • 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 • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • 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 July 2023 -The 2023 version of the National Clinical Guideline for Stroke for the United Kingdom and Ireland (April 2023) has been published. Ongoing work across CTM UHB and the wider region to assess current services against the guidelines and identify any gaps. - Regional working continues to progress between CTM UHB and Cardiff and Vale UHB in development of the South Central Wales Stroke Delivery Network. Communications and Engagement Plan in place and phase 1 of the engagement scheduled to commence in July 2023 with the distribution to all patients who have experienced a stroke and been under the care of one of the South Central Wales Health Boards, within the last year. This will give the Programme Board insight in to the lived experience of service users and help establish a baseline position of experiences of care. -The NHS Wales Executive Delivery Unit has identified that patients are self-presenting to emergency departments in units who are both specialist stroke centres and emergency departments in hospitals that do not specialise in stroke. The Delivery Unit has, therefore, established an all-Wales review of self-presenters in stroke care, which aims to establish whether the practices and processes in each Health Board are appropriate for timely stroke care and to make quality improvement recommendations. -Stroke Operational Group Meeting established with first meeting at the end of July with the intention to establish specific work streams for improvement of services and approaches. - The pathway between RGH and PCH with the ring-fencing of an additional bed has been implemented. It is the expectation that there will be improvement over the coming months as this is embedded. -lack of resources for implementation of AI software (£20K per annum) which will limit CTMUHB to provide timely thrombectomy and extend thrombolysis to wake up strokes and 9 hours, as per the new national stroke guidelines.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	11.6.2023	31.07.2023
5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	This is a new service in early stages of development and delivery. Optimisation of capacity is supported by continuous review of pathway design (Timeframe July 2023). Capacity and Demand is being closely monitored (Timeframe August 2023).	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	New Risk to Organisational Risk Register - Escalated July 2023	07.06.2023	08.06.2023	31.07.2023

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
4907	Executive Nurse Director / Deputy Chief Executive	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	Update July 2023: New operating model in respect of quality, safety and governance almost fully implemented. Claims handler post awaiting approval. New systems and processes, including escalation developed and implemented to assist with effective management of cases.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	03.07.2023	31.08.2023
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Nurse Director / Deputy Chief Executive	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.	Update July 2023 - "Coffee mornings" have been held for spouses of CTM UHB employees to undertake an assessment of eligibility to apply for the registered nurse adaptation process. The evaluation of data following the coffee morning activity is underway to inform the adaptation programme for international nurses. CTM have project plans around recruitment, retention and attraction, linked in to the Health Education Improvement Wales Retention Toolkit. Focussed activity is underway in terms of Nurse Bank to ensure that there are an appropriate number of nurses / trained staff available to meet the demands. CTM is working closely with the University of South Wales to support their international student nurse recruitment and are exploring mentorship arrangements and pastoral care in conjunction with CTM's existing international nurse cohort. Mobile recruitment fairs have been undertaken which have been collaborative events across all sites resulting in students coming into CTM, where Students have not taken up these opportunities the data is being evaluated to understand the reasons for their decision not to join CTM. Practice Facilitator Nurses are supporting the third year consolidation nurses in their career development and through the streamlining process. Corporate Nursing colleagues are working with the People Services and Communication and Engagement Teams to share information with Senior Nurse Teams in order to raise awareness of streamlining to support recruitment and ensure vacancy opportunities are promoted Face to Face sessions with the Student Academy's (Bridgend and Merthyr College to date) have been held to attract students into the nursing profession. Engagement events within the community continue. CTM are linked into the National Band 4 workforce activity underway on a National basis. The outcomes of these activities will be considered with a view to assessing the likelihood score for this risk in its next review at the end of August 2023.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022 (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)	13.7.2023	31.8.2023
3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, 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. June Update: Improvement plans in place as part of the Six Goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for the USC group relating to 4 hour ambulance delays and patients waiting over 12 hours within the department which will improve overcrowding. This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. Risk score reviewed by the USC Care Group in June and initial consequence score of a 5 was considered too high and therefore risk scoring reviewed utilising the Health Boards risk scoring domain matrix.	Quality & Safety Committee	16 ↓ 20	C4xL4	12 (C4xL3)	↓ Risk score decreased from a 20 to a 16 in July 2023	24.09.2019	26.06.2023	31.08.2023
4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	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 New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases.	Update July 2023 New operating model in respect of quality, safety and governance almost fully implemented. Claims Claims Handler post still awaiting approval and sickness absence within the team has re-escalated this risk. Review 31.8.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	Risk Re-escalated to the Organisational Risk Register July 2023	02.11.2021	04.07.2023	31.08.2023
5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	AHU to be independently assessed by an external expert from NWSSP. Timeframe end of July 2023.	Quality & Safety Committee	16	C4xL4	4 (C4xL1)	New Risk to Organisational Risk Register - Escalated July 2023	29.11.2022	11.07.2023	31.08.2023
5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Escalation mechanism for high level discussion with Coroners services: Exec support needed with discussion around future management of the increase in demand for PM's by the Coroners service. Timeframe 31.7.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	New Risk to Organisational Risk Register - Escalated July 2023	13.04.2023	03.07.2023	23.07.2023
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	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.	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. Risk reinstated as considered not to align with 5214 in terms of the AHP workforce risk. Update: Following discussion with wider MDT this AHP critical care workforce risk was agreed to remain separate rather than combined with the medical/nursing workforce risk as the mitigations available to medical and nursing workforce were not applicable AHP workforce gaps, as these relate to non-funding rather than recruitment challenges. No progress in attaining additional funding for AHP workforce. Further update 27.6.23 - The lack of SLT service has triggered a Duty of Candour response in relation to a patient safety incident, which has led to progress in relation to SLT funding, and ability to commence recruitment. Gaps in funding other AHPs remain.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	27.6.2023	31.8.2023

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3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy 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.	Update June 2023: - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Reviewed following further scrutinisation of relevant guidance, which suggests this might be appropriate for urgent releases recognizing risk. Timeframe 31.7.2023. - Review processes to encourage collection by Funeral Directors. Explore options to reduce length of stay of the deceased and engagement with stakeholders. Timeframe 31.7.2023.	Quality & Safety Committee	16	C4xL4	C3xL2	↔	05.03.2018	23.6.2023	31.8.2023
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Service Director - Diagnostics, Therapies, Pharmacy 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 April 2023 - Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.we have consciously reduced the risk to 16 as we have had funding to year end to continue the outsourcing and there is a tentative commitment for a significant amount to continue the outsourcing through 2023-24 which we are comfortable that it allows us to reduce the risk on that basis. We will keep this under review and should the situation change we will update the risk register and adjust the risk assessment appropriately. Update July 2023 - position remains unchanged from that reported in April 2023. No change to score or mitigation.	Quality & Safety Committee	16	C4 x L4	6 (C3xL2)	↔	02.03.2022	07.07.2023	30.09.2023
5254	Executive Nurse Director / Deputy Chief Executive	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 July 2023 Robust incident triage process now in place, managed by the Heads of Quality & Safety. Currently the impact of Duty of Candour is manageable within current resources. The operational model is currently not fully implemented. Awaiting approval for claims officer post to be advertised, which will assist in addressing the current Redress backlog and will manage any new redress cases identified via the Duty of Candour process.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	03.07.2023	31.08.2023
4479	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly 1LG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	The planning application for the centralised decontamination unit has been approved by Bridgend County Borough Council and the tender has been shared with 5 companies. Update 30/6/23 - Capital planning are in a position to develop the business case for WG however, awaiting Executive steer on future plans for decontamination. Ongoing concerns with Urology decontamination equipment in POW, care delivery group informed and awaiting a response. Review 31.8.2023.	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	30.06.2023	31.08.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	Update June 2023 - Medium term and substantive plans for workforce requirements and innovations to be worked through as part of the six goals board and advanced practice board. New target score of 8. New review date 30/09/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	8 (C4xL2)	↔	20.02.2014	26.06.2023	30.09.2023
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	~~Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.~~ Poor compliance with Medical Gas Safety Training	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	The current risk rating will remain the same, as there has not been any significant increase in attendance on the Medical Gas training courses., across CTM. Medical Devices Training have promoted said course on SharePoint and by emailing ward managers/lead nurses, however attendance remains low. The training department are actively liaising with Swansea Bay medical device training and BOC, to establish an E-learning package, to try and increase course accessibility. Next review 3 months. (DG 27/06/2023).	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	28.06.2023	30.09.2023
4148	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - 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. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - 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. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - 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. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update June 2023 - Recurrent Welsh Government funding has been approved to continue to reduce the DoLS backlog and further strengthen Mental Capacity Act awareness. Procurement are sourcing an agency to complete authorisations through tender. Once an agency is agreed and contracts confirmed they will be utilised to address the backlog. The backlog has already been reduced through the appointment of two further BIA and performance management. Review 31.8.2023.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	04.07.2023	31.08.2023

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4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy 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. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update July 2023 - The referral pathway for lower gastrointestinal (GI) investigations has been modified following national guidance and FIT testing. This is ensuring the patients are receiving the correct investigation at the start of the pathway. Referral criteria for non-obstetric ultrasound scans have been updated to include national guidance. This ensures scanning only when clinically indicated. Next review due 31.8.2023.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	7.7.2023	31.08.2023
4906	Executive Nurse Director / Deputy Chief Executive	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.	Update July 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. The business intelligence team have developed reports and dashboards. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Penalties have recently been realised. Letter from Medical Director outlining the importance of engagement in the quality and safety agenda has been distributed.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	3.7.2023	31.08.2023
5364	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required	Due to a national shortage of SCPHN students qualifying across Wales, all vacant SCPHN posts will be recruited into at every opportunity. Band 5 development plan, to support succession planning and future of SCPHN workforce Timeframe: 21.7.2023	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	New Risk to Organisational Risk Register - Escalated July 2023	03.02.2023	20.06.2023	31.08.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	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. This approach will encompass – recruitment, job planning (compliance and standardisation), regular establishment monitoring, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, managing attendance. All of these impact on the workforce and are part of the Medical Workforce Productivity Programme agenda. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction. Key Updates from MWPG: - Proposed paper for localised CTMUHB Rate Card to be presented to exec team for approval (May '23) - Milestones agreed as realistic and achievable (Apr '23) - Interface with Care Groups for benefits realisation in development (May '23) - Work underway with Care Group managers to ensure job plans have standardised approach (May '23) - Medical Recruitment strategy being finalised (May '23) Whilst the uncontrollable national medical workforce recruitment issues continue, the MWPG has now been re-established with realistic and achievable targets. With a senior workforce now fully engaged with accountability for achieving the targets with the Care Groups, the overall score has been reflected. The likelihood of this risk has now been reduced to a score of 3.	Quality & Safety Committee People & Culture Committee	15 ↓ 20	C5 x L3	10 (C5xL2)	↓ Risk Score Reduced July 2023	01.08.2013	17.5.2023	31.8.2023
4928	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Special care baby unit infrastructure does not comply with recommendations.	The current neonatal unit infrastructure is based on a dated footprint that does not comply with current recommendations. (Health Building Note 09-03:Neonatal Units, DoH, 2013) IF the unit remains the same as it is now the ability to provide safe patient care will be compromised. THEN as well as patient care being effected we will continue to fail IPC audits and medicines management audits. We will not be able to provide the best possible care for the families on the unit and staff morale will continue to suffer. RESULTING IN long term damage to the patient experience, staff wellbeing and the predicted future of the unit.	In order to mitigate the ongoing situation all available areas of the ward have been utilised to support patient safety. An extra cubicle has been created by moving the ward managers office to a family room. Storage for equipment has been temporarily sought in the parent accommodation. The patient areas have been moved around to try to ensure space between cots is optimised.	Update June 2023:Meetings to be convened with capital colleagues.Latest IPC audits to be highlighted.	Quality & Safety Committee	15	C3xL5	C3xL3	New Risk to Organisational Risk Register - Escalated July 2023	01.12.2021	20.06.2023	31.08.2023
4650	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Ensuring correct establishment for Special Care Baby Unit	IF: the current staffing levels are maintained as minimum BAPM level of staffing requirement THEN: safe staffing of the unit will not comply with WTE directive. Also there will be an increase in the use of overtime/ bank/ agency to cover shift patterns. RESULTING IN: a core staffing deficit of 2.45 wte NNEB, as per BAPM requirements.	Care Group are currently running a roster that aims to maintain 4 staff (3 registered and 1 nursery nurse)on each shift by utilising bank and overtime when available. Ward manager/Practice development Nurse also steps in to cover short fall when needed. Shifts are managed depending on patient acuity and skill mix.	Continue to utilise bank and overtime shifts when needed. Continue to work collaboratively with paediatric staff if support is needed. Acknowledging the shortfall and filling the vacancy will ensure the use of overtime and bank is reduced and give staff confidence in the staffing levels.	Quality & Safety Committee	15	C3xL5	C3xL3	New Risk to Organisational Risk Register - Escalated July 2023	19.05.2021	20.06.2023	31.08.2023
2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 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 - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place 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. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	05.07.2023	31.07.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	20.06.2023	31.08.2023
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	Update 26 June 2023 - Orthogeriatrician service model is being reviewed and CTM as part of the trauma and orthopaedic reconfiguration of service. New review date 30/09/23.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	26.6.2023	30.09.2023

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. Also linked to 4804.	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 November to be confirmed).	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. Update July 2023 - : A further review of this Risk is underway aligned to the new WCCIS Programme Board. A new Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	05.07.2023	30.09.2023
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.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A scoping document case to be prepared and submitted to Welsh Government -COMPLETE scoping Document submitted and agreement to commence a Strategic Outline Business Case received. 3. Develop a strategic outline business case. Timescale March 22 currently scoping the configuration of a future focused mental health unit - paused due to pandemic 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5.work paused due to pandemic. Resource to be identified to progress business case process 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. COMPLETE Update July 2023 - MHLD Care Group : A further review of this Risk is underway to separate the two key issues. The ligature risk and actions have been managed however the wider environmental issues of the unit remain. It is proposed that the risk is therefore restructured to reflect this residual risk which will be held by the Care Group Health & Safety, Fire & Capital Group. Review 30.09.2023.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	05.07.2023	30.09.2023
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 strategic review is planned to determine what is required to provide an integrated whole system approach for IPC. Update June 2023 - position remains as statement above.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	28.6.2023	31.08.2023

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
5207	Executive Director of Strategy & Transformation	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. 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 Update June 2023 -Risk reduced as the situation has not escalated as anticipated last summer. Consider again at next review point. Review 31.10.2023.	Quality & Safety Committee Planning, Performance & Finance Committee	10 ↓ 15	5	Central Planning Function propose for de-escalation as the situation has not escalated as anticipated last summer. Consider again at next review point - 31.10.2023.
4772	Chief Operating Officer	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. 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	June 2023 - Health Board is now ready for the installation of the software upgrade to the 13-stage press. Prior to the software upgrade, specialist engineering work is required. This work has been requested and we are waiting for confirmation of when the engineers will attend site. The upgrade is anticipated to be completed before the end of August The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August. There is no IPC impact associated with this risk.	Quality & Safety Committee Planning, Performance & Finance Committee	12 ↓ 15	4	The risk score has been reviewed and the score has reduced to a risk rating 12 – moderate risk due to the robust contingency plans in place and the work now being scheduled for the 2nd week in August.
4679	Executive Director for People (Executive Lead for 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 for May 2023 - A new process has been mapped which needs to be ratified with the Occupational Health Dr provision, Specialist Respiratory Nurse Team and Pharmacy before training and implementation of TB screening can take place. A meeting is being arranged to progress. Update July 2023 - process has been ratified by OH Doctor and two OH nurses have undergone training. Pharmacy have confirmed vaccines are available to order. Prioritisation of at risk groups to be confirmed and then clinics can commence	Quality & Safety Committee People & Culture Committee	8 ↓ 16	8	Proposed for de-escalation and then closure as process in place and ratified. Closure of the risk to follow once clinics have commenced.

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
4458	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Review 26.06.2023 - to combine with risk 3826.	Quality & Safety Committee Planning, Performance & Finance Committee	Jul-23	The Unscheduled Care Group propose that this risk is captured within Datix ID 3826 - Emergency Overcrowding and recommend this risk is closed.
3585	Chief Operating Officer.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. Update June 2023 - The disabled access toilet is now open. This has been deescalated and will be closed.	Quality & Safety Committee	Jul-23	The Unscheduled Care Group propose that this risk is closed as The disabled access toilet is now open.
4721	Chief Operating Officer	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 June 2023 - Risk reviewed, 4 patients attend a day with an additional 2 qualified nurses to manage. A full nursing establishment to be undertaken and this risk should now be de-escalated and closed.	Quality & Safety Committee	Jul-23	The Unscheduled Care Group propose that this risk is closed as risk reviewed, 4 patients attend a day with an additional 2 qualified nurses to manage. A full nursing establishment to be undertaken and this risk should now be de-escalated and closed.
3638	Executive Medical Director	Inspiring People	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Pharmacy & Medicines Management - Training & Development Infrastructure	**IF:** the planned HEIW led changes to the education and training of pharmacists and pharmacy technicians with increased numbers of trainees across both primary and acute care are fully implemented **Then:** the there will be insufficient capacity within the medicines management team to provide the required training, supervision and management of the planned trainees. **Resulting in:** a lack of appropriately qualified pharmacy professionals to meet future service demands in all sectors and particularly in hard to recruit to ILGs such as Merthyr where we have established a "grow our own" model. This can impact the primary care sustainability MDT model. Also a reduction in reputation of a HB that has a very high level of % qualifying and a reduction in future applicants. Current capacity is overstretched and a robust education, training and development infrastructure is needed to meet these demands for specialist & advanced practitioners in primary and secondary care.	This CTM Pharmacy issue that has stalled at various times in the past which has added to delay. Initially started in 2018 as an SBAR propose increase training capacity in order to meet the demand. Included in IMTP and prioritised as number one priority, as part of the PRIMARY CARE pacesetter for education and development in primary care academic hubs and was successful. This element of the ed/tr will be implemented in 2018 for 3 years with evaluation. As such is in place and continues to run. Funding approved for primary care lead pharmacist - commenced in post April 2019.SBAR for Nov CBM on new technician training requirements. Progress and evaluate primary care pacesetter plan to increase training infrastructure to inform business case to continue funding and scale up. SECONDARY CARE elements were not supported in the IMTP prioritisation process	Update July 2023 - DTPS Care Group have proposed this risk for closure due to the new structure established and that Education and Training (ET) has been incorporated into Job Planning. The education and training and workforce development team within the pharmacy department consists of an acute site Head of Pharmacy, who is responsible for developing the workforce development strategy, and the necessary education and training to deliver this. The principal pharmacist will support the development of the strategy, and will lead on project delivery. The remainder of the ET team will be engaged in service provision, project delivery and support of education and training of medical, nursing and allied staff, the pharmacy team, students and undergraduates. The whole pharmacy workforce is expected to engage in the education and training, and this will be achieved through use of job planning software, as suggested in the HEIW strategic pharmacy workforce plan, and expectations set within job descriptions and managed through PADRs, and 121s. The strategic vision for the workforce development for the CTM pharmacy team will aim to be completed, and launched by April 2024.	People & Culture Committee	Jul-23	Update July 2023 - DTPS Care Group have proposed this risk for closure due to the new structure established and that Education and Training (ET) has been incorporated into Job Planning. See update in column H.

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
4743	Chief Operating Officer	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.	July 2023 - ongoing capital works project is the completion of the ligature proof fencing in the car park stairwells which completed last year.	Quality & Safety Committee	Jul-23	Confirmation received from the Acute Services General Manager that works are complete so this risk can be closed.

AGENDA ITEM
8.2

QUALITY & SAFETY COMMITTEE

DATIX CYMRU – INCIDENT REPORTING

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Presented by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

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

1. SITUATION/BACKGROUND

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

It was reported at the Health, Safety & Fire Committee on 12.10.22 that since the implementation of the Incident Management Functionality, there had been a decrease of 50% in the number of incidents reported relating to staff. Following the initial report, a further update summarising the position and mitigating actions was provided to Quality & Safety Committee in January 2023.

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

2.1 Incident Reporting Data

A comparison of the incidents reported for the current and previous 3 years has been undertaken and the numbers are highlighted in the chart below.

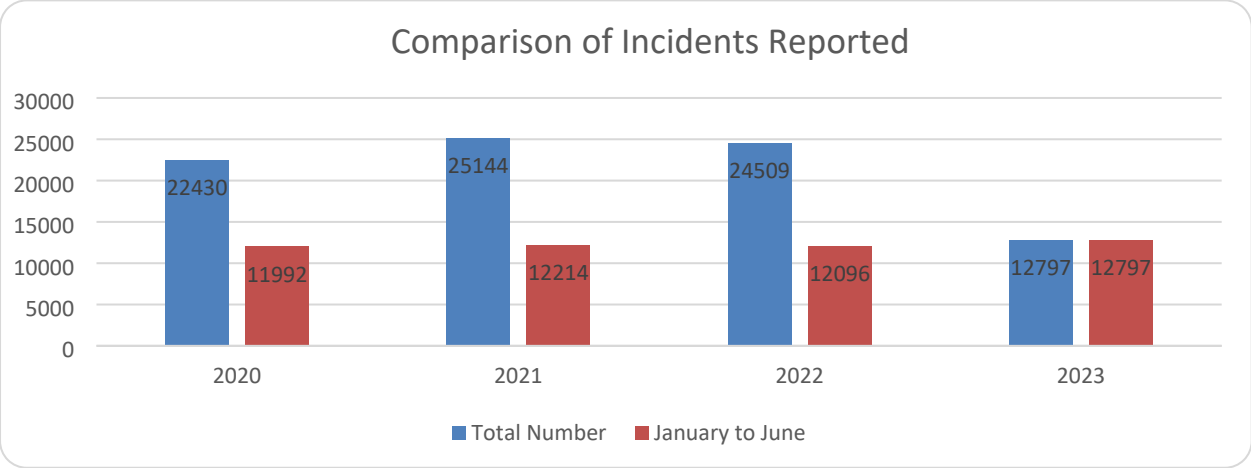


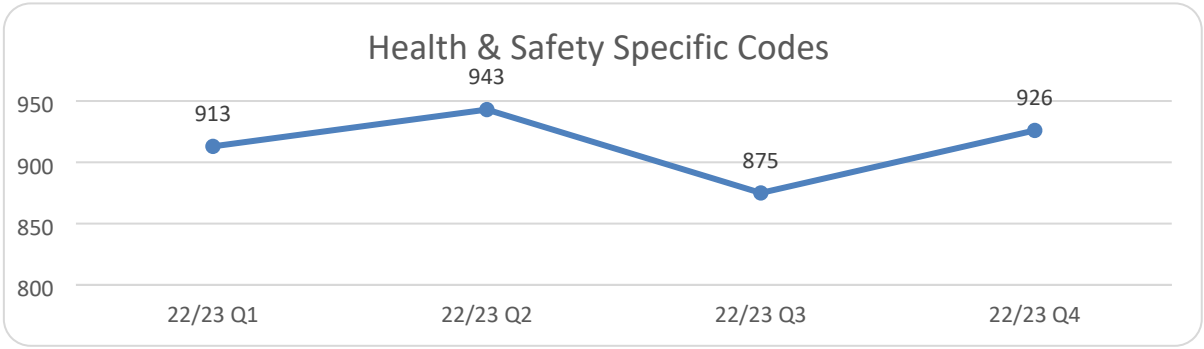
Chart 1: Comparison of Incidents Reported

It was noted in previous reports that the overall number of incidents reported in 2022 has slightly decreased (by 635) compared to 2021. The decrease in 2022 can be attributable to the increase in 2021 associated with the Covid Pandemic and the transition to a new system where a decrease in reported incidents would be expected. When comparing the 6 months (January to June) data for the 4 year, the number reported for 2023 has increased and is consistent with the number reported prior to 2022.

Within the last report to Committee it was recommended that that direct comparison at a granular level with incident data prior to 01.04.22 should not be undertaken. However, review of high level incident data provides an assurance that incidents continue to be reported. In addition, further review of information extracted from Datix Cymru relating to specific Health & Safety codes identifies that incidents continue to be reported as reflected in the chart below. Analysis and interpretation of these incidents continues to be undertaken, reflecting the current functionalities and coding structure within Datix Cymru. This information is presented to the Health, Safety & Fire Committee on a quarterly basis.

Chart 2: Health & Safety Specific Codes

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



It should be noted that some challenges remain with the effective and efficient extraction of data from Datix Cymru. These relate to:

- Providing detail at a Care Group, Clinical Service Group and Speciality level
- Availability of system functionality that reflects internal processes and board information
- Incident type tiered coding structure. An All Wales group has been established to review the codes to improve identification of the appropriate type at the incident reporting stage and enhance the analysis of themes and trends.

Alternative mechanisms to support the processes have been identified. These options are more resource intensive, due to the increased manual intervention required in presenting information.

Whilst there are system requirements that have been escalated to the National team, there are a number of local measures being implemented to improve the validity of data held within the system. These include corporate validation of incidents following initial reporting, analysis of data to identify potential anomalies and provision of training.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The RLDatix system provides data to enable opportunities for improvement in safety and experience to be identified.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Relates to the implementation of an All Wales System.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the contents of the report.

AGENDA ITEM
8.3

QUALITY & SAFETY COMMITTEE

CRUDE MORTALITY DATA

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Rob Jones Head of Information
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	
PPB1	Project Portfolio Board – [Form 1] This is the form required to initiate an ICT project development.

1. SITUATION/BACKGROUND

The Organisation is seeking to better understand the causes for patient deaths in Hospital and has been reviewing available mortality data to further this aim.

Concerns were raised about the reliability of mortality measures and consistency in relation to how data is collected. This dialogue crossed with a discussion around crude mortality– a related but separate measure that was not directly in question. This prompted a review of mortality related data to enable the Health Board to have an improved understanding of cause of death and identify any themes arising.

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

There are two forms of mortality data in consideration for patients: crude mortality measure and cause of death codification.

Crude Mortality Measure:

- This measure represents the proportion of discharges in a given period that are deceased and should be taken solely as the crude measure it is intended to be (i.e. no further context).
- Investigation revealed that the data supporting the Crude Mortality measure was based on the WPAS system's recording of ADT's (Admissions, Discharges, and Transfers).
- Discussions with the WPAS Data quality team and staff involved in discharging deceased patients confirmed the robustness of the data.

Cause of Death Codification:

- Cause of death data is recorded in a less robust manner, using various non-quality controlled methods (e.g. spreadsheets) and does not cover every death in Hospital.
- This data is not used for any internal or national statutory reporting, as it comes from the ONS (Office for National Statistics) and registry data.
- This data is likely the cause of the concerns being highlighted.

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

Actions being undertaken include:

- Engage with hospital sites: Initiate discussions with all hospital sites within the organization to establish a consensus on the data items to be collected for cause of death codification.
- PPB1 form completion: Submit a PPB1 form to Digital, requesting the implementation of a mechanism that allows controlled recording of cause of death data.
- Reporting: Once the mechanism is in place, utilise the collected data to improve the accuracy and reliability of cause of death reporting within the organisation.

Note: It is important to acknowledge that the Crude Mortality measure based on WPAS system data is already robust and should continue to be used as a crude measure of mortality without further modifications.

In addition to the actions highlighted above, analysis of available data from Medical Examiner referrals in relation to hospital deaths is undertaken. Triangulation with this information enables a wider picture of mortality within the Health Board to be reflected. This will provide an indicator of the quality and safety issues being identified in relation to hospital deaths to inform opportunities for learning and will be included in the Quality & Safety Dashboard going forward.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	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.
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 contents of the report.

AGENDA ITEM
8.4

QUALITY & SAFETY COMMITTEE

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas Business Manager Patient Care & Safety
Presented by	Greg Padmore-Dix, Executive Nurse Director / Deputy Chief Executive
Approving Executive Sponsor	Executive Nurse Director / Deputy Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	
HIW	Healthcare Inspectorate Wales

1. SITUATION/BACKGROUND

The main purpose of this report is to present an update to the Quality & Safety Committee on reported progress of the newly developed HIW tracker for the actions and recommendations noted from ongoing open improvement plans following acceptance by HIW following their Inspection(s) across the organisation.

As previously reported and in line with the organisational changes, the Care Groups have ownership and accountability for each HIW improvement plan which has been developed following an inspection.

Oversight and continuous review for assurance will be reported to the Quality, Patient Safety and Experience Committee(s) and to this Quality & Safety Committee. The HIW tracker will be utilised until all open and live HIW inspection improvement plans are transitioned over to AMaT by the Assurance and Compliance team allowing for continuous monitoring of all the HIW improvement plans.

1.1 The spreadsheet tracker will be sent to each of the responsible Care Group leads on a monthly basis for an update on actions, status as to whether the agreed actions are complete or where these have yet to be completed and whether in the agreed timeframe, where the actions remain outstanding a status update is requested.

2. The scope of this report relates to both announced and unannounced inspections following which an improvement plan will have been developed and accepted by HIW. There is a total of 16 improvement plans reported on in this report over the time period December 2020-January 2023.

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

3.1
As this is the first iteration of the HIW tracker to be presented to committee members progress will be closely monitored to ensure the actions are completed in a timely manner, through regular reporting. It is anticipated that members will start to note changes and progress on the actions which remain as open as these turn to closed actions throughout future reports.
Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can be kept live and up to date ensuring all actions are completed in a timely manner. Where actions are reported as complete/closed the care groups are responsible for ensuring the supporting evidence is available to support the closure and completeness of such actions. everyday practice where practicably possible.

- 16 improvement plans have been added to the HIW Tracker to date with the date range of December 2020-January 2023 with the exception of the actions from the National review of Ophthalmology services review which

was undertaken in 2017, updated in 2019 and a further update provided in December 2022.

From these 16 action plans there are a total:

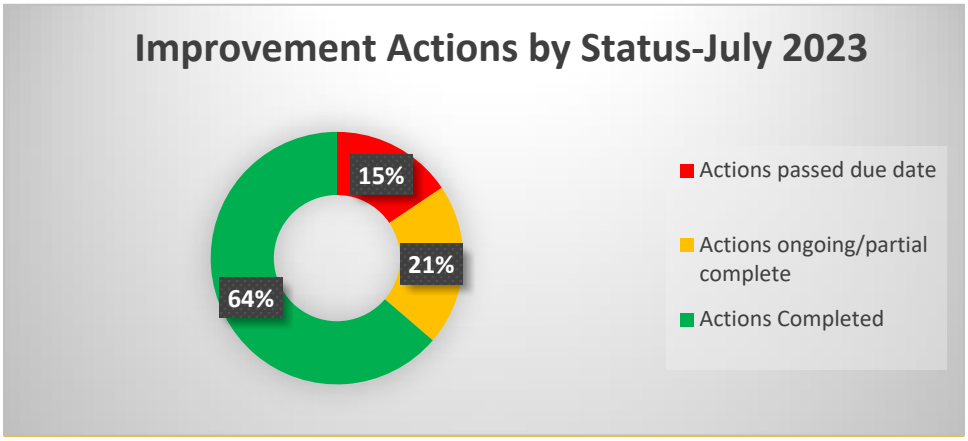
- 159 actions to be completed however, a number of these have sub actions associated with them i.e. 1 action may have 4 components for completion with a total of 372 individual actions.

Out of these 372 actions the following breakdown is reported as at July 2023

- 237 reported as Green - Completed actions
- 77 reported as Amber – actions partially complete
- 58 reported as Red with the actions being those which are incomplete and have passed the agreed due date

3.1.2 **Current Position**

The tables below provide a summary of the current position in relation to HIW actions following an inspection, noting that the proportion of red status actions has commenced at 58, it is anticipated that as this new reporting process embeds across the health board this figure will improve as this is the starting point for the position in July 2023. As we move forward HIW improvement plans will be added to this tracker therefore members will note fluctuating numbers as improvement plans increase for new ones added and decrease as completed improvement plans are reported and deducted, moving in a positive direction.



Actions by Status			
Total Actions	Actions passed due date	Actions ongoing/partial complete	Actions Completed
372	58	77	237

4 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

4.1 As outlined above, the HIW actions tracker will continue to be updated with a targeted focus on actions where the action agreed due by date has passed.

4.2 Steps have been taken to seek updates from the Care Group leads in relation to outstanding HIW improvement plans to ensure full closure and assurance of actions taken to compete all the improvement plans in an agreed and timely manner.

5 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Robust internal processes aligned with a strong governance framework is essential to ensuring patient experience is at the greatest possible levels of safety and quality.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All the Health and Care Standards apply across the various actions in a variety of forms
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required as report is for information and assurance,
Legal implications / impact	Yes (Include further detail below)
	There may be an adverse effect on the organisation if the UHB does not fully implement learning and improvements identified as part of actions/improvements identified in the HIW Inspections and supporting improvement plans.
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

6 RECOMMENDATION

6.1 The Quality & Safety Committee are asked to **NOTE** the report.

AGENDA ITEM
8.5

QUALITY & SAFETY COMMITTEE

DEPRIVATION OF LIBERTY SAFEGUARDS

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Claire O'Keefe – Head of Safeguarding
Presented by	Claire O'Keefe – Head of Safeguarding
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	
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
LPS	Liberty Protection Safeguards
BIA	Best Interest Assessor
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 UK Government recently announced that they do not intend to bring forward the necessary legislation to implement the Liberty Protection Safeguards (LPS) within this Parliament. This means that Welsh

Government cannot bring forward its own regulations to implement the LPS in Wales. In light of the UK Government decision, Welsh Government are considering how to strengthen the current Deprivation of Liberty Safeguards (DoLS) system in Wales and continue to protect and promote the human rights of those people who lack mental capacity.

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

The Welsh Government have recently published a **summary of responses** following its consultation on the Draft Regulations for Wales for the Liberty Protection Safeguards. Since the development of this report, it is clear that DoLS will remain in Wales for the next few years, therefore it is recommended that all Supervisory Bodies consider how best to strengthen their resources to better meet the needs of those deprived of their liberty.

Recommendations from this report include; the only way for Supervisory Bodies to ensure they are acting in accordance with the European Convention on Human Rights, something they are required to do by s6 Human Rights Act 1998, is to significantly and permanently increase the number of DoLS assessments carried out.

In support of this recommendation, Welsh Government have written to CTMUHB to inform them of recurrent funding that will be made available to support work;

- to address the DoLS backlog;
- to deliver Mental Capacity Act training;
- to improve monitoring and reporting on DoLS, including the collection and quality of DoLS data and supporting systems and processes;
- to embed the principles of the Mental Capacity Act across care, support and treatment planning;
- and to take forward any other work necessary to improve the application of DoLS as we await a future UK Government decision to implement the LPS

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

3.1 CTMUHB have been granted funding for 2023/2024. This has enabled the team to retain two whole time equivalent BIAs, Mental Capacity Practice Facilitator and Mental Capacity Practitioner.

In preparation for the implementation of LPS, CTMUHB have progressed at pace to improve awareness and knowledge of the MCA principles. This has included the development of mandatory training packages for use across CTMUHB, MCA awareness raising events and the distribution of information for both staff and carers.

The improvement work being delivered by the MCA practitioners and the team, has resulted in a significant increase to the amount of applications received, increasing numbers to the backlog. This is seen positively, as it evidences improved awareness and appropriate referrals being submitted. However, as a result, at times the applications have doubled, having an impact on the ability to reduce the backlog further. The increase in referrals was also contributed to by the focus on training on MCA and DoLS.

3.2 In response to the DoLS backlog, the Health Board are exploring an external agency option to assist in reducing this backlog to comply with the statute timeframes and to reduce the risks associated with the number of patients unlawfully deprived of their liberty. The Health Board will require the provider to supply a DoLS Best Interests Assessor (BIA) and S12 approved doctor, to fully complete the statutory requirements of a DoLS assessment, resulting in a completed DoLS Authorisation.

Once the backlog has been cleared, the team will be in a better position to assess what resource is required to meet the current and future demand of authorisations. To further aid this decision, performance management is undertaken on a monthly basis to further understand any themes or barriers.

3.3 An all Wales task and finish group has been developed by Public Health Wales, with the first meeting to be held in July. CTMUHB's Practice Facilitator has put forward an all Wales MCA form for consideration. It is envisaged that this form will be used by wards when undertaking MCA assessments. This forum will further influence the development of a strategy to strengthen DoLS processes.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If 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	Yes (Include further detail below)
	The backlog of DoLS may result in patients being unlawfully deprived of their liberty.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The use of an agency and additional workforce will be funded by recurrent WG funding.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 Members of the Committee are asked to consider, discuss and note the current plans to address the DoLS backlog within CTMUHB and plans to embed the MCA in everyday practice.

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

AGENDA ITEM
8.6

QUALITY & SAFETY COMMITTEE

COVID 19 PUBLIC INQUIRY PREPAREDNESS

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Greg Dix, Executive Nurse Director / Deputy Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	
N/A	

1. SITUATION/BACKGROUND

1.1 The purpose of this paper is to provide the Quality & Safety Committee with a progress update in respect of the Health Board's preparedness for the Covid-19 public inquiry.

1.2 The Covid-19 pandemic, which took hold in March 2020, has been one of the greatest challenges faced by the country and in the history of the NHS; challenges which have been predicated on unprecedented levels of demand

across the whole system that have called for an equally unparalleled response.

1.3 In 2021, the Prime Minister announced his intention to commission an independent public inquiry into the Covid-19 pandemic enabling the UK government to discharge its obligations and examine the actions it took to respond to the pandemic and to learn every possible lesson for the future. On the 15th December 2021, the Rt Hon Baroness Heather Hallett DBE was appointed as Chair of the forthcoming public inquiry into the Covid-19 pandemic.

1.4 The Inquiry was established under the Inquiries Act 2005, with full powers, including the power to compel the production of documents and to summon witnesses to give evidence on oath. The Inquiry began circa spring 2022.

1.5 Four Modules have already begun:

- Resilience and preparedness (Module 1);
- Core UK decision-making and political governance (Module 2);
- Impact of the Covid-19 pandemic on healthcare (Module 3)
  and most recently;
- Vaccines and therapeutics (Module 4) which started on 5 June 2023.

Future modules:

- Government procurement
- Care sector

1.6 The Modules of the Inquiry are announced and then are opened in sequence, after which Core Participant applications are considered. Each module has a corresponding preliminary hearing and full hearing, details of which are published by the Inquiry.

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

2.1 The Health Board Members are collectively and statutorily accountable for the safe and effective provision of health services to the population of Wales both in peace time and during a crisis with the responsibilities of the organisation set out in legislation.

2.2 Regulatory and inspectorate bodies such as Audit Wales and Internal Audit have already concluded, during separate reviews, that the Health Board largely maintained good governance throughout the pandemic to ensure the right decisions were made in the right way and at the right time. However, many decisions were made tactically, pragmatically and delivered at speed within newly formed operational strategies during this time and it is vital, therefore, that the Health Board takes steps now to ensure that the wealth of evidence is collated in full and reviewed to ensure that it has all been catalogued and securely stored.

Inquiry Preparedness - Preparations to Date:

2.3 *Core Participant Status*

The Health Board has Group Core Participant Status for Module 3 *(Impact of the Covid-19 Pandemic on Healthcare)* along with the following NHS Wales organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Hywel Dda University Health Board
- Swansea Bay University Health Board
- Velindre University NHS Trust (excluding NHS Wales Shared Services Partnership)

The benefits of Core Participant Status is:

- The ability to see the evidence of others submitted to the Inquiry prior to a hearing;
- Based upon early sight of evidence, you can manage risks and work with the Inquiry to clarify your position;
- You have the right to attend the Inquiry Hearings and to make legal submissions. You have the ability to raise questions of Inquiry witnesses and/or to specify the witnesses we would like the Chair to request statements from;
- You have the option of opening and closing speeches to the Inquiry to clarity our involvement, as well as written submissions;
- You will receive a copy of the Inquiry report prior to publication on a confidential basis, can fact check for accuracy and can prepare for adverse comments before they are made public;
- Your independence in the Inquiry is preserved and you will retain control over the evidence we present, including to direct the Inquiry to specific issues that should be addressed.

2.4 *Legal Guidance and Support*

- The Health Board has appointed Legal & Risk Services to act on its behalf as legal advisors. The appointed team meet regularly with Health Board Leads, attend the Working Group as required and provide regular briefings on the progress of the inquiry and themes arising from Preliminary Hearings into Modules.
- Queens Counsel has been instructed given the significant impact on the Health Boards population and high nosocomial rates.
- Joint Legal Representation has been instructed to act on behalf of the Core Participant Group for Module 3 and costs are shared equally as appropriate between health bodies.

2.5 *Programme Management Approach*

- There is a Covid-19 Pandemic Inquiry Working Group which has two clear functions, this is to:
    - **Prepare:** the CTMUHB for the COVID-19 Public Inquiry
    - **Respond:** Provide the UK government, when requested, with accurate and complete information pertaining to the COVID-19 public inquiry

- A preparedness plan has been developed which is received and updated via the working group.
- The Health Board is represented on the Group: 'All Wales Covid-19 Public Inquiry Channel", established by Legal & Risk Services, the purpose of this channel is twofold. Firstly, to provide a place for members to communicate with each other and share useful information and, secondly, to allow Legal & Risk Services to communicate updates quickly to organisations.

2.6 *Information Project Management*

- The Health Board appointed a Covid-19 Pandemic Inquiry Information Manager who commenced with the Health Board in December 2021. The main purpose of the role is to undertake robust, comprehensive, efficient, organised and confidential record and information management practices in relation to CTMUHBs pandemic response, and apply a programme / project management approach to the Health Boards preparedness. Unfortunately, following the departure of the post holder at the end of August 2022, the Health Board has had to pause proactive progress for a period of nine months due to unsuccessful recruitment to this role. The Senior Responsible Officer (Executive Nurse Director / Deputy CEO) and the Assistant Director of Governance & Risk have provided a reactive role to support any requests during this time.

- On the 30th May 2023, following a third round of recruitment the Health Board has been successful in appointing to the Fixed Term position and activity has commenced, however, the impact of the period of limited activity has significantly affected the Health Boards pace in ensuring its preparedness. This has been recognised as a significant risk and has been escalated to the Organisational Risk Register (Datix Risk ID 4922 - Covid-19 Inquiry Preparedness - Information Management – Risk Score of 20).

2.7 *Wellbeing Support*

- Dedicated resources to support staff have already been considered and any staff called to give evidence or impacted by the inquiry (past or present) are supported by the Health Board.

2.8 *Nosocomial Investigations*

- The Working Group does have a lead representative from the Nosocomial Work Programme to ensure activity is aligned. As the CTM Quality & Safety 'In Committee' has previously received updates on this area, it has not been captured in this report.

Future Preparation Activities

2.9 ***Rule 9 Letters*** will be sent if the inquiry panel requires either disclosure of documents, a written statement or oral evidence. The Rule 9 letter may be sent to the Health Board, to facilitate the disclosure or evidence, or direct to an individual within the Health Board. It is therefore important that all staff at Executive level know the action to undertake if they receive a Rule 9 letter. At the time of drafting this report the Health Board Chief Executive and Former Chief Executive have received a Rule 9 Letter with a response

due at the end of September 2023. A colleague within the Health Board has also received an individual Rule 9 Letter directly, support was provided by the Legal Team.

2.10 ***A substantial timeline of the pandemic*** describing the powers that the Executive Team and Tactical Commanders were using at the time crucial decisions were being made is a key piece of work and is necessary to track and order the Health Board's evidence against these timelines. This is a substantial piece of work and will take time and resources; however, it will clearly and easily demonstrate the steps that were taken and the decisions that were made as the pandemic guidance evolved.

