Quality & Safety Committee

Tue 19 January 2021, 13:30 - 16:30

Virtually via Microsoft Teams

Agenda

13:30 - 13:30
0 min

1.
PRELIMINARY MATTERS

Information *Jayne Sadgrove*

1.1.
Welcome & Introductions

Information *Jayne Sadgrove*

1.2.
Apologies for Absence

Information *Jayne Sadgrove*

1.3.
Declarations of Interest

Information *Jayne Sadgrove*

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0 min

2.
CONSENT AGENDA

2.1.
FOR APPROVAL

2.1.1.
Unconfirmed Minutes of the meeting held on 18 November 2020

Decision *Jayne Sadgrove*

For approval

2.1.1a Unconfirmed Minutes QSC 18 November 2020 QSC 19 January 2021.pdf (20 pages)
2.1.1b Appendix 1 QA Summary Draft Unconfirmed Minutes QSC 18 November 2020 QSC 19 January 2021.pdf (21 pages)

2.1.2.
Unconfirmed Minutes of the meeting held on 22 December 2020

Decision *Jayne Sadgrove*

For approval

2.1.2 Unconfirmed In Committee Minutes QSC 22 December 2020 QSC 19 January 2021.pdf (2 pages)

2.1.3.
Revised Quality & Patient Safety Governance Framework

Decision *Greg Dix*

2.1.3a Quality Governance Framework December 2020 QSC 19 January 2021.pdf (4 pages)
2.1.3b CTMUHB Quality Governance Framework Nov 2020 FINAL V2 QSC 19 January 2021.pdf (44 pages)

2.1.4.
Quality & Safety Committee Annual Cycle of Business

Decision *Georgina Galletly*

For approval

2.1.4a Quality & Safety Committee Cycle of Business - Cover Paper QSC 19 January 2021.pdf (2 pages)
2.1.4b Quality Safety Committee Cycle of Business QSC 19 January 2021.pdf (4 pages)

2.2.
FOR NOTING

2.2.1.
Action Log

Information *Jayne Sadgrove*

2.2.1 Committee Action Log QSC 19 January 2021.pdf (4 pages)

2.2.2.
Policy Management Improvement Plan - Clinical and Non Clinical Policies

Information *Georgina Galletly*

2.2.2 Policy Management Improvement Plan QSC 19 January 2021.pdf (3 pages)

2.2.3.
Quality & Safety Committee Forward Work Programme

Information *Georgina Galletly*

2.2.3 Forward Look QSC 19 January 2021 QSC 19 January 2021.pdf (8 pages)

2.2.4.
Medicines Management Committee Highlight Report

Information *ALAN LAWRIE*

2.2.4 MMEC Highlight Report QSC 19 January 2021.pdf (7 pages)

2.2.5.
Update from the Listening & Learning Forum (to include the Terms of Reference)

Information *Greg Dix*

2.2.5a Listening & Learning Referral QSC 19 January 2021.pdf (3 pages)
2.2.5b Shared Listening & Learning Forum TOR QSC 19 January 2021.pdf (6 pages)

2.2.6.
Staff Incident Reporting Feedback

Information *Greg Dix*

2.2.6 Feedback from Incident Reporting QSC 19 January 2021.pdf (5 pages)

2.2.7.
Quality Impact Assessment of Services Being Stood Down

Information *Lyons Nick*

2.2.7 CTMUHB Covid 19 Surge Plans Service Suspension Quality Impacts QSC 19 January 2021.pdf (5 pages)

2.2.8.

Community Health Council Briefing - Living with Coronavirus: Health and Care Services During Winter

Information *Greg Dix*

2.2.8 CHC briefing paper re public feedback Nov 20 (v2) QSC 19 January 2021.pdf (5 pages)

2.2.9.
Community Health Council Briefing - Maternity Services in Wales: What CHCs have heard during the coronavirus Pandemic

Information *Greg Dix*

2.2.9 CHC briefing paper maternity service feedback QSC 19 January 2021.pdf (6 pages)

2.2.10.
Welsh Ambulance Services NHS Trust Patient Experience Highlight Report November 2020

Information *Greg Dix*

2.2.10 WAST Patient Safety Experience Report CTMUHB QSC 19 January 2021.pdf (15 pages)

2.2.11.
Audit Wales Operating Theatre Department Review - Referral from Audit & Risk Committee

Information *ALAN LAWRIE*

To note for information

2.2.11 Audit Wales Operating Theatre Department Review QSC 19 January 2021.pdf (26 pages)

2.2.12.
Internal Audit Follow Up Review - Head & Neck Position Statement - Referral from Audit & Risk Committee

Information *ALAN LAWRIE*

To note for information

2.2.12 IA Head Neck Directorate Position Statement - Final QSC 19 January 2021.pdf (8 pages)

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3.
MAIN AGENDA

3.1.
Matters Arising not considered within the Action Log

Discussion *Jayne Sadgrove*

To note for assurance

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0 min

4.
CO-CREATE WITH STAFF AND PARTNERS A LEARNING AND GROWING CULTURE

4.1.
Shared Listening & Learning - Patient Experience Story

Discussion *Greg Dix*

To note for assurance

4.2.
Assurance on Risks Assigned to the Quality & Safety Committee

Discussion *Georgina Galletly*

- 4.2a Organisational Risk Register - November 2020 QSC 19 January 2021.pdf (5 pages)
- 4.2b Appendix 1 - Organisational Risk Register - Risks Rated 15 and Above - H....pdf (10 pages)

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5.
WORK WITH COMMUNITIES AND PARTNERS TO REDUCE INEQUALITY, PROMOTE WELL-BEING AND PREVENT ILL HEALTH

5.1.
Covid-19 Update - To follow

Discussion *Kelechi Nnoaham*

5.2.
Learning Disability Services Covid Reflections

Discussion *Julie Denley*

- 5.2a LD Services Covid Reflections QSC 19 January 2021.pdf (2 pages)
- 5.2b SBUHB LD Covid-19 Response Update QSC 19 January 2021.pdf (6 pages)

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0 min

6.
PROVIDE HIGH QUALITY, EVIDENCE BASED AND ACCESSIBLE CARE

6.1.
Maternity Improvement Programme Update

Discussion *Greg Dix*

6.1.1.
Improving Quality & Preventing Reoccurrence

Discussion *Greg Dix*

- 6.1.1 Maternity Improving Quality & Preventing Recurrance QSC 19 January 2021.pdf (7 pages)

6.1.2.
Resilience in the Workforce in Maternity Services

Discussion *Greg Dix*

- 6.1.2 Resilience in the Workforce in Maternity Services QSC 19 January 2021.pdf (9 pages)

6.2.
Integrated Locality Group Quality & Safety Reports

Discussion

6.2.1.
Bridgend ILG Quality & Safety Report

Discussion *gibson anthony*

- 6.2.1a Bridgend ILG Quality & Safety Report QSC 19 January 2021.pdf (12 pages)
- 6.2.1b Bridgend ILG Quality Dashboard Dec 20 amended QSC 19 January 2021.pdf (2 pages)

6.2.2.
Rhondda Taff Ely ILG Quality & Safety Report

Discussion *Stuart Hackwell*

6.2.2 RTE ILG QS January 2021 Final 11.01.21 QSC 19 January 2021.pdf (13 pages)

6.2.3.
Merthyr Cynon ILG Quality & Safety Report

Discussion *Sarah Spencer*

6.2.3a Merthyr Cynon ILG QS Report QSC 19 January 2021.pdf (10 pages)
6.2.3b Appendix 1 Merthyr ILG Quality Dashboard Dec 20 QSC 19 January 2021.pdf (2 pages)
6.2.3c Appendix 1 Copy of Merthyr Cynon December Data 2020 (003) QSC 19 January 2021.pdf (24 pages)

6.2.4.
Primary Care Quality & Safety Report

Discussion *Julie Denley*

6.2.4 Primary Care Quality & Safety Report QSC 19 January 2021.pdf (8 pages)

6.3.
Patient Safety Quality Dashboard (including an update on the Future of the Quality Dashboard)

Discussion *Greg Dix*

6.3a Quality Dashboard Report QSC 19 January 2021.pdf (26 pages)
6.3b Appendix 2 231120 SBAR Quality Dashboard v5 QSC 19 January 2021.pdf (5 pages)

6.4.
Neonatal Services - An Update of Perinatal Mortality Review

Discussion *Lyons Nick*

6.4 NNU PMRT QSC 19 January 2021.pdf (6 pages)

6.5.
DELIVERY UNIT REPORTS

6.5.1.
Delivery Unit Action Plan - Cancer Services

Discussion *Nick Lyons*

6.5.1a Delivery Unit Action Plan Cancer Services QSC 19 January 2021.pdf (6 pages)
6.5.1b Annex 1 - DU CTMUHB Cancer Services findings report QSC 19 January 2021.pdf (3 pages)
6.5.1c Annex 2 CTMUHB DELIVERY UNIT ACTION PLAN QSC 19 January 2021.pdf (5 pages)

6.5.2.
Update Report – Delivery Unit Report – Cardiac Waiting Times Follow Up

Discussion *ALAN LAWRIE*

6.5.2a Cardiology Follow Up Review QSC 19 January 2021.pdf (3 pages)
6.5.2b Action plan to DSU Cardiac Surgery Waiting Time Review rewrite 07 January QSC 19 January 2021.pdf (4 pages)

6.6.
Resetting Operating Framework - Quality Implications of the Quarter3/Quarter 4 Plan

Discussion *Lyons Nick*

6.6 Resetting Operating Framework QSC 19 January 2021.pdf (8 pages)

6.7.
Royal College of Anaesthetists & Royal College of Surgeons Invited Service Review on the Intensive Care Service for General Surgery Patients at Princess of Wales

Discussion *Lyons Nick*

- 6.7a RCoA RCS joint review update QSC 19 January 2021.pdf (3 pages)
- 6.7b RCOA action plan updated 5.1.21 QSC 19 January 2021.pdf (11 pages)

6.8.
Update on Follow Up Outpatients Not Booked - Ophthalmology

Discussion *Lyons Nick*

- 6.8a Ophthalmology Position Statement Jan v3 QSC 19 January 2021.pdf (8 pages)
- 6.8b Terms of Reference for Ophthalmology Service Review (002) QSC 19 January 2021.pdf (2 pages)

6.9.
Update on Follow Up Outpatients Not Booked - Verbal Update

Discussion *ALAN LAWRIE*

6.10.
Infection, Prevention & Control Committee Highlight Reports

Discussion *Greg Dix*

- 6.10a Highlight Report for IPCC - July 2020 QSC 19 January 2021.pdf (4 pages)
- 6.10b Highlight Report for IPCC - Nov 2020 QSC 19 January 2021.pdf (4 pages)

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7.
ENSURE SUSTAINABILITY IN ALL THAT WE DO, ECONOMICALLY, ENVIRONMENTALLY AND SOCIALLY

7.1.
Update on Covid19 Nursing Workforce Plan to Support Increased Capacity

Discussion *Greg Dix*

- 7.1 Nursing Workforce Paper QSC 19 January 2021.pdf (11 pages)

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8.
ANY OTHER BUSINESS

Discussion *Jayne Sadgrove*

8.1.
Committee Highlight Report to Board

Discussion *Georgina Galletly*

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0 min

9.
DATE AND TIME OF NEXT MEETING

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

DRAFT 'UNCONFIRMED' MINUTES OF THE MEETING OF THE QUALITY & SAFETY COMMITTEE, HELD ON 18 NOVEMBER 2020 VIRTUALLY VIA MICROSOFT TEAMS

PRESENT:

Jayne Sadgrove	-	Independent Member (Chair)
Maria K Thomas	-	Independent Member
Dilys Jouvenat	-	Independent Member
Nicola Milligan	-	Independent Member
Paul Griffiths	-	Independent Member

IN ATTENDANCE

Greg Dix	-	Executive Nurse Director
Alan Lawrie	-	Executive Director of Operations (In part)
Kelechi Nnoaham	-	Executive Director of Public Health (In part)
Georgina Galletly	-	Director of Corporate Governance/Board Secretary
Hywel Daniel	-	Interim Executive Director of Workforce & Organisational Development (OD)
Nick Lyons	-	Executive Medical Director (In part)
Marcus Longley	-	Health Board Chair
Julie Denley	-	Director of Primary, Community & Mental Health Services
Gaynor Jones	-	Royal College of Nursing Convenor (In part)
Louise Mann	-	Assistant Director of Quality & Safety
Rowena Myles	-	Cwm Taf Morgannwg Community Health Council
Chris Beadle	-	Head of Health, Safety & Fire
David Jenkins	-	Independent Advisor to the Board
Sara Utley	-	Audit Wales
John Murray	-	Deloitte (Observing)
Uschi Turoczy	-	Creative Writing Facilitator (In part)
Esyllt George	-	Arts & Health Co-ordinator (In part)
Emma Samways	-	Internal Audit
Stuart Hackwell	-	Integrated Locality Group Director – Rhondda & Taff Ely
Sarah Spencer	-	Integrated Locality Group Director – Merthyr & Cynon (In part)
Lesley Lewis	-	Integrated Locality Group Nurse Director – Merthyr & Cynon (In part)
Anthony Gibson	-	Integrated Locality Group Director – Bridgend
Amie Symes	-	Head of Quality & Patient Safety (Observing)
Emma Walters	-	Corporate Governance Manager (Committee Secretariat)

PART A. PRELIMINARY MATTERS

QSC/20/134 **AGENDA ITEM 1.1 WELCOME AND INTRODUCTIONS**

J Sadgrove (Chair) **welcomed** everyone to meeting, and advised that as a result of diary commitments, there were a number of colleagues who would need to leave the meeting early, therefore the running order of the agenda had been changed slightly.

J Sadgrove **commenced the meeting** by paying tribute to Mark Simons, who had sadly passed away recently. J Sadgrove advised that Mark had been a regular attendee at the Committee for some time and had made some excellent contributions. To pay tribute to Mark and his family, J Sadgrove invited Members of the Committee to take part in a one minute silence.

J Sadgrove welcomed Uschi Turoczy and Esyllt George to the meeting. Members **NOTED** that Uschi Turoczy was a creative writing facilitator and was attending the meeting to present a patient story following a visit she had made to Ysbyty's Seren to meet with a patient, hear his story and turn his words into a poem.

J Sadgrove also **welcomed** Amie Symes, Head of Quality & Patient Safety who was observing today's meeting.

J Sadgrove advised that a Question and Answer process had been implemented prior to the meeting and added that the Questions & Answers received had been included in Admincontrol and had also been circulated outside of the meeting.

QSC/20/135 **AGENDA ITEM 1.2 APOLOGIES FOR ABSENCE**

Apologies had been received from Dom Hurford, Assistant Medical Director for Quality & Clinical Effectiveness and Ana Llewellyn, Integrated Locality Group Nurse Director - Bridgend Locality.

QSC/20/136 **AGENDA ITEM 1.3 DECLARATIONS OF INTEREST**

There were none.

QSC/20/137 **AGENDA ITEM 5.4.1 DELIVERY UNIT REVIEW OF OPHTHALMIC DIAGNOSTIC AND TREATMENT CENTRE (ODTC) – PROGRESS REPORT**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

A Lawrie presented the report and advised that the report identified that the Delivery Unit had been commissioned to undertake a review of the self-assessment, with a review undertaken against three areas of assurance. Members **NOTED** that an action plan had been developed, with a number of recommendations now marked as complete, with some recommendations which were close to completion.

Members **NOTED** that two areas of concern had been identified, one of which was the development of an agreed vision for Ophthalmology and the second being the interface with Primary Care.

Members **NOTED** that management changes and changes to the operating model, together with the Covid pandemic, had impacted some of the progress made and **NOTED** that it had now been agreed that Ophthalmology Services would be hosted by the Bridgend Integrated Locality Group by 1 December 2020.

Members **NOTED** that a review had also been instigated by the Royal College of Ophthalmology. Members **NOTED** that Terms of Reference for this review had been developed and were currently in the process of being reviewed by the Royal College. In response to a question raised by P Griffiths as to the likely start date of this review, N Lyons advised that service reviews usually commenced within three months of receipt of Terms of Reference which meant that the review was likely to commence in January 2021, with findings reported in March 2021. Members **NOTED** that the Terms of Reference for the review had been included as a separate agenda item.

In response to a question raised by G Jones in relation to the current position regarding the appointment and training up of Nurse Injectors, A Lawrie advised that an update on staffing had been included in the action plan and added that slow progress had been made in appointing staff.

Members **RESOLVED** to: **NOTE** the report and **ENDORSE** the Improvement Plan.

QSC/20/138 **AGENDA ITEM 5.4.2 DELIVERY UNIT REVIEW ON CARDIOLOGY TO CARDIAC SURGERY FOLLOW UP – PROGRESS REPORT**

A number of comments and questions were received prior to the meeting, as outlined in Appendix 1 together with the responses provided.

A Lawrie presented the report and advised that the implementation of the new operating model had impacted on the focus being placed on this matter. Members **NOTED** that whilst some progress had been made, further progress was required and A Lawrie requested that a more detailed update was presented to the Committee at its next meeting. J Sadgrove **AGREED** to receive a more detailed update at the next meeting **(added to the forward work programme).**

In relation to the question raised prior to the meeting regarding the ICT issues experienced regarding the merger of Patient Administration System (PAS) systems and the Welsh PAS (WPAS) interface, J Sadgrove confirmed that this issue had already been added to the agenda for the Digital and Data Committee.

Members **RESOLVED** to: **NOTE** the update provided.

QSC/20/139 **AGENDA ITEM 5.5 RATIONALE FOR THE OPENING OF THE FIELD HOSPITAL AND ASSURANCE RECEIVED BY GOLD TO INFORM THE DECISION**

A question had been raised by an Independent Member prior to the meeting, as outlined in Appendix 1 together with the response provided.

A Lawrie presented the report and advised that the report highlighted the background as to why the field hospital had been opened, which largely related to the capacity constraints being experienced within the District General Hospitals and Community Hospitals. Members **NOTED** that the report identified the work being undertaken in relation to Medical and Nurse staffing, with a group of GP's who were keen to work at the field hospital providing medical cover. A Lawrie advised that Therapy input was also in place.

Members **NOTED** that positive experiences were being received by patients at the hospital and **NOTED** that all mitigation standards had been worked through with building control and the Fire Safety Team in relation to Estates issues.

M K Thomas advised that she now felt assured that all risks had been mitigated and added that she also felt assured in relation to the governance processes as all issues had been dealt with via gold command.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/140 **AGENDA ITEM 5.2.2 MERTHYR CYNON ILG QUALITY & SAFETY REPORT**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

L Lewis presented the report and provided Members with an update against the following key areas:

- In relation to the Covid outbreak at Prince Charles Hospital, as of yesterday there had been 142 cases that make the case definition of an outbreak. There had sadly been 35 deaths. Members **NOTED** that whilst cases were rising, the outbreak was being managed whilst the Hospital remained open;
- There had been a small outbreak at Ysbyty Cwm Cynon, with 6 cases reported, and sadly one associated death;
- There was a 15 point action plan in place which was being scrutinised three times weekly;
- The Hospital were seeing a large number of community acquired Covid-19 infections;
- Additional resource was now in place to enable the closure of historical serious incidents;
- There had been two serious incidents reports in relation to Ambulance Delays and a meeting had been held with the Welsh Ambulance Services NHS Trust to address the issues;
- There were seven serious incidents reported in relation to Mental Health. These related to a Covid outbreak at Marsh House where 27 patients contracted Covid, with three associated deaths;
- In relation to Concerns, whilst the target was not being met at present, significant progress was being made in relation to the closure of historical outstanding concerns. Members **NOTED** that 11 concerns had been closed this month, with 36 remaining open, 24 of which were within the 30 day response target.

In response to a number of questions raised prior the meeting, S Spencer provided Members with an update on the Harm Review process, which was being implemented on a phased approach. Members **NOTED** that a review had been undertaken of 12 hour breaches, where no harm had been identified to these individuals. Members **NOTED** that a Cancer Harm Review process had commenced, with validation currently being undertaken with Clinicians. A Merthyr & Cynon ILG Harm Review Panel was in the process of being established, with the harm review process being embedded into the Multi-Disciplinary Team function and clinical care delivery.

In response to a question raised by M K Thomas in relation to the process for Quality & Safety Committee moving forwards, S Spencer advised that the embedding of Harm Reviews would be reported into the Clinical Service Groups and then into the ILG Quality reports, which were then being reported to the Committee. M K Thomas advised that the Committee would be interested in having sight of the improvement plan **(added to the action log).**

P Griffiths sought clarity as to what extent the Health Board looked wider than CTM in relation to the establishment of the harm review process and added that there still seemed to be some inconsistency across ILG reporting. S Spencer advised that a discussion had been held with the Clinical Director of Cancer Services as to the processes that were being followed in other Health Board's. N Lyons assured Members that the approach being taken was correct and added that clinical ownership of this piece of work was key.

L Lewis advised that the Quality Dashboard contained information from all three ILG's, with certain areas being reported on collectively. L Lewis assured Members that ILG's were not working in isolation.

M K Thomas also reminded Members that a Quality Governance Framework was in place, which had changed slightly following the establishment of the ILG's and added that there would be an assurance group below the Quality & Safety Committee which would provide further assurance to Committee Members.

M K Thomas sought clarity as to whether there was adequate resource in place, across all three ILG's, to manage the backlog of Serious Incidents. Members **NOTED** that a number of staff who had been shielding had been trained to undertake Root Cause Analysis and a review would need to be undertaken of skill mix within the Team to ensure they have the skill set to undertake this work. M K Thomas thanked L Lewis for the update and advised that the Committee would need to be made aware if additional resource was required.

G Dix advised that Welsh Government were in the process of revising the Serious Incident Framework which was due to be published shortly. G Dix advised that the backlog of Serious Incidents would need to be addressed and hopefully, with better guidance from Welsh Government, the Health Board would have clarity on what should and should not be reported.

Members **NOTED** that a meeting had recently been held with Welsh Ambulance Services Trust (WAST) Nurse Directors where a discussion was held in relation to some patient stories. J Sadgrove advised that WAST had shared a presentation with the Health Board and requested that this presentation was shared with Committee members for information. J

Sadgrove added that this may require a discussion at a future meeting of the Committee **(added to the forward work programme).**

J Sadgrove extended her thanks to the Team for the update and for the detailed responses provided.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/141 **AGENDA ITEM 4.0 LISTENING FROM AN IMPROVEMENT STORY**

J Sadgrove welcomed U Turoczy and E George to the meeting and invited U Turoczy to read out the patient story.

Following the story, J Sadgrove advised that Uschi had read out the story incredible well and added that she had found the story very moving. G Dix also extended his thanks to Uschi for sharing the story which was articulated extremely well. Members **NOTED** that this story would also be shared at the November Board meeting.

M K Thomas advised that the story really expressed the connectivity between Arts and Patient Care and added that the Arts could have a positive impact on the wellbeing of patients.

G Galletly also extended her thanks to U Turoczy for presenting the story and advised that she would ask the Communications Team to get in contact so that the work being undertaken could be promoted **(added to the action log).**

CONSENT AGENDA – FOR APPROVAL/NOTING

Members **NOTED** that there were no items which needed to be moved onto the main agenda.

QSC/20/142 **AGENDA ITEM 2.1 TO RECEIVE THE UNCONFIRMED MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2020**

Some comments and questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

The minutes of the Quality & Safety Committee held on 8 September 2020 were **received** and **confirmed** as an accurate record of the meeting.

Members **RESOLVED** to:

- **APPROVE** the minutes of the meeting held on 8 September 2020.

QSC/20/143 **AGENDA ITEM 2.2 QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2019/2020**

Members **RESOLVED** to: **ENDORSE FOR APPROVAL BY BOARD**, the Quality & Safety Annual Report 2019/2020

QSC/20/144 **AGENDA ITEM 2.3 ONCE FOR WALES CONCERNS MANAGEMENT SYSTEM**

Some questions and comments were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses.

Members **RESOLVED** to: **NOTE** the report**.**

QSC/20/145 **AGENDA ITEM 2.4 HEALTH, SAFETY AND FIRE SUB COMMITTEE TERMS OF REFERENCE (TOR)**

Some comments and questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

Members **RESOLVED** to: **APPROVE** the Terms of Reference for the Health, Safety & Fire Sub Committee.

QSC/20/146 **AGENDA ITEM 2.5 AMENDMENT TO THE STANDING ORDERS – QUALITY & SAFETY COMMITTEE TERMS OF REFERENCE (TOR)**

A comment was received by an Independent Member prior to the meeting as outlined in Appendix 1 together with the response provided.

Members **RESOLVED** to: **ENDORSE FOR BOARD APPROVAL** the amendments to the Health Board Standing Orders.

QSC/20/147 **AGENDA ITEM 2.6 COMMITTEE ACTION LOG**

A question was raised by and Independent Member prior to the meeting, as outlined in Appendix 1 together with the response provided.

Members **RECEIVED** the Action Log and **RESOLVED** to: **NOTE** the Action Log.

QSC/20/148 **AGENDA ITEM 2.7 POLICY MANAGEMENT IMPROVEMENT PLAN (CLINICAL AND NON CLINICAL POLICIES)**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the response provided.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/149 **AGENDA ITEM 2.8 NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP) LEGAL & RISK SERVICES – IMPACT & REACH REPORT**

A question was raised by an Independent Member prior to the meeting as outlined in Appendix 1 together with the response provided.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/150 **AGENDA ITEM 2.9 COVID 19 LESSONS LEARNT REPORT**

A number of questions were raised prior to the meeting, as outlined in Appendix 1 together with the responses provided:

Members **RESOLVED** to: **NOTE** the Report.

QSC/20/151 **AGENDA ITEM 2.10 SHARED LISTENING & LEARNING FORUM**

A question was raised by an Independent Member prior to the meeting, as outlined in Appendix 1 together with the response provided.

Members **RESOLVED** to: **NOTE** the Report.

MAIN AGENDA

QSC/20/152 **MATTERS ARISING NOT CONSIDERED WITHIN THE ACTION LOG**

There were no matters arising.

GOVERNANCE, PERFORMANCE AND ASSURANCE

QSC/20/153 **AGENDA ITEM 5.1 COVID-19 UPDATE**

K Nnoaham presented Members with the latest update in relation to the Covid-19 position and provided the following key updates:

- The fire break had a positive impact on the numbers of positive cases, with Rhondda Cynon Taff (RCT) and Merthyr in day 14 of consistent day to day reductions and Bridgend in day 11 of consistent day to day reductions;
- In relation to age specific patterns, the most infections were being seen in young to middle age adults in Bridgend, and middle age to older adults in RCT and Merthyr;
- In relation to Test Turnaround Times, 93% of staff tests were being returned in 48 hours;
- Each Hospital outbreak was being analysed and assessed, with a report being presented to Gold Command showing a deteriorating position across all three District General Hospital sites;

- In the last two weeks, critical care occupancy had risen in RGH and PCH, and had fallen in Princess of Wales (POW). The rise in RGH and PCH was possibly linked to community acquired infections;
- There had sadly been 28 deaths in Cwm Taf Morgannwg week ending 28 October. Members **NOTED** that it was unlikely that Covid deaths had peaked, as deaths were currently significantly lower compared to the first peak.

J Sadgrove extended her thanks to K Nnoaham for presenting the update and advised that the Board were receiving regular weekly updates on the current position. J Sadgrove sought clarity as to the latest position regarding a vaccination. K Nnoaham advised that there had been two vaccine platforms that had passed the phase three clinical trials, with the next step being to gather safety data which would be submitted to the regulators. Members **NOTED** that Welsh Government had suggested that the first vaccines could possibly be delivered from 1 December to priority groups, which included patients and staff in care homes. Members **NOTED** that discussions were being held at Gold Command in relation to whether there was sufficient workforce in place to deliver the vaccine. Members **NOTED** that approval had now been given for Healthcare Support Workers to assist with administering the vaccine.

K Nnoaham advised that an update received this morning indicated that there may be challenges with the Pfizer vaccine which had to be stored at a certain temperature. This was a national issue and may be challenging in terms of delivery of vaccines to care homes.

M K Thomas advised that she was pleased to see the vaccination programme that had been submitted and sought clarity as to why there had been a deterioration in the number of infections being seen across all three hospital sites. K Nnoaham advised that there would be a number of factors attributed to this, including how many infections were from known/unknown contacts and how many staff had been infected.

R Myles sought clarity in relation to the Pfizer vaccine and questioned whether the allocation to Wales would be on a per capita basis. K Nnoaham confirmed that this was correct and added that it was hoped that the Astra Zeneca vaccine would be approved soon as there were more vaccines available.

Members **RESOLVED** to: **NOTE** the update provided.

QSC/20/154 **AGENDA ITEM 5.1.1 QUARTER 3 & QUARTER 4 PLAN IMPLICATIONS ON POTENTIAL HARM**

N Lyons presented Members with a verbal update and advised that a Planned Care Taskforce had been established to consider innovative ways

of delivering planned care moving forward. J Sadgrove advised that the Committee would welcome a more comprehensive update report at the next meeting **(added to the forward work programme).**

Members **RESOLVED** to: **NOTE** the update provided.

QSC/20/155 **AGENDA ITEM 5.1.2 PRIMARY CARE COVID-19 MORTALITY REVIEW – UPDATE REPORT**

N Lyons presented the report and advised that a significant amount of work was being undertaken on Mortality Reviews, with the Team now looking at Advanced Care Planning to deliver the most optimal care in the last days of a patient's life.

J Denley added that this was an area that Care Homes currently find it difficult to deliver, with skill sets being quite variable across care homes. Members **NOTED** that this had been noted by the National Primary Care Strategic Board.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/156 **AGENDA ITEM 5.2 INTEGRATED LOCALITY GROUP – QUALITY & SAFETY REPORTS**

A number of questions had been raised in general by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

Rhondda Taff Ely Integrated Locality Group Report

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

S Hackwell presented the report and highlighted the following key points:

- In relation to Covid-19, the ILG had implemented its 15 point Covid Action Plan, with compliance being monitored across Ysbyty Cwm Rhondda (YCR) and Royal Glamorgan Hospital (RGH) sites;
- There had been an alteration made to the RGH admission guidance a month ago and the Hospital had been assisting Merthyr Cynon and Bridgend with some of their flows;
- The 46 deaths associated with the outbreak had been reviewed internally, and would now be subject to a mortality review;
- There had been no new outbreaks at YCR for 28 days;
- Work was continuing to be undertaken in relation to embedding the Quality Governance Framework. A Quality, Safety & Risk Group had been held within the ILG;

- Healthcare Inspectorate Wales/Audit Wales were planning on undertaking a return visit this month and had already attended some meetings that had taken place within the ILG;
- Cancer Harm Reviews had commenced, 12 hour ED reviews were ongoing, with further work to be undertaken on RTT and FUNB responses;
- Further progress should be made moving forwards in relation to the development of the Dashboard now that the Information post had bene filled within the ILG;
- Risks and mitigations were being reviewed, with the majority of risk now being stratified;
- There had been an increase in concerns and enquiries, which was strongly linked to the changes that had been made to visiting guidance. Members **NOTED** that this would have an impact on the 30 day response target and a phased approach would be put into place to improve the position.

J Sadgrove extended her thanks to S Hackwell for presenting the report and for providing a detailed response to the questions raised prior to the meeting. J Sadgrove added that the level of individualised ILG data had been really helpful to the Committee also.

M K Thomas sought clarity as to when the Once for Wales System was likely to be in place, given the concerns raised in relation to the use of Datix. G Dix advised that the first element of the system, the Complaints Management System should be in place by the end of March 2021, with the remaining modules being rolled out throughout the year

Members **RESOLVED** to: **NOTE** the report.

Bridgend Integrated Locality Group Report

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

A Gibson presented the report and provided an update against the following key points:

- A Covid outbreak had been declared at Princess of Wales (POW) on 5 October and on the Llynfi Ward at Maesteg Hospital on 7 November. The ILG were in the process of working toward implementation of the 15 point improvement action plan;
- As of today, there were 77 positive cases, 66 of which were on covid recovery. There had been 205 cases in total associated with the outbreak, and 57 deaths linked to the outbreak. Mortality reviews had commenced on the patients who had sadly passed away;
- There had been significant challenges at POW in relation to the creation of Red, Amber, Green areas and thanks were extended to

Rhondda Taff Ely (RTE) ILG colleagues for helping the Bridgend ILG create space;

- Patient movement and staff movement were both areas of challenge, with each move being risk assessed;
- The Cancer Harm Review process had commenced, with the first meeting being held yesterday. In relation to Follow up Outpatients Not Booked (FUNB) harm reviews, focus had been placed on two areas, one of which was Cardiology, which had been completed;
- The Quality Dashboard continued to evolve across all three ILG's, with trend data now starting to be seen;
- The number of complaints received remained within formal variation with an improvement now being seen in response times. There were 33 open serious incidents which were being progressed by Investigating Officers;
- Following concerns raised at the last meeting in relation to rising C Difficile rates at POW, Antimicrobial ward rounds had now increased and the position had now improved;
- There remained ongoing issues in relation to environmental ligature points. The Health Board had made a commitment to invest non-discretionary capital for the completion of these works;
- In relation to leadership and culture issues on the Llynfi Ward at Maesteg Hospital, an action plan had now been developed, however, the work had not been concluded as the ward had been closed due to the Covid outbreak;
- The Child & Adolescent Mental Health Services (CAMHS) had been placed into internal enhanced monitoring. A dedicated CAMHS manager had been appointed to manage the position;
- Further work needed to be undertaken in relation to reporting of risks within Clinical Service Groups.

In relation to the Ligature works, Members **NOTED** that it was hoped that all works would be completed by 2022. M K Thomas requested sight of a report that provided assurance to the Committee that the ligature works were being undertaken. A Gibson **AGREED** to provide this to the Committee and **AGREED** to ensure that a detailed action plan was included with future reports **(added to the action log).**

In response to a question raised by P Griffiths in relation to 22 patients experiencing harm within Urology and the timescales when patients families would be contacted advising them of the harm, A Gibson advised that it would be difficult quantify the risk of harm and added that once harm was identified, this would get reported into the Datix system and a discussion held with the patients concerned. N Lyons advised of the need to ensure Duty of Candour is taken into consideration during this process.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/158 **AGENDA ITEM 5.2.4 QUALITY DASHBOARD**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

L Mann presented the report which reported data up until end of September 2020. The following key points were **NOTED**:

- The report focussed mainly on secondary care measures;
- Complaints and Serious Incidents numbers were returning to their pre Covid level at this reporting period;
- The current organisational concerns response rate was 65% (set against a target of 75%);
- In relation to Incident Themes & Trends, a review of Falls was being undertaken to determine whether there were any areas of concerns;
- There had been an increase in Serious Incident reporting which related to Covid Healthcare acquired infections and unexpected death by suicide or trauma;
- There had been an increase in C Difficile rates across Cwm Taf Morgannwg, with an increase in community acquired C Difficile being reported by the Infection, Prevention & Control Team, who were under a significant amount of pressure at present;
- 61 compliments had been received during September. The use of Have Your Say cards had increased and real time reporting had commenced in some 'green' areas.

J Sadgrove extended her thanks to L Mann for presenting the report and welcomed the increasing accuracy and validity of data. J Sadgrove added that improved timeliness of data would be welcomed by the Committee. M K Thomas added that consistency was required across ILG's in relation to provision of information that was accurate and up to date.

In response to a question raised by M K Thomas as to whether the Team felt there was enough resource in place to address the backlog of Serious Incidents, L Mann advised that she felt given the additional support that had been recruited into the Directorate, there was enough resource in place. Members **NOTED** that the majority of the team had been deployed to the mass testing project and further redeployment of the central nursing team to Ysybty'r Seren to support patient care may be required.

P Griffiths also raised concerns in relation to resource, particularly within the Infection, Prevention & Control Team, and advised that issues had been experienced in the past in relation to recruiting staff at the right level with the appropriate skills. Members **NOTED** that there was a national recruitment issue in relation to Infection, Prevention & Control Nursing, which had greatly been impacted by the Covid-19 pandemic, particularly within the Community setting.

G Dix advised that in relation to timeliness of data, there were issues with reporting timelines which impacted on the ability to provide the most up to date data. J Sadgrove requested that a review was undertaken of the timing of future Committee meetings to ensure the Committee was as best informed as it could be **(added to the action log).**

Members **RESOLVED** to: **NOTE** the report.

QSC/20/159 **AGENDA ITEM 5.2.5 PRIMARY CARE QUALITY & SAFETY REPORT**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

J Denley presented the report. The following key areas were highlighted:

- National work had commenced in relation to the scope of a clinical governance model for Primary Care;
- Key risks identified in the report included Dentistry, which was a high risk area for Covid, with services gradually being brought back into place. The availability of PPE supplies continued to remain a challenge nationally. There was also a growing risk associated with children with severe dental needs who required secondary care treatment. The Team had been asked to undertake a full assessment of this risk

In response to a question raised by J Sadgrove regarding FFP3 masks, J Denley advised that the position had not improved since the report had been written, however, she remained confident that a national solution would be found.

In response to a question raised by M K Thomas, J Denley confirmed that information on the metrics and improvement work being undertaken by the Team would be reported to a future Committee meeting.

R Myles advised that the report identified that the number of concerns and complaints received in relation to GMC Primary Care was quite low, which she had found to be surprising given the number of concerns that had been received by the Community Health Council. J Denley advised that this may be as a result of patients not wanting to make a formal complaint, which was not unique to Cwm Taf Morgannwg.

J Sadgrove extended her thanks to J Denley for presenting the report.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/160 **AGENDA ITEM 5.3 MATERNITY SERVICES UPDATE**

A number of questions were raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

G Dix presented the report and provided Members with an update against the following key areas:

- There were 20 recommendations remaining open out of the original 79, most of which primarily related to Leadership & Culture. It was hoped that the leadership and culture work would be completed by the middle of February, depending on the Covid-19 position;
- The analysis of the culture questionnaire had now been made available, which identified some positive feedback and some areas of concern. A new culture survey to staff would be launched shortly;
- The questionnaire identified that whilst staff felt safe to report incidents through Datix, staff still felt concerned when involved in the reporting of serious incidents. Further work needed to be undertaken on timely Datix feedback from Managers to staff members, which was consistent across the Health Board and not just within Maternity;
- In relation to Clinical Reviews, the women that had been part of the initial morbidity review would be receiving their first letter from the Independent Maternity Services Oversight Panel (IMSOP) shortly. Support was in place for women and their families;
- Stillbirth and Neonatal reviews were ongoing. A Neonatal Improvement Director and Neonatal Improvement Manager had been appointed, with N Lyons taking on the role of Senior Responsible Officer moving forwards for Neonatal Services. N Lyons advised that a significant number of actions remained in place following the Neonatal Peer Review undertaken in 2019 and added that a progress report would be presented to the next Committee **(added to the forward work programme);**
- The backlog of complaints had now reduced, with very few being re-opened. The Serious Incident backlog was still being worked through.

D Jouvenat made reference to the action plan contained within Appendix 1 and the statement made under point 4 to 'potentially develop Women's weekly (and informal weekly newsletter). D Jouvenat questioned whether there were only female staff working in this area. G Dix advised he would look further into this.

P Griffiths made reference to staff still having some concerns on their involvement in Serious Incidents and questioned whether this was based on any evidence. G Dix advised that it was not known how many staff had provided these comments, however, about 30% of staff did not feel supported which was concerning. G Dix added that it would be helpful to see the analysis of the next culture questionnaire and suggested that a points prevalence study could be undertaken after December to determine whether the position had improved.

J Sadgrove extended her thanks to G Dix for presenting the update and also welcomed the analysis of the questionnaire.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/161 **AGENDA ITEM 5.4.3 HEALTHCARE INSPECTORATE WALES AND AUDIT WALES JOINT REVIEW INTO QUALITY GOVERNANCE**

G Galletly presented the report and advised that the report provided an update on the planned follow up review following the joint review undertaken this time last year. Discussions were being held with colleagues to ensure that they were sighted on the scope of the review.

Members **RESOLVED** to: **NOTE** the report

QSC/20/162 **AGENDA ITEM 5.4.4 DELIVERY UNIT MANAGEMENT REVIEW OF PATIENT SAFETY INCIDENTS AND CONCERNS**

Some comments and questions had been raised by Independent Members prior to the meeting, as outlined in Appendix 1 together with the responses provided.

L Mann presented the report and advised that there had been 18 recommendations which the Health Board were required to improve on. Members **NOTED** that following a review of the recommendations as a result of the new Operating Model, there were only four recommendations which remained open.

Members **NOTED** that the Quality Governance Framework needed amendment as a result of the new values and behaviours and **NOTED** that the revised framework would be presented to the next Quality & Safety Committee.

Members **NOTED** that recruitment was being undertaken into the Director of Quality Improvement role and that some of the central team had been disaggregated into Merthyr Cynon and Rhondda Taff Ely ILG's to provide them with more support.

Members **NOTED** that the new set of Values & Behaviours would help to ensure staff have the right skills to manage incidents and noted that the new Values & Behaviours would need to be embedded into the organisation. Datix training had commenced, alongside a revised Serious Incident and Root Cause Analysis training tool.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/163 **AGENDA ITEM 5.6 ORGANISATIONAL RISK REGISTER – QUALITY AND SAFETY RISKS**

G Galletly presented the report and advised that that an updated organisational risk register report was being presented to Management Board later today and to the Audit & Risk Committee in December, with the updated report containing Rhondda Taff Ely locality data and the domains discussed at Board Development session.

Members **NOTED** that Internal Audit would be undertaking a review of Risk Management which would be reported in December and the joint review being undertaken by Healthcare Inspectorate Wales and Audit Wales would also be reviewing Risk Management processes.

Members **NOTED** that there were a number of risks relating to workforce and the impact this had on service delivery. There were also some risks on the register which related to ligature works. G Galletly advised that there were a number of risks which stated that action plans were to be developed and added that she would ensure these were updated for the next meeting.

J Sadgrove welcomed the report and the significant progress that had been made.

Members **RESOLVED** to: **APPROVE** the Organisational Risk Register and the assessment and management of individual risks.

QSC/20/164 **AGENDA ITEM 5.7 UPDATE ON FOLLOW UP OUTPATIENTS NOT BOOKED TO INCLUDE AN UPDATE ON THE OPHTHALMOLOGY POSITION STATEMENT**

A number of questions were raised by Independent Members prior to the meeting as outlined in Appendix 1 together with the responses provided.

S Hackwell presented the report and advised that the issues relating to the Macular Clinics had now been resolved, however, issues still remained in place regarding the Glaucoma service, as at present the Health Board did not currently have a Glaucoma Consultant in post, with a Consultant being utilised from another Health Board.

Members **NOTED** that the Macular Root Cause Analysis had been approved and **NOTED** that another Macula Consultant had been recruited. Members **NOTED** that the Glaucoma Root Cause Analysis was now progressing. Members **NOTED** that Ophthalmology remained a key risk and that a request had been made for a Royal College Review to be undertaken of the service.

J Sadgrove advised that the Committee had been concerned about Ophthalmology for some time and welcomed the review that would be undertaken by the Royal College. J Sadgrove expressed the importance of ensuring that improvements were being made and added that the Committee would continue to receive regular updates on this matter.

M K Thomas sought clarity as to what improvement plans were in place for Optometry. S Hackwell advised that there were a number of Optometrists who were keen to support the Health Board with the work required in relation to Glaucoma, however, there were ICT issues which needed to be resolved. Members **NOTED** that an update would be provided in the next iteration of the report.

P Griffiths advised that the Committee had been concerned in relation to harm issues for some time and welcomed the appointment of the Ophthalmology Governance Nurse. In response to a question raised by P Griffiths, S Hackwell advised that he would ensure the next iteration of the report included an update on patient engagement and how patients were reacting to the current position **(added to the action log).**

Members **RESOLVED** to: **NOTE** the report.

QSC/20/165 **AGENDA ITEM 5.8 HIGHLIGHT REPORT FOR THE HEALTH, SAFETY & FIRE SUB COMMITTEE**

C Beadle presented the report which identified the key issues discussed at the last meeting.

D Jouvenat advised that as Chair of the Sub Committee, she would like to extend her thanks to C Beadle and the Team for all of the hard work that had been undertaken. Members **NOTED** that there was one area which required escalation, which related to resources within the fire safety team, with the Team experiencing significant staff shortages at present. Concerns had particularly been expressed on the impact this had on the provision of training, fire training in particular.

C Beadle advised that the Fire Safety Team was quite small, with the Team being down to two Fire Officers at one stage as a result of staff sickness. Members **NOTED** that the work being undertaken across the Estate in relation to redesign had impacted on the resource available and funding had now been allocated to increase the resource within the Team.

Members **RESOLVED** to: **NOTE** the report.

QSC/20/166 **AGENDA ITEM 5.9 SPECIALIST COVID MORTAILITY REVIEW OVERSIGHT GROUP DRAFT TERMS OF REFERENCE**

Members **RESOLVED** to: **NOTE** the draft Terms of Reference.

QSC/20/167 **AGENDA ITEM 5.10 IMPROVING SERIOUS INCIDENT MANAGEMENT IN CTM: REVISED SERIOUS INCIDENT TOOLKIT AND SERIOUS INCIDENT TEAM**

A Symes presented the report and advised that a snapshot review had been undertaken by the Delivery Unit, with several recommendations made. As a result, the Serious Incident Toolkit had been amended and shared with the Delivery Unit for comment. Members **NOTED** that the Toolkit was being presented to Management Board later today and the Committee were being asked to approve the toolkit in principle, subject to Management Board approval.

Members **RESOLVED** to: **APPROVE** in principle the Serious Incident Toolkit.

ITEMS FOR INFORMATION

QSC/20/168 **ITEMS FOR INFORMATION**

The Committee received the following items for information:

- CTMUHB Ombudsman Report;
- Committee Forward Work Plan 2020/2021
- Committee Highlight Report to Board

QSC/20/169 **ANY OTHER URGENT BUSINESS**

There was no other business to report.

QSC/20/170 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place at 1.30pm on 19 January 2021.

…….

J Sadgrove, Chair

Date……

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

Summary of Questions & Answers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Answer: *See above response*

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

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

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

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

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

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

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

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

Agenda Item 5.2.2 Merthyr Cynon ILG Quality & Safety Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda Item 2.3 Once for Wales Concerns Management System

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

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

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

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

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

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

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

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

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

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

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

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

Agenda Item 2.6 Committee Action Log

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda Item 2.9 Covid 19 Lessons Learnt Report

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

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

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

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

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

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

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

Agenda Item 2.10 Shared Listening & Learning Forum

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

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

Agenda Item 5.2 Integrated Locality Group Reports

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

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

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

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

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

Answer: *The comment above has been noted.*

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

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

Rhondda Taff Ely Integrated Locality Group Report

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

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

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

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

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

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

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

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

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

Answer*: The comment above has been noted*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Bridgend Integrated Locality Group Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plans for improvement over the coming weeks/months –

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

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

Agenda Item 5.2.5 Primary Care Quality & Safety Report

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

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

Agenda Item 5.3 Maternity Services Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

DRAFT 'UNCONFIRMED' IN COMMITTEE MINUTES OF THE MEETING OF THE QUALITY & SAFETY COMMITTEE, HELD ON 22 DECEMBER 2020 VIRTUALLY VIA MICROSOFT TEAMS

PRESENT:

Jayne Sadgrove	-	Independent Member (Chair)
Dilys Jouvenat	-	Independent Member
Paul Griffiths	-	Independent Member
James Hehir	-	Independent Member
Maria K Thomas	-	Vice Chair/Independent Member

IN ATTENDANCE

Greg Dix	-	Executive Nurse Director
Nick Lyons	-	Executive Medical Director
Georgina Galletly	-	Director of Corporate Governance/Board Secretary
David Jenkins	-	Independent Advisor to the Board (Observing)
Rowena Myles	-	Cwm Taf Morgannwg Community Health Council
David Deekollu	-	Clinical Director
Jane O'Kane	-	Neonatal Service Improvement Director
Emma Walters	-	Corporate Governance Manager (Committee Secretariat)

PART A. PRELIMINARY MATTERS

QSC/IC20/016 **WELCOME AND INTRODUCTIONS**

J Sadgrove (Chair) **welcomed** everyone to the In Committee meeting, particularly D Deekollu and J O'Kane who were attending the meeting to support N Lyons in the presentation of the Neonatal Services report.

QSC/IC20/017 **APOLOGIES FOR ABSENCE**

Apologies were received from Nicola Milligan, Alan Lawrie, Kelechi Nnoaham and Fiona Jenkins.

QSC/IC20/018 **DECLARATIONS OF INTERESTS**

There were no interests declared.

MAIN AGENDA

QSC/IC20/019 **QUALITY ASSURANCE IN NEONATES**

N Lyons presented Members with the report which highlighted that due to the following concerns, a programme of improvement work had progressed within Neonatal Services:

- Historical concerns relating to infant care and management at the former Royal Glamorgan Hospital Neonatal site
- Issues of concern that relate to cultural practices and working relationships at Prince Charles Hospital
- The commonality with some of the Royal College of Obstetricians & Gynaecologist Neonatal specific recommendations

The committee received detailed updates on specific issues contained within the report, noting the planned actions. Members supported the approach outlined in the report, noting the actions to be taken to review and learn from any emerging issues.

It was noted that the CTMUHB Maternity Improvement Programme had been adapted to incorporate Neonatal Improvement and subsequent actions would be delivered primarily through the overarching programme. The Quality & Safety Committee would monitor delivery of the improvement programme with reference to the Board.

Following discussion, the Committee **RESOLVED** to: **NOTE** the report.

QSC/IC20/020 **ANY OTHER BUSINESS**

J Sadgrove extended her thanks to P Griffiths who was attending his last engagement for the Health Board in attending this meeting. J Sadgrove thanked P Griffiths for the excellent contribution he had made.

QSC/IC20/021 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place at 1.30pm on 19 January 2021.

…….

J Sadgrove, Chair

Date……

AGENDA ITEM
2.1.3

QUALITY & SAFETY COMMITTEE

REVISED QUALITY & PATIENT SAFETY GOVERNANCE FRAMEWORK

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director, Quality & Safety
Presented by	Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ILG	Integrated Locality Group
IMTP	Integrated Medium Term Plan

1. SITUATION/BACKGROUND

CTMUHB Health Board has established three Localities based around the geographical areas of **Merthyr Tydfil & Cynon Valley**, **Rhondda Taf Ely** and **Bridgend**. By using this integrated approach, services from primary care through to specialist care are provided as close to home as possible, from pre-conception to end of life and from prevention through to complex care; building on the ambition in Welsh Government legislation and CTMUHB IMTP to move to a more population health and wellness approach. The model aligns quality, outcomes and how resources are used so that quality is embedded in every day operations of the Health Board

This final version has been subject to consultation internally and with external stakeholders, whose comments have been welcomed and reflected. The CTMUHB operating model has been embedding and developing in respect of how the integrated locality structures function, such as what is devolved and what is supported at a corporate level, or hosted in a systems group. Quality governance and assurance within these structures that link across the assurance route to committees are developing robustly and at pace.

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

This report will ensure the Quality & Safety Committee are sighted on the revised CTMUHB Quality Governance and Patient Safety Framework.

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

CTMUHB is committed to improving the health of our communities and the quality and safety of our services. Following the challenges of external reporting on organisational governance, the need to put quality at the heart of everything we do is recognised and significant work is ongoing to change systems and processes across the organisation to ensure that this becomes embedded across all our sites, teams and communities. Particular focus is being placed on making significant changes to improve the way we work and provide the conditions for our staff to deliver the best quality care. The impact of the coronavirus pandemic response in 2020 has stymied the progression and pace of change, however significant improvements in quality governance have been made thus far.

High quality care and patient safety is also dependent on strong clinical leadership, as well as an organisational culture that promotes the active involvement of all staff. The recent introduction of patient and workforce led

values and behaviours will make a positive difference to our employees, our organisation, our patients and our communities. A quality culture with shared values and behaviours is central to providing good quality, personalised and effective care. Improving quality requires us to actively listen to our staff, partners, patients and communities; engaging and involving these key groups facilitates positivity and co-production of our services.

The Quality Governance and Patient Safety Framework is a key document to provide assurance to the Board that quality drives the organisation. The established Integrated Locality Groups (ILG's) is an opportunity to have a shared understanding of quality and localised governance in relation to reporting, management and review of Patient Safety Incidents and Concerns. Progress in relation to the governance structure within the ILG's to facilitate robust systems continue to be refined under the appointment of a governance lead within each ILG. A locality based governance team support a refreshed approach with strong central oversight, quality assurance and integrated organisational continuous learning and development.

Another key areas of focus is ensuring that the flow of information through the governance structures is comprehensive and effective, including the quality of the reporting, emphasising themes/trends and learning from concerns.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Define quality governance and provide structure to what it means to govern for quality across an organisation Provide support to Integrated Locality Groups in achieving and delivering quality governance Identify and provide links to further publications, documents and concepts that provide detail on supporting aspects of quality governance
Related Health and Care standard(s)	Safe Care
Equality impact assessment completed	Not required

Legal implications / impact	Yes (Include further detail below)
	Legal implications relate to already established statutory obligations including those related to Putting Things Right.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There are resource implications to further develop the governance arrangements within ILG's however these have been agreed.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 That the content of the report is **NOTED**.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

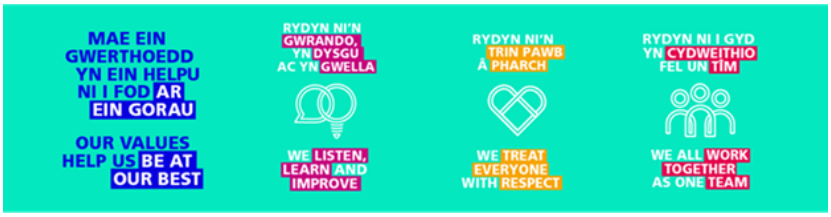
Quality Governance & Patient Safety Framework

June 2020

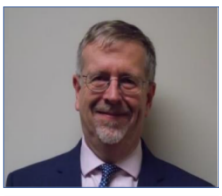
Revised November 2020

#QCTM

Version 2



Sharon Hopkins
Interim Chief Executive



Marcus Longley
Chair

Foreword

"**Cwm Taf Morgannwg UHB** is committed to improving the health of our communities and the quality and safety of our services. The need to put quality at the heart of everything we do is recognised by the Board and significant work is underway to change systems and processes across the organisation to ensure that this becomes embedded across all our sites, teams and communities.

It has been a difficult year for our organisation following the Royal Colleges' report into maternity services, the increase in our escalation status, the joint report by Healthcare Inspectorate Wales and the Wales Audit Office, and the independent review into the handling of the Consultant Midwife report. While the challenges that continue to exist are not to be underestimated, focus is being placed on making significant changes to improve the way we work and provide the conditions for our staff to deliver the best quality care for our communities.

High quality care and patient safety is also dependent on strong clinical leadership, as well as an organisational culture that promotes the active involvement of all staff. Work is underway to embed a new set of values and behaviours for our organisation using the experience and feedback of staff and our communities. Programmes to support staff to develop their confidence and skills in leadership are also underway.

Putting quality at the centre of care also requires us to listen to our staff, partners, patients and communities, and we have developed a programme, called Let's Talk, to engage and involve these key groups so their feedback and input can shape our services.

While work continues to address the challenges, there is much to be proud of. Progress demonstrates evidence of compassionate care and quality improvement taking place across the organisation. It important that this good practice and experience of the teams is captured and built on.

The Board remains fully committed to ensuring that quality and safety are paramount in everything we do as an organisation and improvements continue to be made for the benefit of our staff and our communities".

Signatures

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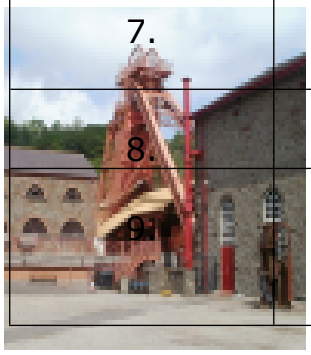
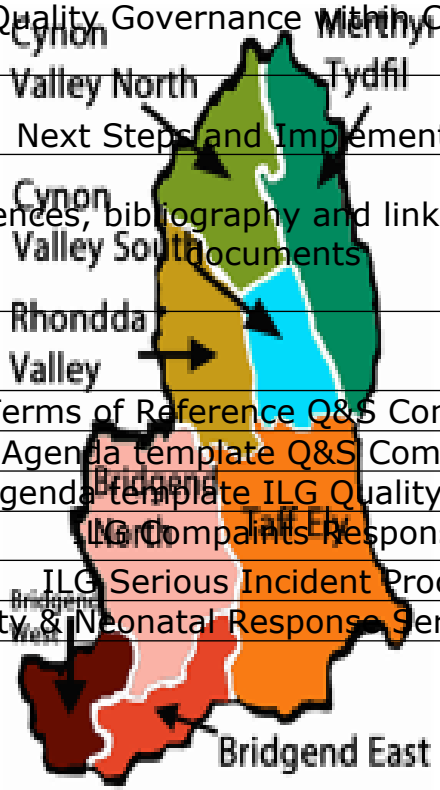
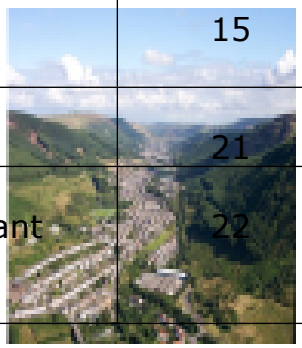
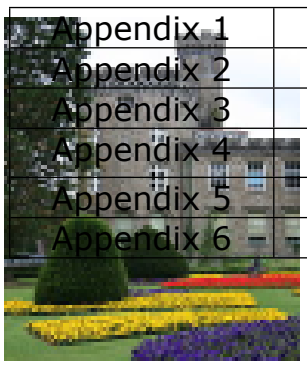
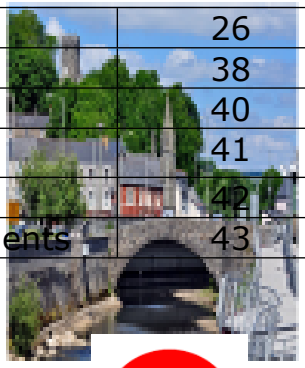










1. Introduction

Cwm Taf Morgannwg University Health Board (CTMUHB) covers the catchment area outlined in the map below (Figure 1).