2.11 ***Develop a full electronic catalogue/repository*** of decisions, policies, procedures, communications, legislation and guidance that are linked to the Health Board's Covid-19 preparations and ongoing response (all relevant electronic and hard copy information). This system will need to be a secure and searchable electronic storage tool.

2.12 ***Communications: Internal Staff Awareness*** - preparation to inform staff of the Inquiry preparation and to preserve all potentially relevant documents to staff. External in terms of the public facing updates to the Health Boards stakeholders.

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

3.1 Organisational memory risk - consideration is provided to the records when staff move roles across NHS Wales in terms of their O365 account, this is assessed on a case by case basis.

3.3 Additionally, consideration should also be given to the retention and storage of emails outside of the seven year automatic retention period and whether emails of key decision makers are retained and backed up separately. The issue presented is that pandemic related emails cannot be extracted from the day to day business and so every email will need to be retained and could create a challenge in relation to the Data Protection Act 2018. Under the current arrangements there is capability to recover emails and one drive documents even after deletion; however, this is only for a period of 7 years which may not cover the period of an inquiry.

3.4 Research and decisions are needed to consider how telephone calls, voice mail, text messages, WhatsApp messages and social media may feature as part of the inquiry and the Health Board's evidence portfolio given the complexities of including these in the record given their very nature. This extends to the collation of Teams 'chats'.

3.5 Resource impact – the level of activity and legal support required is uncertain at this stage. The financial risk in relation to the legal fees likely to be incurred was escalated via the Corporate Development functions Integrated Medium Term Plan (Financial Return) and is identified as an unavoidable cost pressure for which funding has been identified based on actual costs.

3.5 The above areas of risk are monitored and reviewed through the Working Group. A programme risk log is monitored via the working group, and as indicated in section 2.6 of this report, the group have escalated Datix Risk ID 4922 to the Organisational Risk Register to ensure the Board are sighted on the impact of pace and the current preparedness of the Health Board to respond to requests from the Inquiry Team in a timely and efficient manner.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	Yes – and Legal Representatives have been instructed.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Staff time and resource.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee are asked to:

- **NOTE** the contents of the report and receive assurances on the preparations for the inquiry to date.
- **NOTE** the risks identified in section 3 of the report.
- **NOTE** the next steps the Covid-19 Pandemic Inquiry Working Group will take to consider the full programme of work identified in this report.

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 24 May 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Jonathan Morgan	Health Board Chair
Sallie Davies	Deputy Medical Director
Lauren Edwards	Executive Director of Therapies & Health Sciences (In part)
Hywel Daniel	Executive Director for People (In part)
Gethin Hughes	Chief Operating Officer (In part)
Greg Dix	Executive Director of Nursing
Cally Hamblyn	Assistant Director of Governance & Risk
Richard Jones	Consultant Anaesthetist
Suzanne Hardacre	Director of Midwifery
Rebecca Pockett	Neonatal Governance Nurse (In part)
Nigel Downes	Assistant Director of Quality & Safety
Becky Gammon	Head of Nursing Professional Standards & Education
Dawn Casey	Macmillan Lead Nurse for Cancer Services
Ana Llewellyn	Primary Care, Community and Mental Health - Care Group Nurse Director
Sharon O'Brien	Planned Care - Care Group Nurse Director
Esther Flavell	Consultant Anaesthetist (In part)
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Chris Beadle	Head of Operational Health, Safety & Fire (In part)
Gaynor Jones	Royal College of Nursing (RCN) Convenor (In part)
Bryany Tweedale	(In part)
Nicola Bresner	Healthcare Inspectorate Wales
Lisa Love-Gould	Clinical Director of Allied Health Professionals (In part)
Stephen Sarasin	Clinical Director, Planned Care
Alex Brown	Clinical Director, Unscheduled Care (In part)
Melanie Barker	Assistant Director of Therapies & Health Sciences (In part)
Jenny Oliver	Governance & Patient Experience Manager (In part)
Emma Walters	Corporate Governance Manager

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.

The Committee Chair acknowledged the progress being made in relation to Equality Impact Assessments and recognised the continued focus that is required in this area. Executive sponsors were asked to ensure that this area was completed appropriately within reports moving forwards.

1.2 Apologies for Absence

Apologies for absence were received from:

- Dom Hurford, Medical Director;
- Julie Denley, Deputy Chief Operating Officer;
- Richard Hughes, Deputy Executive Director of Nursing

1.3 Declarations of Interest

There were no additional interests declared.

2.0 SHARED LISTENING AND LEARING

2.1 Listening & Learning Story

R Pockett shared the Listening & Learning Story with Members of the Committee, which related to a mum's journey, following the birth of her baby who was very unwell and had to be transferred to the University Hospital of Wales (UHW) and then back to Prince Charles Hospital (PCH) for after care.

C Donoghue welcomed the story which she found to be powerful and emotional and highlighted the wonderful illustration of the care provided across Cwm Taf Morgannwg University Health Board and Cardiff & Vale University Health Board, which was a huge testament to all the staff involved.

In response to a question raised by G Hughes as to whether could have been done to ensure the mother was transferred to UHW in a more manner to be with her baby, R Pockett advised that the mother wished to assure Members that it was her choice to discharge herself quickly from the hospital following a telephone call received from the Consultant at the University Hospital of Wales. Members noted that the team had reflected on this event and considered that on this occasion there was no more that they could have done to prevent the mother from leaving the hospital at this time as she did not provide them time to respond and put transfer arrangements in place, as she had arranged for a family member to collect her without delay.

In response to a question raised by N Milligan as to why mothers could not be transferred alongside their babies in an ambulance, R Pockett advised that there are provisions in place to support this where circumstances allow, however, on this occasion the mother was very unwell so this would not have been possible.

The Committee Chair extended her thanks to R Pockett for sharing the story and was delighted to learn that the baby was doing well and recognised the efforts of both Neonatal Teams at Prince Charles Hospital and the University Hospital of Wales. Members noted that the parents asked for their thanks to be shared with all staff for the support they had provided and the Committee Chair advised that she wished to share her thanks to the family for sharing their story.

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

2.2 Care Group Spotlight Presentation – Planned Care (Focus on Cancer Services)

D Casey shared the presentation with Members.

In response to a question raised by J Hehir on the methods for assessing whether health inequalities for patients across the Health Board were being reduced, D Casey advised that there was a Reducing Inequalities in Cancer Task Group in place who had undertaken a number of pieces of work over several years, which included reviewing screening uptake and referral practices across GP clusters alongside the identification of clusters within poorer areas of the community. Members noted that the Task Group had an annual plan in place which was being monitored for progress.

In response to a query raised by P Roseblade as to whether there were occasions where patients would need to be placed on a general ward as opposed to a cancer ward, D Casey advised that the Health Board did not have any cancer wards and confirmed that patients would be placed on a general surgical or medical admission ward. Members noted that if a patient was immuno compromised then they would be isolated and nursed in cubicles with appropriate Infection, Prevention and Control measures in place.

G Hughes confirmed that the Health Board did not have a Hematology-Oncology inpatient facility and confirmed that patients were managed within general ward areas. Members noted that the new Velindre Cancer Centre (nVCC) Business Case investment would provide a regional service for patients requiring Systematic Anti-Cancer Therapy and noted that from a surgical perspective, patients who had operations related to cancer would be cared for on the appropriate general ward. G Hughes provided assurance to Committee Members that no cancer patients requiring surgery had been cancelled as a result of unavailability of beds.

A Brown provided further assurance that patients were being treated under the relevant specialty areas, for example, a patient with lung cancer would be admitted under the care of a Respiratory Physician. Members noted that if

patients experienced any complications from cancer treatments, they would then be cared for by the Acute Oncology Teams that support Health Boards. S O'Brien added that patients would also be cared for post-operatively by specialist nurses and clinical nurse specialists.

The Committee Chair extended her thanks to D Casey for sharing the presentation.

Resolution: The presentation was **NOTED.**

2.3 Care Group Spotlight Presentation – Primary & Community Care

A Llewellyn shared the presentation with Members.

D Jouvenat welcomed the presentation which she had found to be very clear and informative.

N Milligan made reference to a recent walkabout she had undertaken with the Health Board Chair at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda where a concern was raised at both hospitals that student nurses did not consolidate. N Milligan sought clarity as to whether a discussion could be held with Universities on this matter as it was felt that if student nurses did consolidate in community hospitals the Health Board would have an improved chance of retaining them as registered nurses. A Llewellyn advised that discussions were already being held with Universities in relation to student placements and added that work was also being undertaken in relation to retention of staff. Members noted that a deep dive had recently been undertaken to determine the reasons why staff were leaving the organisation, where it was noted that retirement and career development were the two main reasons why staff were leaving. A Llewellyn advised that a rotational post was being piloted to enable career development between community and inpatient settings and added that the team were also exploring overseas nursing which had not been utilised within community hospitals previously.

L Edwards welcomed the presentation and advised that whilst she recognised the scale of the services that were covered within this Care Group, she would welcome greater reference to the work being undertaken by Allied Health Professionals within the Community moving forwards. A Llewellyn advised that these were critical members of the community team and added that the team were fortunate to have secured additional investment into this area and were looking forward to seeing the impact of this.

C Donoghue welcomed the update provided that Safe to Start was now being used within the Community and advised that she would welcome further updates on progress on this moving forwards.

In response to a question raised by C Donoghue in relation to the risk score of 12 that had been allocated to the risk relating to the deficit of registered nurses,

A Llewellyn advised that this was a deteriorating position and the risk score will be reviewed.

In relation to concerns raised by C Donoghue in relation to a practice that had been deleting unread referral update messages, A Llewellyn advised that she would be happy to provide more detail on this matter outside the meeting. Context was sought outside of the meeting that clarified this action in that the GMS primary care team were alerted to a practice which had a number of unread and deleted WCCG (electronic communication system) referral updates. Following this information, the Care Group notified the practice, and also asked one of the primary care Clinical Directors' to review all the records of the deleted referrals to provide assurance that this had not led to any impact / harm to patients, and that any outstanding actions had been addressed. The Care Group will receive the outcome of this review in July and will update Committee as part of the regular highlight reporting arrangements.

P Roseblade advised that it would be helpful if Members could be provided with more detail in relation to issues regarding spirometry testing within GP surgeries. A Llewellyn advised that she would be happy to provide more information on this matter to Committee Members outside the meeting.

The Committee Chair advised that it was helpful to see the range of activities being undertaken within this Care Group and welcomed continued briefings on the challenges and opportunities moving forwards.

The Committee Chair extended her congratulations to the Senior Nurse from the Specialist Immunisation Service who had been awarded a Lifetime Achievement award for a range of vaccination related initiatives.

Resolution: The presentation was **NOTED**.

Actions: Updates on progress to be included in future iterations of the report in relation Safe to Start

Risk score of 12 that had been allocated to the risk relating to the deficit of registered nurses to be reviewed outside the meeting to determine whether risk score was appropriate given the deterioration in the position.

More detail to be provided to Committee members outside the meeting in relation to the practice that had been deleting unread referral update messages.

More detail to be provided to Committee Members outside the meeting in relation to issues regarding spirometry testing within GP surgeries.

3 CONSENT AGENDA

3.0 For Approval/Noting

3.1.1 Unconfirmed Minutes of the Meeting held on the 16 March 2023

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

3.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 27 March 2023

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

3.1.3 Quality & Safety Committee Annual Report

Resolution: The Annual Report was **ENDORSED for Board APPROVAL**

3.1.4 Chairs Urgent Action – Policy Approvals

Resolution: The Chairs Urgent Action was **APPROVED**.

3.1.5 Ratification of Urgent Committee Chairs Action – Policy Approval

Resolution: The Urgent Chairs Action was **ratified for APPROVAL.**

3.1.5 All Wales Model Policy for Consent to Examination for Treatment

Resolution: The Policy was **APPROVED.**

3.1.6 Policy for the provision of Intraoperative Cell Salvage

Resolution: The Policy was **APPROVED.**

3.2.1 Committee Action Log

P Roseblade made reference to the response that had been provided against action log entry 2.3 Unscheduled Care Group Spotlight report, which related to the request made for data to be shared with Committee Members in relation to ambulance handover delays for each individual hospital. P Roseblade added that the response provided indicated that data was not readily available per hospital and had to be manually collected. G Hughes confirmed that the data was available at site level and added that there were discrepancies with the data, which had resulted in the Health Board retaining its own record to ensure that the data being provided by the Welsh Ambulance Services NHS Trust was accurate. G Hughes agreed to review the response provided within the action log to ensure it was worded correctly.

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

3.2.2 Annual Cycle of Business

Resolution: The Annual Cycle of Business was **NOTED**.

3.2.3 Quality & Safety Committee Forward Work Programme

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

3.2.4 Human Tissues Act Progress Report

Resolution: The Report was **NOTED**.

3.2.5 WHSSC Quality & Patient Safety Committee Chairs Report

Resolution: The report was **NOTED**.

3.2.6 Infection, Prevention & Control Year End Update

Resolution: The report was **NOTED**.

3.2.7 Quality Governance – Regulatory Review Recommendations & Progress Updates

Resolution: The report was **NOTED.**

3.2.8 Cancer Services Annual Report

Resolution: The report was **NOTED.**

3.2.9 RADAR Committee Highlight Report

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 highlighted the key matters for Members attention.

P Roseblade welcomed the comprehensive update that had been provided against risk 4632 which related to stroke services and sought clarity as to when the Committee would be next presented with the Stroke Action Plan. L Edwards confirmed that a progress report on Stroke Services, which would include the action plan, would be presented to the July 2023 meeting.

P Roseblade made reference to risk 4743 which related to the Failure of Appropriate Security Measures/Safety Fencing and advised that following on from the previous comments she had made about this risk, it had not been updated since October 2022. C Hamblyn confirmed that a review had been requested which was further endorsed by G Hughes who confirmed that a significant review of this risk had been requested by the end of May.

P Roseblade made reference to the update provided for Risk 5267 which refers to coffee mornings being provided for spouses and sought clarity as to what this related to. G Dix advised that this related to spouses of the internationally educated nurses who were working within the Health Board, some of which had worked as Registered Nurses within their own country that had not yet obtained NMC registration.

P Roseblade made reference to Risk 5036, Pathology Services unable to meet current workload demands, and sought clarity as to what had happened to lead to a change in the consequence of this risk. C Hamblyn advised that she had recently held a session on risk with Pathology colleagues where a discussion was held in relation to risk consequence and added that she hoped this would be addressed for the next iteration of the report. P Roseblade advised that there were quite a few risks, new risks in particular, where the consequence of the risk had been changed, which would need to be reviewed further.

G Hughes advised that the work being undertaken by C Hamblyn in relation to risks was essential and added that a detailed discussion had been held at the Operational Management Board in relation to risk scoring and moderation and that .Care Groups are undertaking a review of their Care Group risks at pace.

C Donoghue welcomed the work being undertaken in strengthening the risk register. C Donoghue commented that when updates indicate that plans are being developed to address the risk, it would be helpful if timescales could be identified. C Donoghue also commented that mandatory training appeared to be a theme, drawing particular attention to risk 3133 which related to Medical Gas training which did not seem to be improving. C Donoghue queried the risk treatment and whether there were a series of risks that the Health Board would need to tolerate or whether a set of new actions needed to be identified in order to treat the risk.

C Hamblyn advised that further work is required to identify risk treatment options which will be taken forward by the end of the calendar year.

N Milligan suggested that where risk controls and mitigations identify implemented activity, the updates could be further strengthened to capture the analysis undertaken as a result of such action, and the next steps being taken to further mitigate the risk. Datix risk ID 5267 was provided as an example around exit questionnaires.

The Committee Chair acknowledged the progress to date and recognised the further work to be undertaken to further mature the risk register. The Committee Chair suggested that queries on the risk register be sought in advance of the meeting in future.

Resolution: The report was **NOTED**

Actions: Comments raised by Members in relation to specific risks, will be addressed by the Assistant Director of Governance & Risk outside the meeting with the relevant risk owners

Members to submit queries on the risk register in advance of meetings in future to enable responses to be sought where possible.

5.2 Healthcare Inspectorate Wales Action Plan Tracker - Prototype

G Dix presented the report. Members noted that a Healthcare Inspectorate Wales Action Plan Tracker had now been developed, noting that AMaT will continue to be explored as a future automated option to support the process. G Dix also advised that three monthly updates would be submitted to Healthcare Inspectorate Wales in relation to progress being made against outstanding actions.

C Hamblyn advised that interviews were being held in June for two Compliance and Assurance roles whose remit would include identifying one central place to capture all recommendations, including internal and external audit recommendations.

P Roseblade advised that she felt it was far more appropriate to develop the AMaT system to capture Healthcare Inspectorate Wales (HIW) recommendations as opposed to adding them to the Audit Recommendations Trackers that had been developed for Audit & Risk Committee. P Roseblade also advised that she felt it was more appropriate for the HIW recommendations to be presented to Quality & Safety Committee.

In response to a question raised by the Committee Chair as to whether this system would be able to identify thematic issues across the Health Board, for example, a number of inspections undertaken across Mental Health had identified similar issues, G Dix advised that whilst the AMaT system would be able to identify specific recommendations by specialty, it would not be able to identify specific themes. Members noted that the thematic analysis would need to be undertaken by the Quality Governance Team and at Care Group level.

Resolution: The report was **NOTED.**

6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

S Hardacre presented the report highlighting key matters for the attention of Committee Members. The Committee Chair recognised the significant amount of activity that had been undertaken in this area.

N Milligan commented that in the PREMS report, she had found it helpful to see the actions that had been undertaken as a result of the feedback that had been received.

In response to a question raised by C Donoghue in relation to medical staff training and the need to increase this and whether this related to capacity or cultural issues, S Hardacre advised that this related to the 10 statutory and mandatory training modules all colleagues within the Health Board are required to undertake. Members noted that the Team have support from the People Services Team to address this and it was hoped that this issue would be resolved by July.

In response to a question raised by P Roseblade as to what the main causes were regarding unavailability of staff to work in the Neonatal Unit, S Hardacre advised that this was a combination of long and short term sickness as opposed to unavailability of staff through vacancies. Members noted that the Team was small so any staff sickness results in an impact on the ability of staff to attend training. Members noted that workforce plans were being developed to address this issue in the longer term.

G Dix made reference to the Royal College of Midwifes Conference that had taken place on the 19 May which was a joyous occasion for CTM Midwifes who had attended the event for the first time.

G Dix made Members aware that there had been an increase in MRSA colonisation of babies within the Special Care Baby Unit (SCBU) at the Princess of Wales Hospital (POW) in Bridgend. Members noted that there had been sporadic cases between November 2022 and February 2023, with a further cluster being seen in April 2023. G Dix advised that the last colonisation was on the 20 April, with no further cases since. Members noted that the estate within SCBU, POW was fairly old and tired and noted that significant work had been undertaken by the Estates Team over the last few weeks to ensure the environment complied with Infection, Prevention and Control standards. G Dix advised that it was likely that the unit would need to close to enable the contractors to complete the estates work required and added that Public Health Wales and the Maternity & Neonatal Network had been kept up to date on the matter. Members noted that no babies had come to any harm.

The Committee Chair advised that a demonstration had been provided at the recent meeting of the Maternity & Neonates Improvement Board as to how the information contained within the dashboard could actively be used to inform change practices and reflection. The Committee Chair added that a detailed discussion was also held in relation to the Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries across the UK (MBRRACE) report and advised that she was pleased to see that information was now being provided in a timely way following concerns raised previously by MBRRACE that the Health Board was not providing information. Members noted that there was still a gap in relation to capturing the ethnicity of babies which was in the process of being addressed.

Resolution: The report was **NOTED.**

6.2 Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

L Edwards presented the report and highlighted the key matters for Members attention.

D Jouvenat welcomed the report and recognised the improvement measures that have been implemented. D Jouvenat supported the activity on the importance of saying 'thank you' and added that she was aware that the Health Board was currently exploring recognition and reward. L Edwards advised that she had attended the staff engagement event and added that it was great to see the Team coming together following the impressive journey they had all been on.

A Llewellyn advised that the Team were looking to hold another stakeholder event with patients following the successful event held last year and added that Members of the Committee would be receiving an invite to this event once a data had been confirmed. The Committee Chair encouraged all members to attend if possible.

The Committee Chair advised that she had visited the unit and had been pleased to see the continuing improvements being made to the environment. In response to a question raised by the Committee Chair as to when phase two of the building works was likely to commence, A Llewellyn advised that a proposal had been developed, costed and submitted and was now being considered alongside other requests for capital investment.

The Committee Chair welcomed the reduction in restricted practices which evidenced the change in approach being taken under the new leadership. The Committee Chair also welcomed the level of compliments being received. The Chair extended her thanks to the Team at Ty Llidiard for all of the work undertaken.

Resolution: The report was **NOTED.**

6.3 Mental Health In-Patient Improvement Progress Report

A Llewellyn presented the report and highlighted the key matters for the Committee's attention. The Committee Chair advised that Members had been well briefed on the Healthcare Inspectorate Wales inspection reports and added that she was pleased to see that coherent action was being taken.

N Milligan made reference to the update provided on page five of the report in relation to revised completion dates for four areas of training and questioned whether training could be provided to staff whilst in their areas of work given the pressures in relation to staff availability. A Llewellyn advised that she would be meeting with Resuscitation Leads later this week to discuss the provision of resuscitation training and added that trajectories were in place in relation to other mandatory and statutory training. Members noted that balance would be required given the scale of improvement required and the ability to release staff to attend training.

D Jouvenat advised that in relation to Manual Handling Training, the Health, Safety & Fire Sub Committee had received reports in relation to this issue where it had been noted that staff had been booking onto sessions and then not attending the session. D Jouvenat expressed the importance of ensuring that staff attend the session they had booked onto. A Llewellyn confirmed that she was reinforcing this with staff.

H Daniel advised that as well as capacity issues within the training teams, there remained a backlog within training areas as a result of the Covid-19 pandemic. H Daniel added that clarity was required as to what training could be delivered locally and how the model could be adapted. Members noted that the Health Board's performance in relation to Statutory and Mandatory training was poor compared to other Health Board's and noted that discussions would need to be held at a national level to share experiences and determine how other organisations were achieving their positions.

Members noted the comment made by G Jones in relation to reviewing the model used previously in relation to shift patterns with the six hour make up shift being utilised for training.

Resolution: The report was **NOTED.**

6.4 Quality Dashboard

N Downes presented the report and highlighted the key matters for the attention of the Committee.

C Donoghue made reference to the introduction of a specific Community Pharmacy form which had a number of fields missing, including the harm field which had impacted on data collection and sought clarity whether this had now been corrected. K Jenkins-Forrester confirmed that this had now been rectified and the data would be available for the next meeting.

C Donoghue advised that in relation to falls and pressure damage, whilst she was aware that initiatives were in place to address this, she expressed concerns that there did not appear to be any significant improvement being made and questioned when it was likely that improvements would be seen. N Downes advised that a more holistic picture was required as to the reasons behind patient falls.

In response to a question raised by N Milligan as to what was meant by medication supply errors of which there were 64, N Downes advised that he would review this and would provide a response to members outside the meeting.

N Milligan commented that in relation to the high numbers of falls within Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, it would be helpful if the reasons could be identified within the report as to why these falls were occurring, for example, were there high numbers of vacancies and high levels of acuity within these areas. N Downes advised that he would be happy to provide further information in future iterations of the report.

N Milligan drew attention to the Delivery Unit Compliance Summary of Patient Safety solutions and advised that some of the data was quite old and dated back to 2014. In response to a query raised by N Milligan as to whether the Health Board reviewed its compliance against these notices on a regular basis, K Jenkins-Forrester confirmed that these were being monitored weekly at the Executive Director led Patient Safety meetings and added that the process had recently been reviewed. Members noted that a consolidation exercise was also being undertaken to ensure that the data contained within the Delivery Unit report and the data held within the Health Board aligned. Members noted that there was now only one Patient Safety Notice, which related to Naso-Gastric Tubes, which the Health Board were not compliant with and noted that the process was changing to ensure these were adhered to within the correct guidelines and parameters.

P Roseblade made reference to the number of patient safety incidents reported on page two of the report which had been reported as a percentage and questioned whether there was still an issue with Datix not being updateable with accurate information once an investigation had been undertaken. P Roseblade also added that it would be more helpful if actual numbers could be included in the report as opposed to percentages given that this was a public facing document.

P Roseblade also made reference to the closed incidents reported by severity on page 7 of the report and questioned whether this was indicating that there had been five incidents that had been catastrophic and four that had been severe. P Roseblade made reference to the statement made on page 8 of the report which advised that work continued to develop and refine safety metrics and advised that this statement read as if the Health Board was placing more focus

on how to present the data as opposed to how it was preventing the incidents from occurring.

In relation to the number of patients safety incidents reported as a percentage on page two of the report, N Downes advised that further data was included on page 6 of the report which advised that there were 13 incidents that were closed with severity post investigation of severe harm or catastrophic/death. P Roseblade advised that this needed to be made clearer within the report. In relation to the statement made on page 8 of the report, N Downes agreed that this needed to be reworded as it did infer that metrics were being reviewed as opposed to processes.

L Love-Gould advised that in relation to falls, whilst nobody would want to see injurious falls, patients do need to walk and mobilise to aid their recovery. Members noted that a bid had been submitted to Welsh Government in relation to establishing a Health Board wide Falls Service which had not been in place previously.

In response to a question raised by J Hehir as to reasons behind the absconsions referred to on page 10 of the report, A Llewellyn advised that the majority of the absconsions data related to Mental Health patients who had been detained under the Mental Health Act and had been late returning from planned leave, which was then being categorised as an absconsion. Members noted that work is underway in relation to variation of reporting within Mental Health and noted that the Health Board was an outlier in Wales in terms of the numbers and types of absconsions reported. The Committee Chair advised that data definitions were important in order for the context to be understood.

G Dix advised that he would welcome any further comments from Members as to how the content of the quality dashboard could be further improved.

G Dix advised that in relation to Duty of Candour, there had been some challenges in relation to categorisation of harm as an incident occurs. Members noted that between 1 April and 11 May, 434 incidents had been categorised at moderate and above. 322 of these incidents were reviewed, and following review 269 were downgraded. 52 incidents out of the 322 reviewed triggered a duty of candour implementation which was moderate and above. Members noted that a significant amount of work needed to be undertaken to ensure staff were categorising incidents correctly. G Dix advised that future iterations of the Quality Dashboard report would include an update on Duty of Candour triggers.

Resolution: The report was **NOTED**

Actions: Review to be undertaken of the medication supply errors referred to within the report. Response to be provided to Members outside the meeting to confirm what this relates to.

Update to be included in the next iteration of the report as to the reason behind the high number of falls being experienced at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda

Number of patients safety incidents to be reported as a number as opposed to a percentage in future iterations of the report

Statement made on page 8 of the report which advised that work continued to develop and refine safety metrics to be reviewed and reworded as it inferred that metrics were being reviewed as opposed to processes.

Members to share any further comments as to how the content of the quality dashboard could be further improved.

6.4.1 Emergency Department Spotlight Presentation – A Review of Falls and Pressure Ulcers

B Gammon highlighted the key presentational points for Members attention.

G Dix advised that whilst a reduction had been seen within our community acquired pressure ulcers and stage 3 and 4 ulcers, he remained concerned in relation to the number of avoidable pressures ulcers being reported within the general wards. Members noted that an update would be provided at the Board meeting tomorrow in relation to the developing correlation between staffing and nurse sensitive measures in relation to falls and pressure ulcers. G Dix also advised that he remained concerned in relation to over-crowding within the Emergency Departments and the impact on care.

In response to a query raised by N Milligan regarding the information contained within slide 5 in relation to the number of patients falls by hospital site, which appeared to show a decrease in falls at Prince Charles Hospital (PCH), with the data indicating an increase in reporting at PCH, B Gammon advised that she would obtain an update from R Hughes outside the meeting and will share the response with Members.

G Hughes advised that if you view the incidents as rates of 1000 per attendees, it can then be determined whether this is related to over-crowding. G Hughes advised that it would be important to record whether a patient was on a trolley or in a chair within the Emergency Department and added that unless the chair being used was a pressure relieving chair, it was not appropriate for a chair to be used.

The Committee Chair welcomed the discussion held which she found to be helpful and requested that a further report was presented to the Committee on this matter in due course clarifying the points that had been raised.

Resolution: The presentation was **NOTED.**

Actions: Update to be obtained from the Deputy Director of Nursing in relation to the number of patients falls by hospital site, which appeared to show a decrease in falls at Prince Charles Hospital, with the data indicating an increase in reporting at PCH

Further report to be presented to the Committee in due course clarifying the points that had been raised.

6.4.2 Lessons Learnt – Learning and Actions following a death in Maesteg Hospital

G Dix shared the presentation with Members reiterating that this matter had been discussed a number of times at In Committee Quality & Safety Committee meetings. Members noted the presentation provided some assurance around how care issues have been addressed as a result of the incident and the work that had been undertaken to date.

C Donoghue drew attention to the Impact Assessment section of the cover report seeking clarification as to what was meant by the entry "Impact will rest with output and associated reporting structures described in presentation" and the entry in the "Has an EQIA been completed section". G Dix agreed to discuss this with the report author and C Hamblyn outside of the meeting for further advice if required.

Resolution: The presentation was **NOTED.**

Action: Statements made within the cover section regarding the entry "Impact will rest with output and associated reporting structures described in presentation" and the entry in the "Has an EQIA been completed section" to be discussed with report author outside the meeting and with C Hamblyn if further advice is required.

6.4.3 Executive Director and Independent Member Quality Patient Safety Walkrounds January – April 2023

G Dix presented the report and advised Members that when they were undertaking their walkabouts there is flexibility to have a fluid conversation based on what had been observed through speaking to Teams, as well as asking the suggested questions identified within the framework.

P Roseblade echoed the comments made by G Dix on the importance of having fluid conversations. In response to a comment made by P Roseblade regarding the content of paragraph 1.7 which implied that it would be the Independent Members role to agree actions for improvement, G Dix confirmed that it would be the responsibility of the Executive Director to agree actions for improvement with the relevant Care Group and not the Independent Member and this will be amended.

The Committee Chair welcomed the report and advised that she looked forward to receiving future updates

Resolution: The report was **NOTED.**

Action: Report to be amended to reflect that it would be the responsibility of the Executive Director to agree actions for improvement with the relevant Care Group Lead and not the Independent Member.

6.5 Care Group Highlight Reports

The following updates were received in relation to the Care Group Highlight Reports. Members noted that focus is targeted on the areas of escalation.

Planned Care

Members noted the item highlighted within the alert/escalate section which related to Duty of Candour process which will require increased reporting for the cohort of Follow Ups Not Booked Ophthalmology patients.

D Jouvenat made reference to appendix 1 which highlighted that a number of areas that were either unable to complete a core audit or had not submitted an audit and questioned how this was being addressed. S O'Brien advised whilst the AMaT system was now being used within Care Groups and by Heads of Nursing as part of the triangulation process, actions would now need to be recorded on the system to enable progress to be monitored. Members noted that there were still some areas that did not have access to the AMaT system and were completing audits on a paper based system, Theatres for example, and noted that the longer term plan would be to roll out the AMaT system across the Health Board.

Unscheduled Care

Members noted the item highlighted within the alert/escalate section which informed the Committee that from the 1 April 2023, the Minor Injuries Unit at Ysbyty Cwm Rhondda had become a walk-in service following the cessation of telephone triage services provided by 111. Members noted the introduction of this service had been well received by members of the community.

C Donoghue advised that was she pleased to see that out of the 74 actions that had been identified following the Healthcare Inspectorate Wales inspection of the Emergency Department at Prince Charles Hospital in October 2021, 72 had now been completed. C Donoghue made reference to the Infection Prevention Control (IPC) environmental review undertaken at Prince Charles Hospital and the environmental audit score given for PPE being 17% and advised that this may be something the Committee would wish to receive an update on in the future. C Donoghue also noted that an improvement plan was being developed and advised that it would be helpful if timescales for the improvement plan could

be identified. A Brown agreed to discuss this request with E James outside the meeting.

Action: Timescales for the improvement plan that was being developed following the Infection Prevention Control (IPC) environmental review to be identified.

Mental Health & Learning Disabilities

The Care Group Highlight report was received. Members noted that the items highlighted in the alert/escalate section were discussed earlier in the meeting at agenda item 6.3.

Children and Families.

The Care Group report for Children and Families was received. Members noted that the Team were still awaiting the outcome of the discussions in relation to the timescales for transferring the School Entry Hearing Scheme from Audiology into the Children & Families Care Group.

Diagnostics, Therapies, Pharmacy and Specialties

The Care Group report was received. L Love-Gould highlighted some points that required amending and advised that complaints compliance for Therapies should read 100% resolved with early resolution, Radiology should read 75% and overall compliance against patient safety incidents was 94%. In relation to the Moderate and Sever Harm incidents, Pathology should read 2. Members noted that the report would be corrected and republished on the website.

6.6 Report from the Chief Operating Officer

G Hughes presented the report and highlighted the key matters for the attention of the Committee. The Committee Chair recognised the significant amount of work being undertaken that had been reflected within the report.

In response to a query raised by P Roseblade as to whether the reference made to the Planned Care Recovery bid that had been submitted was part of the 5.5m that had been allocated for Planned Care Recovery, G Hughes confirmed that this was part of the 5.5m that had been allocated and added this it was clear that this remained the Health Board's commitment which would be discussed further at the May Board meeting.

In response to a question raised by the Committee Chair in relation to the reduced capacity within Sonography as a result of colleagues being unable to scan as a result of Repetitive Strain Injury and whether practices were being reviewed to ensure further cases do not occur, G Hughes confirmed that this was being addressed by the Diagnostics, Therapies, Pharmacy and Specialties Care Group and was linked to obstetric ultrasound and the volume of scans being undertaken. S Hardacre advised that this was an issue for Maternity Services in particular and issues were being experienced with Sonography Capacity as a result of the impact of gap and grow and the enhanced foetal surveillance that

needed to be undertaken. Members noted that consideration was being given to different models of working and the issues being experienced had also been highlighted to Welsh Government.

Resolution: The report was **NOTED.**

6.7 Learning From Events Backlog – Progress Report

N Downes presented the report and highlighted the key matters for the attention of the Committee.

The Committee Chair welcomed the progress that had been made and sought clarity as to when a further update on progress would be presented to the Committee. G Dix advised that a progress report would be presented to the September meeting.

In response to a question raised by P Roseblade as to whether the completion date of 31 December 2023 for all historic Learning From Events cases had been discussed and agreed by the Welsh Risk Pool, N Downes advised that the Welsh Risk Pool had been informed, however, as of yet had not responded. In response to a question raised by P Roseblade as to whether the Health Board were likely to incur any further fines following the 31 December, N Downes advised that there were 17 cases which had been deferred for 10 months and focus was being placed to target these so the potential for them to breach the 12 month deadline was low.

G Dix advised that the Welsh Risk Pool had met recently to discuss proposals of placing fines on cases being deferred over 6 months not just 12 months and advised that he would keep the Committee updated in regards to this matter.

Resolution: The report was **NOTED.**

6.8 CTM Allied Health Professionals & Healthcare Science Delivery Plan

M Barker presented Members with the report and highlighted the key matters for the attention of the Committee. Members noted that the plan would be launched on 5 July 2023.

In response to a question raised by J Hehir as to whether the plan had been fully costed, M Barker advised that the plan had not been costed as of yet and added that she did not expect there to be any additional costs at this point in time.

The Committee Chair welcomed the report and advised Committee Members would look forward to seeing the outcomes in the future.

Resolution: The report was **NOTED** and the Focus of the Plan was **ENDORSED.**

7. ANY OTHER BUSINESS

There was no other business to report.

7.1 HIGHLIGHT REPORT TO BOARD

Members noted that the highlight report would be drafted outside the meeting by the Corporate Governance Team.

7.2 HOW DID WE DO IN THIS MEETING TODAY?

A discussion was held in relation to how Members felt the meeting went today. The following key points were noted:

- It was felt that whilst there were still a considerable amount of agenda items the Committee were receiving more relevant information in a more structured way;
- It was felt that the quality of the information being received was good and the Care Group presentations were helpful and succinct;
- It was felt that consideration may need to be given to the order of the agenda to ensure items receive sufficient discussion time, for example Care Group reports may be better placed towards the start of the agenda;
- It was suggested that it may be helpful if only one Care Group Spotlight Presentation was received at each meeting;
- It was suggested that it would be helpful if the Listening & Learning Story could align with the Care Group Spotlight Presentation.

8. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 2:00pm on Monday 24 July 2023. An In Committee session would also be held on Wednesday 31 May 2023 at 2:00pm.

Agenda Item Number: 9.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 31 May 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Greg Dix	Executive Director of Nursing
Gethin Hughes	Chief Operating Officer
Sallie Davies	Deputy Medical Director
Brian Hawkins	Chief Pharmacist, Medicines Governance
Wendy Penrhyn-Jones	Head of Corporate Governance and Board Business
Ana Llewellyn	Care Group Nurse Director
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:

- Patsy Roseblade, Independent Member
- Dom Hurford, Executive Medical Director
- Hywel Daniel, Executive Director for People
- Lauren Edwards, Executive Director of Therapies & Health Sciences

1.3 Declarations of Interest

2 MAIN AGENDA

2.1 Unconfirmed Minutes of the In Committee held on 27 March 2023.

Resolution: The Minutes were **NOTED**.

2.2 Action Log

The action log was received and discussed.

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

2.3 External Review of Practice into Care of a Patient by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council

A Llewellyn presented a verbal update on the current position. Members noted that as the matter was no longer subject to judicial review, a further update would be presented at a future public session of the Quality & Safety Committee, once the matter had been discussed via the appropriate governance routes.

Resolution: The update was **NOTED**.

Action: Further updates on progress to be presented at a future public session of the Quality & Safety Committee.

2.4 Controlled Drugs Local Intelligence Network (CDLIN) Annual Report: April 2022 – March 2023

B Hawkins presented the report and highlighted the key matters for Members attention.

The Committee Chair extended her thanks to B Hawkins for presenting the report.

Resolution: The report was **NOTED.**

3. ANY OTHER BUSINESS

The Committee Chair extended her thanks to colleagues for presenting their respective reports.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on Tuesday 25 July 2023 at 9:30am

AGENDA ITEM
9.1.3

QUALITY & SAFETY COMMITTEE

VOLUNTEER SERVICE POLICY

Date of meeting	25 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Sarah Morgan-Jones, Volunteer Service Manager
Presented by	Jenny Oliver, Head of People's Experience
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Informal consultation: Sharon O'Brien	06/02/2023	SUPPORTED
Health board wide consultation	14/04/2023	
Equality Impact Assessment	17/03/2023	SUPPORTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This policy sets out the approach to management of volunteers in Cwm Taf Morgannwg University Health Board.

Purpose of the policy to ensure:

- The impact of volunteers within CTMUHB
- Volunteer recruitment process, governance and training requirements
- Staff to understand the role of volunteers, processes and guidelines

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	17/03/2023
Informal Consultation with interested parties	06/02/2023
Formal Consultation	14/04/2023
Committee – For approval	Corporate policy approval committee Date 25 July 2023

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

2.3 The Head of Peoples Experience and Assistant Director of Nursing & People's Experience 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 following amendments have been made: Only minor typographical amendments were made as a result of the various consultation stages.

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
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Yes
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 Volunteer Service budget allows the out-of-pocket expenses for volunteers, including travel expenses, uniforms and additional costs for the provision of services.
Link to Strategic Goal	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee is asked to **APPROVE** the Volunteer Service 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.

Volunteer Service Policy

Document Type:	Policy
Author:	Sarah Morgan-Jones – Volunteer Service Manager
Executive Sponsor:	Director of Nursing
Approved By:	Assistant Director of Nursing & Peoples Experience, Head of People's Experience
Approval / Effective Date:	6/02/2023
Review Date:	
Version:	V3

Target Audience:

People who need to know about this document in detail	Authors & owners, Head of Patient Experience, Executives with responsibility for volunteering
People who need to have a broad understanding of this document	Board Members, Management Board Senior Leaders, Board Committees, Staff responsible for volunteers
People who need to know that this document exists	Staff, Public, CVC'S

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome:**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

POLICY STATEMENT

Cwm Taf Morgannwg University Health Board (CTMUHB) recognises the importance and valuable contribution of each and every volunteer for the benefit of patients, their relatives and carers and to support/compliment the work of staff. The Health Board also recognises that volunteering can improve wellbeing and is a multi-way process which benefits volunteers, patients and the organisation.

It is our policy to:

- Treat all volunteers fairly and with respect by promoting and emphasising our values and behaviors
- Develop volunteer roles that are meaningful and make a positive difference to our patients, relatives and carers and to complement the work of staff
- Recruit all Health Board volunteers utilising a robust process ensuring all necessary checks are completed in a timely manner and in line with governance
- Never use volunteers to replace paid staff
- Support volunteers to gain the most from their experience
- Ensure volunteering is safe and effective in line with all relevant policies and standards
- Ensure our volunteers receive a values based induction and relevant training to support their role
- Develop measures that show the impact of volunteering across the Health Board

We expect volunteers to:

- Respect the Health Board's values and behavior principles, and adhere to the organisation's policies and procedures
- Treat everyone with dignity and respect
- Attend a values based induction and mandatory training sessions, along with additional training as and when required
- Understand their role and principles as set out in the Volunteer Agreement **(Appendix 1)**

SCOPE OF POLICY

This policy applies to all volunteers recruited directly by the Health Board's Volunteer Service and to employees working with volunteers.

CTMUHB recognises that Voluntary Organisations providing a service (such as RVS, Age Connect, and Stroke Association) are independent organisations with their own identities and values. Individuals who volunteer with these organisations will be subject to their own recruitment, selection and training procedures and are not covered by this policy, which will be set out in Planning and Partnerships Service Level Agreements.

ACCOUNTABILITY

The Chief Executive is ultimately accountable for the safe provision of volunteering across CTMUHB. Executive accountability rests with the Executive Nurse Director ensuring volunteering is recognised and aligned with the organisations strategies, long term plans and championed at board level. Strategic direction and leadership for volunteering lies with the Senior Manager for People's Experience in line with national policy and best practice.

The Volunteer Service Team has centralised operational responsibility for the delivery of a safe, effective and robust volunteering programme. However, the success of volunteering projects and the retention of volunteers relies on the support of both the Volunteer Service and staff responsible for the delivery of volunteer roles.

PARTNERSHIP WORKING
This policy supports the importance of partnership working between CTMU HB, local CVC'S and Third Sector Organisations and is intended to demonstrate their commitment of delivering strategic principles, outcomes and ambitions, along with the benefits of working in collaboration. In line with co-production the Volunteer Service has developed a Memorandum of Understating (MoU) which supports joint working and is independent of any other formal or contractual agreements for example Service Level Agreements (SLA's) and not intended to be a binding legal agreement, rather a statement of their shared intentions and responsibilities.

DEFINITION OF VOLUNTEERING
The Welsh Government definition of volunteering is:

"Volunteering is the commitment of time and energy for the benefit of society and the community and can take many forms. It is undertaken freely and by choice, without concern for financial gain"

There is no contractual obligation on the volunteers to attend or the organisation to provide regular volunteering duties.

IMPLEMENTATION
There is a defined strategic approach in terms of priority areas for volunteer support across the Health Board, set out in the Volunteer Service Strategy and aligned to CTM's 2030 long term plan. The Volunteer Service has operational responsibility for the approval, implementation and formal development of new and updated volunteer role descriptions and areas considering the introduction of volunteers. They will be required to:

- Consider ways in which volunteers can improve patient experience as part of their operational planning
- Areas that identify the opportunity for a new role or the development of an existing volunteer role, must at all times be discussed in the first instance with the volunteer service team manager to look at how the service can support prior to taking any further action
- Complete a pro forma application **(Appendix 2)** which will require details relating to the need for volunteers, amount of volunteers and an identified contact to support volunteers in chosen areas
- Consider a clearly defined draft role description stating the purpose, specific detailed tasks and guidance on what would be considered to be outside the remit of a volunteer

All volunteer role descriptions must be approved and formally developed by the Volunteer Service

To ensure the safety of patients, volunteers and staff are at the forefront of any new and updated roles, volunteers are informed at induction the importance of only undertaking tasks defined and agreed in the role description. If unsure to contact the volunteer service manager for any queries or concerns around these tasks and / or unsure of what would be considered outside the role of a volunteer.