Figure 1. CTMUHB catchment area

This framework aims to:

- **Define quality governance and give shape to what it means to govern for quality across an organisation**
- **Seeks to provide support to Integrated Locality Groups in achieving and delivering this quality governance**
- **Looks to identify and provide links to further publications, documents and concepts that provide detail on supporting aspects of quality governance**

2. What is Quality?

Quality in health care is defined as:

- the effectiveness of health services,
- the safety of health services, and
- the experience of individuals to whom health services are provided [Health and Social Care (Quality and Engagement) (Wales) Act 2020]

The importance of understanding the components of quality are fundamental to addressing improvements in health care delivery. These are detailed by the Institute of Medicine (IOM, 2001) as **safety**, **timeliness**, **effectiveness**, **efficient**, **equitable** and **person-centred**; providing a valuable framework to evaluate and advance quality of care.

Whilst it is important to identify and deliver against the six separate elements that comprise quality, it is critical to recognise that, though different, they are all aspects of the same thing: high quality care. Quality is only achieved if all six of these domains are present equally and simultaneously in care – delivering on just one or two in isolation is not enough.

What is our Quality Governance Framework?

Quality governance is the combination of structures and processes from point of care to board and within our communities. This includes commissioned services and provides support and monitoring of health board wide quality performance.

Quality governance provides board assurance through a systematic approach to maintaining high quality care and standards which uses ongoing measurement and reporting on safety, effectiveness, staff and user experience, identifying areas for improvement and enabling the sharing of good practice in accordance with statutory obligations.

The Health Board is committed to achieving the vision clearly articulated in 'A Healthier Wales' (WG 2018) and in particular echoing the NHS core value of putting quality and safety first, providing high value evidence based care for our citizens at all times.

The purpose is to embed the framework across the Health Board, its services, localities, hospitals, and all who work in it; to monitor and continuously improve the standards of care planned and delivered directly, or by others on our behalf and to avoid unintended harm.

It is intended to support the delivery of the following outcomes:

- ✓ Support people who receive care, their families and the people who provide it.
- ✓ Supports culture and practice to promote and facilitate continuous improvement by listening and learning
- ✓ Demonstrates a just culture, where the whole system works to reduce opportunities for patient safety incidents occur; individuals are appropriately accountable and there is a duty of candour with when things go wrong.
- ✓ Underpins the delivery of safe, timely, effective, efficient, equitable and person centred care.
- ✓ Increases the level of assurance for all stakeholders through its implementation, with the aim of increasing public trust and confidence.

- ✓ Articulates the expectations of the Board in relation to quality, patient safety & risk management.
- ✓ Better informs and shapes the Health Board's Annual Quality Statement through a commitment to quality information
- ✓ Improves the opportunity for the provision of safe care through clear lines of communication and reporting from 'Ward to Board' and 'Board to Ward'*

***Please note that 'ward' represents any service or point of care delivery**

- ✓ Supports clarity in roles, responsibilities and lines of reporting

The framework is an important part of the Board Assurance Framework (BAF) and links with the Health Board risk management strategy 2018 – 2023

As defined by IOM and Welsh Government, high quality care can be described as care that is safe, effective, patient-centred, timely, efficient, equitable [this also includes care that is *accessible* to those who experience any form of disadvantage] (Fig 2).

How do we define quality of care?

Principles:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Timely**: Reducing wait times and harmful delays impacting smooth delivery of care.
- **Effective**: Providing services based on scientific knowledge to all who could benefit. This also refers to refraining from providing services to those unlikely to benefit from them.
- **Efficient**: Using resources to achieve the best possible value. This can include reducing wasteful resource allocation and reducing production and administrative costs.
- **Equitable**: This guards against all forms of discrimination in delivering care. Essentially, an equitable health care worker should provide care that does not vary in quality according to personal characteristics like gender, income, ethnicity or location.
- **Patient-Centred**: Providing care that is respectful of (and responsive to) individual patient preferences, needs and values.

Figure 2. Welsh Government Quality Domains

The framework is relevant to the population and public within the catchment area (and beyond for some services), individual patients, the workforce within CTMUHB and all its partners.

Following on from the former framework published in April 2019, the key changes arise from updated legislation (Section 2), the development of agreed values and behaviours across the Health Board (Section 3) and the establishment of the new operating model within CTMUHB (Section 4).

This document outlines how quality governance functions within the new operating structures which is based on the principle of clinically led and managerial supported care and well-being services (Section 6).

Its aim over time, is to develop an outcome focused, values based approach as articulated in the Integrated Medium Term Plan (IMTP) 2020 - 2023. A key approach in that plan is to develop a health and care system that is more preventative and person centric with access to health care services only when needed.

3. Strategic Context

Since 2006 there have been many legislative and policy documents to direct and advise the NHS in Wales. This section outlines the key documents within the context of quality governance. Hyperlinks to the documents are in the references section

- **Legislation**

The NHS (Wales) Act 2006 is the principal legislation governing the NHS in Wales.

The Social Services and Well-being (Wales) Act 2014 establishes the legal framework for meeting people's needs for care and support and imposes general and strategic duties on local authorities and LHBs to work in partnership in order to effectively plan and provide a sufficient range and level of care and support services.

The Wellbeing of Future Generations (Wales) Act 2015 places health care within its wider social, economic and environmental context.

Nurse Staffing levels (Wales) Act 2016 outlines the requirements for minimum staffing levels for the nursing workforce.

The Health and Social Care (Quality and Engagement) (Wales) Bill passed by the Senedd on the 17 March 2020 has now received Royal Assent. Its overall aim is to improve the quality of health services across Wales with the citizens of Wales at the heart of improving health and social care. The Act will focus on a system-wide approach to quality improvement and strengthens a culture of openness, honesty and including the public in the design and delivery of health and social care services. It has four main objectives:

- to greatly **strengthen the existing duty of Quality** on NHS bodies and extend this to Welsh Ministers (in relation to their health service functions);
- to **institute a duty of Candour** on NHS bodies in Wales (including primary care providers who provide NHS services), requiring them to be open and honest with patients and service users as soon as they are aware that things have gone wrong, or may have gone wrong, with their care or treatment;
- to strengthen the voice of citizens, by replacing Community Health Councils with a new, **all-Wales Citizen Voice Body** ('the CVB'), to represent the views and interests of people across health *and* social care;
- To enable the appointment of **vice chairs for NHS trusts**, bringing them into line with health boards.

- **Policy & Guidance**

The Welsh Government articulated a vision in 'A Healthier Wales' (Welsh Government 2018). The focus of services shifts towards prevention, reiterating the philosophy of 'Prudent Healthcare' and the Quadruple Aim. The core values that underpin the NHS in Wales are:

- **Putting quality and safety above all else:** providing high value evidence based care for our patients at all times
- **Integrating improvement into everyday working** and eliminating harm, variation and waste
- **Focusing on prevention, health improvement and inequality** as key to sustainable development, wellness and wellbeing for future generations of the people of Wales
- **Working in true partnerships** with partners and organisations and with our staff
- **Investing in our staff** through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively

These core values are supported by the good governance principles outlined in the Citizen Centred Governance Principles (2010)

Putting Things Right guidance, 2013:

- This guidance is produced for the NHS in Wales to enable responsible bodies to effectively handle concerns according to the requirements set out in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 ("the Regulations").

NHS Wales Health and Care Standards, 2015:

- The Health and Care Standards aim to identify outcomes relating to social services and public health and can be implemented in all health care services, settings and locations. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. The health board's quality delivery plan is currently under review.

Listening & learning to improve the experience of care, 2015:

- This Identifies that all patients should be given opportunities to give feedback, without recourse to the concerns process, and more extensive spread of the Framework beyond secondary care is needed. The value of triangulating staff feedback with patient feedback and other relevant information should be exploited as part of the approach to assuring and improving the patient experience.

Framework for Assuring Service User Experience, 2018:

- The framework has been updated following Keith Evans' report "Using the Gift of Complaints" and now links with the amended Health and Care Standards which include a standard to promote listening and learning from feedback.

Prosperity for all – the national strategy: The Welsh Government's well-being objectives, 2017:

- Linked to the 7 wellbeing goals within the Future Generations Act and focusses on how services are delivered, as well as what is being delivered.

The Parliamentary Review of Health and Social care in Wales

- This presented the case for change, and a demand for a new approach to maintain and improve the quality of health and care, as a result of the impact of a growing and changing pattern of need, expectations of services, and the challenge of securing a future workforce. Recommendation 6 is particularly applicable to the PCSD as it describes a health & care system that is always learning.

• Additional Guidance

Further direction and support is provided in The NHS Wales Values and Standards of Behaviour Framework which articulates the expected values and behaviours from all people working in NHS Wales.

Quality Improvement (QI) is a key principle of good governance, building on learning. To enable this, the all Wales organisation **Improvement Cymru** works in partnership with the UHB. This will support methodical and planned improvement work delivered in a safe way, to ensure any changes are long term improvements for the better. A Health Board wide QI function has been established. This will work to support across the Health Board and will place the health Board in a positive position to meet the QI element of the new Quality Act outlined above.

To ensure the needs of each population are planned for, a planning framework is in place for Quarter 1 and 2 (NHS Delivery Framework, Welsh Government 2020).

4. What is our Quality Strategy and key priorities?

With the boundary change which created CTMUHB in April 2019, the Health Board refreshed its mission, vision and strategic objectives:

Our Mission	✓ Building healthier communities together
Our Vision	✓ Across every community people begin, live and end life well, feeling involved in their health and care choices
Our Strategic Well-being Objectives	✓ Work with communities and partners and to reduce inequality, promote well-being and prevent ill-health. ✓ Provide high quality, evidence based, and accessible care. ✓ Ensure sustainability in all that we do, economically, environmentally and socially. ✓ Co-create with staff and partners a learning and growing culture.

Table 1. CTM's Mission, Vision and Strategic Objectives

A focus on quality:

- To ensure that quality has a focus in every part of the Health Board, the approach outlined comprises **quality planning, quality improvement** and **quality control**. Together these provide **quality assurance**. The three components form a key part of the Health Board's Quality and Governance Targeted Intervention Maturity Matrix, to track progress embedding improvement against these three areas.
- To support the delivery of the strategic and quality objectives outlined in the IMTP, it is planned to develop a clear strategy for quality in 2020 for 2020-23 and onwards. This will be co-produced in partnership with the local population, the workforce and all key stakeholders.
- Within the strategy, the quality priorities for the next 3 – 5 years will be clearly articulated.
- To further embed quality, Improvement CTM, a Health Board wide resource, will support services to test, learn from and spread improvements, thus helping to improve care and reduce unwarranted variation.
- Improvement CTM will work in partnership with and be supported by Improvement Cymru.

Figure 3. The quality triangle

Overarching quality statements CTM IMTP 2020 – 2023

1. **Strengthened focus on quality in strategic planning**: to include a whole system, population health perspective shaped by the wider integrated partnership agenda, aligned with each of the 5 ways of working outlined within the WBFG (Wales) Act 2015. This includes the development of an Integrated Health & Care Strategy with quality as the golden thread throughout it, and a revised, joined up approach to developing the IMTP, including a 'panel' approach and strengthened guidance related to quality impact assessment
2. Individuals' voices are better heard: actively enabled through coproduced values and behaviours, investment in real time and friends and family test, a strategic approach to patient stories and targeted focus on the individuals' experience of the services provided by the Health Board, through the Patient Experience sub-group, reporting directly to Quality & Safety Committee. The Once for Wales Concerns Management System currently being procured for Wales, will support the Health Board in the planning, capture and analysis of Service User feedback. Equally the voice of staff will be better heard. This priority aligns with involvement and collaboration as aspects of the 5 ways of working.
3. Shared learning and continuous quality improvement: Development of Cwm Taf Morgannwg Improvement**,** aligned with prevention and long term as aspects of 5 ways of working, through improved triangulation of intelligence and data integrity via investment in data systems and staffing, review of national audit where outlier status is applied, development of a database of external reviews, reports, and improvement plans, utilising the learning and governance sub group appropriately.
4. Risk better articulated, shared & mitigated: following an **e**xtensive revision of the Health Board's approach to and management of risk, improving sight of significant service specific concerns and risks, improved exception reporting to Quality & Safety Committee and development of a harm review process. This priority aligns with each of the 5 ways of working.
5. Strengthened two-way 'point of service delivery' to Board sight: ensuring that quality governance and patient safety shapes and features strongly in new organisational structure supported by continued implementation and refresh of the framework.
6. Extensive review and improvement of the management of concerns and serious incidents: through full engagement with supportive intervention of the Delivery Unit and achievement of the improvement plan.

Table 2. CTMUHB IMTP Quality Statements 2020 - 2023

5. Quality Culture, Values and Behaviours

The culture of an organisation and the commitment to quality of all members of staff is a crucial determinant of quality performance. Our values and behaviours exist to make a positive difference to our employees, our organisation, our patients and our communities. A quality culture with shared values and behaviours is central to providing good quality, personalised and effective care. Having a clear values and behaviours framework enables organisations to effectively support individuals who fit with their organisation's culture to deliver the best outcomes for people who need its care and services and to speak up when things go wrong. We want our people not just knowing our values and behaviours but feeling connected to and supported by them. Most importantly, we want to inspire change.

CTMUHB recognises that organisations and their leaders have a key role in fostering quality culture through their own focus on quality and through bringing the knowledge and skills needed to provide an informed challenge to the organisation:

- CTMUHB undertook extensive work with patients and staff to develop the new values and behaviours for 2020 onwards.
- Our values and behaviours builds on the principles outlined in the NHS Wales Values and Standards of Behaviour Framework.

Our three key themes for CTM are:

WE LISTEN, LEARN AND IMPROVE

- ✓ We take time to ask and listen carefully to people's worries, views and ideas – then actively do something to make a difference.
- ✓ We make it safe and easy for people to speak up - as well as being open to giving and receiving feedback as an opportunity to learn.
- ✓ We welcome change, bring a positive, 'will do' attitude and find ways to actively improve the way we do things.

WE TREAT EVERYONE WITH RESPECT

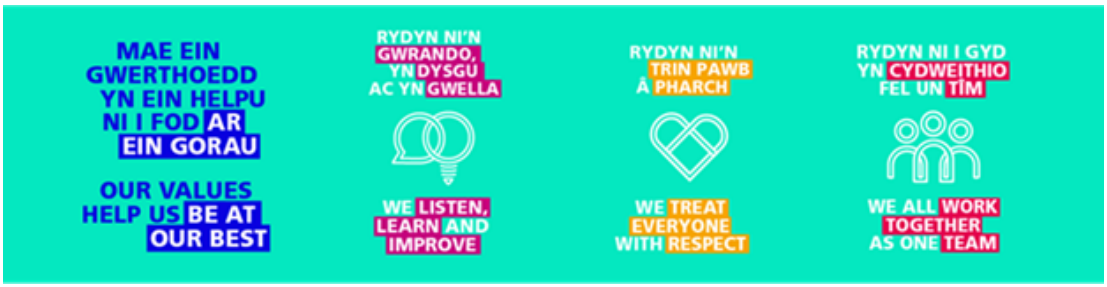
- ✓ To show that we value other people and see them as equals, we treat everybody with kindness and fairness.

- ✓ We go out of our way to be supportive, helpful and friendly.
- ✓ We recognise what people do every day to make a difference, and say 'thank you'.

WE ALL WORK TOGETHER AS ONE TEAM

- ✓ We bring people together and build strong, trusting relationships by including others in decisions and activities.
- ✓ We look out for people's wellbeing and safety – both physical and psychological – and support them if these are at risk.
- ✓ We are open, clear and honest in the way we communicate, and – if we need to – change the way we explain something to help people understand.
- ✓ When we learn something useful and inspiring, we share it with others.

- This work outlines how staff across the organisation can be clear about their role, responsibility and accountability in relation to quality of care and reinforces that **quality is everybody's business**.
- By adopting the values and behaviours, all staff commit to delivering or supporting the delivery of high quality care, which places the population served, and the people who access care with us at the heart of all CTMUHB do.



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

cwmtafmorgannwg.wales

Quality in Integrated Locality Groups

Drivers → Legislation → Policy → External reports → Escalation status

Quality Planning	Quality Assurance	Quality Improvement
Develop innovative care models that can deliver better population outcomes at lower cost	Ensure achievement of intended improvements and maintain standards when these are in place	Decrease unwarranted variation within services and across organisations so that the best becomes the norm
IMTP	Quality & Governance Framework	Building QI capacity & capability
Quality Strategy	Quality intelligence: aggregation, triangulation & instrumentalisation	Culture of continuous improvement
Quadruple aim – measurable & meaningful outcomes	Hard Data (metrics, PROM's, inspections, concerns) Soft Data (PREM's, staff feedback, site visits, patient stories)	Exploiting national & local expertise & partnerships (Improvement Cymru, HEIW, Academi Wales, Universities)
Population Health Management	Internal (Q&S committee, dash boards, staff survey) External (Regulators, CHC's, Professional bodies, Benchmarking & Peer Review)	Culture and Safety II approaches
Values Based Care & Prudent Health Care	Closing the loop	Service Improvement & Service Transformation

New Operating Model → Values & Behaviours Framework → Increased public Engagement → People → Enablers

6. The CTM Operating Model - Integrated Locality Groups (ILG) and Systems Groups

The Health Board has established three Localities based around the geographical areas of **Merthyr Tydfil & Cynon Valley**, **Rhondda Taf Ely** and **Bridgend**. Alongside there are four CTM wide systems groups responsible for securing standards and planning; **pre conception to 1000 days**; **1000 days to 25 years**; **adulthood** and **older people**. By using this integrated approach, services from primary care through to specialist care are provided as close to home as possible, from pre-conception to end of life and from prevention through to complex care building on the ambition in the IMTP to move to a more population health and wellness approach.

The model has been developed to be clinically led and managerially supported, strengthening the commitment to strong clinical leadership across the Health Board.

The model aligns, quality, outcomes and how workforce, estates and financial resources are used so that quality is embedded in every day operations of the Health Board (Fig4).

The principles of the operating model are:

- ✓ Empowering People
- ✓ Community Leadership and Involvement
- ✓ Clinically Led, Community Focused Services
- ✓ Learning and Innovating for Continual Quality Improvement
- ✓ Robust, Simplified and Safe Decision Making

Figure 5. Quality, Outcome & Resource triple aim

To achieve these, the ILGs are supported by central services partners from the following teams: Patient Care and Safety, Planning, Workforce and Organisational Development, Finance, Procurement, IT and Performance and Information. The ILGs and System Groups will be accountable for confirming the standards of care, developing new pathways and sharing national and international best practice and innovation. Business partners are accountable to Group Directors and are key members of the leadership team.

Under the remit of the Executive Director of Operations, some functions will be led at a CTM level though the service delivery will sit within the ILGs. Examples include; Primary Care Contracting and Regulation, strategic planning and commissioning of mental health and community services, Dental and Optometry services and medicines management.

Some services are hosted by one or two ILG's. These services are either specialised or too small to be delivered separately in each localities. Wherever services are delivered in CTM, there will be consistent standards across the organisation and no unwarranted variation between localities.

In terms of committee structures, the ILG Board and sub-committees are illustrated in Fig 5 and outline both the delivery and assurance lines.

CTM Operating Model

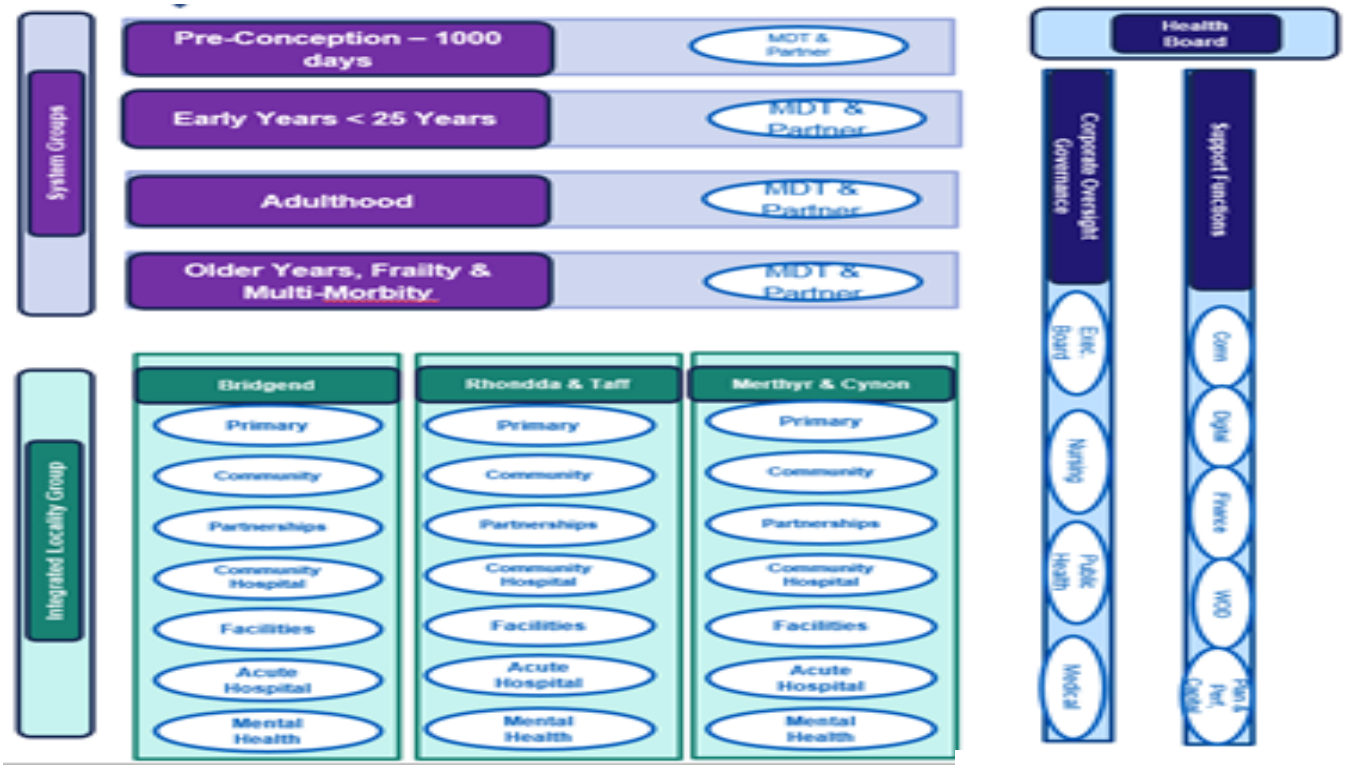


Figure 5. ILG Operating Model

ILG Governance Structure

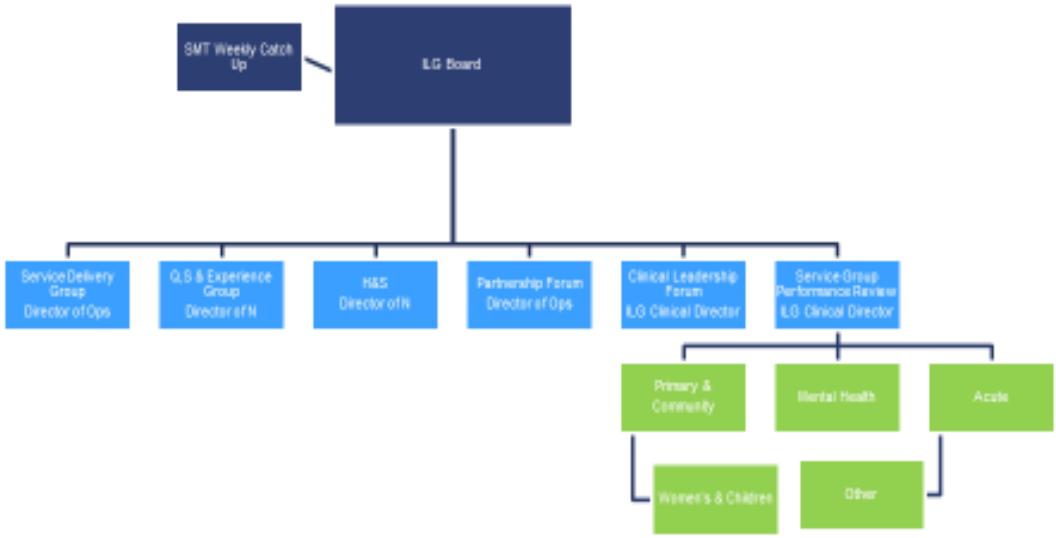


Figure 6. ILG Internal Governance Structure

7. Quality Governance within CTMUHB

The NHS (Wales) Act 2006 includes a requirement for LHBs to work to Standing Orders (SO) to provide the legislative framework for the regulation of its proceedings and business as part of its corporate governance arrangements.

This framework therefore sits under the umbrella of the Health Board and forms an important part of the Board Assurance Framework (BAF). The BAF provides assurance to the Board on the delivery of its core purpose and organisational objectives expressed through the IMTP.

Quality Governance is the combination of structures and processes at and below Board level to lead on Health Board-wide quality performance.

The functional elements include:

- **Compliance with legislation and regulation**: e.g. Health & Care Standards (2015) the Nurse Staffing Levels (Wales) Act, 2016, Putting Things Right including redress & clinical negligence, safeguarding & public protection, health and safety, external regulatory frameworks including Health Inspectorate Wales, regulatory notices issued by HM Coroner, recommendations made by the Public Services Ombudsman for Wales.

- **Quality planning**: e.g. via the Integrated Medium Term Plan, demonstrating learning and using a quality dashboard based on robust data analysis, through robust public engagement, value based health care and patient experience, based on understanding population health, principles of equality and diversity, workforce development and wellbeing.
- **Quality improvement**: e.g. clinical effectiveness via research, audit, implementation of NICE guidelines professional and service specific standards, learning, education & training, embedding a culture of quality improvement, a shift to Safety II approaches, research & development, medicines management, organisation-wide and national sharing of learning.
- **Quality control and assurance**: e.g. improvements using learning generated by internal and external scrutiny, including those undertaken by HIW, Community Health Council, and other regulatory, speciality, service specific and professional standards, mortality review, evidence based policies and protocols
- **Managing risk** e.g. assessing, understanding and articulating risk via risk registers, infection prevention and control, decontamination, clinical incident reporting and investigation, managing concerns, implementation of patient safety solutions alerts and notices applying learning.

As outlined above (Section 1) the Health Board has developed corporate objectives which support the delivery of quality. These are:

- Work with communities and partners to reduce inequality, promote wellbeing and prevent ill-health.
- Provide high quality, evidence based, accessible care
- Ensure sustainability in all that we do, economically, environmentally and socially
- Co-create with staff and partners a learning and growing culture

To ensure that planning is underpinned by quality, the Quality Impact Assessment (QIA) procedure has been revised to encompass any new plans, service change, programmes, projects or savings schemes. This is a fundamental process to ensure that **any** service changes or plans are thought through, understood and the potential consequences on quality are considered, with mitigating actions outlined in a comprehensive way. Any risk impact should be added to the relevant risk register. The QIA procedure is available on the intranet and there is an expectation that these will be submitted to the Q&S committee for further scrutiny.

Being able to measure quality with high reliability is a key element in a high quality, learning organisations. Building on the minimum dataset informed

by national quality and performance indicators, robust data is required to be able to evidence quality outcomes.

Over the past year, a Quality Dashboard has been developed which is updated on a bi-monthly basis and presented to the Quality and Safety (Q&S) Committee through to Board. The metrics and indicators will be further developed to provide a greater breadth of measures, including primary care and commissioned services.

The Quality Dashboard was initially Health Board wide. Since April 2020 as part of its ongoing development and alignment with the Operating Model, there is now a Localities based section in the Dashboard. This will be continuously improved to ensure robust assurance.

The Dashboard presents numerical information about key quality indicators and Statistical Process Control (SPC) charts for a rolling 12 month period. Narrative analysis is also provided, however it is recognised that this is retrospective exercise. Additionally, quality narrative is included in the Integrated Performance Report at Management Board and Board. Further improvements include the setting of improvement trajectories. These have been set initially for pressure damage and falls but will be used along with improvement cycles to support purposeful change.

The Localities are supported by central functions such as: Patient Care and Safety, Planning, Workforce and Organisational Development, Finance, Procurement, IT and Performance and Information. The Central element of the Executive Director of Operations will also provide support.

As the new system groups develop, they will play a central role in standard setting, outcomes, quality planning, improvement and assurance both independently for their areas of responsibility and through support to the ILGs. Systems groups will be key in co-producing patient pathways using values based principles. This is going to be central to re-defining the quality care that will then be delivered by the ILGs

Additional professional support is provided to the systems groups and ILG senior teams from individuals and services with key strategic roles.

Assurance is then provided to the Board through the Quality and Safety Committee.

Where there are matters of concern, a clear escalation pathway is in place from individuals through to the Board through the procedure of NHS Wales Staff to Raise Concerns Policy.

▪ Corporate Assurance Process

The Board (Executives and Independent Members) are ultimately accountable for quality within the Health Board and are responsible for:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives though effective challenge and scrutiny of the UHB's performance across all areas of activity

Organisational governance and assurance of quality is scrutinised through Quality and Safety (Q&S) Committee, a sub-committee of the Board and an in-public meeting.

The Q&S Committee has an annual work programme, meets bi-monthly and is chaired by an Independent Member.

The Committee Chair is supported by the Clinical Executives though any Executive can be required to attend.

Recognising that quality is everybody's business, the Executive leadership of quality is shared by the four Clinical Executives, The Medical Director, The Director of Nursing, the Director of Therapies and the Director of Public Health. Each Director has specific responsibilities:

Medical Director	Director of Nursing	Director of Therapies	Director of Public Health
Professional standards and regulation – Medicine	Professional standards and regulation – Nursing and Midwifery	Professional standards and regulation – Allied Health Professionals and Healthcare Scientists	Public Health
Clinical Governance	Clinical Governance & QI Lead	Clinical Governance	Clinical Governance
Standards support to Systems Groups	Patient Experience	Health and Safety	Improvement and Transformation
Medicines Management	Safeguarding and Deprivation of Liberties	Fire	Research, Innovation and Development
Clinical Audit and Effectiveness	Serious Incidents	Stroke	Health Protection
	Infection Prevention & Control		

Table 3. Clinical Executive Responsibilities

The Clinical Executives are supported by corporate teams who will provide assistance to the ILGs and systems groups and they will be held to account by the Director of Operational Services.

The Terms of Reference and Standard Agenda and reporting templates are attached as appendices.

In the previous framework, the Q&S Committee had four sub-committees for quality. As the new operating model has been established with the ILG Quality Groups reporting through the ILG Board to Q&S Committee, the need for these has changed and new Health Board wide shared listening and learning group has been established to support assurance and evidence learning to the Q&S Committee.

- **Locality Assurance Process**

At locality level, the Group Director is accountable for quality governance. There is a shared responsibility for quality and the delivery of quality governance with the Nurse Director, and Director of Operations.

Where ILGs host a service, the hosting ILG is accountable for upwardly reporting assurance, gaining that assurance from other relevant ILGs or sites.

Assurance of quality is through the Quality and Safety Group, ILG Board to the Q&S Committee.

The locality Q&S Group, a multi professional group, will have an annual work programme.

It meets bi-monthly and is chaired by the ILG Director.

Each Locality also has a Head of Quality and Safety role to support the quality governance agenda.

The ILG Team works collaboratively with the Systems groups, whom set standards for the services provided. These standards are based on national guidance and best evidence.

The Terms of Reference and Standard Agenda and reporting templates are attached as appendices.

ILG Q&S Governance Structure

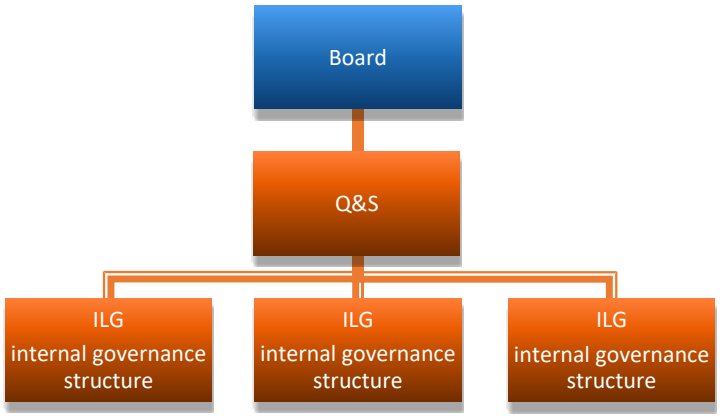


Figure 7. ILG Q&S Governance Structure

- **Other Health Board wide quality support and assurance**

Some services will continue to work across all three ILGs and will need to provide assurance in their own right. These include: elements of Primary Care (as outlined in the Operating Model document), Medicines Management, Health and Safety, Safeguarding and Infection Prevention and Control.

In addition to providing assurance through a Health Board wide meeting, they will work in partnership with the ILGs and the System Groups.

Additional advisory groups, again to support the ILGs and advise the Board will be established as and when required.

- **Hosted Bodies**

The standards within the framework will also apply in respect of the roles and responsibilities of Committees hosted by the UHB namely, Emergency Ambulance Services Committee, Welsh Health Specialised Services Committee and the National Imaging Academy, as appropriate. Any quality and safety issues associated with services commissioned for Cwm Taf Morgannwg residents and those services provided by Cwm Taf Morgannwg UHB will be raised to Quality & Safety Committee.

8. Next Steps and Implementation

Following approval of this revised framework, the implementation phase throughout the organisation will continue to embed and establish. This will be led by the ILG senior teams and supported by corporate teams.

9. References, bibliography and links to relevant documents:

- WAG, 2010. *Citizen Centred Governance Principles, Making Sense of Them* Welsh Assembly Government. Cardiff

- NLC, 2010 *The Healthy NHS Board, Principles of Good Governance* https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf

- ICSA (2011) *Mapping the Gap, Highlighting the disconnect between governance best practice and reality in the NHS* http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framewhttps://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-23%20.pdf

- NHS (Wales) Act 2006 http://www.legislation.gov.uk/ukpga/2006/42
- NHS Act 2006 http://www.legislation.gov.uk/ukpga/2006/41/contents

- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 http://www.legislation.gov.uk/wsi/2011/704/contents/made

- Social Services and Well-being (Wales) Act 2014 http://www.legislation.gov.uk/anaw/2014/4/contents

- Wellbeing of Future Generations (Wales) Act 2015 http://www.legislation.gov.uk/anaw/2015/2/contents/enacted

- The Nurse Staffing levels (Wales) Act 2016 http://www.legislation.gov.uk/anaw/2016/5/contents/enacted

- The Health and Social Care (Quality and Engagement) (Wales) Bill https://gov.wales/written-statement-health-and-social-care-quality-and-engagement-wales-act-2020

- 'A Healthier Wales' (Welsh Government 2018) https://gov.wales/healthier-wales-long-term-plan-health-and-social-care

- Citizen Centred Governance Principles (2010) http://www.wales.nhs.uk/governance-emanual/citizen-centred-governance-principles.

- Putting Things Right guidance, 2013, http://www.wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20%20CLEAN%20VERSION%20%20-%2020140122.pdf

- Evans, K (2014) *Using the Gift of Complaints* http://www.wales.nhs.uk/sites3/Documents/932/MB%20MD%202702%2014%20-%20Report%20-%20A%20review%20of%20concerns%20(complaints)%20handling%20in%20NHS%20Wales%20-%20Using%20the%20gift%20of%20complaints%20by%20Keith%20Evans%20-%2020140611%20Doc%201.pdf

- NHS Wales Health and Care Standards, 2015 http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

- Listening & learning to improve the experience of care, 2015 http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Listening%20and%20Learning%20to%20Improve%20the%20Experience%20of%20Care.pdf

- Prosperity for all – the national strategy: The Welsh Government's well-being objectives (2017) https://gov.wales/about/cabinet/cabinetstatements/2017/prosperitforallwellbeingstatement/?lang=en

- The Parliamentary Review of Health and Social care in Wales https://beta.gov.wales/sites/default/files/publications/2018-01/Review-health-social-care-report-final.pdf

- The NHS Wales Values and Standards of Behaviour Framework (2013) (http://www.wales.nhs.uk/governance-emanual/values-and-standards-of-behaviour-framew)

- Improvement Cymru https://phw.nhs.wales/services-and-teams/improvement-cymru/

- Planning framework (https://gov.wales/sites/default/files/publications/2019-09/nhs-wales-planning-framework-2020-to-2023.pdf)

- CTMUHB Risk Management Strategy 2018 – 2023 (http://ctuhb-intranet/Policies/_layouts/15/WopiFrame.aspx?sourcedoc=%7b53FA657F-0F50-4ED6-A38F-4E17C19F72C5%7d&file=Risk%20Management%20Strategy%202018%20-%202023%20-%20V4.0.docx&action=default&DefaultItemOpen=1)

- CTMUHB Operating Model 2019 (http://ctuhb-intranet/dir/OM/Shared%20Documents/Final%20Operating%20Model%20-%20Dec%2019.pdf

Appendices

- **Appendix 1: Terms of Reference Quality and Safety Committee**

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

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE & OPERATING ARRANGEMENTS

http://ctuhb-intranet/Policies/_layouts/15/WopiFrame.aspx?sourcedoc=%7BA9BF2C1C-652E-4AD4-B25B-F42E5D6C3840%7D&file=GC01%20Standing%20Orders%20-%20Schedule%203-8%20-%20Quality%20%26%20Safety%20Committee%20ToR%20-%20Final%2030.07.2020.docx&action=default&DefaultItemOpen=1

INTRODUCTION

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

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

The term locality team, when used within this document, is to describe out of district general hospital services e.g. Community (in and out of hospital) and Independent Contractor services (GPs, Dentists, Pharmacists and Optometrists).

CONSTITUTION & PURPOSE

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

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

The Committee will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Ensure appropriate arrangements are in place to support workplace health & safety.

- Provide evidence based and timely advice to the Board, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Board in relation to the CTMUHB's arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.

SCOPE AND DUTIES

SCOPE:

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

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

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

DUTIES:

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

Strategy

- Oversee and monitor the development and implementation of the UHB's Strategies for patient quality and safety and staff workplace health & safety:

- **Patient Quality and Safety**
  - Provide assurance to Board on implementation of the Quality aspects within the Integrated Medium Term Plan (IMTP) for CTMUHB
  - Provide assurance to the Board in relation to the Quality Governance Framework.
  - Contribute to and oversee the development of the Health Board's Annual Quality Statement
  - Monitor quality via the Quality Dashboard
  - Approve the content of the CTMUHB Annual Quality Statement which relates to the committees work programme
- **Workplace Health & Safety**
  - Provide assurance to Board on the development of related strategies and operating practices to ensure arrangements for staff workplace health & safety are safe and in compliance with associated legislation.

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

Hosted Bodies

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

Organisational Risk

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

Policies and Procedures

- Approve appropriate Policies (once reviewed and endorsed by the appropriate sub group) and where appropriate any related Procedures.
- Oversee the register of policies, ensuring that it is maintained, and that all assigned policies are subject to review at least every three years.

Research & Development

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

Quality Improvement activities

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

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

Patient Experience

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

Concerns

- Receive as presented within the quarterly quality report, reports on Concerns (reported patient safety incidents, complaints, compliments, clinical negligence claims and inquests) reporting trends, with particular emphasis on ensuring that lessons are learnt, and to inform the Annual Quality Delivery Plan

- Receive assurance of effective and timely management of concerns across the University Health Board
- Receive, review and approve the Annual Concerns Report on behalf of the UHB.

Staff Experience

- Receive assurance that there are appropriate systems in place to support workplace health & safety and to listen to staff views, embracing the principles of the Listening Organisation, in order to promote effective team working and staff satisfaction to provide the best possible outcomes for patients.
- Receive assurance that the workforce is appropriately selected, trained and responsive to the needs of the service, and that professional standards and registration/revalidation requirements are maintained.

DELEGATED POWERS

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

AUTHORITY

The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its terms of reference. It may seek relevant information from any:
    - employee (and all employees are directed to cooperate with any legitimate request made by the Committee), and
    - Any other committee, or group set up by the Board to assist in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements
- approve policies relevant to the business of the Committee as delegated by the Board.

Sub Committees

The Committee may, subject to the approval of the Health Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

ACCESS

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

MEMBERSHIP

Members:

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

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

Attendees

- Executive Nurse Director
- Medical Director
- Director of Public Health
- Director of Therapies and Health Sciences
- Executive Director of Operations
- Community Health Council Representative

- Director of Workforce & Organisational Development
- Staff side representative
- Staff side safety chair or vice chair
- Director of Governance / Board Secretary

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

By Invitation:

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

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

Secretariat

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

Member Appointments

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

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

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

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

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

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

COMMITTEE MEETINGS

Quorum

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

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

Frequency of Meetings

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

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

Withdrawal of individuals in attendance

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

Circulation of Papers

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

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

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

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

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

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

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

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

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

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

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

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

- sharing of information

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

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

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

CHAIR'S ACTION ON URGENT MATTERS

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

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

REVIEW

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

Appendix 2:

- **Standard Agenda Template Q&S Committee**

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board		
QUALITY & SAFETY COMMITTEE		
The next meeting of the Committee will be held on xxxxx **Chair:**		
AGENDA		
Patient Story –		
PART 1. PRELIMINARY MATTERS		
1.1	Welcome and introductions	**Oral**
1.2	Apologies for absence	**Oral**
1.3	Declaration of Interests	**Oral**
1.4	Unconfirmed minutes of the meeting held xxxx	**Attachment** Chair
1.5	Committee Action Log	**Attachment** Director of Governance/Board Secretary (Interim)
1.6	Matters Arising not considered within the Action Log	**Oral** Chair
PART 2. ITEMS FOR APPROVAL/ENDORSEMENT		
2.1		
PART 3. GOVERNANCE, PERFORMANCE AND ASSURANCE		
3.1		

3.2		
3.3		
3.4		
3.5	**Directorate Exception Reports**	
3.6		
3.7		
3.8		
3.9		
3.10		
3.11	**Minutes/Reports from Sub Groups**	
PART 4. ITEMS FOR INFORMATION **(Please note these items will not be discussed unless raised with the Committee Chair in advance)**		
4.1		
PART 5. OTHER MATTERS		
5.1	Any other urgent business	**Oral** Chair
5.2	Forward Look	**Attachment** Chair
Date & Time of next meeting:		

Appendix 3:

- **Standard Agenda Template ILG's**

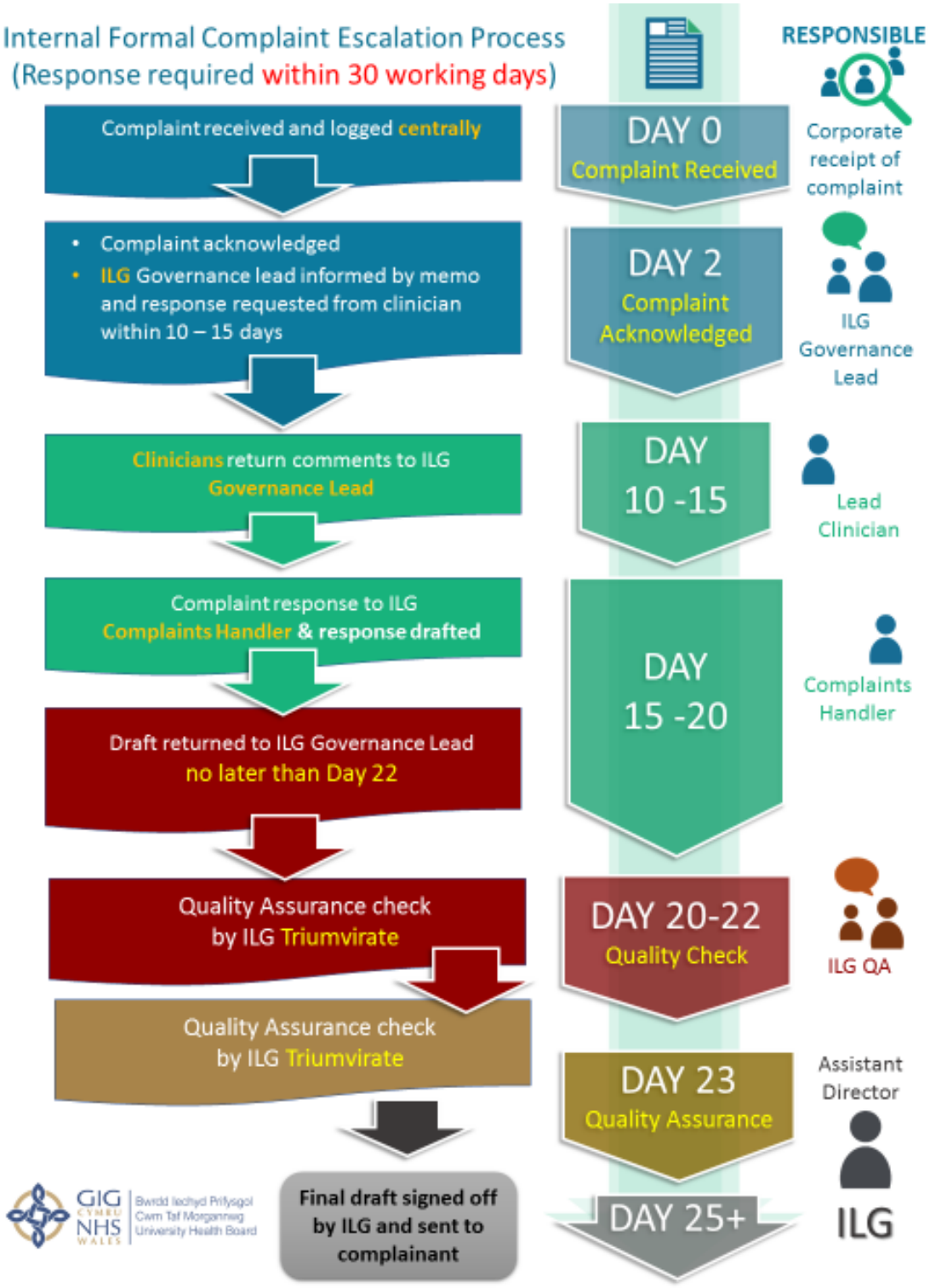
ILG – Merthyr/Cynon *Insert Title of Meeting, date time, venue*

No.	Agenda	Item Lead	HCS+	Papers / RAG
1.	**Welcome and introduction**			
1.1	Apologies			
1.2	Action log from previous meeting held on the ……			
2.	**Matters Arising**			

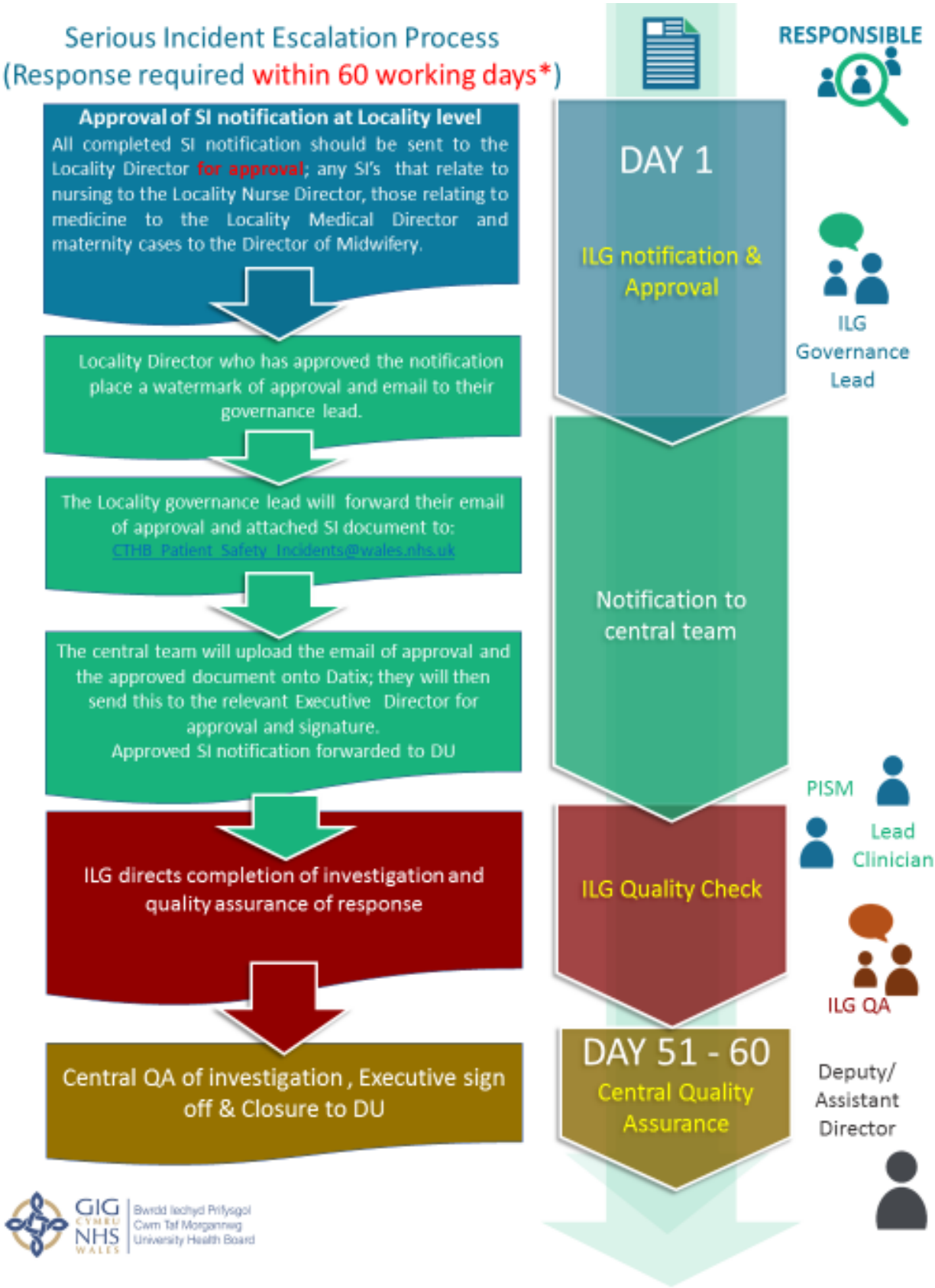
3.	**Patient experience e.g.**
	• Internal assurance, peer review
	• trends and themes:
	  ○ real time, informal & structured patient feedback
	  ○ Incident reporting
	  ○ Serious incident investigation status, action planning
	  ○ mortality review
	  ○ Concerns, redress, claims & personal injury			

4.	**Assurance e.g.** • New unannounced or scheduled visits/inspections • Progress with remedial action plans: HIW, HM Coroner, Ombudsman, CHC, external and internal audit reports, other			
5.	**Quality planning: e.g.** • triangulating data analysis & soft intelligence • workforce development: education, learning • wellbeing: staff survey			
5.	**Quality improvement and clinical effect effectiveness e.g.** • QI initiatives, overview and progress • clinical audit including results of relevant national audit • implementation of NICE guidelines • research, • medicines management • policies and protocols • sharing of learning			
6.	**Compliance with legislation and regulation**: **e.g**. • health and safety, including fire • safeguarding & public protection, • patient safety notices & alerts • Welsh Language, equality and diversity • business continuity • GDPR			
7.	• **Managing risk e.g.** • review risk register, • infection prevention, control and decontamination, • staff sickness, • capital asset registers • agree any items for escalation			
8.	**Any Other Business**			

Appendix 4: ILG Formal Complaint Process



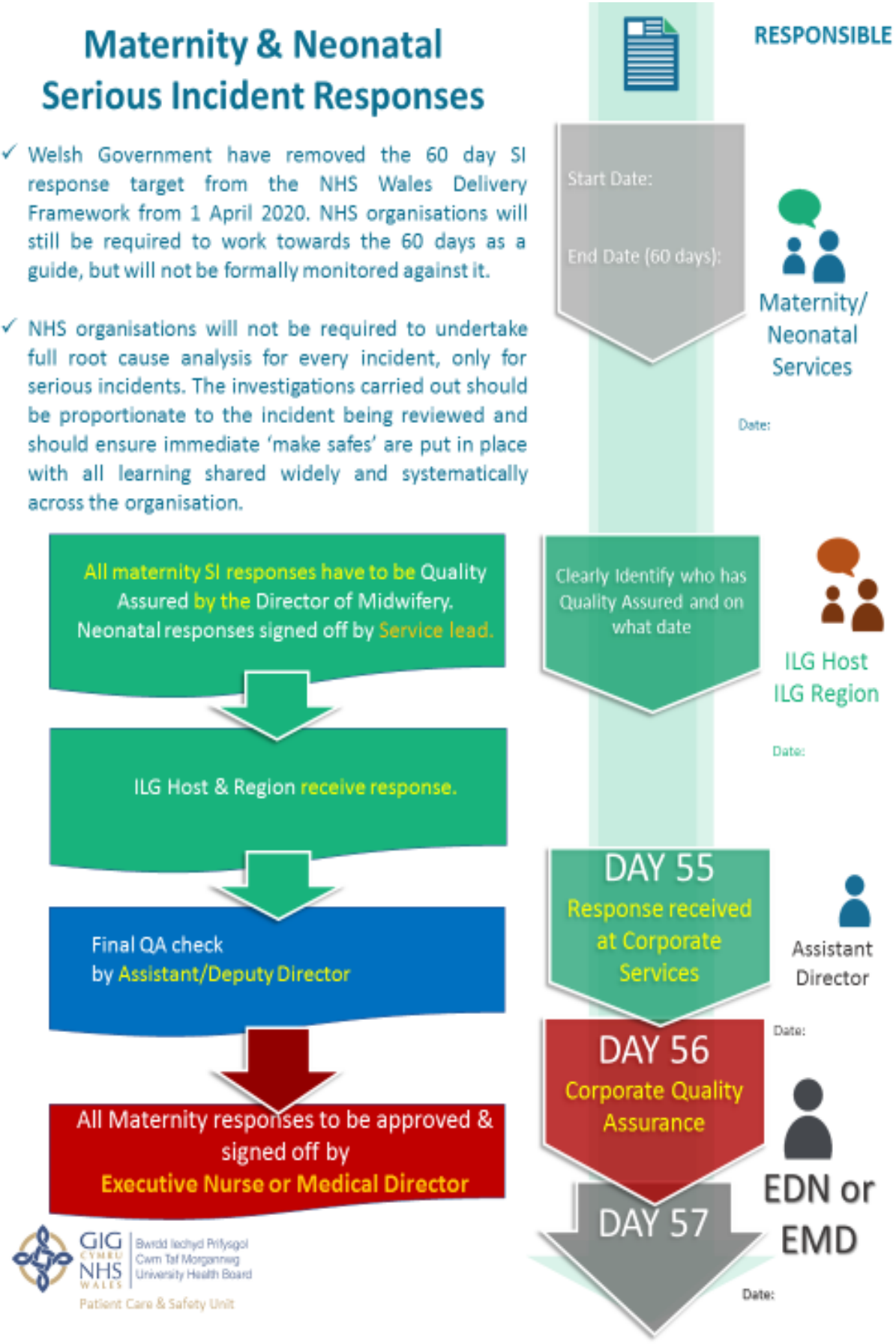
Appendix 5: ILG Serious Investigation (SI) Process



ILG concerns responses and SI Investigations will be subject to a monthly audit cycle

CTM SI Toolkit relaunched December 2020

Appendix 6: Maternity & Neonatal SI Process



AGENDA ITEM
2.1.4

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE cycle of business

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Georgina Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR APPROVAL

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 The Cycle of Business covers the period 1 January 2021 to 31 March 2022.

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.

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 completed	No (Include further detail 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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

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

Quality & Safety Committee

Cycle of Business

(1st January 2021 – 31st March 2022)

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 2021 to 31st March 2022.

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.

Board Cycle of Business (1st January 2021 – 31st March 2022)

Strategic Objectives	Provide high quality, evidence based and accessible care	Work with Communities and partners to reduce inequality, promote well-being and prevent ill health	Ensure sustainability in all that we do, economically, environmentally and socially	Co-create with staff and partners a learning and growing culture
Threats to the Strategic Objectives	• Failure to deliver a high quality, safe and effective service that improves population health • Failure to provide timely health and wellbeing care & services • Failure to deliver a service user and carer focussed service.	• Failure to engage effectively with our communities to inform, develop and deliver an effective, safe and responsive service that meets the health needs of our communities • Failure to engage, listen and act on issues / feedback that would help to reduce inequalities, promote wellbeing and prevent ill health within our communities.	• Failure to make robust, informed decisions for our communities and execute them within a sound system of Governance • Failure to deliver and maintain financial sustainability • Failure to continually adapt and respond to a changing environment. • Failure to adopt new technology and innovations to enable change and sustainability	• Failure to listen, learn and respond appropriately to the views of our staff and partners to enable continual improvement in our services and culture. • Failure to engage, listen and act on feedback to shape services and culture. • Failure to engage constructively with partners and have a mutual understanding of each other's issues. • Failure to sustain an engaged and effective workforce.
Principal Risks	1. **If:** there is a significant deterioration in standards of patient safety and care provided by the Health Board. **Then:** there could be an increase in incidents across the Health Board **Resulting In:** Potentially avoidable harm and poor clinical outcomes, reduction in trust and confidence in the service, and regulatory action and intervention. 2. **If:** demand exceeds capacity **Then:** service quality, safety and performance could deteriorate. **Resulting in:** Potentially avoidable harm and poor clinical outcomes, reduction in public trust and confidence in the service. Regulatory action and intervention.	1. **If:** engagement and collaboration with the Health Board's communities does not fully deliver the required outcomes **Then:** it may have failed to effectively understand the health needs of its communities and reflect them in its services. **Resulting In:** the inability to reduce inequalities, promote wellbeing and prevent ill health in its communities.	1. **If:** the Health Board's financial strategy / objectives are not met **Then:** it will have failed to achieve its agreed financial plans **Resulting In:** Qualification of the accounts, potential regulatory action, adverse impact on longer term financial sustainability and reduced ability to invest in improvement and take associated financial risks. 2. **If:** the Health Board fails to recognise and adopt advances in digital technology and innovations in the design of its business and clinical services. **Then:** it its ability to remain competitive and sustainable will be affected. **Resulting In:** the inability to deliver high quality, safe, effective and robust sustainable services for the future (WBFGA).	1. **If:** the Health Board does not embed its values and behaviours and develop an engaged and motivated workforce / collaboration with its partners 2. **Then:** there is likely to be a deterioration in patient, staff and partner experience, wellbeing and morale. 3. **Resulting In:** an adverse impact on patient care and the recruitment and retention of an engaged and effective workforce.