EQUALITY AND DIVERSITY
Under the Equality Act 2010, all service users have the right to be treated fairly and with dignity and respect. In order to avoid discrimination or putting any individuals or protected groups at a disadvantage, it is essential that needs are met and barriers can be removed to ensure a positive experience. Therefore, the volunteer service is committed to ensuring that opportunities are accessible to all and to make reasonable adjustments in order to remove barriers that may affect the ability for someone to undertake a volunteering role, **for further information refer to the Health Boards Equality and Diversity webpage**

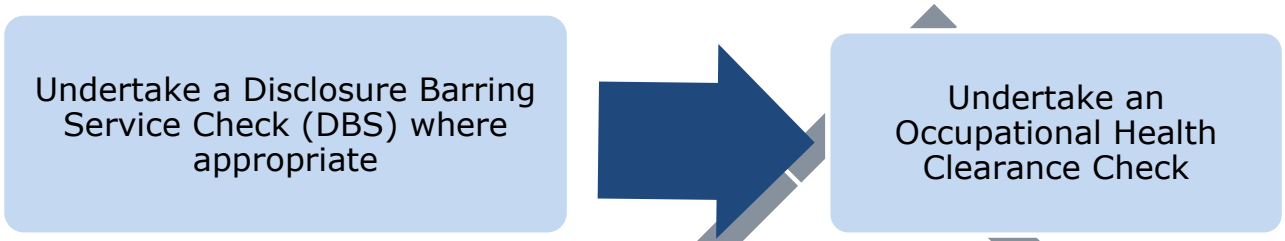
http://ctuhb-intranet/dir/Equality/default.aspx

RECRUITMENT AND RETENTION

Information regarding the recruitment process **(Appendix 3),** roles available, contact details and further information will be available on the Volunteer Service section within CTMU HB's website.

Following an expression of interest, volunteers must complete an application form and attend a semi-structured informal interview and will be selected based on their suitability for the role, matching their skills, talents and interests. The Volunteer Service is solely responsible for the recruitment and retention of all Health Board volunteers, with all requests for any new volunteer posts or roles being directed to the service.

The offer of a volunteer position is subject to the following checks:



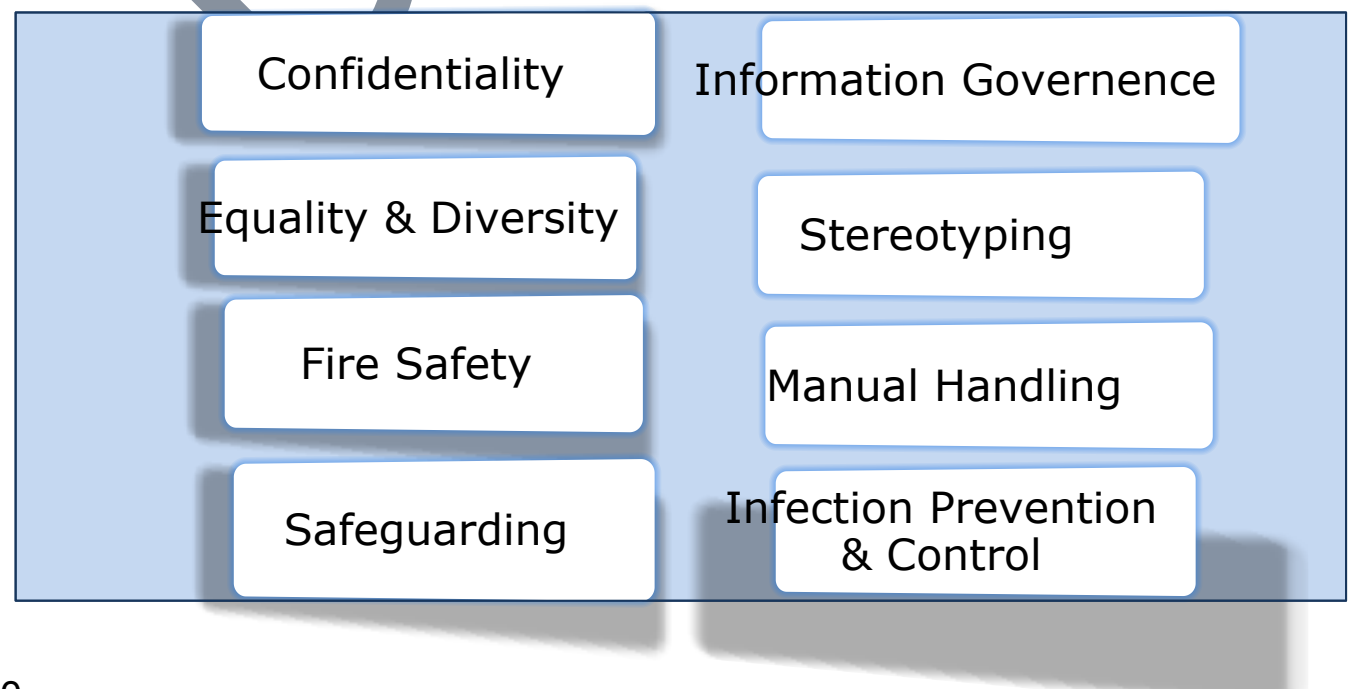
No volunteer may start in a role until all checks are satisfactorily completed

INDUCTION AND TRAINING

As part of the recruitment process volunteers must attend a values based induction session delivered by a member of the Volunteer Service Team, Manager or appropriate representative. This provides a consistent approach and introduction to the organisation covering matters pertinent to volunteering including:

- Volunteer Roles
- Stereotyping
- Boundaries

The following provides an overview of mandatory topics which are also covered at induction and pertinent to volunteers to ensure they are able to carry out their role safely, adhering to the Health Boards learning and development framework:



Volunteers are also required to undertake a local orientation into their specific area, which should be undertaken where possible by the ward/departmental manager. An orientation checklist **(Appendix 4)** should be completed in a timely manner and a signed copy returned to the Volunteer Service for retention in the volunteer's personnel file.

REVIEW PERIOD

In order that volunteers have an enjoyable and worthwhile experience and to enable any improvements or adjustments to be made where applicable, feedback forms form part of the introduction to volunteering and supports the retention of volunteers across the organisation. Volunteers are informed at induction of the importance of feedback and that the volunteer service is contactable during office hours and a member of the team will be on hand to capture their comments or offer information or support if necessary.

TRAINING AND DEVELOPMENT

Volunteers should have the option of ongoing training and development opportunities to support them in their roles. These opportunities can be delivered internally or externally of the organisation and identified via their specific ward / department or by the volunteer service. All additional training will be captured on the individual volunteers file and the volunteer service database. Future training dates will be offered via regular volunteering updates or the volunteer services closed Facebook page.

SUPPORT AND SUPERVISION

The volunteer will be managed on a daily basis by an identified employee nominated by the ward / department manager and identified on the pro forma. In order that they receive appropriate and regular support and guidance. On arrival for each session every volunteer should be briefed about who is providing them with support on that day. Volunteer should have the opportunity to talk about their role with their named contact and Ward and department managers are responsible for ensuring that volunteers receive appropriate levels of support whilst undertaking their role. In addition, a member of the Volunteer Service Team will meet with the volunteer as and when required and able to be contacted by phone and / or email to check on progress and provide additional support if necessary.

RECOGNITION

It is vital that volunteers feel valued and respected both as individuals and in their roles. Ward and department managers are encouraged to ensure their volunteers are recognised and appreciated, this includes nominating for awards linked to CTM's recognition awards and Third Sector recognition events. In addition, the Volunteer Service Team will ensure the role of volunteers and their positive impact is promoted during national annual "Volunteer's Week" (1st – 7th June) and throughout the year. Partnership work with the Health Boards Communications and Engagement Team along with local CVC's support the development of promotional material in recognition of the commitment, dedication and impact of volunteers.

NEXT STEPS

All volunteers leaving their volunteering role should give as much notice as possible by notifying the Volunteer Service Team. All volunteers leaving CTMU HB will be offered the chance to complete an exit questionnaire or attend an exit interview with a member of the Volunteer Service.

All volunteers are required to wear a uniform so that patients and visitors can easily identify Health Board volunteers and to ensure adequate infection control measures are in place. Uniform is paid for and supplied by the Health Board.

MAJOR INCIDENT (PANDEMIC / EPIDEMIC)

In the event of a national or local pandemic or epidemic and under the guidance of the Health Boards Executive Team and Infection Prevention and Control Senior Management, the Volunteer Service has the right to withdraw their volunteers from Hospital sites and

settings. The volunteer's health and safety is at the forefront of any decision made and actions taken are with their best interest in mind. Regular review of Government, local and national guidance will be strictly observed and all Health Board Volunteers will receive regular updates on matters that may affect their ability to volunteer.

However, during this time the Volunteer Service Team will arrange meetings, these will be undertaken virtually/in-person to protect volunteer's dependent on guidelines at the time. Whilst Volunteers are stood down the Volunteer Service in line with the Senior Manager for People's Experience will make decisions on the best approach to keep volunteers engaged. The volunteer's new role may look very different to what they undertook prior to being stood down and every effort will be made to look at utilizing this support in different formats with the volunteer's involvement in this process. Volunteers will also be signposted and referred to local community volunteer centers and the All Wales Volunteer Website, in order that they have the opportunity to support local community projects and help those in most need in their area. The Volunteer Service has the absolute right to stand down volunteers at any time if continuing to undertake their roles puts them at risk or potentially cause harm.

RAISING A CONCERN

If a volunteer has concerns about the treatment of a patient, member of staff or any other individual at any time, the volunteer must pass the information on without delay to a relevant member of staff, for example, the person in charge at that time, the Ward or Department Manager, or the Patient Advice & Liaison Service.

In addition, they should always contact the Volunteer Service Team to pass details on.

VOLUNTEER DISPUTES, DISAGREEMENTS & TERMINATION

Any problems involving a volunteer must be reported to the Volunteer Service Team, examples of which may include:

- A member of staff is concerned about the behavior or conduct of a volunteer
- A member of staff is concerned about the capability of a volunteer

All problems will be dealt with fairly, consistently and transparently using our problem solving procedure.

Occasionally it may be necessary to remove a volunteer from their role and ask them to stop volunteering. Once a volunteer has started in their role, deselection can only occur by following the problem solving procedure (**Appendix 5)**

ABSENCE

All sickness and holidays must be reported to the named contact e.g. ward or departmental manager and volunteer service as soon as possible.

In the event that the volunteer has not notified the ward / department or volunteer service that they are unable to undertake their shift which lasts more than 2 weeks. Will be contacted by the volunteer service to ensure there are no concerns or reasons preventing them from being able to carry out their role.

In the event that a volunteer has to take long term sick e.g. after surgery appropriate cases will be referred to the Health Boards Occupational Health Team before the volunteer is able to return to their role. The referral and assessment is necessary to ensure the volunteer is fit and well and able to return to their role, furthermore, to evaluate whether any reasonable adjustments will need to be implemented in order that the volunteer is able to undertake their tasks.

LONE WORKING

Volunteers must never undertake their role alone with patients in isolated areas (such as cubicles or behind curtains) without the authorisation of the ward or departmental manager. With the exception of Volunteer Drivers due to the role requiring them to transport clients to and from Day Units etc. The Volunteer Service driver's handbook provides clear guidance on the expectations of a volunteer driver and who to contact in an emergency or for additional advice or guidance, details of which can be found in **(Appendix 6)**

RISK ASSESSMENT

All volunteering roles and activities will be risk assessed by ward or departmental managers, unless managed directly by the Volunteer Service Team, all volunteers will be informed of general health and safety requirements along with personal safety procedures.

A signed copy of the completed risk assessment form will be forwarded to the Volunteer Service Team for audit purposes.

CONFIDENTIALITY AND GDPR

Volunteers are expected to uphold the same confidentiality standards as employees and during the course of volunteering, service users and colleagues may reveal confidential information about themselves for example: home address, telephone number or personal details about their life or circumstances. It is important for people to feel confident that that information **will not** be passed on to anyone without their permission. It is equally important for people to feel confident in giving us this information so we can deliver the best possible service.

On no account must identifiable information be divulged by a Health Board volunteer to anyone either verbally, in writing or via social media. Discussions should only be held with authorised staff, who are directly concerned with the patient's healthcare. If a Volunteer is in any doubt whatsoever as to the authority of a person or body asking for information of this nature, or aware of a breach of confidentiality, they are informed at induction to report this to the department/ward manger, person in charge and Volunteer Service Team.

As part of the recruitment process all volunteers regardless of role are required to sign a copy of the Volunteer Service confidentiality agreement **(Appendix 7)** to show that they fully understand the need for confidentiality, agree to keep information confidential and the standards expected within CTMU HB and elsewhere.

SOCIAL MEDIA

NHS organisations across Wales recognise the role and value of social media as a means of communication and of improving the way it reaches out and interacts with different communities, internally and externally. However, with the increased use of these networks, organisations have a responsibility to ensure that the operational effectiveness of its business and the security of its information assets are protected and its reputation maintained. CTMU HB acknowledges everyone has a right to express themselves using social media and its role in offering advice on safe use, highlighting the responsibility of individuals to be aware of the potential consequences of posting content on to publically accessible platforms and their responsibility to adhere to national policy.

The Volunteer Service provide guidance on the best use of social networks at induction sessions to ensure volunteers fully understand the blurring of boundaries between their private life and their role as a volunteer. Volunteers are advised at induction about the implications of the misuse of these type of platforms and the

damage it can cause, in terms of their reputation as well that of others, including family, friends, colleagues and service users. The Health Boards Volunteer Service provide regular updates, information, training opportunities and forthcoming events on their closed Facebook page which only allows registered Health Board Volunteers to join and is used under strict rules, including control and authority over any new members or posts from volunteers, refer to the NHS Wales Social Media Policy for further information
http://ctuhb-intranet/Policies/_layouts/15/WopiFrame.aspx?sourcedoc={A8B9EDFC-4761-4BBD-BDB2-D0517DC6E3EE}&file=Social%20Media%20Policy.doc&action=default

LIABILITY

CTMU HB aligns to the All Wales Policy for the use of insurance, contract management and the indemnity arrangements for the financial administration of potential losses and special payments. The principles and scope of the policy includes volunteers carrying out agreed roles within the organisation and covered by public indemnity insurance through Welsh Risk Pool.

OUT OF POCKET EXPENSES

Health Board volunteers are entitled to out-of-pocket expenses and the Volunteer Service is responsible for providing information, guidance, relevant forms to be completed and cross referenced with timesheets for audit purposes. All volunteers are entitled to receive the current rate for expenses in line with Welsh Government, refer to webpage for further information regarding volunteer's rights and expenses:
Volunteer opportunities, rights and expenses: Pay and expenses - GOV.UK (www.gov.uk)

In terms of public transport e.g. bus, train, the full amount of journey will be reimbursed in full. The volunteer must retain and provide a copy of the receipt of travel and will not receive travel expenses without this. The reimbursement for meal allowances are only payable where a volunteer has agreed with the Volunteer Service and ward / department to volunteer for longer than initially agreed e.g. undertaking a full day shift.
Further information about expenses / timesheets procedure is set out in **(Appendix 8)**

SECURITY

It is the responsibility of the volunteer to ensure that on arrival of their agreed shift that their valuables and cash are in a safe place. CTMU HB will not be held responsible or liable for any claims arising as a result of any loss. Volunteers are informed of this at induction and advised to only carry a small amount of cash if needed and the requirement to avoid wearing personal items of any value.

RECORDS AND DATA PROTECTION

Individual electronic records will be kept for all CTMU HB's volunteers. This will include personal information and training records. These are held on the Volunteer Service works drive and only accessible to the Volunteer Service Team. Individual paper copies held for volunteers e.g. files, are stored in the Volunteer Centre office which is locked outside of office hours and only accessible by authorised staff e.g. Volunteer Manager, Volunteer Coordinator, Volunteer Service Administrator and on site Security Officers. All records will be stored, retained and disposed of in accordance with CTM's Information Governance and GDPR data Protection Act.

POLICY IMPLEMENTATION

The updated Policy and Equality Impact Assessment will be approved by CTMUHB generic Corporate Policy Approval Group.

MONITORING AND AUDIT PROCEDURES

The Volunteer Service Team will monitor compliance within this updated policy under the leadership of the Senior Manager for People's Experience.

POLICY REVIEW

This document is valid for three years (2023 -2026) however, the volunteer service team will regularly keep the policy under review to ensure it is up to date with regulations, best practice and the delivery of the volunteer service is consistent and effective.

(Appendix 1)

Volunteer Agreement

This agreement sets out what you as a volunteer can expect from our organisation to ensure your volunteering experience is worthwhile, rewarding and mutually beneficial.

Cwm Taf Morgannwg University Health Board

We, Cwm Taf Morgannwg University Health Board (CTMUHB) Volunteer Service commit to:

- Provide you with a 'values-based' induction to meet the requirements of the health board along with any ongoing additional training.
- Provide access to the health board's Occupational Health services as and when required.
- Ensure you have access to and support from the Volunteer Service should you experience any problems whilst undertaking your volunteering role.
- Support your development whilst volunteering with us.
- Reimburse reasonable, agreed, out-of-pocket expenses as stated in the volunteer policy.
- Provide you with an ID badge and uniform as required, which will need to be worn at all times whilst undertaking your volunteering role.
- Update you on health board changes that may affect your volunteering role.
- Provide health board insurance cover whilst on duty.
- Provide a reference and/or authorisation to apply for internal posts within CTMUHB, provided the agreed volunteer time commitment has been fulfilled.
- Ensure you are treated fairly in accordance with the health board's Equal Opportunities policy.
- Attempt to resolve any problems that may arise in a timely manner. In the event of an unresolved issue we will initiate the health board volunteer 'problem solving' procedure.

Cont'd

The Volunteer

I _____ agree to:

- Respect the health board's values and behaviour principles and adhere to the organisation's policies and procedures.
- Maintain patient, family and colleague confidentiality by not discussing or disclosing personal information as stated in the confidentiality agreement and to adhere to the General Data Protection Regulations (GDPR).
- Perform my volunteering role to the best of my ability.
- Inform the Volunteer Service of any changes to my personal circumstances which may affect my Disclosure & Barring Service status.
- Meet my volunteering time commitments to the best of my ability and give reasonable notice when unavailable.
- Attend induction and mandatory training sessions, along with additional training as required.
- Wear issued volunteer uniform and identity badge at all times whilst undertaking my volunteering role.
- Return all property issued by the health board when I stop volunteering, including my identity badge, uniform and any other items supplied by the organisation.
- Fulfil the agreed volunteer time commitment before applying for internal posts within CTMUHB and to provide the details of the Volunteer Manager as a referee when doing so.
- Sign in and out of each shift when undertaking my volunteering role.
- Notify the Volunteer Service of any changes to my personal details or circumstances, including physical or emotional wellbeing that could impact on my ability to undertake my volunteering role safely.
- Inform the Volunteer Service if I am no longer able to volunteer or need to take a break for a set period.

This agreement is binding in honour only and is not intended to create a legally binding contract, and may be cancelled at any time at the discretion of either or both parties.

Name: .....

Signed: .....

Dated: .....

(Appendix 2)

Cwm Taf Morgannwg University Health Board

New Volunteering Role Request

Thank you for showing an interest in including volunteers on your ward/department. In order to assess the suitability of the role that you have in mind, please complete the details requested below and return to the Volunteer Service Department (ctuhb_volunteering@wales.nhs.uk)

Please note the following requirements:

- Volunteer roles should not replace paid members of staff.
- Volunteers are recruited to enhance patient experience and therefore any service delivery should not essentially depend on volunteer attendance
- All departments involving volunteers are required to nominate a staff member who will act as a buddy/mentor to the volunteers
- Any departmental specific training will need to be provided locally

Name of person completing this form:	
Ward / department / unit name:	
Telephone Number / extension:	
Email address:	
Date of request:	

Why would you like volunteer support for your area:

Please describe what tasks you want the volunteer(s) to do:

Please explain how this will benefit the patient experience and the department:

What days and times do you require volunteer support?

	AM	PM	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Who will supervise the work of the volunteer(s)?

Will the role involve working in the community? Yes / No
If yes please give details:

Thank you for completing this form – a member of the central volunteering team will be in contact to discuss further.

Attend a volunteer information session (on line or face to face) If interested you will be required to complete an application form. If your application is successful you will be invited to attend an informal interview. This will either be a virtual on line interview or face to face.

After the interview we will be in touch to let you know if you have been successful. If the role is deemed not suitable to your interests we will sign post you to your nearest community volunteer centre who can assist you with finding a suitable role. If successful you will be contacted by the volunteer centre to inform you of the next steps. Please not that from this stage it make take a few weeks depending on priorities and service demand before we complete all necessary checks and training before you can start volunteering.

Documentation:
We will send you all necessary documentation including an occupation health check form. You will be required to complete and send to our occupational health team. You may receive a telephone call or appointment for a quick assessment dependent on your medical history. We will also need references so will be required to get permission from your referees in readiness.

Documentation:
You will be required to complete a DBS criminal record check. Guidance will be provided on how to do this. If you have received a conviction or caution, we encourage you to be up front and honest. It does not mean that you will be unable to volunteer, but will be dependent on the nature of this. The volunteer service can offer guidance and a one to one confidential meeting to discuss any concerns or worries.

Next Step:
As part of your induction into our organisation you will need to attend a local orientation to your ward / department. This will be arranged by the volunteer service and you will have the opportunity to meet your named contact who will offer you support during the course of your volunteering.

Training:
In line with our recruitment process, you will be invited to attend an induction session. This will either take place on line or face to face classroom based and will cover all necessary topics relevant to your volunteering role. You will be issued with a uniform and arrangements made for an ID badge, you will also receive guidance and documentation to complete in order for you to claim travel expenses and your timesheet, which is important as a record of shifts undertaken.

Welcome

Once all of the above has been completed you are now ready to start your volunteering journey with us.
Welcome to volunteering at Cwm Taf Morgannwg University Health Board

(Appendix 4)

New Volunteer - Local Orientation Checklist

Please see below details of a new volunteer who is now ready to start in your area. This checklist is to be completed during their first shift and retained by the department. The sign off sheet should be returned to the Volunteer Centre at Glanrhyd Hospital where it will be placed in the volunteer's personnel file. Details of which can be found at the bottom of this form.

Volunteer Contact Details	
Name	
Telephone	
Mobile	
E-Mail	
Emergency Contact Name & No	
Relationship	
Volunteers Signature	

Ward / Department	
Hospital Unit / Site	
Ward / Department	
Volunteering Commencement Date	
Date Local Induction Completed	
Local Induction completed by	
Staff Signature	

Local Orientation Checklist

Action	Tick all appropriate topics covered
Reception	
New volunteer received by:	
Introduction to Ward/Unit Manager	
Introduction to staff	
Location of volunteer signing in and out form	
Department layout	
Health & Safety	
Fire procedure – location of fire alarms, fire panels, fire exits and an explanation of the testing times for fire alarms.	
Emergency first-aid, identification of first-aiders and location of first-aid box.	
Accident and incident reporting procedure	
Security/responsibility of personal property	
Hand washing (Demonstrate)	
Non handling of sharps/clinical waste	
Control of infection	
Protective clothing & skin sensitivity	
Correct use of personal protective equipment	
Cleaning products e.g. wipes	
Food hygiene and service	
Use of kitchen equipment	
Volunteer Shift Arrangements	
Arranging shifts	
Reporting in for shift instructions	
Location of break rooms and toilets	
Duties and responsibilities outlined	
Sickness/absence procedures	
Access to copies of policies & procedures	
Dealing with Clients & Visitors	
Complaints/concerns procedure	
Confidentiality	
Patient feedback forms and post boxes	
Volunteer Support & Development	
Identification of a named contact to support volunteer	
Additional training opportunities	
Additional Information	
Please add any other topics covered pertinent to your individual ward or department:	

Once completed please return to:
Volunteer Centre
Glanrhyd Hospital
Bridgend
CTUHB_Volunteering@wales.nhs.uk
01656 753781 / 753783

(Appendix 5)

Cwm Taf Morgannwg University Health Board (CTMUHB)

Volunteer Problem Solving Procedure

Introduction

Volunteers are essential to the work of CTMUHB and our aim is to provide a positive volunteer experience for everyone who gives their time and provide volunteer opportunities that make a difference. To make sure that we succeed in this aim, we need to be able to address any problems affecting or involving a volunteer and identify ways of learning and improving how we work together.

All volunteers should have a named contact who is responsible for supporting the volunteer on a day to day basis. Most problems can be resolved successfully without the need for a specific policy or procedure by making sure that volunteers and the named contact regularly discuss how the volunteer role is progressing.

However, some problems are not resolved easily and informally. This procedure aims to make sure that problems are addressed consistently, in a timely manner, and in a way which ensures everyone involved is treated with respect and feels safe in raising concerns and problems.

We expect a volunteer to raise any issues in good faith and to co-operate with their named contact and the Volunteer Service Team to resolve the issues by means of this procedure.

1. Scope

The procedures outlined are to be used when dealing with problems or concerns that relate to volunteers in relation to their volunteering role or status as representatives of CTMUHB

For example, this procedure is used when

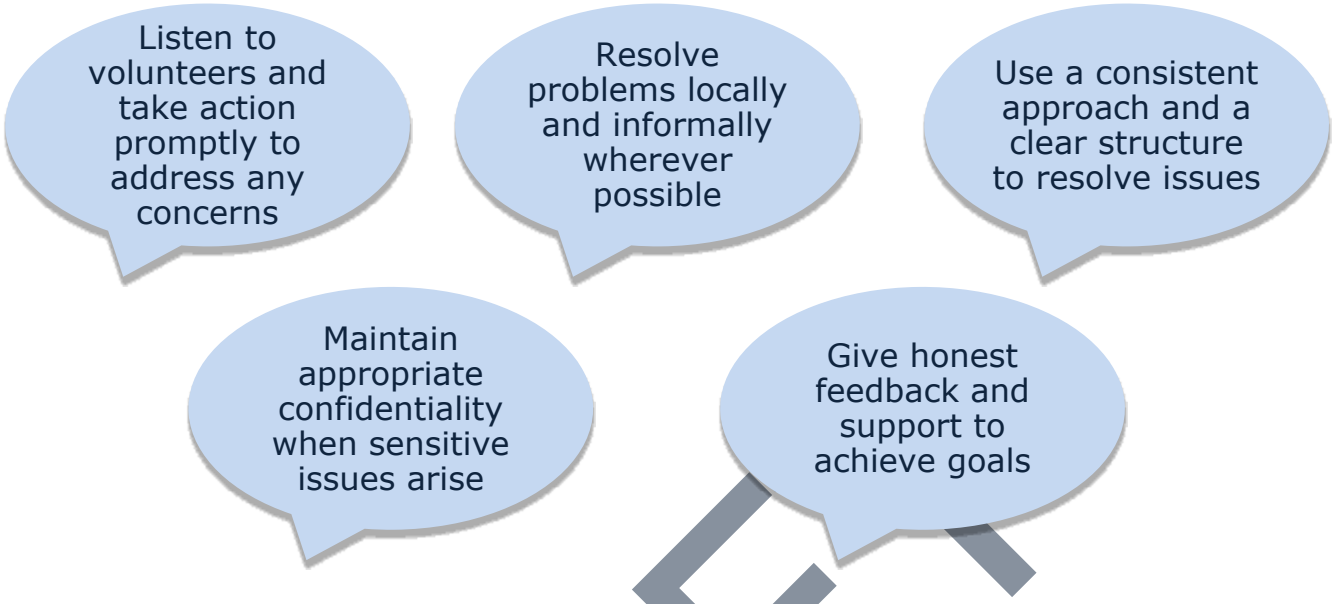
- A volunteer is unhappy with their role
- A volunteer is unhappy about the behaviour of another volunteer or employee
- There are concerns about the competence of a volunteer
- There are concerns about the behaviour of a volunteer

To be clear, staff grievance and HR disciplinary processes can never be used to address issues relating to volunteers.

If an external complaint is made about a volunteer, it should first be addressed using the putting things right procedure. Otherwise, this procedure should be used to address any concerns.

2. Problem Solving Principles

Whenever there is a problem affecting a volunteer, our aim is to:



Volunteers who, in good faith, report concerns about serious malpractice either internally using this procedure, or externally to the relevant authorities are protected by our Whistleblowing policy

Problem Solving Procedure

Definition – for the purposes of the procedure the named contact relates to the member of staff who manages the volunteer on a day to day basis e.g. ward / department manager. The Volunteer Service Team consists of a Volunteer Manager, Volunteer Coordinator and Administrator

Stage 1 – Informal process

Most problems can be dealt with through day to day discussions and supervision. If a problem occurs the named contact should seek to resolve this as soon as possible. The sooner a problem is addressed the more likely it is to be resolved locally and informally.

The named contact should seek advice immediately from the Volunteer Service Team and agree with the volunteer how to resolve the problem. This should include timescales over which any changes will be introduced and how they will be monitored and should always be explicit about any changes or improvements expected and keep a brief note of any relevant discussions and agreements.

In some cases it may be impossible to resolve a problem informally. Examples include where:

- An informal agreement has failed to improve e.g. a volunteer continues to arrive late despite having agreed to be on time
- A volunteer and named contact cannot agree on a suitable resolution to a problem e.g. a volunteer feels that the named contact has not dealt with a dispute appropriately
- A problem is serious and has the potential to damage the reputation of CTMUHB e.g. a volunteer is alleged to have been drunk whilst volunteering

- **In these circumstances the problem moves to stage** 2

Stage 2 – Structured process

The problem should be put in writing to the Volunteer Service Team. Discussions will be undertaken to decide on which staff member should deal with the problem. In most cases this will be either be the volunteer co-coordinator or the manager but may be another suitable employee if appropriate e.g. The Senior Manager for Governance and Patient Experience

This identified Volunteer Service Team member should carry out a suitable investigation e.g. talking to anyone who witnessed the situation that led to the problem – and understand why the informal process has not resolved the problem.

The volunteer should be invited to a meeting to formally discuss the problem. The invitation must make the purpose of the meeting clear. A volunteer may be accompanied by a friend to offer emotional support if required but not mandatory. During the meeting the staff member will discuss the problem in detail and ask further questions as required and detailed notes should be taken of all relevant information.

After the meeting has taken place, the named person dealing with the concern will write to confirm their understanding of the problem, and the actions to be taken to resolve it and the letter will explain why they believe this to be a reasonable and fair response.

The letter will also explain who to contact if they disagree with the response, this will be a more senior manager and should normally take no more than three weeks to complete.

Stage 3 – Appeal

If a volunteer feels the outcome of Stage 2 is unfair or unreasonable, they have 14 days from the date of the letter explaining the outcome of Stage 2 to appeal.

The volunteer should write to the senior manager named in the letter setting out the reasons why they feel the outcome is unreasonable.

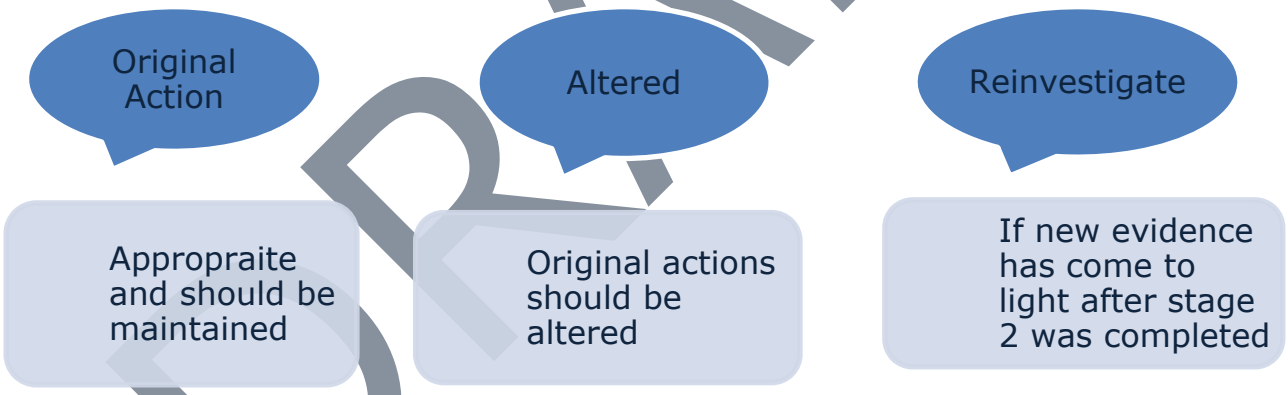
- The senior manager will review the evidence collected in stage 2 and the actions to resolve the problem

- The senior manager will invite the volunteer and manager to a meeting. The volunteer may be accompanied by a friend to offer emotional support

During this meeting the volunteer will be asked to explain why they feel the outcome is unreasonable and the manager will be asked to explain why they believe it to be reasonable. The appeal should not rehear the evidence about the original problem – the appeal aims to decide whether the actions put in place by the manager are reasonable and proportionate.

Following the meeting, the senior manager will make a final decision on the outcome and write to the volunteer and the Volunteer Service to explain their decision.

The decision may be:



There is no further right of appeal following this decision

The stage 3 process should normally take no more than 3 weeks, so the whole process should take no longer than 8 weeks unless there are unforeseeable delays.

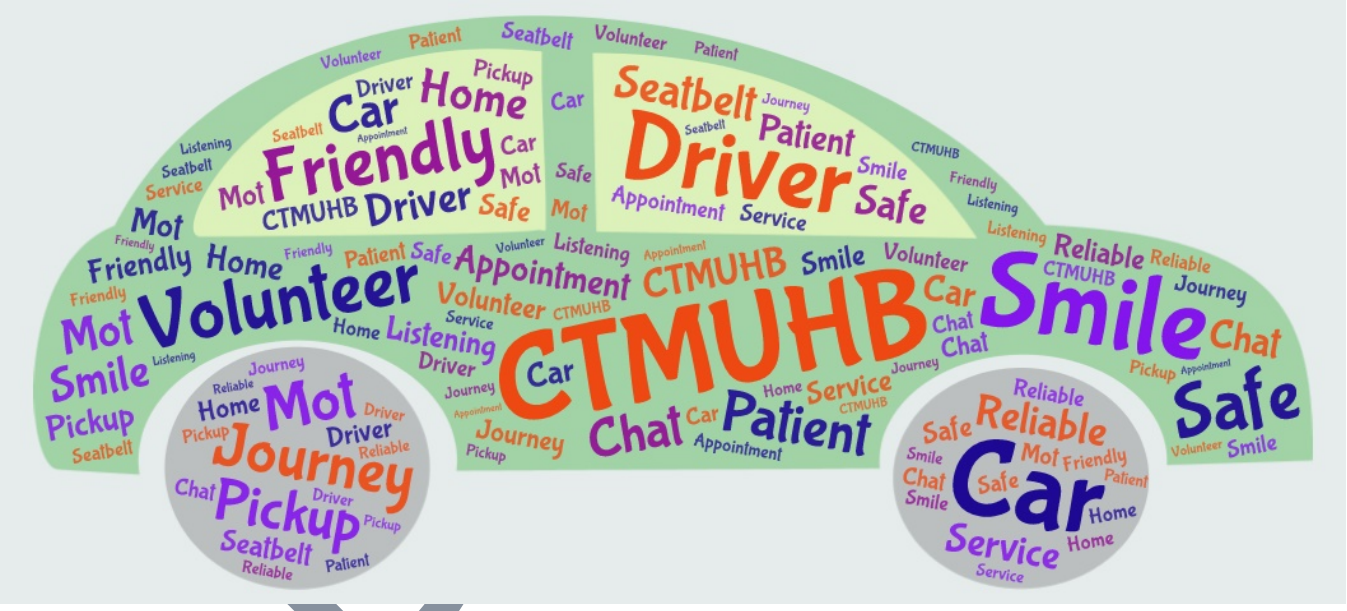
Ending a Volunteer's Involvement

The procedure set out above should always be followed before ending a volunteering relationship unless there are exceptional circumstances.

Exceptional circumstances are where the matters are serious and trust in the relationship has been lost. This would include situations where the volunteer has caused damage or financial loss or is potentially involved in criminal or antisocial behaviour. In such circumstance a volunteer placement and agreement may be ended without following this process. This can only happen with the agreement of the Director responsible for volunteering in the Health Board.

(Appendix 6)

Volunteer Service
Volunteer Drivers Information Handbook



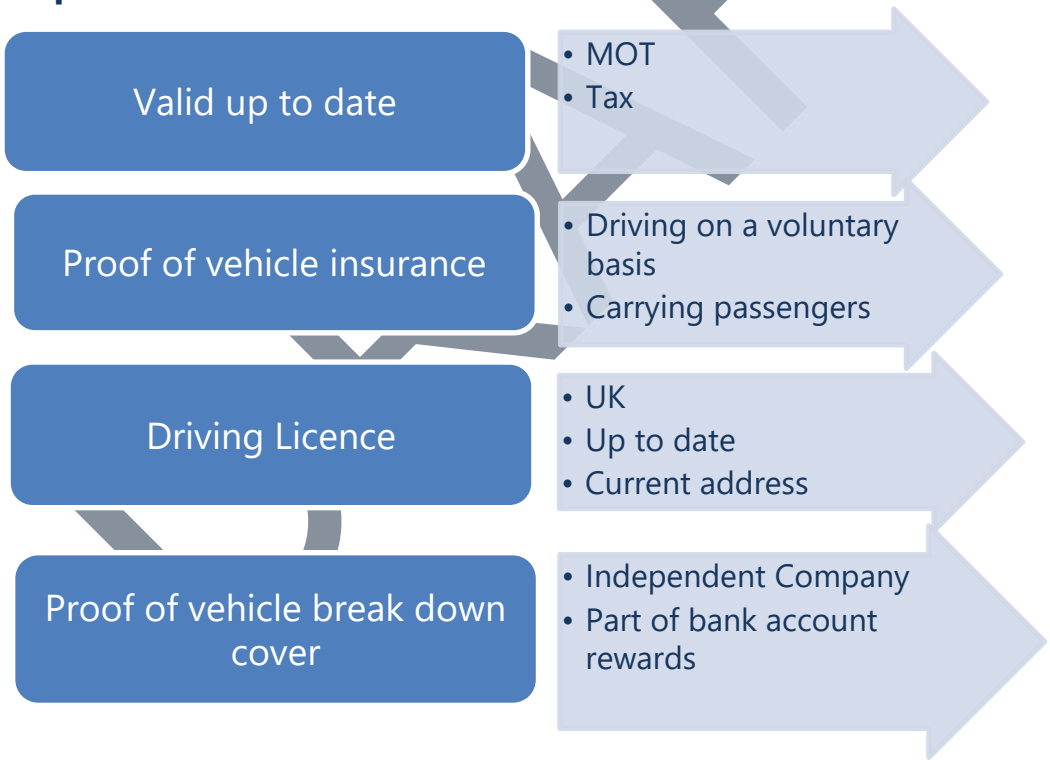
Purpose

Volunteer Drivers provide a friendly face and listening ear by putting patients at ease during what can be an anxious and stressful time. They provide that personal touch to brighten their day as they collect a patient from their home, help get them to where they need to be and make sure they get back home safely.

Responsibility

Whilst the Health Board is responsible for the management and assurance of this handbook, it is ultimately the responsibility of the volunteer to provide the following documents on an annual basis or any document changes within 7 days. If these documents are not forthcoming then volunteers will not be allocated any patients until such time as the documentation is received.

Important Documents



- In addition it is also the responsibility of the volunteer to inform the volunteer service and named contact of any subsequent endorsements or convictions which must be reported immediately

- All volunteer drivers are required to have fully comprehensive insurance cover at all times whilst carrying out their duties, which will need to include business miles in order to claim out of pocket travel expenses

- CTMUHB does not accept any responsibility or liability for damage or injuries to either volunteers or patients incurred whilst operating under the scope of the vehicle insurance.

- It is essential that volunteers ensure that they obtain a letter of authority from their insurance company confirming that they are covered to undertake voluntary car driver activity with full passenger liability

- The volunteer driver must make it clear to their insurance company that they will only receive out-of-pocket expenses and that the vehicle is not used for commercial purposes

- The volunteer through their insurance company, will pursue all claims for damage or injury resulting from Road Traffic Accidents

- Any fine incurred, whilst acting as a volunteer, is the responsibility of the individual. Volunteers must comply with motoring law and any relevant parking regulations

- Where appropriate volunteers are required to have an annual health check. This will be arranged by the contact lead and undertaken by the Health Boards Occupational Health Department

- All Volunteer travel expenses must be logged and signed off on the volunteer service travel expenses / timesheet form **Appendix 1.** This must be submitted to the volunteer service on a monthly basis, no payments can be made without completion and submission of appropriate form

- Volunteers will be paid in line with current Welsh Government travel expense mileage allowance as indicated below:

Vehicle	First 10,000 miles	Above 10,000 miles
Cars and Vans	45p	25p
Bikes	20p	20p
Motorcycles	24p	24p
Passenger Payments	5p	Passengers (this can be claimed as well as the car and van mileage rates)

Referral Procedure and Contacts

Drivers will receive details of clients requiring transport by their named contact. The information will be received by phone, or by prior arrangements and will include:

- Clients name
- Contact details
- Address (including postcode),
- Time of pick up and drop off

Emergency Procedure

The volunteer Driver will be responsible to ensure they call 999 immediately in the case of an emergency and will be informed of situations that may require urgent action by their contact lead in the area that they provide their services. The following are a few examples of what is classed as a medical emergency or serious injury:

- Loss of consciousness
- An acute confused state
- Fitting
- Breathing difficulties
- A suspected heart attack or stroke, **every second counts with these conditions**

We recommend that you carry sick bags and bottled water in the vehicle in the event that you or your passenger may be feeling nauseas.

In March 2020, the UK went through extraordinary times due to a pandemic. If you are required to provide transport during unprecedented times your named contact will be responsible for updating all their drivers with current Government and Health Board precautionary measures and infection prevention guidance at that time. If required your named contact will also provide you with appropriate Personal Protective Equipment (PPE).

Drive Safely

Ensure the vehicle remains safe and road-worthy. You should carry out basic vehicle maintenance checks at the start of every shift. This should include a visual check on all lights, oil and water levels, tyres, mirrors, seat belts and access ramps (where applicable).

It is important to note that this is a transport service to drop off and collect and not a service providing chaperone or assistance helping passengers

into their appointment such as pushing wheelchairs, please inform staff within the area if your passenger requires support getting into their appointment.

Reassurance and awareness

We recognise older people need to identify staff for reassurance. For these purposes you will be issued with a uniform e.g. polo shirt, fleece jacket, lanyard with a photograph ID name badge and a notice to display in your vehicle advising that you are driving on behalf of Cwm Taf Morgannwg University Health Board

Volunteer Service

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

Volunteer - Monthly Timesheet

Full Name ..... Hospital / Base .....

Ward / Unit ..... Days ..... Times .....

Date	Tasks	Hours From - To	Staff Signature (Ward Based Staff)	Checked √

In order to receive your travel expenses, please complete the claim form overleaf. Please note that all expenses must be claimed on a monthly basis, be completed and signed in full. Remember that fares other than mileage must be supported by an official receipt and/or ticket.