Item of Business	Executive Lead	Reporting period	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021	July 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Preliminary Matters																	
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Action Log	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Governance, Risk, Performance & Assurance																	
Shared Listening & Learning Story	Executive Director of Nursing & Midwifery	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Maternity Services Improvement Programme Update	Executive Director of Nursing & Midwifery	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓

Item of Business	Executive Lead	Reporting period	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021	July 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Integrated Locality Group Quality & Safety Reports	Director of Operations/ Executive Director of Nursing & Midwifery	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Quality Dashboard	Executive Director of Nursing & Midwifery	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Safeguarding & Public Protection Annual Report	Executive Director of Nursing & Midwifery	Annually							✓								
Follow Up Outpatients Not Booked	Director of Operations	All Regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Follow Up Outpatients Not Booked – Ophthalmology	Medical Director	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Covid-19 Update	Director of Public Health	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Mortality Indicators Update	Director of Public Health	Annually					✓										
Mortality Reviews Update	Medical Director	Quarterly			✓				✓				✓				✓
Quality & Safety 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					✓										
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Annual Quality Statement	Executive Director of Nursing & Midwifery	Annually									✓						
Organisational Wide Policies Update (Clinical and Non Clinical)	Director of Corporate Governance / Executive Director of Nursing & Midwifery	Bi-Annually	✓						✓								
Quality Governance – Regulatory Review Recommendations and Progress Updates	Executive Director of Nursing & Midwifery	All regular meetings	✓		✓		✓		✓		✓		✓		✓		✓
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Director of Operations	Annually			✓												
Resetting CTM Operating Framework – Harm Review	Medical Director	Quarterly	✓				✓				✓				✓		
Research & Development Update	Director of public Health	Bi-Annually					✓						✓				
Clinical Audit Quarterly Update	Medical Director	Quarterly			✓				✓				✓				✓

Item of Business	Executive Lead	Reporting period	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021	July 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Review of the Governance Matrix (Targeted Intervention)	Director of Corporate Governance	Bi-Annually			✓						✓						✓
Cancer Services Annual Report	Medical Director	Annually			✓												
Prescribing Annual Report	Director of Operations	Annually							✓								
Reports from Sub Groups																	
Infection, Prevention & Control Committee	Executive Director of Nursing & Midwifery	Quarterly	✓				✓		✓				✓		✓		
Infection, Prevention & Control Annual Report	Executive Director of Nursing & Midwifery	Annually					✓										
Medicines Management Expenditure Committee	Director of Operations	Quarterly	✓				✓				✓				✓		
Health, Safety & Fire Sub Committee	Director of Workforce & OD	Quarterly			✓				✓		✓				✓		
Shared Listening & Learning Forum	Executive Director of Nursing & Midwifery	Quarterly			✓				✓				✓				✓

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

QUALITY & SAFETY COMMITTEE ACTION LOG
19 JANUARY 2021

Minute Ref.	Date	Agreed Action	Lead	Timescale	Status as at January 2021
QSR/17/39 &	9 May 2017	**Clinical risks / patient safety issues associated with follow up outpatients not booked (FUNB)** Members reinforced their expectation that they required a report on the agreed three specialities to consider whether there was any avoidable harm as a consequence of patients waiting longer than originally planned, to undergo their outpatient follow up appointment.	Director of Operations	May 2018 agreed that FUNB be a standing item on the agenda until further notice. March 2020 July 2020	**Ongoing** Regular update reports have been scheduled into the Committees Annual Cycle of Business
QSR/19/78 QSC/20/96	August 2019 July 2020	Full update report on FUNB to be presented to the September meeting with specific focus placed on Ophthalmology Revised FUNB plan to be presented to the September meeting, with particular focus being place on Ophthalmology, which also identified the reduction of risk and identification of harm.		September 2020 November 2020	
QSR/18/81	Dec 2018	**Policy Review** **a)Corporate Policy Sub Group** A corporate policy review sub group to be introduced to support the corporate policy review process, which will be in addition to the existing group in existence for reviewing workforce policies.	Board Secretary/ Director of Corporate Services & Governance	June 2019 Was March 2020 Was May 2020	**Completed** Report presented to the November 2020 outlining the progress made and process moving forwards. Regular progress reports have been scheduled into the Committees Annual Cycle of

Minute Ref.	Date	Agreed Action	Lead	Timescale	Status as at January 2021
				Now July 2020 September 2020 November 2020	Business
QSC/19/181	December 2019	**Directorate Exception Report – Children & Young People** Concerns expressed at the nurse staffing levels and shortage of Paediatric Doctors identified within the report. Update to be provided at the January 2020 meeting regarding the proposal being developed to address the position	Medical Director	May 2020 Now July 2020 Now October 2020 Due to the redeployment of resources in response to Covid, we are unable to provide the Committee with a revised proposed date for completion at the present time.	**In progress** The Covid response has intervened again, however, recruitment is continuing.
QSC/20/060	May 2020	**Primary & Community Services Quality Report** Outcomes of the investigations undertaken into the Serious Untoward Incidents to be shared with Committee Members	Director of Primary, Community & Mental Health Services	July 2020 Now December 2020	**In progress** It is anticipated that the Serious Incident Review will be completed by mid-November. The outcomes will be shared with Members following the completion of the review.

Minute Ref.	Date	Agreed Action	Lead	Timescale	Status as at January 2021
QSC/20/065	May 2020	**Royal College of Anaesthetists & Royal College of Surgeons Invites Service Review on the Intensive Care Service for General Surgery Patients at Princess of Wales Hospital** In Committee discussion to be held at a future meeting regarding the significant HR issues associated with this review	Medical Director	September 2020 Due to the redeployment of resources in response to Covid, we are unable to provide the Committee with a revised proposed date for completion at the present time.	**On agenda**
QSC/20/091	July 2020	**Maternity Service Improvement Programme Report** Review to be undertaken of the job planning data contained within the report which Independent Members found difficult to understand. Response to be provided outside of the meeting	Assistant Medical Director	December 2020 February 2021	**In progress** Progress remains slow, partly due to further changes in structure within the department. So far, 77% of consultants are recorded as overdue as are 62% of SAS doctors. A number of these are at the "awaiting sign off" stage however, so this should improve over the coming months. Job Planning was paused as a result of the Covid 19 Pandemic.
QSC/20/116	September 2020	**Merthyr & Cynon Integrated Locality Group Quality & Safety Report** Report to be presented to the November meeting of the Committee outlining the consequences of the opening of the Grange Hospital on Prince Charles Hospital	Director of Operations	November 2020	**Completed** This report was presented to the December Planning, Performance & Finance Committee for noting.

Minute Ref.	Date	Agreed Action	Lead	Timescale	Status as at January 2021
QSC/20/140	November 2020	**Merthyr & Cynon Integrated Locality Group Quality & Safety Report** Harm Review improvement plan to be shared with Committee members	Director of Operations	January 2021	**In progress**
QSC/20/141	November 2020	**Listening from an Improvement Story** Communications Team to be put in contact with the Creative Writing Facilitator so that her work could be promoted	Director of Corporate Governance	January 2021	**Completed** Details shared with the Communications Team and patient story shared at the Staff Gratitude Event
QSC/20/144	November 2020	**Once for Wales Concerns Management System** Report to be shared with the Digital & Data Committee as a result of this being a major IT implementation programme.	Director of Nursing	January 2021	**Completed** Report presented to the December 2020 meeting of the Digital & Data Committee
QSC/20/156	November 2020	**Bridgend Integrated Locality Group Quality Report** Additional assurance to be provided to Committee Members in relation to the ligature works being undertaken within the Bridgend ILG. Detailed action plan to be included with all future reports	Integrated Locality Group Director	January 2021	**Completed** Ligature Action Plans shared with Committee Members outside of the meeting
QSC/20/158	November 2020	**Quality Dashboard** A review to be undertaken of future committee meeting dates to ensure the Committee was as best informed as it could be in relation to the data being presented	Director of Corporate Governance	January 2021	**In progress** Verbal update to be provided by the Assistant Medical Director of Quality & Clinical Effectiveness to the January meeting outlining the proposed way forward.
QSC/20/164	November 2020	**Update on Follow Up Outpatients Not Booked – Ophthalmology** Next iteration of the report to include an update on patient engagement and how patients were reacting to the current position	Medical Director	January 2021	**On agenda** Verbal update to be provided at the meeting

AGENDA ITEM
2.2.2

QUALITY & SAFETY COMMITTEE

policy management improvement plan (clinical and non-clinical policies)

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	C. Hamblyn, Assistant Director of Governance & Risk D Hurford, Assistant Medical Director
Presented by	G. Galletly, Director of Corporate Governance
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	FOR NOTING

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

ACRONYMS	
	Not Applicable

1. SITUATION/BACKGROUND

1.1 The Cwm Taf Morgannwg University Health Board has a statutory duty to ensure that appropriate policies are in place. Policies ensure that the Health Board complies with legislation, meets mandatory requirements, and enable staff to fulfil their roles safely and competently.

1.2 A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Health Board must maintain a system to support the development or review, approval, dissemination and management of polices.

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

"Review of the Policy on Policies"

2.1 The "Policy on Policies" is under review and organisational wide consultation has been sought. The revised policy was submitted to the Management Board in December to endorse for Board approval in January 2021.

Non-Clinical Policies

2.2 The Management Board previously supported a Policy Risk Assessment approach to support the timely review of policies and procedures that were passed their review date and this is currently underway in relation to non-clinical policies. **The progress on this stage of the improvement plan has been limited and it has been proposed that the Policy Risk Assessment process be placed on hold as a result of the impact the Covid-19 response is having on the Health Board. This pause will support colleagues to appropriately focus on managing the pandemic and prioritising the operational and clinical demand facing the Health Board at this time.**

2.3 A Master Policy Register which includes the non-clinical policies has been developed and as and when risk assessments are completed the Management Board are asked to support the revised review dates, the priority review plan and the removal of policies and/or procedures that have been assessed as no longer required.

Clinical Policies

2.4 The "Policy on Policies" is under review with closer alignment with Clinical Policies to ensure a consistent approach in relation to templates, master libraries and referencing with the development of a central location on SharePoint for ease of accessing policies and key policy related documents, support and guidance.

Policy Approval Routes

2.5 The review of the "Policy on Policies" will include defined routes of approval for clinical and non-clinical policies ensuring that where approval has been delegated to Committees and/or the Clinical Policy Sub Group the relevant Terms of Reference are clear in relation to their delegated authority for approval.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The impact of Covid-19 has significantly impacted the pace on the completion of the risk assessments in relation to non-clinical policies. The position will be reviewed at the end of January 2021 to consider if the process can be reinstated.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5 RECOMMENDATION

5.2 The Committee is asked to **NOTE** the progress being made in relation to the Policy Management Improvement Plan.

QUALITY & SAFETY COMMITTEE FORWARD LOOK

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
19 January 2021	Shared Listening & Learning Story Minutes Action Log Declarations of Interest Forward Work Programme	Revised Quality Governance Framework	Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon • Rhondda & Taff • Bridgend • Primary Care Quality Dashboard (to include an update on the future of the Quality Dashboard) Follow Up Outpatients Not Booked Follow Up Outpatients Note Booked – Ophthalmology Covid 19 Update Report Organisational Risk Register – Risks Assigned to the Quality & Safety Committee Organisational Wide Policies Update (Clinical and Non Clinical Policies) Quality Governance – Regulatory Review Recommendations and Progress Updates Resetting CTM Operating Framework – Harm Review	Medicines Management Expenditure Committee Highlight Report Infection, Prevention & Control Committee Highlight Report

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
			Resetting CTM Operating Framework – Quality Implications of the Quarter 3/Quarter 4 Plan DU Review Management Review of Patient Safety Incidents and Concerns - Quarterly Update Learning Disability Services Covid Reflections (Report prepared by Swansea Bay UHB) Update on Joint College Report Action Plan Peer Review Update for Critical Care Delivery Unit Action Plan – Cancer Services Quality Assurance in Neonates Serious Incident Review – CAMHS Ty Llidiard (to include an update Ligature Works being undertaken) Update Report – Delivery Unit Report – Cardiac Waiting Times Follow Up	
16 March 2021	Shared Listening & Learning Story Minutes Action Log Declarations of Interest	Environmental Policy	Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon • Rhondda & Taff • Bridgend • Primary Care Quality Dashboard	Controlled Drugs Local Intelligence Network (CDLIN) Annual Report Health, Safety & Fire Sub Committee Highlight Report

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
	Forward Work Programme		Follow Up Outpatients Not Booked Follow Up Outpatients Not Booked – Ophthalmology Covid 19 Update Report Mortality Review Update Organisational Risk Register – Risks Assigned to Quality & Safety Committee Quality Governance – Regulatory Review Recommendations and Progress Updates Clinical Audit Quarterly Update Review of the Governance Matrix (Targeted Intervention) 6 monthly update Report – Peer Review Systematic Anticancer Therapies (First Round) Health, Safety & Fire Sub Committee Highlight Report Leave No-One Behind Report Ockenden Report – Learning Points for CTM High Level Update on Mortality Indicators Committee Annual Self-Assessment Questionnaire Responses – Update Report	

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
18 May 2021	Shared Listening & Learning Story Minutes Action Log Declarations of Interest Forward Work Programme	Quality & Safety Committee Annual Report 2020 – 2021 Quality & Safety Committee Terms of Reference	Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon • Rhondda & Taff • Bridgend • Primary Care Quality Dashboard Follow Up Outpatients Not Booked Follow Up Outpatients Not Booked – Ophthalmology Covid 19 Update Report Organisational Risk Register – Risks Assigned to Quality & Safety Committee Quality Governance – Regulatory Review Recommendations and Progress Updates Resetting CTM Operating Framework – Harm Review (Quarterly Update) Research & Development Update (6 monthly update report)	Medicines Management Expenditure Committee Highlight Report Infection, Prevention & Control Committee Highlight Report Infection, Prevention & Control Annual Report
20 July 2021	Shared Listening & Learning Story Minutes		Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon	Health, Safety & Fire Sub Committee Highlight Report

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
	Action Log Declarations of Interest Forward Work Programme		• Rhondda & Taff • Bridgend • Primary Care Quality Dashboard Safeguarding & Public Protection Annual Report Follow Up Outpatients Not Booked Follow Up Outpatients Not Booked – Ophthalmology Covid-19 Update Mortality Reviews Update Organisational Risk Register – Risks Assigned to Quality & Safety Committee Organisational Wide Policies Update (Clinical and Non Clinical) Quality Governance – Regulatory Review Recommendations and Progress Updates Clinical Audit Quarterly Update	Infection, Prevention & Control Committee Highlight Report Annual Prescribing Report
21 September 2021	Shared Listening & Learning Story Minutes Action Log Declarations of Interest	Annual Quality Statement	Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon • Rhondda & Taff • Bridgend • Primary Care	Medicines Management Expenditure Committee Highlight Report

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
	Forward Work Programme		Quality Dashboard Follow Up Outpatients Not Booked Follow Up Outpatients Not Booked – Ophthalmology Covid-19 Update Organisational Risk Register – Risks Assigned to Quality & Safety Committee Quality Governance – Regulatory Review Recommendations and Progress Updates Resetting CTM Operating Framework – Harm Review (Quarterly Update) Review of the Governance Matrix (Targeted Intervention)	Health, Safety & Fire Sub Committee Highlight Report
16 November 2021	Shared Listening & Learning Story Minutes Action Log Declarations of Interest Forward Work		Maternity Services Improvement Programme Report Integrated Locality Group Reports: • Merthyr & Cynon • Rhondda & Taff • Bridgend • Primary Care Quality Dashboard Follow Up Outpatients Not Booked Follow Up Outpatients Not Booked – Ophthalmology	Infection, Prevention & Control Committee Highlight Report

Meeting	Standing items	For Approval	Governance Performance and Assurance	Information
			Covid-19 Update Mortality Reviews Update Organisational Risk Register – Risks Assigned to Quality & Safety Committee Quality Governance – Regulatory Review Recommendations and Progress Updates Research & Development Update Clinical Audit Quarterly Update	

Need to add in

Community based interventions e.g Valley Steps etc – to be confirmed

Patient harm – from Follow up Appointments not booked to be confirmed

Composite report on the outcomes of the reviews being undertaken by the Delivery Unit and Healthcare Inspectorate Wales / Wales Audit Office

Update on Primary and Community Care Services and the Bridgend Boundary Change

Report Inability to release staff to attend Statutory & Mandatory Training Sessions (was due to be received in May 2020 but deferred due to COVID-19)

Internal Assurance Report – 'Know the Score' A Review of NCEPOD of the Quality of Care Provided to Patient aged over 16 Years with a new Diagnosis of Pulmonary Embolism (was due to be received in May 2020 but deferred due to COVID-19)

Update on the National Bowel Cancer Audit (was due to be received in May 2020 but deferred due to COVID-19)

Update report on the Safe Storage of Medicines (was due to be received in May 2020 but deferred due to COVID-19)

WAST Presentation

AGENDA ITEM
2.2.4

QUALITY & SAFETY COMMITTEE

MEDICINES MANAGEMENT AND EXPENDITURE COMMITTEE (MMEC)- CHAIRS REPORT

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kathryn Howard, Team Leader Medicines Governance and MMPU
Presented by	Executive Director of Operations
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

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

ACRONYMS	
MMEC	Medicines Management and Expenditure Committee

1. SITUATION/BACKGROUND

1.1 The following report provides a summary of key issues discussed at the MMEC meetings held between beginning of April 2020 and the end of October 2020.

1.2 The MMEC is the key forum underpinning the governance and assurance frameworks for all the processes involving medicines within Cwm Taf Morgannwg University Health Board (CTMUHB).

1.3 The Medicines Management & Expenditure Committee is the key conduit for medicines management communication issues, and receives the reports from and decisions of the:

- Medicines Management and Expenditure Scrutiny Group
- CTMUHB Medication Safety Steering Group
- CTMUHB Antimicrobial Resistance Group
- CTMUHB Medical Gases Committee
- All Wales Medicines Strategy Group (AWMSG) and National Institute of Clinical Excellence (NICE) via the Formulary Report

1.4 The MMEC reports to the CTMUHB Quality & Safety Committee.

1.5 All Clinical Policies, Procedures and Guidelines endorsed or approved by the MMEC are available on the Medicines Management Clinical Policies and Procedures page on Share Point, or on the Primary Care Clinical Portal (if a Primary Care Only document). They are also cross-referenced to the corresponding policies and procedures page of the specialty they originated from.

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

2.1 MMEC as part of CTMUHB Governance and Integrated Locality Group (ILG) Structures

The MMEC has continued to meet and function throughout the new structure change and throughout the COVID pandemic.

MMEC has a Health Board wide medicines governance function and also needs to align with the new ILG structure.

In the past a lack of consistent representation from acute sector medical practitioners has resulted in a number of meetings being non-quorate.

Mitigation
In response to the new CTMUHB Governance Framework & Structure, The MMEC Terms of Reference (TOR) will be updated to include new locality structure representation and to re-focus the committee on

Health Board wide medicines management governance and assurance.

Further discussions are required around incorporating MMEC membership into the roles of clinical leads.

Medicines Management are represented on the newly formed CTMUHB Clinical Policies Group.

2.2 **Access to Medicines Management Policies, Procedures and Guidelines**

Sharepoint currently houses these documents, approximately 48% require review by the relevant clinical directorate.

The search function on the front page of Share Point is not always directing users to the appropriate documents. It has on occasion directed users to documents that should have been archived.

Bridgend Locality access the Swansea Bay UHB (SBUHB) clinical document system "COIN" which houses legacy Abertawe Bro Morgannwg UHB (ABMUHB) documents, but will be inaccessible to CTMUHB staff in the future.

This poses a number of governance risks to the Health Board.

Mitigation

A review of all documents on the MMEC page has been undertaken. Any documents that are no longer relevant/required have been archived. Directorate clinical leads are being contacted and asked to confirm whether their documents are still required and if so, what the timeline for review and update will be. This review has been extended to include the corresponding Bridgend documents. This will ensure all clinical policies and procedures are relevant for the new organisation.

A recommendation at a recent MMEC meeting was that a Health Board wide clinical guidance and document storage, management and control system is required which provides mobile access to support clinical near patient access and use.

This issue will be progressed with the new Clinical Policies Group and the Assistant Medical Director (AMD) for Quality.

2.3 **Medicines Shortages**

The UK is currently experiencing a high number of medicines shortages. In addition the COVID pandemic has adversely affected the supply chains and the full impact of the European Union (EU) exit deal could further adversely affect medicines supplies.

There have been approximately 94 medicine shortage alerts, some for multiple medications, in the current financial year.

There have been no reported clinical incidents due to medicines shortages.

CTMUHB maintained medicines supplies to critical care patients during the first wave of the COVID pandemic when supplies were most fragile and are continuing to closely monitor this situation.

Mitigation

The Department of Health and Social Care (DHSC) are responsible for ensuring the continuity of supply of medicines in the UK and has longstanding arrangements for dealing with medicines shortages. To strengthen the existing arrangements in Wales, the Medicines Shortage Advisory Group Wales (WMSAG) was established in February 2019. This group provides clinical advice on medicines shortages to the Chief Pharmaceutical Officer, who where appropriate, will then issue a letter with recommendations to NHS Wales. CTMUHB Medicines Management teams are alerted to these shortages directly from both the DHSC and from the WMSAG.

CTMUHB has established processes for responding to the shortage alerts and will continue to follow the advice of the Medicines Shortage Advisory Group Wales.

The Medicines Governance Team (MMPU) coordinate the dissemination of all information and actions on medicines shortages across the Heath Board to both Primary and Secondary Care and also to Community Pharmacy teams. The information is cascaded out and targeted as appropriate, is available on the Medicines Management Page on Share Point and the Primary Care Portal and News Items are also generated for the medicines shortages that affect multiple clinical areas e.g. Clexane shortage.

Forward planning for potential COVID and EU exit supply issues are on-going on both All Wales and Health Board levels with Health Boards and Trusts in Wales having a "mutual aid" agreement.

2.6 **Approved Documents and Formulary Items**

The MMEC has continued to function and prioritise the scrutiny and approval of key medicines governance and guidance documents. See Appendices for detail.

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

Nil at present

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The MMEC is the key forum underpinning the governance and assurance frameworks for all the processes involving medicines within Cwm Taf Morgannwg University Health Board
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	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

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

Appendix 1

Formulary Decisions April 2020- October 2020

Formulary Update reports can be found on the Formulary section of the Medicines Management pages on Share Point. The links below take you to the appropriate Formulary update reports following formulary decisions agreed at MMEC.

April-June 20

http://ctuhb-intranet/dir/MM/Formulary/Cwm%20Taf%20Morgannwg%20Formulary%20Updates%202020/CTMUHB%20Formulary%20Update%20June%202020.pdf

July-Oct 20

http://ctuhb-intranet/dir/MM/Formulary/Cwm%20Taf%20Morgannwg%20Formulary%20Updates%202020/CTMUHB%20Formulary%20Update%20October%202020.pdf

Appendix 2

Guidelines, Procedures and Protocols

The table below summarises the documents approved or endorsed by MMEC between April-October 2020.

Policies (Endorsed)	• None
Procedures and Guidelines	• Hospital Acquired Pneumonia • Secondary Care UTI Guidelines • Intrapartum Care Guidelines • Obstetric Cholestasis Guidelines • Preterm Labour Guideline • Induction of Labour Guideline • Hypertension in Pregnancy Guideline • Anaemia in Pregnancy guideline • Covert Medicines Administration of Medication in Adults Procedure – 1 year extension • CAMHS Repeat Prescription Procedure • WFFN 2020 Hip Fracture Guidelines • Postnatal contraception Guideline • Antepartum Haemorrhage Guideline • Caesarean Section Guideline • Management of Third and Fourth Degree Perineal Repairs Guideline • Uterine Inversion Guideline • Penthrox in Emergency Department Guidelines • Prevention of Neonatal Early Onset Group B Streptococcal Disease Guidelines • All Wales Adult Asthma Management and Prescribing Guideline • Discharge Medication Order Sets for Welsh Clinical Portal Procedure • Pelvic and Genital Antimicrobial Guidelines • Obstetrics and Gynaecology Antimicrobial guidelines • CAP and COVID Antimicrobial Guidelines • Influenza Guidelines 2020 update
Others	• SNAP Protocol • Thromboprophylaxis in COVID-19 Patients • REMAP-CAP Sarilumab worksheet and risk assessment • RECOVERY toculizumab worksheet ad instructions • REMAP-CAP Anakinra Risk assessment and preparation and administration documents • Denosomab Shared Care Protocol • Ralvo Switch SOP • Tenecteplase Administration Protocol (RGH and PCH) • Dobutamine, dopamine, GTN and Isoprenaline Adult Drug Monographs • COVID 19 Variation in Practice addendum to Medicines Administration Procedure • Orthoptic Botox Clinic Document Suite • Analgesic, antidepressant and gabapentinoid trial leaflets • Furosemide Accufusor Document suite • Clostridium difficile Care Pack (endorsed) • Symptom Management for Patients with COVID 19 Medication Chart • Primary Care Medicines Management Housekeeping SOP • Primary Care Ascorbic Acid SOP • Remdesivir Criteria Form

AGENDA ITEM
2.2.5

QUALITY & SAFETY COMMITTEE

SHARED LISTENING & LEARNING FORUM

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director, Quality & Safety
Presented by	Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ILG	Integrated Locality Group

1. SITUATION/BACKGROUND

CTMUHB requires a cross organisational mechanism for spreading and celebrating learning and improvement.

The Listening & Learning Forum will, in respect of its provision of **advice** and **assurance**;

- Oversee the Health Board's framework for listening to and learning from quality and patient/staff related concerns and experiences, to ensure it is consistent with the requirements and standards set for NHS bodies in Wales. This will include a full and proper consideration of whether the Health Board is fulfilling its duties in relation to legislation and guidance relevant to the provision of quality and safe care, and that management structures and roles within the Health Board support a culture of collective responsibility for quality and safety at all levels.
- Champion a patient and staff safety culture, seeking assurance on all aspects of learning from adverse events (incidents & near misses) and concerns, including assurance that themes from internal and external investigations and reviews are coordinated, that actions are being taken forward at an appropriate pace, and best practice is recognised and shared across the organisation;
- Seek assurance that patients, families, carers and staff are involved in reviews and investigations, and that nominated staff have adequate training and protected time to undertake investigations and reviews;
- Oversee the Health Board's framework for listening to and learning from feedback from patients, families/carers and staff, seeking assurance of an improvement culture, underpinned by the Health Board's Values and Behaviours Framework, openness and candour
- Oversee the management of the Health Board's obligations under the Quality & Engagement Act 2020 in relation to compliance with the Duty of Candour and the Duty of Quality.
- Ensure that there is a balance of fairness, justice, learning and taking responsibility for actions.

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

This report will ensure Quality & Safety Committee are sighted on the planned CTMUHB Listening and Learning Forum.

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

High quality care and patient safety is dependent on strong clinical leadership, as well as an organisational culture that promotes the active learning.

Improving quality requires us to actively listen to our staff, partners, patients and communities; engaging and involving these key groups facilitates positivity, greater effectiveness and co-production of our services.

CTMUHB requires a cross-organisational method of continual learning and growing to shape and improve services for the people we serve and those who work for and with us.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	To continually improve the effectiveness and quality of services and to prioritise patient safety. Listening to and learning from incidents and patient/staff related concerns and experiences.
Related Health and Care standard(s)	Safe Care
	Improving quality & patient safety through sharing and spreading themes and trends.
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below)
	Legal implications relate to already established statutory obligations including those related to Putting Things Right.
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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 That the content of the report is **NOTED**.
5.2 That the draft Terms of Reference are **NOTED.**

CTM Shared Listening & Learning Forum

Terms of Reference

Draft Version 6– 8.12.2020

1. INTRODUCTION & PURPOSE

1.1 The **Shared Listening and Learning Forum** has been established to provide oversight and assurance of the Health Board's framework for listening to and learning from incidents and patient/staff related concerns and experiences which promote and support a 'Just and Learning Culture'.

1.2 The detailed terms of reference in respect of this Forum are set out below.

2. DELEGATED POWERS AND AUTHORITY

2.1 The Forum will, in respect of its provision of **advice** and **assurance**;

- Oversee the Health Board's framework for listening to and learning from quality and patient/staff related concerns and experiences, to ensure it is consistent with the requirements and standards set for NHS bodies in Wales. This will include a full and proper consideration of whether the Health Board is fulfilling its duties in relation to legislation and guidance relevant to the provision of quality and safe care, and that management structures and roles within the Health Board support a culture of collective responsibility for quality and safety at all levels;

- Champion a patient and staff safety culture, seeking assurance on all aspects of learning from adverse events (incidents & near misses) and concerns, including assurance that themes from internal and external investigations and reviews are coordinated, that actions are being taken forward at an appropriate pace, and best practice is recognised and shared across the organisation;

- Seek assurance that patients, families, carers and staff are involved in reviews and investigations, and that nominated staff have adequate training and protected time to undertake investigations and reviews;

- Oversee the Health Board's framework for listening to and learning from feedback from patients, families/carers and staff, seeking assurance of an improvement culture, underpinned by the Health Board's Values and Behaviours Framework, openness and candour

- Oversee the management of the Health Board's obligations under the Quality & Engagement Act 2020 in relation to compliance with the Duty of Candour and the Duty of Quality.

- Ensure that there is a balance of fairness, justice, learning and taking responsibility for actions.

2.2 To achieve this, the Forum's programme of work will be designed to ensure that, in relation to all aspects of quality and safety good practice and lessons learn, that:

- there is clear, consistent strategic direction, strong leadership and transparent lines of accountability to lead change within the organisation;

- the organisation, at all levels (CSG, ILG, System Groups, Corporate Functions) have a citizen centred approach, putting patients, patient quality and safety and safeguarding above all other considerations; Consider stakeholders, i.e. patient representatives, staff representatives as a "partner" in the development and delivery of interprofessional learning and care where appropriate.

- the care and services planned or provided across the breadth of the organisation's functions (including those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;

- the organisation, at all levels has the right systems and processes in place to deliver, from a patients/staff perspective - efficient, effective, timely and safe services;

- there is an ethos of continual quality improvement and regular methods of updating the workforce in the skills needed to demonstrate quality improvement throughout the organisation;

- there is good team working, collaboration and partnership working to provide the best possible outcomes for its citizens;

- incidents and near misses are reported and acted upon to inform, prevent further harms and enable continuous service and quality improvement;

- incidents, claims, complaints that reach an agreed certain threshold and/or those that present with a repeated theme will be reviewed and acted upon to enable continuous quality improvement

- risks are actively identified and robustly managed at all levels of the organisation;

- decisions are based upon valid, accurate, complete and timely data and information;

- there is continuous improvement in the standard of quality and safety across the whole organisation and are continuously monitored;

- all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided, and in particular that:

    - sources of internal assurance are reliable

- recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
- lessons are learned from concerns, incidents, complaints and claims.

- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer.

- That there is correlation between learning actions and innovation within the Health Board.

Authority

2.3 The Forum is authorised by the Management Board to investigate or have investigated any activity within its terms of reference. In doing so, the Forum shall have the right to inspect records or documents of the Health Board relevant to the Forum's remit and ensuring patient/service user/client and staff confidentiality, as appropriate.

Access

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

3. MEMBERSHIP

3.1 Chair – Executive Nurse Director

Vice Chair –Director of Corporate Governance

- Executive Lead for H&S
- Executive Medical Director
- A Director representative from each Integrated Locality Group
- System Group Representative
- Primary care representatives
- Commissioned care reps i.e. WHSSC
- Director of Midwifery
- CHC representative
- HIW representative
- Corporate leads holding portfolios containing aspects of quality & safety, currently:
  - Assistant Director of Quality & Safety & Safeguarding
  - Assistant Director of Nursing and People's Experience
  - Assistant Director of Governance & Risk
  - Assistant Director of Corporate Business and Transformation
  - Assistant Director Communications & Engagement (to ensure messages/stories are cascaded outside the membership of the meeting)

- Claims Manager
- People's Experience Manager
- Head of Quality and Patient Safety
- Head of Nursing for Mental Health
- Head of Nursing for Paediatrics

Note: Deputies to be sent in the absence of the those members above

By invitation — The Forum Chair may extend invitations to attend meetings as required to the following:

Directors of Hosted Organisations
Public and Patient Involvement Representatives
Trade Union Representatives

As well as others from within or outside the organisation who the Forum considers should attend, taking account of the matters under consideration at each meeting.

Secretariat

To be secured through Improvement CTM team.

Member Appointments

3.3 The membership of the Forum shall be determined and reviewed by the Management Board.

4. FORUM MEETINGS

Quorum

4.1 At least 4 members must be present to ensure the quorum of the Forum, one of whom should be the Chair or Vice Chair.

Frequency of Meetings

4.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Forum deems necessary.

Withdrawal of individuals in attendance

4.3 The Forum may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. RELATIONSHIPS & ACCOUNTABILITIES WITH THE CTMUHB MANAGEMENT BOARD

5.1 The Forum is directly accountable to the Management Board for its performance in exercising the functions set out in these terms of reference.

5.3 The Forum, through its Chair and members, shall work closely with other Groups to provide advice to the Management Board through the:

- joint planning and co-ordination of business; and
- sharing of information

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

5.4 The Forum shall embed the Health Board's Strategic Objectives and Values and Behaviours in delivering its responsibilities.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Forum Chair shall:

- Report formally, regularly and on a timely basis to the Management Board. This includes verbal updates on activity, the submission of highlight reports and other written reports, as well as contributing to the Annual Quality Statement.

- Bring to the Management Board's specific attention any significant matters under consideration by the Forum;

- Ensure appropriate escalation arrangements are in place to alert the Chief Executive or Health Board of any urgent/critical matters that may compromise patient/staff care and affect the operation and/or reputation of the Health Board.

7. REVIEW

7.1 These terms of reference shall be reviewed annually by the Forum with reference to the Management Board.

Date Terms of Reference Approved: XXXXXXX

AGENDA ITEM
2.2.6

QUALITY & SAFETY COMMITTEE

FEEDBACK FROM INCIDENT REPORTING

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Once for Wales Project Manager
Presented by	Kellie Jenkins-Forrester, Once for Wales Project Manager
Approving Executive Sponsor	Executive Director of Nursing, Midwifery and Patient Care
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

A significant barrier to a good incident reporting culture is a lack of feedback to staff following submission of an incident. Through surveys, staff have highlighted that there is little or no response following an incident report, along with no sharing of lessons learned to inform improvement in safety.

The mechanisms to address this are multifaceted and the Health Board has taken steps to explore how feedback to staff following an incident report can be improved.

The options available within the Health Board's Quality, Safety and Risk Management System (RLDatix) were reviewed, with the automatic feedback message functionality identified as a key action to be progressed. This process involves the automatic sending of an email notification to the reporter on the incident being moved to the final approval stage by the responsible manager.

The email notification contains information directly from the *feedback to reporter of what action was taken* field within the investigation screen of the RLDatix system. This feature was activated on the 01.10.19 and applied to all incidents reported after this date.

A review was undertaken on the 23.11.2020 of incidents reported between the 01.10.2019 and 31.10.2020. As this is live information, with incidents moving through the approval process constantly, the information provided in this report is accurate as at that point in time.

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

The review undertaken focused on the number of incidents that were moved to final approval without the *feedback to the reporter of what action was taken* field (feedback field) being completed.

Between the 01.10.2019 and 31.10.2020 a total of 24,071 incidents were reported. At the time of collating the data, of the total 18,569 incidents had been moved to final approval. 21.85% (4058) of these incidents were moved to final approval without the feedback field being completed. Feedback was therefore provided in 78.15% of reported incidents moved to final approval during the period.

Of these incidents 47 were reported as a no surprises to Welsh Government, which would contain sensitive information and be subject to restricted access. A feedback message would not be generated in these circumstances. There is a separate process for the management of these.

The percentage of incidents moved to final approval without the feedback field completed has continued to decrease over the time period and is reflected in the chart below.

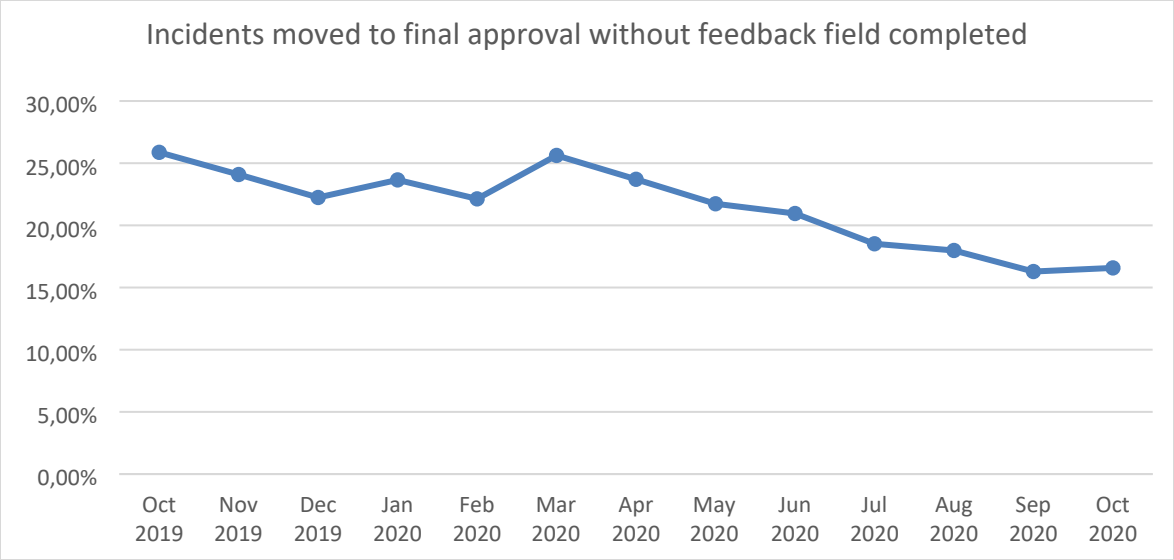


Chart 1: % of incidents moved to final approval without feedback field completed (total)

On average 1428 incidents are moved to final approval per month, with 21.49% moved to final approval without the feedback field being completed.

Merthyr & Cynon Locality are significantly over the Health Board's average with an average of 37.68% of incidents moved to final approval without the feedback field completed.

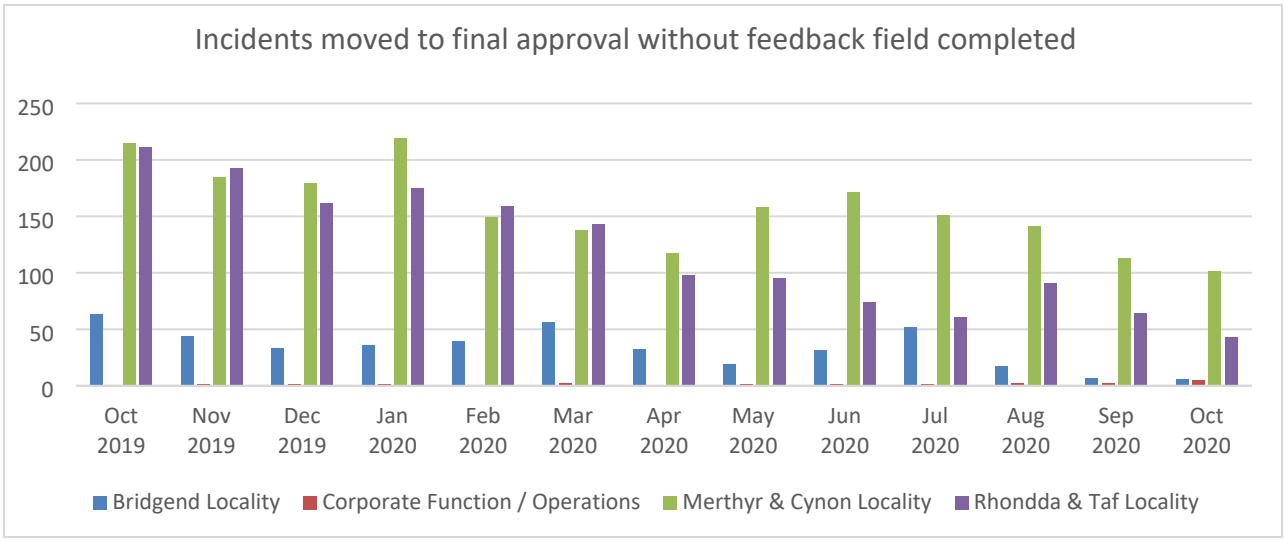


Chart 2: Number of Incidents moved to final approval without feedback field completed by Locality

The top five service groups for incidents moved to final approval without the feedback field completed are consistent across the Health Board. These are:

- Medicine
- Mental Health

- Community
- General Surgery
- Obstetrics & Gynaecology

It should be noted that these are areas with the highest number of reported incidents.

Improvement Action
To ensure that a 100% of incidents are moved to final approval with the feedback field completed, an update to the RLDatix system will take place with effect from the 01.12.2020.

When an incident is moved to Investigation Completed the *feedback to the reporter of what action was taken* field will appear and become mandatory. This means that before the record can be saved in that status the feedback field will have to be completed. This will also ensure that when the responsible manager moves the incident to final approval the field will have been previously completed.

Following activation, the number of incidents moved to final approval will require monitoring to ensure that this is not impacted by the improvement action.

To further strengthen the feedback process, in addition to the feedback field, the notification email is being updated to contain a standard paragraph advising the reporter of how further information can be obtained and to discuss with their line manager any concerns they still have.

3. KEY RISKS/MATTERS FOR ESCALATION TO GROUP

There are 1712 incidents currently within the investigation completed status for incidents reported prior to the 01.10.2019. A batch update exercise will be applied to these incidents which means no feedback message will be sent.

Whilst the data highlights an improving picture in relation to the number of incidents moved to final approval with the appropriate field completed, the quality of the detail contained within the feedback field cannot be substantiated currently. The reason for this is that the feedback field is a free text field completed by the investigation officer or responsible manager, and each case would require individual review. It is proposed a mechanism for assessment of the quality of feedback is established within the Health Board, i.e. staff survey.

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 completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Resources to support the implementation of the system are being applied for in accordance with the Health Board processes.
Link to Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

5. RECOMMENDATION

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

AGENDA ITEM
2.2.7

QUALITY & SAFETY COMMITTEE

CTMUHB COVID 19 SURGE PLANS SERVICE SUSPENSION QUALITY IMPACTS

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Marc Penny, Programme Consultant
Presented by	Nick Lyons, 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**
CTMUHB COVID Gold Command	16/12/2020	Approved

ACRONYMS	
CAI	Community Acquired Infections
3Cs	3 level command structure
ITU	Intensive Treatment Unit
DGH	District General Hospital
CPAP	Continuous Positive Airway Pressure
FH	Field Hospital
LA	Local Authority
WTE	Whole Time Equivalent
RN	Registered Nurse
HCSW	Health Care Support Worker
USC	Unscheduled Care

WG	Welsh Government

1. SITUATION/BACKGROUND

1.1 The Health Board is currently operating its emergency response 3Cs structure (Gold, Silver, Bronze) to co-ordinate its response to COVID.

1.2 COVID forecasting and modelling has shown a significant surge of COVID CAIs with a peak of admissions and bed occupancy for the first two weeks of January 2021.

1.3 CTMUHB Gold Command asked for assurance on the following key questions:

- That we have plans in place and assurance that we have sufficient staffed capacity (ITU and Non ITU Beds) to meet forecast demand which includes Oxygen / CPAP, DGH, Community and FH capacity until end of January 2021
- SILVER Cell 1 – That plans are in place with LA partners to enable patient discharges are at a sufficient level in order to deliver capacity up until end of January 2021
- SILVER Cell 2 – That plans are in placer across the Health Board to ensure key staffing and workforce supply requirements are in place to respond to the COVID situation across Cwm Taf Morgannwg (CTM) and deliver capacity up until end of January 2021
- SILVER Cell 3 – That plans are in place to manage CTM's elective program in order to respond to the deteriorating COVID situation across CTM.

1.4 At the current modelled peak based on current available and open / staffed beds there was a forecast deficit of:
- -19 Critical Care Beds (103.6 WTE RNs required)
- -145 Non Critical Care Beds (46 WTE RNs / 122.7 HCSW required)

1.5 In order to provide enough staffed bed capacity to meet the forecast surge Gold Command approved on the 16/12/2020 the suspension of a number of services to enable the redeployment of staff to increase staffed bed capacity for critical and non-critical care. Gold agreed to cease selected services (continue life, limb and USC pathway) specifically by reducing the following Services by 100%:

1.5.1 Cancel 100% outpatient clinics (Face to Face and Virtual)
1.5.2 Cancel 100% specialist nurse clinics
1.5.3 Cancel 100% non-urgent diagnostic services (e.g. radiology/endoscopy), and:

1.5.4 Fully redeploying clinical staff from non-clinical roles
1.5.5 Mental Health Clinical Service Group (CSG) Reduce Nursing establishments on Ward 14 + Psychiatric Intensive Care Unit (PICU)
1.5.6 Suspend 'Choice' policy for all discharges as per current WG guidance
1.5.7 Allow 'Temporary' and 'Out of Area' placements

1.6 The assessment and decision to suspend services was made in-line with Welsh Government Guidance. A copy of the guidance is available upon request.

- It is assumed that all options to expand and augment the available workforce have been exhausted, recognising that there are competing priorities for the workforce.
  - Workforce & Organisational Development (WF&OD) have exhausted all available options for augmenting RN workforce including overseas recruitment, bank and enhanced overtime rates
- It will also be important to facilitate a reduction in non-patient facing work for clinical staff before these options are activated.
  - Minimal opportunity in this area, however release of non-patient facing clinical staff included in this proposal
- Reducing involvement in education and training is another consideration in these exceptional circumstances; however this needs to be balanced with the cumulative risks in our professional pipeline and training needs, including a particular risk in surgical specialties.
  - HB has already approved changes to trainee doctor rotas to increase COVID rota cover

1.7 Assessment on which services to suspend were informed by the HB Quality Impact Assessment (QIA) process.

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

2.1 For Quality & Safety Committee to formally **NOTE** the above decision by Gold and be assured that the Quality Impact Assessments for suspended services was completed as follows (the full Quality Impact Assessments can be shared with Committee Members upon request):

2.2 QIAs for approved suspension of services:

- Outpatient & Specialist Nurse Clinics;
- Non Urgent Diagnostic Services (e.g. Radiology/Endoscopy);
- Local Authority Temporary Placements;

- Local Authority – Current Policy (not using temporary placements)

2.3 QIAs for other services considered but not approved for suspension:

- Community Based Care – Group B: Dental Services/Non-Critical Clinics/School Nursing;
- Community Based Care – Group A: Health Visiting/Non-critical home based Therapies;
- Surgery – Cancer Surgery and Urgent Elective;
- Surgery – Non-Urgent Elective Surgery

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

3.1 To note the below QIA scores:

3.1.1 Cancel 100% outpatient clinics (Face to Face and Virtual) QIA score = 12
3.1.2 Cancel 100% specialist nurse clinics QIA score = 12
3.1.3 Cancel 100% non-urgent diagnostic services (e.g. radiology/endoscopy) QIA score = 12
3.1.4 Suspend 'Choice' policy for all discharges as per current WG guidance QIA score = 12
3.1.5 Allow 'Temporary' and 'Out of Area' placements QIA score = 12

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	See individual QIAs Annex 2
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
	Suspension carried out in-line with WG guidance (Annex 1)
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.

	Any financial impacts are covered by Gold command and its delegations
Link to Strategic Well-being Objectives	Choose an item.

5. RECOMMENDATION

5.1 For the Quality & Safety Committee to formally **NOTE** the decision to suspend selected services and the associated QIAs.

AGENDA ITEM
2.2.8

QUALITY & SAFETY COMMITTEE

BRIEFING PAPER, PROVIDING SUMMARY FOLLOWING COMMUNITY HEALTH COUNCIL (SEPTEMBER 2020) LIVING WITH CORONAVIRUS: HEALTH AND CARE SERVICES DURING WINTER

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Sharon O'Brien, Assistant Director of Nursing & People's Experience
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	
CHC	Community Health Council

1. SITUATION/BACKGROUND

Since the coronavirus pandemic the Community Health Council (CHC) have focused on engaging with people in different ways, including surveys, apps, video conferencing and social media to hear form people directly about their

views and experiences of NHS services across Wales, as well as through community representatives and groups.

During the first three weeks in August, the CHC asked people across Wales to tell them what is important to them about their own health and care and the health and care of their loved ones in the winter months ahead.

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

Over 350 people responded to the survey and below is a brief synopsis of the main themes and comments that were captured:

A second wave of Covid-19

- The influx of students to our university towns
- Second wave coinciding with flu and the strain this will place on our limited health services
- Is there capacity to test the huge increase in those with symptoms

What we did in CTMUHB

- In partnership with the Department of Health and Social Care (DHSC), commissioned Local Testing Sites (LTS) at the University Campus in Treforest, two more opened in December 2020, one in Merthyr and one in Bridgend.
- Prior to the Christmas holiday, DHSC offered students Lateral Flow Testing (LFTs).
- Worked with our education partners with Lateral Flow Testing across secondary schools in Merthyr Tydfil and Lower Cynon, with the option of a confirmatory RT-PCS (swab) testing.
- Supporting the Integrated Locality Group (ILG) leads with the Pathfinder phase and roll out of Lateral Flow Testing (LFT) for CTM staff. The requirement is for staff to self-test twice a week. This is currently voluntary however we would hope staff will participate to ensure their workplace is safe for themselves, their colleagues and the people they are caring for. Currently working with ILG leads to identify, and target, services with high risk of virus transmission.
- Working collaboratively and in partnership, the Research & Development, Point of Care Testing (PoCT) and Clinical Biochemistry Teams, to recruit participants to a national UK wide study called FALCoN, at both Royal Glamorgan Hospital (RGH) and Keir Hardie Health Park (KHHP) Covid Testing Units. Evaluating the effectiveness of a new PoCT device, which can detect Coronavirus proteins within 12-15 minutes from a simple nasal swab. This research and the results it has generated will be used to establish if such a device can be used in practice and in turn inform national decisions on how to undertake rapid testing for Coronavirus.

Catching Covid- 19 and other illnesses

- People concerned to make sure there is quick action and good information to people if there is a serious outbreak.
- Reluctance to attend for regular health care appointments as concerned about safety of healthcare settings
- May become more ill as they have not been receiving the usual level of checks or treatment for their existing health conditions.
- If they feel unwell they won't know if their symptoms are Covid-19. How will they differentiate between flu and COVID for example?

What we did in CTMUHB

- Implemented a number of multi-disciplinary tactical, incident and outbreak management teams to support the management of any issues across the CTM footprint.
- Worked with Local Authority Partners with Lateral Flow Testing in Merthyr Tydfil and Lower Cynon 21 November – 20 December. Confirmatory RT-PCR testing offered.
- Based on surveillance and senior Public Health Wales (PHW) advice, targeted testing was undertaken. Incident or outbreak codes were assigned for ease of tracking.
- Mobile Testing Units (MTU) were deployed via Serco/DHSC (Light house laboratories) and access has been given to the Welsh Ambulance Services NHS Trust (WAST) reserve MTUs (PHW Labs). Currently testing over 900 tests daily.
- Working with Community Testing Units (CTU) located at KHHP and Bridgend to open up testing requests to the general public.

Getting a flu vaccine

- Will there be enough vaccines to go around

Keeping safe and well indoors and outside

- The bad weather will keep them housebound or increase their chances of falling. If they live alone, falling indoors
- Will carers be able to reach them, not receiving as much carers support as pre covid-19
- Worried about caring for their loved ones, inability to receive respite care

Mental Health Wellbeing

- Feeling lonely and being isolated, especially if they are shielding
- Routine services for learning disabilities and mental health support still not available
- Work related worries

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

The feedback above shows how clearly everyone's lives have been, and continue to be affected by COVID-19. This paper emphasises key messages from the CHC in relation to Health and Care leaders thinking about what they need to do to organise services to meet the challenges we will face during the winter period. It is vital that Health Boards (HBs) think about and take action in response to the things people in Wales have shared about what matters most about their health and care services.

People Suggestions and Ideas for the Health Boards to consider:

- Clear, easy to find and simple public heath advice and information about keeping well this winter including COVID -19 advice
- Creative thinking to design services in a way that keep both COVID and non-COVID services running
- Community based social activities in spacious venues
- Regular human contact 'checking in' or keep in touch arrangements for a people who are living alone of self-isolating
- Providing local residential homes and avoiding out of county care
- Easy access to counselling service
- Regularly updating people who are waiting for treatment
- Ensure health care services use a range of approaches to meet people's needs
- Drop in assessment centres with facilities in one place so people can be diagnosed quickly
- Clear plan rather than reactive actions
- Clear, co-ordinated action between the NHS and local councils when we have a vaccine for COVID-19

The CHC emphasise that they will continue to work hard in their local communities to help make sure that the NHS continually listens and responds to things that matter to people locally**.**

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Choose an item.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

The Committee is asked to **NOTE** the All Wales CHC report and the public feedback that they have provided. The Committee and Board will need to consider the public feedback and suggestions as the Health Board sets out plans for Winter and the challenges of COVID-19.

AGENDA ITEM
2.2.9

QUALITY & SAFETY COMMITTEE

BRIEFING PAPER
MATERNITY SERVICES IN WALES: WHAT CHCS HAVE HEARD DURING THE CORONAVIRUS PANDEMIC (OCTOBER 2020)

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Sharon O'Brien, Assistant Director of Nursing & People's Experience
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	
CHC	Community Health Council

1. SITUATION/BACKGROUND

Since the coronavirus pandemic the CHC have focused on engaging with people in a different ways, including surveys, apps, video conferencing and social media to hear form people directly about their views and experiences

of NHS services across Wales, as well as through community representatives and groups.

The CHC have produced a paper summarising feedback from women receiving maternity services and care throughout Wales during the COVID-19 pandemic. Below are some of the main themes and comments that were captured.

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

Whilst people told the CHC that they understood things, they also heard how this was affecting them. They heard that for some people this was not only affecting their experience of antenatal care and labour, but also on their on-going care and support after birth.

The CHC emphasise that they will continue to work hard in their local communities to help make sure that the NHS continually listens and responds to things that matter to people locally**.**

During Pregnancy

- Overall, people felt supported and cared for throughout their pregnancy
- Good support from community midwives
- Fantastic level of consultant led care and midwives and doctors were fantastic
- Successful on-going and antenatal care
- For some whom it was their first pregnancy, felt very anxious at the start of the pandemic as their level of contact was reduced as was their contact with health services to ask questions
- Some women who were deemed high risk pregnancy felt forgotten about as essential appointments were not provided
- Majority of feedback referred to the level of anxiety and impact on families of not being able to have partners and loved ones involved in antenatal appointments, including scans

What we did in CTM for antenatal care during Covid-19

- Despite staffing challenges, we were able to maintain all core antenatal services during the pandemic
- Reduced the number of face to face contacts but maintained contact virtually and by telephone
- Staff used social media platforms to continue virtual parent education and tours of our units
- Families found the restrictions around attendance at scans difficult and upsetting. We were able to maintain Public Health Wales recommendations and continued to offer partners attendance at 12 and 20 week scanning appointments despite challenges for our sonographers

- We have recently risk assessed antenatal attendance for partners following publication of the All Wales Hospital Visiting Guidance, unfortunately, due to the current rates of COVID we continue to be in a high risk category and therefore previous restrictions remain in place. We continue to work with families to review these arrangements in some circumstances.

Giving birth

- People were very grateful to the healthcare workers for the care and support they provided when giving birth during the pandemic
- Once again in the early stages of the pandemic, women were worried about giving birth without having their birth partner present

Some women did not have good experiences and fed back that they felt alone, unsupported as staff were busy and under pressure.

What we did in CTM for intrapartum care during Covid-19

- We were able to maintain all types of care during Covid-19. Unfortunately the Tirion Birth Centre at the Royal Glamorgan site did temporarily need to close however, it maintained the numbers of births in a midwifery led setting by transferring care to the alongside facilities at the Prince Charles and Princess of Wales sites. The Tirion Birth Centre has now re-opened
- Partners have continued to support mothers once in established labour. Although this has meant that some mothers may have faced induction or early stages alone with their partners, the feedback from families has been overwhelmingly positive
- During the pandemic staff have made videos to introduce themselves to families on social media platforms and have also filmed demonstrations of what staff will look like in the various forms of Personal Protective Equipment (PPE).

Care and Support after birth

- Overwhelming feedback regarding the anxiety and distress at not allowing partners to visit and support after the birth
- Continued anxiety because their birth partner was not able to stay with them after they gave birth to provide them with help and support and this made it much harder for women
- Improved well-being as partner at home to support and enjoy time with their new baby
- Mixed feedback regarding GP and Health Visiting support from excellent support to delayed and disjointed check-ups.