Volunteer - Claim For Out Of Pocket Expenses

Full Name .....

Address ..... Post Code .....

Date	Car Total Miles Travelled	Bus/Train Tickets £ - P	Other (please state) Attach Receipts	Total £ - P	Checked √
			Total Claimed		

I confirm that this claim is in resepect of expenses actually incured for the purpose of performing my duties as a Health Board Volunteer. I declare that the information given is correct and complete. I understand that if I provide false information I may be liable for prosecution.

Signature ..... Print Name ..... Date .....

Office Use:

Certified ..... Date ..... Cost to .....

Processed By Checked By

Appendix 8

Volunteer Confidentiality Agreement

During the course of your volunteering, service users and colleagues may reveal confidential information about themselves. This could be their home address, telephone number or personal details about their life or circumstances. It is important for people to feel confident that information they give **will not** be passed on to anyone without their permission. It is equally important for people to feel confident in giving us this information so we can deliver the best possible service.

On no account must identifiable information be divulged to anyone either verbally, in writing or via social media. Discussions should only be held with authorised staff, who are directly concerned with the patient's healthcare. If you are in any doubt whatsoever as to the authority of a person or body asking for information of this nature, or you become aware of a breach of confidentiality, you must seek advice from or report to the department/ward manger or Volunteer Service Team.

We ask all volunteers within our health board to sign a copy of the statement below to show they understand the need for confidentiality and agree to keep information confidential within Cwm Taf Morgannwg University Health Board and elsewhere.

I, the undersigned, do willingly promise to hold in confidence all the matters that come to my attention whilst volunteering with Cwm Taf Morgannwg University Health Board, including information about any patient or other persons using the services of, or working within the health board.

- I will respect the privacy of service users, other volunteers and staff, and confer appropriately with those designated as my supervisors.
- I will use all information gained in the course of my service in a responsible manner.
- I understand that information relating to patients is strictly confidential and must never be divulged or discussed outside of the hospital.
- I will adhere to the All Wales Social Media policy.
- I understand that misusing information will lead to my suspension or dismissal.

Name: .....

Signed: .....

Date: .....

(Appendix 8)

Volunteer Service

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

Volunteer - Monthly Timesheet

Full Name ..... Hospital / Base .....

Ward / Unit ..... Days ..... Times .....

Date	Tasks	Hours From - To	Staff Signature (Ward Based Staff)	Checked √

In order to receive your travel expenses, please complete the claim form overleaf. Please note that all expenses must be claimed on a monthly basis, be completed and signed in full. Remember that fares other than mileage must be supported by an official receipt and/or ticket.

Volunteer - Claim For Out Of Pocket Expenses

Full Name .....

Address ..... Post Code .....

Date	Car Total Miles Travelled	Bus/Train Tickets £ - P	Other (please state) Attach Receipts	Total £ - P	Checked √
			Total Claimed		

AGENDA ITEM
9.1.5a

QUALITY & SAFETY COMMITTEE

USE OF RAPID TRANQUILISATION. GUIDANCE FOR RAPID CONTROL OF ACUTELY DISTURBED YOUNGER PATIENTS AGED 6-17YEARS

Date of meeting	25 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Diana Osman, Pharmacist and Non Medical Prescriber, CAMHS. Originally written by Katie Price (Pharmacist) and Dr Halford (both previously worked at Tŷ Llidiard)
Presented by	Diana Osman, Pharmacist and Non Medical Prescriber, CAMHS
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Clinical Policies Approval Group	17/04/2023	ENDORSED FOR APPROVAL

ACRONYMS	
CAMHS	Children and Adolescent Mental Health Service

1. SITUATION/BACKGROUND

- The purpose of updating this document was to support the treatment pathway work for managing a distressed child or young person who presents to the Emergency Department or a Paediatric inpatient ward in addition to the Tier 4 Tŷ Llidiard ward at Princess of Wales Hospital.

By putting this policy on Sharepoint, it would then be available for staff to refer to when children present to Non Mental Health Clinical areas.

- The original document was written in July 2016 by Dr Halford (CAMHS psychiatrist) and pharmacist Katie Price who were both working at Tŷ Llidiard. Both staff have left the Health Board now but consent to update the document was given. The original document is in use at Tŷ Llidiard currently.

- The document has been updated by Diana Osman CAMHS Pharmacist and then also checked by Anne Marie Mehegan, Senior Mental Health Pharmacist, Princess of Wales Hospital.

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	Equality Impact Assessment document completed 11/5/23 and sent to the Business Manager, Medical Directors Office. A copy has also been sent to the Equality team but have been informed that they currently are recruiting a new Equality lead member of staff and so there may be a delay until they can approve it.
Informal Consultation with interested parties	The policy was circulated to the following staff for their comments during the updating process; Anne Marie Mehegan-Senior Mental Health Pharmacist Dr Aicha Hammami and Dr Amanda Farrow, Emergency Medicine Consultants Tina Davies, Child Health, Senior Nurse Dr Jaya Natarajan , Consultant Paediatrican, Royal Glamorgan Hospital

	Giovanna Nelms, Senior Paediatric Pharmacist, Royal Glamorgan Hospital. Policy also scheduled for presentation at Paediatric audit meeting on 21/06/23.
Formal Consultation	The policy was reviewed at the CTM Clinical Policy Approval Group meeting on 17/04/23.
Committee – For approval	

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

2.3 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 following amendments have been made:

Typographical amendments were made as requested after the Clinical Guidelines meeting and all suggestions made by the original group of staff were made. Further details can be provided if required.

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
	If more than one Healthcare Standard applies please list below:

Equality impact assessment completed	Yes
	Awaiting review and approval by the Equality Team
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goal	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee are asked **APPROVE** the Use of Rapid Tranquilisation – Guidance for rapid control of acutely disturbed younger patients aged 6 – 17 years 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.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Use of Rapid Tranquilisation.

Guidelines for rapid control of acutely disturbed younger patients

(Aged 6-17years)

Document Type:	Clinical Guidelines
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Diana Osman CAMHS Non Medical Prescriber and Pharmacist
Executive Sponsor:	Executive Medical Director
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	1.2

Target Audience:

People who need to know about this document in detail	Child and Adolescent Psychiatrists Senior Nursing staff, CAMHS and Tŷ Llidiard Accident and Emergency Consultants Chief Pharmacists
People who need to have a broad understanding of this document	Lead Pharmacists, Paediatrics and Psychiatry Paediatric Consultants and Senior nursing staff Tŷ Llidiard medical and nursing staff
People who need to know that this document exists	Tŷ Llidiard ward staff Paediatrics ward staff Accident and Emergency clinical staff Pharmacy staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	No

Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS PAGE

1 STATEMENT

The aim of rapidly tranquillising a patient is to quickly calm the severely agitated child/adolescent in order to reduce the risk of imminent and serious violence to self or others, rather than treat the underlying psychiatric condition. The aim is not to induce sleep or unconsciousness, the child/adolescent should be sedated but still able to participate in further assessment and treatment, however there may be occasions when sedation is an appropriate goal.

2 SCOPE

This guidance applies to all staff working in clinical areas where adolescents may present in Mental Health crisis

3 AIMS AND OBJECTIVES

The aim of the guidance is to provide guidance for staff on rapid tranquilisation for young people who present in mental health crisis

4 RESPONSIBILITIES

All clinical staff working with children with mental health conditions have responsibility to be aware of the guidance. The management team will ensure circulation and compliance of the guidance.

5 IMPLEMENTATION/POLICY COMPLIANCE

The guidance will be implemented using Sharepoint

5.1 Children/adolescents should only be treated with the following medicines after an assessment of risk and when it has been established that the risk of not doing so is greater than the risk of acute pharmacological treatment.

Staff should be trained in how to assess and manage potential and actual violence using de-escalation techniques, safe holding, time out and rapid tranquillisation. Staff should also be trained to use and maintain the techniques and equipment required to undertake cardiopulmonary resuscitation.

Intervention should take the form of talking to the patient in a calm manner and by being seen by the child/adolescent to be listening to their worries or concerns. Refer to local unit specific policies (eg behaviour management policy, safe holding policy).

Other non-pharmacological interventions should, where possible, also be explored, for example increasing the level of observations of the patient, increasing the level of staffing, or changing the child/adolescent's setting.

If a child/adolescent is acutely disturbed, then the nurse in charge should assess the situation to determine whether medical assessment of the child/adolescent is required.

If a psychiatrist is required to attend, it is vital that s/he obtains as much history as possible from the child/adolescent and other sources before medication is given, as the opportunity to make a diagnosis may be lost if the child/adolescent is sedated before an understanding of their mental state is reached. However, the immediate safety of the child/adolescent and staff is of prime concern. Due consideration should be paid to potential non-psychiatric causes for the disturbed behaviour (eg organic, psychological, intoxication or withdrawal states). Past medication history and plans for future pharmacological management may influence pharmacological management plans.

In reaching a decision to use rapid tranquillisation, the senior nurse and doctor should undertake a risk assessment of the situation, considering the risks to the child/adolescent, other patients and staff and the risks to the environment.

Each patient requiring tranquillisation should have an individual treatment plan taking account of the patient's mental state, physical condition, medical history, allergies, personal preferences/ advanced directives and risks, paying note to previous bloods, ECG's(Electrocardiograms), history of side effects and recently prescribed medication including when necessary medications (PRN's) .

In all cases the child/adolescent must be informed that medication is going to be given and must be given the opportunity at any stage to accept oral medication voluntarily. In children/adolescents who are not Gillick competent, parents/carers should be informed of the situation and consent sought for such treatment. It is good practice to inform both the child/adolescent and their parents/carers.

In all cases, the minimum effective dose of medication should be used, BNF maximum doses should only be exceeded in extreme circumstances and with the advice of a Consultant Child and Adolescent Psychiatrist or Senior Emergency Department Doctor.

5.2 Pharmacological treatments

All of these drugs are being used "off label " ie licensed products being used for unlicensed indications, which follow best practice.

See Appendix 1 for a quick reference guide

Poly-prescribing within a class of medication (eg antipsychotics) should, where at all possible, be avoided. Consideration should be given to any co-existing medical illnesses and any regularly prescribed medication as this may impact on dose requirements and potential side effects Consideration should be given to past experiences with medication as this may influence drug choices.

Oral medication should be offered before parenteral (eg intramuscular [IM]) treatment is administered, although IM medication has a faster onset of action (apart from lorazepam). If there is a valid 'when required' (prn) prescription for this, this may then be given by nursing staff.

There may be occasions where it is appropriate to give one class of medication orally and another via the intramuscular route.

Children/adolescents who are acutely disturbed may be psychotic, have a non psychotic disorder or it may be unknown what the problem is (eg presenting in an acutely disturbed way in the Emergency Department).

For all these young people it is good practice to try to sedate without the use of neuroleptic medication. However in some circumstances, this may be the best way to manage them, but it should only be used as third line. It is more acceptable to use neuroleptic medication where it is known that the young person has a psychotic illness, and is not neuroleptic naïve.

Promethazine has limited evidence for efficacy but maybe of particular benefit where a sedative agent is needed in those who are antipsychotic naive, who have been administered the maximum dose of other medication, those that are benzodiazepine tolerant or suffering paradoxical reactions from benzodiazepines

Intravenous Ketamine can be used for children>5years in the Emergency Department ONLY and NOT within CAMHS or Paediatric wards. There must be full resuscitation facilities available.
Please see the following document for further guidance;

Ketamine procedural sedation for children in the emergency department; The Royal College of Emergency Medicine. Best Practice Guideline Feb 2020. Ketamine_Procedural_Sedation_-for_Children_in_EDs_Feb_2020.pdf (cloudinary.com) accessed 27/4/23.

Below are both generalised and specific risks for medications used in rapid tranquilisation. Risks can be compounded when using these drugs in combination

. General risks:

- Over-sedation leading to loss of consciousness
- Loss of airway protection
- Cardiovascular collapse (arrhythmia, Hypotension, sudden death)
- Respiratory depression (acute dystonia may further compromise respiratory rate)
- Interaction with other medications including illicit drugs
- Detrimental effect on therapeutic relationship
- Interaction with underlying medical disorders Benzodiazepines:
- Loss of consciousness
- Respiratory depression/arrest
- Cardiovascular collapse (compounded by clozapine)
- Paradoxical increased agitation

Antipsychotics:

- Loss of consciousness
- Cardiovascular collapse
- Respiratory Depression
- Seizures
- Restlessness (akathisia)
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome

Antihistamines

- Cardiovascular collapse
- Pain at injection site
- Antimuscarinic side-effects
- Arrhythmia

The following steps are recommended as **oral medication** regimens:

ORAL Pharmacological Treatments-

Non-Psychotic Illness &/or No history of Antipsychotic use		
Lorazepam(oral)[8,9,10] **Onset of action=20-30mins** <12yrs: 0.5 mg to 1 mg >12yrs: 0.5 mg to 2 mg (max 4mg in 24hours) Doses can be repeated after 45-60minutes if necessary	**OR**	**Promethazine(oral)[11,12]** **Onset of action=20mins** <12 years 5mg to 10mg up to TWICE daily (maximum of 25mg in 24hours) >12 years 10mg to 25mg up to TWICE daily (maximum of 50mg in 24hours) Doses can be repeated after 45-60minutes if necessary

Psychotic Illness &/or Confirmed history of Antipsychotic use				
(Consider PRN Procylidine[18] by intramuscular injection(IM)to treat acute dystonias and extrapyramidal side effects(EPSE) such as laryngeal spasm or orally(PO) for less acute dystonias/EPSE). These can occur with any antipsychotic. See page 13 for doses				
Risperidone **(oral)[13,14]** **Onset of action=30-60mins** <12years not advised >12years 1mg to 2mg at intervals of at least 1 hour(maximum of 2mg in 24hours)	**OR**	**Olanzapine** **(oral)[15,16]** **Onset of action** **=60-120mins** <12 yrs: Not appropriate >12 yrs: 2.5mg to 10mg (maximum of 20mg in 24hours by any route)	**OR**	**Haloperidol(oral)[17]** (pre treatment ECG required where possible) **Onset of action** **=60-120mins** <12yrs 0.5mg to 1mg (max 10mg/24hrs) >12yrs 1mg to 5 mg (max 15mg/24hrs)
With or without				
Lorazepam		**Promethazine**		

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If Oral medication is repeatedly refused, the decision to forcibly medicate (Intramuscular injection) a child/adolescent will be taken jointly by medical and nursing staff. Once the decision has been made to forcibly medicate, the child/adolescent must be isolated from other children/adolescents on the unit. Nursing and medical staff involved in safe holding the child/adolescent should be proficient in the safe holding used (see local unit specific policies) and adhere to safe practice of administration of medication and adherence to PPE. A CAMHS Consultant or Senior Emergency department doctor should be contacted.

If Intramuscular injections are used outside of psychiatric wards or Accident and Emergency departments then consider asking Psychiatry for advice.

The following steps are recommended as **parenteral medication** regimes for children/adolescents who have not been adequately settled by non-drug measures or oral medication, or who are refusing oral medication again note should be taken to a patients, physical and psychiatric complaints, history of response to medication both neuroleptics and benzodiazepines.

Intramuscular(IM) Pharmacological treatments

Consider if, patient refuses oral medication/ by previous clinical response/ oral ineffective or effect essential within 30 mins* of administration

Non-Psychotic Illness and /or No history of Antipsychotics use (Consider PRN Procylidine[18] by intramuscular injection(IM)to treat acute dystonias and extrapyramidal side effects(EPSE) such as laryngeal spasm or orally(PO) for less acute dystonias/EPSE). These can occur with any antipsychotic. See page 13 for doses		
Lorazepam[1]*(IM)(kept in Fridge) Onset of action=20-40mins <12 yrs 0.5mg to 1mg >12yrs 0.5mg to 2mg max 4mg/24hrs (Intravenous Flumazenil should be available) Doses can be repeated after 30-60minutes if insufficient effect	**OR**	**Promethazine[2](IM)** Onset of action=up to 60mins <12yrs:5mg to 25mg (max 50mg/day) >12yrs:25mg to 50mg (max 100mg/day) Doses can be repeated after 30-60minutes if insufficient effect

Psychotic Illness &/or Confirmed history of Antipsychotics us
Olanzapine[3&4] (IM) Onset of action 15-30mins <12years Not appropriate >12yrs 2.5mg to 10mg max 10mg in 24hours (Possibly increased risk of respiratory depression when administered with benzodiazepines, allow one hour between IM Olanzapine and IM Lorazepam) **Haloperidol[5](IM)(pre –treatment ECG required)** Onset of action 20-30mins <12 years 0.025-0.075mg/kg/dose(max 2.5mg per dose and in 24hrs) >12 years 2.5mg to 5mg (max 5mg in 24hrs) With or without**: Promethazine** (see above for dosage)

*Please note that IM lorazepam confers no faster onset of action compared to oral.

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Promethazine is contraindicated in those with CNS depression or have received a Monoamine oxidase inhibitor in the past 14 days. Cautions of Promethazine include respiratory conditions, coronary artery disease, epilepsy and hepatic and renal insufficiency – please consult BNF.

We do not use intravenous rapid tranquillisation

The maximum BNF dose of IM Lorazepam is 4 mg per day (in Adults), at times doses higher than this may be required, in such circumstances advice should be sought from senior colleagues.

Lorazepam Intramuscular injection(IM) must be stored in the fridge. **Please check the product information with the medication to see dilution is required before administration**

All staff prescribing or administering sedative medication must be aware of adverse reactions or overdoses and how to manage these.

NEVER mix drugs in the same syringe.

Flumazenil (IV)[6] should be given if respiratory rate drops below 10 breaths/minute due to benzodiazepine administration. Repeated doses may need to be given as it is short acting.

Dose as 10 micrograms/kg by intravenous injection every 1 minute (max. per dose 200 micrograms) if required, dose to be administered over 15 seconds; maximum 1 mg per course; maximum 50 micrograms/kg per course.

Flumazenil is best avoided in epileptic patients – start mechanical ventilation instead. Please contact anaesthetics/Intensive care for ventilatory support

5.3 Monitoring requirements

Where possible baseline measurements of the patient's level of consciousness, temperature, blood pressure, pulse and respiratory rate in order for comparison to be made.

Constant visual observation of the patient should be maintained.

Blood pressure, pulse, temperature, respiratory rate, blood oxygen saturation (using pulse oximeters) and level of consciousness should be **monitored** every 15 minutes after IM injections for ONE hour, then hourly for 4 hours or until the child/adolescent becomes active again. Measurements should be documented on the child/adolescents' notes. If staff are unable to monitor any of these parameters, the reasons for such omissions must also be documented in the child/adolescent's notes.

Resuscitation equipment and medication, including flumazenil, must be available and easily accessible; staff should be familiar with their use.

Ensure adequate holding before attempting to administer IM medication in a struggling child/adolescent.

5.4 Children/Adolescents who are physically unwell

Avoid **benzodiazepines** in children/adolescents who are physically unwell, delirious or who have significant respiratory impairment. Use benzodiazepines in preference to antipsychotics in patients with cardiac disease, as these are safe, but beware of accumulation.

5.5 Feedback

The reason for prescribing any medication for the acutely disturbed child/adolescent should be documented in the medical notes as well as the working diagnosis.

Any medication administered to the child/adolescent and the response should be recorded in the medical notes.

Nursing and medical staff should always have a feedback session following emergency restraint and sedation.

After the treatment of an acute disturbance the child/adolescent should be given the opportunity to talk to a member of staff and be given an explanation of events, this should be documented in their notes, and they should be offered the opportunity to write an account in their notes.

After the treatment of an acute disturbance, the staff should also discuss the management and treatment given to the child/adolescent with the parents/carers. This discussion should be documented in the child/adolescent's medical notes.

5.6 Remedial measures in rapid tranquillisation	
Problem	***Remedial measures***
Acute dystonia (these are often related to antipsychotic use) (including oculogyric crises)	Procylidine[7] by intramuscular injection Child 6–9 years 2 to 5 mg for 1 dose, dose usually effective in 5–10 minutes but may need 30 minutes for relief. Child 10–17 years 5 to 10 mg, occasionally, more than 10 mg, dose usually effective in 5–10 minutes but may need 30 minutes for relief. Procyclidine[7] by mouth Child 7–11 years 1.25 mg 3 times a day. Child 12–17 years 2.5 mg 3 times a day
Reduced respiratory rate (<10/min) or oxygen saturation (<90%)	Give oxygen, raise legs, and ensure patient is not lying face down. Give **Flumazenil(IV) see under Flumazenil for dosing** if benzodiazepine-induced respiratory depression suspected. (If induced by any other sedative agent: **transfer to a medical bed and ventilate mechanically**
Irregular or slow (<50/min) **pulse**	**Refer** to specialist medical care immediately.
Fall in blood pressure (>30 mmHg orthostatic drop or <50 mmHg diastolic)	**Have patient lie flat**, tilt bed towards head. Monitor closely.
Increased temperature	**Withhold antipsychotics:** (risk of Neuroleptic Malignant Syndrome (NMS) and perhaps arrhythmia). Check creatinine kinase urgently.

6 REFERENCES

1 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 596

2 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 596

3 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 596

4 Guidelines for the use of rapid tranquilisation in children aged

12 to 17years.Betsi Cadwaladr University Health Board. MM68.1st July2020 Appendix 1&2

5 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 596

6 eChildrens BNF accessed January 2022

7 eChildrens BNF accessed January 2022

8 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 60

9 Rapid tranquilisation in paediatric patients clinical guideline v1.0 Dec 2020. Royal Cornwall Hospitals NHS Trust page 2

10 eChildrens BNF accessed January 2022

11 Rapid tranquilisation in paediatric patients clinical guideline v1.0 Dec 2020. Royal Cornwall Hospitals NHS Trust page 2

12 The Rapid Tranquillisation policy TP/CL/018 v9 Nov 2018 page 26.Sussex Partnership NHS Foundation Trust

13 Guidelines for the use of rapid tranquilisation in children aged 12 to 17 years.Betsi Cadwaladr University Health Board. MM68.1st July2020 Appendix 1&2

14 The Maudsley Prescribing Guidelines in Psychiatry. 14th Ed. 2021 page 60

15 Rapid tranquilisation in paediatric patients clinical guideline v1.0 Dec 2020. Royal Cornwall Hospitals NHS Trust page 2

16 The Rapid Tranquillisation policy TP/CL/018 v9 Nov 2018 page 26.Sussex Partnership NHS Foundation Trust

17 Use of Rapid Tranquilisation guidelines 2021 University Hospital of Wales

18 eChildrens BNF accessed January 2022

7 Other relevant documents and legislation

Ketamine Procedural Sedation for children in the emergency department. The Royal College of Emergency Medicine. Best Practice Guideline February 2020

Guidelines for the Management of Excited Delirium/Acute behavioural disturbance(ABD) The Royal College of Emergency Medicine. Best Practice Guideline May 2016

NICE. Violence and aggression: short-term management in mental health, health and community settings. 2015

Mental Health Act 1983

Mental Health Measures (2012)

The Mental Capacity Act 2005

8 Acknowledgements

University Hospitals of Leicester NHS Trust Guidelines for Rapid Control of Acutely Disturbed Patients over the age of 12 years in CAMHS

Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust. Management of acutely disturbed Children & Adolescents

Lancashire Care NHS Foundation Trust , CAMHS RT policy

South West London and St George's Mental Health NHS Trust, Guidelines for Rapid Tranquillisation (for young people aged 6 – 17 years) 2015

Royal Cornwall Hospitals NHS Trust. Rapid tranquillisation in Paediatric patients clinical guideline v1.0 December 2020

Sussex Partnership NHS Foundation Trust . The rapid tranquilisation policy v.9 Nov 2018

Betsi Cadwalader University Health Board . Guidelines for the use of Rapid Tranquillisation in children 12y to 17y . Version number MM68 July 2020

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

APPENDIX 1(Page 1 of 2)

Guidance for Rapid Control of Acutely Disturbed Younger Patients (Please refer to policy for full guidance)

1st: De-escalation using non drug approaches

(Maintain adequate distance, ensure environment calm, move to safe place or seclude, use non threatening, non-verbal communication

<table>
<tr><th colspan="5">2nd: ORAL THERAPY</th></tr>
<tr><td colspan="3">Psychotic Illness &/ Confirmed history of Antipsychotics use

Consider PRN Procylidine[18] by intramuscular injection(IM)to treat acute dystonias and extrapyramidal side effects(EPSE) such as laryngeal spasm or orally(PO) for less acute dystonias/EPSE). These can occur with any antipsychotic.See page 13 for doses</td><td colspan="2" rowspan="2">Non-Psychotic Illness and / No history of Antipsychotics use</td></tr>
<tr><td>Risperidone(oral)[13,14]

Onset of action=30-60mins

<12years not advised

>12years 1-2mg at intervals of at least 1 hour(maximum of 2mg in 24hours)</td><td>Olanzapine(oral)[15,16]

Onset of action=60 to 120mins

<12 yrs: Not advised

>12 yrs: 2.5mg to 10mg

(maximum of 20mg in 24hours by any route</td><td>Haloperidol(oral)[17]

(pre treatment ECG required where possible)

Onset of action=60-120mins

<12yrs 0.5mg to 1mg

(max 10mg/24hrs)

>12yrs 1mg to 5 mg

(max 15mg/24hrs)</td><td>Lorazepam(oral) [8,9,10]

Onset of action=20-30mins

<12yrs: 0.5 mg to 1 mg

>12yrs: 0.5 mg to 2 mg

(max 4mg in 24hours)

Doses can be repeated after 45-60minutes if necessary</td><td>Promethazine(oral)[11,12]

Onset of action=20mins

<12 years 5- 10mg up to TWICE daily

(max 25mg in 24hours)

>12 years10 - 25mg up to TWICE daily

(max 50mg in 24 hours)

Doses can be repeated after 45-60minutes if necessary</td></tr>
<tr><td colspan="3">With or without</td></tr>
<tr><td colspan="2">Lorazepam</td><td>Promethazine</td><td colspan="2"></td></tr>
</table>

Continue talking and using non-drug approaches . See next page for 3rd line Intramuscular therapy

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<table>
<tr><td colspan="3">3rd: INTRAMUSCULAR THERAPY-

Consider if patient refuses oral/ by previous clinical response/ oral ineffective or effect essential within 30 mins* of administration</td></tr>
<tr><td>Psychotic Illness &/ Confirmed history of Antipsychotics use

Consider PRN Procylidine[18] by intramuscular injection(IM)to treat acute dystonias and extrapyramidal side effects(EPSE) such as laryngeal spasm or orally(PO) for less acute dystonias/EPSE). These can occur with any antipsychotic. See page 13 for doses</td><td colspan="2">Non-Psychotic Illness and / No history of Antipsychotics use</td></tr>
<tr><td>Olanzapine[3,4] (IM) Onset of action 15-30mins

<12yrs-not appropriate

>12yrs 2.5-10mg max 10mg in 24hours (Possibly increased risk of respiratory depression when administered with benzodiazepines ,allow one hour between IM Olanzapine and IM Lorazepam)

Haloperidol[5](IM) Pre treatment ECG required.

Onset of action 20-30mins

<12 years 0.025-0.075mg/kg/dose(max 2.5mg per dose and in 24hrs)

>12 years 2.5mg to 5mg (max 5mg in 24hrs)

With or without: Promethazine</td><td>Lorazepam[1]*(IM)(kept in fridge)

Onset of action=20-40mins

<12 yrs 0.5mg – 1mg

>12yrs 0.5mg – 2mg

max 4mg/24hrs

Doses can be repeated after 30 to 60minutes if necessary

Intravenous Flumazenil should be available</td><td>Promethazine(IM)[2]

Onset of action up to 60mins

<12yrs:5mg-25mg (max 50mg/day)
>12yrs:25mg-50mg (max 100mg/day)

Doses can be repeated after 30 to 60 minutes if necessary</td></tr>
<tr><td colspan="3"></td></tr>
</table>

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AGENDA ITEM
9.1.6

QUALITY & SAFETY COMMITTEE

CWM TAF MORGANNWG CARERS END OF YEAR PROGRESS REPORT 2022/23

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cerys Gamble, Carers Coordinator, Cwm Taf Morgannwg University Health Board
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
CTM Carers Partnership Group	(07/02/2023)	ENDORSED FOR APPROVAL

ACRONYMS	
CBC	County Borough Council
CTM	Cwm Taf Morgannwg
CTMUHB	Cwm Taf Morgannwg University Health Board
IMTP	Integrated Medium Term Plan
WG	Welsh Government

1. SITUATION/BACKGROUND

1.1 In 2019, Cwm Taf Morgannwg (CTM) Carers Partnership Group was established with member and senior officer representatives from across Bridgend County Borough Council (CBC), Rhondda Cynon Taff CBC, Merthyr Tydfil CBC, Cwm Taf Morgannwg University Health Board (CTMUHB) and the Third Sector. The CTM Carers Partnership enables the Local Authorities and the Health Board to work together to promote the wellbeing of carers and develop services to address the support needs of carers in the local population, as required under the Social Services and Wellbeing Act (Wales) 2014, which came into force in April 2016.

1.2 In 2019/20 the CTM Carers Partnership developed a Carers Statement of Intent which has five aims:

- Aim 1: Identifying Carers of all ages and recognising their contributions
- Aim 2: Providing up to date, relevant and timely information, advice & assistance to Carers of all ages
- Aim 3: Providing support, services & training to meet the needs of Carers of all ages
- Aim 4: Giving Carers of all ages a voice, with more choice & control over their lives
- Aim 5: Working together to make the most of our resources for the benefit of Carers of all ages.

1.3 The following three National Priorities for Carers in 2020/21 were identified:

1. Supporting life alongside caring – all Carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care, and to have a life beyond caring;

2. Identifying and recognising Carers – fundamental to the success of delivering improved outcomes for Carers is the need to improve Carer's recognition of their role and to ensure they can access the necessary support;

3. Providing information, advice and assistance – it is important that Carers receive the appropriate information and advice where and when they need it.

4. Supporting unpaid carers in education and the workplace - Employers and educational/training settings should be encouraged to adapt their policies and practices, enabling unpaid Carers to work and learn alongside their caring role.

1.4 In March 2021, Welsh Government (WG) launched the new Strategy for Unpaid Carers which represents their renewed commitment to improving the recognition of and support to unpaid carers in Wales. It set out WG's revised national priorities for unpaid carers, including the addition of a new priority on education and employment.

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

2.1 The responsibilities of the CTM Carers Partnership includes the commissioning of services for carers using the WG Carers Grant which is allocated to Health Boards across Wales on an annual basis (the value of which for CTM Region in 2022/23 was £161,000.00).

2.2 Appendix 1 contains the CTM Carers End of Year progress report 2022/23. The CTM Carers End of Year Progress Report reflects eligible activity that WG had set in the terms of the grant:

1) **Supporting Carers in General Practice**
Working with your partners, through the primary care clusters, to implement a scheme that supports health professionals working in primary care and community care to develop their Carer awareness and understanding of how to identify Carers, the issues that Carers face and ways of working to better support Carers.
2) **Discharge from Hospital Planning**
Taking steps to support and engage Carers in the patient's discharge planning, for example better information, advice, involvement and assistance provided to all Carers when the person they care for is discharged from hospital.

2.3 The development of services for Carers is a key element of the CTMUHB IMTP 2020-2023 and the Annual Plan 2022/23. The Carers End of Year Progress Report shows that despite challenges from the Covid Pandemic, we have continued to drive forward and implement projects. Some organisations have had to adapt their working practice due to the restrictions of the pandemic, for example, the mode of delivery of support groups changed to virtual meetings. The CTM Carers Partnership Group has continued to meet and key leads for Carers across the region have also held regular meetings. Working with partners, the Partnership Group has continued to

provide relevant, timely information for Carers and staff delivered virtually through the Carer Champion Network which includes GP surgeries and community pharmacies. There has been the continued development of a pilot project, working closely with partners in the third sector, to support Carers of all ages within a hospital (acute and community) setting particularly around discharge planning. This project has been extensively promoted virtually and has responded to the increased mental health and financial impact upon Carers.

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

3.1 In 2023/24, we continue building the recovery of Carers Services in CTM. Lockdown for Carers added pressure to their roles and this is likely to increase demand on services. The CTM Carers Partnership Group is aware of this and the Partnership will work with them in supporting organisations across the CTM region.

3.2 CTMUHB will continue to work with partners to deliver national priorities to further improve the support available to Carers by focusing on issues that matter to them. This includes supporting carers to have a life beyond caring; identifying, recognising and supporting carers so that they can continue to care; and providing information and advice when they need it.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Quality, safety and patient experience is a major theme underpinning the development of innovative, integrated service solutions (for example in mental health, older people's, children's services or Carers services.)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	A Statement of Intent (available on request) has been developed by CTMUHB, BCBC, MTCBC and RCTCBC in response to WG funding that was awarded to Health Boards in 2019-20. The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes: Staying Healthy Safe Care Effective Care Dignified Care Timely Care

	Individual Care Staff & Resources http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf The work relating to Carers takes into account many of the related quality themes.
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.
	The EIA is from the previous Cwm Taf Carers Strategy and does not reflect the new CTM working. This will be updated in due course.
Legal implications / impact	Yes (Include further detail below)
	The Planning & Partnerships Team works within a framework of statutory regulation. The Cwm Taf Carers Strategy reflects the likely impact and implications of the Well-Being of Future Generations (Wales) Act and the Social Services & Well-Being (Wales) Act. The latter has particular implications for Carers as a range of requirements and duties under the Act will affect the way their needs for care and support must be assessed and met. The SSWB Act repealed the majority of community care legislation including the Carers Strategies (Wales) Measure 2010. The new Act provides a definition of a Carer as "a person who provides or intends to provide care for an adult or disabled child" and removes the requirement that Carers must be providing a "substantial amount of care on a regular basis."
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Any resource implications to the UHB as part of the collaborative implementation of the Cwm Taf Carers Strategy and its associated Action Plans have been or will be considered as part of the prioritisation process

	underpinning the development of the 3-Year Integrated Plan. WG have provided transitional funding for 2016/17, 2018/19, 2019/20,2021/22 on the understanding that we develop proposals setting out how health, local authorities and the third sector will work in partnership to support Carers. The detailed criteria for use will be discussed at the Cwm Taf Carers Partnership Group and they will make recommendations to the Transformation Leadership Group and the SSWB Partnership Board.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

5.1 To **ENDORSE** for Board Approval the Carers End of Year Progress Report 2022/23, attached as Appendix 1.

Cwm Taf Morgannwg Carers End of Year Report 2022 – 2023

Eligible activity includes:

1) **Supporting Carers in general practice** - working with your partners, through the primary care clusters, to implement a scheme that supports health professionals working in primary care and community care to develop their carer awareness and understanding of how to identify carers, the issues that carers face and ways of working to better support carers; and

2) **Discharge from hospital planning -** taking steps to support and engage carers in the patient's discharge planning, for example better information, advice and assistance (IAA) provided to all carers when the person they care for is discharged from hospital.

1) Supporting carers in general practice

What action/ activity have you undertaken to work with partners to support health professionals working in primary care and community care to develop their carer awareness and understanding of:

- how to identify carers,
- the issues that carers face and,
- ways of working to better support carers.

Action taken

In order for services to continue to meet the need of Carers across the Cwm Taf Morgannwg (CTM) region, organisations have adapted their working practices. Bridgend County Borough Council (BCBC), Merthyr Tydfil County Borough Council (MTCBC), Rhondda Cynon Taf County Borough Council (RCTCBC) and Cwm Taf Morgannwg University Health Board (CTMUHB) continue to work collaboratively in improving support, information and recognition of Carers, whilst making best use of a wide range of knowledge, expertise and support services.

Services for Carers in CTM are provided by a range of organisations in the statutory and Third Sector. As well as accessing general services, like GP Surgeries, there are also specific services to support Carers, including young Carers and young adult Carers. These include:

- In RCT, a Carers Support project run by the Local Authority.
- Services commissioned from the Third Sector including Action for Children, Barnardos and Age Connects Morgannwg.
- A network of Carers Champions in settings across the health sector.
- In Merthyr, services to support Carers were commissioned from third sector organisations and MTCBC have appointed a Carers Coordinator.
- Across Bridgend, the Care Collective provide Information and Advice to Carers.
- Citizens Advice Bureau Merthyr Tydfil deliver a Carers Hospital Discharge project across the CTM Region.
- Marie Curie, funded via the CTM Steering Group also support carers to meet their needs through volunteers to both prevent admission to hospital and also help facilitate safe discharge.

In CTM to enable GP surgeries to identify Carers, we encourage each surgery to have a Carers Champion, a Carers noticeboard that is updated regularly and dissemination of relevant and timely Carer related information to enable swift signposting of Carers to Carers services in their area.

In addition, CTM delivered Agored Carer Awareness training, this accredited course assists learners to identify and support unpaid Carers. Training has been adapted to be delivered online with participants from community mental health and GP practices. With the easing of covid-19 CTMUHB are driving the Agored training forward and are seeing a positive response from health, GP practices and third sector organisations.

The transitional funding to support Carers provided by Welsh Government (WG) since 2016/17 to support the implementation of the Social Services and Well Being (Wales) Act 2014 (which came into force April 2016), is very welcome in maintaining the momentum of the Carer related work achieved to date.

The Cwm Taf Morgannwg (CTM) Carers Partnership Group works to prevent any negative impact on Carers services and support. The CTM Carers Partnership Group ensures the continued development and raising awareness of Carers throughout the region, meeting the increased responsibilities for partners under the Social Services Well Being Act.

CTM continue to have representation at the COLIN (Carers Officer Learning and Improvement Network) meetings with representatives from Local Authorities and CTMUHB attending.

During 2022/23 CTMUHB, Bridgend CBC, MTCBC and RCTCBC have sustained the success of the previous years and continue to work collaboratively in improving support, information and recognition of Carers. This CTM end of year report highlights the key areas of work and provides examples of the progress made.

Following discussion with colleagues from Bridgend CBC, MTCBC, RCTCBC, Bridgend Association Voluntary Organisation (BAVO), Interlink Rhondda Cynon Taf, Voluntary Action Merthyr Tydfil (VAMT), the CTM Regional Planning Board (RPB) and CTMUHB – recommendations were made to the CTM Carers Partnership Group and then approved by the RPB's Transformation Leadership Group in the allocation of the 2022/23 Welsh Government's Carers Grant.

£161,000.00 of the WG Carers funding was allocated through an application process. Organisations were able to bid up to £55,000 of projects to engage with Carers of all ages. The successful projects are listed below:

Name of organisation	Project Name	Outline of project/Areas included	Duration	Funding Received
CTMUHB	Carers Co-ordinator	The Carers Co-ordinator will work across the region with GP practices, hospitals etc. and engage with Local Authorities and Third Sector organisation assisting them to identify Carers in the community and support carers within the hospital discharge process.	1 year	55,000
Citizens Advice Merthyr Tydfil (CAMT)	CAB4Carers	CAMT will deliver a bespoke service focussing on Carers: • Hospital Discharge • Ongoing support in the community This will be delivered across the region.	1 year	45,989
Marie Curie		Marie Curie sitting service		35,002

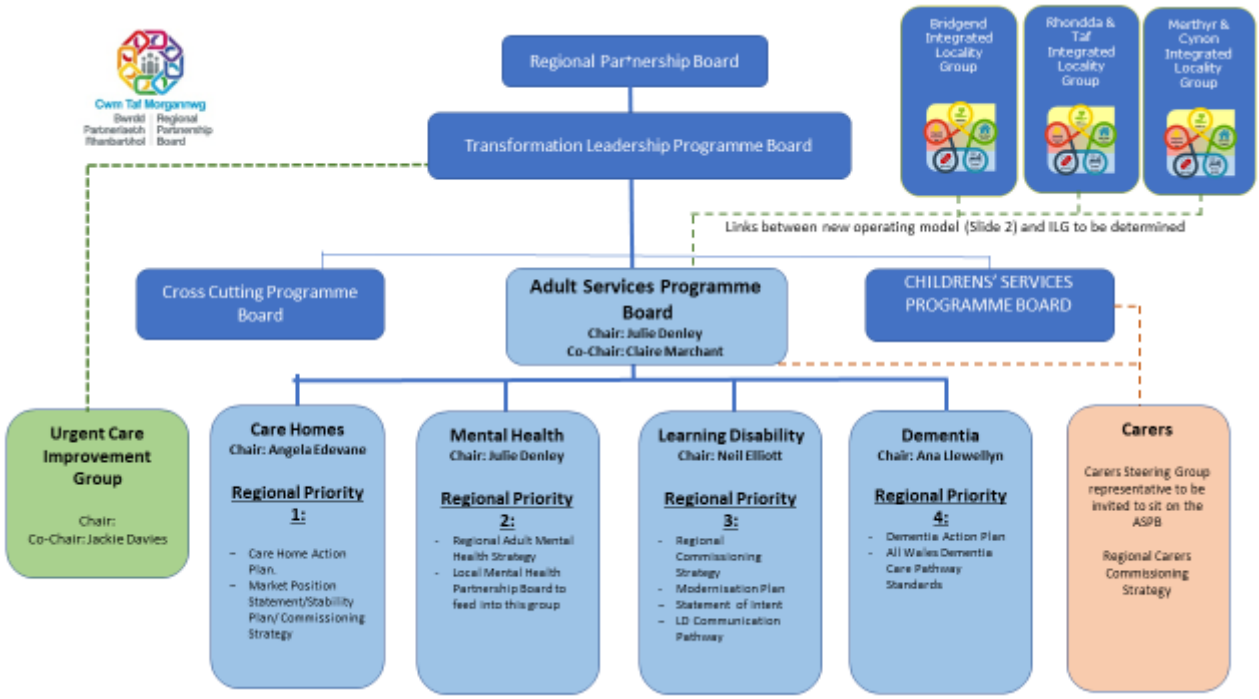
ASD Rainbows	Rainbows families	This project will employ a Family Outreach Worker to work across CTM. They will carry out community work with families offering the individualised support needed to enable families to access community activities/support. They will also run a parent and child group for a year.	3mths	6,923
MTCBC	Barnardos	MTCBC with Barnardos supports opportunities for Young Carers to socialise with other Young Carers outside of school and offers opportunities to be active and go on holidays without the people they care for.	1 year	5,000
RCTCBC	Carers Support Project	A bespoke counselling service to support young Carers during the Covid-19 pandemic	1 year	5,000
Bridgend County Borough Council	Bridgend County Borough Council	Aims to set up a young Carer network in Bridgend giving young Carers a voice and delivery of service	1 year	5,000
Cwm Taf Morgannwg UHB	CTMUHB	Reprint of Hospital Discharge information		3,000

Please explain:

How you have **worked with partners** to implement and deliver improved support for carers?

The Cwm Taf Morgannwg Carers Partnership Group

The CTM Carers Partnership Group was established in 2019 and oversees the CTM Carers Statement of Intent. The governance of the partnership has been reviewed by the CTM RPB. The CTM Carers Partnership will report to the Adults Services Programme Board that sits underneath the RPB's Transformation Leadership Programme Board.



The CTM Carers Partnership Group has met during 2021-22. Currently membership consists of: Bridgend CBC, Merthyr Tydfil CBC, RCT CBC, VAMT, BAVO, Interlink, Citizen Advice Bureau RCT, CTM MIND, a Carer representative and CTMUHB.

Statement of Intent for Carers

Following the end of the Cwm Taf Carers Strategy on the 30th March 2019, CTMUHB, in partnership with BCBC, RCTCBC and MTCBC produced a Statement of Intent for Carers.

The CTM Carers Partnership Group await guidance from WG on their proposed Action Plan and the Ministerial Advisory Group as to whether there will be a requirement to produce a regional Carers Strategy or a regional Action Plan to implement WG proposals.

CTM Carers A-Z Guide

CTMUHB has sustained the delivery of A-Z Carer Guides across our region. This resource is available online or hard copy and has proven to be a valuable resource for organisations and Carers living in the CTM region. Copies have been sent to GP practices and outpatient departments on all Acute General Hospital sites.

Rhondda Cynon Taf County Borough Council

Leadership there are interim arrangements in place with a new, (temporary) service manager. The post has responsibility for all carers, including young carers, sibling carers, young adult carers, parent carers and adult carers; as well as direct payments and service user engagement. The CSP co-ordinator is currently on secondment, so the service manager is also responsible for the day-to -day management of the project at the moment.
Young Carers - Action for Children successfully tendered for the Young Carers Contract, and continue to be the commissioned service that delivers activity-based support to carers under eighteen within RCT. (The assessment element of young carers continues to sit within Children's Services) Action for Children are now co-located with the CSP, allowing joint working. As part of the new contract, Action for Children now have responsibility for the Sibling Carer support, which was previously held within the CSP team. Our young carers support, which is provided via Action for Children, run regular age-specific groups in

each of the three localities (Rhondda, Cynon and Taf) for young carers. During 22/23 110 groups or events were offered to a total of 421 young carers.
The CSP continues to deliver high quality information, assistance, advice, and signposting to carers throughout Rhondda Cynon Taf. The variety of support offered by the service aims to best support Carers with varying circumstances and needs, providing them with information, advice, and signposting, whilst supporting a life outside of their caring role. The project offers regular support groups every month with additional workshops and training events. In 22/23, CSP provided a total of 102 training sessions, workshops, and events to adult Carers, which resulted in 1976 Carer attendances.
Young adult carers age 18 to 25, (YACs) continue to receive specific support via a dedicated YAC worker. Our primary focus is to improve emotional wellbeing and resilience, however the support offer for this particular group has been reviewed and is now more targeted and bespoke. The YACs have their own constituted group called CASE through which they are able to apply for external funding for activities. In 22/23, as well as the individual support, our YACs were offered a total of 32 events, involving 108 YACs. (These are YAC specific events, they are also able to access all events offered via the main CSP).
CSP facilitated a very successful event to celebrate Carers Rights Day with seventy-four unpaid carers, sixteen working cares and twenty-seven information stalls. This is higher than any other CRD events we have previously facilitated.
Feedback was very positive, and the event raised awareness of carer services in RCT.

Bridgend County Borough Council

Young Carers

With regard to young carers support, there have been 77 additional young carers assessments since April 2022 and young carers connected into additional support, some into a range of supportive opportunities. There were 27 instances where no additional support was needed or wanted. Partners signposted included Action for Children, Barnardo's, BCBC Early Help and the Young Carers in Schools project.

The coordination of support for young carers is based within the Safeguarding and Family Support Service within the Multi-Agency Safeguarding Hub (MASH). The service is able to connect young carers into a range of internal and external support.

A specific support programme for young carers is being operated by Whitehead Ross and being funded via Welsh Government anti-poverty investments. This programme supports referrals via the Young Carers Coordinator following a carers assessment with a short-term intervention.

The interventions can include youth engagement activities (wellbeing, arts, workshops etc.) and also one to one support sessions in outreach or centre-based settings. A maximum of 18 young carers are supported over eight-week periods providing respite and lifestyle, and wellbeing interventions. On completion of the programmes, any residual needs are reviewed and connections to broader opportunities explored.

Since 2020, the Prevention and Wellbeing service has supported a number of programmes and activities for young carers and young adult carers. This has included the launch of the national Young Carers card, developing a young carer-led network and supporting community-based engagement opportunities:

- A series of young carers "You are valued" days to support friendship groups has seen 170 participants and there have been 11 awareness-raising events.

- Young adult carers are supporting the development of the Young Carers Network which has attracted 70 participants and advocacy resources and campaigns have been co-created. Young carer ambassador roles are developing.

- The Carers Network has engaged primary and secondary schools, Bridgend Carers Centre, Whitehead Ross, Bridgend Inclusive Network Group, Bridgend College and the Council.

- The network has helped to distribute 280 young carers' identity cards and the Council has been developing partnership working with 8 local businesses to add value to the card.

Bridgend Carers Wellbeing Service

Since 2019, the Council has supported a Carers Wellbeing Service delivered by the Care Collective to support unpaid carers to maintain their wellbeing and have a life beyond caring in addition to providing practical support and share information and advice. This has supported four roles actively supporting people in communities.

By the end of March 2022, the service had supported 5850 beneficiaries . This approach has been successful in helping to identify those previously not identified as unpaid carers with 47% previously not known.

This partnership approach conducted 1400 'what matters' conversations and was able to share information and connect people to community support in the majority of instances.

For much of this period, services and support have needed to be delivered flexibly and creatively through the pandemic and in line with national restrictions. This lower-level support in addition to reducing demand has been able to escalate required support also where a need is identified.

Halo

- Through the Healthy Living Partnership, joint working with Halo Leisure has further developed community support opportunities for unpaid carers.
- The Carers Wellbeing and Respite programme has created a six-week intervention focused on improving wellbeing, knowledge and confidence.

- Information sessions have been integrated involving BAVO, Care and Repair, Alzheimer's and Carers Trust.

- 80% of carers reported increased physical activity, 100% were confident to manage nutrition, 100% felt able to manage their wellbeing and 87% felt more knowledgeable about their rights and entitlements:

"I *have met some lovely people…. all unpaid carers themselves, who understand what I am going through and felt great support from speaking to them".*

- The Feel Good for Life programme has been supporting people with a cognitive impairment or dementia and their unpaid carers and Halo have secured 5 years of investment. A hundred unpaid carers are regularly supported.

- Digital approaches have been successfully developed including loan equipment and training with weekly streamed opportunities to help carers to remain connected.

"*You have no idea how much this session means to us and the effort you put into it. It gives us something to look forward to every week".*

- Beyond this, carers have been supported via free access when accompanying the cared for person and cost-effective access arrangements to transition into broader opportunities.

Merthyr Tydfil County Borough Council

Throughout 2022/23, partners in the region built upon the success of the previous year and continued to work collaboratively together and with other stakeholders in improving recognition of Carers and providing appropriate information and support.

Key areas of work that were undertaken were:

- Worked with partners to deliver the annual Action Plan.
- Continued work with the Cwm Taf Morgannwg Partnership Group to oversee implementation of the Strategy, reporting to the SSWB Partnership Board.
- Carers short breaks Welsh Government grant

- Carers support hubs and groups
- Carer support contract re-evaluated by carer coproduction to retender to provide a service for carers that is not diagnosis pacific.

Worked with Third sector partnership work within Merthyr Tydfil to deliver:

- MIND CTM Carers STAR project providing preassessment and services to carers with poor mental health and wellbeing.

- VAMT community coordinators provided information, advice and signposting to local community groups, activities and services.

- Merthyr college hair and beauty section to provide carer wellbeing days.

- Funding was secured by Citizens Advice Bureau to create the CAB for Carers project and carers information hub that can be utilised by third sector and LA for work with carers.

We have been working to provide support in alternative ways such as direct payments and more sitting services in the person's home

We recognise the need to support carers and in order to do this we have needed to seek alternative ways of engaging with them to develop and evaluate new services and the following are now in place:

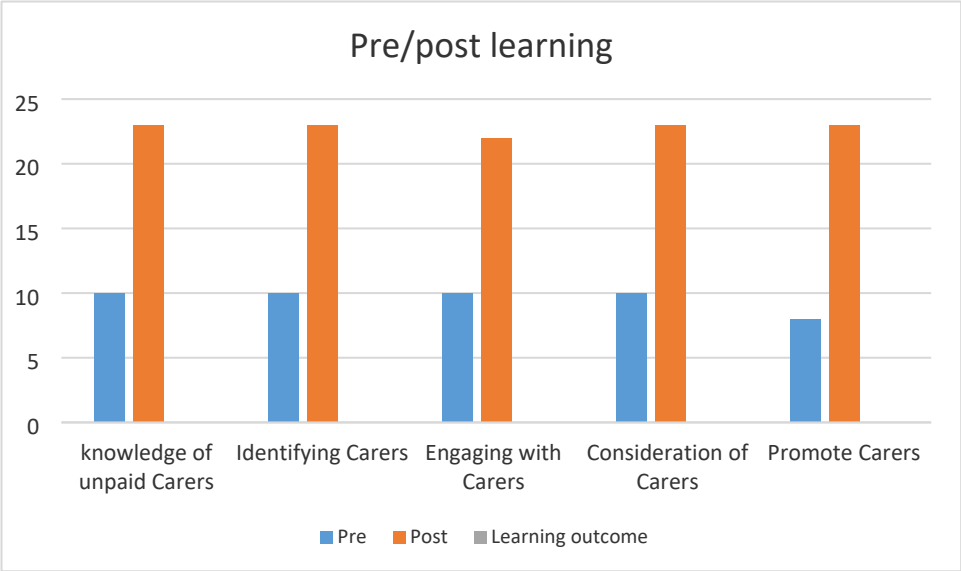
- The Carers Officer has been undertaking coproduction work with carers to understand what carers needs currently are.
- A well-established social media group for carers in Merthyr Tydfil to share up to date information from the Local Authority and our third sector partners.
- Funding acquired for carers to access short breaks away from their caring role.
- Review of the current carers assessment to identify what needs to change for it to be more carer friendly.
- Review and development of the regional carers strategy (ongoing).
- Development of a local carers strategy for Merthyr Tydfil carers
- Worked with our WCCIS team to identify how many carers have had carers assessments undertaken and work on promoting these.

How you have **measured success** using qualitative and quantitative data, (including the number of General Practices registered/compliant)

Using course feedback forms we have been able to evidence the benefit of the Agored training in GP surgeries (graph 1)

There is a stark difference in the pre and post course knowledge which demonstrates GP surgeries who have undertaken training are more knowledgeable in recognising, identifying and supporting unpaid Carers.

Graph 1



Annual Action Plans

The CTM Carers Action Plan is not a fixed and final plan, but a framework which sets out work to be taken forward over 2023/24. The Action plan is developed with detailed key actions, lead responsibilities, timescales, resource implications and performance measures, which will focus on the outcomes we (the partners) want to achieve. This may change going forward to achieve a more strategic plan across CTMU HB with the support of the RCT/BCBC/MCBC due to the funding distribution being allocated through the Regional Integrated Fund (RIF) from April 2023.

Outcomes we want to achieve and monitoring progress

The success of this Action Plan and the benefits it delivers will be reviewed regularly. It will be a partnership plan and a variety of staff within a wide range of sectors will be responsible for working in collaboration to implement it effectively.

An annual report on progress of the action plan will be reported to the CTM Transformation Leadership Programme Board, as well as the individual organisations i.e. the three Local Authorities, CTMUHB and WG.

Feedback from carers who have accessed and used these services.

We received this case study from the Citizen Advice Bureau Merthyr Tydfil's Carers Hospital Discharge Project called "CAB4Carers":

…. is a carer for her husband, …. Both have health conditions. Over the last few months …..health has deteriorated and he has spent a number of nights in hospital. Whilst visiting, …… was given the CAB4Carers number. We advised …… that she needs to contact her GP and let them know she is a carer. "Does your GP surgery know you are a carer?" Carers A-Z guide to provide details of some extra support services …… and her husband were assisted to make claims for Attendance Allowance (AA) - an extra £9,500 each year. ….. now uses his extra income to get a taxi to see some of his friends who live "up the valley". ….. stated the money has been life changing - paying for someone to come and do cleaning jobs in the house. They both said their well-being had massively improved due to our input.

Specific questions to be addressed:

What awareness raising has been undertaken with practice staff (all professions) on the needs of carers, including young carers?

Cwm Taf Morgannwg Carers Co-ordinator

In CTMUHB, there is a Carers Co-ordinator who:

- Attends public and virtual events such as the Health & Wellbeing forum
- Delivers Agored training to health and third sector organisations.
- Produces promotional materials and merchandise.
- Attends Senior Nurse meetings to promote the role of a Carer.
- Organises the annual Carers conference
- Facilitates TCM staff carer network ensuring staff are supported in their caring responsibilities.
- Uses social media as an information sharing platform
- Attended D2RA task & finish groups to ensure carers were represented
- Facilitates carer champion network, sharing information with primary, secondary health, third sector organisations.

The CTM Carers Co-ordinator has continued to send Carers Champions based in the GP practices information to inform them of any relevant and timely Carers information.

Carers Conference

Due to the Coronavirus pandemic there was no Carers conference in 2022-23. This is an event we hope to achieve in 2024.

Awareness Sessions

CTMUHB and partners have continued to make progress in raising the awareness of Carers of all ages. This has been done through social media and press releases.

Cwm Taf Morgannwg Intranet/internet page

CTMUHB have a designated Carers page in the intranet for internal staff to access the latest information, advice and support. We recognise an organisation of our multitude have a high number of Carers and promote the CTMUHB Staff Carers Policy.

CTMUHB also played an integral part in raising awareness of the Covid Vaccine for Carers across our region through information on webpages, social media and fielding telephone calls from Carers.

GP Support Officers (GPSO)

Merthyr Tydfil Primary Care Cluster have GP Support Officers (GPSO's) who engage, signpost, offer advice and work with patients to influence cultural and behavioural change for service users within a Primary Care setting. They advise/assess service users and address social issues and offer support. They promote independence and enable service users to take responsibility for their own health and wellbeing. GPSO's support the reduction of attendance within general practice for non-medical intervention and will make referrals to Merthyr Tydfil CBC and the Third Sector.

GPSO's, during consultations, have often identified Carers who have not identified themselves as a Carers (they are a family member that feel it is their duty to look after their relatives). This cohort of service users were not claiming carers allowance or receiving any support from any groups, such as Alzheimer's or Stroke Society.

GPSO's have been able to support these Carers by identifying what is causing stress and putting some extra support and ensuring the correct financial assistance are put in place. They also ensure links with the relevant agencies and particularly ensuring the required adaptations are made at home.

How many General Practices / health centres have implemented Investors in Carers, something similar, or are planning to implement this accredited scheme?

AGORED Cymru

The CTM Carers Co-ordinator encourages GP practices to enrol on the Carer Awareness AGORED Cymru training course. The course is a tool which GP practices can access to develop their awareness of Carers and how they can be supported within the community.

There are currently 0 learners registered for the Agored training and 7 have completed. Learners are from health, GP and third sector organisations.

Regular updates are posted on social media and internally to inform Carers what is available to them, there is also a designated Carers page in the internet which provides information for staff who are Carers. This also promotes and encourages Carer champions to be identified throughout clinical settings, we currently have 61 Carer Champions registered who are sent regular bulletins on carer events and information which they can promote in their area of work.

How and what specific support are General Practice staff providing to carers?

GP Leaflets

The Carers Co-ordinator has designed and distributed Carer booklets to GP Practices which has a registration form enabling a Carer to complete and hand to their Carer Champion. This has encouraged Carers to self-identify and engage with their GP surgery. These are available to all GP surgeries across the region.

Carer Notice Boards

Each surgery signed up to the Agored training is given a Carers Notice Board that is updated by the Carers Champion monthly. There is also a Carers Champion poster to notify patients who their Carers Champion is. Relevant information has continued to be disseminated throughout the pandemic.

Carers Champion Badges

Each Carers Champion wears a badge so they are easily recognisable to patients.

Primary Care Communications Lead

The Carers Co-ordinator has liaised with key personal in Primary Care to promote good practice by using case studies of the Carer related work being undertaken in GP surgeries across CTM.

What are the tangible outcomes for carers?

All of the positive outcomes as previously mentioned throughout the report.

What signposting arrangements are in place within the General Practice to enable carers to access other support where needed e.g. third sector helplines, websites or local carers services?

Each GP surgery has a designated Carer Champion who has been issued with a Carers notice board. This is regularly updated by the Carer Champion with information on what events or services are being held in their locality. They also have posters displaying who their Carer Champion is for their surgery.

The CTMUHB Carer's Co-ordinator also sends timely and relevant information they may find beneficial. If there is a specific request that Carer Champions may not know where to signpost, they are able to contact the CTMUHB Carer Co-ordinator for advice. There are also community coordinators in each GP surgery which Carer Champions are able to signpost Carers for further information and advice. GP surgeries also use their television monitors to inform patients of Carer services.

2) **Discharge from hospital planning**

What action/ activity have you undertaken to support and engage carers in the patient's discharge planning? For example: better information, advice and assistance (IAA) provided to all carers when the person they care for is discharged from hospital.

Action taken

Carers Hospital Discharge Project

Citizens Advice Bureau Merthyr Tydfil are currently commissioned to deliver a hospital discharge service across the CTM region. A weekly presence on all three DGH insures staff and visitors are provided with up to date information. Over 2022-23 CAB4Carers have built a good rapport with hospital staff. Due to lack of office space there is no facility where CAB are able to confidentially meet with carers therefore, it is reliant on the carers contacting CAB at a later date to arrange a consultation.

CTMUHB have produced a carers guide for hospital discharge. These are bilingual and available as a PDF download on the health boards intranet and internet and limited hard copies.

Please explain:

How you have **worked with partners** to implement and deliver improved support for carers

By increasing our engagement network we have been able to establish good working partnerships with more departments within Local Authorities and other third sector organisations.

For young Carers we have sustained our partnership with Barnardos, Merthyr Tydfil.

On Carers Rights Day we raised awareness of Carers of all ages on our social media platforms. This was in place of the information stands in each of our general hospitals with third sector organisations that would have normally been held. These information stalls enable our partners to promote their services to Carers.

How you have **measured success** using qualitative and quantitative data, (including the number of General Practices registered/compliant)

Throughout Merthyr Tydfil, Rhondda Cynon Taf and Bridgend there is a total of 80 General Practitioners. All were sent letters inviting them to nominate a Carer champion and the opportunity to undertake the AGORED training. We had an initial response from 18 requesting more information.

From these, 10 practices enrolled staff to undertake the training, in total 13 staff (with some practices putting two through training). To date we have successfully certificated 7 learners (2022-23) In addition we send letters to all 80 General Practitioners, dentists, pharmacies and opticians on a regular basis to try to engage them further and increase nominations for this course.

Feedback from learners indicates the learning has given them the confidence to approach a "What matters" conversation with Carers and they feel more confident identifying Carers. Largely due to the training course they are able to signpost Carers for additional support and advice.

Specific questions to be addressed:

Have hospital procedures regarding patient discharge been adapted, or introduced, to improve staff awareness of, and input from carers?

CTMUHB are currently delivering Agored Carer Awareness training to the Mental Health services. This training is scheduled until June 2022 ensuring all staff are captured. Early feedback form learners is positive and are identifying ways in which they can adapt services to increase Carer support.

How are carers being proactively involved in the hospital discharge/discharge plans for the patient?

If Carers are identified by clinical staff, they can be referred to our hospital discharge project. This will give the Carer the opportunity to raise any concerns they have regarding the service user being discharged.

It may be they require additional support or home adaptations. If identified these issues could be addressed before discharge, therefore giving the Carer more confidence to continue with their caring role at home and possibly reduce the need for re-admission.

We continue to make the links with other projects being run from the hospital setting, such as Care & Repair and Age Connects Morgannwg.

Are carers being pro-actively signposted to third sector support or local authority social services for information, support, or to obtain a carers needs assessment (as appropriate), as part of the patient's discharge process?

Since April 2021 Cab4Carers have identified and signposted 168 Carers for further support.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

AGENDA ITEM 9.1.7

QUALITY & SAFETY COMMITTEE

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

DATE OF MEETING	25 July 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 15 June 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, approve and monitor delivery against the health and Safety priority action plan and ensure compliance with the relevant standards for Health Services in Wales.

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

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

3. HIGHLIGHT REPORT

ALERT / ESCALATE	Nil
ADVISE	• The **Assistant Director of Health, Safety & Fire Report** was received. A number of queries were raised against the open risks and it was requested that a discussion was held outside the meeting in relation to ensuring there was appropriate Care Group representation at future meetings to provide responses to the questions being raised; • The **Health & Safety Performance Report** was received. Members raised concerns in relation to the low levels of compliance for the use of equipment which stood at 13.27%. Members were assured that staff would have received initial training on the use of equipment and were out of date with refresher training only. Concerns were also raised in relation to low levels of compliance for manual handling training amongst nursing and midwifery staff and members expressed the importance of ensuring staff were appropriately trained to limit the risk of injury occurring; • Members received a **Spotlight Report on Manual Handling Training Compliance.** Members noted that the Business Case for additional Manual Handling resource had recently been approved which would help to address some of the challenges being experienced;

	• The **Fire Safety Report** was received. Members noted that the risks highlighted at the last meeting in relation to patients being placed in areas that were blocking fire exits had now been addressed and the risks had now been removed. Members noted the ongoing issues being experienced in relation to Fire Training Compliance, and noted that it was the responsibility of Senior Management Teams within Care Groups to ensure their staff were appropriately trained in statutory and mandatory training; • The **Organisational Risk Register** was received and noted; • The **Care Group Health, Safety & Fire Report** was received. Members noted that an operational Health, Safety & Fire Group was in the process of being established which would report into this Sub-Committee. A discussion was held in relation to smoking on hospital premises and whether the ban put in place previously applied to Mental Health. Members noted that agreement had previously been given to allow some smoking in designated areas within Mental Health, some of which were not 10m away from a building. Members noted that that the South Wales Fire & Rescue Service are scrutinising false alarm calls to establish whether they were as a result of tobacco smoke or vaping.
ASSURE	• The **Estates Safety & Compliance Report – Electrical Safety Compliance** was received. Members welcomed the reasonable assurance rating that had been allocated to the review, with one area obtaining substantial assurance.
INFORM	The following items were received for approval/noting via the consent agenda: • Unconfirmed Minutes of the Meeting held on the 7 March 2023; • Health, Safety & Fire Sub Committee Annual Report 2022-2023 (minor grammatical changes have been made since the report was endorsed at the June meeting); • Health, Safety & Fire Sub Committee Forward Work Programme.
APPENDICES	**NOT APPLICABLE**

4. RECOMMENDATION

4.1 The Quality & Safety Committee is asked to **NOTE** the report and **APPROVE** the Health, Safety & Fire Sub Committee Annual Report for 2022/2023.

Appendix 1

Health, Safety & Fire Sub Committee

Annual Report 2022-2023

HEALTH, SAFETY & FIRE SUB COMMITTEE
ANNUAL REPORT 2022-2023

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Quality & Safety Committee and reviews the work the Health, Safety & Fire Sub Committee, for the financial year 2022-2023.

During the year, I have received a wealth of support from members Nicola Milligan, IM Trade Union Lead and James Hehir, IM Legal Lead and Vice Chair of this Sub Committee. Their skills and experience have supported the Sub Committee to deliver its important role in providing assurance to the Quality & Safety Committee with regard to health, safety and fire related activity.

My sincere thanks also go to Hywel Daniel, Executive Director for People and Chris Beadle, Assistant Director of Health, Safety & Fire, for their significant contributions. I would also wish to extend thanks to colleagues within the Corporate Governance Team for their support throughout the year.

Going forward, the Sub-Committee will continue to pursue a full programme of work covering health, safety and fire activity with the aim of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

Dilys Jouvenat
Chair of the Quality & Safety Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

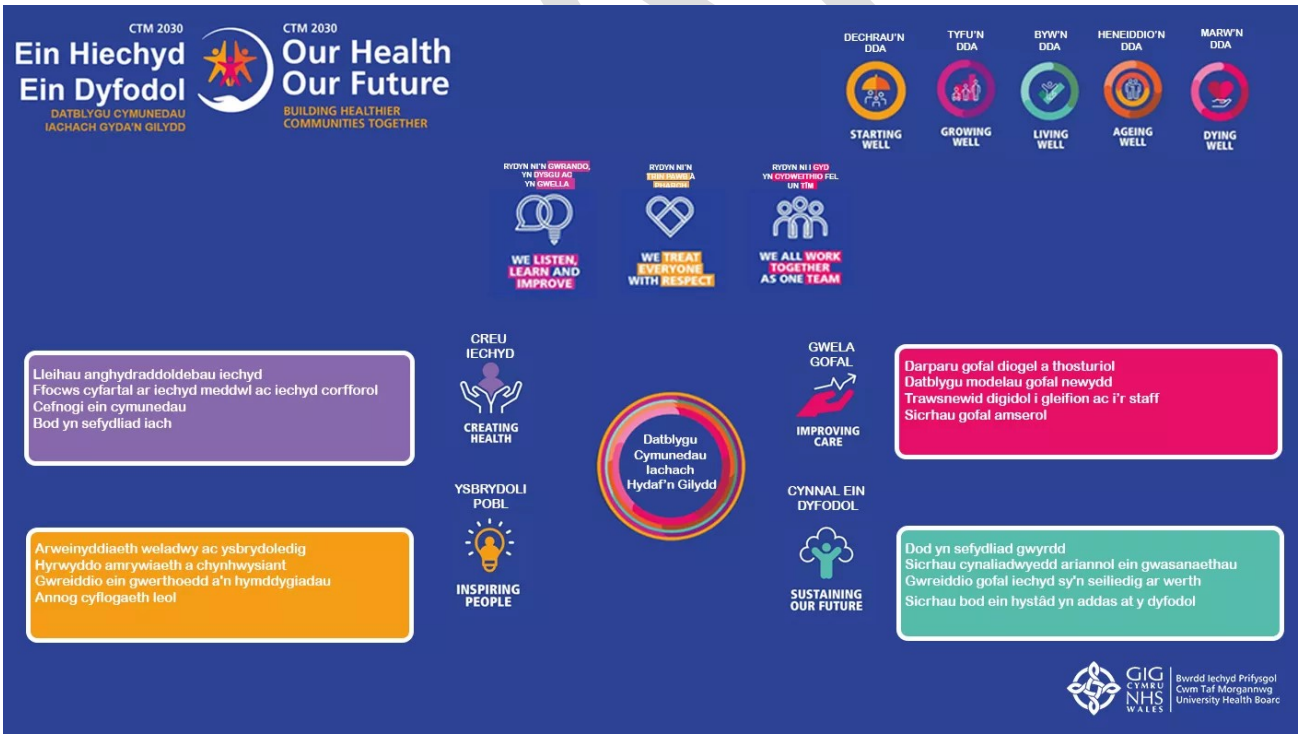
The purpose of the Health, Safety & Fire Sub Committee "the Sub Committee" is to:

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

- Encourage strong leadership in health, safety and fire, championing the importance of a common sense approach to motivate focus on core aims distinguishing between real and trivial issues.

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

The Sub-Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.



The Sub-Committee meets quarterly, with the key function to provide scrutiny on behalf of the Quality & Safety Committee on all matters relating to Health, Safety and Fire.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Sub-Committee is to support the Board through the Quality & Safety Committee with regard to its responsibilities for health, safety and fire:

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

3.2 MEMBERSHIP

The membership of the Health, Safety & Fire Sub-Committee comprises of three Independent members, enabling the Sub-Committee to provide robust scrutiny and assurances to the Board as appropriate through the Quality & Safety Committee.

A summary of the Independent membership during 2022-2023 is outlined in table 1 below:

Table 1 – Composition & Membership of the Health, Safety & Fire Sub- Committee Apr 2022-March 2023

Name	Period
Members	
Dilys Jouvenat (Sub-Committee Chair) Independent Member	April 2022 – March 2023
James Hehir (Vice Chair) Independent Member	Apr 2022 - March 2023
Nicola Milligan Independent Member	Apr 2022 – March 2023

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2022-2023

During the year, the Sub-Committee met on three occasions. All meetings held during 2022/2023 were quorate as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2022-2023

In Attendance	5 May 2022	12 Oct 2022	7 Mar 2023	Total
Dilys Jouvenat – Independent Member Chair of the Committee	✓	✓	✓	**3/3**
James Hehir – Independent Member (Vice Chair of the Committee)	✓	x	✓	**2/3**
Nicola Milligan – Independent Member	x	✓	✓	**2/3**

3.4 ATTENDEES

The Sub-Committee's work is informed by reports provided by leads within CTMUHB, colleagues from these areas are invited to attend each meeting of the Health, Safety & Fire Sub-Committee. Invitations to attend the Sub-Committee meetings are also extended, where appropriate and on an 'ad-hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

4. HEALTH, SAFETY & FIRE SUB COMMITTEE BUSINESS

The Health, Safety & Fire Sub-Committee provides an essential element of the Health Board's overall assurance framework. The meetings continued to be held virtually via Microsoft Teams during 2022-2023 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the 'Main Agenda' were discussed during each meeting. The Health, Safety & Fire Sub Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2022-2023 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards

Key risk areas from the Health, Safety & Fire Sub-Committee are highlighted at the Quality & Safety Committee by the Sub-Committee Chair via a highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Sub-Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Sub-Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Sub-Committee and from the Sub-Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference;
- Committee Annual Report;
- Highlight Reports from the Sub-Committee to the Quality & Safety Committee meetings;
- Committee Self Assessment
- Forward Work Programme.

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

7. ASSURANCE TO THE BOARD/QUALITY & SAFETY COMMITTEE

The Health, Safety & Fire Sub Committee considers, that on the basis of the work completed by the Sub-Committee during 2022 -2023, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2023-2024 and beyond ensures that the Sub Committee retains scrutiny on key areas of activity.

The Forward Work Programme has continued to be presented to each meeting of the Sub-Committee during 2022-2023. This supports and helps identify the key areas of focus for the Sub-Committee and is one of the key components in ensuring that the Sub-Committee is effectively carrying out its role. It also facilitates the management of agendas and Sub-Committee business.

8. LINKS WITH OTHER COMMITTEES

The Health, Safety & Fire Sub-Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Quality & Safety Committee and Audit & Risk Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are presented to the Quality & Safety Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the

Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

APPENDIX 1

1. Preliminary Matters

This included the apologies for absence, welcome and introductions and declarations of interest.

2. Consent Agenda

During 2022 – 2023 the following items were received on the Consent Agenda for Approval/Endorsement:

- Unconfirmed minutes;
- Sub Committee Terms of Reference.

During 2022 – 2023 the following items were received on the Consent Agenda for Noting/Information

- Sub-Committee Action Log;
- Forward Work Programme.

3. Main Agenda

During 2022 – 2023 the following items were received:

Health & Safety Executive Review of Maesteg Incident Update Reports
Head of Health, Safety & Fire Reports
Health & Safety Performance Reports
Fire Safety Report
Organisational Risk Register
Spotlight Report on Bridgend ILG Health, Safety & Fire Issues
Internal Audit Review into Fire Safety Management - Progress Report
Estates Safety & Compliance Reports
Internal Audit Follow Up Review - Fire Arrangements at Princess of Wales Hospital Theatres
Deep Dive into Fire Safety Risks
Health, Safety & Fire Sub Committee Annual Report
Health Surveillance Programme Background Report

Integrated Health, Safety & Fire Exception Reports were received from the following areas:

- Bridgend Integrated Locality Group;
- Merthyr & Cynon Integrated Locality Group
- Rhondda Taff Ely Integrated Locality Group;
- Primary Care Directorate.

Moving forwards, given the implementation of the new Operational Model during 2022/2023, the Sub Committee will have appropriate representation from each Care Group.

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 July 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	January 2024	**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 **Now August 2023**	**In Progress** The All Wales Rate Card is yet to be agreed Nationally. A paper proposing a localised Rate Card is being developed with finance colleagues engaged as an interim solution. This will be presented through the relevant committees for

					approval. Work is also being undertaken to combine workforce related risks on the Risk Register.
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	January 2024	**In progress** Date to be agreed. Being considered alongside other Listening & Learning stories that need to be scheduled into the programme.
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	24 May 2023 **Further report to be presented to 19 September 2023 meeting**	**In progress** Report received and discussed at the meeting held on 24 May 2023. Further progress report to be presented to the meeting being held on 19 September 2023. 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	25 July 2023	**On agenda** Report on agenda for the July meeting.
6.7	24 January 2023	**Liberty Protection Safeguards** Report to be shared with Committee Members later in	Head of Safeguarding	25 July 2023	**On agenda** Report on agenda for the July meeting.

		the year on progress being made in this area.			
2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Data to be shared with Members outside the meeting in relation to ambulance handovers to include the data for each individual hospital for the numbers for requested for immediate release and number agreed.	Care Group Nurse Director – Unscheduled Care	24 May 2023 **Now 25 July 2023**	**In Progress** The report currently received in relation to ambulance handovers is for the whole of CTM. The Team have started to interrogate this data and will have to start manually recording at each front door. The Unscheduled Care Senior Management Team are also working collaboratively with WAST to ensure transparent and robust processes are in place. Once this is completed the data will be shared and presented to the Quality & Safety Committee. **Awaiting a revised action log update from the Chief Operating Officer**
6.1	16 March 2023	**Maternity Services & Neonates Improvement Programme** Review to be undertaken of the metrics included within the report to ensure they aligned with data contained	Director of Midwifery	24 May 2023 **Now 21 September 2023**	**In progress** Director of Midwifery has met with the Assistant Director of Quality & Safety and the Head of Quality & Safety on 21 April 2023 to discuss the challenges of consistent information. Work is being

		within other reports, for example, the number of concerns and incidents being reported.			undertaken between the Patient Care & Safety Team and Maternity Services to ensure this is rectified as soon as possible.
6.5	16 March 2023	**Stroke Services Progress Report** Future iterations of the action plan to include realistic target dates for completion and each action to be linked to the Quality Improvement Measures where applicable.	Director of Therapies & Health Sciences	25 July 2023	**On agenda** Report on agenda for the July meeting.
2.3	24 May 2023	**Care Group Spotlight Presentation – Primary Care and Communities** Updates on progress to be included in future iterations of the report in relation Safe to Start More detail to be provided to Committee members outside the meeting in relation to the practice that had been deleting unread referral update messages.	Care Group Nurse Director – Primary Care and Community	25 July 2023	**In Progress** Future deep dive and highlight reports form Primary Care and Communities will update on participation in Safe to Start. GMS primary care team were alerted to a practice which had a large number (approx. 490), of unread and deleted WCCG (electronic communication system) referral updates. Following this information, the Care Group notified the practice, and

					also asked one of the primary care CD's to review all the records of the deleted referrals to have assurance that no patient harm was made, and that any outstanding actions had been addressed. The Care Group will receive the outcome of this review in July and will update Committee as part of the regular highlight reporting arrangements.
5.1	24 May 2023	**Organisational Risk Register** Comments raised by Members in relation to the content of the risk register to be considered by the Assistant Director of Governance & Risk outside the meeting.	Assistant Director of Governance & Risk	25 July 2023	**Complete** 4632 – has been updated in the July iteration of the Organisational Risk Register. 4743 – has been updated in the July iteration and is to close. 5267 – updated in July iteration of the Organisational Risk Register. 5036 – session with DTPS colleagues in August to discuss scoring methodology which will address target scores.

					Further work is ongoing with risk leads to strengthen mitigating actions in terms of outcomes and timeframes.
6.4	24 May 2023	**Quality Dashboard** Update to be included in the next iteration of the report as to the reason behind the high number of falls being experienced at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda Members to share any further comments as to how the content of the quality dashboard could be progressed further.	Deputy Director of Nursing Committee Members	25 July 2023	**In progress** Verbal update to be provided by the Deputy Director of Nursing as part of the Quality Dashboard report at the July meeting. **In progress**
6.4.1	24 May 2023	**Emergency Department Spotlight Presentation – A Review of Falls and Pressure Ulcers** Further report to be presented to the Committee in due course clarifying the points that had been raised.	Deputy Director of Nursing	25 July 2023	**In progress** Deputy Director of Nursing to provide a verbal update at the July meeting as part of the Quality Dashboard report.
6.4.3	24 May 2023	**Executive Director and Independent Member Quality Patient Safety Walkrounds January – April 2023**	Director of Nursing	25 July 2023 Now August 2023	**In progress** This will be actioned accordingly within the framework. The Business Manager for Patient Care &

		Report to be amended to reflect that it would be the responsibility of the Executive Director to agree actions for improvement with the relevant Care Group Lead and not the Independent Member.			Safety will ensure that this is communicated that the responsibility is with the Executive Director to agree actions for improvement with the relevant Clinical Lead and Care Group Lead supporting the Walkround.
6.5	24 May 2023	**Care Group Report – Unscheduled Care** Timescales for the improvement plan that was being developed following the Infection Prevention Control (IPC) environmental review to be identified.	Unscheduled Care Group Nurse Director	31 July 2023	**In progress** The environmental scores were poor, lowest score in minors PCH (52%), highest score in paeds area PCH (80%). ED RGH 55%, POW ED 69%. Action plans sent to each department. Paediatrics at PCH have returned their completed action plan with the others ongoing (to be submitted by end of July 2023) with monitoring and time scales in place. Hand hygiene was 100% in POW but all other areas scored <85%. Non-compliance was addressed at the time of the audit but better engagement from medical colleagues is required. Work is currently

					ongoing to address this with IPC colleagues. PPE – main issue identified during the audit was mask wearing. This was discussed with IPC colleagues, as the guidance has changed. This matter is not being addressed at present. If mask wearing becomes compulsory again in the future support would be required to drive this forward.

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 May 2023)
2.2	16 March 2023	**Care Group Spotlight Presentation – Mental Health & Learning Disabilities** The risk relating to the implementation of the Welsh Community Care Information System to be highlighted as a matter of escalation to the Board within the Committee Highlight Report.	Committee Chair	30 March 2023/25 May 2023	**Completed** Verbal update on this escalation provided to the Board at the meeting held on 30 March 2023 meeting. Written update was included in the Highlight Report presented to the May Board

2.2	16 March 2023	**Care Group Spotlight Presentation – Mental Health & Learning Disabilities** Mental Health In-Patient Improvement Progress Reports to be presented to future meetings from May 2023 onwards.	Mental Health & Learning Disabilities Care Group Nurse Director	24 May 2023	**Completed** Added to the annual cycle of business as a regular item.
2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Concerns raised by Committee Members in relation to the boarding of patients in fire evacuation routes to be escalated to the Board within the Committee Highlight Report.	Committee Chair	30 March 2023/25 May 2023	**Completed** Verbal update on this escalation provided to the Board at the meeting held on March 2023 meeting. Written update was included in the Highlight Report presented to the May Board
6.3	16 March 2023	**Quality Dashboard** Review to be undertaken to the data discrepancies contained within the report and the wording of paragraph 2.2 on page 5 of the report.	Assistant Director of Concerns and Claims	24 May 2023	**Completed** Report updated for the meeting held on 24 May 2023
3.1.5	16 March 2023	**Independent Member Walkround Protocols** Report to be re-circulated to Members once amendments had been made.	Director of Nursing	24 May 2023	**Completed** Amended report re-circulated to Members on 10 May 2023 for review. No further comments were submitted by Independent Members

					regarding amendments made.
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 24 May 2023	**Completed** Report received and discussed at the meeting held on 24 May 2023.
5.1	16 March 2023	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Response to queries raised against a number of risks to be shared with Members outside the meeting.	Assistant Director of Governance & Risk	24 May 2023	**Completed** The July iteration of the Organisational Risk Register included on the agenda for the July meeting includes updates against risks 4732 and 4721 as required.
2.3	24 May 2023	**Care Group Spotlight Presentation – Primary Care and Communities** Risk score of 12 that had been allocated to the risk relating to the deficit of registered nurses to be reviewed outside the meeting to determine whether risk score was appropriate given the deterioration in the position.	Care Group Nurse Director – Primary Care and Community	24 July 2023	**Completed** The risk has been reviewed and has a new risk score of 16. In keeping with all clinical workforce risks the risk ID has been mapped and aligned to the Clinical Workforce Risk on the organisational risk register.
6.4.1	24 May 2023	**Emergency Department Spotlight Presentation – A Review of Falls and Pressure Ulcers**	Deputy Director of Nursing	24 July 2023	**Completed** Discussion held with N Milligan outside the meeting

		Update to be obtained from the Deputy Director of Nursing in relation to the number of patients falls by hospital site, which appeared to show a decrease in falls at Prince Charles Hospital, with the data indicating an increase in reporting at PCH			in relation to the points made.
6.4.2	24 May 2023	**Lessons Learnt – Learning and Actions following a death in Maesteg Hospital** Statements made within the cover section regarding 'Impact will rest with output and associated reporting structures described in presentation' and 'Exciting' arrangements to be reviewed outside the meeting.	Director of Nursing/Assistant Director of Governance & Risk	25 July 2023	**Completed and Ongoing** Future reports will be reviewed to ensure appropriate statements are made within the cover report section.
5.1	24 May 2023	**Organisational Risk Register** Members to submit questions against the risk register in advance of the July meeting to enable responses to be sought	Committee Members	25 July 2023	**Completed** Members are being asked to submit questions ahead of the meeting when papers are distributed
6.4	24 May 2023	**Quality Dashboard** Review to be undertaken of the medication supply errors referred to within the report. Response to be provided to	Assistant Director of Quality & Safety Committee	25 July 2023	**Completed** Report included on the agenda for the July meeting.

		Members outside the meeting to confirm what this relates to. Number of patients safety incidents to be reported as a number as opposed to a percentage in future iterations of the report Statement made on page 8 of the report which advised that work continued to develop and refine safety metrics to be reviewed and reworded as it inferred that metrics were being reviewed as opposed to processes.			This has been included in the Quality Dashboard report for the July meeting This has been amended within the report for the July meeting.