What we did in CTM for postnatal care during Covid-19

- To minimise separation from Partners (and to minimise transmission risk) where possible families have been discharged from the delivery suite once Mothers and Babies were assessed as fit for discharge

- When further inpatient care was required, partners were allowed to stay until transfer to the postnatal wards
- Staff have worked hard to provide additional support and again feedback has been overwhelming positive. There have been unintentional benefits of the no-visiting policy with Mums commenting on more restful recovery and the opportunity to get to know other Mums. For others, the situation has been very upsetting and we will continue to risk assess the situation on a regular basis.

Care when things go wrong

Most pregnancies and child birth led to healthy mother and baby. However when things do go wrong, the impact can be devastating and long lasting. Some women shared their distressing experiences including:

- One woman was bleeding early on in pregnancy and refused an early visibility scan. She had suffered a ruptured ectopic
- Baby born requiring Neonatal Intensive Care Unit (NICU), father could not visit for 10 days which was extremely stressful for both mother and father
- A woman who was bleeding was informed she needed to attend an urgent scan alone whilst under the care of fetal medicine. During the scan informed that there was no fetal heartbeat.

Our care within CTM when things go wrong

- We have worked alongside our sonography colleagues to provide an environment whereby partners can attend as per the All Wales guidance, and if possible in exceptional circumstances. The size of scan rooms has presented a challenge and led to considerable stress for sonography colleagues
- Visiting to all in patient areas such as NICU have been maintained in line with All Wales guidance, and IT has been used where possible to support family interaction.

Communication, advice and information

- Positive feedback and how grateful people were when they felt communication was good
- In the early stages of the pandemic, people struggled to find advice and information they needed
- Feedback on the importance to keep up regular contact and ongoing communication
- Important to take time to explain things without rushing making sure information is shared between healthcare staff.

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

Learning from the feedback

People wanted to share their experiences good and bad because they want to make a difference. Some people struggled with some aspects of maternity care and services as health boards first responded to the pandemic. Most importantly the involvement of loved ones in appointments such as scans over the summer period.

The NHS needs to drive further development and improvement in areas highlighted in the report where things didn't go so well:

- Making sure everyone gets the support and information they need easily when they need it
- Actively keeping in touch and 'checking in' to provide support families need before and after birth
- Understanding and responding to the individual needs of women and their families, including those who may have had difficult experiences in the past.

As the COVID-19 pandemic continues, the NHS decision makers need to continue to think about and balance the impact of COVID-19 restrictions with the mental health and wellbeing of women and their families going through this life changing experience in such difficult circumstances.

Within CTMUHB this report will be shared with our user group – My Maternity My Way, to support co-production of a questionnaire to enable wider user engagement in responding to the findings of the report to ensure the service remains responsive to the on-going needs of our families during the pandemic

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.

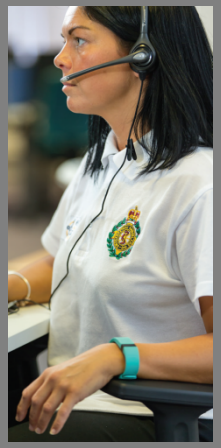
Resource (Capital/Revenue £/Workforce) implications / Impact	Choose an item.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

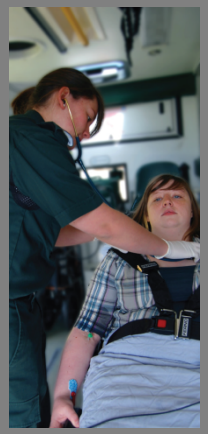
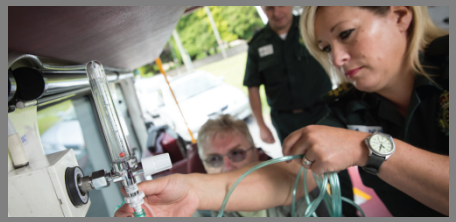
5. RECOMMENDATION

The Committee is asked to **NOTE** the All Wales CHC report and the feedback that they have provided regarding women's experiences and the impact that the pandemic has had on their mental health and wellbeing. The Committee and Board will need to consider the public feedback and suggestions as the Health Board sets out plans for winter and the challenges of COVID-19.

Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru

Welsh Ambulance Services
NHS Trust


Patient Safety & Experience Highlight Report

Cwm Taf Morgannwg University Health Board

Reporting Period November 2020

Introduction

This Patient Safety and Experience Highlight Report provides an 'at a glance' update on the current patient safety and experience landscape within the Welsh Ambulance Services NHS Trust and Cwm Taf Morgannwg University Health Board area. It specifically focusses upon the following key areas:

- Summary
- Secondary Care
- Delayed community responses
- Delayed response impact
- Resource availability
- Joint Investigation Framework – Appendix b
- Regulation 28 and Prevention of Future Deaths
- Adverse media attention
- Patient Experience

Summary

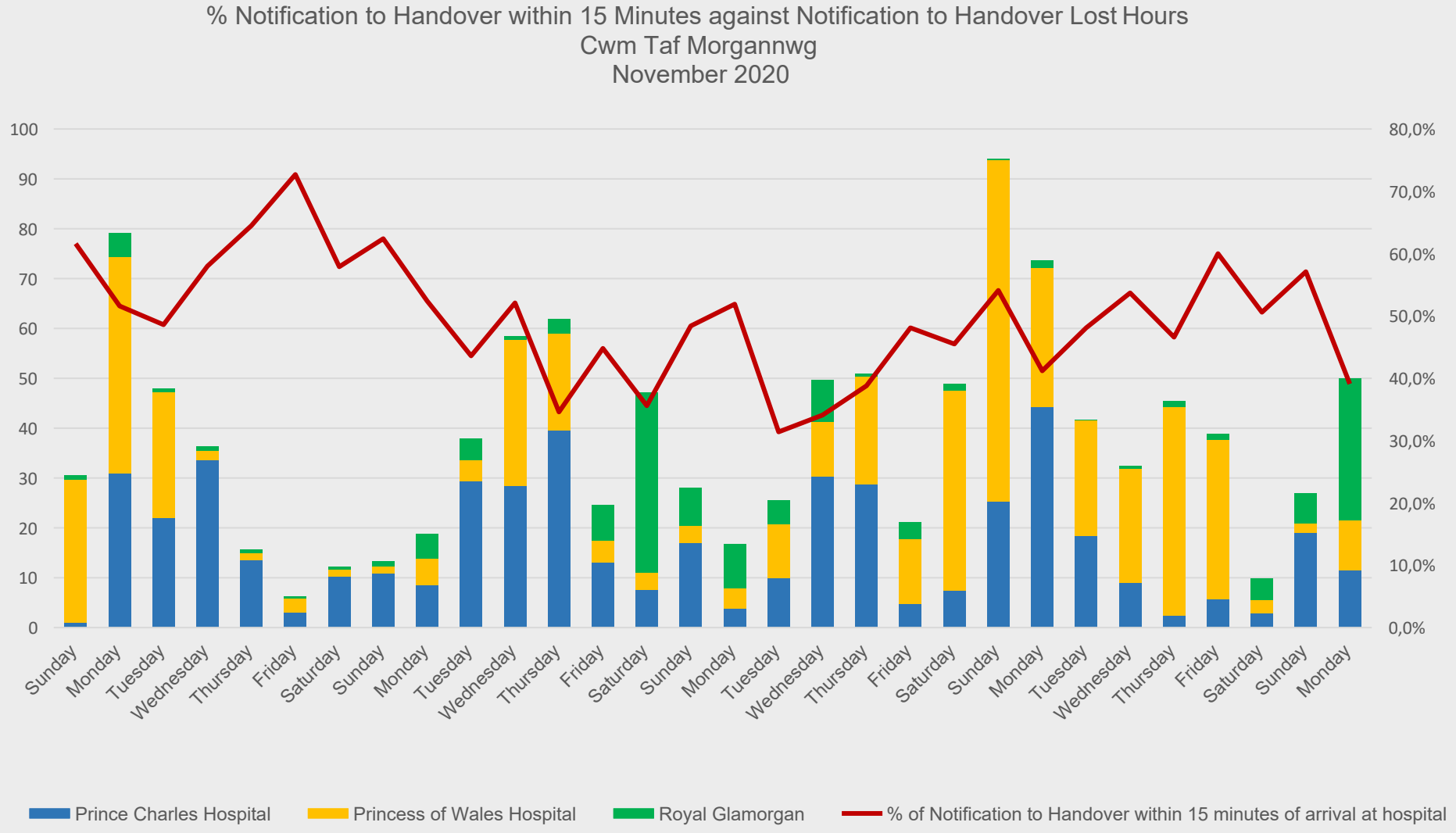
We can see from the data presented in the following slides, that following 2,500 handover presentations at Emergency departments within Cwm Taf Morgannwg, 1,254 were outside of the 15 minute notification to handover target time.

In addition to this, 460 patients waited between 1 hour and 10 hours to handover care to Emergency department staff. With an additional 6 patients waiting in excess of 10 hours.

During the month of November, 257 patients awaited a primary response in the community between 6 and 21 hours. From the data contained within slide 6, it can be seen that 198 of these patients were in the Amber 1/2 category. These categories include, chest pain, stroke, dyspnoea, overdose, abdominal pain, allergic reactions, unconsciousness (and fainting). Significantly, the chest pain and stroke patients (if confirmed +ve) would by definition have missed the opportunity for clinical intervention such as PPCI and Thrombolysis.

60 patients (5 x Amber1, 40 x Amber2, 4 x Green2, 11 x Green3) waited beyond 12 hours to 21 hours for a community response.

Secondary Care

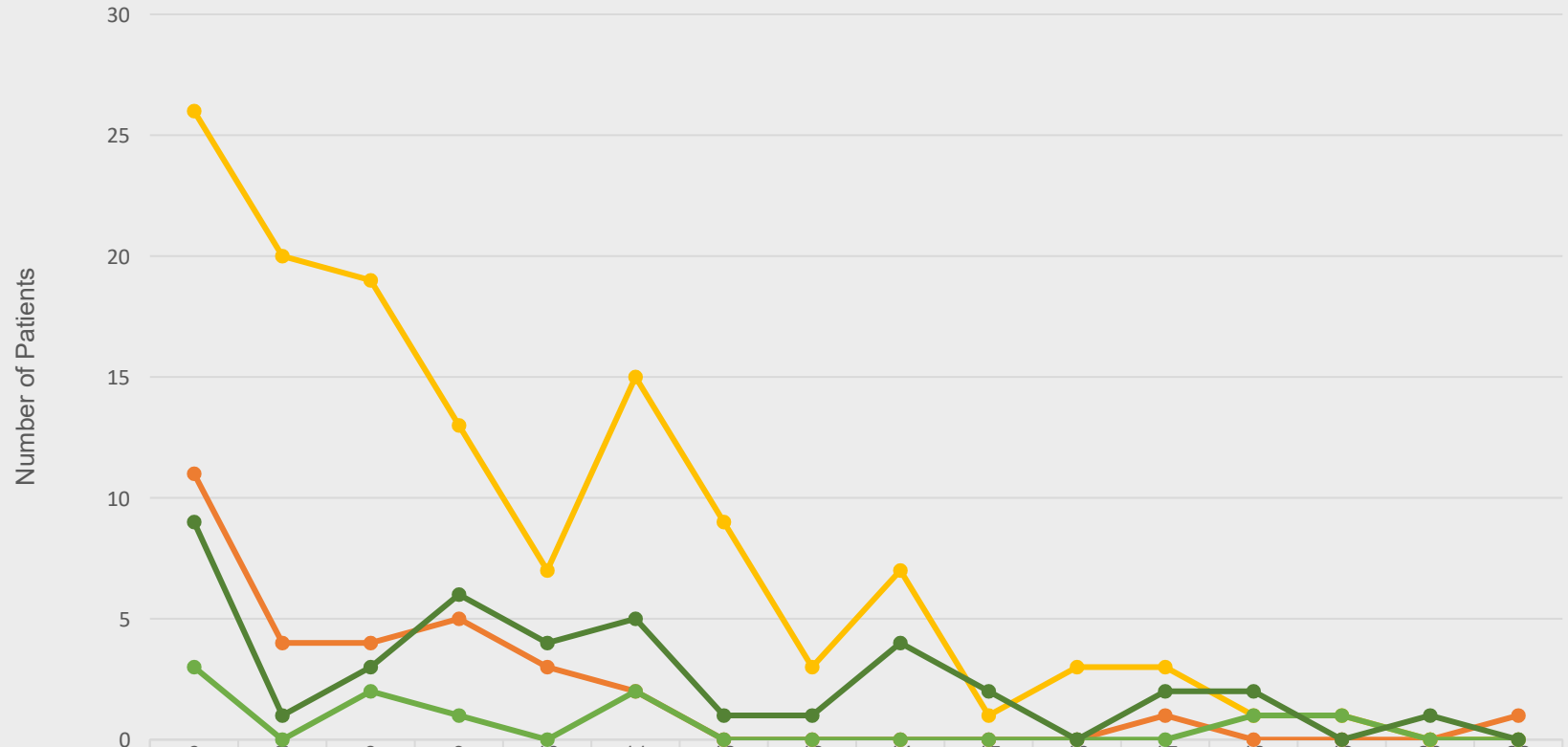


Secondary Care

Hospital Health Board	Notification to Handover - Delays by Time Band													
	<15 mins	15-30 mins	30-60 mins	1-2 hrs	2-3 hrs	3-4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9-10 hrs	>10 hrs	Grand Total
All Health Boards	**5,559**	**4,001**	**2,583**	**1,654**	**750**	**417**	**224**	**122**	**72**	**44**	**27**	**7**	**11**	**15,471**
	35.9%	***25.9%***	***16.7%***	***10.7%***	***4.8%***	***2.7%***	***1.4%***	***0.8%***	***0.5%***	***0.3%***	***0.2%***	***0.0%***	***0.1%***	
Aneurin Bevan	339	414	492	315	148	85	64	36	22	18	5	0	2	1,940
	17.5%	*21.3%*	*25.4%*	*16.2%*	*7.6%*	*4.4%*	*3.3%*	*1.9%*	*1.1%*	*0.9%*	*0.3%*	*0.0%*	*0.1%*	
Betsi Cadwaladr	1,243	1,254	708	477	247	120	58	17	4	1	0	0	0	4,129
	30.1%	*30.4%*	*17.1%*	*11.6%*	*6.0%*	*2.9%*	*1.4%*	*0.4%*	*0.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Cardiff And Vale	539	616	449	241	50	9	2	1	0	0	0	0	0	1,907
	28.3%	*32.3%*	*23.5%*	*12.6%*	*2.6%*	*0.5%*	*0.1%*	*0.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Cwm Taf Morgannwg	1,246	509	279	182	90	75	31	28	28	14	9	3	6	2,500
	49.8%	*20.4%*	*11.2%*	*7.3%*	*3.6%*	*3.0%*	*1.2%*	*1.1%*	*1.1%*	*0.6%*	*0.4%*	*0.1%*	*0.2%*	
Hywel Dda	1,227	587	256	192	90	47	26	8	5	1	3	1	1	2,444
	50.2%	*24.0%*	*10.5%*	*7.9%*	*3.7%*	*1.9%*	*1.1%*	*0.3%*	*0.2%*	*0.0%*	*0.1%*	*0.0%*	*0.0%*	
Out of Area	303	308	140	44	16	1	1	0	0	0	0	0	0	813
	37.3%	*37.9%*	*17.2%*	*5.4%*	*2.0%*	*0.1%*	*0.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
Swansea Bay	662	313	259	203	109	80	42	32	13	10	10	3	2	1,738
	38.1%	*18.0%*	*14.9%*	*11.7%*	*6.3%*	*4.6%*	*2.4%*	*1.8%*	*0.7%*	*0.6%*	*0.6%*	*0.2%*	*0.1%*	

Delayed Community Responses

Cwm Taf Morgannwg: Number of Patient Waits over 6 Hours by Priority Type
Cumulative Position
November 2020

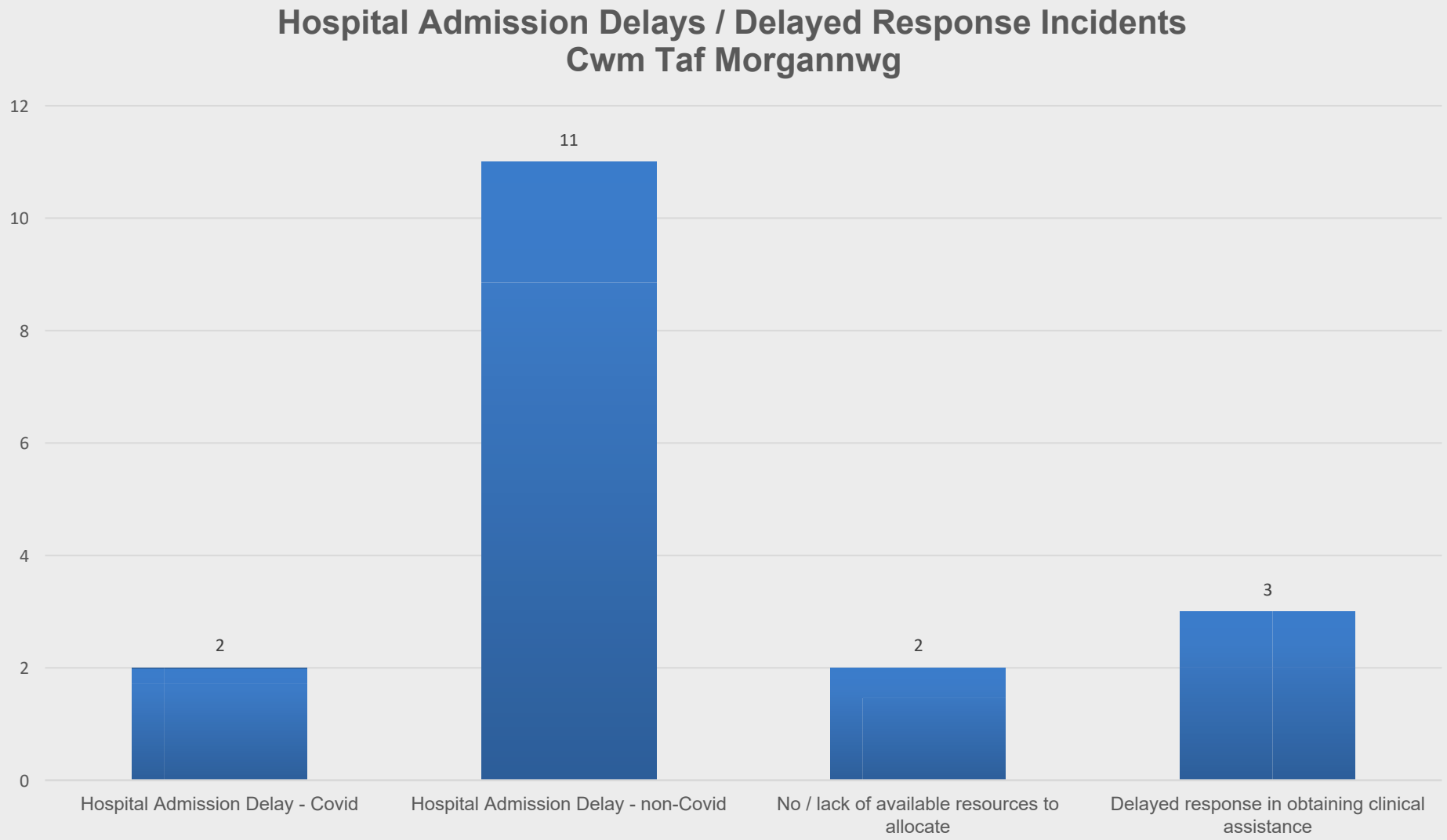


	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	22
AMBER1	11	4	4	5	3	2	0	0	0	0	0	1	0	0	0	1
AMBER2	26	20	19	13	7	15	9	3	7	1	3	3	1	1	0	0
GREEN2	3	0	2	1	0	2	0	0	0	0	0	0	1	1	0	0
GREEN3	9	1	3	6	4	5	1	1	4	2	0	2	2	0	1	0

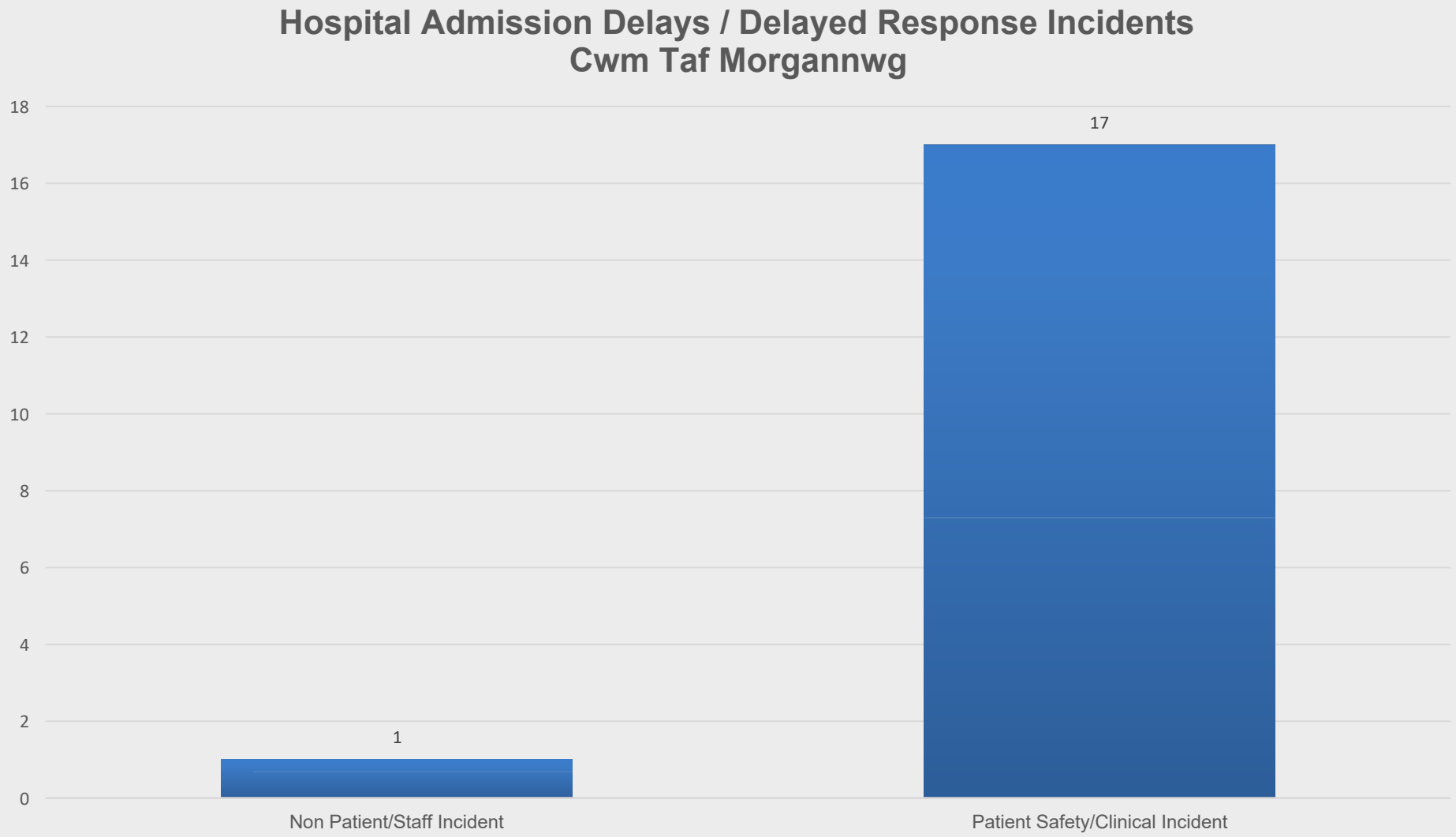
Delayed Community Responses

Patient Waits in Hours over 6 Hours - Cwm Taf Morgannwg																		
Date	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	Grand Total
01/11/2020		2	1		1													4
02/11/2020	2	1	1	2		2												8
03/11/2020	2		3	3	1		1											10
04/11/2020	2	1			1			1										5
05/11/2020	1																	1
06/11/2020			1	1	1													3
07/11/2020	1	2			1	1	1											6
08/11/2020	1	2																3
09/11/2020	1	2	1			1												5
10/11/2020	2	2		2	1									1				8
11/11/2020	1		3	2	2													8
12/11/2020		2	1															3
13/11/2020	1	7	1	2		1	1	1	3	1								18
14/11/2020	2	3		1	1	1			1		2	2	1	2				16
15/11/2020	4	2		2			1											9
16/11/2020	3		2					1	1	1	3	1		1				13
17/11/2020	3	1			1		1						1			1		8
18/11/2020	3																	3
19/11/2020	3	2	1	3	1	1	1											12
20/11/2020		2																2
21/11/2020	4	2	2		1	2	1	1	1		1							15
22/11/2020		4				2	1					1						8
23/11/2020	2	2	1	2	1	2	2											12
24/11/2020		2	2	1	1	1							1					8
25/11/2020	1	3	2	3	1													10
26/11/2020	3	2	1	1				1				1						9
27/11/2020	2		2	1	1	2	1	1	1	2	1						1	15
28/11/2020	1	2			1		1			1	1				1			8
29/11/2020	2	3	1	1		1	1	1										10
30/11/2020	2	4	1	2	3		1	2	1		1							17
Grand Total	49	55	27	29	20	17	14	9	8	5	9	5	3	4	1	1	1	257

Delayed Response Impact



Delayed Response Impact



Resource Availability

NHS Wales | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | **Cwm Taf Morgannwg** | Hwyel Dda | Powys | Swansea Bay

Cwm Taf Morgannwg 14

Incidents & Polling

Calls Polling

23	0	16	7	0
On Route/At Scene	RED	AMBER	GREEN	ROUTINE
14	3	9	2	0

Resource Availability

EA

15	2	8	1	4
RRV	Unavailable	Dispatched	Available	At Hospital
5	2	3	0	0

Polling Delays

Resource Availabilty (EA)

Incidents Allocated and Waiting

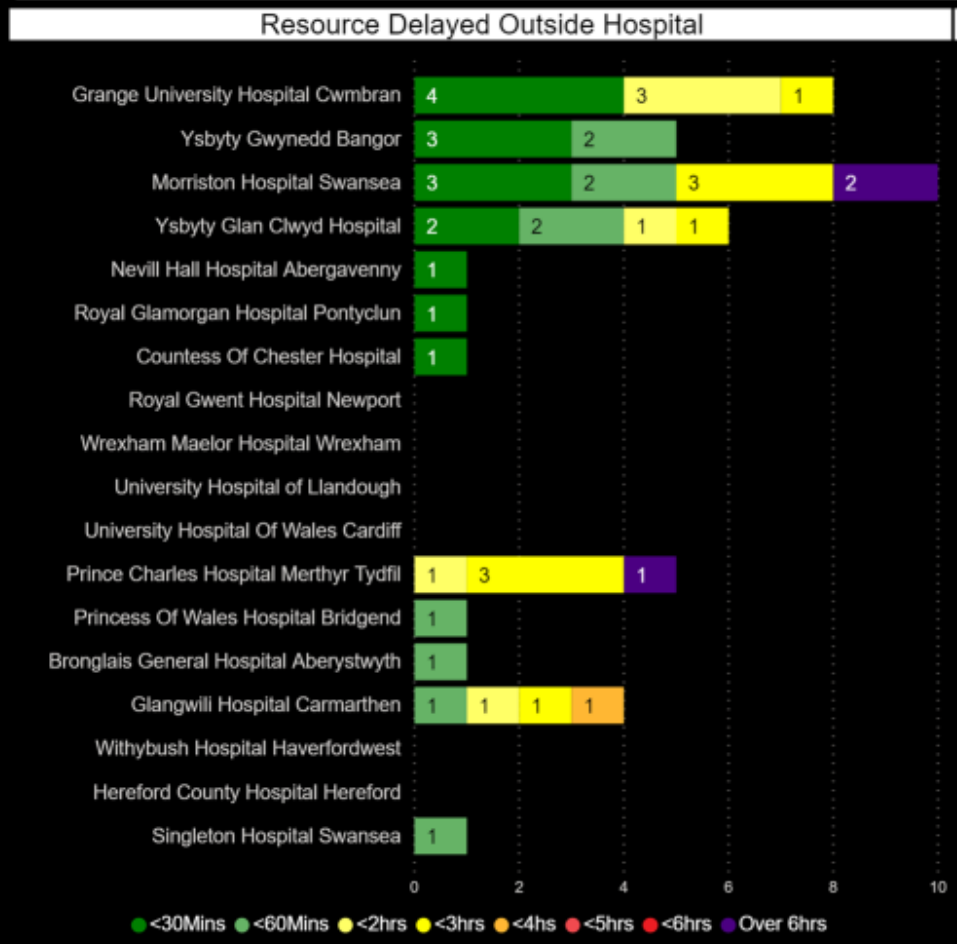
Resource Availabilty (RRV)

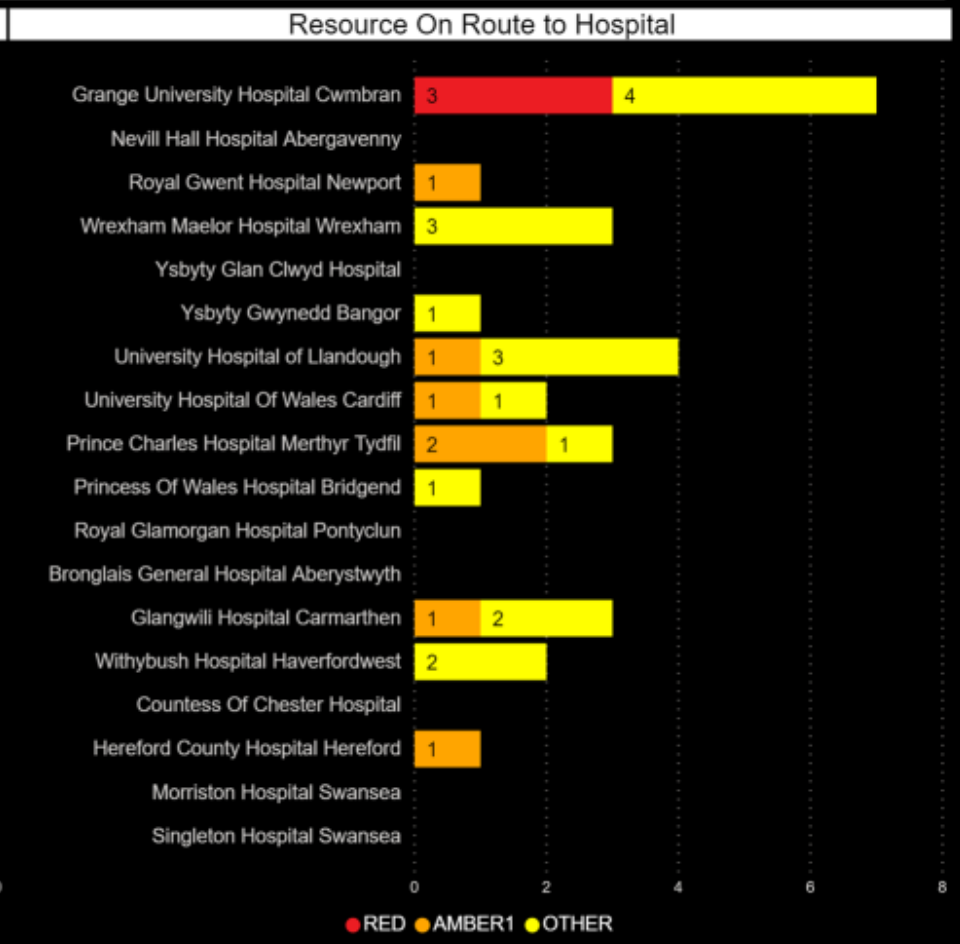
*Data snapshot 26/11/2020

Resource Availability

NHS Wales | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Cwm Taf Morgannwg | Hwyel Dda | Powys | Swansea Bay

29





*Data snapshot 18/11/2020

Joint Investigation Framework – Appendix b

Joint Investigation Framework – Appendix b (Source: SCIF)

The Joint Investigation Framework includes all Health Boards and Trusts in Wales, and relates to patient safety incidents escalated by The Welsh Ambulance Services NHS Trust (WAST) that have been considered at the Serious Case Incident Forum (SCIF) and where the primary causal factor relates to or as a consequence of Health Board hospital handover delays.

During November there were four incidents that were reviewed at the SCIF which met the criteria for the appendix b framework.

- Delayed response (3.5hrs) to a 66 year old female who was reported as short of breath and feverish. ROLE implemented at scene. Hospital handover delays were a significant factor in our ability to respond sooner.
- Delayed response (7.5hrs) to a 79 year old male reported to be Covid+, not eating or drinking, very weak with rapid breathing. Gentleman had a DNR in place and end of life care plan commenced. Hospital handover delays were a significant factor in our ability to respond sooner.
- Delayed response (4hrs) to an 89 year old female reported as having difficulty in breathing. Hospital handover delays were a significant factor in our ability to respond sooner.
- Delayed response (5hrs) to a 74 year old male reported as Covid+ and experiencing difficulty in breathing. ROLE implemented at scene. Hospital handover delays were a significant factor in our ability to respond sooner.

Regulation 28 Prevention of Future Deaths

Regulation 28 (Source: Coroner)

During November the Trust has received no Regulation 28's in relation to hospital handover delays within the Cwm Taf Morgannwg Health Board Area.

Patient Experience

Patient Experience

Feedback from Patient Experience and Community Involvement Team;

- No reported negative feedback reported during November

Adverse Media Attention

There has been one negative media coverage about WAST in the CTMU Health Board area in November 2020.

BBC, MSN, 19 November – Ryan Bullimore inquest Pontypool fatal mountain bike crash 999 call was 'not a priority' - BBC News

Archwilio Cymru
Audit Wales

Follow-up of Operating Theatres – Cwm Taf Morgannwg University Health Board

Audit year: 2020

Date issued: December 2020

Document reference: 2159A2020-21

This document has been prepared for the internal use of Cwm Taf Morgannwg University Health Board as part of work performed in accordance with statutory functions.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

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The Health Board has made reasonable progress in addressing the issues highlighted in the previous review, but further improvements could be made in respect of the use of theatre efficiency data and standardising preoperative processes across the Health Board.

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Summary report

Introduction

1 Operating theatre services are an essential part of patient care. Efficient management of theatres results in cost effectiveness, supports the achievement of waiting-time targets and contributes to high-quality patient care.

2 In 2011-12, the Auditor General undertook a review of operating theatre services across Wales. In 2014-15, follow-up work was undertaken across health boards to gauge progress in implementing our original audit recommendations.
Those reviews focussed on the efficiency and effectiveness of operating theatres and included aspects of the wider surgical pathway including;

- how patients waiting for surgery were listed;
- the consistency of pre-operative assessment arrangements;
- surgical admissions and theatre utilisations; and
- the quality process including the World Health Organisation (WHO) checklist.

3 Information on how services are performing. We have undertaken a further review to examine the progress made by Cwm Taf Morgannwg University Health Board (the Health Board) in addressing the recommendations made in our previous reviews. The follow up work has included a review of recommendations previously made to Abertawe Bro Morgannwg University Health Board in respect of services in Bridgend, given the transfer of healthcare services for the people of Bridgend to the Health Board on 1 April 2019.

4 The follow up work reported here draws upon the following work:

- review of relevant data and documentation;
- a self-assessment of its progress against the recommendations by the Health Board; and
- interviews with staff to discuss progress, current issues and future challenges.

5 We summarise our findings in the following section. **Appendix 1** provides specific commentary on progress against each of our previous recommendations. We were unable to confirm the original target dates for implementation of the recommendations therefore have provided a current progress update.
The commentary reflects fieldwork that was undertaken prior to the COVID-19 pandemic[1], however, where possible we have looked to update our findings on actions that have taken place since our fieldwork was undertaken.

1 In March 2020, the Auditor General for Wales suspended all onsite performance audit work, which included the clearance of draft reports, to allow NHS bodies to focus their attention on responding to the COVID-19 pandemic.

Our findings

6 **Exhibit 2** and **Exhibit 3** summarises the status of previous audit recommendations.

Exhibit 2: Progress status of our 2014 recommendations: Cwm Taf Morgannwg University Health Board

Total Number of Recommendations	Implemented	In progress	Superseded
20	9	8	3

Exhibit source: Audit Wales

Exhibit 3: Progress status of our 2015 recommendations: Bridgend Area

Total Number of Recommendations	Implemented	In progress	Superseded
6	1	5	-

Exhibit source: Audit Wales

7 The Health Board has made reasonable progress in addressing the issues highlighted in the previous review, but further improvements could be made in respect of the use of theatre efficiency data and standardising pre-operative processes across the Health Board.

8 Since our previous work, use of the WHO[2] surgical checklist in the Health Board has increased significantly and progress has been made in implementing pre-list and post-list briefings.

9 Theatre session and list planning has improved following the appointment of scheduling managers to support effective list planning. These staff have fostered close working relationships with surgical staff, and the Health Board has also

2 The World Health Organisation (WHO) surgical safety checklist was developed after extensive consultation and aims to decrease errors and adverse events and increase communication and teamwork in surgery.

introduced routine multidisciplinary meetings which seek to identify and address any issues with lists that could result in cancellations and delays.

10 Work to monitor patient experience has been strengthened though the use of real time surveys. The impact of COVID-19 has affected the scale of this work, but the Health Board has worked to maintain this activity as much as possible.

11 However, pre-operative assessment models remain inconsistent across hospital sites. And, although operating theatre performance information is available, there was a lack of focus and scrutiny on efficiency, productivity and utilisation across the Health Board. The Health Board recognise this and further work is planned in this area to maximise capacity as part of the planned care recovery following COVID-19. There remain opportunities to involve clinical staff more widely in these discussions.

12 Within Bridgend, there remains work to do in relation to theatre improvement. Access to information has improved recently but there are still inconsistencies in the theatre information systems the Princess of Wales have access to. Further improvements are needed to ensure oversight of theatre efficiency productivity and safety, and the new operating model recently implemented will seek to address these issues.

Recommendations

13 In undertaking this work, we have made no new recommendations. The Health Board however needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in **Exhibit 4** and **Exhibit 5**.

Exhibit 4: outstanding recommendations Cwm Taf Morgannwg University Health Board

Outstanding recommendations
Five Steps to Safer Surgery
R1c Begin reporting compliance with the five steps to safer surgery alongside efficiency/productivity metrics to ensure a more holistic review of performance, quality and safety.
Preoperative Processes
R6a Deliver a project to improve performance management of pre-operative assessment. The Health Board needs to know more about its effectiveness and its impact on cancellations.

Outstanding recommendations	
R6b	Analyse by speciality/surgeon, where day of surgery admission (DOSA) rates are low. Work with these specialties/surgeons to understand/overcome the barriers to increasing DOSA rates.
Short Stay Surgery	
R7a	Formally nominate surgeons on each hospital site to act as champions for short stay surgery.
R7b	The champions should lead a project with the aim of increasing short-stay surgery rates within the next 12 months.
Driving efficiency by generating greater shared ownership	
R8a	Reintroduce optimisation charts to reinvigorate the focus on efficiency (without sacrificing quality and safety).
R8b	One of the clinical directors should lead a project to increase awareness and use of the theatre performance dashboard. The project should seek to understand and address any barriers relating to clinicians not owning the clinician-level efficiency data.
R8c	Share learning by clinical directors annually, peer reviewing theatre data and observing performance in different specialties. Feed this into job planning, revalidation and appraisals.

Exhibit 5: outstanding recommendations Bridgend Area

Outstanding recommendations	
Operating Theatre Improvement	
R1	Reintroduce a structured programme for theatre improvement, possibly as a workstream within the Surgical Pathway Board.
Performance Management and Efficiency, Productivity and Safety	
R2	Develop an approach to performance management in theatres that ensures good quality data is widely used to drive improvement.
R3	Introduce a mechanism to ensure more regular executive oversight of theatre efficiency, productivity and safety.

WHO Checklist and Briefings (Five Steps of Safer Surgery)

R5 Draw on the expertise of the Health Board's Communications team to promote to staff the benefits of using the WHO checklist and briefings.

Sickness Absence Rates

R6 Carry out further work to understand and manage down the high sickness absence rate in theatres.

Appendix 1

Health board progress against our recommendations

Assessment of progress against recommendations arising from the Operating Theatres Follow-Up Review at Cwm Taf University Health Board (2014)

Recommendation	Status	Summary of progress
Five Steps to Safer Surgery The five steps to safer surgery are a surgical safety checklist, developed by WHO. It involves briefing, sign-in, timeout, sign-out and debriefing, and is advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures. In 2014, we found good practice in the Health Board's approach to encouraging the use of safety briefings and the surgical safety checklist. But, compliance with WHO checklist was being inaccurately reported to the Welsh Government, in addition there were some inconsistencies in the completion of the pre-list briefing process and post-list team de-briefings were rare. We recommended that the Health Board should:		
R1a Continue with roll out of the new (WHO) surgical checklist	Implemented	The Health Board recognises the use of the WHO checklist as good practice. Our discussions with staff and review of the Health Board's self-assessment and performance information indicated that compliance with the WHO checklist has

Recommendation	Status	Summary of progress
and repeat the covert audit on both sites in 12 months.		improved significantly since our 2014 review, with compliance rates reaching 89% for the period 1st April 2018 to 31st March 2019.
R1b Take a decision on the importance of post-list briefings. If the Health Board deems these important, they must be promoted, in particular by the clinical directors who should lead by example.	Implemented	The Health Board has implemented both pre-list and post-list debriefs, and staff felt that these were useful. Performance information received from Royal Glamorgan Hospital (RGH) for the period 28/10/2019 to 03/02/2020 showed improvement in the compliance rates.
R1c Begin reporting compliance with the five steps to safer surgery alongside efficiency /productivity metrics to ensure more holistic review of performance, quality and safety.	In Progress	At the time our fieldwork we found there is discussion around five steps of safer surgery at departmental and theatre team leader meetings. However, better use of this information could have been made at Directorate Integrated Governance Business meeting or the Clinical Business meeting. Since our review the Health Board has implemented a new operating framework with three locality areas, each with a Clinical Service Group for surgery. This has increased capacity within the Health Board. COVID-19 has understandably affected the pace of implementation, as well as the impact on elective throughput. However, the Health Board are committed to monitoring compliance with the five steps of safer surgery to ensure a more holistic view of performance and will be embedding this in the new arrangements and as such are developing monitoring arrangements through the newly established Clinical Service Groups and Service planning group meetings. Further work is needed in this area in order to fully address this recommendation.

Recommendation	Status	Summary of progress
Patient Experience Our 2014 work found that Clinical Business Meetings and the Theatre Quality Improvement Group were providing more focus on quality. However, surgical patient experience information was not routinely measured, the process for doctor revalidation was not sufficiently independent of the doctor seeking revalidation and the various sources of quality information needed to be brought together and considered holistically. We recommended that the Health Board should:		
R2a Monitor surgical patient experience at least every six months.	Implemented	The Health Board has developed its arrangements for monitoring patient experience and has now rolled out a consistent Health Board approach to using real time surveys. The results of which are discussed at the three Integrated Locality Group Meetings. COVID-19 has affected the amount of survey and real time work that can be undertaken.
R2b Audit the process of doctor validation to assess whether patient surveys are sufficiently independent of the doctor in question.	Implemented	Processes for doctor revalidation have changed since 2014. There is currently an All Wales agreement for 360 multi-source (patient and colleague) feedback with an external organisation. For Patient feedback, the external organisation will post surveys to the Doctor for distribution and collection is made via a third party (Ward Clerk, Nurse, Secretary etc), which ensures the patient is able to provide feedback anonymously and doctors are sufficiently independent of the process. We understand that the All Wales contract is due to end in March 2020, however an alternative system provided by Health Education and Improvement Wales (HEIW) will be phased in as the current contract ends.

Recommendation	Status	Summary of progress
Analysis of Incidents Our 2014 work found error reporting was encouraged and staff were positive about reporting processes. Incident data and themes were considered weekly by theatre managers at various governance meetings, but there was limited learning from incidents for staff below band 7 grade and mechanisms for providing feedback to staff were underdeveloped. There was also scope to use more sophisticated statistics to analyse trends in theatre incidents. We recommended that the Health Board should:		
R3a Access help and tools from Public Health Wales to enhance the trend analysis of theatre incidents and use Statistical Process Control charts.	Implemented	Statistical Process Control tools are no longer published by Public Health Wales NHS Trust, but access is available through the NHS Improvement Website. However, since our 2014 review the Health Board has introduced a theatre incident dashboard which provides real-time information on incidents which is positive and comprehensive. The Senior Nurse for Theatres accesses the information to discuss incidents with staff.
R3b Analyse the reasons for the significant increase in incidents during 2012.	Superseded	This recommendation no longer applies. The Health Board are undertaking work to review incidents as they happen through their Datix reporting system.
R3c Set an objective of increasing incident reporting and monitor the ratio of low harm incidents to all incidents at least every six months.	Implemented	A specific objective has not been set by the Health Board, but incidents are discussed at departmental and team leader meetings, where the Senior Nurse for theatres shares a printout of the theatre incident dashboard with staff. There is evidence to suggest learning from individual incidents at a departmental level, with some changes or improvements being made as a result. For example, development of Standard

Recommendation	Status	Summary of progress
		Operating Procedures (SOPs), Local Safety Standards for Invasive Procedures (LocSSIPs), and more focus on completion of the WHO checklist. Following the introduction of the new operating model in April 2020 there is further work being undertaken on reviewing incidents, and reports are being scrutinised through the new Integrated Locality Group structures.
List Planning Our 2014 work found that list planning at Royal Glamorgan Hospital (RGH) had changed to match the process at Prince Charles Hospital (PCH), but the change was problematic and not supported by all staff. Theatre staff wanted more input into the compilation of the list and there was a desire to improve communications with those charged with putting the lists together. There were also some concerns around overambitious lists and inaccurate information recorded on IT systems. We recommended the Health Board should:		
R4a Review the effectiveness and safety issues associated with list planning, particularly at Royal Glamorgan. Change the process to ensure theatre staff are fully involved in the quality assurance of lists.	Implemented	Operating theatres have introduced the 6-4-2 system at both RGH and PCH which provides a consistent process and 'forward look' for theatre session and list planning. The Health Board have appointed two Scheduling Managers who lead and co-ordinate the 6-4-2 system, assist with daily operational issues, identify and prevent any issues prior to patient surgery and work collaboratively with key operational staff. Positively the health board has introduced theatre huddles to ensure the 6-4-2 system operates effectively. The huddles take place twice a day and are attended by a multidisciplinary team. The purpose is to review the progress of the surgical lists and identify and resolve any issues that could result in case cancellations and delays. An internal evaluation of theatre huddles has indicated a reduction in cancellations and the improvements in communication have reduced outsourcing, improved patient safety and experience, theatre productivity and inter-team relationships.

Recommendation	Status	Summary of progress
		However, COVID-19 has affected list planning, with the reduction in elective activity and the focus on urgent and cancer care. Work has been undertaken to review every patient and assess their clinical need. This has been done with clinical engagement which does demonstrate progress against this recommendation.
Annual Leave Our 2014 work found that only 14 out of 45 consultants were consistently meeting the six-week notice of leave rule with some operations cancelled due to surgeon leave. We recommended the Health Board should:		
R5a Enforce compliance with the six weeks leave rule for consultants. Monitor compliance at least every six months.	Implemented	Both consultant and anaesthetists are still required to give six weeks' notice for annual leave. However, our interviews with staff found there are some instances where annual leave is requested within this time period. Authorisation is at the discretion of the department, for instance where the annual leave does not compromise services. Our analysis of Health Board cancellation data for 2019 indicates that 39 out of a total of 4624 cancelled operations across RGH and PCH were due to the surgeon being on annual leave. Our work found no evidence to suggest the Health Board regularly monitors compliance with the 6-week notice rule to understand its impact on cancellations, however cancellations due to annual leave are low at 0.84%.
Pre-operative Processes		

Recommendation	Status	Summary of progress
Pre-operative assessment clinics (POAC) are used to assess a patient before surgery, with the aim of identifying any pre-existing health conditions, screening for infection (such as MRSA), determining clinical risk and to ensure a patient is operated on in a suitable facility. In 2014, we found pre-operative assessment was recognised as an issue by the Health Board and the service was brought into the Anaesthetics, Critical Care and Theatres Directorate. There were also some mixed views amongst staff regarding its effectiveness. Some progress was made in standardising the service across hospital sites, but that work had not been completed at the time of the review. A screening questionnaire was also introduced and there was more anaesthetist involvement in pre-operative assessment. We found that day of surgery admission rates within the Health Board were the lowest in Wales and there was scope to improve this performance. The Health Board had introduced admission lounges to improve their day of surgery rates, however there were patient experience issues around dignity. We recommended the Health Board should:		
R6a Deliver a project to improve performance management of pre-operative assessment. The Health Board needs to know more about its effectiveness and its impact on cancellations.	In Progress	Staff were positive about the pre-operative assessment service and its impact on reducing cancellations at both RGH and PCH. There have been some site-specific projects to improve pre-operative assessment. For example, completing pre-operative assessment in day surgery at PCH. However, we found the service is not available to all specialities. For example, it has only recently been introduced for Urology. Our discussions with staff suggested there are inconsistent pre-operative assessment models at RGH and PCH and there was limited evidence to suggest there are performance management arrangements in place for this service. Further progress on this has been affected by COVID-19, and the Health Board is aware that work going forward will need to focus on improving pre-operative assessment as part of the planned care recovery programme following COVID-19.

Recommendation	Status	Summary of progress
R6b Analyse by speciality/surgeon, where day of surgery admission (DOSA) rates are low. Work with these specialties/surgeons to understand/overcome the barriers to increasing DOSA rates.	In Progress	DOSA rates are monitored at PCH at RGH. There was limited evidence to indicate whether the Health Board is working with surgeons and/or specialties to secure improvements. As part of the COVID-19 recovery plans further work is planned in this area to maximise capacity as part of the planned care recovery. Scrutiny of information will be undertaken within Integrated Locality Groups.
R6c Address the patient experience issues on SEAL units revealed by the recent patient survey and the Wales Audit Office audit.	Superseded	The SEAL unit was permanently closed in 2019 this recommendation is no longer applicable.

Short Stay Surgery

Short stay surgery reduces the patient length of stay in hospital and the risk of hospital acquired infections, which increases patient satisfaction and yields more efficient use of hospital beds.

In 2014, we found that the Health Board had taken several actions to promote short stay surgery and whilst the day-case rate improved during 2013, it remained comparatively low. We recommended the Health Board should:

Recommendation	Status	Summary of progress
R7a Formally nominate surgeons on each hospital site to act as champions for short stay surgery.	In Progress	The Health Board has a nominated consultant champion at PCH for short stay surgery, however the Health Board was unable to confirm if there are similar arrangements at RGH. As the Health Board moves forward with its planned care recovery there is an opportunity to ensure there are champions at all sites to improve short stay surgery rates. However, it is noted that the Health Board are working proactively to identify where improvements could be made.
R7b The champions should lead a project with the aim of increasing short-stay surgery rates within the next 12 months.	In Progress	The champion for short stay surgery at PCH has completed some site -specific audit/improvement work focussing on unplanned admissions following planned day surgery, improving day case laparoscopic cholecystectomies and adequacy of day surgery post-operative analgesia. However, no evidence was provided to indicate whether short stay surgery rates are formally monitored across hospital sites and there is limited evidence to suggest that any projects have been completed across the hospital sites to increase short-stay surgery rates. Due to COVID-19 planned elective work has been affected significantly, opportunities for maximising short-stay surgery will be explored as part of COVID-19 recovery planning.

Recommendation	Status	Summary of progress
Driving efficiency by generating greater shared ownership Our 2014 work found that whilst there had been some positive actions to improve performance management, clinical directors were unclear whether theatre data and information was being used optimally to drive improvement. We recommended that the Health Board should:		
R8a Reintroduce optimisation charts to reinvigorate the focus on efficiency (without sacrificing quality and safety).	In Progress	The Health Board uses the Qlik sense system to collate and monitor operating theatre performance with data available for on the day cancellations, in session utilisation, missed opportunities, non-fallow empty sessions, unused planned time and cost of unused planned time. However, there doesn't appear to be any focus on surgical productivity. Our analysis of the performance trends from July 2018 to December 2019, indicates that operating theatre performance is improving, but more work can be done to secure further improvements around on the day cancellations, in session utilisation, non-fallow empty sessions and unused planned time. Our discussions with staff suggest there is a lack of focus on operating theatre efficiency, despite having the performance information available. This view was reflected during our walkthrough of the operating theatre departments at RGH and PCH which revealed that information on late starts, overruns, cancellations and reasons for these are not recorded on theatre quality improvement boards / optimisation charts. We were told that efficiency information is not always recorded if it's not considered an issue.

Recommendation	Status	Summary of progress
		The impact of COVID-19 has significantly affected theatre throughput and activity. As part of recovery planning the Health Board recognise the need to ensure effective monitoring of efficiency and capacity. There are tools in place, and the new Integrated Locality Structures as well as the new general managers and surgery Clinical Service Groups are planning to drive improvements in this area.
R8b One of the clinical directors should lead a project to increase awareness and use of the theatre performance dashboard. The project should seek to understand and address any barriers relating to clinicians not owning the clinician-level efficiency data.	In progress	Our discussions with staff indicate that clinicians may be kept informed of theatre efficiency performance verbally, but they do not access the theatre performance dashboard themselves. Following the introduction of the new operating model across the Health Board there has been an increase in senior clinical leadership within the Integrated Locality groups and also within the surgical areas through the new clinical service group managers. Further strengthening has been achieved though the appointment of the clinical directors for two of the three surgical clinical service groups. Work on this area has been affected by COVID-19 however the structures should support the achievement of this recommendation.
R8c Share learning by clinical directors annually peer reviewing theatre data and observing performance in different specialties. Feed this	In Progress	Our discussions with staff found that the monthly Clinical Leaders forum provides opportunities to share learning, analyse theatre data and performance of different specialties, but at the time of our fieldwork, the Clinical Director for ACT had just been appointed and as such had not attended a meeting. We were also not provided with any minutes or papers for this meeting during the audit fieldwork, therefore we were

Recommendation		Status	Summary of progress
	into job planning, revalidation and appraisals.		unable to verify this statement. Further progress against this recommendation has been affected by COVID-19, it is hoped that the new arrangements and operating model will support this process.
R8d	Inform theatre staff by publicising minutes of Band 7 meetings and summarising the key issues in posters/leaflets or emails.	Implemented	The Health Boards self-assessment indicates that theatre efficiency information is shared with staff at bi-monthly departmental and team leader meetings.
Bed Management Role Our 2014 work found that unscheduled care pressures had eased, partly due to a more proactive approach to bed management by the senior theatre nurses. Although, there was a risk that their bed management role means they spend less time in operating theatres. We recommended that the Health Board should:			
R9a	In six months, assess whether the bed management role of senior theatre nurses is having a negative impact on their role in theatres.	Superseded	Due to the new operating model this recommendation is no longer needed

Assessment of progress against recommendations arising from the Operating Theatres Follow-Up Review at Bridgend (Abertawe Bro Morgannwg University Health Board (2015)

Recommendation	Status	Summary of progress
Operating Theatre Improvement In 2014, we found that the theatre work programme and theatre board had been disbanded, but the surgical pathway board had secured some broader improvements. We recommended that the Abertawe Bro Morgannwg Health Board (the Health Board) should:		
R1 Reintroduce a structured programme for theatre improvement, possibly as a workstream within the Surgical Pathway Board.	In Progress	Since the transfer of Princess of Wales Hospital from Abertawe Bro Morgannwg University Health Board to Cwm Taf Morgannwg University Health Board, there has been no work to reintroduce a structured programme for theatre improvement. The Health Board has recently introduced a new operating model which is expected to help support this work. COVID-19 has affected further improvements at this time. The Health Board agrees that Theatre Improvement will need to feature strongly in recovery plans post COVID-19 as Health Board seeks to improve planned care throughput following the COVID-19 impact.

Recommendation	Status	Summary of progress
Performance Management and Efficiency, Productivity and Safety In 2015, we found that action was underway to strengthen performance monitoring, but the Health Board was not driving improvement through the use of good quality data. We recommended that the Health Board should:		
R2 Develop an approach to performance management in theatres that ensures good quality data is widely used to drive improvement.	In Progress	There are differing arrangements to monitor operating theatre efficiency at Princess of Wales hospital with operating theatre departments at the Health Board's other hospital sites. Currently, Swansea Bay University Health Board provide Princess of Wales hospital with a monthly theatre utilisation report produced to share among operating theatre staff. Our review of the report found it to contain information on session utilisation and late starts / early finishes. This contrasts with the information available to operating theatre departments at RGH and PCH which is more frequent and has a focus on different performance metrics. Although there have been recent improvements in access to the Qliksense system. Princess of Wales Hospital can generate other theatre data internally to answer specific queries, but there was no evidence to suggest monitoring of other aspects of theatre performance and no plans yet to merge systems.
R3 Introduce a mechanism to ensure more regular executive oversight of theatre efficiency, productivity and safety.	In Progress	Our interviews with staff found there are no meetings to discuss operating theatre performance. Our review of Quality and Patient Safety meetings, as well as operating theatre departmental meetings found limited evidence of discussion or any action taken to address areas of performance. Previously, the theatre user group monitored theatre performance, but this was disbanded because of poor attendance from

Recommendation	Status	Summary of progress
		surgeons. The Health Board's Integrated Performance Dashboard presented at committee and board level includes information on theatre efficiency, but this primarily focusses on cancellations at all three of its hospital sites and doesn't provide a complete picture of operating theatre performance. The introduction of the new Integrated Locality groups and the new quality governance framework agreed formally by the Health Board in September 2020 should lay the structure in place to improve the opportunity for theatre efficiency and productivity to become more focused. This combined with how the Health Board are moving to recovery following COVID -19 for their planned care workload will also drive conversations in this area.
Clinical Director Role In 2015, we found that the new Clinical Director for Surgical Services (covering theatres) was an interim appointment due to an ongoing management restructure, so there was a risk of further change and disruption to theatres leadership. We recommended that the Health Board should:		
R4 Review the role of Clinical Director for theatres to ensure they are empowered to troubleshoot problems	Implemented	Following the Health Board merger in 2019 Operating Theatres became the responsibility of the Clinical Director for ACT at Cwm Taf Morgannwg University Health Board.