AGENDA ITEM
9.2.2

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL CYCLE OF BUSINESS

Date of meeting	25 July 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 <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

Quality & Safety Committee

Cycle of Business

(1st January 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	24 May 2023	June 2023	25 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					✓ Deferred to July 2023		✓ Deferred to Sept 2023		✓			
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	24 May 2023	June 2023	25 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Update has been included in the Unscheduled Care Group Highlight Report for July 2023							Deferred to July 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					✓ Will be discussed at In Committe e QSC 31/5							
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			✓ Deferred to May 2023		✓				✓			
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							✓ Deferred to Sept		✓			
Health, Safety & Fire Sub Committee Highlight Reports	Director for People	Quarterly			✓				✓				✓	
Radiation Safety Committee Annual and Mid Year Updates	Director of Therapies & Health Sciences	Bi-Annually			✓ Deferred to May		✓ Deferred to July		✓				✓	
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			✓ Deferred to May		✓ Deferred to July		✓		✓			
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					✓						✓	
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually							✓					

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
GOVERNANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
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 Now Quarterly			✓				✓				✓	
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							✓ Defer to Sept 2023		✓			
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Director of Nursing	Annually	✓											
Mental Health In-Patient Improvement Progress Reports Agreed following discussion at the In Committee Quality & Safety Committee that this matter would need to be reported to all regular meetings from May onwards.	Director of Nursing	All regular meetings					✓		✓		✓		✓	

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 on 25 July 2023. **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. A further update on progress was presented to the May 2023 meeting. Members requested a further update on progress to be presented to the **21 September 2023 meeting**
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	**In progress** Planned for March 2023 – The Deputy Director of Nursing requested that this item was deferred to the May 2023 meeting. Report received at the May meeting. Members requested a further update be presented to a future meeting confirming points of clarification requested by Members. **Verbal update to be presented to the meeting taking place on 25 July 2023 as part of the Quality Dashboard report.**

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 Volunteer Manager	Additional Item	Volunteer Service Policy – For approval	Executive Director of Nursing	Planned for May 2023 – Now deferred to 25 July 2023. **On agenda**
Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report	Executive Medical Director	Planned for May 2023 – Deferred to July 2023. **Now Deferred to 21 September 2023**
Email Request from the Patient Care & Safety Team	Additional Item	Concerns Policy	Director of Nursing	Planned for May 2023 – Deferred to 25 July 2023. **On agenda**
Assistant Director of Governance & Risk advised of this email verbally	Additional Item	Clinical Policies Approval Process	Medical Director	Planned for 25 July 2023 – **Now deferred to 21 September 2023**
Email request received from the Medical Directors Office	Additional Item	Rapid Tranquilisation Policy	Medical Director	Planned for 25 July 2023 – **On agenda**
Request made by the Chair at the In Committee session of the	Additional Item	External Review of Practice into Care of a Patient by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf	Director of Nursing	Planned for November 2023

Quality & Safety Committee held on 31 May 2023		County Borough Council – Action Plan Progress Update		
Email request received from the Director of Midwifery	Additional Item	MBRRACE response to the 2021 Perinatal Mortality	Director of Nursing	Planned for 21 September 2023
Email Request received from the Interim Director of Public Health	Additional Item	Recovery Plan Hep B and Hep C	Interim Director of Public Health	Planned for 25 July 2023 – **On agenda**
Request made by the Chair and Vice Chair at the agenda planning session for the July Board	Additional Item	Mortality Report	Medical Director	Planned for 25 July 2023 – **On agenda**
Email Request received from the Chief Executive requesting this item be added to the agenda	Additional Item	Ombudsman Wales Report – Groundhog Day 2: An Opportunity for Cultural Change in Complaint Handling	Director of Nursing	Planned for 21 September 2023
Email Request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	Welsh Risk Pool Claims Final Internal Audit Report and Action Plan	Director of Nursing	Planned for 25 July 2023 – **On agenda**
Email Request received from the	Additional Item	Concerns Final Internal Audit Report and Action Plan	Director of Nursing	Planned for 25 July 2023 – **On agenda**

Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics				

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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
Agreement made at the February Agenda Planning Session	Additional Item	Patient Falls and Unexpected Exits Lessons Learnt Report	Deputy Director of Nursing	**Completed** Reports received at the meeting held on 24 May 2023.
Email request from the Quality & Safety Committee Chair	Additional Item	Healthcare Inspectorate Wales Action Plan Tracker – Prototype	Deputy Director of Nursing	**Completed** Report received at the meeting held on 24 May 2023
Email Request from the Assistant Director of Therapies & Health Sciences	Additional Item	Development of a CTM Allied Health Professionals & Healthcare Science Strategy	Executive Director of Therapies & Health Sciences	**Completed** Report received at the meeting held on 24 May 2023
Email request from the Medical Directors office	Additional Item	Ratification of Urgent Committee Chairs Action - Policy Approval	Assistant Director of Governance & Risk	**Completed** Report received at the meeting held on 24 May 2023
Email request from the Medical Directors office	Additional Item	All Wales Model Policy for Consent to Examination for Treatment	Medical Director	**Completed** Report received at the meeting held on 24 May 2023
Email request from the Medical Directors office	Additional Item	Policy for the provision of Intraoperative Cell Salvage	Medical Director	**Completed** Report received at the meeting held on 24 May 2023

WHSSC Joint Committee
18 July 2023
Agenda Item: 4.9.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**14 June 2023**

Summary of key matters considered by the Committee and any related decisions made

1.0 IMMUNOLOGY PATIENT STORY

Members received an informative patient story on the benefits of self-administering subcutaneous immunoglobulin infusions at home. The patient story highlighted the positive impact that the Immunology Services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK (WKN)

Members received a report outlining the current Quality Patient Safety (QPS) issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 2 May 2023 and the WKN Board meeting on 31 May 2023. It was noted that there were 13 items on the current WKN risk register. One risk related to COVID-19 had recently closed.

Members noted the updates to the Renal Funding risk and the limited outpatient dialysis capacity risk in Swansea and it was highlighted that these risks remain on the Corporate Risk Assurance Framework (CRAF).

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the table at the end of the report.

- **Cancer & Blood**

The main issue to note was the traction on the performance issues within the all Wales Lymphoma Panel service. The Escalation meetings were closely monitoring progress against the action plan. Arrangements were being put in

place to look at the sustainability of the service model and clinical leadership as part of the WHSSC planning work.

The North Wales Plastic Surgery service remains an area of concern. WHSSC is contributing to the Welsh Government escalation arrangements and officers continue to attend the local Task and Finish Group as an advisor. The Harm review is underway and there is traction with the operational issues within the context of the wider issues within BCUHB.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB and this remains a concern for WHSSC, with escalation levels being reviewed.

Workforce issues within the Neuro Endocrine Tumour Service (NETS) have been addressed with the support of a visiting consultant with NET expertise to oversee the delivery of the service. A full review of the service with stakeholders is planned in June 2023 with the aim of finding a sustainable solution going forward.

- **Neurosciences**

There were no changes in risks since the last update, with no red risks in the portfolio and no services are in escalation.

- **Cardiac**

Within the Cardiac surgery services, there have been significant improvements in both South Wales services. No new risks for the portfolio have been added to the Risk Register since the last report.

Members noted that SBUHB and CVUHB Cardiac Services have been de-escalated from level 3 to level 2 following the improvements put in place. The services will continue to be monitored through their action plans. The Cardiff service was recently de-escalated to Level 2 in May 2023 and will be reviewed in 6 months for assurance that the improvement actions have been fully embedded.

- **Fertility Service South Wales**

Members noted that a number of concerns had been raised following a relicensing inspection by the Human Fertilisation and Embryology Authority (HFEA) of the Women's Fertility Institute (WFI) in Neath Port Talbot Hospital, which was undertaken in January 2023. A new risk has been added to the CRAF and the escalation level is being reviewed.

- **Paediatric Surgery**

The service remains in Escalation Level 3 and the Risk remains on the CRAF. Members noted the issues in relation to the waiting list and the actions in place to improve the situation. It was noted that CVUHB have provided assurance that

they will meet the contract volumes and they have committed to producing a revised demand and capacity plan and waiting times trajectory.

Waiting times have decreased and the service is meeting the Ministerial measures for waiting times. However, because this relates to children WHSSC have set an objective for further significant reduction over the next year. Outsourcing arrangements to NHS England and the private sector will remain in place to support this.

- **Paediatric Intensive Care Unit (PICU)**

The Paediatric Intensive Care service remains in escalation Level 2 due to concerns regarding capacity, staffing levels, quality and contract monitoring. In line with the WHSSC Escalation Framework clear objectives have been set for improvement and an action plan was received in June 2023. Members advised they were unable to be assured on the pressure damage report from the Health Board as this had been shared in summary by letter. The DoN undertook to write to the UHB to request the full report. An update will be provided at the next QPSC meeting.

- **Neonatal Cot Availability in South Wales**

The Neonatal Cots Reconfiguration recommendations were approved by the Joint Committee in March 2023 and members noted that the investment as agreed in this year's ICP had been released which should stabilise the position and see the reduction in risk over the next year.

- **Mental Health & Vulnerable Groups**

Members noted that there were currently two Mental Health services in escalation. Ty Llidiard remains at Escalation Level 3 and FACTS is currently in escalation Level 2.

The committee received an update regarding the Gender Development Service (GIDS) for Children and Young People. NHS England have published an update on their progress towards improving and expanding services for children and young people experiencing gender incongruence and gender dysphoria and it is anticipated that the early stages of service provision at the Southern Hub will begin in autumn this year (2023) – with the Northern Hub mobilising by April 2024.

The Cass Review published a journal entry detailing the research programme and made some recommendations with regard to Hormone Therapy for Children.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the report highlighting the new risk related to sustainability and delivery of the service due to workforce issues. Alternative options were being explored and outsourcing to a service in Bristol is being considered.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation level. Members noted the three services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 3 from 4 in December 2022,
- Paediatric Surgery C&VUHB had been escalated to level 3 in March2023,
- Burns service in SBUHB remains in Escalation level 3.

Members provided very positive comments on the report and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report ***Appendix 1***

4.2 WHSSC Committee Effectiveness Survey Results

Members received a report providing feedback from the Annual Committee Effectiveness Self-Assessment 2022-2023.

4.3 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

4.4 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period April to June 2023 was presented to the committee.

4.5 Incident and Concerns report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. A request was made to include an in-depth review of the women and children's incidents. This was following queries raised by members as to whether there were any themes linked to these concerns.

Members noted the content of the report.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 16 May 2023

• WHC/2003/017 National Policy on Patient Safety Incident Reporting • QPSC Distribution List; and • QPSC Forward Work Plan.
Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above.
Summary of services in Escalation • Attached (***Appendix 1***)
Matters requiring Committee level consideration and/or approval • N/A
Matters referred to other Committees As above.
Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	16 August 2023 at 14.00hrs

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

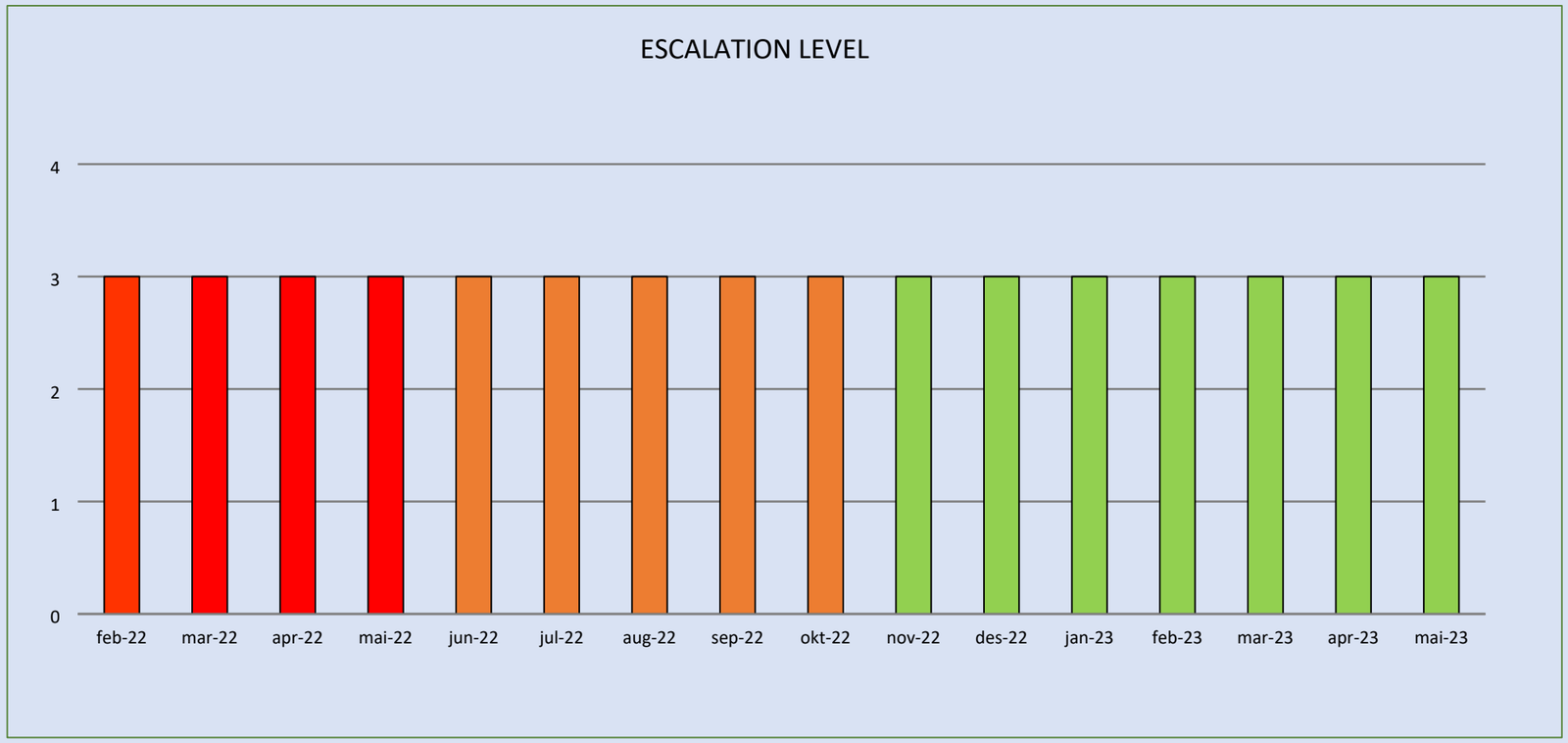
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case remains on target with the planned timeline.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which will go their Investment in Infrastructure Board on 22nd July. It had been hoped that the works would commence in May. There may therefore be a 2 month or so departure from original timelines. At the SLA with Swansea on Monday of this week, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23, 12/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

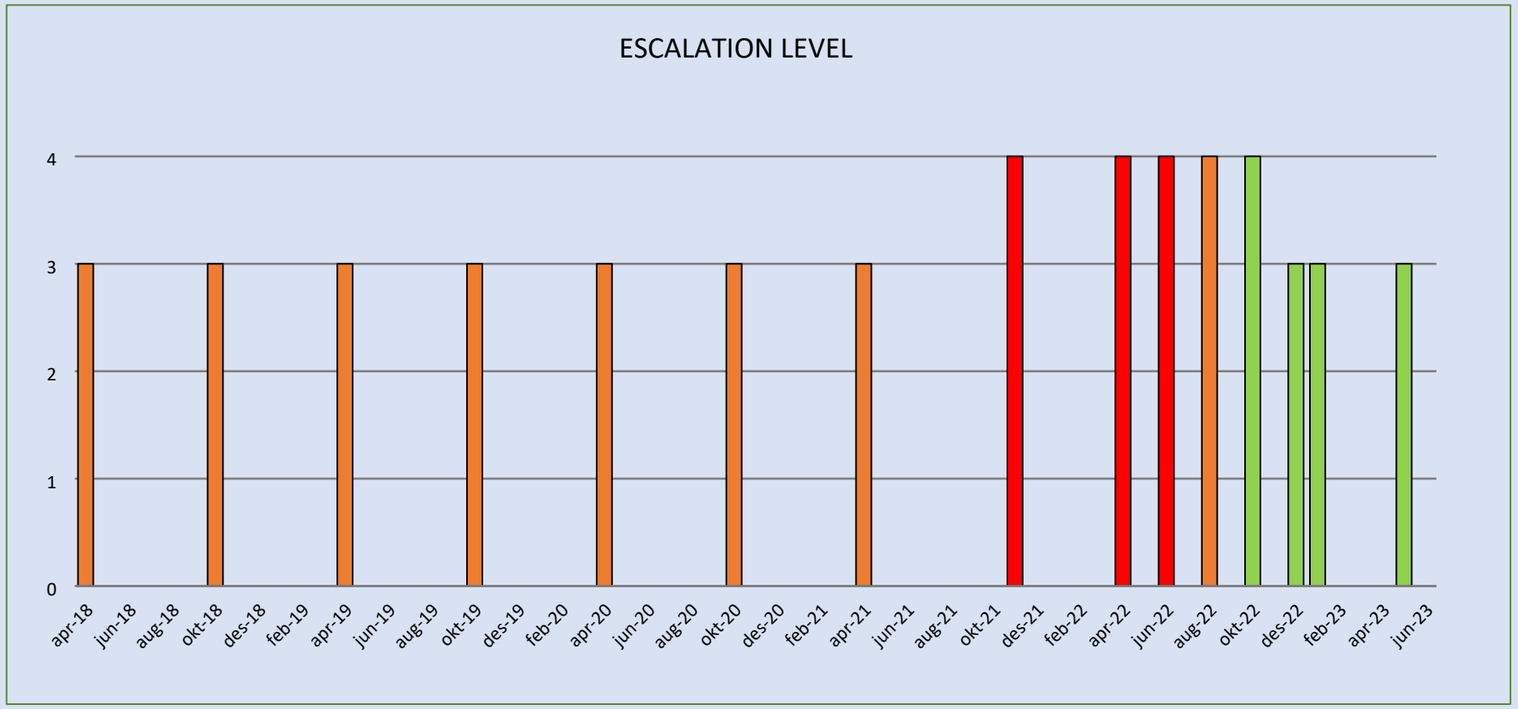
Service in Escalation: Ty Llidiard

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3

Rationale for Escalation Status :
De-escalated to level 3.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.
September 2022 - Recruitment plan underway with all vacancies out to advert; interview dates arranged.
December 2022 - This service has been de-escalated to Level 3 as agreed by CDGB on 14th December.

Actions:

Action	Lead	Action Due Date	Completion Date
Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
Service specification action plan agreed.	Senior Planner		Completed March 22
Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
Reviewed service specification.	Senior Planning Manager		Completed
Monitor training status of the staff by QAIS.	Shane Mills		Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Ongoing

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.

July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments
May 23 - There has been no change to the Ty Llidiard escalation status and no meetings have been held pending a report from NCCU next meeting planned for June 12 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac

Date of Escalation Meetings: 01/06/22, 20/07/22, 21/11/22, 05/04/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/23

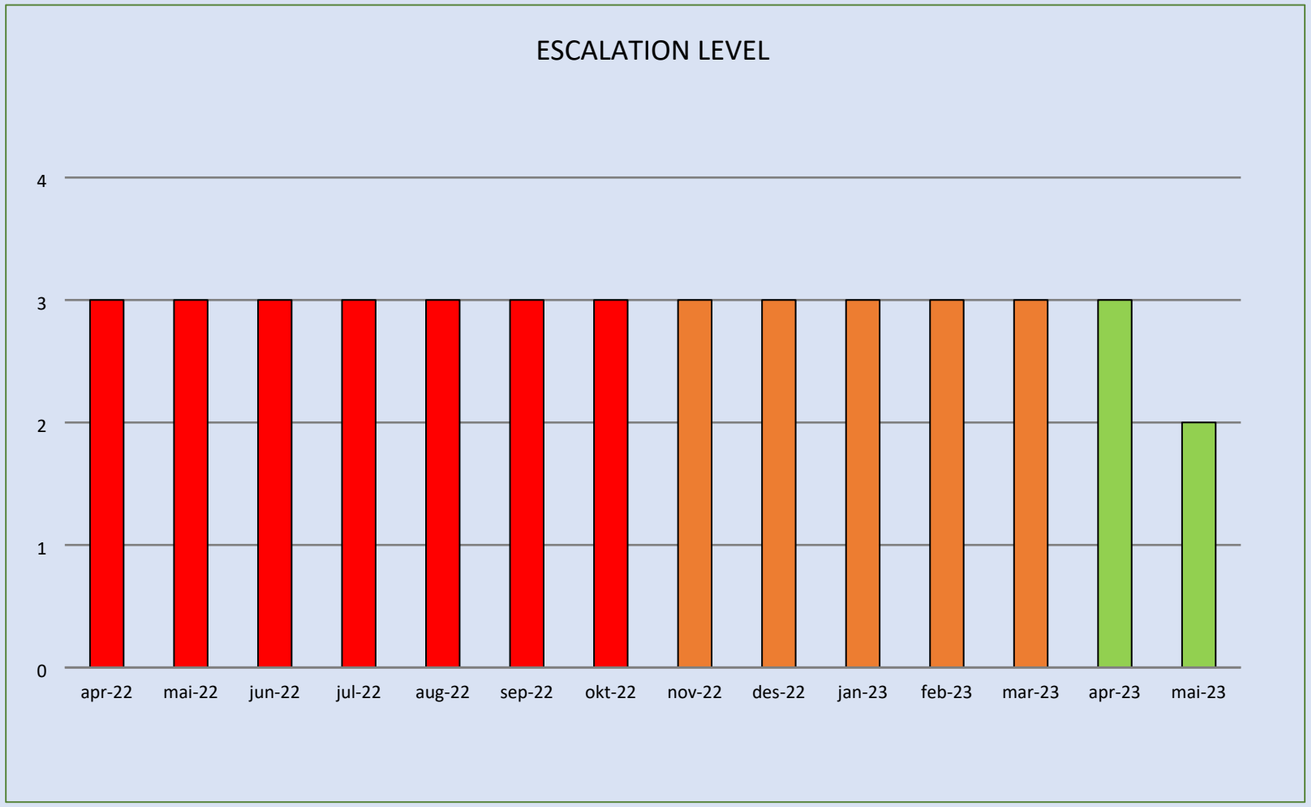
Service in Escalation: Cardiac CVUHB

Current Escalation Level
2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2022– WHSSC escalation	**3**
June 2022– WHSSC escalation	**3**
November 2022– WHSSC escalation	**3**
May 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :

Following an escalation meeting on 5 April 2023, the escalation status of the Cardiff and Vale Cardiac Surgery service was considered by the Cardiac Commission Team, which recommended a reduction to Level 2. When considering the service's escalation status, the Cardiac Commissioning Team found that:

- The majority of the actions contained in the GIRFT/HEIW action plan were complete and that there had been evident progress towards the delivery of the GIRFT indicators
- Those actions that remained outstanding were subject to a number of interdependencies that may delay delivery
- The requested HEIW report had been received, and the Cardiac Surgery service had shared detail of progress against the report's recommendations and follow-up visits via Level 3 escalation meetings

- There had been had been improved engagement from the Health Board senior team in respect of escalation issues.

Background Information:

Owing to the failure of Cardiff and Vale University Health Board to…

1. Implement the outcomes of the GIRFT review (June 2021), for which no appropriate SMART action plan has been shared with WHSSC
2. Communicate and address (via a SMART action plan) the additional issues recently identified by HEIW, arising from the concerns with the cardiac surgical service raised by trainees

…there is a risk that people waiting for Cardiac Surgery delivered by Cardiff and Vale University Health Board may receive suboptimal or delayed treatment, and that WHSSC will be unable to effectively monitor.

The following controls have thus been put in place:

- Instituting of regular (every 6 weeks) Stage 3 escalation meetings with Cardiff and Vale University Health Board – with monitoring to be taken forward via regular Cardiac Services Risk, Assurance and Recovery meetings following de-escalation to Level 2, and with a formal review planned for October 2023.
- HEIW report and action plan shared with WHSSC and discussed in escalation meetings.
- Development of SMART action plan to take forward the recommendations of the GIRFT review, shared with WHSSC at escalation meetings to enable the monitoring of progress and identification of any required remedial actions.

WHSSC assurance and confidence level in developments:

Medium – Although the service has been de-escalated and commended both for the improvements made and the engagement of the senior team since the service was escalated to Level 3 in April 2022, further de-escalation will depend on the delivery of a number of interdependent actions, including the repatriation of the Cardiac Surgery service from UHL to UHW and additional

Actions:

Action	Lead	Action Due Date	Completion Date
De-escalate service to Stage 2 of the WHSSC escalation process	Director of Planning		Completed
Utilise regular bi-monthly Cardiac Services Risk, Assurance and Recovery meetings to oversee escalation process	Senior Planning Manager		Completed
Receive a SMART action plan from the service that addresses the recommendations contained in the GIRFT report.	Senior Planning Manager	In progress - chased 10/06/22	Completed
Receive HEIW report concerning issues with the cardiac surgical service raised by trainees.	Senior Planning Manager		Completed
Monitor implementation of the SMART action plan at escalation meetings.	Senior Planning Manager	In progress	
Development of de-escalation criteria based on recommendations in GIRFT report and action plan.	Associate Medical Director		Completed

recruitment. Although appropriate planning has been undertaken and progress will be monitored, any delay in the interdependent actions will see consideration of further de-escalation similarly delayed.	

Issues/Risks:
June 2022 – Service escalated to Stage 3 of the WHSSC escalation process in April 2022 owing to continuing concerns with engagement; agreed at the 28 June 2022 Cardiac Commissioning Team meeting that the escalation constituted a risk (as opposed to an issue) owing to concern that the failure to implement GIRFT/HEIW recommendations will impact on patients, but that the accompanying narrative should be revised to clarify the precise concerns; escalation meeting held on 01 June 2022, at which an apparently extant action plan was discussed, but not subsequently shared.
July 2022 – Action plan now shared with WHSSC. Second escalation meeting held on 20 July 2022 at which – mindful of the long-term nature of many of the HB's objectives – progress was noted. Agreed that WHSSC would refer to both the GIRFT report and the action plan in order to develop de-escalation criteria in time for the next escalation meeting (September). No change to risk score.
August 2022 – Draft de-escalation criteria shared with Health Board in readiness for discussion at September escalation meeting. No change to risk level.
September 2022 – The de-escalation criteria was discussed with the Health Board in the September escalation meeting. It was agreed in the meeting that the Health Board would provide a formal response in regards to the proposed de-escalation criteria. No change to the risk score.
October 2022 - Health Board had not yet provided formal response to proposed de-escalation criteria. Planned October escalation meeting had been rescheduled to Monday 21 November owing to Health Board availability; Health Board had submitted updated action plan in lieu of meeting. No change to risk score.
November 2022 – Further progress was noted at November escalation meeting; de-escalation criteria discussed – agreed that focus would be on evidencing positive trajectory, assisted by cardiac surgery dashboard; risk score unchanged.
December 2022 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
January 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
February 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
March 2023 – No escalation meetings since the last CRAF review. Risk level remains unchanged; next meeting scheduled for 5 April 2023.
May 2023 – Following the de-escalation of the service (from Level 3 to 2 in May 2023) and the subsequent review of the risk by the Commissioning Team, the risk score has been reduced to 9. Regular monitoring will continue through the Cardiac Risk, Assurance and Recovery meetings. The Health Boards position will be formally be reviewed in six months' time following an assessment of progress against the actions as outlined in the de-escalation letter.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

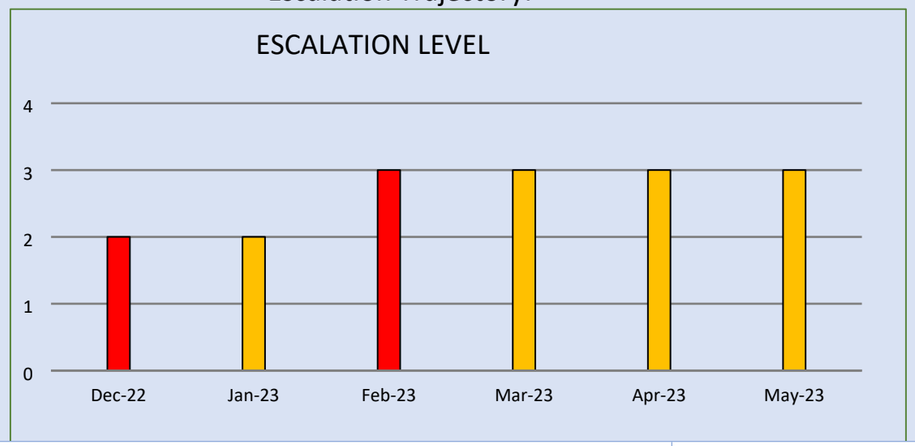
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ May 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The current plan does not deliver contracted volumes,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in implementing a number of new pilot schemes and securing additional capacity. Currently it is premature to consider the de-escalation of the service as these pilot schemes need to roll out and additional lists undertaken to measure success against the waiting list position. Commitment to re-cast trajectories in light of action plan with ultimate aim to meet contracted volumes.

Actions:

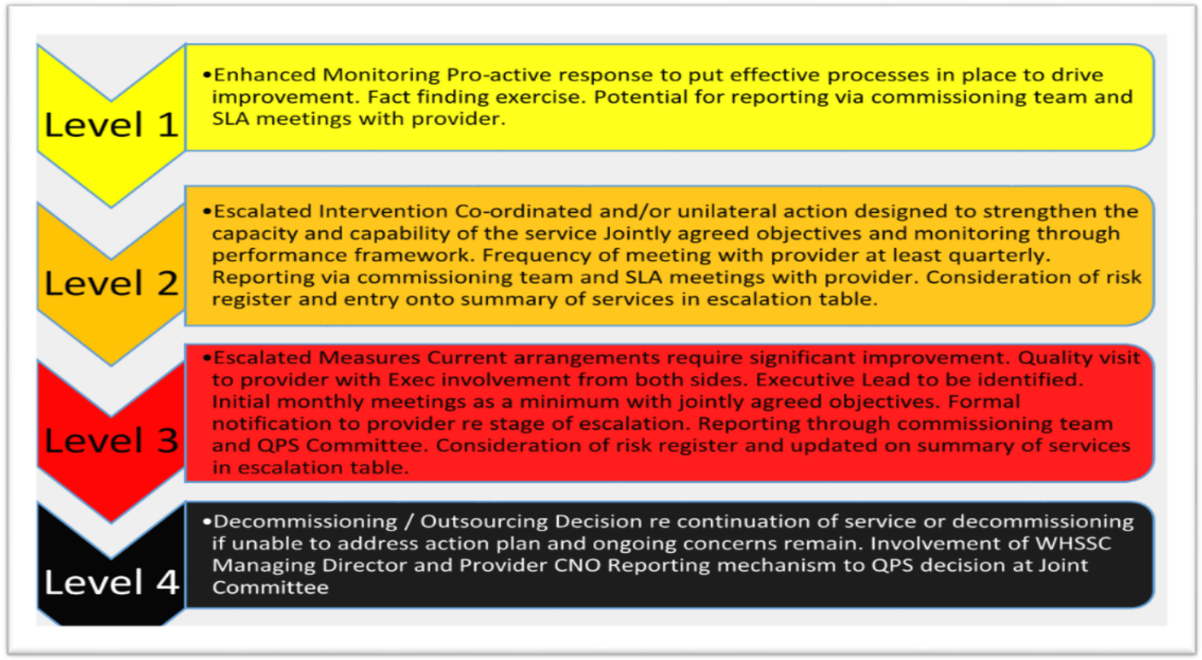
Action	Lead	Action Due Date	Completion Date
To establish monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.

May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

AGENDA ITEM
9.2.5

QUALITY & SAFETY COMMITTEE

Putting Things Right – Annual Report

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Presented by	Nigel Downes, Assistant Director of Quality & Safety
Approving Executive Sponsor	Greg Dix, Executive Director of Nursing, Midwifery & People Services
Report purpose	FOR NOTING

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

ACRONYMS	
PTR	Putting Things Right

1. SITUATION/BACKGROUND

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, compliments claims and redress between 1st April 2022 and 31st March 2023.

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

The key areas to note from within the Putting Things Right annual report for 2022/2023 include:

- Reduction in the number of formal complaints received
- Achieving and maintaining compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Increase in number of new claims received
- Increase in number of cases referred to Redress
- Themes arising from complaints and patient safety incidents remain consistent with previous years

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

As the Health Board progresses the transition to the new operating model during 2023/2024, the Quality Governance Central Team will continue to embed the processes for managing concerns across the Organisation, with a focus on ensuring learning is identified and acted upon.

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 quality & safety metrics.

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,	If no, please provide reasons why an EIA was not considered to be required in the box below.

changed or withdrawn policies and services.	• 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	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 contents of this report.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT

Annual Report 2022/2023

Head of Concerns & Business Intelligence

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

PUTTING THINGS RIGHT ANNUAL REPORT 2022/2023

PUTTING THINGS RIGHT ANNUAL REPORT 2022/2023

SUMMARY OF ACTIVITY

863 Formal Complaints Received

93 Redress

140 Claims

76 Ombudsman

21,523 Patient Safety Incidents

95 NRI's

3 Never Events

866 Compliments

PUTTING THINGS RIGHT ANNUAL REPORT 2022/2023

1.0 Introduction

The purpose of this report is to provide a summary of people's experience with Cwm Taf Morgannwg University Health Board (the "Health Board"), including complaints, incidents, compliments claims and redress between 1st April 2022 and 31st March 2023.

Putting Things Right (2013) was established to review the existing processes for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible Body in Wales. The aim is to provide a single, more integrated and supportive process for people to raise concerns which:

- Is easier for people to access;
- People can trust to deliver a fair outcome;
- Recognises a person's individual needs (language, support, etc.);
- Is fair in the way it treats people and staff;
- Makes the best use of time and resources;
- Pitches investigations at the right level of detail for the issue being looked at; and
- Can show that lessons have been learnt

2.0 How we manage concerns

The Health Board has a Concerns Management policy to support the effective management of complaints, patient safety incidents and redress. It is supported by the Health Board's incident reporting policy and procedure and should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

During 2022/2023, as part of the transition to the new Care Group operating model, a new structure of Quality Governance was introduced. The new model for Quality Governance supports a central cohort of professional and technical expertise to support our services in responding to complex issues. The services within the 'Quality Governance Central Team' work hand in glove with the Care Groups and Clinical Service Groups to ensure a quality service from the outset, but when things do go wrong, lessons are learnt and acted on swiftly and our patients and families are supported appropriately.

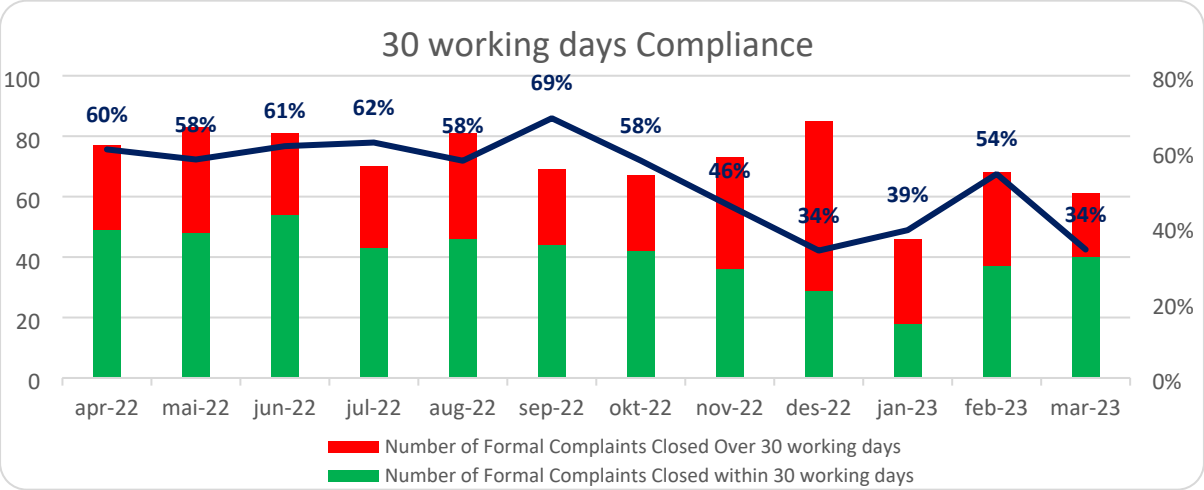
3.0 Complaints

During 2022/2023 at total of 3,175 complaints were received by the Health Board. Of these, 863 complaints were managed via putting things right, a decrease from the 1453 received during 2022/2023. The remaining 2,312 were managed as early resolution complaints.

Complaints will often highlight a number of issues of concern regarding the services or care and treatment being provided by the Health Board. Identification of these complaints assists in highlighting themes and trends, to inform areas for focused improvement work. Consistent with the previous year, the following top 3 themes remain the same as for the year:

Top 3 Themes	Total
Clinical Treatment/Assessment	1144
Appointments	553
Communication Issues (including Language)	402

863 complaints managed via Putting Things Right ("PTR") were closed during 2022/2023. Of these, 468 (54%) were responded to within 30 working days. The following graph sets out the Health Board's monthly response compliance rates for 2022/2023:



A plan is in place to continue to improve compliance with the 30 working day target to respond to complaints. Improvement actions are summarised below:

- Triaging of complaints to increase number of complaints managed via early resolution
- Revised process in place for management of Formal Complaints - early escalation requirements highlighted and being embedded
- Daily Complaint Team Huddles in place to review cases and support escalation process
- Enhanced process for managing MP/MS correspondence
- Trajectory plan in place to address complaints open over 30 working days.
- Monitoring in place to ensure that updates are provided to all complainants where cases have been open over 30 working days.
- Internal Audit provided reasonable assurance (limited assurance provided 2021/2022) – action plan developed to address recommendations

4.0 Redress

If during the investigation of a complaint or incident a breach of duty of care is identified which has potentially resulted in harm to the patient, there may be a qualifying liability. At this stage, the complaint will transfer into the Redress process for a further detailed investigation.

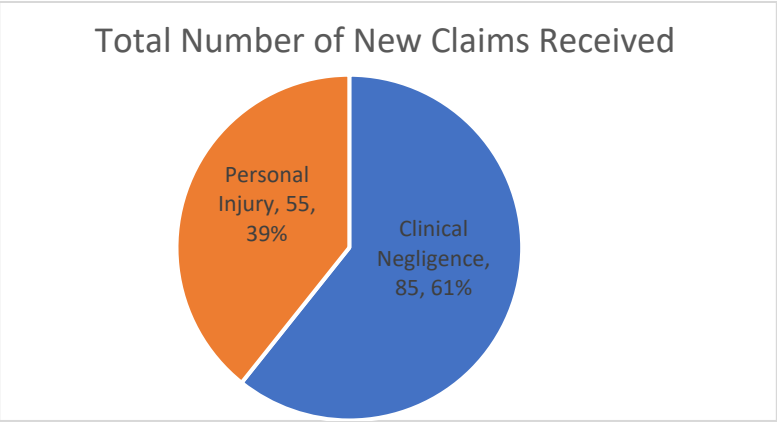
Between 01.04.22 and 31.03.23, 93 cases were referred to Redress for review of breach of duty and for consideration as to whether the case is suitable for Redress. 53 were referred from the complaint process and 40 from the incident process.

It should be noted that Redress cases will not always be referred and closed within the same financial year. Therefore, the cases closed during 2022/2023 may have been received in previous years. 84 redress cases were closed between the 01.04.22 and 31.03.23, of these 42 were concluded with confirmation of a qualifying liability.

5.0 Claims

Where a case is of a higher value than £25,000, it will be transferred out of the Redress process and managed as a claim.

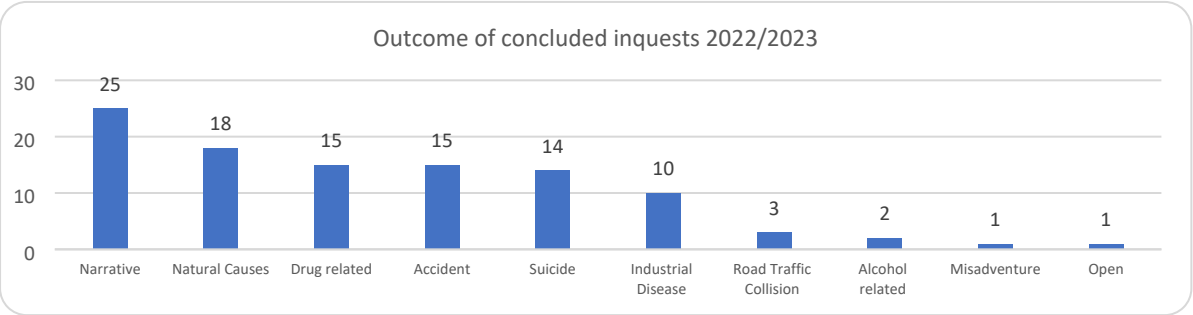
Between the 01.04.22 and 31.03.23 the Health Board received notification of 140 new claims. These take the form of a clinical negligence or personal injury claim.



6.0 Inquests

An inquest is a formal investigation by the Coroner to determine how a person died. They are held in certain circumstances, for example if the death was sudden or unexpected. The Health Board must provide information in line with the directions of Coroner.

Between the 01.04.22 and 31.03.23 the Health Board received notification of 248 new inquests. During the same period 112 inquests were concluded with the following outcome. It should be noted that inquests will not always be referred and closed within the same financial year.

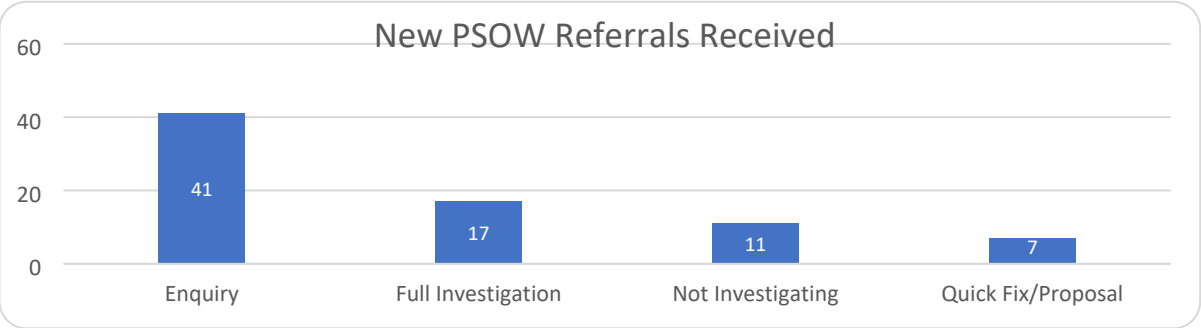


On conclusion of an Inquest, under the Coroners Regulations 2013, the Coroner has the power to make a report to prevent future deaths, referred to as Regulation 28 reports. During 2022/2023 the Coroner issued no regulation 28 reports to the Health Board.

7.0 Public Service Ombudsman for Wales (PSOW)

The Public Service Ombudsman for Wales (PSOW) has the power to review complaints about public services in Wales. If a complainant is not content with the response they receive from the Health Board, they can request the PSOW to review the case independently.

Between 01.04.22 and 31.03.23 the Health Board received notification of 76 referrals to the PSOW. Of these, 17 were proceeded to full investigation. A breakdown of PSOW referrals is provided in the chart below.



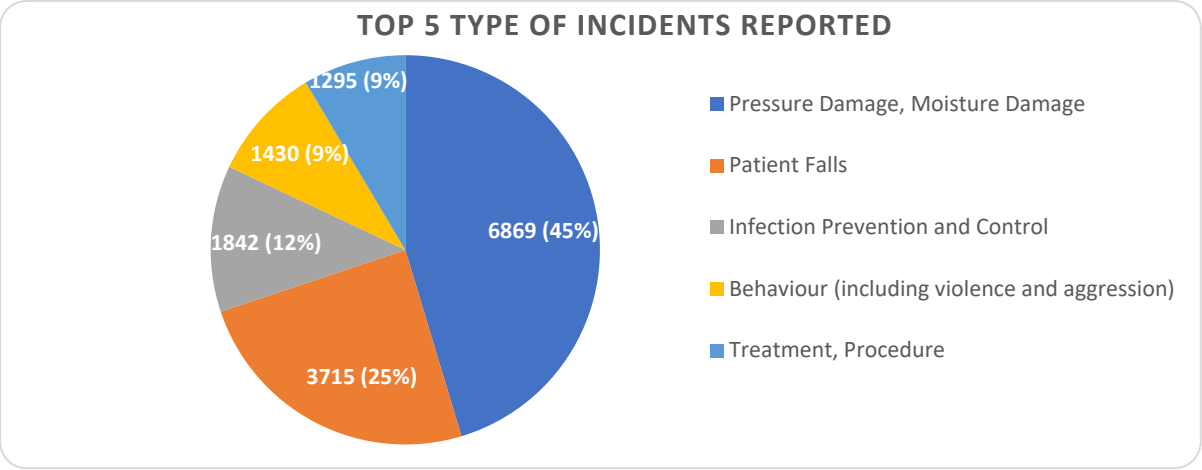
During 2022/2023 the PSOW issued 33 final reports to the Health Board. Of these 19 were fully upheld, whereby the Health Board accepted the recommendations and implemented actions to address the learning identified. A summary of the outcome of PSOW investigation final reports is provided in the table below.

PSOW Final Reports Issued	Total
Upheld - Section 27	14
Not Upheld	11
Partially Upheld	3
Upheld - Section 23	5
Total	**33**

8.0 Patient Safety Incidents and Nationally Reportable Incidents

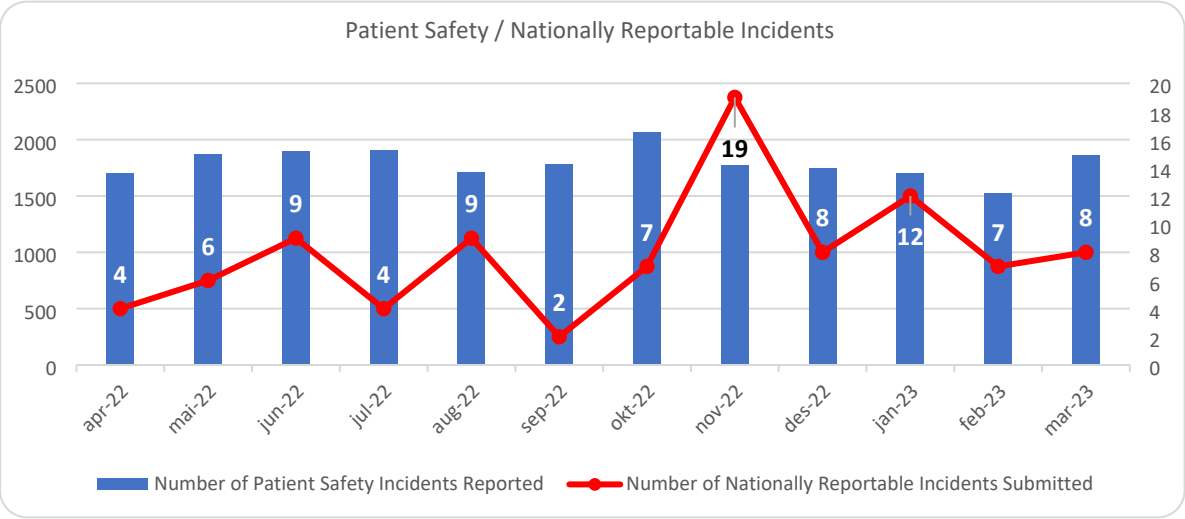
There were 24,698 incidents reported between 01.04.22 and 31.03.23, of which 21,523 (87%) were reported as patient safety incidents.

Accounting for 70% (15,151) the top five Patient Safety incidents reported for the year relate to: Pressure Damage/Moisture Damage; Patient Falls; Infection Prevention & Control; Behaviour (including violence and aggression); and Treatment, Procedure. A breakdown of these is provided in the chart below.



Within the time period, 95 nationally reportable incident notifications were submitted to the NHS Executive (Delivery Unit). As a result of the changes in the nationally reportable incidents criteria introduced in the NHS Wales National Incident Reporting Framework on the 14.06.21, comparable information with previous years is not available. In addition following the implementation of Datix Cymru within the Health Board, comparison of data on a granular level is not recommended.

The incident reporting trend for 2022/2023 is reflected in the chart below.



9.0 Never Events

Never Events are patient safety incidents that are wholly preventable, where there is guidance and safety measures that provide strong systemic protective barriers available at a national level.

Never events have the potential to cause serious harm or death, although serious harm or death does not have to occur for it to be classed as a never event.

The Health Board reported 3 never events between 01.04.22 and 31.03.23, which relate to:

- Right sided femoral component being implanted in the left knee
- Overdose of insulin due to abbreviations or incorrect device
- Wrong site surgery – laser surgery delivered to incorrect eye.

10.0 Compliments

Compliments provide a valuable source of learning and are metric to assess patient/service users experience of the services provided by the Organisation. 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, with 866 being recorded during 2022/2023. A plan to improve the recording of compliments has been compiled and is being implemented within 2023/24.

11.0 Learning from Event Reports

The Health Board is required to submit a signed Learning from Events Report (LFER), within 60 working days of the decision to settle a case, to the Welsh Risk Pool. During 2022/2023, 119 Learning from Events Reports were triggered for submission.

A summary of activity for Learning from Events Reports due during 2022/2023 is summarised below:

	Claims	Redress	Total
Number of LFERs Due	52	59	111
Number of LFERs submitted	45	56	101
Number of LFERs Approved	11	24	25

All cases considered for reimbursement by the Welsh Risk Pool (WRP) are scrutinised for evidence of the lessons learned and improvement actions taken by the Health Board. Reimbursement, both interim and final reimbursement, will be deferred until the WRP Committee is satisfied with learning and the actions taken in a case. Between 01.04.22 and 31.03.23, the WRP deferred 142 cases for reimbursement for the Health Board.

13.0 Conclusion

The key areas to note in relation to Concerns for 2022/2023 include:

- Reduction in the number of formal complaints received
- Achieving and maintaining compliance with the 30 working day target
- Decrease in the number of Public Service Ombudsman for Wales referrals received
- Increase in number of new claims received
- Increase in number of cases referred to Redress
- Themes arising from complaints and patient safety incidents remain consistent with previous years

As the Health Board progresses the transition to the new operating model during 2023/2024, the Quality Governance Central Team will continue to embed the processes for managing concerns across the Organisation, with a focus on ensuring learning is identified and acted upon.

AGENDA ITEM
9.2.6

QUALITY & SAFETY COMMITTEE

REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATE RELATING TO HEALTHCARE INSPECTORATE WALES (HIW)

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas, Business Manager Patient Care & 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
CTM UHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales activity and correspondence since the last report presented to the committee in May 2023. Due to the bi-monthly nature of these meetings, this report will cover the 2-month period from the previous report.

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

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

2.0 HIW activity 1st May – 30th June 2023

HIW activity across Cwm Taf Morgannwg University Health Board:

Number of Unannounced	**0**
Number of Announced	**0**
Number of patient/staffs concerns via HIW	**1**
Number of concerns raised through Fieldwork	**0**
Number of HIW & CIW joint Reviews	**0**

2.1 **Unannounced Inspections:**

There has been no (zero) unannounced inspections since the last report to the committee in May 2023.

2.2 **Whistle-blower Concern raised via HIW**

Healthcare Inspectorate Wales were contacted by a whistle-blower in relation to concerns over patient safety. HIW strongly encouraged the whistle-blower to contact the health board directly through the whistleblowing policy to raise their concerns directly.

The concerns raised were promptly and fully responded to within the timeframe set by HIW.

2.3 **Local Review:**

No new local reviews have commenced within the time frame of May – June 2023

A separate report is presented to the committee with regards to 'A focus on Mental Heath In-Patient Improvement and HIW Inspections', this can be

found under agenda item 7.3 Mental Health In-Patient Improvement Progress Report.

2.4 **National Reviews:**

Child Protection Rapid Review – April 2023
The required documentation and supporting information to support the Child Protection Rapid Review has been submitted to HIW. This work is being led across the health board by the Head of Safeguarding.

An overall report on the findings will be prepared and published noting that there will not be individual health board reports published.

Further updates will be provided to future Quality & Safety Committee meetings and also shared with the Safeguarding Executive Committee and Safeguarding Board.

National Review of Maternity Services Phase 1 – November 2020

Members will be aware that Healthcare Inspectorate Wales (HIW) published a report for its phase 1 National review of Maternity Services on 19 November 2020.

The report made 32 recommendations for all Health Boards to consider and act upon. Following the submission of CTM UHB initial action plan, which was submitted in 2021, HIW have now requested a further update on the progress made against the actions in their report recommendations. This is being actioned as part of HIW's review follow-up process, which assists HIW to consider the work undertaken by the organisation and the sustainability of implemented actions.

Following a review of both the previous submission and this latest submission to HIW, HIW will review and evaluate the responses and provide a review impact summary to the organisation, which will also be published on HIW's website.

3.0 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE
For assurance the governance, monitoring, scrutiny and oversight of improvement plans in relation to HIW inspections and all service reviews are maintained without interruption within the new Care Group Model.

The new post of Head of Quality Assurance and Compliance has been appointed into and, with appointment into the new Quality Assurance and Compliance Officer role, compliance in this area will transition over to the Assurance and Compliance team in due course.

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 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.

AGENDA ITEM
9.2.6b

QUALITY & SAFETY COMMITTEE

QUALITY GOVERNANCE – REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATES – HOME OFFICE CONTROLLED DRUGS LICENCE TRACKER

Date of meeting	(24/07/2023)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Hannah Wilton, Clinical Director Pharmacy and Medicines Management
Presented by	Dom Hurford, 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	

1. SITUATION/BACKGROUND

1.1 **Situation:** Following experiences of several Health Boards with the Home Office, the Controlled Drug Accountable Officer (CDAO)/Clinical Director for Pharmacy and Medicines Management has determined that each of the CTM Health Board acute pharmacy departments require a Home Office Controlled Drug License to continue supplying controlled drugs.

1.2 **Background:**

A joint letter from Welsh Government and Home Office on 28th February states

"Health boards and NHS trusts should as a matter of priority, review all services where they possess controlled drugs and arrangements where they supply controlled drugs to different services within their organisation or to other organisations and assure themselves of compliance with the requirements for controlled drugs licensing".

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

The review concluded that the following Home Office Controlled Drug Licensing is required:

Premises	Licence type	Responsible Person	DBS applied	DBS complete	Application submitted	Date of inspection	Licence issued
RGH	Supply	Kathryn Howard					
PCH	Supply	Rhian Carta					
POW	Supply	David Hughes					
YCR	Supply	Janine Edmunds					
HMP Parc	Possession	Rebecca Hunter				30.01.23	
Ty Elli	Possession	Sarah Bradley					
Community Dental Clinics	Possession	Laura Andrews/ Sarah Pick					
CDAT: Dewi Sant	Possession	Elaine Lorton					
CDAT: Celtic Court	Possession	Elaine Lorton					
CDAT: Trealaw	Possession	Elaine Lorton					
CDAT: YCC	Possession	Elaine Lorton					
CDAT: Kier Hardy	Possession	Elaine Lorton					

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

Progress with the licencing is requested on a weekly basis and the table above updated, and reported monthly to OMB. The Medicines Management Team continue to offer support for the application process.

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
	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.
	N/A
Legal implications / impact	Yes (Include further detail below)
	Compliance with Misuse of Drugs Act 1971 and Misuse of Drugs Regulations 2001
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	N/A to this report as documented and accepted at previous meeting.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The committee are asked to note progress with licence applications.

AGENDA ITEM
9.2.7

QUALITY & SAFETY COMMITTEE

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2023-2024

Date of meeting	25 July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lauren Dyton – Clinical Audit Manager & Mark Townsend – Head of CA&QI
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
NEIAA	National Early Inflammatory Arthritis Audit
NAIF	National Audit of Inpatient Falls
NHFA	National Heart Failure Audit
NELA	National Emergency Laparotomy Audit
NLCA	National Lung Cancer Audit
PWH	Princess of Wales Hospital

PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital

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 2023-2024 aligned to the National Clinical Audit and Outcome Review Plan for 2023/24. The Welsh Government have yet to confirm the official release date for the 2023-24 plan.

1.2 **29** out of 33 national audits and 10 clinical outcome reviews (tier 1) are green fully compliant and **4** 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 amber because of a delay receiving information (NCEPOD Endometriosis Study). **1** clinical outcome review audit is red because the deadline has passed, and we were only able to achieve limited participation (NCEPOD Epilepsy Study).

1.3 The Consent (all-Wales) Tier 2 organisation priority audit has been completed, report in development. The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) audit specifically reviewing fractured neck of femur cases is in progress.

1.4 National Heart Failure Audit report published June 2023, highlighting the positive developments implemented by Dr Aaron Wong, Consultant cardiologist and colleagues.

1.5 The AMaT ward and area module continues to develop with work in progress including the release of 5 new audits for the mental health unit and work commencing on operating theatre department audits.

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

2.1 Clinical Audit Forward Plan 2023-2024 Current Position

A number of national audits have completed during the current reporting period and full participation achieved:

Table 1: National Audit	PCH	PWH	RGH
COPD (%) 2022/23	100%	97%	97%
Adult Asthma (%) 2022/23	100%	95%	100%
MINAP (%) 2022/23	100%	100%	100%
NELA (%) 2022/23	100%	100%	100%

The exceptions to note are as follows:

National Early Inflammatory Arthritis Audit (NEIAA) remains amber due to Rheumatology service limitations (PWH in particular).

NAIF requires clinical input for case note review activity on all three DGH sites.

NHFA in PWH achieved just over the minimum data submission for 2022/23 (74%), due to limited clinical input. Improvements in clinical input noted for 2023/24, PCH and RGH hospitals achieved 100% compliance.

TARN 2022/23 activity lower than anticipated due to fluctuating staffing levels (notably quarter 3 data (PCH)), plan in place to address the backlog of cases. TARN web platform down for multiple days in June 2023, issue ongoing, may impact on July deadline for quarter 4 case submission.

A clinical lead remains outstanding for the Chronic Obstructive Pulmonary Disease (COPD) National audit for PCH and clinical leadership for respiratory national audits in general is problematic. A Health Board clinical lead yet to be identified for the National Audit of Dementia (Round 6) due to commence August 2023.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

2.2 Key clinical audit publications, findings and actions

NELA National Emergency Laparotomy Audit
Based on data from 22, 132 patients who had emergency bowel surgery in England and Wales between December 2020 and November 2021, this report found that improvements in in-hospital mortality have levelled off (9.2% in year 8 compared to 9.1% and 9.6% in years 7 and 6 respectively).

It also found that there has been improvement in various aspects of care around emergency laparotomy, such as direct consultant delivered care in theatre and length of postoperative hospital stay. Specific concerns remain around delays in pathways of care for many patients between time of arrival in hospital and definitive surgical intervention ('door-to-surgery time'):

- Patients experienced long delays from time of arrival at hospital to time of surgery, including those with suspected sepsis
- 77.7% of patients with suspected sepsis on arrival did not receive antibiotics within an hour

- One in five high-risk patients did not receive postoperative care in a critical care unit.

The report also found that frailty doubled the risk of mortality of patients aged 65 and over.

Local NELA data has been reviewed by the lead clinicians which highlighted the need for:

- Elderly Care Support / Perioperative frailty team input
- Improved access to critical care for high-risk patients
- Improved links to Radiology and Emergency Department

NLCA - National Lung Cancer Audit

Published a State of the Nation Report 2023. Based on patients diagnosed with lung cancer in England during 2021, in Wales in 2020-2021, it summarises the performance of lung cancer services on a set of performance indicators and patient outcomes.

It found that the Covid-19 pandemic had an impact on the number of patients diagnosed in Wales, which fell from 2,240 in 2019 to 2,067 in 2020 (with a subsequent recovery in 2021 to 2,244).

For Wales, there was a reduction in the number of patients with NSCLC undergoing surgery or treatment with curative-intent, compared with 2019 – and, by 2021, the number of patients undergoing these treatments had not recovered to 2019 pre-pandemic levels.

The Clinical Audit team is working with Cancer Services to develop a local improvement plan in relation to the national recommendations.

2.3 **Clinical Audit Training**

Clinical Audit training continues to be provided to health professionals across the Health Board and the department is liaising with the Medical Education teams to ensure that trainees have access to training.

In addition, Clinical Audit experience for student nurses remains a priority with links forged with the University of South Wales.

A programme of AMaT ward and area module dashboard and action plan training has been commenced for all Nurse Staffing Act ward health board wide that will run until October 2023.

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. Ward audit compliance now forms part of the Care Group assurance framework.

The AMaT ward and area module rollout continues to progress 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 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/July 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 WG in June/July 2023.

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

3.1 National Early Inflammatory Arthritis Audit. Due to a lack of administrative support for the consultant lead clinics in the Princess of Wales hospital, only limited participation for this audit has been achieved meaning the national audit outcomes are not an accurate reflection of the service provided.

3.2 The organisation was only able to achieve 74% compliance for the Heart Failure audit in the PWH due to limited Heart Failure nurse availability to complete the nursing assessments compared to 100% compliance achieved in the RGH and PCH. Therefore, the audit findings are not an accurate reflection of the service provided.

3.3 Clinical leadership for national audit activity is becoming increasingly problematic, with consultant's time allocated to direct patient care, there is limited opportunity for involvement in national clinical audits. Clinical leadership is a necessary requirement to support robust data quality and subsequent improvement activity.

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

AGENDA ITEM
9.2.8

QUALITY & SAFETY COMMITTEE

Radiation Safety Committee – Annual Report

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	PAUL JOHNSTON, SUPERINTENDENT RADIOGRAPHER
Presented by	Lauren Edwards, Executive Director of Therapies and Health Science
Approving Executive Sponsor	Lauren Edwards, Executive Director of Therapies and Health Science
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Radiation Safety Committee	21/07/2023	FOR NOTING

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This is a summary report for the period 01.04.2022 to 31.03.2023 which has been prepared to provide the Board with details of items considered by the Health Board Radiation Safety Committee and to

identify any actions taken or areas of outstanding concern in relation to radiation safety across the Health Board

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

2.1 Report highlights:

2.2 As per the terms of reference for Radiation Safety Committee, there have been 2 meetings in the 12-month period that this report applies to; 13th July 2022 and 19th January 2023. Both meetings were chaired by the Assistant Director of Therapies and Health Science, representing Executive Director of Therapies and Health Science, and both meetings were quorate with excellent representation from all sites within the Health Board as well as attendance by our Radiation Protection Advisors and Medical Physics Experts from Cardiff and Swansea.

2.3 During the monitoring period there have been several policies and procedures updated and agreed and are now being utilised across the Health Board – these have included the 'Employers Procedures' which comprise of a subset of procedures related to the Ionising Radiation (Medical Exposure) Regulations 2017 as well as other procedures related to non-medical referrers, quality assurance of x-ray equipment and Local Rules to satisfy the requirements of the Ionising Radiation Regulations 2017.

2.4 There have been several incidents involving ionising radiation across the Health Board premises. All incidents have been investigated in accordance with our local procedures and, where applicable, have also been reported to Healthcare Inspectorate Wales.

2.5 Although incidents have taken place, suitable measures have been taken to address all of the reported incidents and there are currently no causes for concern in terms of volume or type of incidents. No concerns have been raised by Healthcare Inspectorate Wales following submission of incidents and actions.

2.6 A series of audits have been carried out by the Radiation Protection Service with no major concerns identified and any points of note have been discussed and acted upon.

2.7 A new format for radiation risk assessments is currently being worked on and this will soon replace current risk assessments that are in place.

2.8 A clinical scientist has been working with Radiology at Royal Glamorgan Hospital for a period of time and helping review and optimise radiation doses for examinations performed in our CT scanners and fluoroscopy suite.

2.9 New Diagnostic Reference Levels for CT have recently been issued nationally (guidance as to 'typical' doses that should give an 'average' patient). The clinical scientist is going to support the review of those

doses at a local level to ensure our scans have been optimised appropriately and we are able to perform examinations below the national guidance.

2.10 The Health Board has engaged a physicist to support MRI service – this has initially taken place in Princess of Wales Hospital but will also be implemented in Royal Glamorgan Hospital and Prince Charles Hospital in October 2023. This will provide support both in documentation for the service and also advice on the scanning of patients who may have implanted devices which need thorough assessment prior to being allowed in to the scan room where the magnetic field is highest. This should enable patients to be scanned where previously they may have not been able to undergo MRI as we did not have staff who were sufficiently qualified to perform the MRI safety assessments.

2.11 Princess of Wales Hospital was the subject of a planned inspection by Healthcare Inspectorate Wales on 27th and 28th September 2022. Compliance with the Regulations was recognised as generally being very good with some suggestions for improvement identified and subsequently actioned.

2.12 During the visit, the use of the mini-c-arms which are owned and operated by staff in theatre, was suspended as the inspectors were not able to be assured regarding the use of the equipment. The equipment was subsequently removed to Radiology who are now overseeing the quality assurance testing of the equipment and have issued theatre staff with instructions for storing and sending images.

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

3.1 Continued provision of safe radiation services will depend upon ongoing engagement and interaction with all service providers.

3.2 Ongoing provision of advice and guidance will require appropriate resourcing to ensure equitable cover across CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Annual Report

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 contents of this report.

AGENDA ITEM
9.2.9

QUALITY & SAFETY COMMITTEE

CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Debbie Bennion, Head of the Covid-19 Nosocomial Investigation Team
Presented by	Nigel Downes, Assistant Director of Quality and Safety
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Nosocomial COVID-19 Incident Management Programme Group	29th June 2023	ENDORSED FOR APPROVAL

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

NNCP	National Nosocomial COVID-19 Programme
PHW	Public Health Wales
PTR	Putting Things Right
RGH	Royal Glamorgan Hospital
SRO	Senior Responsible Officer

1. SITUATION/BACKGROUND

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

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

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

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

PROGRAMME OVERSIGHT

2.0 Delivery pace has continued to increase significantly now that the team is well established and the investigation approach embedded. A monthly completion target of 166 cases per month has been agreed in order to ensure that all investigations can be completed within the life span of the programme. Currently the team are delivering ahead of this target trajectory.

2.1 The Head of Programme left the Health Board in March 2023 and a new part time Head of Programme was appointed from 1st April 2023.

2.2 The Programme Management and its associated budget transferred in April 2023 from Planned Care to the Central Patient Safety department, sitting in the portfolio of the Assistant Director for Quality and Safety. This will ensure continued effective oversight, clear leadership for the incorporation of the Duty of Candour responsibilities and closer liaison with business-as-usual quality and governance processes for healthcare associated infections.

2.3 Letters from Welsh Government to Health Boards' SROs were received in April 2023. It is confirmed the funding will remain at the same figure as last year. Year 1 programme spends remained within allocated budget and accurate forecasting of total spend for 2023/24 has been completed.

2.4 The current programme spending is within allocated budget and the allotted funding for 2023/24 is fully accounted for in the planned workforce spend. It should be noted that several members of the team have contracts (fixed term and/ or secondments) which extend to July 2024 i.e. beyond the life span of the programme (31st March 2024).

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

WORK STREAMS

2.6 **Establish team, investigation methodology and governance arrangements**

2.6.1 A further clinical investigator is due to be appointed in August 2023; this will allow all clinical investigators to support the small PTR team in providing response letters which contain detailed clinical information.

2.6.2 An administrative position remains vacant and two recent attempts at recruitment have been unsuccessful. It is hoped the third attempt at recruitment in the first week of July 2023 will prove successful. This unfilled vacancy means that team resource is having to be diverted to complete necessary administrative tasks including physical selection of medical records.

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

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

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

2.7 Investigations and quality assurance

2.7.1 The status of investigation work is presented in **Appendix 1,** with the required trajectory illustrated in **Appendix 2**.

2.7.2 As of 31st May 2023 49.80% of the total number of investigations (3233) have been completed. In April 2023 179 were completed and in May 2023 172 were completed.

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

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

2.7.5 The PTR position is illustrated in **Appendix 3**. As of 22nd June 2023 there are 311 completed patient care reviews within Wave 2, 114 of which (37%) have been completed from a PTR perspective i.e. reports sent to families; there are 143 active cases (46%), 7 of which require contact details sourcing(2%), 41 (13%) patient care reviews have been completed but the team have been unable to make contact with the families. 6 (2%) of the completed patient care reviews relate to families who have confirmed that they do not wish to receive a PTR response.

2.7.6 Mortality work continues to progress well, there are now only 10 cases remaining for completion through all waves of the COVID-19 pandemic. It is expected that all cases will be completed by mid-July 2023.

2.7.7 The DU are planning to visit CTMUHB in August 2023 with the remit of sense checking the learning from the investigations to date, discuss any organisational changes that may have been implemented on the back of the learning and to hold an informal programme evaluation session with the Nosocomial Team.

2.8 Stakeholder, patient and family contact

2.8.1 The CTMUHB Communications Lead continues to liaise with the Delivery Unit Communication COVID-19 programme lead.

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

2.8.3 In April 2023 further legal support was received, assisting the team to navigate complex areas of infection control practice, with care being taken to prevent incorrect legal admissions being made. Legal and Risk Services have now provided an update on the cases where the CTMUHB are seeking the mandatory legal advice where breach of duty has been proposed.

2.8.4 To date there have been three COVID 19 Putting Things Right panels which discuss, consider and decide whether any unreasonable care identified by the COVID 19 review panel amounts to a breach of the Health Board's duty of care to that individual patient.

2.8.5 Proactive contact into the patient-facing helpline remains at a low level and to date, only two families have contacted the team following receipt of their investigation pack and covering letters. Both these families requested face to face meetings. These meetings took place with the Head of the Programme, Consultant Physician and the Governance Manager for the programme. Both families have expressed gratitude in being afforded the time to discuss their experiences and are satisfied with the responses given to their additional questions.

2.8.6 To date the Programme Team has received two requests for Freedom of Information data related to programme, these have been responded to in the required time frame via the usual Health Board governance process.

2.8.7 The use of the CIVICA Survey on "COVID-19 Investigation Programme Relatives Feedback" will be used from August 2023. This is a standard survey which will be used by all Health Boards in Wales. The Programme Lead is discussing the plan to roll this out with the Head of Patient Experience.

2.9 **Thematic learning and improvement**

2.9.1 Since the last reporting period, the National Nosocomial COVID-19 Programme Delivery Unit has published the "Learning Report". An overview of this report along with two patient stories will be presented to the Improving Care Board in late July 2023 and at a Quality and Safety Committee meeting later in the year.

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

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

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

4. IMPACT ASSESSMENT

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

	than through existing legal Redress and Claims provision.
Link to Strategic Goals	Improving Health

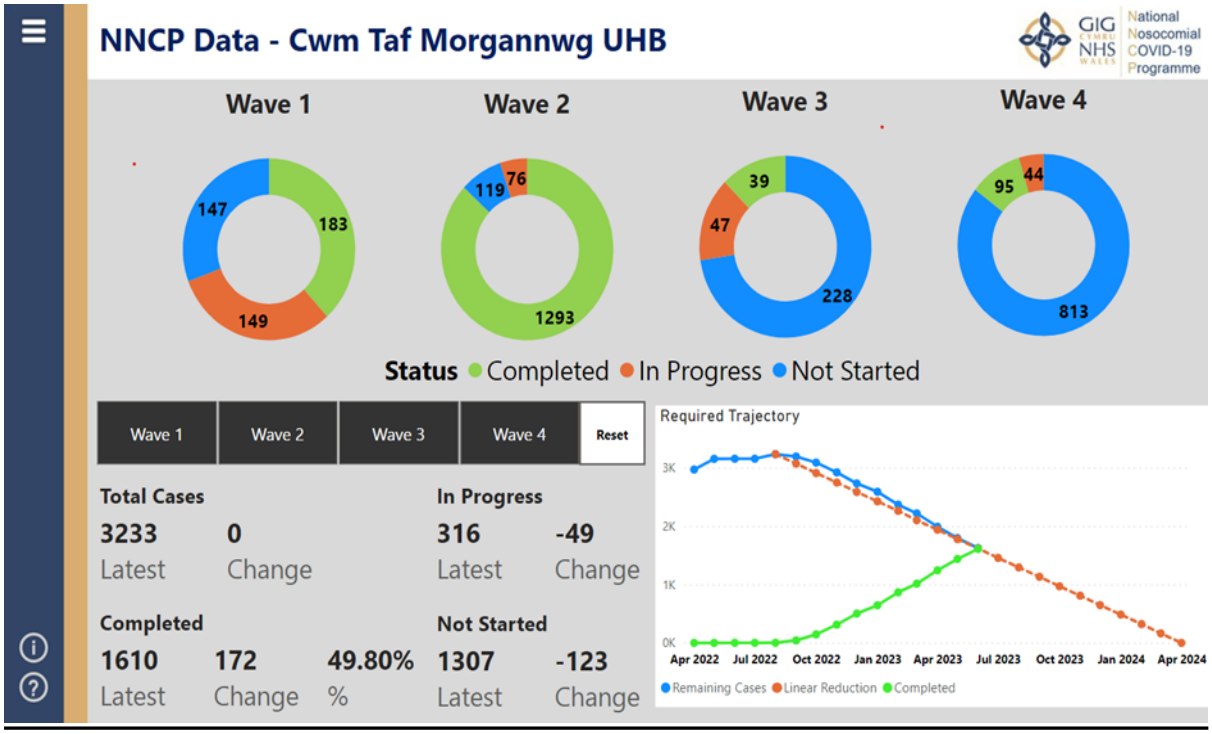
5. RECOMMENDATION

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

Appendix 1

(Data up to and including the end of May 2023)

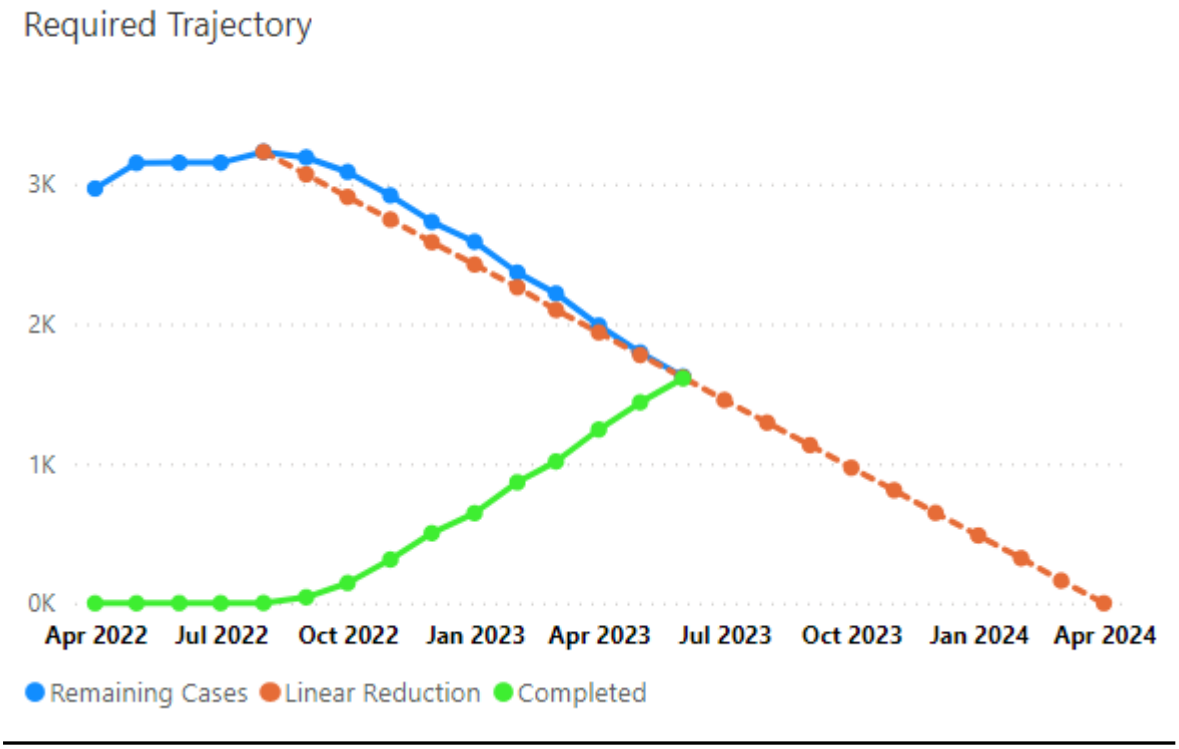
Nosocomial Dashboard (Waves 1-4)



Appendix 2

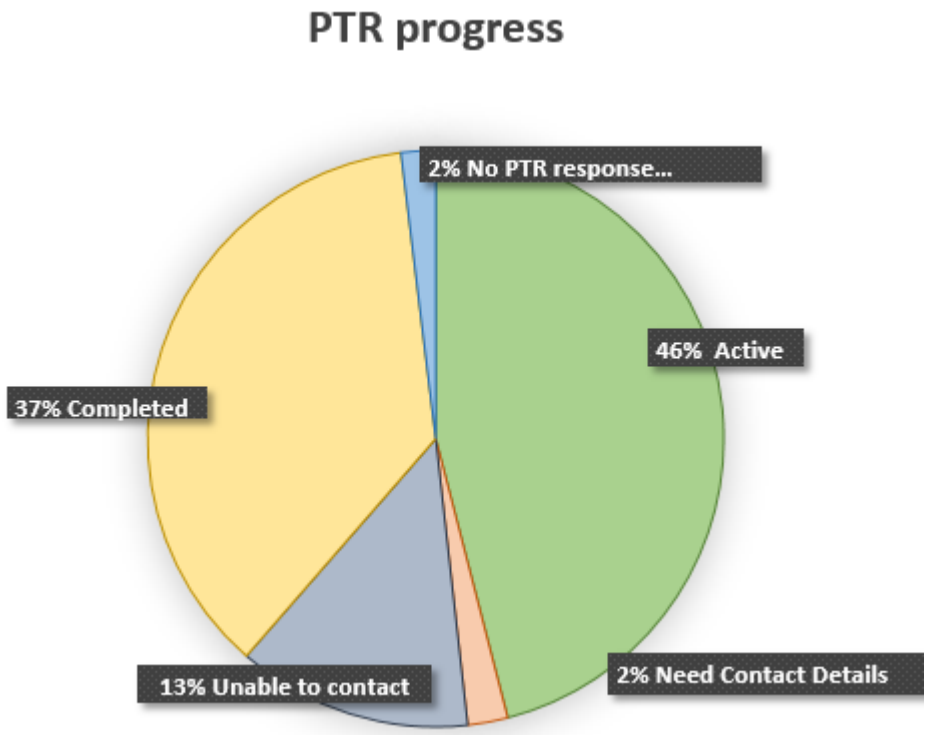
Cwm Taf Morgannwg University Health Board Required Trajectory

(Data up to and including the end of May 2023)



Appendix 3 – PTR progress

(Data up to and including 22nd June 2023)



AGENDA ITEM
9.2.10

QUALITY & SAFETY COMMITTEE

RECOVERY PLAN: ELIMINATING HEPATITIS (B AND C) AS A PUBLIC HEALTH THREAT IN WALES BY 2023

Date of meeting	25th July 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dr Dai Samuels, Clinical Lead For Liver Disease, CTM Philip Daniels, Interim Director Public Health Ceri Ford, Lead Officer, Area Planning Board Marie Evans, Head Of Planning & Commissioning, Adulthood Strategy Group
Presented by	Philip Daniels, Interim Director Public Health
Approving Executive Sponsor	Executive Director of Public Health
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Liver Disease Planning and Implementation Group Area Planning Board Public Health Wales Hepatitis B & C Elimination Working Group Executive Leadership Group	January 2023 – July 2023	ENDORSED FOR APPROVAL

ACRONYMS	
APB	Area Planning Board
CDAT	Community Drug & Alcohol Team
CTMUHB	Cwm Taf Morgannwg University Health Board
HITT	High Intensity Test and Treat Pathway (HITT)
LDIG	Liver Disease Implementation Group
POCT	Point of Care Testing
WHO	World Health Organisation

1. SITUATION/BACKGROUND

1.1 This report provides an update on the work being progressed following publication of A Welsh Health Circular *(Appendix 1)* which was issued to Health Boards in January 2023 identifying actions needed to be taken to ensure progress on hepatitis B and C elimination across Wales.

1.2 The Hepatitis B and C Elimination Programme Oversight Group has been established by Welsh Government to provide a renewed strategic focus on elimination in line with the World Health Organisations (WHO) strategy.

1.3 Elimination of hepatitis B and C has significant benefits for the individual, population health and wider society. The benefits of prevention and treatment to individuals are clear in terms of their longer term physical and mental health. Preventing onward transmission of the virus to other individuals results in wider societal benefits. Elimination is highly cost effective as it prevents development of hepatitis related liver disease and all of its complications: end-stage liver disease (cirrhosis) and hepatocellular carcinoma which are extremely costly to manage, and require utilisation of scarce resource. As well as the cost savings that are realised, prevention and treatment of hepatitis B and C frees up hospital beds and liver transplants for people with other conditions.

1.4 Hepatitis B and C interventions have traditionally been delivered through hospital-based services and by specialists. While there will always be a role for specialised services, to eliminate hepatitis B and C we must simplify service delivery, including testing and treating at the most appropriate setting for the individual, whether that be in primary care, harm reduction services or settings such as prisons. Identifying individuals for testing and supporting linkage to treatment is crucial and will require investment in peer workers and patient navigators. Delivery of care and treatment needs to be increasingly undertaken by non-specialists, which could include primary care professionals.

1.5 Despite many successes to date, and the dedication that continues to be shown by staff providing key services, the elimination of hepatitis B and C remains challenging, exacerbated by the impact of the pandemic. Updated modelling for hepatitis C alone suggests there could be another 8,000 people in Wales who we need to reach. Without further action, elimination may not be achieved until at least 2040.

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

2.1 Joint Recovery Plan

Health Boards have been requested to lead the development of Joint Recovery Plans for their respective areas, working with the Area Planning Boards and Public Health Wales. High level plans were to be submitted by 31st March 2023 (*Appendix 2*) with a more detailed delivery plan required by 13th July 2023 for assessment by the Hepatitis B and C Elimination Programme Oversight Group at Welsh Government.

There are 13 actions outlined by the Welsh Government roadmap to achieving elimination all of which have been addressed within the Cwm Taf Morgannwg Recovery Plan: Eliminating hepatitis (B and C) as a public health threat in Wales by 2023. This was brought before the Executive Leadership Board for approval prior to submission to Welsh Government by 13th July 2023. The Plan is enclosed as **Appendix 3.**

2.2 Across Cwm Taf Morgannwg, we have passionate and dedicated clinicians and third sector providers with a real commitment and drive to work in partnership to make the necessary continuous progress towards the elimination of Hepatitis B and C. A multi-agency Hepatitis B and C Elimination working group has been established chaired by Dr David Samuel who is the CTMUHB wide Hepatology Clinical Lead. It is this group who have made the contributions and determined the way forward with the development of the CTM Recovery Plan.

2.3 It must be noted that this Year 1 plan **does not request members of the Executive Leadership Group to commit to any additional funding.** The aim is to "build firm foundations" by mapping our service across sectors, making best use of the resources we already have in particular for testing across partner organisations as well as improving our data collection and data entry for testing on the Harm Reduction Database. To be noted with the establishment of the new national Clinical Networks, £1m was allocated to the then Liver Disease Implementation Group, and this is part of these current funding plans, with no additional funding beyond this. As such there is no external funding identified for the delivery of this plan.

2.4 The additional resource already identified to increase testing and treatments this year and beyond are as follows:

- A Harm Reduction Nurse funded by the Area Planning Board for 2 years.
- A High Intensity Test and Treat Pathway (HITT) project is due to commence in June 2023 at five Community Drug & Alcohol Team sites across CTM UHB using a two tiered Point of Care Testing (POCT) Pathway.
- The Community Drug & Alcohol Team (CDAT) and Board will ensure all individuals entering treatment will be offered BBV testing. Numbers have increased but improvement still needed, this improvement will be undertaken within existing resource.
- Utilisation of CTMUHB Health Protection Team for increased testing of Hepatitis C.
- Continuation of the ongoing elimination work in Parc Prison

2.5 The Plan provides a range of information relating to our prevalence of disease, our current levels of testing and treatment and our aspiration targets. Our key challenges are described which will not be too dissimilar to any other health board in Wales. The current position and actions to be undertaken are described throughout the plan categorised under the following themes:

- Prevention
- Testing
- Treatment
- Re-engagement of patient programme (All Wales initiative)
- Improving data at a national and local level

2.6 To note in the financial year 2022-23, 65 patients were treated for active Hepatitis C infection within CTMUHB. The target for the financial year was 135 patients. It must be highlighted that this target is set nationally by statistical modelling. It was acknowledged in the recent All Wales Hepatitis C meeting held in March 2023 that the targets may be over-estimated (A comparison is Aneurin Bevan UHB with a comparable population those target is 85 for this coming year).

3. 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)	Staying Healthy
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications /	There is no direct impact on resources as a result of the activity outlined in this report.

Impact	
Link to Strategic Goals	Creating Health

4. RECOMMENDATION

Members of the Quality & Safety Committee are asked to **NOTE** the report.

APPENDICES (available on request)

Appendix 1: WHC/2023/01 - Eliminating hepatitis (B and C) as a public health threat in Wales – Actions for 2022-23 and 2023-24

Appendix 2: High Level Strategic Plan

Appendix 3: CTM Recovery Plan: Eliminating Hepatitis B and C as a public health threat in Wales (this is the document we are seeking approval from the ELG)

AGENDA ITEM
9.2.11

QUALITY & SAFETY COMMITTEE

INTERNAL AUDIT REPORT ON WELSH RISK POOL CLAIMS

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Claims
Presented by	Stephanie Muir, Assistant Director of Concerns & Claims
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Director led Patient Safety weekly meeting	(03/07/2023)	SUPPORTED

ACRONYMS	
WRP	Welsh Risk Pool

1. SITUATION/BACKGROUND

1.1 Internal Audit have undertaken a review of Welsh Risk Pool concerns and compensation claims in line with their workplan.

1.2 The purpose of the review was to provide assurance that the correct processes have been followed and reimbursements are compliant with the Welsh Risk Pool standard and claims are accurate.

1.3 The review provides recommendations for improvement and an action plan has been developed to ensure that recommendations are achieved.

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

2.1 The review provided "**reasonable assurance"** with some management actions required.

	Management Action	Assurance
1	Completed documents within set timescales	**Limited**
2	Evidence to support costs incurred	**Substantial**
3	Appropriate authorisation	**Substantial**
4	Accurate claims data within Datix	**Substantial**

"Reasonable Assurance - Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved".

2.2 It is noted that of the 4 areas reviewed, 3 areas achieved substantial assurance, with one area having limited assurance which affected the overall assurance rating.

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

3.1 The review identified that matters requiring management attention include:

- Ensuring that the status recorded on Datix have been correctly classified when cases are closed, and the Standard Operating Procedures (SOPs) are updated to reflect this process.
- Ensuring the completion of documentation in line with WRP timeframes.
- Ensuring that staff are aware of the need to save relevant information to Datix.
- Ensuring consistency in approach when capturing information in Datix, including dates and financial transactions

3.2 A detailed action plan has been developed on all management actions and substantial progress has been made on all action points, with only a few remaining at amber stage.

3.3 The action plan will be regularly monitored through the weekly Executive Led Patient Safety meeting.

3.4 This report has already been presented to the Audit and Risk Committee.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are quality and safety implications. If actions arising from WRP and IA reviews are not undertaken and improvements note made.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If 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)
	Resource realised through the operating model re-alignment will be required to take forward this work.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee is asked to review and confirm that they are sufficiently assured that the action plan and management responses will address the recommendations

Internal Audit Action Plan - Welsh Risk Pool Claims

Reference	Date added	Matters Arising	Assurance Rating	Recommendations	Priority	Agreed Management Action	Target Date	Responsible Officer	Progress	Update
1.1 a	31.05.23	Accuracy of Closed Case Reports	Limited	Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases.	Medium	Staff will be reminded of importance in next meeting in respect of closure.	09.06.23	Head of Claims & Inquests Legal Services Manager	Completed	Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases.
						A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records.	09.06.23	Head of Claims & Inquests Legal Services Manager	Completed	Draft checklist developed, to be tested on Datix.
						A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team.	30.06.23	Head of Concerns & Business Intelligence	Partially Completed	The SOP to support the training has been completed, further guidance regarding stages is in the process of being completed.
						A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required.	30.06.23	Head of Concerns & Business Intelligence	Partially Completed	In progress, audits will commence when guidance and training has been completed. Audit tool being drafted.
1.1b	31.05.23	Accuracy of Closed Case Reports	Limited	Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	Medium	In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	30.06.23	Head of Concerns & Business Intelligence	Partially Completed	Baseline validation exercise of open claims currently being undertaken. Feedback being provided to Claims Team Manager.
1.2 a	31.05.23	Accuracy of Closed Case Reports	Limited	The 'closure' section within the SOP should be reviewed and updated with clear guidance on what the stages are for closed cases in Datix.	Medium	The relevant section of the Standard Operating Procedure will be reviewed to ensure that it clearly outlines all requirements associated with the closure of claim file, including the Datix Cymru components.	09.06.23	Head of Claims & Inquests Legal Services Manager Head of Concerns & Business Intelligence	Completed	Review of Standard Operating Procedure completed.
1.2b	31.05.23	Accuracy of Closed Case Reports	Limited	Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	Medium	The updated Standard Operating Procedure will be shared with all staff and training will be provided at the next team day following update. This will include training on the Datix Cymru System.	09.06.23	Head of Claims & Inquests Legal Services Manager Head of Concerns & Business Intelligence	Completed	Joint training session to be provided on the team day on 06.07.23
2,1	31.05.23	Timeliness of submission to WRPS	Substantial	Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	High	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's.	30.06.23	Head of Claims & Inquests	Partially Completed	Standard Operating Procedure for LFERs drafted. Whilst escalation is taking place this needs formalising to ensure a consistent approach. SOP is out for consultation and will be ratified imminently.
						In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process.	30.06.23	Head of Concerns & Business Intelligence	Partially Completed	CMRs and LFERs are already monitred via the weekly reporting process. Further development of dashboard will ensure that appropriate staff have easy access to this data. Dashboard development forms part of the work plan for Business Intelligence Team, which is well underway.
						Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	30.06.23	Head of Claims & Inquests	Completed	Staff remined of work deadlines and prioritisation.
2,2	31.05.23	Timeliness of submission to WRPS	Substantial	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	Medium	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP.	26.05.23	Legal Services Manager	Completed	Staff were reminded of the importance of completing all required fields in Datix Cymru during the weekly team meeting. All Officers have been asked to ensure the Datix Cymru Record is up to date when reviewing their cases.
						The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	30.06.23	Head of Concerns & Business Intelligence	Completed	Validation of LFER is completed as part of the production of the weekly report. However, audit programe doesn't start until 01.08.23
		Access to		The reasons for not being able to access all information saved to Datix should be identified and attempts made to resolve the issue		The Staff member has been identified and the issue will be raised with IT. This will be followed up by the Legal Services manager to ensure this issue is swiftly resolved.	26.05.23	Legal Services Manager	Completed	This issue has been resolved. No further issues have been identified.