Recommendation	Status	Summary of progress
wherever they arise in the pathway.		In April 2020 this was further strengthened with new appointments to strengthen clinical leadership capacity. The new Integrated Locality Group structure has resulted on a general manager appointment to the Princess of Wales site as well as a Surgery Clinical Service Group which has increased management capacity. The Health Board has reviewed the clinical director roles and there are currently two in place. These have been in post since 2016. At the time of our review these roles were being reappointed as part of the new operating model process.
WHO Checklist and Briefings (Five Steps of Safer Surgery) In 2015, we highlighted numerous failings in the completion of the WHO checklist and team briefings were not mainstreamed in all theatres. We recommended that the Health Board should:		
R5 Draw on the expertise of the Health Board's Communications team to promote to staff the benefits of using the WHO checklist and briefings.	In Progress	There was no evidence to suggest the operating theatre department have drawn on the expertise of the communications team to promote to staff the benefits of using the WHO checklist and briefings. However, discussions with staff at Princess of Wales Hospital as part of our 2020 work found that compliance with the WHO checklist has improved and prelist briefings are regularly completed. Compliance with post list briefings could be further improved, however the team is confident that where an adverse incident has occurred a post list briefing is completed and are committed to continue to improve coverage in this area and improve learning.

Recommendation	Status	Summary of progress
Sickness Absence Rates In 2015, we found that staff sickness had increased in 3 of the 4 theatre sites across the Health Board and had exceeded more than 10% at some sites. We recommended that the Health Board should:		
R6 Carry out further work to understand and manage down the high sickness absence rate in theatres.	In Progress	Sickness levels remain of a concern. However, the local teams are aware and are monitoring this position routinely. COVID-19 is currently having an impact on these levels due to staff self-isolating and shielding, as well as vacancies. With the support of the local workforce business partners there is ongoing work to reduce sickness levels. We were informed that this is a mixture of short and long-term sickness which was being managed in accordance with the Health Boards Sickness Absence Policy. Ongoing focus will be needed in this area.

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Head & Neck Governance Arrangements

Position Statement

Cwm Taf Morgannwg University Health Board

2020/21

November 2020

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Distribution:	Alan Lawrie – Director of Operations
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.

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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.

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1. Introduction and Background

A follow-up review of the Head & Neck Directorate's governance and risk arrangements was due to be completed in addition to the 2020/21 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

Our original Head & Neck Directorate review was undertaken in the autumn of 2019, but our two reports (management arrangements and compliance) were not finalised until August 2020, after the 2020/21 Internal Audit plan had been agreed, due to the Covid-19 pandemic. Of the four audit opinions issued within the two reports, three were 'Reasonable Assurance' and one was 'Limited Assurance'. The area of limited assurance related to the governance and risk arrangements in place within the directorate. We made five high and medium priority recommendations. As such, we added an additional review, focussing on the five governance and risk recommendations, to our programme of work.

The relevant lead for the review is the Director of Operations.

2. Scope and Objectives

The overall objective of this review, was to provide the Health Board with assurance regarding the implementation of the management responses agreed against our original recommendations.

In April 2020, the Health Board implemented a new operating model, which saw a shift from directorates operating over multiple sites, to a locality based approach for the delivery of services. Three Integrated Locality Groups (ILGs) now exist, each responsible for one main district general hospital and all other services and facilities in their geographical area.

As a result of the new operating model, the Head & Neck directorate as it was, no longer exists. Instead, the previous services that made up the directorate now form part of the Surgery Clinical Service Group within each of the three localities.

There are new arrangements for monitoring governance within the ILGs. Each ILG has a Board and a number of groups report into the Board, providing assurance on various areas including service delivery, quality, health and safety, planning and partnerships.

Furthermore, in recent months, there has been a number of corporate initiatives undertaken to strengthen some existing Health Board wide processes such as declarations of interest. Other areas, such as risk management, has been completely revised and the new strategy now aligns to the new operating model.

As a consequence of the above changes, it has not been possible for us to undertake a follow up review of the recommendations made in our 2019/20 report, in our normal way. A number of the recommendations made in our report link to corporate processes that, following the implementation of the new operating model, have been superseded. The

management responses within our original report allude to the fact that some of the recommendations will be superseded by the wider Health Board changes, whereas the implementation of other recommendations will become the responsibility of the new formed ILGs.
In the context of the Health Board wide changes or actions taken within the new ILGs, this position statement aims to update members on the status of the agreed management actions, and the potential risks the recommendations were addressing.
The relevant potential risks highlighted in our original report were:

- The directorate is not appropriately governed which could result in a service that is not being delivered safely and effectively.
- Risks materialise as they have not been identified and / or addressed.

Personal interests are not considered meaning inappropriate decisions are made.

3. Summary of findings and update position

The table below summarises the five governance and risk findings from our original review and the current position in relation to actions that have been taken to address the recommendations made.

The implementation of the operating model means that the functions of the Head & Neck directorate have been transferred to Surgery Clinical Service Groups and are no longer within one directorate. These changes to governance arrangements means that we will consider the Health Board's progress against the original recommendations that related to the Head & Neck directorate through separate audits that we have planned for this year. The implementation of the agreed management actions will still be monitored through the Internal Audit action log tracker.

As such, it is our view that a formal follow up opinion relating to the directorate's agreed actions has been superseded.

Finding ref.	Summarised Recommendation	Rating	Current Position	Status
1	<u>Governance Arrangements</u> The terms of reference (ToR) for the Clinical Business Meetings (CBMs) should be reviewed, particularly in relation to required attendance. The ToRs remain in draft and should be finalised. CBMs and other key directorate governance meetings should take in line with the regularity outlined in their ToRs and with key officers or deputies in attendance.	High	Following the introduction of the operating model, new governance and reporting mechanisms have been introduced and CBMs no longer exist. In their place are Service Group Performance Review (SGPR) meetings, whose remit is to oversee the performance (quality, activity and outcomes, resources) of each of the ILG's Service Groups. A draft template ToR for the SGPR is in place which is to be adopted by each ILG. The ToR clearly states who should be in attendance for each meeting and the regularity of meetings. We understand that there was a delay setting up the SGPR meetings, but they are now meeting each month.	The draft ToR for the SGPR meetings addresses the concern we raised about attendees. The ToR still need to be finalised and adopted by each ILG. We will confirm that monthly meetings are taking place through our planned reviews of the Clinical Service Groups. Original recommendation has been **superseded**.
2	<u>Policies and Procedures</u> A centralised database of all policies and procedures relevant to the directorate should be developed, along with a process for ensuring timely review and updates. Policies and procedures should be accessible to all staff. Particular concerns were raised in relation to ophthalmology and audiology policies.	High	The departments that made up the Head & Neck directorate now sit within the Surgery Clinical Service Group. Ophthalmology and ENT services are operated from both the Bridgend and Rhondda Taf Ely (RTE) ILGs. We contacted the Surgery management teams in both of these ILGs. Bridgend confirmed that they had not been made aware of our recommendation but would now explore this further with ophthalmology and audiology colleagues. RTE will initiate a phased plan to review all policies and procedures saved on the intranet and locally within departments. They will also establish a database with review dates and responsible officers to ensure effective oversight and ensure accessibility to all.	Our recommendation in relation to policies and procedures remains **open** at the current time. Progress against this recommendation is monitored via the internal audit tracker.

Finding ref.	Summarised Recommendation	Rating	Current Position	Status
3	Risk Monitoring Monitoring of risks recorded in Datix should be undertaken through regular reporting and monitoring within the CBM.	High	The introduction of a new risk management strategy means that risk management processes align to the new operating model. Training is due to take place in all Clinical Service Groups on the new process. As stated above, CBMs have been replaced by the SGPR meetings. The draft ToR for this group shows that the group will provide the forum for escalation of risks and issues, and will monitor and ensure action is being taken to address actual and potential risks and issues.	Responsibility for risk monitoring has been defined. We will confirm if risks are being monitored in these groups through our planned audits of the Clinical Service Groups and at an ILG level through our corporate risk management audit. Original recommendation has been **superseded**.
4	Risk Recording on Datix The risk records held in Datix should be reviewed to ensure they are accurate and up to date. Processes should be put in place to facilitate regular review by risk handlers, including a process for when risk handlers are absent for work for a period of time.	Medium	As stated above, the process around risk recording and risk monitoring has been revised within the Health Board. As part of the revised process, and in order for each ILG to have a meaningful and accurate risk register, each ILG Nurse Director has been reviewing all risks that formed the risk registers for the previous directorates and now form the ILG risk registers. We understand that this review will incorporate a check of the risk score attributed, the risk handler, and that all information against each risk is accurate. A peer review process will then take place between the three ILG Nurse Directors to ensure consistency. The new risk management strategy, alongside the responsibilities outlined in the ToRs for the various governance groups should provide a robust framework for recording of risks in Datix	The revised risk management arrangements will ensure more effective capturing and monitoring of risks. The work we undertake as part of our corporate review will help to confirm if these revised processes are starting to embed and operate effectively in the Health Board. Original recommendation has been **superseded**.

Finding ref.	Summarised Recommendation	Rating	Current Position	Status
			and the subsequent review, update and monitoring of them.	
5	Declarations of Interest Management should ensure that Declarations of Interest (DoIs) are in place for all relevant staff within the directorate.	Medium	Since the time of our audit, the Health Board has revised the process it follows in relation to Declarations of Interest. Whilst the same groups of staff are still required to make declarations, the process for completion of returns has been strengthened. Proactive, as opposed to retrospective returns are now required and line managers will be sighted on the declarations that are made by their teams. Under the new approach, each April all relevant individuals will be asked to make their declarations for the forthcoming year. Due to the revision of process and the impact of Covid there was a delay in requesting the returns for 2020/21. These requests were made in August and September 2020 and a report of the declarations and nil returns made to date will be taken to the December Audit and Risk Committee. As the system is now electronic, reporting is now easier and automatic reminders are continuing to be sent for those that have failed to make a return.	The new process means controls should have now strengthened. We will be able to confirm this through our future audits of the Clinical Service Groups. Original recommendation has been **superseded**.

AGENDA ITEM
4.2

QUALITY & SAFETY COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	19/01/2021

FOI Status	Public

If closed please indicate reason	Not applicable Public Meeting

Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Director of Corporate Governance

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 Review	October 2020/November 2020	RISKS AMENDED
Management Board	18/11/2020	REVIEWED AND ENDORSED
Health Board	26/11/2020	REVIEWED AND ENDORSED
Audit & Risk Committee	14/12/2020	REVIEWED AND ENDORSED

ACRONYMS	
ILG's	Integrated Locality Groups
IMTP	Integrated Medium Term Plan

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Committee to review and discuss the risks from the Organisational Risk Register that have been assigned to the Quality & Safety Committee

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

2.1 Further **progress** has been made since the last report received at the last meeting to include;

- The inclusion of the high level risks to the Organisational Risk Register escalated from Rhondda Taf Ely Locality Group.
- The inclusion of Facilities risks. These are not new risks but risks graded 15 and above that had not been escalated to the Organisational Risk Register previously, and are now aligned to the Risk Management Strategy. For ease of reference the facilities risks added this month have been included in the "new risk" section at 3.1.
- All Executive Directors now have full access to Risks on the Datix system.
- An action plan for restructuring the Datix Risk Module to improve alignment with the Risk Management Strategy has been agreed.

Further work will be undertaken in conjunction with corporate functions and the Integrated Locality Groups to further peer review and calibrate risks as appropriate to ensure a consistency of approach to the quantification of risk across the Health Board.

2.2 During the period **Internal Audit Services have initiated a review of Risk Management** in the Health Board. The outcome is anticipated in January 2021.

2.3 **Gold Command – Covid-19 Risks -** As Gold Command was re-established in September 2020 in response to a rise in infection rates in the CTM communities, a COVID-19 Gold Command Risk Log has been developed. This risk log is being held separately to the Organisational Risk Register due to the evolving position. The Covid-19 Risk log is updated weekly following Gold meetings and shared with Board Members through the Admincontrol portal. As with the previously established Covid-19 Risk Log, when Gold Command is stood down, any relevant legacy risks will be transferred to the Organisational Risk Register as appropriate.

Integrated Locality Groups have considered the risks on the current Covid-19 Gold Command Risk Log and have only escalated risks specific to their localities to avoid duplication.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS TO THE ORGANISATIONAL RISK REGISTER (RATED 15 OR ABOVE)

Integrated Locality Groups

- **Bridgend Locality Group**

No new risks added for November Management Board.

- **Merthyr Cynon Locality Group**
  - Datix ID 4332 – "Anticipated Impact of the Opening of the Grange University Hospital (GUH)" – Rated 25.

- **Rhondda Taf Ely (RTE) Locality Group**

In October Management Board it was noted that RTE high level risks will be reported to the November Management Board meeting following a triage of high level risks within the locality group. The new risks triaged for escalation are:

- Datix ID 4281 – "Delivery of Rehabilitation for repatriated major trauma patients".
- Datix ID 4248 – "Care of Patients with Mental Health needs on Community Hospital Sites".
- Datix ID 4401 – "Risk of absconding on Ward 23".
- Datix ID 1793 – "Provision of negative pressure rooms in CTMUHB in line with WHC(2018)033".
- Datix ID 816 – "Follow up capacity and clinic cancellations (FUNB)".
- Datix ID 4292 – "Long Waiting Times and large backlog for Cardiac Echo".

Further triage on RTE high level risks will be undertaken and further updated at the December Management Board meeting.

3.2 RISKS WHERE THE RISK RATING INCREASED DURING THE PERIOD

No risks were increased in terms of risk rating since the last report to Board.

3.3 RISKS WHERE THE RISK RATING DECREASED DURING THE PERIOD

No risks were decreased in terms of the risk rating since the last report to Board.

3.4 **CLOSED RISKS**

The following risks were closed during the period:

- Datix ID 4097-"Failure to meet Fire Safety Standards across the Health Board". This risk was closed as it has been replaced by the above new risks 4392, 4417, 4356 and 4360 which better articulate the fire risks within the Health Board.
- Datix ID 3915 – "Ligature Points – Inpatient Rehabilitation Services – Merthyr & Cynon". This risk has been amalgamated within an ILG wide risk on Ligature Points – Datix Risk ID 4253.

3.5 During December 2020/early January 2021, risk leads and owners were asked to review the risks in detail to ensure that the control measures and actions remain fit for purpose particularly in relation to trends that have become stagnant. Any updates following this review will be reflected in the report to the next meeting of the Committee.

3.6 Some risks included in the Organisational Risk Register are assigned to two Committees where there might be a dual aspect to the risk e.g. quality of care and workforce, in this instance the risk will be received at this meeting and the People & Culture Committee as appropriate.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Aim to mitigate risks to patients and staff
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All Health and Care Standards are included
Equality impact assessment completed	No
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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Committee are asked to:

- **REVIEW** the detailed Organisational Risk Register at Appendix 1.
- **NOTE** the recommendations in relation to New Risks and updated risks.

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Next Review date
4332	Executive Director of Operations Merthyr & Cynon ILG	Provide high quality, evidence based, and accessible care.	Anticipated Impact of the Opening of the Grange University Hospital (GUH).	**IF:** The flow of patients from North Aneurin Bevan University Health Board and South Powys flow via the Welsh Ambulance Service Trust is conveyed to Prince Charles Hospital (PCH) for time critical patients. **Then:** This will have an adverse impact on flow within PCH **Resulting in:** Severe impact on patient care and provision of care within the Merthyr Cynon locality.	Governance structure developed to ensure clinically led solutions identified to increase transfers from PCH to support increased demand.	See Control Measures	Quality & Safety Committee	20	12	New Risk	12.10.2020	Last reviewed 2.11.2020
4095	Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Lack of control and capacity to accommodate all hospital follow up outpatient appointments	**IF:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in:** Potential avoidable harm to patients	. Continued monitoring of progress at Quality Delivery Meetings with WG. Initial progress with reductions in all specialities. . Exploring patient safety implications for some categories of follow ups not booked for consideration by Management Board and at Q,S&R Committee where further audit related action is being undertaken. . Continued improvement against trajectories in specialties. Surgery the first to achieve a 0 FUNB position. . Outsourcing of 6,500 Ophthalmology cases has now brought us to c.15k patients on the list, reducing to 13.5k. . WG has asked us to put forward a financial bid for balancing the outpatients position to 0 - bid is in the order to 1.5m to deliver 0 position by March 2021. . Harm review process now being piloted in Ophthalmology, with other specialties to follow.	Risk Currently being updated Assistant Director Medicine -Operations to include Covid-19 environment. It is anticipated that due to the amount of activity in this area the risk score is likely to reduce.	Quality & Safety Committee	20	12	↔	01/11/2014	18.11.2020
4100	Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Failure to treat patients in a timely manner resulting in potential avoidable harm	**IF:** The Health Board fails to treat patients in a timely manner **Then:** the Health Board's ability to provide high quality care would be reduced. **Resulting in:** potential avoidable harm to patients due to delays in treatment.	•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. •Immediate 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. All appropriate waiting lists will be reported and will be dealt with in line with RTT waiting times criteria	Speciality specific plans are in place to ensure patients requiring clinical review are assessed	Quality & Safety Committee	20	6	↔	01/07/2019	18.11.2020
4080	Medical Director	Patient / Staff & Public 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 • Explore substantive appointments of staff undertaking locum work in CTMUHB • Feedback poor performance and concerns to agencies • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs	• AMD and workforce to develop recruitment strategy - 31.3.2021 • AMD and DMD to develop retention and engagement strategy - 31.3.2021 • Reduce agency spend throughout CTMUHB • Launch of 'medical bank' to Bridgend ILG locality Autumn/ Winter 2020	Quality & Safety Committee People & Culture Committee	20	16	↔	01.08.2013	18.11.2020
3826	Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases.	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.	Continue to implement actions identified in the control measures.	Quality & Safety Committee	20	16	↔	24.09.2019	31.12.2020

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Next Review date
4253	Director of Operations All Locality Groups	Impact on the safety of patients, staff or public (physical/psychological harm)	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks.	Continue to implement actions identified in the control measures.	Quality & Safety Committee Health, Safety & Fire Committee	20	10	↔	17.08.2020	16.10.2020
4331	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Covid 19 emergency flow and Impact of RGH flow	**IF:** The continued high rates of admissions continue with increased number so of c19 patients during autumn 2020 **Then:** there will be a reduction in non c19 attendances causing significant constraints with regards to the safe flow of patients in PCH **Resulting in:** long WAST waits and delays and inability to increase c19 capacity on PCH site.	Associated plans opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH	See Control Measures	Quality & Safety Committee	20	12	↔	12.10.2020	25.01.2021
4071	Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Failure to sustain services as currently configured to meet cancer targets	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	• Tight management processes to manage individual cases on the cancer Pathway. • Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. • Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk • Harm review process to identify patients with waits of over 104 days and potential pathway improvements. • Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. • All three ILGs are working to maximising access to ASA level 3+4 surgery on the acute sites. • HB working to ensure haematological SACT delivery capacity is maintained. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. • Alternative arrangements for MDT and clinics, utilising Virtual options	Continue close monitoring of each patient on the pathway to ensure rapid flow of patients through the pathway. Active management of the diagnostic backlog (including endoscopy) and exploration of all options to reduce this. Comprehensive planning for repatriation of theatre and haematology services for when private provision is lost. This also needs to consider options for continuation during a potential second surge. These actions are ongoing and assigned to the EDO, DPC&MH and Medical Director.	Quality & Safety Committee	20	12	↔	01/04/2014	18.11.2020
1793	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Provision of negative pressure rooms in CTMUHB in line with WHC (2018) 033	**If:** there are no negative pressure rooms available in CTMUHB. **Then:** the service will be unable to isolate patients in an appropriate environment. **Resulting In:** Non compliance with national guidance/ WG expectation	Patients isolated in single rooms. Apply IPC precautions. Isolation policy in place. Alert organisms are dealt with by the IPCT. IPCN's liaise with wards/ departments giving IPC advice/ instruction. All alerts are discussed at weekly meetings. 2 positive pressure ventilated lobby rooms available at PCH.	Work with Executive Team, Capital, Estates and Shared Services colleagues to consider recommendations outlined in the WHC(2018)033	Quality & Safety Committee	20	12	New Risk to Org RR	16/12/2014	31.12.2020
4106	Nursing, Quality & Safety	Patient / Staff & Public Safety - Physical and /or psychological harm	Increasing dependency on agency staff cover which impacts on continuity of care, patient safety	**IF:** The Health Board increasingly depends on agency staff cover **Then:** the Health Board's ability to provide stability and consistency in relation to high quality care could be impacted. **Resulting in**: disruption to the continuity, stability of care and team communication. Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	Recurring advertisements of posts in and nursing continue with targeted proactive recruitment employed in areas of high agency/locum use. Provision of induction packs for agency staff Nursing workforce will include monitoring nurse and midwifery graduate recruitment , this is now managed via an all wales "streamlining" process. CTMUHB nursing workforce group are currently formulating a targeted approach to proactively encouraging students to choose CTMUHB as their first choice; this includes a senior nurse allocated to lead on this project in collaboration with workforce teams to target recruitment drives in the university settings. Agency nursing staff are paid via an All wales contract agreement, any off framework agency requests must be authorised by an Executive Director prior to booking (system of audit trail in place). Nurse staffing Act monthly meetings established – these are now split into Part A (NSA) and Part B which encompasses work streams aimed at reducing agency usage by national and international recruitment drives and initiatives. Nurse sensitive outcome measures are positive. Fixed Term Contracts being offered to all existing HCSW and RN currently on the Nurse Bank.	Redesign services wherever possible to embrace a healthier Wales and therefore impact upon the workforce required to deliver services. Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's Acuity Audit scheduled for July 2020. All Wales "Safer Care" activity anticipated to be received in due course.	Quality & Safety Committee People & Culture Committee	16	9	↔	01/06/2015	18.11.2020

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4157	Nursing, Quality & Safety	Patient / Staff & Public Safety - Physical and /or psychological harm	There is a risk to the delivery of high quality patient care due to the difficulty in recruiting and retaining sufficient numbers of registered nurses and midwives	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage **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**: Disruption to the continuity and stability of care and team communication Potential to impact on patient safety and staff wellbeing. There are also financial implications of continued use of agency cover.	• Proactive engagement with HEIW continues. • Scheduled, continuous recruitment activity overseen by WOD • Targeted approach to areas of specific concern reported via finance, workforce and performance committee • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Block booking of bank and agency staff to pre-empt and address shortfalls • dependency and acuity audits completed at least once in 24 hrs. on all ward areas covered by the Nurse Staffing Act with a plan to roll these audits to all wards during 2020 • Nursing workforce group (meets monthly) has been revised to include updates and trajectories on delivery against overseas recruitment initiative, retention strategy, retire and return strategy. • Nurse staffing Act monthly meetings established – these are now split into Part A (NSA) and Part B which encompasses work streams aimed at reducing agency usage by national and international recruitment drives and initiatives • Deputy Exec DON is currently reviewing the nurse rostering policy in order to put in place (in conjunction with workforce team) clear roster monitoring KPI's and Bank usage/recruitment KPI's • 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	Continue recruitment campaign - Monitored at Nursing Workforce monthly group. Successful overseas RN recruitment ongoing Action plans, to include annual plan of work to be created and monitored via the Nursing and Midwifery workforce group and Nursing Staffing Act group Review of Skill Mix within Teams	Quality & Safety Committee People & Culture Committee	16	9	↔	01/01/2016	18.11.2020
4156	Nursing, Quality & Safety	Patient / Staff & Public Safety - Quality Complaints & Audit	Patients and/or relatives/carers do not receive timely responses to matters raised under Putting Things Right resulting in learning and improvement being delayed	**IF:** The Health Board fails to provide timely responses to matters raised by patients, relatives and/or carers under Putting Things Right. **Then:** there will be a delay in identifying potential learning opportunities. **Resulting in:** variable quality in responses, not learning lessons, not meeting regulatory response times therefore increasing the number of concerns being escalated to the Ombudsman and not providing complainants with a resolution in a prompt and timely manner.	-Implementation of the Quality & Patient Safety Governance Framework - Values and behaviours work will support outcome focused care - supportive intervention from the Delivery Unit supporting redesign of complaints management - relocation of the concerns team into District General Hospitals - Preservation of the governance resource within the princess of Wales Hospital - New ILG structures now in place - Governance teams embedded within each ILG - Governance processes in place in relation to PTR guidelines and this provides assurance via their ILG Q&S committees and these report into the CTMUHB Q&S committee and Patient Experience Committee. - Corporate/Executive assurance and review undertaken weekly via Executive Director led Patient Safety review meetings and quarterly Concerns scrutiny panel meetings. -Ensure access to education, training and learning. - Review of systems in place to aid assurance and compliance with PTR guidelines in progress by Corporate Governance Team. Level 1 PTR training added to ESR training module and training ongoing for staff in the DLG's. Member of corporate team continues to provide training surrounding PTR guidelines and governance.	Corporate governance team reviewing current Datix system to reflect new DLG structures and working with WRP to ensure alignment with new Once for Wales System which is in progress.	Quality & Safety Committee	16	9	↔	01/04/2014	18.11.2020
4115	Medical Director Director of Operations Integrated Locality Groups	Patient / Staff & Public Safety - Physical and /or psychological harm	Implementing a sustainable model for emergency medicine and inpatient paediatrics across the CTMUHB footprint	**IF:** The Health Board is unable to deliver a sustainable model to deliver Emergency Medicine (EM) and inpatient paediatrics across the Health Board Footprint. **Then:** The Health Board will be unable to deliver safe high quality emergency medicine and inpatient paediatrics services. **Resulting in:** Compromised safety of patients and Staff.	Successful recruitment to EM in Royal Glamorgan Hospital and Prince Charles Hospital continues at consultant and middle grade. Model for delivery of Paediatric care in RGH significantly clearer and this is contributing to some recruitment success.	Recruitment drive continues.	Quality & Safety Committee	16	6	↔	01/07/2019	18.11.2020
4069	Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Failure to achieve Referral to Treatment Times	**IF:** The Health Board fails to achieve Referral to Treatment Times. **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/procedures. Could cause possible harm to patients due to delays waiting for treatment/procedure.	Directorate Demand & Capacity Plans in place with regular RTT meetings. On-going Flow Programme to address capacity issues. Improve capacity for Day surgery and 23:59 case load. Monthly and Quarterly monitoring of trajectories, routinely discussed with CBMs. Routine reporting into Finance, Performance & Workforce Committee Surgical Assessment facilities now available on DGH sites. WG released £7m against a £8.7m resource plan for restoring our trajectory. Several Workshops held to address HMRC tax and pension issues which have significantly eroded consultant sessional availability for ADH and WLI. DU review of unreported waiting lists complete and all trajectories reworked to include patients from those lists - financial plans to achieve trajectories now in place.	Continuing to take forward the activity outlined within the control measures.	Quality & Safety Committee	16	8	↔	Nov-14	18.11.2020

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4103	Director of Operations	Patient / Staff & Public 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.	Action plan developed and on going monitoring - consolidated plan coming forward covering Eye Care	Quality & Safety Committee	16	12	↔	01/04/2014	18.11.2020
4148	Nursing, Quality & Safety	Legal / Regulatory	Non-compliance with DoLS legislation and resulting authorisation breaches	**IF:** due to current capacity the Health Board fails to fully comply with the DoLS legislation. **Then:** the Health Board may have to operate outside the current legislative process. (a change in legislation is coming which will hopefully improve lawfulness) **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.	DoLS process and training has been impacted upon by the Coronavirus pandemic, where face to face capacity assessments have not been made. Staff recruited to manage demand and mitigated by use of independent best interest assessors, a full time secondment transition post and nurse bank hours. Urgent authorisations are prioritised over standard authorisation As a result, although this process is effective in terms identifying patients deprived of their liberty, it is not a lawful process and does not comply with legislation. Therefore we are at greater risk of breach during the Covid period and the rights of those who lack capacity are potentially compromised. Monthly Safeguarding People training increased understanding of DoLS amongst UHB attendees Training paused for Covid 19 but recommenced July 2020. Virtual DoLS processes established and in place within the UH during Covid 9, this is subject to regular review and monitoring. DoLS legislation will subject to change following enactment of the new legislation and statutory guidance. The Liberty Protection Safeguards legislation provides for the repeal of DoLS and replacement with the Liberty Protection Safeguards (LPS). The UK government has not yet announced the date on which the legislation will come into force, possibly October 2020. For up to a year the DoLS system will run alongside the LPS. Whilst requirements have increased, mitigation has also been revised to manage increased risk, the UHB will need to be prepared for new legislation. Audits are undertaken on time to respond to requests. Virtual capacity and best interest assessments involve family, patient representatives and those who care for the patient. Streamlining and target setting implemented which has led to more authorisations taking place in a more timely manner. As the local authority lockdown and site outbreaks has impacted upon the ability of the DoLS team to undertake face to face assessments as routine, following a brief return to business as usual following the first peak. As a result we remain in the position where we are encouraging urgent authorisations by the managing	To resume face to face assessments as soon as it is safe to do so. A retrospective audit of authorisations during the Covid period to be completed and reported to the Safeguarding Executive Group. The Safeguarding Executive Group to establish a working group with multidisciplinary representation to consider the implications for the UHB on how the LPS scheme will have an impact on the current authorisation process for DoLS. Timescale: Paused for Covid 19 new date not yet set.	Quality & Safety Committee	16	9	↔	01/10/2014	18.11.2020
4116	Governance	Provide high quality, evidence based and accessible care	Organisational Reputation - Lack of confidence in the services and care provided by the organisation.	**IF:** the Health Board does not effectively engage with its stakeholders, communities and staff to demonstrate listening and learning from external reviews and more recently the Health Boards response to Covid-19 **Then:** Trust and confidence in the services of the Health Board will be negatively impacted. **Resulting in:** negative media coverage, lack or credibility with our communities and staff, ineffective communication, loss of commitment, deteriorating morale, increase in staff turnover and recruitment.	Rebuild trust and confidence programme under Targeted Intervention Improvement Programme underway. Maintaining public confidence in the Health Boards response to the Covid-19 Pandemic through regular and robust communication and messaging through the Health Board's communication channels. Improved staff engagement and involvement, new approaches to partnership engagement and involvement. Additional capacity bid included in TI investment bid under the TI programme to WG. Additional capacity bid included in TI investment bid under the SW Programme. Ensure balanced news stories are regularly reported and communicated. Relationships with the media have been strengthened. Partnership working with Channel 4 and proactive engagement with other media outlets - resulting in positive working relationships and fair media coverage. 'In Committee' meetings have been significantly reduced. TTP Communications workstream focussed on provision of accurate and timely information to the Public. Live streaming of the Board meetings now in place to improve transparency and involvement.	A programme of public and patient engagement and involvement, Let's Talk programme, developing Values and Behaviours with staff and patients. Open door policy . Delayed due to the impact of Covid-19 - New timescale: September 2020. Stakeholder engagement survey planned for August 2020.	Quality & Safety Committee	16	6	↔	01.07.2019	18.11.2020

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3584	Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Neonatal Capacity/Stabilisation cot at Princess of Wales	**If**: The neonatal unit at POW is required to deliver ITU level care in the stabilisation cot **Then:** This cot is not staffed, therefore the overall staffing position on the unit is depleted while this is managed, noting that in the absence of a 24/7 retrieval service this can be for extended periods. The stabilisation cot requires 1:1 nursing which is the equivalent of staffing for 2 HDU costs or 4 SCU cots. **Resulting In:** A risk of being unable to provide appropriate levels of care to the babies on the unit as staffing will be below the required levels as per BAPM requirements	* Utilise available staff as effectively as possible depending on the capacity position at the time * Escalation policy in place to limit maternity services to reduce the risks of further admissions to neonates * Seek additional staffing e.g. through bank, agency, overtime when required	To continue to implement the activity/actions outlined in the control measures.	Quality & Safety Committee	16	3	↔	31.05.2019	30.11.2019
3585	Director of Operations Bridgend ILG	Environmental Impact	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	Quality & Safety Committee	16	1	↔	31.05.2019	31.12.2020
4337	Executive Director of Planning & Performance (ICT) Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	IT Systems	**IF:** The Health board is unable to deliver vital clinical information services to the Bridgend locality affecting many clinical systems that are not compatible with Cwm Taf University Morgannwg Systems. **Then:** The Health board will be unable to deliver safe, high quality care to patients without vital clinical information available. **Resulting In:** Compromised safety of patients needing treatment that are reliant on clinical test results and information being available to clinicians to plan and deliver the treatment plan.	IT maintenance is currently supported by Swansea Bay UHB via a service level agreement. There are currently a number of systems that are not compatible with Cwm Taf Morgannwg systems and we are 18months post boundary change.	Action Plan currently being updated.	Quality & Safety Committee	16	8	↔	14.10.2020	31.03.2021
4338	Director of Operations Executive Director of Finance (Estates) Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Asbestos Content in roof of main building.	Asbestos is a known significant risk to health. It has long since been banned in construction but there is a recognition that older buildings may still have Asbestos in them (usually roof). Asbestos has been linked through extensive research to lung cancer, asbestosis, mesothelioma and other respirator illness through long term exposure. **If:** he Health Board is unable to safely remove the significant asbestos risk in the roof structure of Maesteg Community Hospital through a structured and planned estates strategy. **Then:** The Health Board will be unable to comply with Health & Safety Legislation in terms of providing a safe environment for staff and patients and run the risk of potentially contributing to significant ill health claims. **Resulting In:** Potential for litigation from HSE, individual staff suffering from illness as defined above	The roof structure has remained undisturbed at present which does not further escalate the risk of loose fibres being released. The capital team are aware of the problem.	The capital team are aware of the problem.	Quality & Safety Committee Health, Safety & Fire Committee	16	16	↔	14.10.2020	31.03.2021

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4294	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Long waiting times and large backlog of patients awaiting Cardiac Echo	**IF:** The health Board is unable to meet the demands for patients awaiting Echo scans for both follow up surveillance **Then:** The RTT WG target will not be met and waits may be 26weeks **Resulting in:** Potential risk to patients from delays in identifying and treating disease and progression of disease	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders)and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post Covid circa 56 / month due to test time changes. (+ currently 1.0 wte lts further 120/month. Will submit SBAR to highlight capacity deficit and cost solutions	See Control Measures Risk also raised via Rhondda Locality which will be reviewed alongside this risk - Datix ID 4292.	Quality & Safety Committee	16	6	↔	14.09.2020	12.10.2020
4235	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Cancer Performance - Gastroenterology Outcome of Covid-19	**IF:** Routine diagnostic activity is not recommenced in full during the C19 pandemic **Then:** there will continue to be a backlog of patients awaiting diagnostic investigations **Resulting in:** Potential harm to patients due to delay in diagnosis and treatment	Endoscopy services have restarted as part of new normal timetables. Backlog is being booked and should be cleared by end of July. 22.9.20 Discussions health board wide to reduce overdue and to work to safe capacity.	See Control Measures	Quality & Safety Committee	16	9	↔	27.07.2020	02.11.2020
3958	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Elective patients surgery cancelled when high level bed pressures are experienced	**IF:** Elective patients surgery is cancelled when high bed pressures are experienced **Then:** There will continue to be a backlog of patients awaiting treatment/procedures to improve their health and wellbeing **Resulting in:** Potential harm to patients due to delay in treatment/procedures	Consultants are asked clinical opinion when each patient case is cancelled. 12/10/20 insufficient capacity to meet current trauma demand and no short term plan to re-introducing elective orthopaedics during C19 pandemic. Seal area identified but delayed due to RGH IPC issues. As per UHB SoP, clinical prioritization undertaken weekly to list patients with high clinical need. Risk to patients who cannot access	See Control Measures	Quality & Safety Committee	16	8	↔	14.01.2020	31.03.2021
3682	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Risk to Obstetric Theatres National Standards	**If:** There is an aim for 'Gold standard' compliance with theatre staffing standards. Workforce is used from midwifery establishment, and the establishment is impacted by this. **Then:** Midwifery workforce reduced to undertake theatre roles and undertake an agreed robust there is a competency training Programme in the UHB for midwifery staff who scrub **Resulting In:** inefficient staff utilization, where there is a national shortage in the workforce.	Scrub training in place and a rolling programme organised with main theatres There is a business case that has been previously been partially approved for revised staffing levels to achieve compliance with the national standards Acuity impact with no additional resource when midwives are used as scrub midwives impacting on ability to provide a full compliment of midwives for labour ward. Staffing and birth-rate acuity compliance.	Action: Service to update and re submit business case for the Surgical CSG to take ownership of maternity theatres.	Quality & Safety Committee	16	6	↔	26.06.2019	01.03.2021
3011	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Non compliance with appropriate fetal growth detection and management guidance	This is an All Wales risk for all HB`s **If:** there is a lack of USS slots to address the demand we will not be in compliance with the guidance for fetal surveillance and wellbeing. **Then:** 1. Compliance against the Growth Assessment Protocol (GAP) cannot be met. CTMUHB does not have a 7 day USS service which would support compliance and the management of the small for gestation age (SGA) fetus. **Resulting In:**: Women at the greatest risk of SGA receive less surveillance of growth than women with uncomplicated pregnancies resulting in potential harm.	1. Capacity to comply with GAP/GROW 3 weekly - current regime 3-4 weekly 2. Woman are risk assessed, they are allocated one of two pathways. One pathway SFH can be delivered, Serial scanning (37% of population) unable to receive full recommended scanning regime or protocol due to scanning capacity issues. Current regime 4 weekly as apposed to three weekly. 4. The Directorate is working closely with the Radiology department to review low value scans requested. 5. The Directorate is reviewing the option of midwife sonographers being employed. 7. Scanning group for the UHB established. 8. Continued to be reviewed with changes to patient flow due to 'The Grange'	See Control Measures. Radiology to develop sustainable service plan to increase capacity and workforce.	Quality & Safety Committee	16	6	↔	01.06.2017	30.03.2021
3008	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 7. Ask other HB`s their MH requirements SBUHB online training package to be shared. 8. Directorate will Seek out any opportunities for online updating to support current practice 9. E-learning module has been sourced for all staff to complete on line update for manual handling.	Organisational plan for compliance training.	Quality & Safety Committee	16	12	↔	01.05.2017	01.12.2020

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3654	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Gynaecology Cancer Service	This affects Gynaecology services across CTMUHB - delay in the pathway requiring multiple consultations on site - Service relies on an individual practitioner - Demand is currently in excess of agreed manageable caseload - Hysteroscopy service capacity requires business case supporting for service development - Gynae Rapid access service development is slow progression	Hysteroscopy service business case is being updated - Increased cancer tracking - Review of pathways and service - tracking of results G17Scrub training in place and a rolling programme organised with main theatres	Action: Agreed COVID pathways. Service to re-submit gynaecology 'one stop' Service.	Quality & Safety Committee	16	9	↔	18.06.2019	30.09.2020
4401	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Risk of absconding from Ward 23.	**If**: Estates work and Covid-19 pathway remodelling is not undertaken urgently **Then:** Mental health patients may continue to abscond **Resulting In**: Potential harm to themselves or the public	All patients risks for suitability of admission to ward 23 assessed. Patients discouraged from smoking where possible. Any patient who goes out into garden is supervised by ward staff at all times. All staff will try to de-escalate increasingly volatile situations. Prompt alert if patients can not safely be stopped from absconding. Staff to follow guidance for managing absconding patients.	Security fence to be erected Remodel ward layouts so that area is no longer used as acute ward space	Quality & Safety Committee	16	4	New Risk	04/11/2020	31.12.2020
816	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Follow up capacity and clinic cancellations (FUNB)	**If:** The Health Board is unable to control and meet the capacity and demand to accommodate all hospital follow up outpatient appointments. **Then:** the Health Board's ability to provide high quality care may be reduced. **Resulting in**: Potential avoidable harm to patients	Organisation plan in place to address the FUNB position across all specialties. Additional funding requirements identified. Regular meetings in place to monitor the position.	Harm review processes being implemented	Quality & Safety Committee	16	12	New Risk to Org RR	18/11/2013	31.12.2020
4292	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Long waiting times and large backlog for Cardiac Echo	**If:** For old Cwm Taf template Total of 2720 pts awaiting Echo scans for both follow up surveillance to monitor disease progress and new referrals governed by RTT. RT -ILG 1520 pts of which 873 would form part of RTT 570 pts waiting greater than 8 weeks longest wait 45 weeks. **Then:** Potential risk to patients from delays in identifying and treating disease and progression of disease eg valves, LV function . **Resulting in:** Delays in receiving appropriate treatment pharmacological, intervention , surgical. Potential risk litigation. triage process reliant on available referral information to assess urgency.	Forms were verified and triaged by Cardiology team. Patients prioritised in relation to clinical need and rated between urgent and routine. I/P room identified away from main department to increase outpatient capacity and to prevent cross infection risks to outpatient services for both staff (inc returning shielders) and patients Clinically urgent completed and move to routine. New forms triaged as received. Overall loss of capacity post covid circa 76 / month due to test time changes. Ill health retirement further 97 / month capacity loss.	Plans to submit SBAR to highlight capacity deficit and cost solutions.	Quality & Safety Committee	16	9	New Risk	10.09.2020	12.01.2021

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Next Review date
4105	Public Health	Patient / Staff & Public Safety - Physical and /or psychological harm	Potential Harm and poor experience for Patients as a result of the Health Board's focus and response to the Covid-19 Pandemic	**IF:** the Health Boards resources and focus is directing into managing the response to the Covid-19 pandemic. **Then**: the Health Board's ability to provide high quality care may be reduced. **Resulting in:** potential harm to patients as a result of reduced service provision and capacity to respond to other areas of the Health Board's population Health need.	Planning preparedness, contingency structures through the Resetting CTM structures. Critical services are operating. Governance process in place for financial and non-financial decision making to support, all predicated on Quality Impact Assessments. Quality & Safety Committee has continued to meet to ensure scrutiny and assurance on behalf of the Board. Indicators of quality and patient safety for all services continue to be closely monitored throughout Covid-19. Processes and guidance in place to ensure clarity on areas such as safeguarding and child protection. Implementation of the Test Track and Trace Programme in June 2020. Regular Population Health Surveys conducted in relation to Covid-19 to gauge attitudes and risk perception within communities. Compliance with National Guidance. The QIA process for service changes relating to Covid-19 management will include an assessment of related impact on any existing service delivery. Deaths are monitored via the mortality review process. Monitoring incidents, complaints and feedback through social media. Monitoring Core quality and safety metrics.	The QIA process for services changes relating to COVID-19 Management will include an assessment of related impact on any existing service delivery.	Quality & Safety Committee	15	12	↔	23/03/2020	18.11.2020
4150	Executive Nurse Director	Patient / Staff & Public Safety - Physical and /or psychological harm	Wearing for FFP3 masks for 2 hours in a high risk area. Normal time spent in ITU performing procedures can be up to 3-4 hours.	**IF:** the FFP3 masks are used for a period of greater than 2 hours at a time. **Then:** there is an increased risk of integrity of the mask and discomfort to the wearer. **Resulting in:** an increase risk to the user of exposure to the Covid-19 virus if utilised for greater periods. Using FFP3 masks for a period of greater that 2 hours at a time increased risk of integrity of mask and the discomfort to the wearer. To change the mask more frequently will require the user to remove all Personal Protective Equipment and remove themselves form the environment. If the mask is utilised for greater periods this can increase the risk to the user of the COVID virus. The user will also need to rehydrate etc. due to the increased body heat generated from the full	Staff are disposing of mask on exiting the unit and to use a new mask before entering.	Update in progress folllowing measures that have been put in place to mitigate this risk which may have reduced the risk rating.	Quality & Safety Committee Health, Safety & Fire Committee	15	4	↔	May-20	18.11.2020
4186	Director of Operations	Patient / Staff & Public Safety - Physical and /or psychological harm	Covid 19 - Gold Risk - 002 Critical Care Beds and Equipment	**IF:** there is an insufficient number of critical care beds, medicines and ventilators. **Then:** the Health Board's ability to provide high quality and safe care would be reduced. **Resulting in**: potential harm to patients.	• Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised • Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery) • National work regularly shared • Local model well underway and informing capacity planning. • More detailed capacity plan available and being shared with WG as requested • Redeploy and retrain staff released from inpatients, day cases and outpatients • UK government removing restrictions on the export of any UK bound stocks. • New systems in place for the assessment and management of stock in hospitals. • Movement of stock between health boards. • Minimising wastage of critical care medicines in the ward and in aseptic production units. • Daily situation report providing stock levels relative to critical care bed usage by health board. • Regular calls between NHS pharmacy procurement leads used to support mutual aid through the movement of stock between health boards. • USC dashboard (to remain Level 1 Green / Level 2 Amber) • Capacity Plan in place with modelling throughout the covid-19 period	• Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain - under constant review. • Working to ensure robust arrangements are in place to identify and move stock rapidly between hospitals and health boards should the need arise	Quality & Safety Committee	15		↔	13.05.2020	18.11.2020
3072	Director of Operations Pharmacy & Medicines Management	Impact on the safety of patients, staff or public (physical/psychological harm)	Temperatures in medicines storage room on the wards in Prince Charles Hospital not fit for purpose.	**If** there is no control of the temperatures in all the medicines storage rooms on the wards in Prince Charles Hospital. The medicines storage room have pipes in ducts which give off significant heat year round and increased issues in the summer months. **Then:** medicines are being kept above the required temperatures as stated in their specifications of storage as part of their license from MHRA. **Resulting in:** medicines stored at a higher temperature than their specifications which could result in them being less active or denatured and affect patient outcomes.	Some wards are placing small fans in rooms but this does not reduce the temperature. alternative rooms for storage have been discussed but unable to progress due to other ward priorities A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	A SON for air conditioning for each ward will be progressed by medicines management on behalf of ILG	Quality & Safety Committee	15	6	↔	05.02.2018	01.12.2020

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Next Review date
3698	Director of Operations Bridgend ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Waiting List for Autism Diagnostic Observation Schedule (ADOS) assessments and Attention Deficit Hyperactivity Disorder (ADHD) medicals over 1 year.	**If:** there are delays in diagnosing children with ADHD and Autism. **Then:** this results in a delay in management including appropriate school placements **Resulting in:** potential harm to patients, poor patient experience, dignity, staff morale. Complaints.	* The team have reviewed their clinical practice in line with the rest of CTM e.g. no longer undertaking ADOS for all children * Discussions underway re: repatriating service from Swansea Bay and investing funding into enhanced local service in Bridgend * New Consultant starting June 2020 with 3 sessions to support community paeds	Vacant sessions to be recruited to - Additional staff appointed who could undertake assessments would ensure this activity was managed in a timely manner.	Quality & Safety Committee	15	4	↔	02.07.2019	16.09.2020
3685	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm) Quality / Complaints / Audit	No Midwifery Specialist for pregnant women with vulnerabilities	**IF:** there is no dedicated services for substance misuse women, prescription medication, or women with vulnerabilities (social) - national best practice is for there to be a lead in vulnerabilities to see women in a dedicated clinic with the multidisciplinary teams which without leads to disjointed care for our most at risk patient group. **Then:** unidentified opportunities to co-ordinate risk management and support in 'A Healthier	Women in PCH/RGH are seen in a general Ante Natal clinics Women in POW currently seen in a dedicated clinic, with an SLA agreement with Swansea Bay UHB .2 resource. The directorate need to develop a Statement of need to secure resources to support services across the HB and ensure standardised service delivery.	Action: Service to develop business case for implementing specialist service for women with vulnerabilities.	Quality & Safety Committee People & Culture Committee	15	6	↔	26.06.2019	01.12.2020
4281	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Delivery of the rehabilitation for repatriated major trauma patients.	**If:** The business case for enhanced rehabilitation services linked to Major Trauma is not supported. **Then:** Patients will not receive the appropriate level of clinical intervention. **Resulting In:** Poorer clinical outcomes, increased lengths of stay (with associated clinical risks) and poor patient experience.	Ensuring current nursing and therapies have access to a training programme - however there are concerns about deliverability during Covid pandemic. The new rehabilitation coordinator post will support the delivery of the immediate care planning once a patient is repatriated. Advance notice means we can ensure staff are aware of immediate needs. The network has systems in place to support early care planning and preparation where possible i.e. The health board is aware of the number of patients likely to be transferred 'Rehabilitation prescription' describes nursing and therapy needs prior to repatriation. Rehabilitation coordinators link with counterparts in UHW to ensure our rehabilitation offer is clear to the patient and their family prior to transfer.	The development of the business case will require support from business partners in planning, HR and finance. Recurrent investment may be required as an outcome of the business case	Quality & Safety Committee	15	6	New Risk	10/09/2020	31.12.2020
4248	Executive Director of Operations Rhondda Taf Ely ILG	Provide high quality, evidence based, and accessible care.	Care of Patients with Mental Health needs on Community Hospital Sites.	**If:** there is a consistent number of patients with mental health needs which are being cared for in community hospital without RMN support or there are delays in discharge to the appropriate EMI setting. **Then:** Patients who have been sectioned and/or are under medication review may remain on the community ward where specialist mental health therapies and input is not possible. **Resulting In:** Incidents of staff and patient assaults may occur. Poor patient experience as not receiving the appropriate support in the appropriate setting. Staff impact due to increased supervision being required to manage behaviour..	MHL Team contacted for each patient for support 1:1 Supervision provided for each patient to reduce risk of harm Ward Manager and Senior Nurse Review patients daily 13/08/2020- reviewed in Tier 2 Gov meeting- new risk gone onto register. Remains high risk 14/08/2020 - remains high risk, Senior Nurse liaising with Mental Health team to establish if mental health can provide some more support to staff on the ward. There are currently 9 patients on site needing input from the mental health team.	See Control Measures	Quality & Safety Committee	15	6	New Risk to Org RR	10/08/2020	31.12.2020

Datix ID	Executive Portfolio	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	Trend	Opened	Closed
4097	Director of Workforce & OD	Patient / Staff & Public Safety - Physical and /or psychological harm	Failure to meet Fire Safety Standards across the Health Board	**IF:** The Health Board fails to meet fire standards across its estate. **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, enforcement notices and/or prohibition notices.	•Training, Fire Wardens, and Fire Evacuation plans in place Robust risk assessment processes in place to ensure the Board manages and mitigates identified risks; •Implementation of Action Plans in response to pro active risk assessments. •Alignment (where appropriate) of UHB risk assessment processes with those of Fire Service •Constructive and positive working relationship in place with SWF&R Service and regular meetings between senior staff with at least Annual review meetings being led by CEO and Chief Fire Safety & Rescue Officer. •Other enforcement actions taken for example ICU at Royal Glamorgan Hospital, but plan in place to address and agreed with SWF&R service. •Ongoing work at the POW site – identification of key issues and mitigation	Pro active management via ILG's to ensure profile for fire safety remains high. Ongoing Formal Annual Reviews with South Wales Fire and Rescue Service as well as Regular inspections and dialogue with South Wales Fire & Rescue Service. Ongoing Robust risk assessment processes in place and good compliance with staff training uptake to be sustained.- Ongoing RCA being carried out into the fire alarm in PCH pre Christmas to assess the effectiveness of the response and take action where appropriate to improve and ensure compliance Director of Therapies and HS February 2020	Health, Safety & Fire Sub Committee Quality & Safety Committee	Closed	Closed	Closed	01/10/2009	9.11.2020 This risk has been closed and replaced by Risks 4392, 4360, 4356, 4315 which better articulate the fire risks within the organisation.
3915	Director of Operations Merthyr & Cynon ILG	Impact on the safety of patients, staff or public (physical/psychological harm)	Ligature Points - Inpatient Rehabilitation Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	Increased Staff observations in areas where risks have been identified. Any areas of the unit not being occupied by patients are to be kept locked to minimise risks.		Quality & Safety Committee	Closed	Closed	Closed	Closed	9.11.2020 This risk has been almalgamated within an ILG wide risk on Ligature Points – Datix Risk ID 4253.

AGENDA ITEM
5.2

QUALITY & SAFETY COMMITTEE

LEARNING Disability SERVICES and COVID 19

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Swansea Bay Learning Disability Services & Head of Nursing
Presented by	Julie Denley Director of Primary, Community Mental Health Services
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Joint Commissioning Group – learning Disability	(18/12/2021)	NOTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to advise CTMUHB Quality & Safety Committee regarding the Impact of COVID-19 on the population of people with Learning Disabilities, service challenges and related activity pertinent to the Quality and Safety agenda. See full report in Appendix 1.

1.2 Swansea Bay University Health Board provide Learning Disability Services for the population of CTMUHB. The Director of Primary Community & Mental Health chairs a Joint Commissioning Provider meeting for Learning Disability Services where alongside Cardiff & Vale University Health board as joint commissioners significant work has been undertaken to strengthen oversight and seek assurance for Board in relation to the provision of Learning Disability Services.

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

2.1 See full report in Appendix.

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

3.1 See full report in Appendix.

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)	Staying Healthy
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail 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 Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5. RECOMMENDATION

5.1 The Committee are being asked to **DISCUSS** and **NOTE** the report.

Meeting Date	**18 January 2021**	**Agenda Item**	
Report Title	**Learning Disability and COVID 19 Report to CTM Quality and Safety Committee**		
Report Author	Dr Rhonwen Parry and Paula Hopes		
Report Sponsor	Learning Disability Joint Commissioning Group		
Presented by	Stephen Jones, Nurse Director, Mental Health & Learning Disabilities (SBUHB) / Julie Denley Director Primary, Community, Mental Health		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to advise CTMUHB Quality & Safety Committee regarding the Impact of COVID-19 on the population of people with Learning Disabilities, service challenges and related activity pertinent to the Quality and Safety Agenda.		
Key Issues	• Health Inequalities further exacerbated by COVID-19 for the learning disability population. • Key Health Indicators as risk factors to morbidity associated with COVID-19. • Considerable redesign of clinical services to ensure that people with learning disabilities (and their families and/or carers) have access to high quality clinical expertise within the constraints of measures imposed through the COVID-19 Pandemic. • Quality assurance through establishment of standard operating procedures associated with a range of adaptations to address IG requirements (associated with remote working), new modes of service delivery e.g. through on-line platforms, informed consent, risk assessments and prioritisation criteria (within the constraints of statutory COVID-19 requirements). • Innovations through the service – MDT innovations have been recognised attracting a range of awards. • SBUHB has supported Welsh Government in the production of a COVID-19 App focusing on Psychological First Aid. • Colleagues have worked on the All Wales Guidelines on the Management of COVID-19 in the Community - developing a video tutorial specific to		

	people with learning disabilities with the Institute of Clinical Science and Technology. • The reducing restrictive practice agenda has remained a priority with SBUHB colleagues delivering webinars on least restrictive approaches through Covid-19 and active involvement in the All Wales Reducing Restrictive Practice working Group.			
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☒	☐
Recommendations	Members are asked to: • **NOTE CONTENT**			

1. SITUATION

The current Pandemic poses specific challenges to people with learning disabilities, their families and / or carers. These include the following, but is not a full representative list:

- minimising the risk of COVID transmission and infection;
- understanding of and access to information on the virus;
- risks of home support breaking down due to infection of the person or support staff;
- risk of increased agitation and distress associated with social constraints and special COVID measures;
- risk of placement breakdown due to any one of these factors and because of behavioural challenges.

Through the pandemic reports indicate that there has been a greater demand on front facing Learning Disability services (e.g. increase in requests for psycho-trophic medication and direct support to manage challenging behaviour). In addition, shielding and isolation measures imposed by Welsh Government Guidance that have needed to be observed in the interest of a significant proportion of the learning disability population due to co-morbid physical presentations. These have been enormously challenging for families and services raising additional potential concerns in regards to safeguarding and the protection of individual human rights and liberty – each of these have been tested through individual decision making and jointly in response to the publication of the guidance through strategic links at national forums.

The impact of all such measures has called for considerable multi-professional expertise to re-design services to enable ready access where possible and prevent further deterioration in the health status of people accessing and in receipt of services which we have sought to undertake robustly whilst seeking to balance the needs of the individual and the requirements of guidance / legislation.

Since the commencement of the covid19 pandemic in March 2020, three of the learning disability inpatient areas have experienced covid19 infection that has met the WG criteria of an outbreak and as such have been managed in accordance with SBU

HB nosocomial procedures. The units effected have been Lletty Newydd (Whitchurch), Bryn Afon (Ferndale) & Ty Garth Newydd (Church Village) demonstrating a spread across the C & V and CTMUHB footprint. In total, across all 3 units all 13 patients tested positive for covid19 even though some patients were asymptomatic.

2. BACKGROUND

It is noted that many people with learning disabilities are at greater risk of infection as a result of a higher prevalence of co-morbid physical health conditions, high prevalence of mental health disorders and high level of social support needs (LeDER review May 2020). Underlying existing health problems, particularly those related to respiratory function, immune system function, heart disease and diabetes are over represented within the population of people with learning disabilities leading to a higher risk of premature death. Depending on the underlying health condition, people with a learning disability may be at greater risk of developing more severe symptoms of COVID-19 if they become infected thus people they are disproportionately impacted by the pandemic particularly given the serious disruption to the services they rely on.

In a review of concerns pertaining to COVID-19 (Tromans et al. 2020) top ranked concerns related to:

a. Mental health and challenging behaviour
b. Physical health and epilepsy
c. Social circumstances and support

3. ASSESSMENT

As mentioned earlier there have been three inpatient unit outbreaks to date. Given that during each outbreak all patients were covid19 positive, implementation of the covid19 clinical pathway into the designated isolation unit was not initiated as there was deemed to be no clinical benefit for patients given that each unit in its circumstance was in isolation.

As part of the outbreak management process, infection Prevention Control measures were reviewed across all areas as part of the management of the outbreak with action plans implemented and lessons learnt being shared across other LD units across the commissioning footprint.

Psychological systems of support have also been introduced across the areas to ensure staff wellbeing.

In Bryn Afon there was the sudden and sad loss of a member of staff through secondary effects of covid19. SBU HB are implementing a serious incident investigation as per WG guidance to examine any lessons learnt and we as a health board have formally passed on our condolences.

From an LD community perspective the impact of covid19 on persons known to community services contacting the virus has appeared to be minimal to date. The main impact seen for LD person in our community services has been around the closure of

local authority day care services and community systems of support placing additional strain on family members and CLDT as they worked to meet the support needs of individuals and their families.

Despite the challenges, Covid-19 has also provided opportunity for services to capitalise on the use of technology, to modernise services and evolve practice. There have been adaptations to service delivery and prioritisation of caseloads using systems to highlight areas of key need and support.

Of particular note is the development of a single point access leading to other improvements related to pathway assessment and intervention approaches, legal considerations e.g. Safeguarding, Mental Health Act (S.17 Leave for example), as well as improved partnerships with the Health Board Information Governance and Infection Control Teams and allowing innovation and creativity within frameworks and policy.

4. RESULTS

The following detail, although not exhaustive, highlights some of the key achievements in response to the pandemic as it has impacted the learning disability population:

Range of targeted interventions

- Promotion and dissemination of accessible information / communication including 'easy read' formats
- Remote delivery of therapy interventions
- Remote clinics / consultations using 'Attend Anywhere' software
- Prioritisation of services using RAG ratings and delivery of accessible well-being packs
- Pathway development in single point access areas
- Staff well-being initiatives - the delivery of 'Giving Care Taking Care mini rounds' (collaboration between Psychology and Swansea Bay Staff Well-being)
- Psychology support to Staff Well-being telephone support line in early period of the pandemic and recruitment of additional counsellors to increase capacity through Staff Well-being to support staff
- Targeted Psychology support to 'outbreak' areas
- Targeted support from the Specialist Behavioural Team to inpatient areas
- Effective deployment of staffing resource to respond to staffing 'hotspot' areas, including the mobilising of community staff to inpatient areas

Development of new processes

- Single point of access for acute admissions to reduce infection / risk of transmission (Single Point of Admission – initially through Dan Y Deri, now via Hafod Y Wennol)
- Established isolation area, closely working with Infection Prevention Control personnel to ensure a robust response to the incidence of infection including appropriate testing regimens

- Developing and interpreting guidance, supporting understanding and implementation e.g. visiting with a purpose, section 17 leave, creative use of technology etc. including 'easy read' versions that ensures accessibility to all

National work and UK wide input

- Work on the Annual Health Check and delivery through Covid-19 with Welsh Government / Improvement Cymru and the role of cluster links from Learning Disability Community Teams
- Paper presented to the Covid-19 Moral Ethical Guidance Advisory Group on testing and ethical / moral dilemmas for staff and providers supporting people with learning disabilities
- Advocated for rights based, person centred approaches and individualised risk assessments throughout the pandemic
- Webinar delivery on reducing restrictive practice during Covid-19
- Psychology contribution to an All Wales COVID App with a focus on Psychological First Aid to support staff and the general population.

Media and use of technology

- Update to SBUHB website with Covid-19 specific information
- On-line platforms and social media to share practice, communication and present accessible information
- Virtual teaching sessions and delivery of 'Lunch and Learn' events in line with our events calendar; promoted virtual learning across all services
- Collections of digital stories - people with learning disabilities and staff who have described their experience of Covid-19
- Delivery of and attendance at online training
- See above re: All Wales Covid App.

Awards and recognition

- Hafod Y Wennol (Assessment and Treatment Facility) and Clare Wyatt, Community Nurse in RCT, received the practice supervision / practice assessor award from Swansea University.
- A number of placement areas and mentors have been commended for their support to student nurses through the pandemic.
- We continue to recognise our colleagues across services with postcards of appreciation, hero award nominations and recognition awards such as Cavell Stars, nominations for internal and external recognition.
- Combined efforts from psychology to support staff well-being recognised nationally with Swansea Bay Staff Well-being Team awarded Well-being Team of the Year 2020 (National Occupational Health Awards).

5. RECOMMENDATION

The Quality and Safety Committee asked to discuss note the content of this report.

Reference:

Tromans et al. (2020) Priority Concerns for people with intellectual and developmental disabilities during the COVID-19 pandemic. Cambridge University Press.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

AGENDA ITEM
6.1.1

QUALITY & SAFETY COMMITTEE

Improving Quality & preventing reOccuraNce

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Valerie Wilson, Director of Midwifery/Maternity Improvement Director
Presented by	Valerie Wilson, Director of Midwifery/Maternity Improvement Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
SUI	Serious Untoward Incidents
WG	Welsh Government
IMSOP	Independent Maternity Services Oversight Panel
CTMUHB	Cwm Taf Morgannwg University Health Board
RCOG	Royal College of Obstetricians & Gynaecologist
RCA	Root Cause Analysis

MDT	Multi-Disciplinary Team
DU	Delivery Unit
WRP	Welsh Risk Pool
CYP	Children & Young People
SI	Serious Incident

1. SITUATION/BACKGROUND

All outstanding SUI's which have been reported to WG since 1 October 2018, have been reviewed by an independent review team as part of the IMSOP process. The review team found that a number of reports did not ensure inclusion of the Neonatal care within the report, and that the scope of the investigations previously carried out/completed required this inclusion to meet the standard for completion. There has been significant progress with the management of SUIs within CTMUHB, prior to and since the RCOG report, which highlighted concerns with:

- Staff not received RCA training
- RCA completion predominantly by a Midwife with no MDT review
- Lack of timely completion

Since 2018, the management of SUIs has evolved to include many aspects required, as set out by the DU & WRP which included:

- MDT rapid review of the case (within 72 hours)
- Investigation not Midwifery led but inclusive of the MDT as required
- Scope of investigation, predominantly from booking until birth, with belief that any concerns with Neonatal care would be escalated within CYP and investigated accordingly
- Improved understanding of the requirement for SMART action plans
- Development of staff training programme (incident reporting and RCA investigation)
- Development of Senior MDT review for all moderate and above incidents, including SI sign off
- Mapping of Maternity Governance against new Health Board processes
- Development of integrated Governance process (Maternity/Neonatal)
- Improved learning to prevent recurrence
- Improve staff communication

The implementation of RCA training has been organisationally led, with 3 staff completing the training in March, 2020 and a further 3 in June 2020. The Directorate held a whole day RCA for the MDT on the 31 July 2020 with 23 members of staff booked to attend. The numbers of those able to complete an RCA investigation will support a more robust and multi Clinician led process, with subsequent improved completion timescales. A number of staff will be offered the opportunity to undertake Health Board R investigation training in January 2021.

The Service is now fully aligned with the Health Board Serious Incident toolkit, and is using the IMSOP/WG assurance checklist as its internal assurance tool. The Associate Director of Patient Safety and Director of Midwifery undertake final quality assurance using the checklist prior to internal sign off.

All action plans have been reviewed to ensure all fundamental factors, root causes and lessons learned have been incorporated and strengthened, if necessary.

To date, no new actions relate to issues not previously identified and included in other improvements. The Service will continue to monitor this closely, and as the number of completed investigations grow, the Service will undertake periodic thematic reviews to monitor this, and to support a final report once all investigations are complete. Closure of action plans will be monitored and included in reporting.

An experienced investigator was allocated 3 days per week to manage the backlog, and following a period of benchmarking and information gathering, the Service has been submitting a steady number each week. Please see table below. The investigator had taken leave week commencing 7.12.20 and, unfortunately, then succumbed to COVID. COVID related service pressure resulted in no additional resource being identified. Therefore, the anticipated progress was not made during December.

The Health Board has supported the Programme with some additional resource and 5 SIs have been allocated to a member of the Corporate Team. Work has been undertaken to identify what additional actions are required for those cases and the information shared back to the Service.

Conversations have begun to assess the possibility of procuring additional external resources to support a more timely resolution to the backlog.

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

46 serious incidents in the identified backlog

2 cases are included in the IMSOP review and are therefore not for Health Board investigation, leaving 44 for on-going review and improvement

Update 31.12.2020								
Process	6 Nov	13 Nov	20 Nov	27 Nov	4 Dec	111 Dec	18 Dec	30 Dec
IMSOP review	2	2	2	2	2	No Progress Lead on A/L and service pressure	2	2
Awaiting Neonatal review	6	2	2	2	2		1	1
Awaiting start	15	1						
In progress	21	30	32	30	28		32	31
Senior service QA	1	8	3	5	5		2	3
HB sign off	0	1	5	1	1		0	0
WG sign off/complete	1	2	2	6	8		9	9
TOTAL	46	46	46	46	46		46	46

Themes of Incidents (as reported on Datix prior to investigation)

NB – some incidents had multiple triggers

Intra partum Still birth	2
Antenatal still birth	4
Therapeutic Cooling	18
Inappropriate care	10
Sepsis	1
Neonatal Death	2
Undiagnosed Breech	2
Birth Injury	3
ITU Admission	5
Fall	3
Cardiac arrest	1
Faulty equipment	1
Never Event	2
Complications of Surgery	2

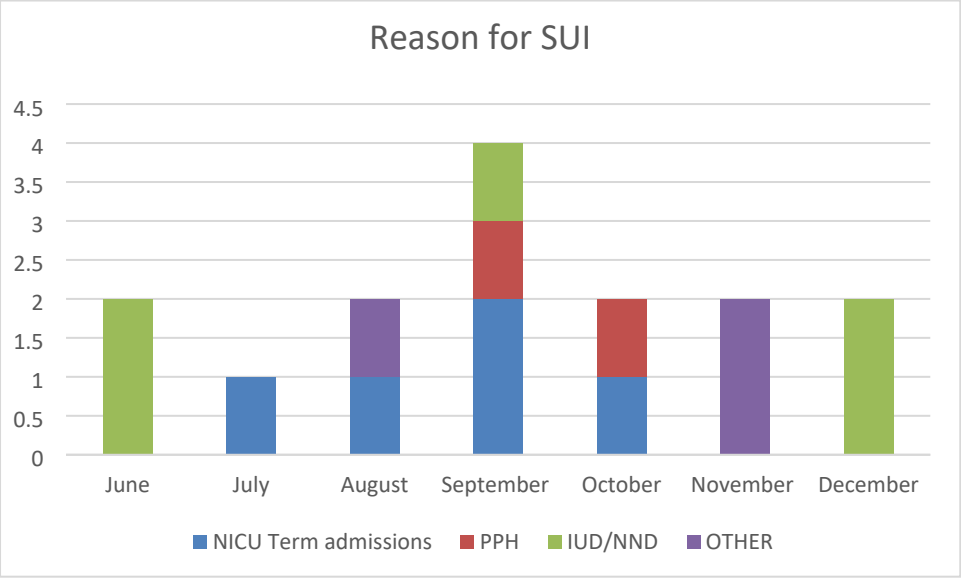
Current Serious Incidents

The Maternity Governance Team is experiencing a significant challenge. It is a relatively small team:

1 wte 8a
1.2 wte Band 7 for 3 sites
1 Band 7 (temp from MIT funding)
1 Band 6 (Complaints Handler from MIT funding)

1 member of the Team is allocated to the SI backlog (Band 7 0.6wte) and 1 member of the Team is sadly on long term sick leave (Band 7 0.6 wte). Short-term backfill has been identified to cover sickness, however, there is no internal back-fill from staff with the requisite investigation experience. We have recently recruited an experienced Quality & Safety Lead Midwife (Band 8a) who will bring significant governance knowledge to the Team. The Team is also currently supported by an additional Band 7 Midwife, funded via the Maternity Improvement Team.

The recent COVID upsurge has placed exceptional pressure on the Clinical teams who would, ordinarily have supported the investigations, which is resulting in delays. The Service has prioritised the weekly site based incident review meetings and the Senior Team Service wide review of moderate and above incidents to ensure make safes are identified in a timely manner to prevent recurrence, where possible.



NICU	Neonatal Unit at term
PHH	Post-Partum Haemorrhage
IUD/ NND	Intrauterine Death/ Neonatal Death
Other	Breast Milk Storage Baby failing from bed Placenta not arrived for histology

Due for Closure						
Sept	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
1	**1**	**1**	**5**	**2**	**2**	**3**

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

- Risk to patient experience if investigations are further delayed or of a poor quality
- Risk of increased regulatory concern of patient experience and patient risk
- Risk to Organisational reputation

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The Service is now fully aligned with the Health Board Serious Incident toolkit, and is using the IMSOP/WG assurance checklist as its internal assurance tool.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail 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)
	Staff resource impact captured in section 2
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

- **NOTE** the report.
- Monitor progress weekly
- Escalate any potential Improvement Board and ILG reporting structure
- Identify additional external support and complete investigations in the backlog
- Include 1wte Band 7 Midwifery post in MIT proposal for 21/22 to support backlog, learning, training and embedding a sustainable SI process
- Increase substantive Band 7 posts from 1.2 WTE to 2.0 WTE

AGENDA ITEM
6.1.2

QUALITY & SAFETY COMMITTEE

Resilience in the workforce in maternity services

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Valerie Wilson, Director of Midwifery/Maternity Improvement Director Kathy Greaves, Deputy Head of Midwifery Sarah Fox, Deputy of Head of Midwifery
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	

Purpose of the Report

This report provides an overview of the current staffing position, to the end of 2020 and focussing particularly on Midwifery within Maternity Services.

Staffing in the Service has been affected significantly by COVID. This is in line with all other Clinical Services, but the lack of resilience in the Workforce, when absence levels increase, is demonstrated.

1. SITUATION/BACKGROUND

1.1 Due to COVID, workforce resilience is severely tested.

1.2 The Maternity Service has used Birthrate plus (BR+) as a framework for workforce planning and strategic decision-making. It is a national tool which has been in constant use in UK Maternity units since 1988.

The surge in COVID infections rates has resulted in an absence rate, due to COVID & non-COVID sickness, of up to 30% in December, 2020.

The Midwifery Bank is not able to fill all absence.

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

2.1 All data/charts follow in Appendix 1.

Managing Sickness

Sickness absence, both long and short-term, is being managed sensitively and robustly in line with the Health Board Sickness & Absence policy. The Effectiveness of this is shown in charts 1 & 2.

Managing Leave

Leave is managed carefully throughout the Service. Charts 3 & 4 show how generally leave falls below the 26.9% recommended maximum level (BR+).

Managing Acuity

Birth Rate Plus acuity tool is implemented and utilised in both Obstetric Units in the Health Board. It requires 4-hourly monitoring, across the 24 hour period, 7 days per week, of the levels of activity, assessing the complexity of the women's needs on the Labour Ward, relative to the available Midwifery staffing levels.

4 week's data was reviewed – 29.11.20 – 27.12.20.

Although there is some concern relating to the efficacy of the tool, it does identify that in approximately 25% of the recording, the acuity exceeded the available Midwifery staff on the Labour Ward.

Acuity is reviewed by the Senior Team on a daily basis, and staffing reviewed weekly in the Senior Team meeting.

Managing Bank Usage

There is a limited Midwifery bank Service. This consists of Midwives, in the main, who are already employed by the Service who wish to supplement their salary.

Table 1 shows the vulnerability of the Service, when absence from work is high. Despite funding availability for Bank usage, there were no Midwives available to fill the depleted shifts.

This shortfall leaves the Service at risk and dependent on the escalation policy, which requires support from Specialist Midwives and, in particular, Community colleagues.

Utilising the Escalation Policy

During December the escalation policy was commenced:
Amber 7 times
Red 2 times

This does not accurately reflect all elements of the Escalation policy used, especially where Midwives are diverted to support acute Inpatient Services. It does not align with the acuity tool (BR+).

Senior Midwifery on-call
This rota is made up of Senior Midwifery Team members, Operational Band 7s or higher to support Clinical decision making, where needed, out of hours.

21 phone calls were made in December, the majority of which were relating to consideration of implementation of the Escalation policy.

Vacancies
There are currently 9 wte Midwife Band 6 vacancies in the Service. Interviews take place on 8.1.2021 and there are 12 applications shortlisted. These posts are across the localities and Service.

Birth Rate Plus
This tool (service last reviewed in November, 2019) demonstrates that the Clinical areas are compliant, see table 2.

When reviewing the report, it is now apparent that the role of the "Scrub Nurse", traditionally undertaken by a Midwife in Obstetric cases, was not included in the final report of wte Midwives required by the Service. This has been confirmed by BR+ via e-mail. This role requires 5.6 wte to cover the Service 24/7.

Birth Rate Plus recommend at 90%/10% split between Midwives and "Midwife Assistants", usually undertaken by Band 4. This has been incorporated in both localities, however, the Band 4 role is a Nursery Nurse, primarily supporting transitional care roles on the Maternity wards. An appropriately funded and staffed traditional care service for CTMUHB could enable this Band 4 role to appropriately support core Maternity Service roles e.g. Community support.

The Birth Rate Plus methodology has not changed to reflect the significant changes to the Public Health role of the Midwife, and the recommended leadership roles identified more recently.

The Health Board has supported development of these roles in excess of the 9% allowance, of total wte, identified in Birth Rate Plus.

There are a number of specialty roles that are not currently provided by the Health Board, or are provided but with less than adequate resource. These are particularly important, given the local demographic and consideration of these will be made during the Service review planned for 2021.

RECOMMENDATION

- Risk Register is updated to reflect the Service is exceeding the BR+ recommendation of 26.9% of staff on leave at any time.
- Invite BR+ Team to meet with the Service to explore how the acuity tool can be aligned to our Escalation policy
- Datix accurately reflects usage of the Escalation policy
- Recruit "at risk" 5.6 wte whist awaiting business case to be developed to support Theatre activity in the Maternity Unit on the PoWH locality
- Service review of transitional care to include Facilities and Workforce

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

3.1 None

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Patient Safety
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: Effective Care
Equality impact assessment completed	No (Include further detail 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)
	Workforce
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

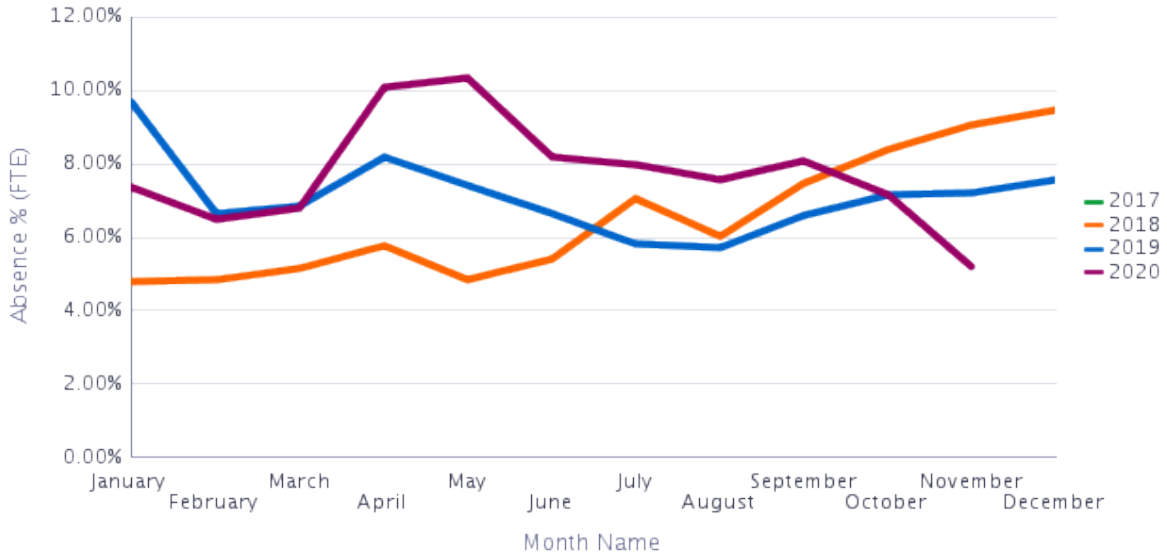
5.1 **NOTE** the report.

Appendix 1

Current workforce position

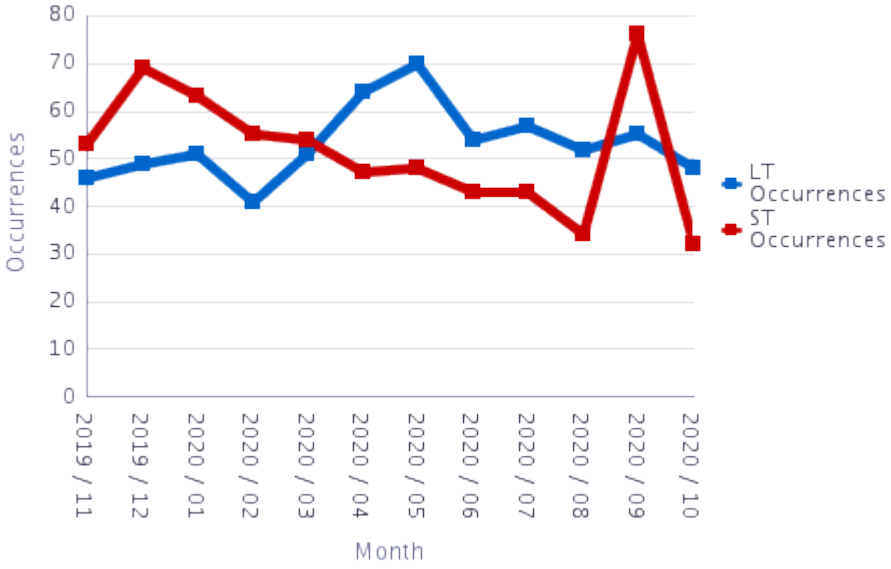
Sickness absence (both long term and short term) is being managed sensitively and robustly in line with the Health Board Sickness and Absence Policy. The effectiveness of this is shown in Chart 1 and 2.

Chart 1 - 3-year Sickness Absence % Trend



This chart shows a stabilising and steady drop of sickness absence from May 2020. The midwifery managers support staff by following the sickness and absence policy to keep in contact and to explore all possible mechanisms to facilitate return to work at the earliest opportunity when safe to do so.

Chart 2 - Absence Long Term / Short Term by %

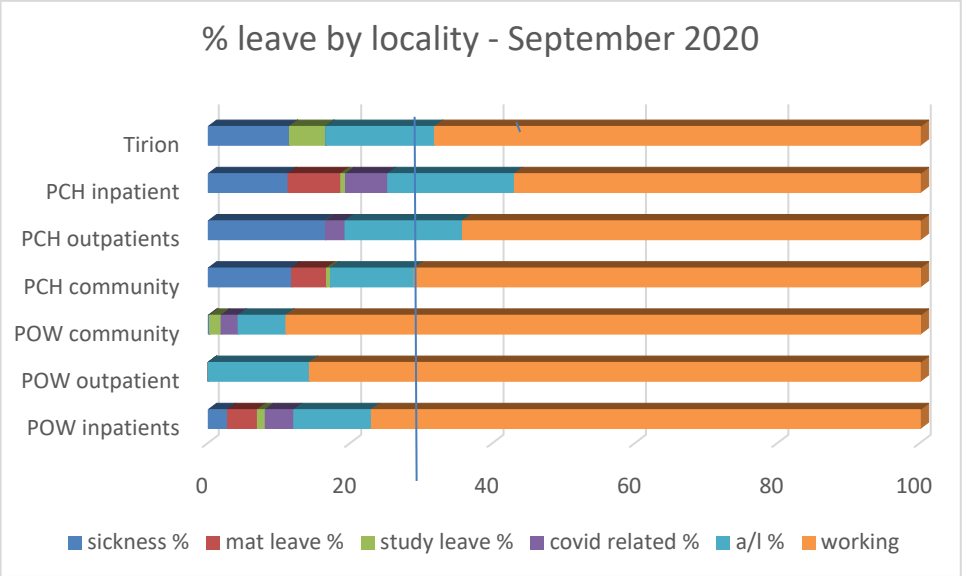


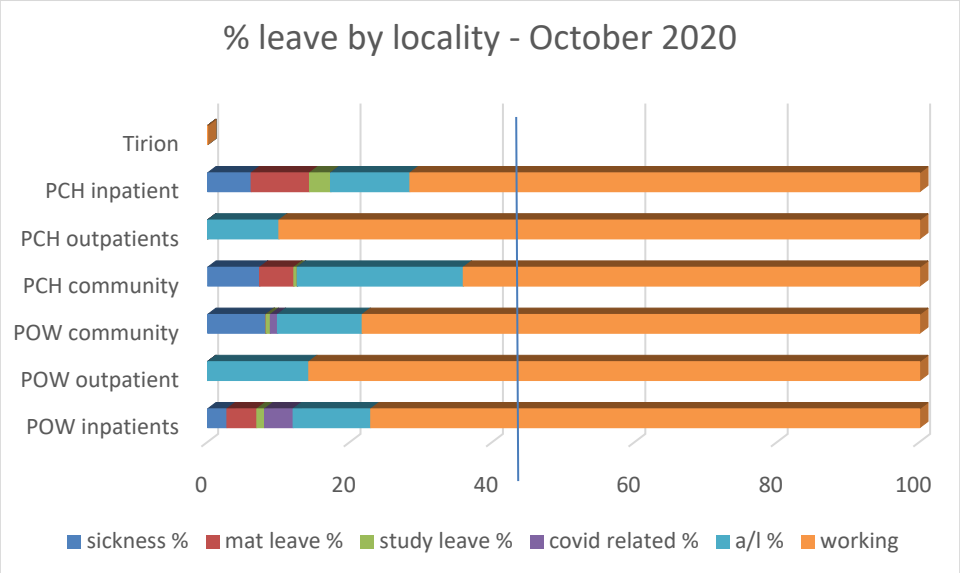
Long-term sickness is shown to match the trend in Chart 1. The peak in short term sickness seen in September 2020 may reflect the return to schools following the 6 months of home schooling imposed with Covid restrictions.

Leave is managed carefully throughout the service. This is shown in chart 3 and 4.

- Annual leave is agreed by department to ensure levels are even throughout the year
- Study leave is agreed annually through identification within PDR's and then service wide via senior management and Practice The Development Midwives
- Maternity leave is back filled (70%) when clinicians are available to do so

Chart 3 – 4





The line on the graph shows 26.9% - this is the level that Birthrate plus suggests is the maximum leave that should be taken by the workforce across the service. The service generally manages to stay within this guidance, although the smaller departments (such as out patients and Tirion) are more prone to breeching this when sickness levels rise.

Table 1 – backfill from bank for midwifery absence

	WTE absent	WTE bank	Deficit midwifery staffing across the service
w/c 7.12.20	32.18	10.52	- 21.66
w/c 14.12.20	47.89	8.12	- 39.77
w/c 21.12.20	48.8	9.57	- 39.23

This table shows the vulnerability of the service, when absence from work is high. In December when sickness (especially related to Covid) was extremely high, the ability to staff the service with bank midwives was limited. It is extremely difficult as midwives are exhausted and may not be in a position to undertake more hours. This leaves the service at risk and dependent on the escalation policy, which requires support from specialist midwives and in particular community colleagues.

Table 2 + 3 – Birthrate plus summary of recommended midwifery staffing levels

Clinical Midwives

Clinical Area	BR+ PCH	WTE PCH	BR+ POW	WTE POW
Acute inpatient	112.01*	99.54 MW 12.66 (band3/4)	55.12	49.0 MW 5.23 (band 4)
Community	36.31	43.00	21.99	20.26
Site total	**148.32**	**155.20**	**77.11**	**74.49**

Specialist/Managerial Midwives

Managers	1 Director of Midwifery 1 Deputy Head of Midwifery 4 Matrons 1 Consultant MW 4 acute band 7 managers (5x0.8) 4.8 com band 7 managers (6x0.8) **15.8WTE**	Birth Rate apply a 9% allowance for managers and specialist roles **20.56 WTE**
Specialist	1.0 Intrapartum Lead 2.4 CSFM 1 fetal surveillance 12. diabetes 1 public health 1.4 PDM 1.4 Bereavement 1.2 governance 1.2 infant feeding 0.26 substance misuse 1 patient experience 1 safeguarding 1 AN Screening **15.0 WTE**	

AGENDA ITEM
6.2.1

QUALITY & SAFETY COMMITTEE

BRIDGEND ILG QUALITY SAFETY AND EXPERIENCE REPORT

Date of meeting	19 January 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Cheryl Hucker, Head of Quality and Safety Bridgend ILG and Ana Llewellyn, Nurse Director and Chair Bridgend ILG Quality, Safety and Experience Group
Presented by	Ana Llewellyn, Nurse Director Anthony Gibson, Group Director
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
ILG Leadership Team	31/12/20	SUPPORTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ILG	Integrated Locality Group
CYP	Children and Young People

CAMHS	Child and Adolescent Mental Health Services
POWH	Princess of Wales Hospital
PALS	Patient Advice, Liaison Support
PTR	Putting Things Right
CSG	Clinical Service Group
QSC	Quality and Safety Committee
EDO	Executive Director of Operations
QSE	Quality, Safety and Experience
HIW	Healthcare Inspectorate Wales
PHW	Public Health Wales
PPE	Personal Protective Equipment
QSIP	Quality and Safety Improvement Plan
YS	Ysbyty Seren Field Hospital

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide members with an update on quality and safety issues in the Bridgend ILG.

1.2 On 1 April 2020 Bridgend ILG became responsible for Bridgend Acute and Mental Health Services. Bridgend ILG also became responsible for hosting CYP and CAMH Services for the entire Health Board. On 1 June 2020 Bridgend Primary Care Clusters and Community Services became the responsibility of Bridgend ILG.

1.3 By 1 February 2021 Maternity Services for Bridgend will transition to Bridgend ILG and CYP Services that are not in the Bridgend area will transition to Merthyr / Cynon ILG. Bridgend ILG will also assume responsibility for all Ophthalmology and Dermatology services across the Health Board.

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

COVID-19

2.1 Following a spike of COVID 19 positive patients at POWH in early October 2020 an outbreak was declared on 5 October 2020. Additionally, an outbreak was declared at Maesteg Hospital from 7 to 23 November 2020.

2.2 The Health Board convened its Outbreak Control Meeting on 5 October 2020 and Bridgend ILG also convened daily locality based Outbreak Control Meetings in response to the presenting situation. These meetings have now reduced in frequency. Monitoring is supported by auditing against the PHW 15 point action plan and undertaking SI reviews and RCAs for HCAI COVID 19 related deaths.

2.3 The ILG has reported a total of 69 HCAI COVID related deaths under the SI process during the period 19 October 2020 to 31 December 2020.

2.4 Outbreak Management strategies and actions were initiated to implement the PHW's 15-point plan. Bridgend ILG continue to work towards implementation of the PHW 15 point plan but given the ongoing challenges posed by increased demands on capacity and staffing across all services it has not been possible to fully enact the recommendations.

2.5 The ILG continues to experience some limitations in enacting the 15 point plan centered around three key recommendations as reported previously in its November paper to this committee:

- All unnecessary patient movements within the hospital cease forthwith. **Update**: Due consideration to the restriction of patient movements is given, but it is not always possible to adhere to this requirement due to the extraordinary site pressures being experienced. All movements are reviewed with IPC colleagues to minimize the risk of transmission.
- The creation of separate red, amber, purple and green wards and cohorting contacts of positive cases. **Update**: Red, Amber and Green areas have been created. All patients are tested for COVID

19 on admission to ED in order to ensure patients are admitted onto the correct pathway. This has contributed to the creation of bottlenecks within the ED area and inhibited flow across the site, and the timeliness of WAST patient handovers.

- Restrict staff movement and use of external agency in red COVID-19 areas. **Update:** A daily site-staffing meeting chaired by the acute site head of nursing, reviews staffing levels and movement across the site to maintain safe staffing levels and minimize staff movement, however due to recent high COVID related sickness rates this has not always been possible.

2.6 Ysbyty'r Seren which was opened in response to the initial outbreaks in October/ November continues to support Bridgend ILG and MC and RTE ILGs' discharge plans by receiving patients post COVID that are deemed to fit the criteria.

2.7 Data provided by PHW indicates that there has been a total of 447 COVID 19 positive patients identified within Bridgend ILG hospitals (since 30 September 2020).

2.8 There has been a total of 143 deaths in COVID 19 positive patients within Bridgend ILG hospitals (excluding Ysbyty'r Seren) since 30 September 2020.

2.9 PHW RCA is undertaken on all COVID related deaths occurring within 28 days of positive test result. HCAI associated deaths and outbreaks are reported to WG via DATIX and SI process and a stage 2 mortality review undertaken. The ILG is awaiting feedback from the independent review.

2.10 In addition to the challenges associated with delivering quality care to all patients when facing such unprecedented demand, the ILG continues to experience high levels of COVID related staff absence. The risks of this increasing absence rate are managed through daily site staffing meetings, but the ILG has seen an increase in locum and agency staff usage to maintain safe staffing levels.

2.11 Bridgend ILG received its first batch of COVID 19 vaccines on the 7/12/2020. As of 1 January 2021, a total of 3895 vaccinations had been administered. Vaccinations have been targeted towards staff and community populations in accordance with WG/PHW prioritisation guidelines. There have been significant staff concerns raised with the postponement of the second dose of vaccine in line with national guidance.

Resetting Services

2.12 Bridgend ILG initiated dynamic and responsive environmental and ward based changes in order to meet service demands arising from COVID 19 and Service Resetting prioritisation. This has included re-designing ED departments and environments to ensure that patients and staff are able to adhere to social distancing, PPE and strict hand hygiene requirements.

2.13 At the beginning of December 2020 and following comprehensive risk assessments and discussion through GOLD command, a Health Board wide decision has been made to cease all elective non-urgent work. This is to release staff to cope with the surges in critical care and acute bed forecast requirements as a result of the second wave and also to release staff to open further beds in Ysybty'r Seren.

2.14 At present only Emergency and Trauma surgery and essential cancer treatments and outpatients appointments for the above are being facilitated.

2.15 Bridgend ILG remains committed to prioritising Harm Reviews for patients with cancer experiencing delays in excess of 104 days. Harm review panels have been established, chaired by the ILG directors and are continuing despite current pressures.

2.16 Since March 2020 the ILG has treated 515 cancer patients throughout the tumor sites, of which 34 exceeded the 104 harm review panel timeframe. 18 harm reviews have been completed with no evidence of harm identified, the remainder of the backlog will be completed this month.

ILG Governance Framework

2.17 In December 2020, following up on the external review of CTM Governance arrangements undertaken in November 2019, the ILG participated in the HIW benchmarking exercise which is reviewing Governance arrangements across all Health Boards in Wales. The ILG is currently awaiting the report.

2.18 During January/February 2021 the ILG Head of Quality (who commenced in November 2020) will be undertaking a review of ILG Governance arrangements within the CSG's to supplement the HIW review undertaken in December 2020. The results will inform the

development of the ILG's Quality and Safety Improvement Plan (QSIP) which is to be drafted and submitted for approval via the ILG's QSE framework in readiness for proposed implementation commencing in April 2021.

2.19 In recognition of anomalies affecting the accuracy of DATIX reports within the ILG, the Governance Team is undertaking a cleansing and validation exercise throughout January 2021 to verify that reporting and notification structures have appropriately aligned to the ILGs CSG Management Structures.

2.20 Due to the current and extenuating circumstances regarding the second COVID 19 pandemic wave, CSG meetings have been temporarily suspended in line with CTM guidance.

Quality Assurance - data

2.21 The quality dashboard continues to develop and mature. Work is ongoing to disaggregate the data to reflect the ILG structures. A validation exercise is being undertaken within the ILG Governance Team to address this issue and will be completed by week commencing 8 February 2020.

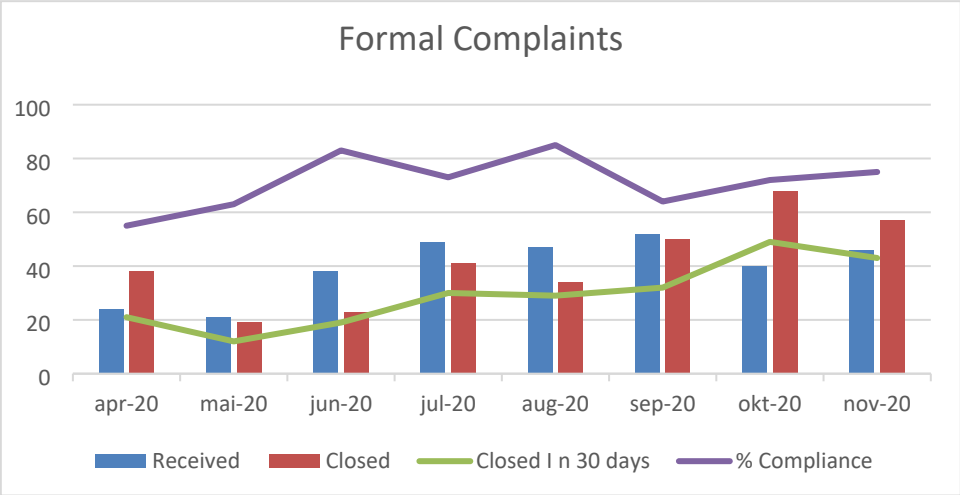
2.22 To ensure consistency of approach regarding data sets, processes and policies etc, Bridgend ILG continues to collaborate with other ILG and CTM colleagues to review, establish and embed CTM/Bridgend ILG QSE frameworks and develop robust and responsive dashboards.

Quality Assurance – Measures Of Note

2.23 The alignment of CAMHS/CYP/Community concerns management to the Bridgend ILG structure on 1 October 2020, and increase in COVID associated incidents accounts for the rise in reported SI's noted in the attached dashboard. It is anticipated that this trend will continue to develop through December 2020 and January 2021.

2.24 In addition to the COVID related SI's, there are currently 27 open serious incidents compared to 33 in the last report , 13 are out of compliance with the recommended Welsh Government target, of which 8 are in final approval stage. The majority of these are complex cases. The Governance Team are supporting the investigating officers to process these reviews.

2.25 The quality dashboard in **appendix one** provides an overview of the numbers in complaints in month and demonstrates that the number is within normal variation. Early data for December indicates that the ILG attained a 91% compliance to the 30 day complaint response target.



2.26 The dashboard shows that hospital acquired infections are within normal variation and members are asked note the continuing downward trend in C Difficile infections noted in the previous report. The ILG has established Joint Infection Prevention and Control, Anti Microbial meetings, and antimicrobial ward rounds in response to concerns regarding antibiotic stewardship and associated infection control implications.

Quality Assurance – Clinical Service Group Issues

2.27 **CYP and CAMHS CSG** advise that progress is being made against the action plan developed in response to the Royal College of Obstetricians (RCOG) review of Neonatal services report of 2019, which is being monitored and reported to Committee via the Maternity Improvement Programme Boards framework.

2.28 The Neonatal Services team have drafted a report for the next Quality Board /Committee which will provide an update on the Perinatal Mortality Reviews (PMRTS), lessons learned and actions underway to progress the same.

2.29 The ILG is working with the improvement program and CSG's to ensure a seamless transition of governance and quality arrangements as the new Women and Children CSG is established.

2.30 **Mental Health CSG** Previously the ILG raised issues of concern related to environmental ligature points. A contractor has now been approved and works will commence on ward 14 (POW) by mid January and will then continue to complete the remainder of the programme of works throughout 2021/2022 with completion of all areas programmed for early 2022/2023.

2.31 **Primary and Community CSG** As previously reported during July 2020 a number of separate concerns were raised about staff practice at Llynfi Ward at Maesteg Hospital. Considered together these concerns were suggestive of leadership and cultural issues that needed to be addressed. **Update**: Phase One and Two (Diagnostic and Analysis) of the Organisational Development action plan are now complete. Recommendations for OD intervention have been approved by the Leadership Team and Phase Three implementation is now progressing, but has been delayed with the closure of Llynfi ward relocation of staff to YS.

2.32 Bridgend ILG have placed the **CAMH Service** into Internal Enhanced Monitoring and Support due to a number of concerns in the service group including quality, performance and staff experience. A dedicated CAMHS Manager commenced in post on 2 November supported by an enhanced clinical leadership team. Stage one of the process to develop an overarching action plan has been completed and reviewed by the ILG, progress against this is being monitored by the ILG in weekly performance meetings, progress against the action plan remains at an early stage. (The high-level action plan forms part of the closed paper submission.)

2.33 **The Acute Service CSGs** main risks centre around significant and sustained pressure associated with COVID 19, staff absence and patient flow across the POWH site. Increasing levels of Staff absence primarily COVID related, has been exacerbated by the need to support the expansion of the field hospital and the increase in critical care beds, the actions to mitigate these have been previously described.

2.34 Ambulance offloads and ED pressures

Date	Number of Handovers Completed Within Specified Timeframe (Minutes) SOURCE : POW ED information system							Total Visits
	0-15:00	15:01-30:00	30:01-45:00	45:01-60:00	60:01-120:00	120:01-180:00	180:01+	
Oct 2020	284	241	122	53	59	42	73	874
Nov 2020	231	198	76	52	61	37	66	721
Dec 2020	195	195	86	60	98	46	107	787

Ambulance offload delays remain a continuing concern within the ILG and were part of the reason that the Princess of Wales Hospital was previously put into targeted intervention in December 2019 (which involved weekly support with the Delivery Unit to address progress). Some early progress was made very quickly working in partnership with Local Authority and WAST colleagues and by February 2020 the rapid improvements made were acknowledged by the Delivery unit.

Measures implemented to minimise the risks of HAI COVID infection in line with the PHW action plan have resulted in patients spending significantly longer in the ED with increasing numbers of patients spending >12 hours in the department, primarily due to access to rapid COVID swabs. These measures combined with significant challenges in discharging patients back to care homes has resulted in bottle necks through the system resulting in an increase in ambulance offload delays but without the previous actions being able to be implemented. The ILG is working with WAST colleagues daily to try and minimise any significant delays.

Mitigation of risk

-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.

The ILG is pleased to note that over the last 2 weeks the number of hours lost to ambulance delays has reduced as a result of the above actions.

2.35 The ILG is reviewing how ambulance delays are recorded on DATIX so that harm can be clearly identified, this will require working with WAST to capture the whole system effect of ambulance offload delays.

2.36 There are variances in the reporting process undertaken in POWH and the DGH's in other ILG's (different version of ED system linked to wider Swansea Bay information provision). The ILG are working with the information team to standardise reporting.

Management of Risk

2.37 The ILG's Risk Register for risks scoring over 15 was presented to the last Committee. Review of risks and CSG registers is progressing and is embedded in the ILG as part of the standing agenda for CSG and ILG QSE meetings.

2.38 There is still ongoing work to both rationalize and standardise the CSG risk registers, this work has been hampered by the operational pressures caused by the COVID pandemic

People's Experience

2.39 The PALS teams has continued to facilitate "virtual visiting" and the ILG has provided the service with additional resource to ensure the service can meet the needs of patients and families through the second wave of the pandemic. The service continues to receive excellent feedback.

2.40 The Laundry Service that facilitates the exchange of used and clean patient laundry is well subscribed to, and valued, by patients and relatives.

2.41 The Family Liaison Service, which is run by shielding clinical staff continues to develop. There are now 10 members of staff involved, mostly part time and working from home due to shielding, however, all wards now have a Family Liaison point of contact and positive relationships are being built with relatives. The Family Liaison Service is being extended to Ysbyty'r Seren, in January 2021.

External Inspections

2.42 Due to the pandemic HIW have adopted a new approach to inspections and have been undertaking Tier 1 Quality Checks. These comprise of a submission of evidence and a virtual interview.

2.43 In September 2020 the Older Adult Mental Health wards at Glanrhyd Hospital were reviewed and the report initially published in October 2020:https://hiw.org.uk/sites/default/files/2020-10/20201001AngeltonClinicGlanrhyden.pdf

2.44 The Improvement Plan for this Quality Check was not initially approved by HIW due to issues related to timescales of environmental works associated with ligature points. The Health Board met with HIW to resolve their concerns. A revised improvement plan was submitted and notification of HIW approval was received on 15 December 2020. At the time of writing, the revised improvement plan has not yet been published on the HIW website.

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

3.1 Members are asked to note the risks associated with ligature points in the Mental Health estates in Bridgend and progress being made toward the imminent commencement of the work programme which will be concluded throughout the Health Board through 2022/2023. **ACTION** Additional staff are still being rostered for night shifts and high risk areas in Bridgend as additional assurance until the remedial work is concluded.

3.2 Members are asked to note the risks associated with the COVID-19 Outbreak at POWH and the ongoing challenges to service delivery and patient safety posed by the concurrent escalation of the second

COVID 19 pandemic wave, which limits full and consistent implementation of the PHW 15 point plan. **ACTION** Bridgend ILG continues to work closely with PHW guidance and the Health Boards Silver Command and Outbreak Control Meetings to take appropriate action to control the spread of COVID 19 and ensure the safety of all ILG staff, patients and communities.

4. IMPACT ASSESSMENT

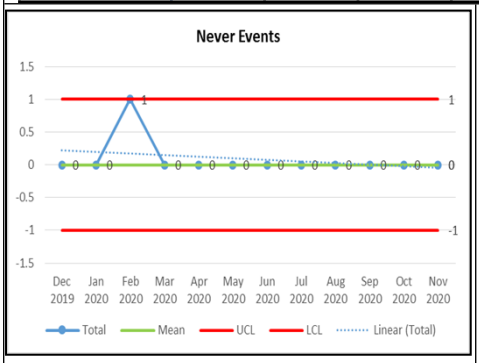
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified Care Effective Care Individual Care
Equality impact assessment completed	No (Include further detail 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 Well-being Objectives	Provide high quality, evidence based, and accessible care

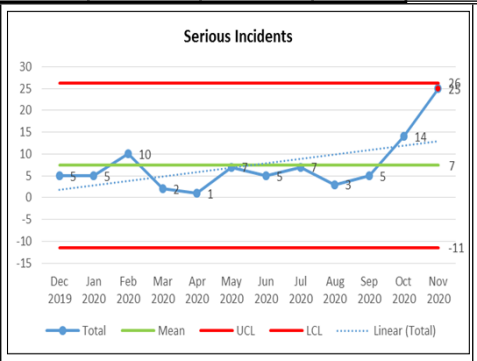
5. RECOMMENDATION

5.1 Members are asked to **NOTE** the progress outlined in this report and **DISCUSS** the matters for escalation.

Bridgend ILG Quality Dashboard – November 2020

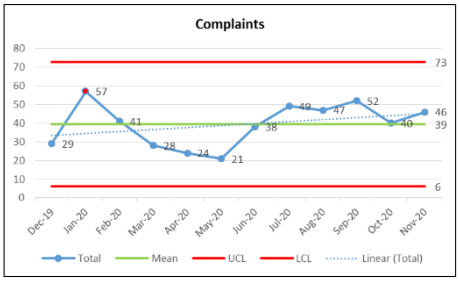
NE & SI	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Never Events	0	0	1	0	0	0	0	0	0	0	0	**0**
Serious Incidents	5	5	10	2	1	7	5	7	3	5	14	**25**

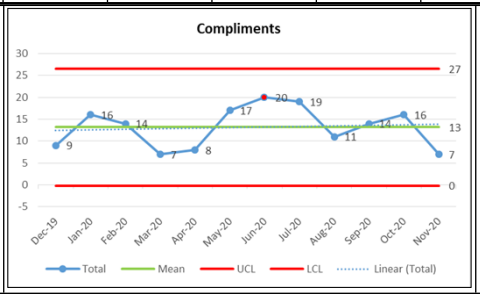




Never Events and Serious Incidents:
Although Serious Incidents for the reported period are within normal range there has been a significant increase in the volumes of SI's reported in October and November. This reflects the additional accountability and management arrangements effected by the alignment of CAMHS/CYP/Community Concerns data to BILG Governance Team on 1st October 2020. However reporting of COVID related SI's is a significant contributing factor to the acceleration towards the upper parameters. It is anticipated that this trend will develop in coming reports for Dec 2020 and January 2021.It is requested that the chart be annotated and recalibrated to reflect these changes in the next reporting cycle.

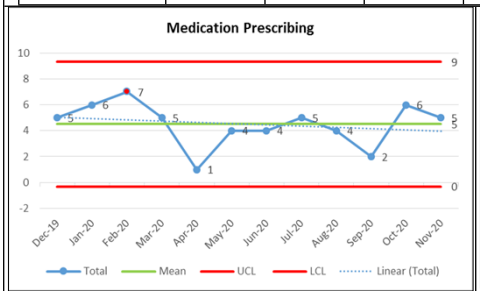
Complaints and Compliments	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Complaints	29	57	41	28	24	21	38	49	47	52	40	**46**
Compliments	9	16	14	7	8	17	20	19	11	14	16	**7**

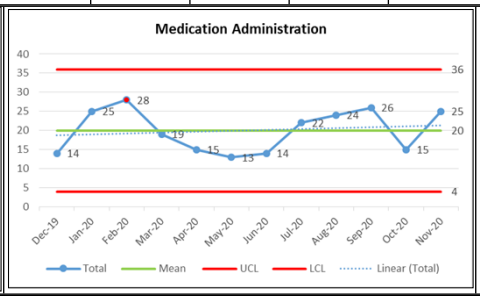




Complaints and Compliments:
The rate of complaints and compliments falls within normal ranges for Bridgend Locality.

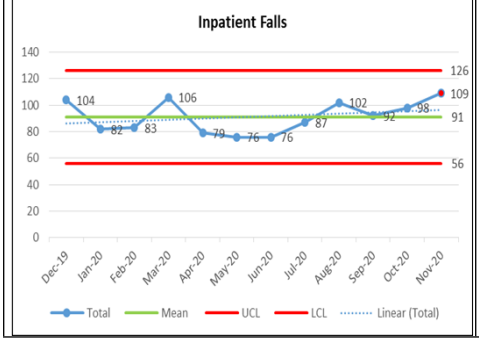
Medication	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Medication Prescribing	5	6	7	5	1	4	4	5	4	2	6	**5**
Medication Admin	14	25	28	19	15	13	14	22	24	26	15	**25**

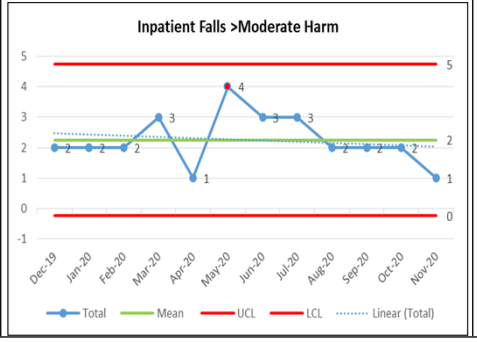




Medication:
Rates of medication incidents fall within normal ranges for Bridgend Locality.

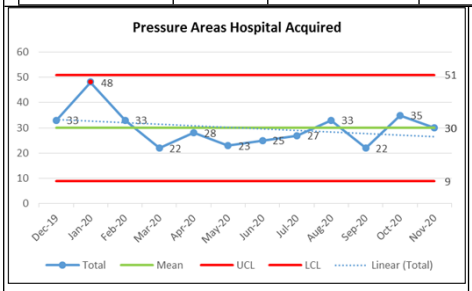
Falls	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Inpatient falls	104	82	83	106	79	76	76	87	102	92	98	**109**
>Moderate Harm	2	2	2	3	1	4	3	3	2	2	2	**1**

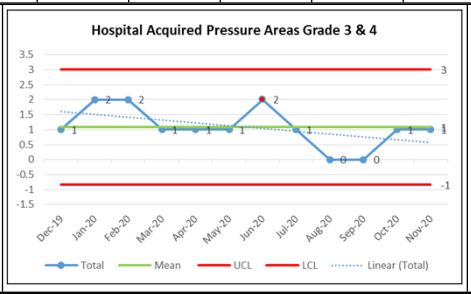




Falls:
Rates of patient falls and harm associated with falls continue to be within normal ranges for Bridgend locality.

Pressure Areas	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hospital Acquired	33	48	33	22	28	23	25	27	33	22	35	**30**
Grade 3/4	1	2	2	1	1	1	2	1	0	0	1	**1**

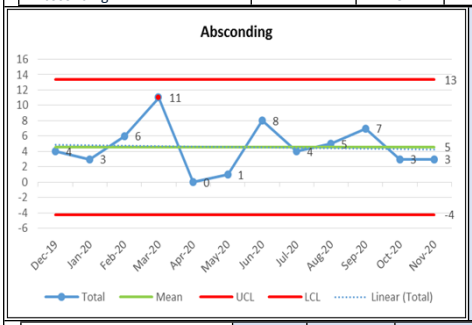




Pressure Areas

Pressure areas continue to fall within normal ranges for Bridgend Locality.

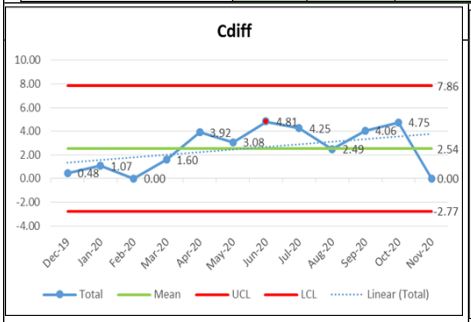
Absconding from Wards	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct-20	Nov-20
Absconding	4	3	6	11	0	1	8	4	5	7	3	3

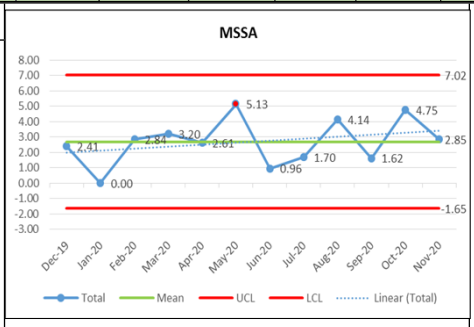


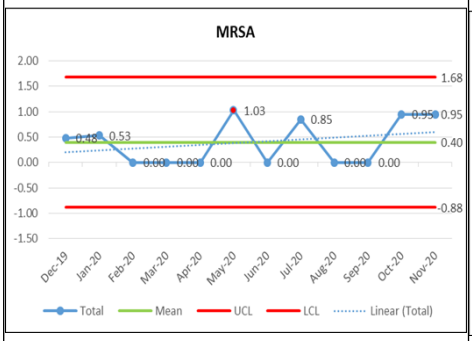
Absconding:

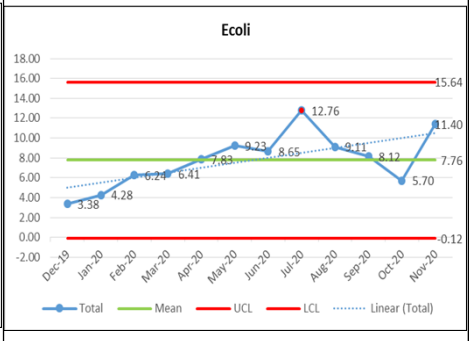
Absconding continues to fall within normal ranges for Bridgend Locality..

Infection Control	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
Cdiff /1000 admiss	0.48	1.07	0.00	1.60	3.92	3.08	4.81	4.25	2.49	4.06	4.75	0.00
MRSA/1000 admiss	0.48	0.53	0.00	0.00	0.00	1.03	0.00	0.85	0.00	0.00	0.95	0.95
MSSA/1000 admiss	2.41	0.00	2.84	3.20	2.61	5.13	0.96	1.70	4.14	1.62	4.75	2.85
Ecoli/1000 admiss	3.38	4.28	6.24	6.41	7.83	9.23	8.65	12.76	9.11	8.12	5.70	11.40









Infection Control:

Infection rates fall within normal ranges for Princess of Wales Hospital.

Members are asked to note that further data cleansing is required before the ILG can confirm the accuracy of data in this report. The ILG is undertaking a data cleansing exercise throughout January 2021 to ensure that CSGs and reporting structures are aligned.

AGENDA ITEM
6.2.2

QUALITY & SAFETY COMMITTEE

Quality and Safety Report fOR Rhondda & Taf Ely Locality

Date of meeting	19/01/2020
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Carole Tookey, ILG Nurse Director, Rhondda & Taf Ely
Presented by	Carole Tookey, ILG Nurse Director, Rhondda & Taf Ely
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**
Integrated Locality Leadership Team	11/01/2021	ENDORSED FOR APPROVAL

ACRONYMS	
AW (formerly WAO)	Audit Wales (formerly Wales Audit Office)
CTMUHB	Cwm Taf Morgannwg University Health Board
HCAI	Health Care Acquired Infection
HIW	Healthcare Inspectorate Wales

ILG	Integrated Locality Group
OCT	Outbreak Control Team
PHW	Public Health Wales
PTR	Putting Things Right
RGH	Royal Glamorgan Hospital
SI	Serious Incident
YCR	Ysbyty Cwm Rhondda

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Quality and Safety Committee with an update on Rhondda & Taf Ely (RTE) ILG patient quality, safety, risk and experience.

1.2 On 1 April 2020 Rhondda & Taf Ely ILG became responsible for the locality Acute and Mental Health Services. From 1 June 2020, Community Services and Primary Care clusters moved into the new Organisational ILG structure. The RTE ILG hosts Clinical Support Services (Pathology, Radiology, Bereavement services and Medical Records) for the whole of the Health Board as well as hosting Urology, Breast and Vascular services. Delivery arrangements for the outstanding hosted services have been finalized however the full realisation of the ILG operating model has been postponed until 31 January 2021.

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

COVID-19

2.1 The 'second wave' of the Covid-19 pandemic began early in RTE ILG with an outbreak having been ongoing at RGH since mid-September despite consistent efforts to control the rates of nosocomial Covid-19. Two outbreaks at the community hospital YCR have been quickly contained and brought under control. This has not proved to be achievable at RGH due to the number of wards and the necessity for patient flow through the site.

2.2 The 15 point action plan developed in conjunction with PHW has been completed which has been supplemented by additional actions arising from a site visit by a Public Health Consultant before Christmas.

2.3 The ILG has unfortunately had no choice but to restrict certain non-urgent services in order to prioritise acute care. Service restrictions were subject to comprehensive risk assessments / Quality Impact Assessments at the decision-making stage and will be lifted as soon as possible. This situation is replicated in the other ILGs in CTMUHB and across Health Boards in Wales.