Reference	Date added	Matters Arising	Assurance Rating	Recommendations	Priority	Agreed Management Action	Target Date	Responsible Officer	Progress	Update
3,1	31.05.23	Access to Datix			Low	Issues in relation to accessing the documents within Datix (Web or Cymru) will be addressed by the Business Intelligence Team.	09.06.23	Head of Concerns & Business Intelligence	Completed	This issue has been resolved. No further issues have been identified.
						A reminder will be issued to escalate system issues to the Business Intelligence Team as they arise.	09.06.23	Head of Concerns & Business Intelligence	Completed	This issue has been resolved. No further issues have been identified.
4.1a	31.05.23	Accuracy and approach to capturing final payment information (Design)		The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should an invoice be disputed.	Medium	The relevant section of the SOP will be reviewed and updated as recommended.	26.05.23	Head of Claims & Inquests	Completed	SOP has been updated and shared with staff.
4.1b	31.05.23	Accuracy and approach to capturing final payment information (Design)		Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process	Medium	The updated SOP will be shared with all staff and training will be provided at the next team day following update	26.05.23	Legal Services Manager	Completed	Training will be undertaken at the next team day on 06.07.23

Welsh Risk Pool Claims
Final Internal Audit Report

May 2023

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

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Final report issued:	31 May 2023
Auditors:	Elizabeth Vincent – Principal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Stephanie Muir, Assistant Director of Concerns and Claims Kellie Jenkins Forrester, Head of Concerns & Business Intelligence Bahar Chowdhury, Head of Claims and Interest Carla Snook, Legal Services Manager
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To provide assurance that the correct processes has been followed and reimbursements are compliant with the Welsh Risk Pool standard and claims are accurate.

Overview

The matters requiring management attention include:

- Ensuring that the status recorded on Datix have been correctly classified when cases are closed, and the SOPs are updated to reflect this process.
- Ensuring the completion of documentation in line with WRP timeframes.
- Ensuring that staff are aware of the need to save relevant information to Datix.
- Ensuring consistency in approach when capturing information in Datix, including dates and financial transactions.

The advisory point is detailed within the report.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	⇔ 2021/22

Assurance summary[1]

Objectives		Assurance
1	Completed documents within set timescales	Limited
2	Evidence to support costs incurred	Substantial
3	Appropriate authorisation	Substantial
4	Accurate claims data within Datix	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Accuracy of 'closed' case reports	1	Operation	Medium
2	Compliance with submission timeframes	1	Operation	High
4	Accuracy and approach to capturing information	1	Operation	Medium

1. Introduction

1.1 Our review of Welsh Risk Pool concerns and compensation claims was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Compensation claims usually take a number of years from receipt of claim to settlement and can involve a large number of payments and repayments; this gives rise to a potential for mistakes to occur. Welsh Risk Pool (WRP) Services requires that claims for reimbursement and repayment are made within specific timescales.

1.3 WRP have developed a standard: The Compensation Claims Management Standard, to ensure that NHS bodies:

- Have an effective process for managing concerns raised by patients and staff.
- Have an effective process for managing legal claims for financial compensation.
- Ensure that there is good organisational learning from all events.

1.4 Reimbursement of settled claims are either under NHS indemnity, or through redress cases.

1.5 The WRP standard requires Internal Audit to review the accuracy of a representative sample of compensation claims for reimbursement by Welsh Risk Pool Services.

1.6 During 2022 the Health Board worked with WRP Services to help resolve the backlog of Learning From Events relating to older, legacy claims.

1.7 Recently, a new cloud based Once for Wales Datix system has been introduced, referred to as DCIQ. Our testing spanned both the old web based Datix system and the new system, due to the historic nature of some cases.

1.8 As part of our review, we have followed up on the progress made implementing recommendations from our previous audit. We acknowledge that a comprehensive set of Standard Operating Procedures (SOPs) is now in place, setting out processes set by step. We have made some further recommendations to enhance the SOPs and would encourage management to discuss them with those involved in the process to ensure they are understood, accurate and complete.

1.9 The potential risk considered in this review is that claims costs reimbursed from the Welsh Risk Pool are inaccurately recorded and not appropriately authorised by the Health Board's senior management.

1.10 The relevant lead for this review is the Executive Director of Nursing, Midwifery & Patient Care.

2. Detailed Audit Findings

Objective 1: An appropriately completed learning from events report, case management report, case financial record and a schedule of costs has been completed for each reimbursement claim within set timescales.

2.1 Datix reports of 'closed' cases were received for Clinical Negligence (CN), Personal Injury and Redress for the financial year 2022-23. There were 65 'closed' cases identified on the CN report, 28 Personal Injury and 69 Redress. We identified that many of the cases did not have the correct status in Datix. Either it had not been correctly updated to the correct stage (for example, reimbursement received), or had no stage showing at all. Our testing focused on those cases that had been correctly closed. We are aware that management are in the process of developing dashboards to allow monitoring and reporting on cases. As such, ensuring the correct classification is essential to making the dashboard reporting accurate and meaningful. **(Matter Arising 1)**

2.2 We tested a sample of 23 cases across the three areas of, Clinical Negligence, Personal Injury and Redress to confirm that each case had an appropriately completed Learning from Events (LFE) report, Case Management Report (CMR), a Finance Case Record checklist (U1/U2), and a Losses and Special Payments Register (LASPAR) schedule of costs. While the documentation had largely been produced, email trails to WRP had not always been recorded in Datix.

2.3 As part of the WRP standards, claims management teams complete a LFE report within 60 days of the 'decision to settle' date. While this requirement became effective for claims received after October 2019, the Health Board is also required to complete legacy LFE reports. We note that the claims management team reviewed the deferred LFE reports in March 2023. There are currently 74 claims and 30 Redress cases with deferred LFR reports, of which 24 have outstanding information and have been deferred for more than nine months. Our testing included 12 legacy claims that were received before October 2019. None of these legacy claims had met the agreed WRP target date of February 2020 for legacy LRFs to be submitted. For the remaining cases in our sample, 9/11 did not meet the 60-day target. **(Matter Arising 2)**

2.4 Claims management teams must complete and submit a CMR and checklist and Finance Case Record (U1/U2) to WRP within 4-months of the final payment date. Our testing identified one case that had been incorrectly categorised within the stages in Datix and so did not require a CMR. The Health Board did not meet the 4-month target for 9/22 cases. The Health Board is at risk of incurring WRP penalty charges if it continues to not meet the target submission dates. **(Matter Arising 2)**

2.5 We compared the key dates on the LFE report, the CMR, and the finance checklist U1/U2 to Datix and found differences with the 'Decision to Settle' date and the 'Final Payment' date. These differences could impact on the monitoring of the target dates. **(Matter Arising 4)**

Conclusion:

2.6 All cases that we tested had the relevant documents. However, there were instances where information had not been submitted to WRP within the required timeframe. We also identified errors in the monitoring reports and differences between the key dates when comparing the documents to Datix.We have provided **limited** assurance against this objective.

Objective 2: There is appropriate evidence to support the costs incurred.

2.7 From our sample of 23 cases, we saw sufficient evidence to support the costs incurred. We had some technical issues when using Datix. We understand that this is not the first occurrence. As such, we recommend retaining copies of information locally until the issue is resolved. **(Matter Arising 3)**

2.8 We also reviewed the LASPAR schedules for each case in our sample to ensure that they reconciled to the amounts reimbursed from WRP. In all cases there was evidence to support that the costs were accurate, and values reconciled to the LASPAR schedule.

Conclusion:

2.9 We confirmed that all the cases that we tested had been appropriately authorised. As such, we have provided **substantial** assurance against this objective.

Objective 3: Forms have been appropriately authorised aligning with delegated limits within the organisation.

2.10 The claims within our sample had an appropriate governance and case manager declaration, and had been appropriately authorised prior to submitting to the WRP.

Conclusion:

2.11 We confirmed that all the cases that we tested had been appropriately authorised. As such, we have provided **substantial** assurance against this objective.

Objective 4: Claims submitted are accurately entered onto the Datix risk management database.

2.12 Reimbursements that we tested were appropriately approved by WRPS, and the amounts received reconciled to the U1 checklists and the finance schedules that were submitted to WRPS.

2.13 The financial information for the claims in our sample had been accurately recorded in Datix and the values reconciled to the relevant checklists.

Conclusion:

2.14 We can confirm that the claim submitted was accurately entered onto the Datix risk management database. As such, we have provided **substantial** assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Accuracy of Closed Case Reports (Operation)		**Potential Impact**
As cases progress though the claims process, their status on Datix should be updated. We were provided with reports of Clinical Negligence (CN), Personal Injury (PI) and Redress cases that showed the cases closed in 2022/23 to date. However, we identified that 41/65 'closed' CN cases and 16/28 'closed' PI cases either had either an incorrect status or no status recorded on Datix. We understand that management are introducing dashboards to be used for monitoring cases. Reporting incorrect stages could affect the results and potentially provide incorrect monitoring data. As a result of recommendations made in our 2021/22 report a series of Standard Operating Procedures (SOPs) have been developed. We reviewed the relevant SOP and note that while the 'Closure' section states that *'officers must ensure that all stages are completed',* it does not elaborate on what the correct closure stages should be.		• Incorrect reporting of data could impact on decision making and statutory reporting requirements
Recommendations		**Priority**
1.1a 1.1b	Management should reiterate to staff the importance of ensuring accurate data in relation to the closure is captured in Datix for all closed cases. Regular monitoring of the 'stages' within Datix should be carried out to ensure compliance and that no 'blanks' are being reported.	**Medium**
1.2a 1.2b	The 'closure' section within the SOP should be reviewed and updated with clear guidance on what the stages are for closed cases in Datix. Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
1.1a	Staff will be reminded of importance in next meeting in respect of closure.		Head of Claims & Inquest
	A check list will be developed to support staff in the completion of Datix at all stages of process. This information will included in the Standard Operating Procedures for the closing of records. A refresher training session will be provided to the Claims Team in relation to Datix Cymru by the Business Intelligence Team.	09.06.23	Legal services Manager
	A monthly audit of closed claims will be undertaken by the Business Intelligence Team. Feedback from this audit will be presented to the Health Board Datix Management and shared with the Claims Team with actions for improvement identified where required.	30.06.23	Head of Claims & Inquests Head of Concerns & Business Intelligence
1.1b	In addition a regular (minimum of monthly) data validation exercise and audit of open claims will be completed. Feedback from this exercise will be shared with the Claims Team and recurring issues escalated to the Senior Team.	30.06.23	Head of Concerns & Business Intelligence
1.2a	The relevant section of the Standard Operating Procedure will be reviewed to ensure that it clearly outlines all requirements associated with the closure of claim file, including the Datix Cymru components.	09.06.23	Head of Claims & Inquest Legal services Manager
1.2b	The updated Standard Operating Procedure will be shared with all staff and training will be provided at the next team day following update. This will include training on the Datix Cymru System.		Head of Concerns & Business Intelligence

Matter Arising 2: Timeliness of submission to WRPS (Operation)	**Potential Impact**
We reviewed a sample of 23 cases, a mixture of CN, PI and redress. Our testing identified: Learning from Events (LFE) Reports The claims management team complete and submit several documents to WRP within specified timeframes. For cases received by the Health Board after October 2019 LFE report within 60-days of the decision to settle date. For cases received before October 2019 a legacy LFE was to be sent to the WRP before February 2020. • 21/23 cases were not submitted to WRP within the 60-day target, this included 12 legacy cases that did not achieve the agreed target date. • 2/23 cases appear to have been submitted within the 60-day target, but key date information was not clear in Datix. Case Management Reports (CMR), U1/U2 Finance Checklist The claims management teams complete and submit a CMR and U1/U2 checklist to WRP within 4-months of the final payment date. • 1/23 cases was incorrectly classified so no CMR or U1/U2 checklist was required. • 9/22 cases did not meet the 4-month target date, with two cases taking over a year to be submitted. • 2/22 the key dates to determine the 4-month target date were not clear from the information available. We are aware that in the past, the Health Board has been at risk of having a penalty imposed by WRP where submissions are late.	• Financial loss to the Health Board.

Recommendations		**Priority**
2.1	Management should ensure that required documentation is submitted to the WRP within the specified timeframes, appropriately recorded on Datix Cymru, and monitoring takes place to ensure compliance with this requirement.	**High**

2.2	Management should ensure that staff are aware of accurately recording date information within Datix to allow the calculation of target dates and monitoring.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
2.1	In respect of LFER's a new process and SOP is being drafted to ensure timely submission of LFER's. In respect of CMR's there is a process that currently picks up on upcoming CMR's. The process around monitoring CMR's will be solidified by the new dashboard which will allow a more robust monitoring process. Individuals who have missed deadlines will be reminded of importance of CMR deadlines and provided with additional training & support.	30.06.23	Head of Claims & Inquest
2.2	Staff will be reminded of the importance of accurately recording date information on Datix Cymru and ensuring it is reflected on documents submitted to WRP. The recording of LFER information will be included in the audit and data validation programme described in action 1.1b.	26.05.23 09.06.23	Legal services Manager Head of Concerns & Business Intelligence

Matter Arising 3: Access to Datix (Operation)			**Potential Impact**
When undertaking our testing, we experienced difficulties opening documents within Datix. We understand that this matter has happened to others on a number of occasions.			• Appropriate evidence trail not available.
Recommendations			**Priority**
3.1	The reasons for not being able to access all information saved to Datix should be identified and attempts made to resolve the issue.		**Low**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The Staff member has been identified and the issue will be raised with IT. This will be followed up by the Legal Services manager to ensure this issue is swiftly resolved	26.05.23	Legal services Manager
	Issues in relation to accessing the documents within Datix (Web or Cymru) will be addressed by the Business Intelligence Team. A reminder will be issued to escalate system issues to the Business Intelligence Team as they arise.	09.06.23	Head of Concerns & Business Intelligence

Matter Arising 4: Accuracy and approach to capturing final payment information (Design)	**Potential Impact**
Claims management teams must complete and submit a CMR and checklist and Finance Case Record (U1/U2) to WRP within 4-months of the final payment date. We found 12/22 cases where the 'Final Payment' date recorded on the paperwork sent to WRP did not agree to the date of the final invoice shown within Datix. The 'Final Payment' date should originate from the date of the last invoice received relating the case. However, there were differences in approach with some staff using the invoice date and some using the date the invoice was paid. We identified the same issue as part of our 2021/22 review and are aware that in response to last year's recommendation, management have undertaken work to review and update their Standard Operating Procedures. However, based on the results of our testing this year, our review of the SOP, and through discussion with Head of Claims and Interest, we have identified that greater clarity is still needed around the 'final payment' date. Furthermore, the SOP should be added to include the process for when invoices are disputed and how this impacts the final payment date and the required amendments to the Datix.	• Inaccurate reporting and monitoring. • Statutory submission deadline missed resulting in financial penalty.

Recommendations		**Priority**
4.1a	The final payment section within the SOP should be reviewed and updated with clear guidance on what constitutes final payment and the process to follow should and invoice be disputed.	**Medium**
4.1b	Consideration should be given to providing additional training to staff to ensure they understand all aspects of the process.	

Agreed Management Action		**Target Date**	**Responsible Officer**
4.1a	The relevant section of the SOP will be reviewed and updated as recommended.	26.05.23	Head of Claims & Inquest
4.1b	The updated SOP will be shared with all staff and offer of training will be provided at the next team day following update.	26.05.23	Legal services Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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AGENDA ITEM
9.2.12

QUALITY & SAFETY COMMITTEE

FOLLOW UP CONCERNS INTERNAL AUDIT REPORT

Date of meeting	25/07/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester Head of Concerns & Business Intelligence
Presented by	Nigel Downes, Assistant Director of Quality & Safety
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

The internal audit of concerns management in November 2021 provided the Health Board with a 'limited' assurance report. The report highlighted a number of risks and included eleven high or medium priority recommendations. Management responses to address all recommendations were identified and regular monitoring of the agreed actions was undertaken via the Audit and Risk Committee.

In March 2023, Internal Audit completed a follow up review of Concerns in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board.

It should be noted that the aim of the follow up review was not to provide assurance against the full review of the original scope and objectives of the original audit. The purpose of the review was to ensure that suitable actions have been undertaken to fulfil the recommendations from the initial review (2022) and where actions remain open, adequate progress has been made. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

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

The review provided the Health Board with "**reasonable assurance"** in relation to implementation of the actions from the original review. "Reasonable Assurance is identified as some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved".

The follow up review determined that sufficient actions had been taken to address six of the recommendations and these were therefore closed. Of the remaining five, it was deemed that action has commenced to address four of the recommendations and as result the priority of these has reduced. One remained the same. A progress summary is provided in the table below.

	Management Action	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Policy and operating procedures	**High**	↑	**Low**
2	Capturing complaints	**Medium**	↑	**Closed**
3	Training	**High**	↑	**Medium**
4	Early resolution classification	**Medium**	↔	**Medium**
5	Accurate records	**Medium**	↑	**Closed**
6	Quality assurance	**High**	↑	**Closed**
7	Re-opened cases	**Medium**	↑	**Closed**
8	Aged open cases	**Medium**	↑	**Low**
9	Lessons learnt	**High**	↑	**Low**
10	Monitoring within the ILGs	**Medium**	↑	**Closed**
11	Health Board monitoring	**High**	↑	**Closed**

A detailed action plan (attached) has been developed to address the outstanding actions, with completion scheduled for August 2023. Key actions relate to:

- Embedding of the revised Concerns Policy and Procedures
- Development and delivery of a concerns management training programme
- Monitoring of complaint timescales, including updates for those cases that remain open over 30 working days
- Implementation of quality assurance and audit processes

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

3.1 Of the eleven high and medium priority recommendations made in the original review, five remain open. There are no high priority recommendations outstanding.

3.2 Since the original review, the Health Board's transition to the new operating model has commenced which included the centralisation of the Complaints Team in February 2023.

Whilst this delayed the conclusion of the Concerns Policy and Procedures review (awaiting final approval), staff are working to the key principles outlined within them, specifically in relation to robust triage and escalation where comments remain outstanding.

3.3 A training needs analysis is being undertaken to identify the training requirements across the organisation, including the level / type of training required by different staff groups.

3.4 A quality assurance checklist has been approved and is being implemented.

3.5 A weekly audit of new complaints received commenced on 03.07.23. The audit of closed complaints is scheduled to commence from the 24.07.23.

3.6 The action plan will be regularly monitored through the Weekly Executive Led Quality & Patient Safety meeting.

3.7 The Internal Audit Report has been presented to the Audit and Risk Committee.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are quality and safety implications. If actions arising from WRP and IA reviews are not undertaken and improvements note made.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If 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)
	Resource realised through the operating model re-alignment will be required to take forward this work.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee is asked to:

- Accept the Internal Audit Report and consider the managerial actions and note progress already made against these actions.

Internal Audit Action Plan - Concerns Management

Reference	Date added	Matters Arising	Recommendations	Priority
1.1 a	31.05.23	Policy and Standard Operating Procedures	The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only.	Low
1.1 b	31.05.23	Policy and Standard Operating Procedures	The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	Low
3.1 a	31.05.23	Training Plans and Activiity	Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes.	Medium
3.1 b	31.05.23	Training Plans and Activiity	A training programme should be put in place to deliver the identified concerns training requirement.	Medium
3.1 c	31.05.23	Training Plans and Activiity	A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	Medium
4,1	31.05.23	Classification of Early Resolution Complaints	The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	Low
4,2	31.05.23	Classification of Early Resolution Complaints	Regular monitoring should be undertaken of cases that remain open and classified as Early Resolution, to ensure they do not remain open indefinitely while waiting for a response. Responses should be chased up frequently for those cases that are open longer, and where necessary a decision should be made to re-classify as a PTR case if the context is appropriate.	Medium
4,3	31.05.23	Classification of Early Resolution Complaints	Consideration should be given to enhancing the Quality Assurance /Audit checklist and SOP by including steps for capturing the outcomes and actions arising from the audits, that can be used for future identification or trends, patterns and training needs.	Low
8	31.05.23	Review and monitoring of aged and open concerns	Consideration should be given to revising the concerns policy and SOP to give an indication of the regularity that contact should be made with complaints for cases that remain open beyond 30 days.	Low
9.1 a	31.05.23	Lessons Learnt	Once the Assistant Director of Quality & Safety has commenced in post, the terms of reference for the Shared Listening and Learning Forum should be reviewed and formally agreed for use.	Low

Agreed Management Action	Target Date	Responsible Officer	Progress
The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained.	mai-23	Head of Concerns & Business Intelligence	Complete
The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	aug-23	Head of Concerns & Business Intelligence	In progress
Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training.	aug-23	Head of Concerns & Business Intelligence	In progress
Once the training needs analysis has been completed, this will inform the training programme.	aug-23	Head of Concerns & Business Intelligence	In progress
This will be developed and be an ongoing rolling programme for the Health Board. Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	aug-23	Head of Concerns & Business Intelligence	In progress
Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	jun-23	Concerns Manager	In progress
Monitoring already occurs on a regular basis. However, in addition quality assurance audits will be undertaken on a minimum of a monthly basis.	jun-23	Concerns Manager	Complete
Quality assurance checklist and SOP to be reviewed and Audit template developed to ensure findings and actions/learning is captured and actioned.	jun-23	Concerns Manager	Complete
Concerns Policy and SOP will be reviewed and updated to include frequency of contact for complaints open beyond 30 working days.	jun-23	Concerns Manager	Complete
Listening and Learning Forum TOR to be reviewed.	jun-23	Assistant Director of Quality & Safety	In progress

Update
A review of the Concerns Policies and Procedures has been undertaken, along with all underpinning Standard Operating Procedures. These have been strengthened to support robust triage and escalation where comments remain outstanding.
The Concerns Policy & Procedure is scheduled to be approved at the July Quality & Safety Committee. The Health Board's Concerns Share Point pages are being reviewed to ensure they are to update and accurate information is available to support staff involved in the management of concerns.
Training Needs Analysis currently being undertaken.
Training Needs Analysis currently being undertaken.
Training Needs Analysis currently being undertaken.
Standard Operating Procedure has been reviewed, with timescales and expectations outlined. Further update will be required following release of updated Putting Things Right Guidance.
Early Resolution Complaints are followed up on a weekly basis where a response has not been received. Monthly management review of cases which remain open past 5 days with a view to re-classification.
Quality Assurnace Checklist has been reviewed and approved. Complaints audit tool for new cases developed and implemented from 03.07.23. Complaints audit tool for closed cases being developed and to be implemented from 24.07.23
The need to ensure monthly updates either by phone, email or letter is provided to all complainants where the response is over 30 working days is included in the Standard Operating Procedure. A review of all holding letter requirements are undertaken on a weekly basis and completed by the administration team.

Follow-up: Concerns
Final Internal Audit Report

May 2023

Cwm Taf Morgannwg University Health Board

Contents

Review reference:	CTM 22/23-29
Report status:	Final
Fieldwork commencement:	22 March 2023
Fieldwork completion:	2 May 2023
Draft report issued:	12 May 2023
Debrief meeting:	18 May 2023
Management response received:	31 May 2023
Final report issued:	31 May 2023
Auditors:	Stuart Bodman – Principal Internal Auditor Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Greg Dix - Executive Director of Nursing, Midwifery and Patient Care
Distribution:	Stephanie Muir – Assistant Director of Concerns and Claims Kellie Jenkins-Forrester - Head of Concerns & Business Intelligence Louisa Hayhurst – Complaints Team Manager
Committee:	Audit and Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

Our review has sought to ensure that for recommendations deemed to be implemented by management, suitable actions have been taken. We have also considered if adequate progress has been made against those recommendations, made in our 2022 Concerns audit review, that remain open.

Overview of findings

A total of 11 High and Medium priority recommendations were made in our original review, though many of those had sub-parts to them.

From our meetings with staff, our review of documentation, and undertaking sample testing we have confirmed that six recommendations have been fully implemented, and work has commenced on implementation of the remaining five.

Since our original review, the Health Board has commenced an organisational restructure that has impacted the concerns team. Despite this, work has progressed on updating the concerns policy and associated procedures, and whilst not finalised, staff are working to the principles of them. However, training in relation to the revised procedures is yet to fully rolled out.

Further work is required in relation to the classification of early resolution cases and the subsequent reporting of them.

Follow-up Report Classification

		Trend
Reasonable 	**Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.	⇧

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Policy and operating procedures	High	⇧	Low
2	Capturing complaints	Medium	⇧	Closed
3	Training	High	⇧	Medium
4	Early resolution classification	Medium	⇔	Medium
5	Accurate records	Medium	⇧	Closed
6	Quality assurance	High	⇧	Closed
7	Re-opened cases	Medium	⇧	Closed
8	Aged open cases	Medium	⇧	Low
9	Lessons learnt	High	⇧	Low
10	Monitoring within ILGs	Medium	⇧	Closed
11	Health Board monitoring	High	⇧	Closed

1. Introduction

1.1 A follow up review of Concerns was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original review of the processes that the Health Board had in place for dealing with concerns was completed in November 2021. We issued a 'limited' assurance report and made eleven high or medium priority recommendations. Management responses to address the recommendations were provided, and during 2022 the Audit and Risk Committee has used the Internal Audit recommendations tracker to monitor the progress made in implementing the management actions.

1.3 This follow up review does not aim to provide assurance against the full review scope and objectives of the original audit. The 'follow-up review opinion' provides an assurance level against the implementation of the agreed action plan only.

1.4 The risks considered during our original review were:

- Learning from complaints does not take place meaning improvements in quality, reduction in adverse events and avoidable harm does not happen.
- Complaints are not investigated in timely, open, honest, consistent or impartial fashion, causing distrust in the process.
- Financial implications where there is a failure to meet regulatory requirements for responses.
- Reputational damage.

1.5 Since our original audit, executive responsibility for Concerns has changed. The lead is now the Executive Director of Nursing, Midwifery and Patient Care.

2. Findings

2.1 The table below provides an overview of progress in implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	5	2	3	-
Medium	6	4	2	-
Low	1	1	-	-
Total	**12**	**7**	**5**	**-**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 For the recommendations that have been closed, management have taken sufficient action to address the matters arising in our original report. This includes:

- The Health Board's internet pages relating to raising concerns have been reviewed and updated to provide clear information to patients, families and carers. The revised policy will be added to the website once formally approved.
- Our sample testing confirmed that accurate records were retained in the Datix system to support the concerns investigations undertaken.
- A revised quality assurance checklist forms part of the new concerns policy. We confirmed that quality checks were undertaken at various stages ahead of response letters being sent to complainants. The response letter template has been updated and we note that letters appear to be more empathetic and provide greater clarity in relation to the outcomes and any lessons learnt.
- In relation to early resolution cases, a dedicated standard operating procedure has been created. Our testing of a sample of cases confirmed suitable information was retained in Datix to support the closure at an early resolution stage. However, we note (Matter Arising four, below) that there are some issues with the reporting of cases classed as early resolution.
- Weekly, executive led, patient safety meetings are in place, where concerns, incidents, and claims data is presented. The data is broken down by Care Group to allow for scrutiny and challenge at a more granular level.
- Patient and quality safety dashboard reports are routinely presented to the Quality and Patient Safety Committee.

2.4 Five recommendations remain open, but we have seen that action has been taken to start to address these findings. As a result, the priority rating of four of these recommendations has reduced, while one has remained the same.

Appendix A: Management Action Plan – for outstanding matters arising

Previous Matter Arising 1: Policy and Standard Operating Procedures not up to date (Control Design)			
Original Recommendation			Original Priority
1.1	The concerns policy should be reviewed and updated to accurately reflect the structure, roles, responsibilities and active involvement of the corporate function and the ILGs in respect of the management, investigation and reporting arrangements relating to concerns and complaints.		**Medium**
1.2	A comprehensive set of Standard Operating Procedures should be developed setting out the process to follow from the point a concern or complaint is received though to the provision of a response. The SOP should include concerns from all sources such as those received via the dedicated email accounts, those made in person or issues raised via local MPs or MSs. The responsibilities of the Corporate Concerns Team and the ILGs should be clearly set out.		**High**
Management Response		Original Target Date	Responsible Officer
1.1	Changes will be made to the Concerns Policy and management process in line with the Concerns Improvement project. This will be undertaken via a collaborative process between Corporate and the ILGs and in light of any changes to the Operating Model following the current review.	June 2022	Interim Head of Concerns, Redress & Legal
1.2	Review the PTR Guidance alongside the CTM structures to identify what Standard Operating Procedures are required and develop and implement to support the new process.	June 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
The concerns policy has been updated to reflect the revised Health Board structure and the roles and responsibilities of the centralised concerns team including their interface with the new care groups.			Complaints are not investigated in timely, open, honest,

An updated concerns Standard Operating Procedure (SOP) has been drafted. We reviewed the draft document and made some minor observations: • The title and introduction may be misleading to the reader, as they refer to the SOP being for 'formal written concerns'. However, the SOP covers the process for concerns raised by email, letter, telephone, and in person. • No cross reference is made to the supplementary SOPs / documents that have been drafted such as the Early Resolution SOP and Quality Assurance /Audit SOP. • A number of the introductory sections of the SOP are yet to be populated. Whilst the revised policy and updated SOP has yet to be formally approved, in the main, the documents became operational from February 2023. We understand that approval will take place at the forthcoming Quality and Safety Committee meeting after which time the CTM internet will be updated.		consistent or impartial fashion, causing distrust in the process.
New Recommendations		**Priority**
1a	The concerns SOP should be revisited ahead of approval to ensure all sections are populated and reference is made to other relevant SOPs / supplementary documents. Consideration should be given to re-naming the SOP and removing the reference to 'written' concerns only.	**Low**
1b	The revised Concerns Policy and Standard Operating Procedures should be formally approved and made available to staff. The concerns pages on the CTM internet site should also be updated with the revised policy and the previous version removed.	
Management Response	**Target Date**	**Responsible Officer**
1a	The Concerns SOP will be reviewed in line with the recommendation above and will be renamed and written concerns will be explained.	May 2023	Head of Concerns & Business Intelligence
1b	The various SOPs/policy will be made available on SharePoint for all staff to access once approval has been received in Quality & Safety Committee in July 2023.	August 2023	Head of Concerns & Business Intelligence

Previous Matter Arising 3: Training plans and activity (Operation)			
Original Recommendation			Original Priority
3.1a 3.1b	A training programme should be developed and rolled out across the Health Board to ensure that staff are suitably trained for the roles they are performing in relation to the Concerns process. A training needs analysis should be undertaken in each ILG and for corporate teams to identify the staff that fall into the three levels of training outlined in the Concerns Training Plan. The PADR process could be used in the future to help identify training needs.		**High**
3.2	Those staff who may have received training previously or are experienced in the role of investigator or quality assurance, should receive 'refresher' training to ensure awareness of current processes and the application of consistent practices across the Health Board.		**Medium**
3.3	Records of all training attended in relation to both PTR/Concerns training and Datix Once for Wales Training should be retained.		**Medium**
Management Response		Original Target Date	Responsible Officer
3.1a 3.1b	CTM Concerns Management training programme to be developed encompassing Putting Things Right, the Once for Wales Concerns Management System and Welsh Risk Pool procedures, more specifically Learning from Events Reports. Training Needs Analysis Template to be developed following development of Concerns Management training programme. To be shared with the ILGs for completion and identification of all staff who should receive the training.	April 2022 June 2022	Interim Head of Concerns, Redress & Legal Interim Head of Concerns, Redress & Legal/ILG Heads of Quality & Safety
3.2	This will be picked up as part of the Training Needs Analysis in 3.1b and where relevant, training will be provided as part of the training programme.	June 2022	Interim Head of Concerns, Redress & Legal

3.3	Undertake scope on training record management and how this is captured within CTM if it is not retained within ESR Discussion with ESR team to ascertain whether training records can be included on ESR for Concerns Management training. Discussion with Organisational Development regarding retention of training records and how this links to PADRs.	February 2022	Interim Head of Concerns, Redress & Legal

Current findings	**Residual Risk**
Over the past year incident management training has been provided to a number of staff. This training provides a small element of concerns training, specifically the link to the management of serious incidents. More recently, as the concerns policy and SOPs have come close to finalisation, specific concerns training has been provided to the central concerns team and some clinicians. This training provision has allowed additional feedback on the SOPs to be provided and further refinement ahead of approval. Work has also commenced on developing a training prospectus and a training needs analysis. The newly formed care groups will be required to identify who will receive training appropriate to their role and involvement with the concerns process, this will incorporate staff that may need refresher training. At the time of our fieldwork, management had yet to decide if the concerns team will hold a central training record that captures the training that staff have undertaken, or whether concerns training undertaken will be recorded on an individual's ESR record.	Staff are unaware of their responsibilities in relation to the concerns process. Reviews and investigations are carried out in an inconsistent way.

	New Recommendations	**Priority**
3.1a	Once the Concerns Policy and SOP have been finalised, the training needs analysis work should be completed in order to identify the training requirements across the Health Board, including refresher training for those that may have previously completed training on previous policies and processes.	**Medium**
3.1b	A training programme should be put in place to deliver the identified concerns training requirement.	
3.1c	A decision should be made on the best method for capturing concerns training attendance, that allows management the ability to review and monitor attendance going forward.	

Management Response		Target Date	Responsible Officer
3.1a	Training Needs Analysis to be developed and sent to all Care Groups to identify staff which require training	August 2023	Head of Concerns & Business Intelligence
3.1b	Once the training needs analysis has been completed, this will inform the training programme. This will be developed and be an ongoing rolling programme for the Health Board	October 2023	Head of Concerns & Business Intelligence
3.1c	Discussions to be held with Learning and Development to ascertain the best method to capture this training on an ongoing basis.	October 2023	Head of Concerns & Business Intelligence

Previous Matter Arising 4: Classification of early resolution concerns (Operation)			
Original Recommendation			Original Priority
4.1	A review should be carried out to establish why Bridgend ILG is closing less of its concerns at an early resolution stage in comparison to the other ILGs. The review should include identifying if there is a link between concerns closed at early resolution stage and concerns re-opened. Any learning identified from the review should be shared across the ILGs and where necessary processes followed should be captured in a Standard Operating Procedure.		**Medium**
4.2a 4.2b	Management should understand why RTE has not been re-categorising early resolution concerns that were not resolved in the timeframe and take appropriate action to resolve and accurately record in Datix. To ensure consistency, a Standard Operating Procedure (SOP) should be in place outlining the process for re-categorising concerns, including who is responsible for performing this task. Training should be provided where necessary.		**Medium**
Management Response		Original Target Date	Responsible Officer
4.1	Audit of Complaints Management to be reintroduced looking at all aspects of complaints management. Audit will commence with BILG to address this risk and will then be conducted across the other sites. A programme of on-going audit will be re-introduced.	April 2022	Complaints Manager
4.2a	As 4.1 above	April 2022	Complaints Manager
4.2b	Standard Operating procedure to be developed as part of a suite of SOPs outlined in 1.2 above.	April 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
Management identified that, at the time of our original fieldwork, staffing pressures in the Bridgend ILG had contributed to problems resolving early resolution stage cases in comparison to the other ILGs. Management plan to undertake audits of cases and data, to allow the team to identify and investigate trend and anomalies and strengthen working practices. A draft Quality Assurance / Audit checklist and SOP has been created.			Information is inaccurately reported, and potential issues are not identified.

However, at the time of our follow up fieldwork, the central concerns team had only been in place for a few months. As such, work in relation to carrying out audits had yet to start.

In the absence of the team performing their own audits, we undertook testing. We reviewed a report of early resolution cases for the period February to March 2023, and identified:

- 22% cases (60 of 269) remained open but had already exceeded the two-day early resolution timeframe and had not been reclassified.
- 38% (80 of 209) of the closed cases, had been closed as early resolution, but had exceeded the two-day timeframe. In the worst case, a case was closed on day 44, but still classified as early resolution.

As such, the matter with regards to the reclassification of early resolution cases does not appear to be fully resolved.

A separate Early Resolution SOP has been prepared which provides some information about the re-classification of concerns from an early resolution status to a full Putting Things Right (PTR) status, if resolution in the two-day time period is not possible. However, the SOP is not detailed in relation to the exact time frame and process in Datix for re-classifying cases.

We acknowledge that closure or reclassification is reliant on timely responses from care groups and / or clinicians, which can be challenging within the two-day timeframe. We understand that until responses are received, then re-classification could be erroneous. However, it is our view that cases should not be left in early resolution status as this may lead to inaccurate reporting.

New Recommendations		Priority
4.1	The information within the draft Early Resolution SOP in relation to re-classification of cases to PTR status should be reviewed to provide greater clarity on the exact timeframe and process to be followed.	**Medium**
4.2	Regular monitoring should be undertaken of cases that remain open and classified as Early Resolution, to ensure they do not remain open indefinitely while waiting for a response. Responses should be chased up frequently for those cases that are open longer, and where necessary a decision should be made to re-classify as a PTR case if the context is appropriate.	**Medium**
4.3	Consideration should be given to enhancing the Quality Assurance /Audit checklist and SOP by including steps for capturing the outcomes and actions arising from the audits, that can be used for future identification or trends, patterns and training needs.	**Low**

Management Response		Target Date	Responsible Officer
4.1	Early Resolution SOP to be reviewed in line with the updated PTR Guidance, with more clarity around timeframes and process.	June 2023	Concerns Manager
4.2	Monitor already occurs on a regular basis. However, in addition quality assurance audits will be undertaken on a minimum of a monthly basis.	June 2023 and ongoing	Concerns Manager
4.3	Quality assurance checklist and SOP to be reviewed and Audit template developed to ensure findings and actions/learning is captured and actioned.	June 2023	Concerns Manager

Previous Matter Arising 8: Review and monitoring of aged and open concerns (Operation)			
Original Recommendation			Original Priority
8.1	In relation to aged open concerns, it should be ensured comprehensive Datix records are maintained including recording the reason / justification for why the case has remained open and that relevant management are aware of it remaining open.		**Medium**
8.2	Where cases remain open beyond 30 days, ongoing progress contact should be maintained with the complainant and evidence of this retained within Datix.		**Medium**
Management Response		Original Target Date	Responsible Officer
8.1	Process already in place which includes dashboards and is monitored via Patient Safety Executive Meeting. The importance of recording regular updates on Datix will be included as part of 3.1a training programme	April 2022	Interim Head of Concerns, Redress & Legal
8.2	Will be addressed in the development of the SOPs as per 1.2 and included as part of the training programme as per 3.1a.	April 2022	Interim Head of Concerns, Redress & Legal
Current findings			**Residual Risk**
We confirmed that the monitoring of aged open concerns takes place at the weekly patient safety meeting. Our testing of a sample of five cases that remained open after 30 days established that in all cases Datix records had been kept up to date with progress and reasons for delays. However, in one case there was no evidence to demonstrate ongoing contact with the complainant to inform them of the progress being made with their concern. The revised concerns policy and associated SOP reference the need for maintaining written contact with the complainant, however there is no information on the frequency of this contact.			Reputational damage and perceived lack of trust in the process if complaints feel uninformed.

New Recommendation		Priority
8	Consideration should be given to revising the concerns policy and SOP to give an indication of the regularity that contact should be made with complaints for cases that remain open beyond 30 days.	**Low**

Management Response		Target Date	Responsible Officer
8	Concerns Policy and SOP will be reviewed and updated to include frequency of contact for complaints open beyond 30 working days.	June 2023	Concerns Manager

Previous Matter Arising 9: Lessons learnt (Operation)			
Original Recommendation			Original Priority
9.1a	A formalised process should be put in place to ensure there is shared learning from the outcome of concerns, complaints and incidents and also the processes followed when dealing with concerns and complaints. This should include how data will be collected and analysed in order High Concerns Final Internal Audit Report Appendix A NWSSP Audit and Assurance Services 33 to identify trends and patterns for example across CSGs, ILGs, specialities or by type of concern. Lessons learnt information should then be shared in a consistent way across the Health Board.		**High**
9.1b	Subsequently, ILGs should ensure they have suitable processes and methods in place for the dissemination of lessons learnt across all of their CSGs.		
9.2	The 'Shared Listening and Learning Forum' meetings should be held on a regular basis and be appropriately attended by ILG and Corporate staff if they are to be an effective platform for learning to take place.		**Medium**
Management Response		Original Target Date	Responsible Officer
9.1a	Regular reports are provided from Datix and monitored via various groups and committees. The quality of information provided will be strengthened with engagement with the RL Datix team.	January 2022	Datix Manager
	Development of a Learning Framework underway to ensure learning is captured from various avenues and shared across the organisation.	January 2022	AD Nursing & Patient Safety and Interim Head of Concerns, Redress & Legal
9.1b	This will form part of the Learning Framework as per 9.1a and included in the SOPs as per 1.2.	January 2022	
9.2	The Listening and Learning forum Terms of Reference have been reviewed and the membership will be expanded to include more clinical and multidisciplinary representation. The forum will also be held as an 'open forum' from Feb 2022 rather than by invitation only as previously.	February 2022	Joint Chairs of Listening & Learning Forum

Current findings		Residual Risk
9.1	The Health Board has a formalised 'Listening and Learning Framework' and a shared learning repository has been established that is accessible to staff. We also saw evidence of the weekly concerns and complaints reports that are provided to care group directors and to the heads of quality & safety within the care groups to allow timely monitoring.	Learning from complaints does not take place meaning improvements in quality, reduction in adverse events and avoidable harm does not happen.
9.2	There is evidence that the Shared Listening and Learning Forum meetings are held regularly, and that each of the past three meetings (September and December 2022, April 2023) were well represented by both Corporate and Care Group management. The terms of reference for the meeting have been circulated for comment, but at the time of our fieldwork, were still under review, awaiting the commencement of the newly appointed Assistant Director of Quality & Safety into post.	

New Recommendation		Priority
9	Once the Assistant Director of Quality & Safety has commenced in post, the terms of reference for the Shared Listening and Learning Forum should be reviewed and formally agreed for use.	**Low**

Management Response		Target Date	Responsible Officer
9	Listening and Learning Forum TOR to be reviewed.	June 2023	Assistant Director of Quality & Safety

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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