2.4 The impact of high rates of staff sickness absence are being felt across all functions of the ILG. Staff deployment has been utilised once again to support the delivery of essential services.

2.5 The ILG is continuing to investigate the deaths of patients involved in the hospital outbreak who tested positive for Covid-19 prior to their passing (within 28 days as defined by PHW). This is being conducted through completion of the PHW HCAI toolkit, RCA reports of the outbreaks and Modified Stage 2 Mortality Reviews. The investigations to date have not yielded novel opportunities for learning and preventing recurrence and have served mainly to emphasise the high transmissibility of the disease.

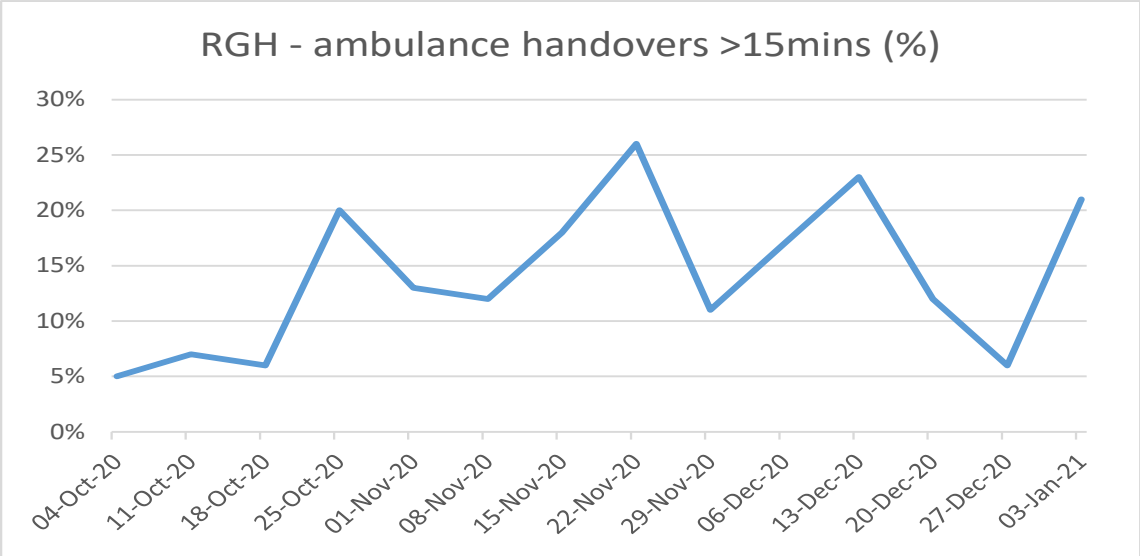
2.6 The roll out of the Covid-19 vaccination programme has been undertaken at pace and the locality has received and administered three entire batches of the Pfizer/BioNTech vaccine to frontline staff. This is now being successfully extended to care homes with mass public vaccination activity already in place. There are stringent training requirements for staff working as vaccinators to ensure appropriate standards of competence and safety are maintained.

Ambulance handovers to ED

2.7 As a result of the current challenges around Covid-19 and the Red (Covid positive) and Amber (Covid negative) pathways implemented within the acute DGH, it is acknowledged that we will encounter some delays due to patient flow movements within and out of the Emergency Department.

2.8 Consequently, there has been a significant increase in incidences of delays in being able to ensure that patients who arrive by ambulance

are handed over to the ED within the target timescale of 15 minutes. An incident report is completed for each patient not offloaded within 30 minutes. Due to anomalies in the way in which ED/WAST handover delays are reported, DATIX has not been able to provide meaningful and accurate data on the number of incidents occurring. The weekly data below has been taken from QLIK.



2.9 In response to this RGH ED has commenced weekly internal harm reviews whereby all patients held in ambulances delayed over 30 minutes are discussed to provide assurances that the standard of assessment, monitoring and intervention is appropriate. To date there has been no harm identified, although some specific learning around a patient who had sustained a fractured neck of femur has been identified.

2.10 The Welsh Ambulance Services NHS Trust (WAST) have alerted the Health Board (HB) to a number of possible SIs that have occurred in the community as a result of ambulances being delayed at ED departments. As the delays apply pan-HB, preliminary steps are being taken to understand the grading of harm in each case before arranging for formal SI reporting and centrally-coordinated investigation of these incidents.

ILG Quality and Safety Governance Framework

2.11 The ILG has participated fully in both the NHS Wales Shared Services Partnership (NWSSP) Internal audit of risk and the HIW/AW follow-up review of governance arrangements. We await the feedback and outcomes of these reviews and will ensure that recommendations are

incorporated into the quality and governance objectives for the ILG moving forwards.

2.12 The locality Patient Quality, Safety, Risk & Experience (QSRE) group is becoming more established with patient stories now included and these are being well-received as an opportunity for instrumental learning. In keeping with the decision to step-down all non-essential Health Board meetings, the next locality QSRE will take place in March. Monitoring and quality assurance continues through other processes such as concerns and incident management.

2.13 There have been early developments in designing a standardised Clinical Service Group (CSG) governance structure, reflective of the ILG governance structure. This work has necessarily taken a backseat against competing operational priorities such as the vaccination programme and pandemic activity.

2.14 The ILG has proactively approved a number of additional permanent and fixed term staff to augment the locality Quality and Governance Team. The additional workforce will support enhanced and more effective team functioning and enable the team to effectively manage the increase in governance work related to Covid-19 concerns and investigations. It is expected that as recruitment to a more robust structure takes place over coming months that a correlational improvement in concern handling and investigation processes becomes evident.

Clinical Harm Reviews

2.15 The first full RTE Cancer Harm Review Panel took place in December 2020 with an opportunity to review 2 moderate harm cases in detail which were subsequently determined to be Low harm. To date there has only been one case of Severe harm identified. This has been categorised as an SI and the investigation process is progressing, including informing and supporting the patient.

2.16 An extended harm review panel took place in early January 2021 to validate and provide panel approval to a backlog of No/Low harm cases that have accumulated due to previous panels being postponed. All completed cancer harm reviews have now been validated and outcomes approved. Completion of the remaining clinical harm reviews is delayed due to Covid-19 and equally the comparatively large number assigned to the Urology speciality.

2.17 The analysis of trends and themes emerging from the harm review panels is being undertaken and will be reported in the March committee meeting.

2.18 The RTE Cancer Harm Review Panel meeting for January 2021 has been stood down. In the interim period until the next meeting, the Locality Head of Quality will continue to monitor outcomes from completed harm reviews to progress them according to usual Health Board investigation processes should this be required.

2.19 Harm review process for RTTs and FUNBs remain at a planning stage in RTE ILG but a broad proposal is being developed that emphasises the importance of a prudent and proportionate approach given the large and growing number of patients that are experiencing treatment delays due to Covid-19. The approach will prioritise clinical time to patient-facing review and care and employ a screening based-approach to target those patients where harm is clinically assessed as having possibly occurred. This will narrow the scope of the harm reviews considerably but in a targeted manner so that the administrative burden associated with routine review completion is minimised.

2.20 **104 day cancer breaches** – please find below the current numbers of patients who have had, or require, a harm review.

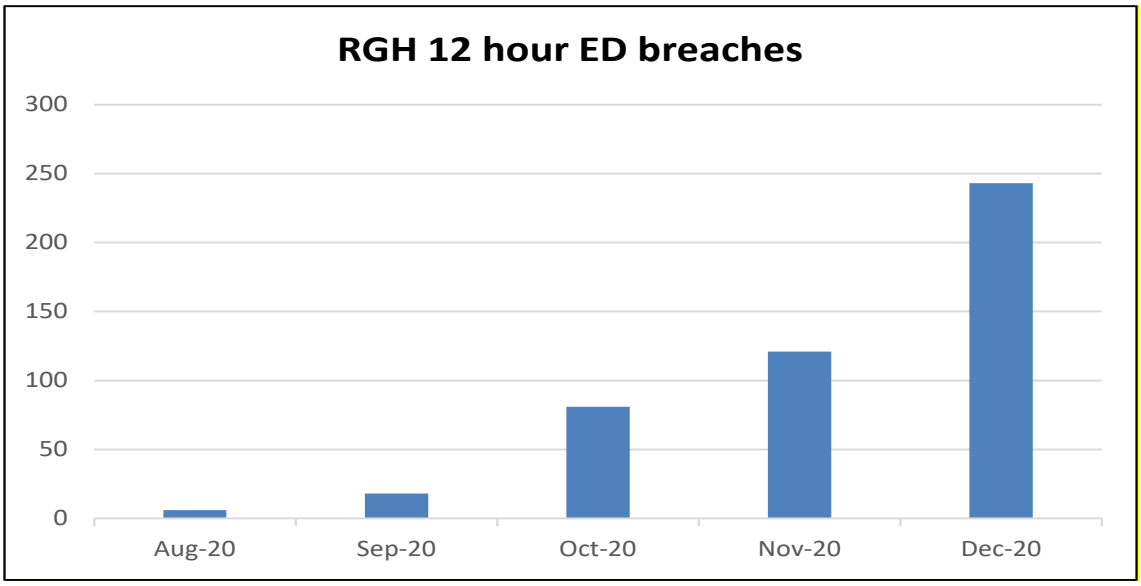
RTE Cancer Harm review - 104 day breaches

Specialty	Patients	Completed Harm Reviews	Outcome
Breast	1	1	1 No/Low harm
Colorectal	8	6	1 severe harm (SI) , 5 No/Low harm
Haematology	1	0	
Head and Neck	1	1	1 No/Low Harm
Lower GI	1	0	
Lung	2	0	
Urology	40	23	23 no/low harm
Total	**54**	**31**	

2.21 **ED 12 hour harm reviews** - the number of 12 hour breaches has increased to a hugely concerning level since the remodeling of admission pathways to reflect PHW guidance on preventing the spread of Covid-19. The breaches have largely resulted from delays in receiving Covid-

19 swab test results and increasingly due to delays in bed availability. A harm review and incident report of each 12 hour breach continues to be undertaken despite the current pressures. Patients are being made as comfortable as possible, receiving planned care interventions and dignity is being fully maintained.

The risks associated with overcrowding, delays to department waiting times and ambulance transfers have been entered onto the locality risk register.



Quality Assurance

2.22 The Committee is asked to note the RTE Locality Quality Dashboard up to November 2020 which is available in Appendix 1.

2.23 Further work on the triangulated RGH Acute dashboard is anticipated once the Locality Head of Performance and Information comes into post. Of note is that the large amount of ward moves and pathway remodeling will make month-on-month comparison difficult and impair the analysis of emerging trends and themes.

2.24 The accessibility and analysis of data at any level of granularity below the locality level remains challenging with the Datix system having once again undergone significant work in December and the CSG dashboards removed.

2.25 Planned HIW Quality Checks that were due to take place in January 2021 have been postponed due to pandemic activity.

Risk Management

2.26 Alignment of the locality risk register to reflect the new operating model was completed in early December. Unfortunately pandemic activity has hampered efforts by CSG Managers and Senior Clinicians to work on updating and reviewing their risks.

2.27 There are currently 40 risks scoring 15 or above on the ILG risk register however some of these are duplicated across each CSG (for example Covid-19 related treatment delays). Work between the Head of Quality (HoQ), the Assistant Director of Risk and Governance and the Datix team as to how best to capture these wide-reaching risks will continue in the New Year.

Patient Experience

2.28 Patient feedback and experience continues to be limited to the receipt of concerns and compliments. Due to continued visiting restrictions combined with a high number of acutely unwell patients, communication with clinical staff is unsurprisingly emerging as a common theme. Senior clinical managers are reinforcing the importance of ensuring empathic and frequent contact with families and relatives but this is reported to be challenging given the staffing shortages.

2.29 Performance against the 85% 30 day PTR formal concerns response target has decreased due to limited availability of clinicians and staff absence. The ILG Quality team is ensuring however that responses remain of a high standard and that complainants are contacted with regularity to inform them of the reasons for any delays.

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

3.1 Difficulties in addressing required improvements in quality Key Performance Indicators (KPIs) due to lack of data availability at CSG level on Datix. Dashboards have not yet been re-developed and there is no capacity/capability to analyse locality performance data at any degree of granularity.

3.2 Members are asked to note the risks associated with data anomalies that limit accurate reporting and interrogation of the DATIX system, particularly those associated with ED/WAST handovers.

3.3 The progress and encouraging start to the Covid-19 vaccination programme including deployment of staff from other areas to support the roll-out.

3.4 The enormous pressures being experienced as a result of the 'second wave' of Covid-19 cannot be over-stated. The ILG continues to provide highly specialist and critical care to a large number of acutely unwell patients and is doing so on a background of staff absence due to Covid-19 related sickness/self-isolation requirements.

3.5 The acuity and occupancy challenges of the 'second wave' of Covid-19 has further highlighted the shortfalls in staffing, particularly in registered general nursing staff and specialist nursing staff to support Critical Care activity.

3.6 The deterioration in performance against ambulance handovers and 12 hour delays in the Emergency Department and the possible negative impact this has on patient experience and safety due to crowding in the department

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: Relevant to all Healthcare Standards
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications /	Yes (Include further detail below)

Impact	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 Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

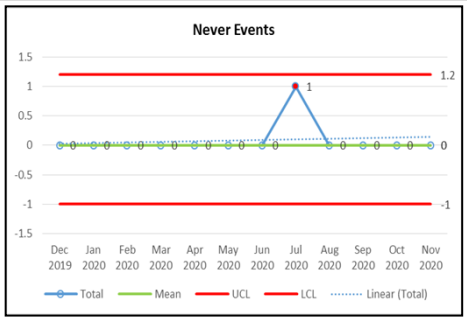
5. RECOMMENDATION

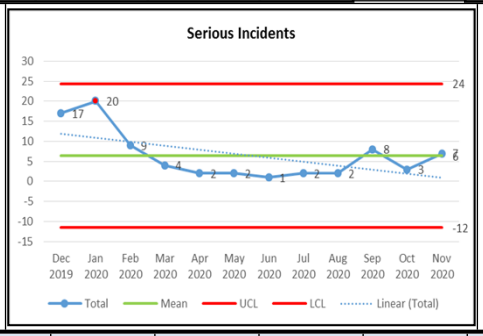
5.1 The Quality & Safety Committee is asked to **NOTE** this report and the progress made so far.

Appendix 1

Rhondda ILG Quality Dashboard – December 2020

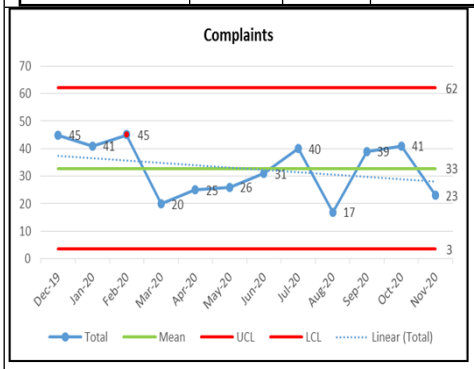
NE & SI	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Never Events	0	0	0	0	0	0	0	1	0	0	0	**0**
Serious Incidents	17	20	9	4	2	2	1	2	2	8	3	**7**

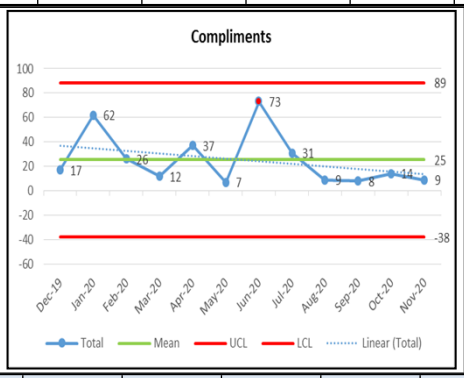




Never Events and Serious Incidents:
There have been no Never Events. There has been an increase in reported SIs which are related to Mental Health patients absconding from the MH unit following remodelling of wards to accommodate Covid-19 patients.

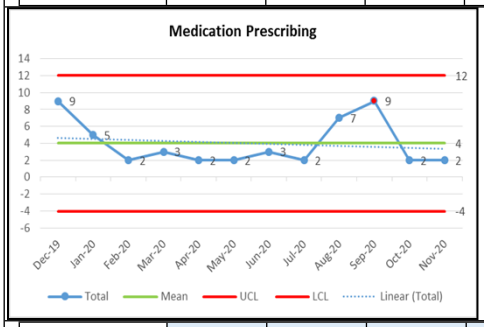
Complaints and Compliments	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Complaints	45	41	45	20	25	26	31	40	17	39	41	**23**
Compliments	17	62	26	12	37	7	73	31	9	8	14	**9**

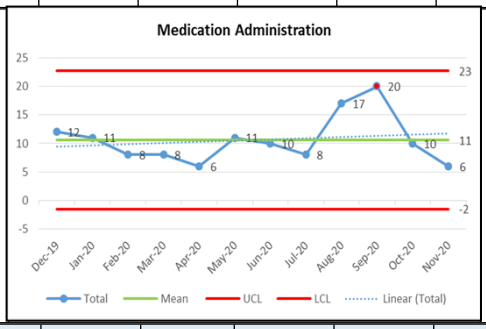




Complaints and Compliments:
There was a slight decrease in concerns received following previous sharp increases. Figures for December have returned to previous high levels.
Due to batch-inputting of compliments onto the Datix system, the number of compliments is not reflective of the true amount. These will be entered as soon as team capacity allows.

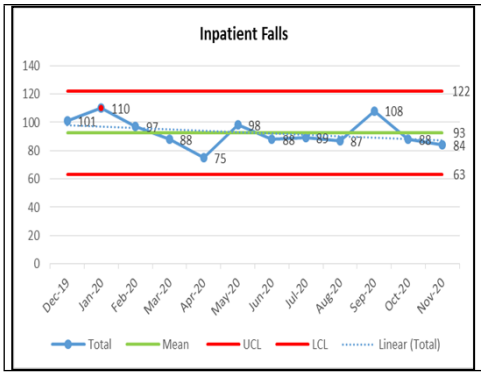
Medication	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Medication Prescribing	9	5	2	3	2	2	3	2	7	9	2	**2**
Medication Admin	12	11	8	8	6	11	10	8	17	20	10	**6**

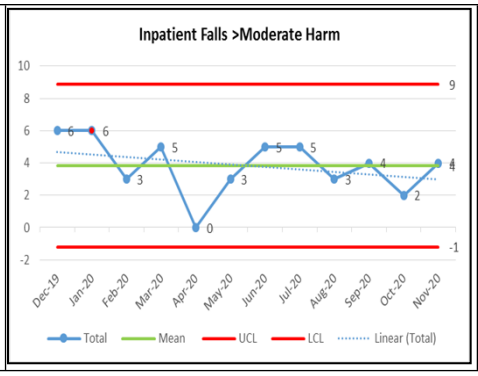




Medication:
Rates of medication incidents have returned to baseline levels for the ILG.

Falls	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Inpatient falls	101	110	97	88	75	98	88	89	87	108	88	**84**
>Moderate Harm	6	6	3	5	0	3	5	5	3	4	2	**4**

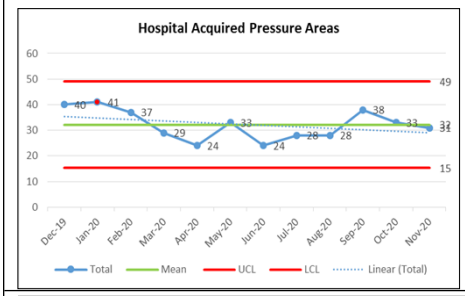


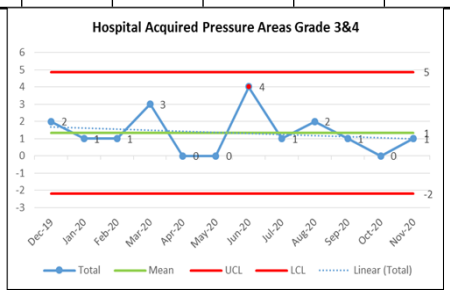


Falls:
The rate of falls, including those resulting in Moderate harm, is in keeping with historic averages.

Falls scrutiny panels have been temporarily stood-down but are due to be recommenced as soon as pandemic activity allows. All falls are individually investigated via Datix.

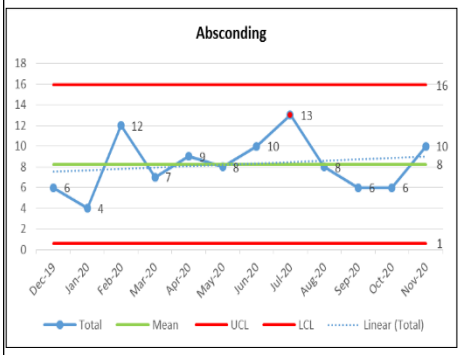
Pressure Areas	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hospital Acquired	40	41	37	29	24	33	24	28	28	38	33	**31**
Grade 3/4	2	1	1	3	0	0	4	1	2	1	0	**1**





Pressure Areas
The number of acquired pressure ulcers is at the ILG baseline level. Pressure Ulcer scrutiny panels have been temporarily stood-down but are due to be recommenced in February as soon as pandemic activity allows. All pressure ulcer reports are individually investigated via Datix.

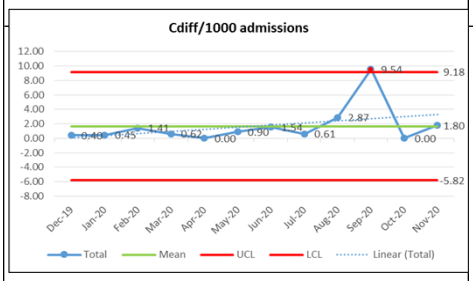
Absconding from Wards	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct-20	Nov-20
Absconding	6	4	12	7	9	8	10	13	8	6	6	10

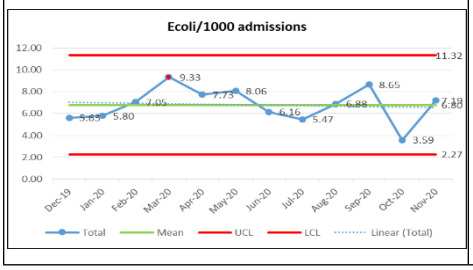


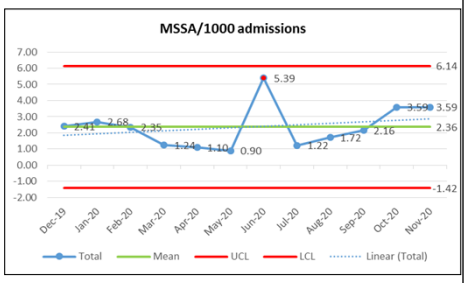
Absconding:
Absconding incidents demonstrate an increase over recent months following a period of consistency. This has been attributed to a remodelling of ward areas to accommodate Covid-19 bays/wards and the necessity to utilise new areas for outside space and smoking areas. It became clear over the course of a few days that the outdoor area selected was not suitable for this cohort of patients and changes were made to the ward arrangements to ensure a more secure outdoor space was identified.

Infection Control	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
Cdiff /1000 admiss	0.40	0.45	1.41	0.62	0.00	0.90	1.54	0.61	2.87	9.54	0.00	1.80
MRSA/1000 admiss	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MSSA/1000 admiss	2.41	2.68	2.35	1.24	1.10	0.90	5.39	1.22	1.72	2.16	3.59	3.59

Ecoli/1000 admiss	5.63	5.80	7.05	9.33	7.73	8.06	6.16	5.47	6.88	8.65	3.59	7.19







Infection Control:
Infection rates fall broadly within normal ranges for RTE ILG. Infection rates for various diseases continue to be monitored by the IP&C team alongside their significant Covid-19 workload.

AGENDA ITEM
6.2.3

QUALITY & SAFETY COMMITTEE

Merthyr & Cynon Integrated Locality Group – Quality safety & EXPERIENCE update REPORT

Date of meeting	19 January 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lesley Lewis - Locality Nurse Director Dr Sarah Spencer – Locality Director Adele Gittoes – Director of Operations
Presented by	Lesley Lewis – Locality Nurse Director
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ILG	Integrated Locality Group
PCH	Prince Charles Hospital
PALS	Patient Advice, Liaison Service

PTR	Putting Things Right
YCC	Ysbyty Cwm Cynon
DSU	Day Surgery Unit
ICU	Intensive Care Unit

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide an update to the Health Board's Quality & Safety Committee about the Quality and Safety agenda for Merthyr & Cynon Integrated Locality Group (ILG).

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

Covid-19 Outbreak Management

2.1 There is a clear case definition defined by Public Health Wales (PHW) for definite Healthcare acquired Covid-19 infection which is; A positive SARS-CoV-2 RNA test since 29 August 2020 or any person who had been an inpatient at PCH in the 14 days prior to a positive test.

2.2 The current position for cases within MC ILG, 273 of those cumulative total deaths linked to the outbreak 67.

2.3 A 15 point action plan has been agreed and the teams are working towards implementation, a number of actions have been completed but increase in numbers of positive Covid-19 patients within the hospital has led to many challenges with regards to flow within the acute site.

2.4 In order to create additional red Covid-19 capacity there has been a change within many clinical areas which now reflects 4 red wards, 2 amber wards, 1 purple ward, main ITU now has capacity for 17 red Covid-19 beds with 8 green ITU beds located in a separate area.

2.5 All deaths associated with the outbreak are required to have the completion of a HCAI toolkit and timeline along with a mortality review, this work has commenced and the documents and findings are to be reviewed by the external Oversight group for HCAI Mortality, feedback is expected imminently.

Covid Vaccinations (data correct 06/01/21)

2.6 Vaccinations commenced in MC ILG on the 18 December 2020 and to 1 January 56% (1949 vaccinations) of all frontline staff in MC ILG have received their vaccination. Further sessions are planned on a rolling programme.

2.7 We have commenced population vaccination in line with priority groups 1 to 4 :

- Over 80s – delivered by General Practice
- Care homes – delivered in residential/care home setting by Health Board staff
- Over 75 – delivered by General Practice
- Over 70 – Mass vaccination centre / General Practice
- Health & Social care staff – Mass vaccination centre

Ambulance Handover

2.8 There are variances in the reporting process undertaken in all 3 DGH's within the CTM footprint. The ILG and the Emergency Department at POWH recognise the importance of providing CTMUHB with robust data that can be consistently and accurately benchmarked against other DGHs. Further work to stratify the timeframes is required. Acute Services in PCH are liaising directly with the Central Information Management Teams, who are essential to addressing this issue and improving reporting accuracy. Delays in progressing this work have been experienced due to pressures associated with COVID 19.

2.9 Previous to the Covid-19 pandemic handover delays occurred infrequently at PCH. During the summer of 2020 PCH placed a renewed focus on the 15 minute handover target and became the best performing in Wales for WAST handover. The pandemic and testing restrictions have taken their toll on this measure but efforts have been made to increase staffing to reflect the delays in handover.

2.10 All patients who experience a delay in handover are provided with a similar level of care and treatment as those in the department. ED nursing and medical staff work very closely with WAST colleagues to ensure that triage, assessment and diagnostics are carried out as appropriate even when patients are cared for in the ambulance.

Month	Handover %

October	40.14
November	45.36
December	37.62

Month	Total Attendances	12 Hr Performance %	No. Breaches
October	4150	89.25	446
November	3953	90.18	388
December	3869	89.04	424

2.11 Within the majors clinical area (PCH) crowding continues to be a concern, the resuscitation room has 4 spaces which are adequately separated with powerful ventilation systems. This room is not suitable for aerosol generating procedures due to the risk of transmission of Covid-19 virus. A Covid-19 resus room has been set up in cubicle A within the Clinical Decisions Unit for the use of AGP.

2.12 The corridor of majors is utilised at all times currently to care for patients, up to 8 patients can be accommodated. This area is utilised as these patients would otherwise be delayed handovers from WAST whilst handover delays are an ongoing issue on the PCH site.

2.13 Both bed capacity and Covid-19 swab result turnaround times have negatively impacted on ED crowding. At all times staff endeavour to provide the best care they can to all patients, including patients cared for in the corridor, on occasion for over 24 hours. The ED is a busy area 24/7 which is not appropriate for inpatient accommodation: it is recognised that corridor care is symptomatic of wider health system pressure, needing a whole system approach to resolution. The ILG is appointing a Head of Patient Flow (8b) to provide real-time support as part of a whole site approach.

External Assurance - Inspections visits

2.14 Healthcare Inspectorate Wales (HIW) Tier 1 Quality Check undertaken at CDU-PCH on the 10 December 2020; 5 actions have been identified and included as areas where improvements are required.

2.15 HIW action plan in progress for ward 7 YCC (Mental Health), one action remains outstanding and is delayed due to Covid-19 pandemic with regards to 85% compliance with mandatory staff training.

Quality and Patient Safety Governance Framework

2.16 The ILG continues to embed the Health Board's Quality Governance Framework, developed to address the community focused, clinically-led approach supported by the new operating model. The Governance Framework reflects that quality and patient safety must be the focus in all our activities, and that the ILG triumvirate share the responsibility for the delivery of high quality, safe services at every level. The development of effective triumvirates at all levels is essential to the ILG's quality agenda.

2.17 Work has been undertaken to review resources required within the governance team whilst ensuring equity across three ILG's with regards to the governance support. A report outlining the team requirements has been submitted for consideration to the ILG Directors.

Quality Assurance

2.18 Members are asked to note the development of a Merthyr & Cynon Locality Quality Dashboard– see Appendix 1.

2.19 This dashboard in the current format is being developed to meet the needs of the Quality and Patient safety agenda and the quality outcome measures are yet to be realised and embedded within it.

Key metrics of concern
Serious Incidents

2.20 There are 86 open SUI within the ILG with 32 of those being managed within the timeframe. Plans to strengthen the governance team with the appointment of an additional Patient Safety Improvement Manager (PSIM) will support the clinical teams to progress the completion of all SUI's that are outside of the compliance framework.

2.21 The number of SUI's reported are steady with an increase in suicides which are being reviewed by the mental health team and no connection has been attributed to the current COVID19 pandemic or local known contacts.

Cancer Harm Review Panel

2.22 Clinically-led development of operational process is ongoing; the process will be implemented and improved incrementally. Reporting will be through the Cancer Steering Group to the Cancer Board, and to Quality & Safety Committee. Importantly, Clinical Service Director appointments essential for this development have been made since the last Quality & Safety Committee meeting: improvement led by ILG Director will now gain pace.

2.23 First MDT panel has been held with monthly meetings planned going forward.

2.24 It is intended that the operational process will support proactive harm review completion as an embedded element of the process.

Concern management

2.25 Ensuring the ILG manage concerns in line with the PTR requirement to respond within 30 days, with a rigorous focus on the initial management of the concern and contact with the patient/family.

2.26 Continuous improvements have been recognised over the past 5 months with continued momentum to achieve the Health Board standard of 85% compliance. Compliance will be achieved with a realistic staged approach ensuring quality of complaint responses.

2.27 Rates of concerns received by the ILG have increased although stable since June 2020 with a recognition of reduction during the COVID19 pandemic acknowledged. Themes and actions from concerns are being triangulated to inform the ward or area action plan for improvement.

Ombudsman

2.28 There continue to be 10 open cases with 6 of those being managed as a full investigation.

Patient Falls & Pressure Areas

2.29 The number of falls appear to have a reduction over the past 3 months with avoidable falls resulting in moderate, severe or death also remaining low. The harm reviews are taking place within the clinical areas to ensure learning and immediate actions required are taken to reduce future incidents, are realised and appropriately shared.

2.30 There is now an opportunity within the ILG to ensure learning is shared across services and ILG footprints. The Quality and Safety Newsletter will enhance the learning opportunities for the ILG.

2.31 Pressure ulcer scrutiny panels are in place for both acute and community hospital sites with robust monitoring and review of avoidable harm. It is pleasing to note that the numbers of pressure areas noted to be Grade 3, ungradeable or deep tissue remain low.

Assurance & Reporting Framework

2.32 The Committee is asked to note that work has commenced on the development of a Merthyr & Cynon ILG Assurance and Reporting framework aligned with the NHS Wales Performance Framework which will incorporate:

- Quality
- Outcomes
- Resources

2.33 Within each of these domains will be a dashboard which will be used to capture, monitor and report activity and improvement in each of the areas. These dashboards will be consistent from Clinical Service Group level to ILG Committee and up to Board level.

2.34 These dashboards will be developed by multidisciplinary teams including clinicians and the ongoing reporting will be transparent throughout the ILG. The ILG Directors plan to ensure that the reporting of ILG business is known across Merthyr Cynon Locality and that regardless of where staff work they have access to and are sighted on the work in all areas to support integrated working.

2.35 The new operating model includes a new post for an ILG Performance and Information post which is pivotal to the development of this framework.

Person Experience

2.36 Post discharge patient surveys have been carried out across the ILG within PCH & YCC covering all wards, over 170 patients have participated in the survey with a 77% success rate. From the surveys carried out the comments include;

"Very happy with all aspects of my care"
"staff were amazing"
"Grateful for all the care I received"
"Food was lovely"
"Not having visitors"
"Not all staff adhered to the PPE guidance"
"I was reassured by the staff always wearing PPE"
"I felt safe"

2.37 The implementation of the CIVICA system which is being managed by the corporate team will support obtaining patient and family feedback in line with a quality outcome measure. The corporate task and finish

group for this work met in October 2020. CTMUHB are the early implementers for this project in Wales with a plan to commence within the maternity service initially.

Management of Risk

2.38 Each former Directorate (now Clinical Service Group) maintains a risk register although the Mental Health, Primary Care and Community Risk Register is currently being disaggregated to support the new Locality model.

2.39 There are 13 risks >15 which have been escalated to the corporate risk register with work continuing within the CSG managers to review all open risks to ensure they aligned in format, scoring and approach. Training has commenced to support this work.

Learning and Quality Improvement

2.40 Supporting staff to embrace and develop a no-blame learning culture is fundamental to ensuring full engagement with all quality governance activity. Encouraging understanding and adoption of both Safety II and Safety I approaches, enabling multidisciplinary engagement with and ownership of the quality of services, will necessitate both training and ongoing administrative support from governance and operational management teams. This will be progressed at pace by the appointment of the Locality Governance Lead.

2.41 Development and implementation of a 'quality governance memory' will be supported by the implementation of the new 'Once for Wales' Datix web system, and will support provision of assurance that learning is sustained and reviewed.

2.42 The ILG review of the current approach to Quality Improvement activity will inform future developments of both QI and local clinical audit activity.

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

3.1 Due to anomalies in the way in which ED/WAST handover delays are reported DATIX has not been able to provide meaningful and accurate data on the number of incidents occurring. Members are asked to note the risks associated with data anomalies that limit accurate reporting and interrogation of the DATIX system, particularly those associated with ED/WAST handovers.
ACTION: To ensure consistency of approach across all CTM sites the ILG will continue to collaborate with key stakeholders in the Central Informatics, Governance and Patient Safety Teams in order to improve accessibility and the integrity of data capture and reporting systems.

3.2 The continued high rates of admissions due to COVID19 infection during the past quarter is causing a significant constraint with regards to safe flow of patients in PCH. This is in turn resulting in long WAST waits and delays and inability to increase COVID19 capacity on site.
ACTION: Associated planned opening of surge capacity of SSU and Ysbyty Seren and agreed support from C&V and ABHB and new pathways in development for RGH.

3.3 Increase in demand to PCH as a result of South Powys and North Gwent implementation of WAST nearest DGH protocol. Impact apparent since WAST confirmation in September 2020 that previous ABHUB plans (all ABHB patients to the GUH) would not be possible for time critical red/amber 1 patients.
ACTION: Governance structure developed to ensure clinically led solutions identified to increase transfers from PCH to support increased demand however with GUH opening being brought forward at present no robust plans to fully mitigate risks.

3.4 Staffing shortages across the ILG due to vacancy pressures and the additional absence due to TTP protocol and COVID19 infection rates within the staff population. The nursing vacancy rate across all specialities within the ILG is 80.78wte (calculated from the funded establishment and staff in post).
ACTION: Forecast allocation of overseas nurses to join the workforce during November - December is 20 with an additional 8 in 2021, there are also 20 Health Care Support Workers (HCSW). The senior nurses review staffing across the site on a shift by shift basis during daily 'safety huddles'. The wards covered under the Nurse Staffing Wales Act (NSA) are also required to provide information on the staffing deficits for their areas. This information is collated at a central point to enable retrospective review in cases where there may have been issues related to patient care. The required staffing levels for NSA wards are displayed in ward areas where the Staffing Act applies. The senior nurses review

the risk for each area where there are staffing deficits and nurses will be moved dependent upon patient need.

4. IMPACT ASSESSMENT

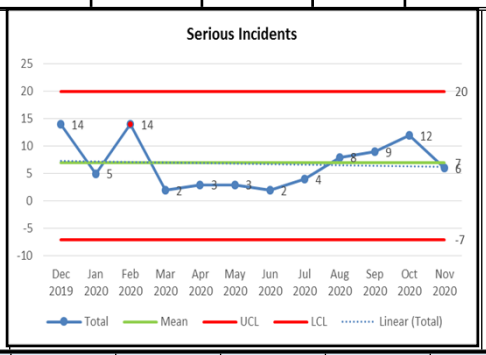
Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care Dignified care Effective Care Individual Care
Equality impact assessment completed	No (Include further detail 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)
	Subject to review of current arrangements further staffing resources may be required.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the content of this report and the proposed next steps and timescales.

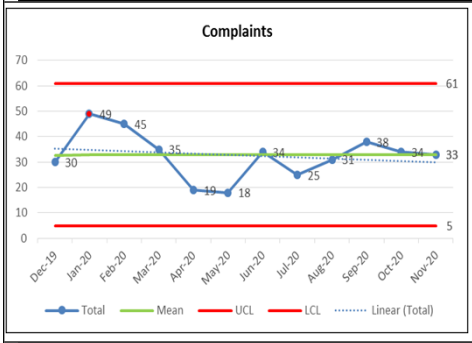
Merthyr & Cynon ILG Quality Dashboard – December 2020

NE & SI	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Never Events	0	0	0	0	0	0	0	0	0	0	0	**0**
Serious Incidents	14	5	14	2	3	3	2	4	8	9	12	**6**



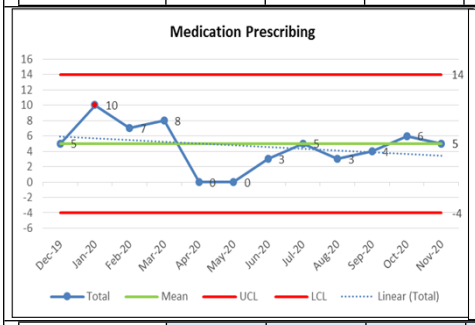
Never Events and Serious Incidents:
Serious incidents continue to be within normal ranges for Merthyr & Cynon. It cannot be reliably concluded that the SI data is accurate for the entire locality at this stage.

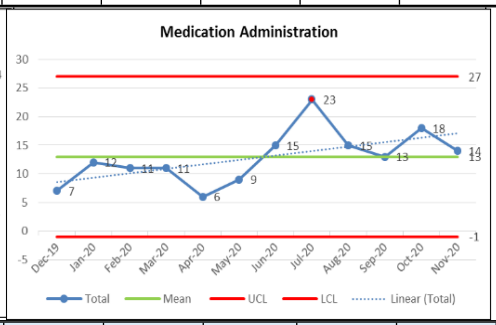
Complaints and Compliments	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Complaints	30	49	45	35	19	18	34	25	31	38	34	**33**
Compliments	17	51	21	5	16	2	61	7	28	40	38	**114**



Complaints and Compliments:
The rate of complaints and compliments falls within normal ranges for Merthyr & Cynon Locality.
Further data cleansing is required before the ILG can reliably confirm that the data includes all Clinical Service Groups.

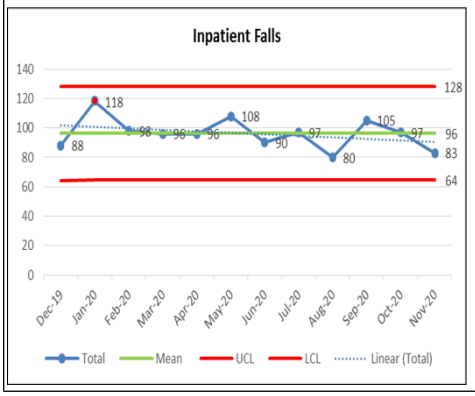
Medication	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Medication Prescribing	5	10	7	8	0	0	3	5	3	4	6	**5**
Medication Admin	7	12	11	11	6	9	15	23	15	13	18	**14**

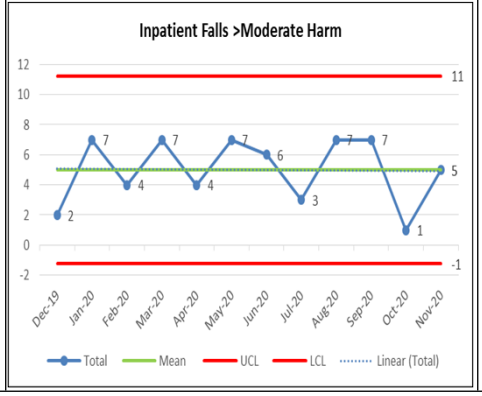




Medication:
Rates of medication incidents fall within normal ranges for Merthyr & Cynon Locality.
Further data cleansing is required before the ILG can reliably confirm that the data includes all Clinical Service Groups.

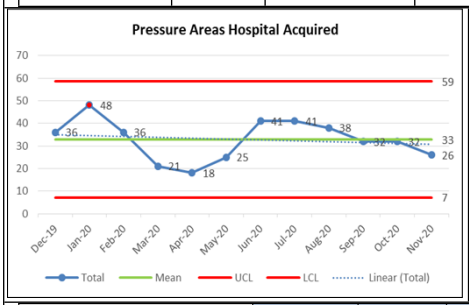
Falls	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Inpatient falls	88	118	98	96	96	108	90	97	80	105	97	**83**
>Moderate Harm	2	7	4	7	4	7	6	3	7	7	1	**5**

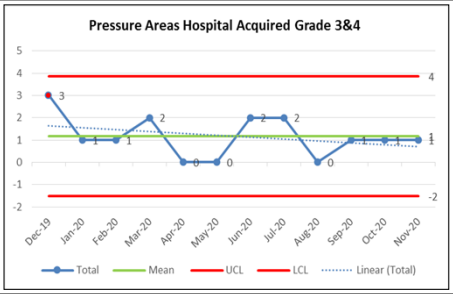




Falls:
Rates of patient falls and harm associated with falls continue to be within normal ranges for Merthyr & Cynon locality.
Falls scrutiny panel is recommencing, having been temporarily stood down during the first peak of the pandemic.

Pressure Areas	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Hospital Acquired	36	48	36	21	18	25	41	41	38	32	32	**26**
Grade 3/4	3	1	1	2	0	0	2	2	0	1	1	**1**



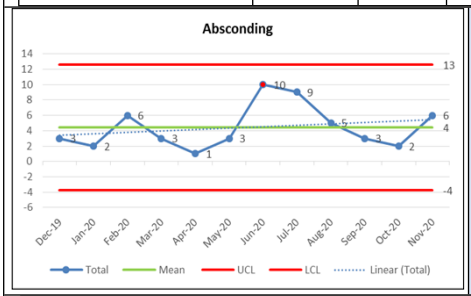


Pressure Areas

Pressure areas continue to fall within normal ranges for Merthyr & Cynon Locality.

Scrutiny panels have recommenced, having been stood down during the first peak of the pandemic. The ILG aim to have a cross ILG approach to the scrutiny of pressure area incidents.

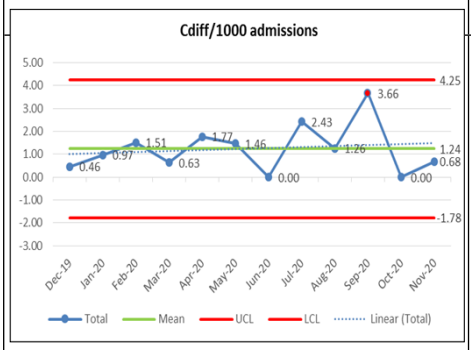
Absconding from Wards	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Absconding	3	2	6	3	1	3	10	9	5	3	2	6

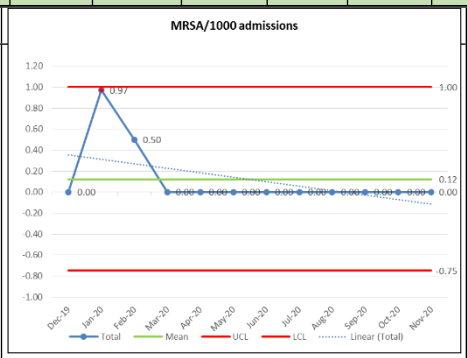


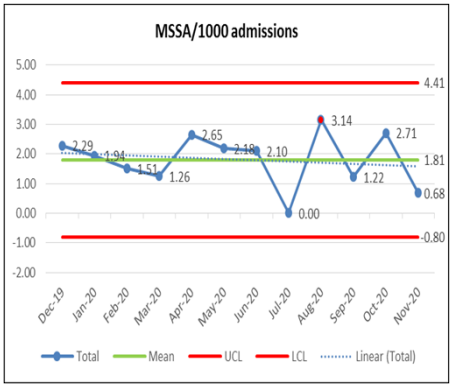
Absconding:

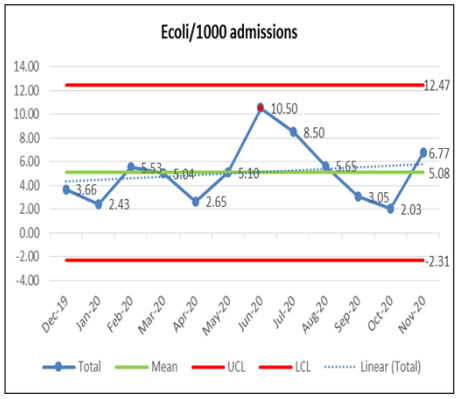
Absconding continues to fall within normal ranges for Merthyr & Cynon Locality.

Infection Control	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
Cdiff /1000 admiss	0.46	0.97	1.51	0.63	1.77	1.46	0.00	2.43	1.26	3.66	0.00	0.68
MRSA/1000 admiss	0.00	0.49	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MSSA/1000 admiss	2.29	1.94	1.51	1.26	2.65	2.18	2.10	0.00	3.14	1.22	2.71	0.68
Ecoli/1000 admiss	3.66	2.43	5.53	5.04	2.65	5.10	10.50	8.50	5.65	3.05	2.03	6.77









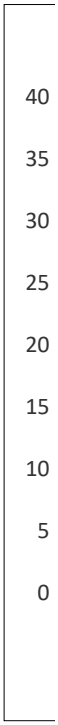
Infection Control:

Infection rates fall within normal ranges for.

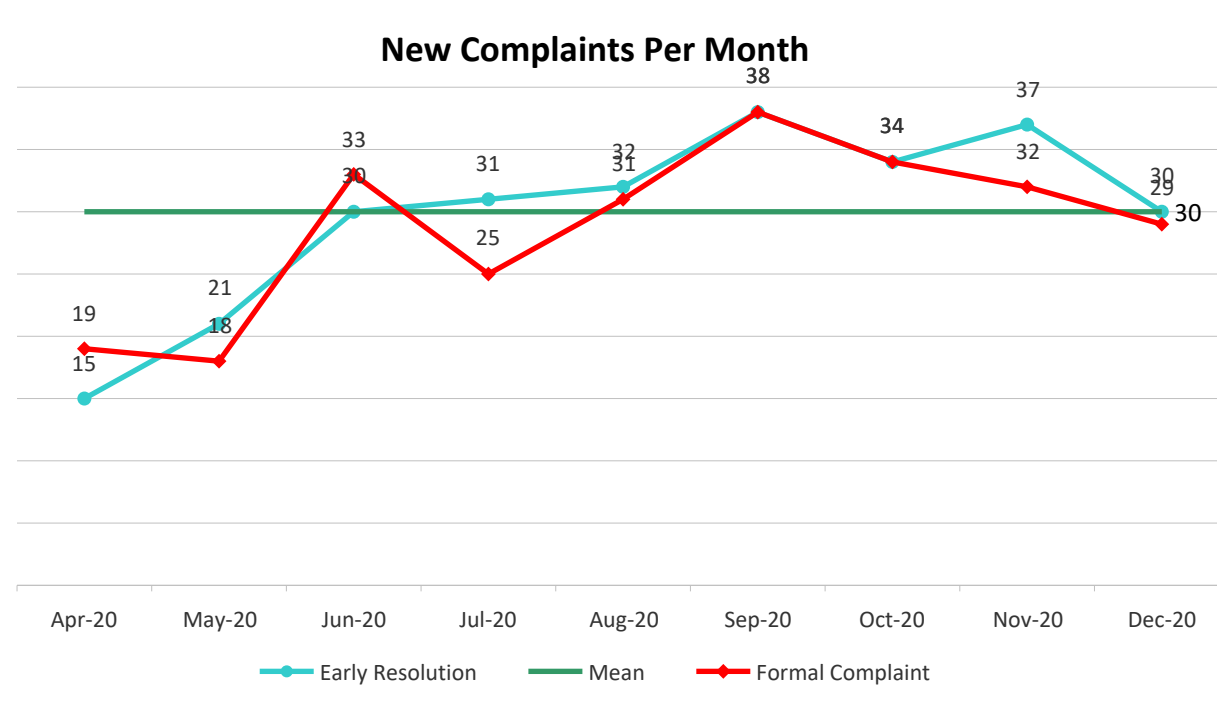
Further data cleansing is required before the ILG can reliably confirm that the data includes all Clinical Service Groups.

The Interim Head of Nursing for Acute Services is taking a lead on Infection Control across the ILG and is developing the Terms of Reference for an ILG meeting. Weekly review of infection control has recommenced at having been stood down during the first peak of the pandemic.

New Complaints Per Month	Early Resolution	Mean	Formal Complaint	Mean
Apr-20	15	30	19	29
May-20	21	30	18	29
Jun-20	30	30	33	29
Jul-20	31	30	25	29
Aug-20	32	30	31	29
Sep-20	38	30	38	29
Oct-20	34	30	34	29
Nov-20	37	30	32	29
Dec-20	30	30	29	29
Total	**268**		**259**	



Open Complaints	Total
Current Open within 30 Days	24
Current Open over 30 Days	46
Current Open over 6 Months	5
Total Open Complaints	**75**


New Complaints Per Month
19
21
33
31
32
38
37
34
32
30
15
18
30
25
31
38
32
29
30
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Early Resolution
Mean
Formal Complaint

Month	Closed Within 30 working days	Mean	Standard Deviation	UCL
Apr-20	40%	51%	10%	80%
May-20	47%	51%	10%	80%
Jun-20	62%	51%	10%	80%
Jul-20	38%	51%	10%	80%
Aug-20	46%	51%	10%	80%
Sep-20	51%	51%	10%	80%
Oct-20	56%	51%	10%	80%
Nov-20	50%	51%	10%	80%
Dec-20	67%	51%	10%	80%

Month	Closed over 30 working days	Mean	Standard Deviation	UCL
Apr-20	60%	49%	10%	78%
May-20	53%	49%	10%	78%
Jun-20	38%	49%	10%	78%
Jul-20	62%	49%	10%	78%
Aug-20	54%	49%	10%	78%
Sep-20	49%	49%	10%	78%
Oct-20	44%	49%	10%	78%
Nov-20	50%	49%	10%	78%
Dec-20	33%	49%	10%	78%

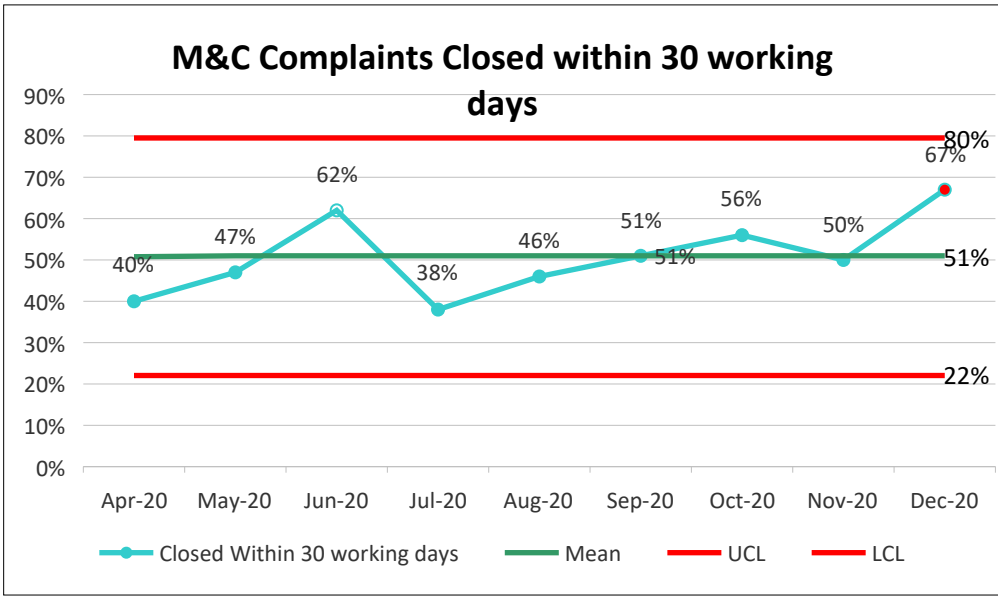
Month	Closed over 6 Months	Mean	Standard Deviation	UCL
Apr-20	7%	4%	3%	14%
May-20	7%	4%	3%	14%
Jun-20	5%	4%	3%	14%
Jul-20	4%	4%	3%	14%
Aug-20	0%	4%	3%	14%
Sep-20	5%	4%	3%	14%
Oct-20	9%	4%	3%	14%
Nov-20	0%	4%	3%	14%
Dec-20	0%	4%	3%	14%
Month	**Complaints Reopened**	**Mean**	**Standard Deviation**	**UCL**
Apr-20	4	3	2	7
May-20	1	3	2	7
Jun-20	4	3	2	7
Jul-20	5	3	2	7
Aug-20	1	3	2	7
Sep-20	3	3	2	7
Oct-20	4	3	2	7
Nov-20	2	3	2	7
Dec-20	1	3	2	7

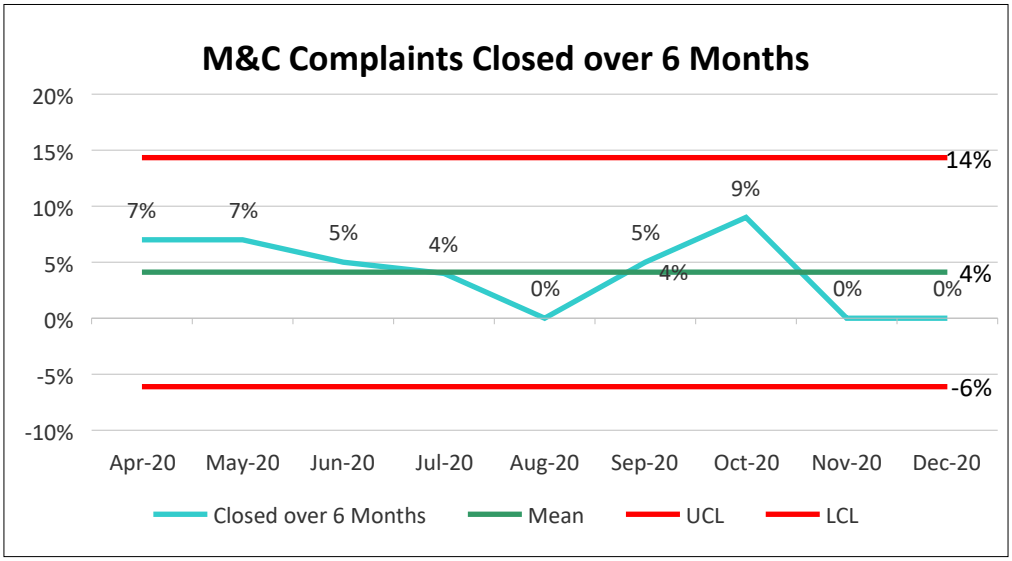
LCL
22%
22%
22%
22%
22%
22%
22%
22%
22%

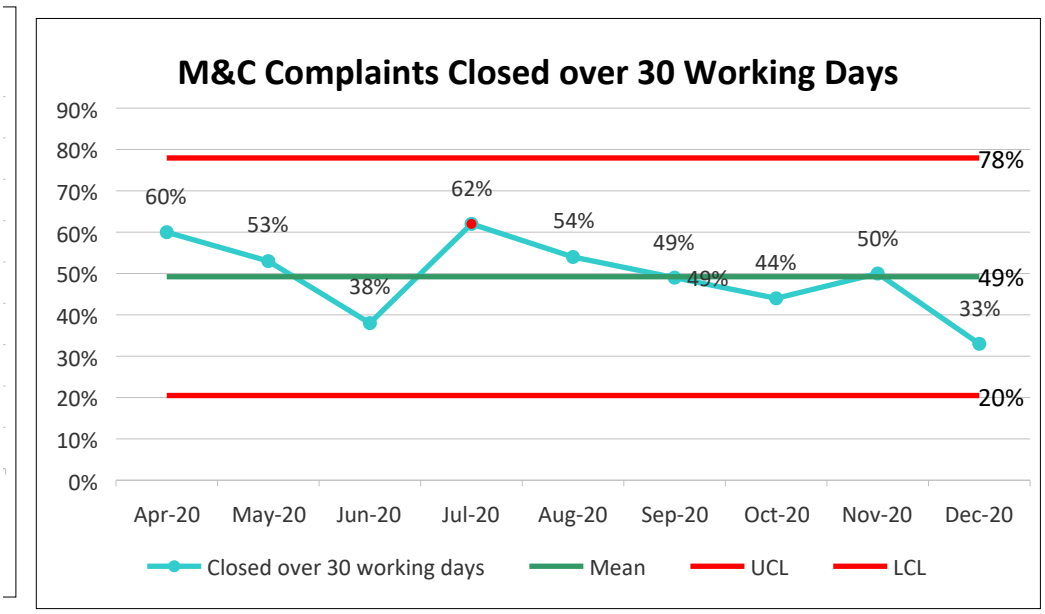
LCL
20%
20%
20%
20%
20%
20%
20%
20%
20%

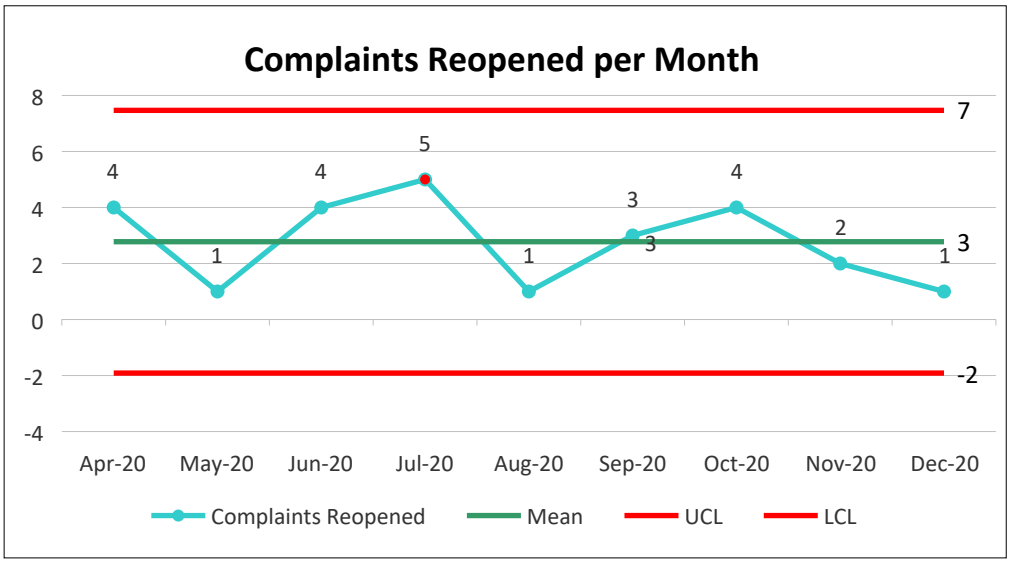
LCL
-6%
-6%
-6%
-6%
-6%
-6%
-6%
-6%
-6%

LCL
-2
-2
-2
-2
-2
-2
-2
-2
-2





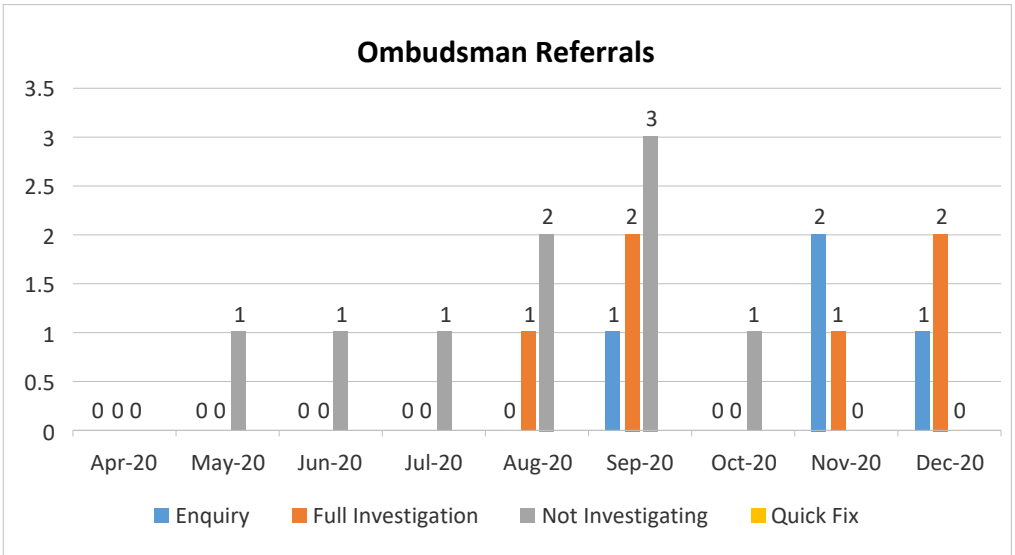

M&C Complaints Closed over 30 Working Days
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
60%
53%
38%
62%
54%
49%
49%
44%
50%
33%
78%
49%
20%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Closed over 30 working days
Mean
UCL
LCL


Complaints Reopened per Month
8
6
4
2
0
-2
-4
4
1
4
5
1
3
3
4
2
1
7
3
-2
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Complaints Reopened
Mean
UCL
LCL

Ombudsman Referrals			
Month	**Enquiry**	**Full Investigation**	**Not Investigating**
Apr-20	0	0	0
May-20	0	0	1
Jun-20	0	0	1
Jul-20	0	0	1
Aug-20	0	1	2
Sep-20	1	2	3
Oct-20	0	0	1
Nov-20	2	1	0
Dec-20	1	2	0
Total	**4**	**6**	**9**

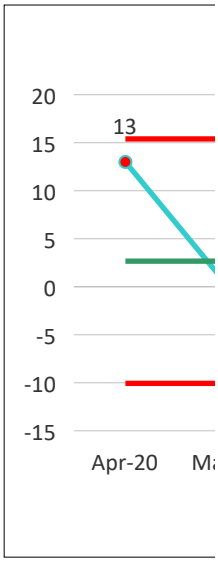
Final Report received by Ombudsman	Not Upheld	Upheld - Section 21	Total
Apr-20	0	0	0
May-20	1	1	2
Jun-20	0	0	0
Jul-20	0	0	0
Aug-20	0	0	0
Sep-20	0	0	0
Oct-20	0	0	0
Nov-20	1	1	2
Dec-20	0	1	1
Total	**2**	**3**	**5**

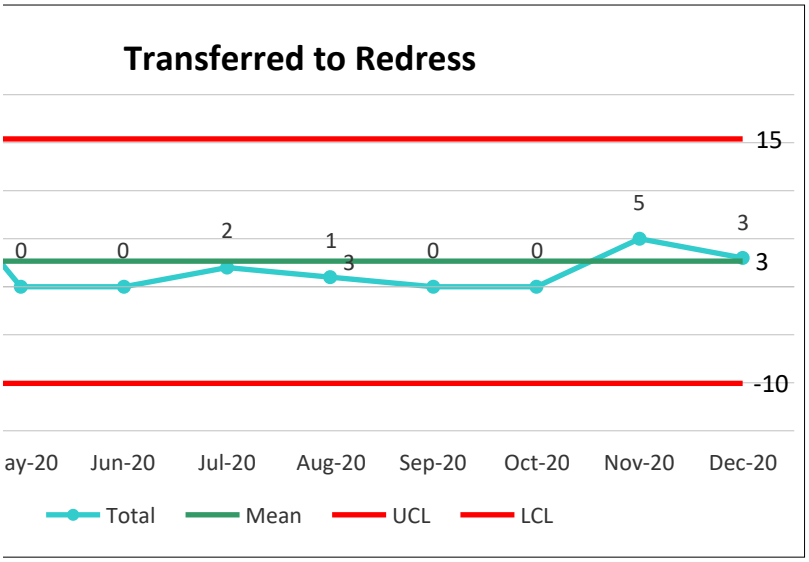
Quick Fix	Total
0	0
0	1
0	1
0	1
0	3
0	6
0	1
0	3
0	3
0	**19**

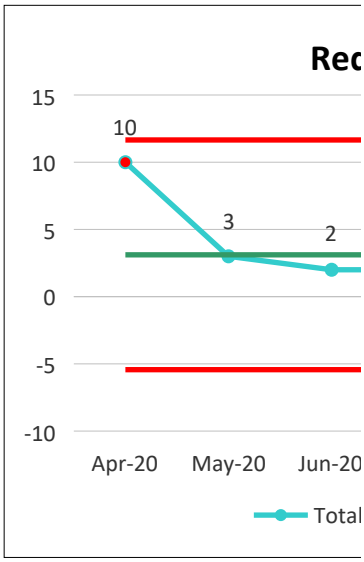


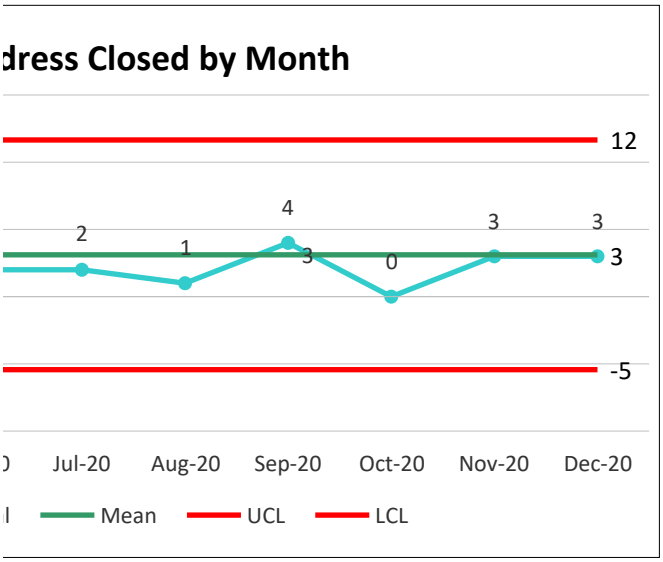
Redress	Total	Mean	Standard Deviation	UCL	LCL
Apr-20	13	3	4	15	-10
May-20	0	3	4	15	-10
Jun-20	0	3	4	15	-10
Jul-20	2	3	4	15	-10
Aug-20	1	3	4	15	-10
Sep-20	0	3	4	15	-10
Oct-20	0	3	4	15	-10
Nov-20	5	3	4	15	-10
Dec-20	3	3	4	15	-10

Redress Closed	Total	Mean	Standard Deviation	UCL	LCL
Apr-20	10	3	3	12	-5
May-20	3	3	3	12	-5
Jun-20	2	3	3	12	-5
Jul-20	2	3	3	12	-5
Aug-20	1	3	3	12	-5
Sep-20	4	3	3	12	-5
Oct-20	0	3	3	12	-5
Nov-20	3	3	3	12	-5
Dec-20	3	3	3	12	-5



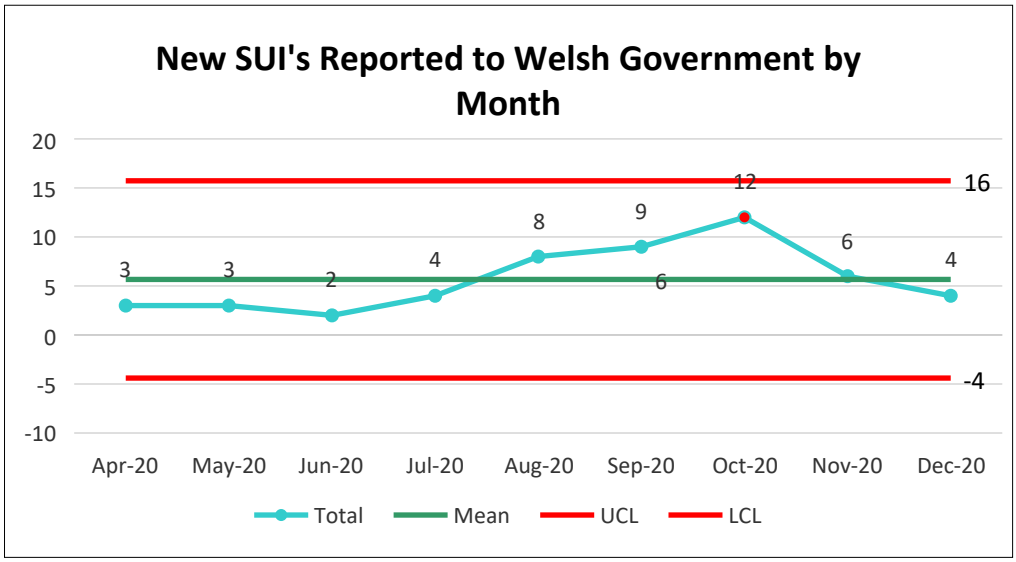

Transferred to Redress
15
-10
3
0
0
2
1
3
0
0
5
3
ay-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Total
Mean
UCL
LCL


Rec
15
10
5
0
-5
-10
10
3
2
Apr-20
May-20
Jun-20
Total

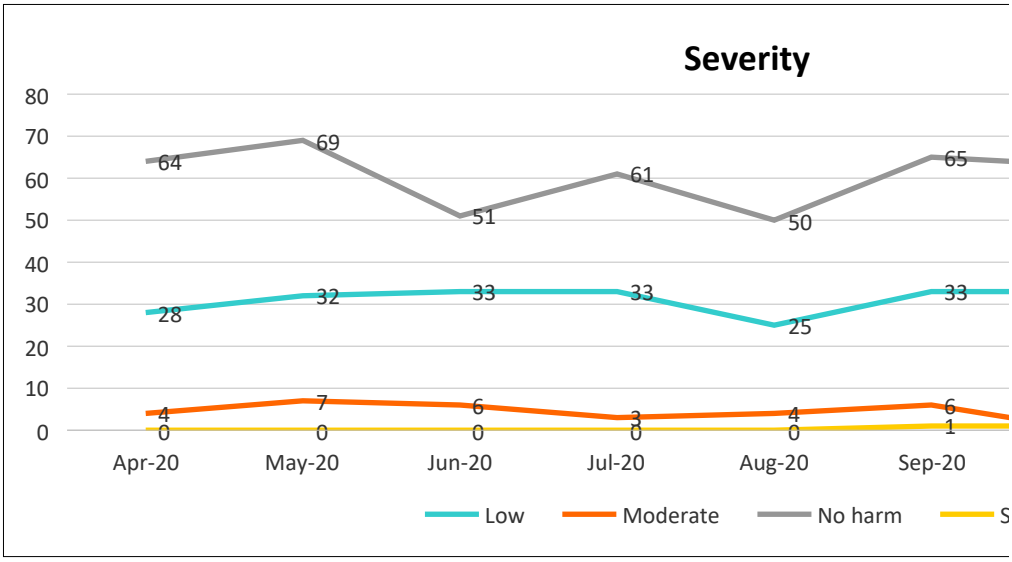

dress Closed by Month
12
2
1
4
3
0
3
3
3
-5
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Mean
UCL
LCL

Month	Total	Mean	Standard Deviation	UCL	LCL
Apr-20	3	6	3	16	-4
May-20	3	6	3	16	-4
Jun-20	2	6	3	16	-4
Jul-20	4	6	3	16	-4
Aug-20	8	6	3	16	-4
Sep-20	9	6	3	16	-4
Oct-20	12	6	3	16	-4
Nov-20	6	6	3	16	-4
Dec-20	4	6	3	16	-4

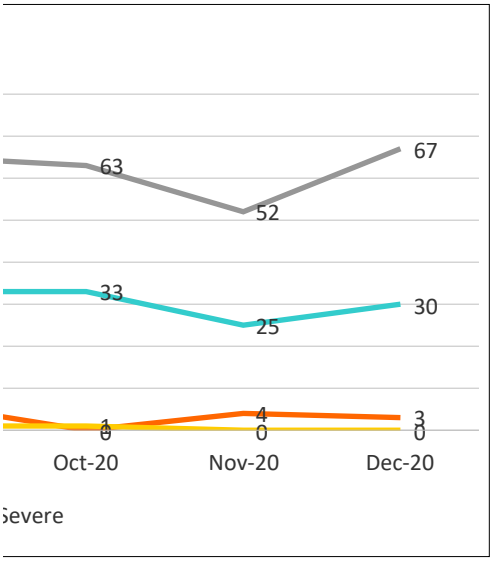
Total SUI's Open	**85**
Number open within Timeframe	**19**
Number open out of compliance	**66**
Number open over 60 days	**32**
Number open over 6 months	**34**

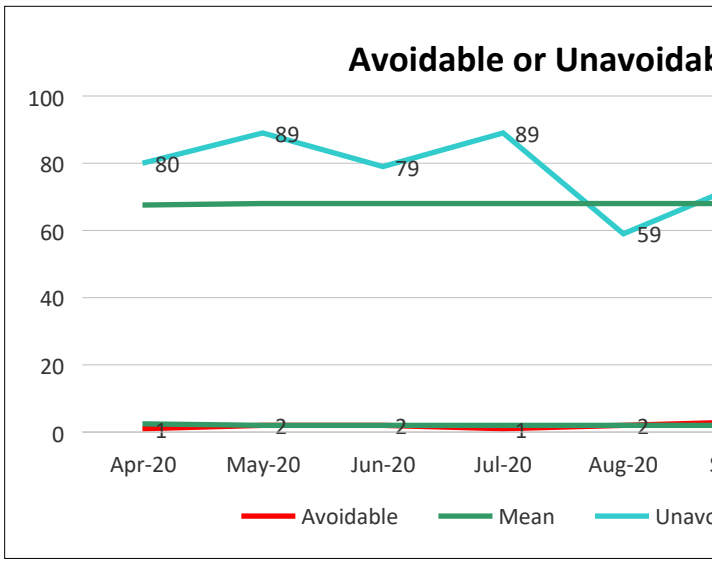

New SUI's Reported to Welsh Government by Month
20
15
10
5
0
-5
-10
3
3
2
4
8
9
12
6
4
6
16
-4
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Total
Mean
UCL
LCL

	No harm	Low
Apr-20	64	28
May-20	69	32
Jun-20	51	33
Jul-20	61	33
Aug-20	50	25
Sep-20	65	33
Oct-20	63	33
Nov-20	52	25
Dec-20	67	30
	Cefn yr Afon Rehabilitation Unit	**Keir Hardie Health Park**
Apr 2020	0	0
May 2020	0	0
Jun 2020	0	0
Jul 2020	0	0
Aug 2020	1	1
Sep 2020	1	0
Oct 2020	0	1
Nov 2020	0	0
Dec 2020	0	0
Total	**2**	**2**

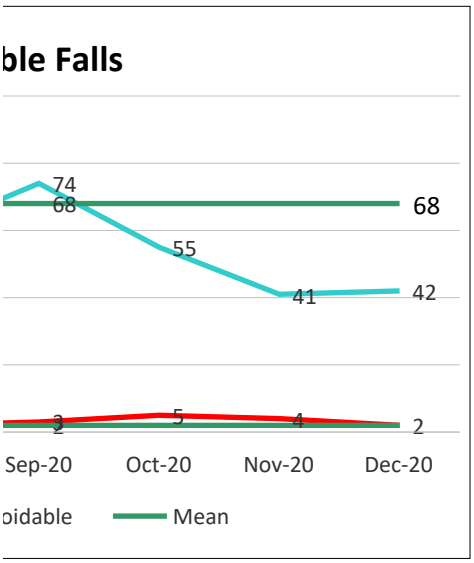


Moderate	Severe		
4	0		Apr-20
7	0		May-20
6	0		Jun-20
3	0		Jul-20
4	0		Aug-20
6	1		Sep-20
0	1		Oct-20
4	0		Nov-20
3	0		Dec-20
Marsh House Facility	**Patients Home**	**Pinewood House**	**Prince Charles Hospital**
0	0	0	58
3	0	0	78
0	1	0	58
1	0	0	69
0	0	0	57
0	0	0	71
0	0	0	69
0	1	1	57
0	0	0	67
4	**2**	**1**	**584**





Avoidable	Mean	Unavoidable
1	2	80
2	2	89
2	2	79
1	2	89
2	2	59
3	2	74
5	2	55
4	2	41
2	2	42
Princess of Wales Hospital	**Royal Glamorgan Hospital**	**Royal Glamorgan Hospital Mental Health**
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
0	0	0
1	1	1
1	**1**	**1**



Mean
68
68
68
68
68
68
68
68
68

Ysbyty Cwm Cynon	Ysbyty George Thomas(Acute)	Total
37	1	**96**
27	0	**108**
31	0	**90**
27	0	**97**
20	0	**79**
33	0	**105**
27	0	**97**
22	0	**81**
30	0	**100**
254	**1**	**853**

Total Pressure Areas	AVOIDABLE	MEAN
Apr-20	6	4
May-20	5	4
Jun-20	6	4
Jul-20	4	4
Aug-20	6	4
Sep-20	4	4
Oct-20	4	4
Nov-20	3	4
Dec-20	2	4
Total	**40**	

Not Present on Admission	AVOIDABLE	MEAN
Apr-20	5	3
May-20	2	3
Jun-20	4	3
Jul-20	3	3
Aug-20	6	3
Sep-20	4	3
Oct-20	3	3
Nov-20	3	3
Dec-20	1	3
Total	**31**	

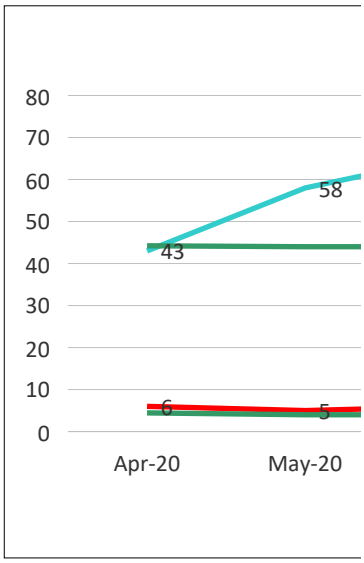
Not Present on Admission	Pressure Damage - Grade 1	Pressure Damage - Grade 2
Apr-20	3	10
May-20	2	17
Jun-20	7	24
Jul-20	5	28
Aug-20	8	16
Sep-20	5	16
Oct-20	5	16
Nov-20	2	20
Dec-20	6	17
Total	**43**	**164**

Severity	Low	Moderate
Apr-20	14	4
May-20	20	4
Jun-20	32	8
Jul-20	36	3
Aug-20	26	9
Sep-20	27	4
Oct-20	22	8
Nov-20	21	5
Dec-20	26	4

Total	**224**	**49**

	KHHP	Marsh House Facility
Apr 2020	0	0
May 2020	0	1
Jun 2020	0	0
Jul 2020	0	0
Aug 2020	1	0
Sep 2020	0	0
Oct 2020	0	0
Nov 2020	0	0
Dec 2020	0	0
Total	1	1

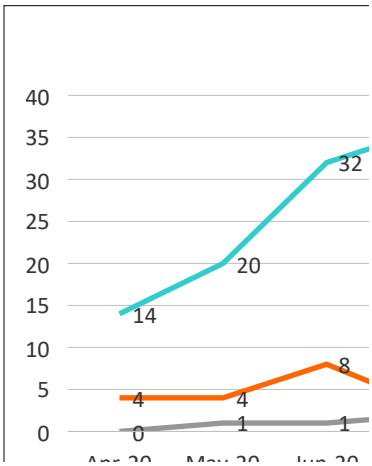
UNAVOIDABLE	MEAN
43	44
58	44
66	44
71	44
45	44
47	44
25	44
26	44
17	44
398	



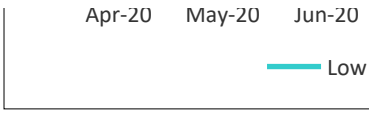
UNAVOIDABLE	MEAN
8	16
19	16
26	16
32	16
12	16
15	16
11	16
10	16
12	16
145	

Pressure Damage - Grade 3	Pressure Damage - Suspected Deep Tissue Injury (SDTI)	Pressure Damage - Ungradeable
0	4	1
0	4	2
2	5	3
2	5	1
0	14	0
1	7	3
1	9	1
1	3	1
0	5	3
7	**56**	**15**

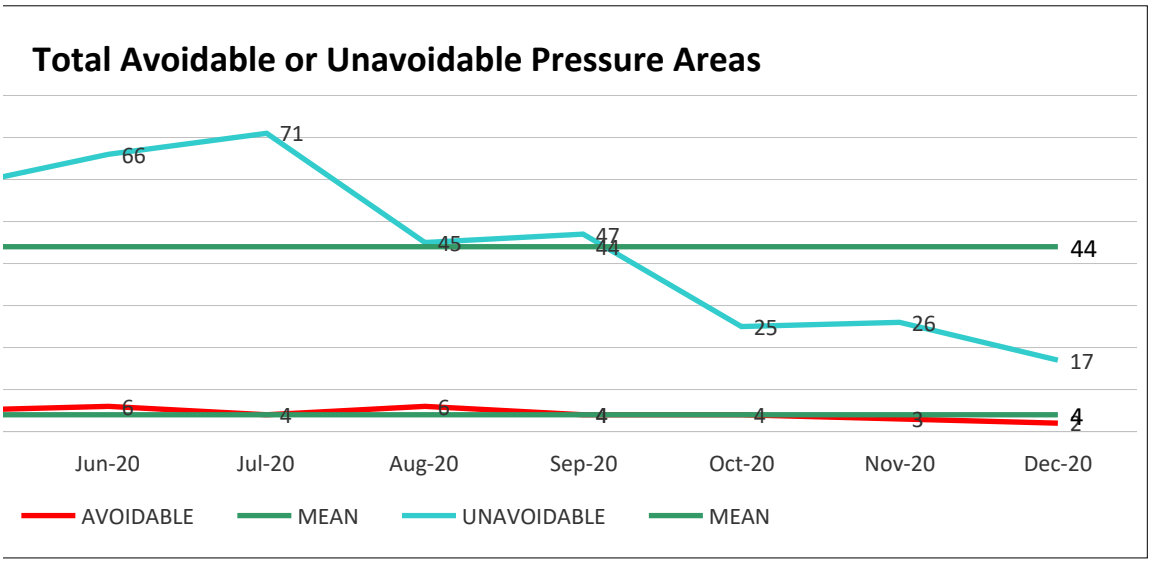
No harm	Total
0	18
1	25
1	41
2	41
3	38
1	32
2	32
1	27
1	31

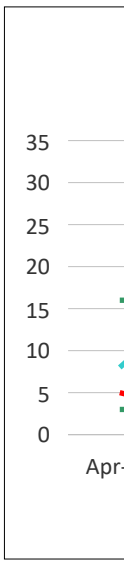


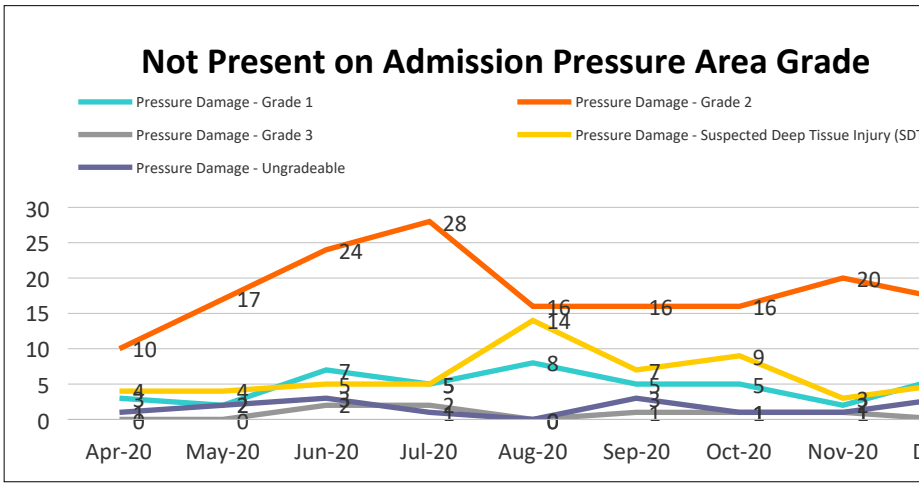
12	285



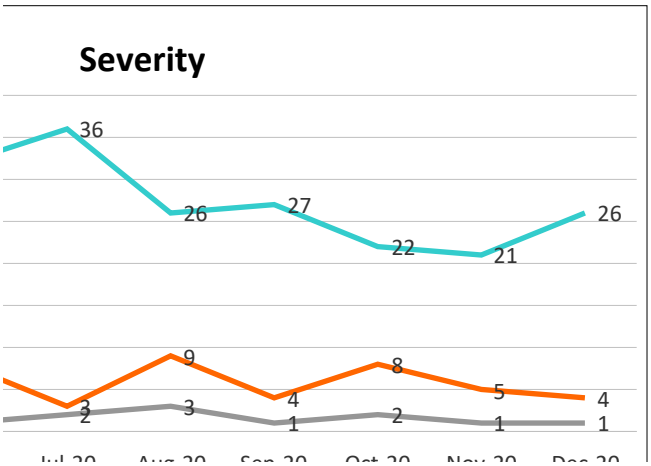
Nursing / Residential Home	Patients Home	Prince Charles Hospital
0	0	14
0	0	18
0	0	37
1	1	34
0	0	32
0	0	30
0	0	30
0	0	27
0	0	27
1	1	249

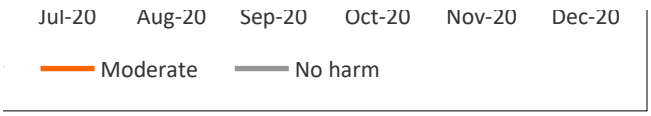




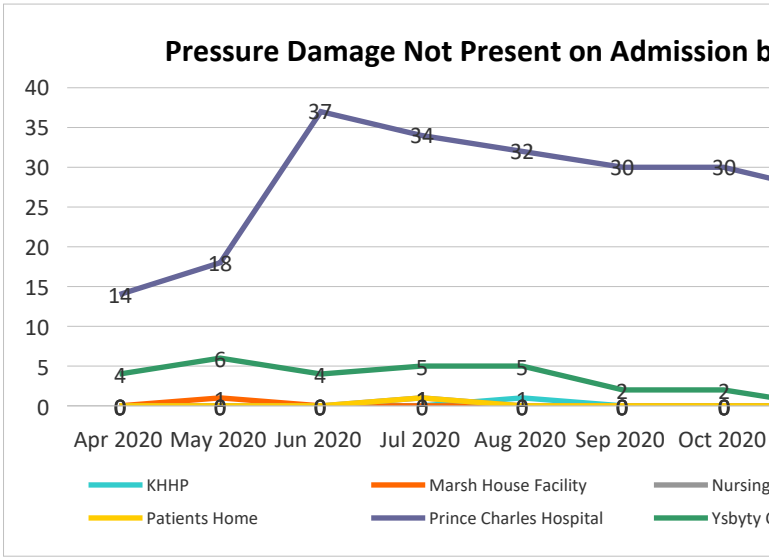


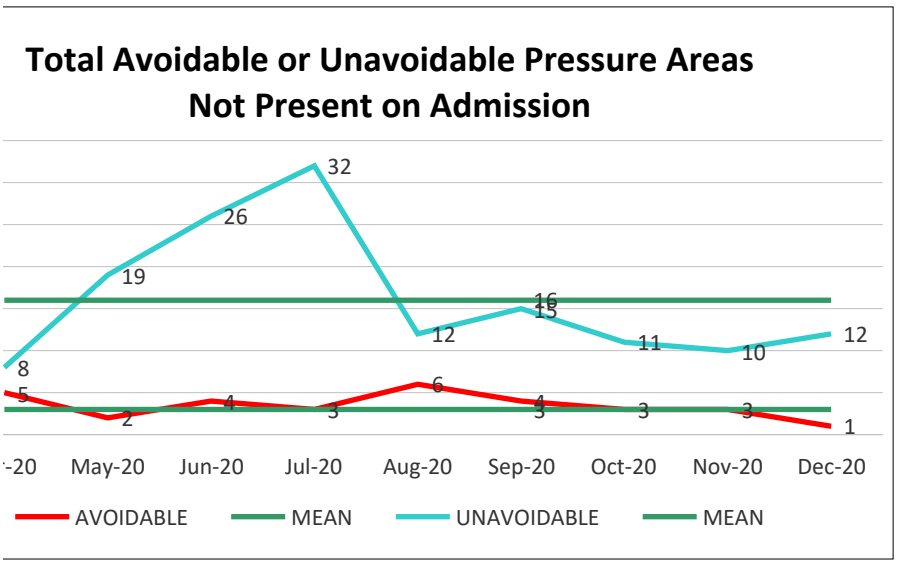
Total
18
25
41
41
38
32
32
27
31
285



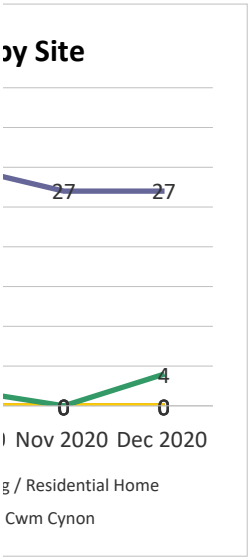


Ysbyty Cwm Cynon	Total
4	**18**
6	**25**
4	**41**
5	**41**
5	**38**
2	**32**
2	**32**
0	**27**
4	**31**
32	285




Total Avoidable or Unavoidable Pressure Areas
Not Present on Admission
32
26
19
8
12
16
15
11
10
12
5
2
4
3
6
4
3
3
1
-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
AVOIDABLE
MEAN
UNAVOIDABLE
MEAN


17
6
3
0
Dec-20


oy Site
27
27
4
0
0
Nov 2020
Dec 2020
g / Residential Home
Cwm Cynon

AGENDA ITEM
6.2.4

QUALITY & SAFETY COMMITTEE

PRIMARY CARE – Quality safety & EXPERIENCE update REPORT

Date of meeting	19 January 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Sarah Bradley, Directorate Manager for Primary Care
Presented by	Julie Denley, Director of Primary, Community & Mental Health
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

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

ACRONYMS	
GMS	General Medical Services
GDS	General Dental Services
GOS	General Optometry Services
DTU	Dental Teaching Unit
CDS	Community Dental Services
D2S	Design 2 Smile
PCSU	Primary Care Support Unit
PCRC	Primary Care Resource Centre
CHW	Community Health & Wellbeing Team

CVD	Cardiovascular Health Check
DES	Directly Enhanced Services
LES	Locally Enhanced Services
NES	Nationally Enhanced Services
CHC	Community Health Council
ED	Emergency Department
YCR	Ysbyty Cwm Rhondda
LMC	Local Medical Committee
PPE	Personal Protective Equipment
GA	General Anaesthesia
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
LACS	Long acting contraceptive services

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Quality & Safety Committee with an update on Primary Care patient quality, safety, risk and experience.

1.2 Primary Care sits under the Corporate Structure and is responsible for commissioning and monitoring of contracting of Primary Care Services, including GMS, GDS and GOS. Primary Care is also responsible for the delivery of a small number of services which are provided across the CTM footprint and these include, CDS, D2S, specialist nursing, PCSU, PCRC, CVD Health Check, directly managed practices (over which there are two), and initiatives funded from primary care delivery funds.

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

Resetting services

General Medical Services

2.1 Despite the intentions to resume GMS services from the 1 October Welsh Government took the decision to once again relax the GMS DES contract requirements back to the March 2020 position with effect from Quarter 3/4. Taking this into consideration and also the fact that the GMS practice workforce has been significantly impacted by absence due to infection and isolation rates it was agreed with LMC that the LES/NES requirements would also be suspended. This is with the exception of

routine immunisations and LACS. A small number of practices are continuing to report level 4 on the escalation tool, this appears to be the larger practices, but it is likely that there are far high numbers struggling with workforce absence that is not always reflected in the tool. The Primary Care team have reminded all practices to update the tool regularly.

2.2 Improving flu uptake position with figures gradually rising. As at 29 December:

65 and over = 74.6% compared to 75% target

65 at risk = 43.67% compared to 48.8% Welsh Average

2-3 year olds = 45.3% compared to 53.3% Welsh Average

Under 65s have never had high uptake figures but is still in a better position than last year. It was noted that the Bridgend Clusters are doing very well hitting the target figures. Historically the higher up you go in the Valley's the less easy it is to get patients through the door and as Merthyr is the worst area, wider health promotion messages are needed for next year. 2-3 year olds flu uptake figures remain significantly low. Parents are simply choosing not to bring children to vaccination clinics. It was noted that a practice in Bridgend had very good figures and lessons will be learnt and shared around good practice.

General Dental Services

2.4 GDS continues to remain in Amber phase. All practices continue to be open (54 in total) with much reduced throughput due to IPC measures. Dentists continue to use their clinical judgement to prioritise patient appointments during this time.

2.5 A key risk on the primary care risk register is the cancellation of GA lists until further notice. The last list in RGH was the 18 December and as a result the waiting list will continue to increase further from the current position of 245 patients waiting. Communications have been sent to GDP and patients to update on the current situation. The specialist dentist in the CDS is currently reviewing the patients on the list and contact is being made with the patients / parents to keep them informed. Further options to support are being sought and will be reported at the next meeting.

General Optometry Services

2.6 Primary Care Optometry services continues to be in the Amber phase. All practices are open (45 in total) and providing the full range of treatments.

2.7 The *Shared Care Glaucoma Scheme* – 205 patients referred but due to IT issues this has now been suspended. The inability to get this project live continues to be an ongoing risk and IT issues have not been resolved, although there may be an option of using 'Open Eyes'. The reality is, because this has taken so much time to resolve and even if this is achieved at the end of January, there is no patient data outcomes to show WG and the Welsh Government funding will cease at the end of March 2021. Funding from within the Health Board will need to be found if the project is to continue.

2.8 *Independent Prescribing Optometry Service*: Services are continuing to deliver. 156 patients seen and 98 follow up appointments treated with IPOS which prevents onward referral / follow up in Hospital Eye Care Services or GP appointment.

Specialist Nursing Services

2.8 Non-essential services have once again been suspended and a number of the specialist nursing team staff are being redeployed to support the Covid Immunisation Programme. Staff who have substantive roles in supporting General Practice have not been withdrawn and redeployed.

2.9 Despite having plans to reduce the waiting list for Aural Care and wax management services through additional weekend clinics, the service has once again been suspended. Patients requiring urgent attention will continue to be triaged and advice will be given. The waiting list will continue to grow but will be monitored.

2.10 Throughout Covid-19 the Community Respiratory/Home Oxygen and Diabetes Services are being maintained as a result of the suspension of services within secondary care. They are continuing to support GPs to keep patients safe within their own homes.

Quality and Safety Governance Framework

2.11 The quarterly quality, safety and risk meetings have continued to take place and work continues to develop a Primary Care quality dashboard. The Governance Team are working with Dental and Optometry Services to streamline a governance process for complaints and incidents. The

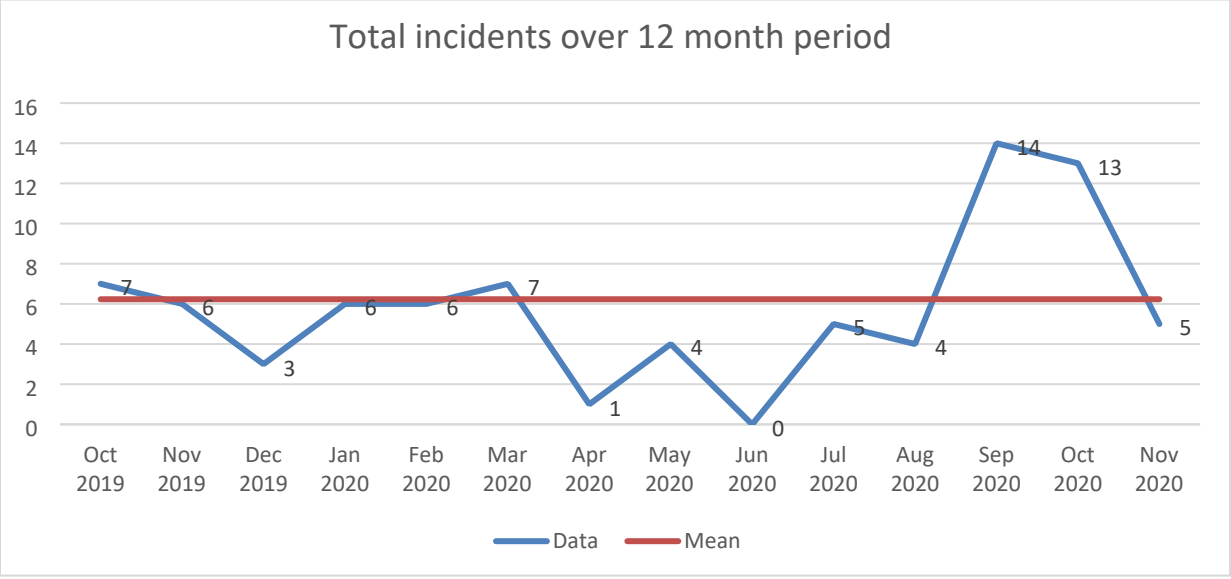
Governance team are in the process of setting up two monthly meetings to review complaints and incidents with key stakeholders for assurance, closure and shared learning. The monthly meetings will comprise of one monthly meeting for Independent GP contractors and one monthly meeting for Dental and Optometry.

Quality Assurance

2.13 Patient Safety Incidents:

There have been 18 incidents reported between the 1 October 2020 and the 30 November 2020.

	No harm	Low	Total
Oct 2020	11	2	13
Nov 2020	4	1	5



2.14 Previous reports highlighted that the Out of Hours incident reporting had improved as a result of greater awareness and training within the team. However, as a result of recent changes to the Datix reporting system, the OOH service is not currently being reported under Primary Care. The Datix Management Team have been notified of this to rectify the issue so the information is captured in the next report. It is known that there are no specific concerns or trends at the current time.

	Oct 2020	Nov 2020	Total
Dental Services	1	1	2
Independent Contractors	5	2	7
Primary Care Specialist Nursing Services	5	0	5
Primary Care Support Unit	2	2	4
Total	13	5	18

2.15 Following the re-launch and update training on Datix, it is hoped that this will have an impact on the number of Primary Care incidents being reported and therefore better assurance. The re-launch has been delayed, mainly due to support currently being provided to the community services within the ILG. A new timetable for the relaunch via teams is currently being drafted and will be sent out to all GP practices.

Approval Status of Incidents

2.16 The table below shows the overall position for the Directorate.

	In holding area	Investigation in progress	Investigation completed	Total
Admin and Clerical	1	0	1	2
Community Dental	0	1	5	6
Home Oxygen Service	0	2	0	2
Immunisation	0	0	1	1
Independent Contractor - GP Surgery	0	43	87	130
Primary Care Nursing Sevice	2	1	4	7
Primary Care Support Unit	0	0	5	5
Teaching	0	1	0	1
Total	3	48	103	154

Claims

2.17 There is one new potential claim within Primary Care. It relates to a District Nursing Service, GP Practice and the Health Boards Practice Nurses (20/3885/CN) at this Practice. Legal and Risk have been instructed and the GP Practice has been advised to forward the letter of Claim to the Insurers as it pre-dates 2019.

2.18 Meetings are currently ongoing regarding a process for the Claims team around receiving and logging of Independent GP contractor claims following change with GMPI.

Concerns

2.19 Between the 1 October and the 30 November 2020, there were 50 concerns raised within the Health Board in relation to Primary Care. The figure is made up of 10 service enquiries, 22 early resolution concerns and 18 formal complaints.

The three top themes for concerns continue to be:-

1. Communication
2. Treatment Error and
3. Response times

There are 26 concerns which remain open. Five are enquiries; two early resolutions and 19 formal complaints. The Governance team are working with managers and service leads to improve on response times. The new monthly primary care concerns review group will aim to pull out the learning from concerns and this will be shared and cascaded with contractors via the quarterly GMS clinical governance newsletter. A similar newsletter is in the process of being established for the Dental and Optometry Service.

Ombudsman complaint

2.20 There was one case referred to the Ombudsman following a formal complaint investigated by a GP Practice. Following review of the practice's response to the complaint the Ombudsman was satisfied with the investigation and the care provided to the patient.

Serious Incidents

2.21 There is one ongoing serious incident for Primary Care. The incident is being led by RGH, however there is an element of the incident relating to OOH.

Management of Risk

2.3 All risks are closely monitored and managed and reported through to weekly Bronze meetings. There are currently no high risks for Primary Care. There are currently 10 moderate risks.

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

3.1 The suspension of Paediatrics dental GAs continues to increase the number of patients waiting as detailed above.

Mitigation: The Special Care Dentist in the CDS service is reviewing the children on the list who are urgent and suitable for redirection to other pathways. A member of the team will continue to phone patients to review their condition. Further options are being explored and will be fed back at the next meeting.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
Equality impact assessment completed	No (Include further detail 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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 Members are asked to **NOTE** the progress outlined in this report and **DISCUSS** the matters for escalation.

AGENDA ITEM
6.3

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY QUALITY DASHBOARD

Date of meeting	19 January 2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Louise Mann, Assistant Director Quality & Safety louise.mann@wales.nhs.uk Mark Townsend, Head of Clinical Audit and Quality Informatics mark.townsend@wales.nhs.uk,
Presented by	Greg Dix, Executive Director of Nursing, Midwifery and Patient Care
Approving Executive Sponsor	Executive Director of Nursing Executive Medical Director Director of Public Health
Report purpose	FOR DISCUSSION / REVIEW

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

ACRONYMS	
	All acronyms defined in the report

EXECUTIVE SUMMARY

The momentum and impact of the second wave of COVID-19 is causing substantial disruption to the way in which care is planned and delivered. Non-urgent services have again been paused and staff deployed to prioritise acute patient facing activity. There will be challenges to maintaining and progressing the quality and safety agenda during this time and it is anticipated that there will be a Welsh Government (WG) directive to temporary reduce the requirements on Putting Things Right (PTR) and incident reporting. In addition, accurately reflecting the experiences of colleagues and those who use and rely on our services, in order to triangulate hard and soft intelligence is being delayed by the pandemic, but also by the lack of consistent, sophisticated methodology to capture this holistic perspective. The Once for Wales risk management model is keenly anticipated to support understanding of peoples experience of our health board, even during times of crisis.

Within this report, presented to committee at Appendix 2 are the proposed set of quality and safety indicators agreed with ILG's, that will provide improved assurance to the Committee and Board that the breadth and reach of the services it is responsible for delivering are of the highest standard and effectiveness. This document will be progressed further with Clinical Service Groups and Planning.

This report outlines the current position in relation to the previous agreed quality metrics up to and including November 2020.

Key areas to note are:

- Complaints, harmful incidents and Serious Incidents (SI's) are increasing to pre-covid rates for the Health Board. Serious incident reporting for covid outbreaks and hospital acquired covid infections (HCAI's) has contributed significantly to this increase – from December 2020, HCAI's related to outbreaks will no longer required to be reported as SI's; this data is produced daily and submitted directly to WG.

- The majority of complaints occur within our Accident & Emergency (A&E) and acute medical services, mental health and primary care/localities. The majority of serious incidents occur within obstetrics and gynaecology, head and neck and mental health.
- Learning from complaints is shared in a number of ways and this is captured and evidenced within newsletters and staff communication in addition to local action plans. Advancing learning throughout the organisation is a key focus of the new Listening and Learning forum, planned to commence in January 2021.
- It is crucial that the voice of the service user, their families and Health Board workforce is heard, however logistically difficult, and alternative methods of

capturing this during the restrictions of covid and until the advent of the Once for Wales model, should be utilised and reported to provide a rounded perspective on quality and safety issues.

1. SITUATION/BACKGROUND

This presentation of the Quality Dashboard provides data up to the end of November 2020. A number of considerations need to be taken into account, not least continuation of the significant impact of the Covid-19 pandemic on our normal business as a Health Board.

There has been significant work undertaken both centrally and within the ILG's to support the migration of data into a locality model to ensure current quality metrics are consistent and reflective of each region. The Health Board is in the process of cleansing data sets for the localities in totality and much progress has been made. Work is progressing to ensure that future reporting captures person centred quality and safety with a greater scope and range of measures (see appendix 2).

As with previous reports, this report includes a section on capturing patient experience across the three localities. This is in order to provide cross-reference and triangulation of hard and soft intelligence to gain a strengthened understanding of how services are provided, delivered and where possible, perceived by our public. Whilst services are affected by the pandemic and restrictions to visiting continue, this report aims to continue to provide patient experience data and what relatives and carers think of care and services provided by the Health Board.

Again, as with previous reports, this report provides (where available) data for the past 12 months and also includes trends as a Statistical Process Control chart (SPC), albeit this illustration could provide greater clarity of an improving or deteriorating picture with control limits. This will be further explored within the ILG reports. The data is taken from the Health Board's Datix system, with further data provided from Myrddin (All Wales system) and other national reporting systems. Additionally, as some data sources are dynamic e.g. Datix and community contact data, metrics are accurate to a specific point in time. These metrics are refreshed every month, therefore data will change from previous reports as new information is included. To ensure clarity, the date that data is captured is noted in the report.

The planning and performance team, in collaboration with the quality informatics team continue to work together to develop and improve data integrity and validation. As with the previous report in August 2020, in developing the report on behalf of the Lead Executive Director, the patient care and safety team have worked in partnership with the ILG's. This collaborative relationship is key to establishing an organisation wide systematic approach to maintaining consistently high quality services through outcomes setting,

ongoing comparative measurement and reporting on safety, effectiveness and experience, identifying areas for improvement and enabling the sharing of good practice and lessons learned.

Covid-19 – Maintaining Quality and Patient Safety

We have endeavoured to maintain normal activity in relation to quality, safety, patient experience and PTR, although the impact of the second wave of the virus has increased pressure on colleagues from a patient facing perspective.

It is anticipated that as a result of the pandemic response there will be a reduction in the requirement for incident reporting, investigation and complaints responses, as in the first wave, however patient safety remains paramount. The Patient Care and Safety Team will attempt to maintain a 'business as usual' ethos to quality assurance, quality effectiveness and patient experience through the pandemic, wherever possible. Despite the challenges of the situation and continued deployment of staff to alternate activities and home working, in addition to staff sickness, incident reporting and making safe will be prioritised, whereby investigations and response timescales will be proportional. Communication with complainants will be maintained. Sustained recovery and improvement planning is compromised by the persistent nature of the virus on the health of our communities.

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

Data run on 09.12.20

Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Health Board Wide Quality Metrics													
Number of never events in month	0	0	1	0	0	0	0	0	0	0	0	0	
Number of serious incidents (SI)	38	31	33	10	7	12	9	13	14	22	29	39	
Number of formal complaints managed through PTR *	104	148	131	83	68	66	106	119	97	133	126	108	
Number of compliments	43	129	61	24	62	26	154	57	49	64	66	130	
Number of medication prescribing errors	19	21	16	17	3	8	10	13	14	16	14	12	
Number of medication administration errors	33	48	47	38	27	34	39	53	56	59	43	47	
Mortality Rate (CHKS)	3.07%	2.89%	2.40%	3.64%	8.31%	4.9%	3.86%	2.47%	3.48%	3.4%	5.24%	6.26%	

* Calculation of formal complaints received is now run from date first received as of 1st July 2020.

Never Events:
There were no never events reported during October to November.

Serious incidents:
During October to November 2020 a total of 3825 incidents were reported. Of these, 68 were categorised as a serious incident i.e. resulting in avoidable severe harm or death. This is 2% of the total incidents reported.

Prompt addressing, making safe and investigation of patient harm continues to ensure good quality care provision is maintained and the learning shared. NHS organisations will not be required to undertake full root cause analysis for every incident, only for serious incidents – it is anticipated that the criteria for SI's will be reduced by WG as HB's manage the pandemic. The investigations carried out should be proportionate to the incident being reviewed.

Prior to December 2020 deaths arising from or with hospital acquired nosocomial covid transmission and hospital outbreaks required Serious Incident notification and investigation. This, was in addition to individually completed investigations using the covid toolkit and mortality reviews will ensure robust effective analysis and learning takes place. Toolkit analysis of all HCAI deaths are maintained.

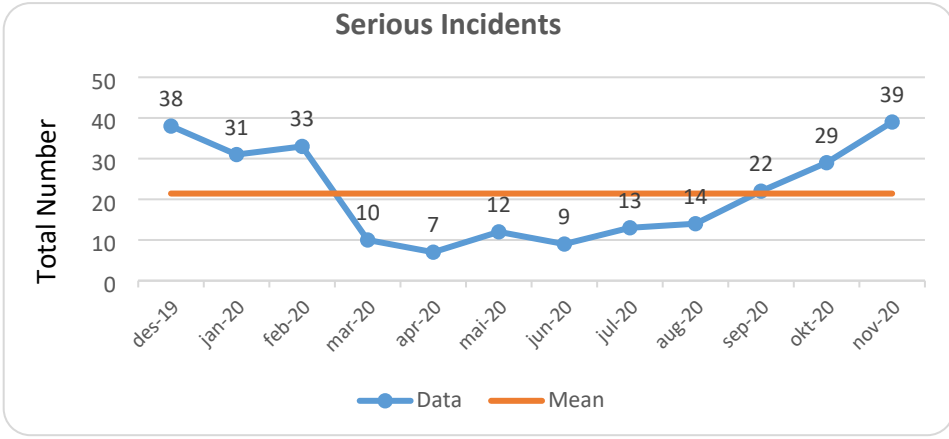
As an organisation we will endeavour to maintain the now removed 60 day target for SI management and to further improve upon our timescales for investigation and closure wherever possible. Overall Health Board mean compliance rate with the 60 day target is 20%. ILG's are working with the central team to develop realistic improvement targets.

SI Categories	Oct 2020	Nov 2020	Total
Infection	16	23	39
Unexpected or Trauma Related Death	4	5	9
Slip, Trip or Fall	2	3	5
Absconding	0	2	2
Self Harm	0	2	2
Admission / Transfer / Discharge	1	1	2
Communication	1	1	2
Delays	2	1	3
Patient injury	0	1	1
Maternal Event	1	0	1
Medication	1	0	1
Neo-Natal Event	1	0	1
Total	29	39	68

Fig 1. Incident by type: October-November 2020

There is an increase in reported SIs for November related to reporting covid HCAI's. The increase in unexpected death as a result of completed suicide has continued through October and November. The decrease in SI's mid 2020 in comparison with the previous year is likely to be the impact of the coronavirus pandemic, where we have seen a reduction in average patient presentation, activity and flow. This has subsequently increased with HCAI and outbreak reporting, returning to 2019 levels overall.

The serious incidents reported are distributed across 12 categories with the top 3 related to covid, unexpected or trauma related deaths, and falls.



As part of ensuring robust, continuous quality governance during the Covid-19 period, quality impact assessments (QIA's) are being undertaken for the key service changes underway to ensure any potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way. It is anticipated for the future that a QIA will be consistently

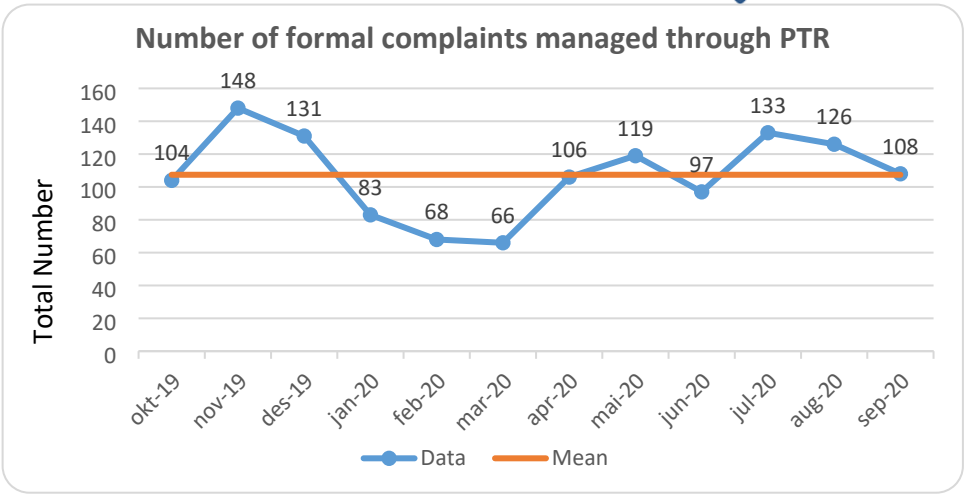
considered as part of all development and proposal stage of new services, and when planning changes to existing services. This will ensure quality remains the driving component in CTM's provision of its services.

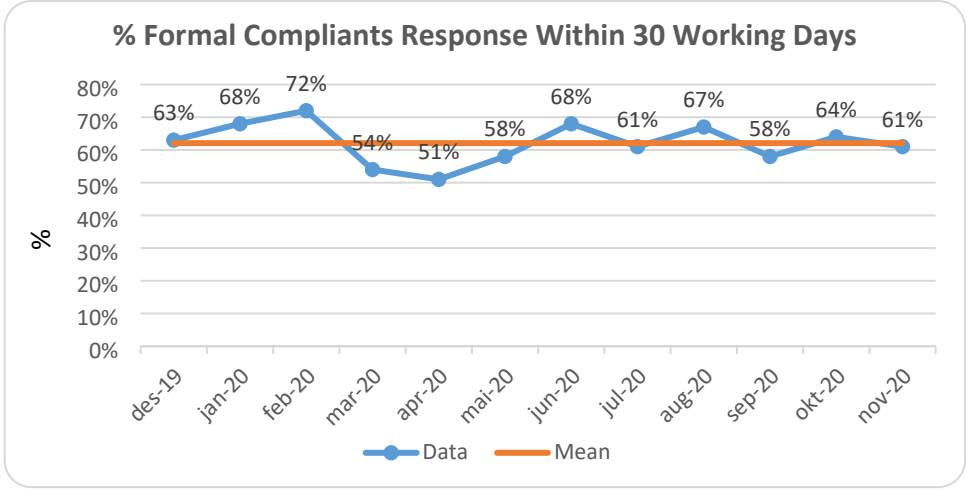
Currently weekly reviews of Datix are being undertaken to ensure that any Covid-19 related harms are captured. Complaints relating to the impact of Covid-19 on those affected by the pause or delay in non-essential services are also being captured.

Complaints:

- During October to November 2020, there were 234 complaints managed through Putting Things Right regulations. The main themes from complaints relate to *communication, delays, admission/discharge/transfer* (ADT) issues and treatment errors. The complaints relating to communication are concerned with lack of information on care pathways, unavailability of certain services due to covid and in poor staff attitudes. The delays relate to waiting times, delays in treatment, follow-ups and investigations in general medicine and radiology. The ADT complaints related to general service user unhappiness with care, or the management of the admission to discharge process.

- Timely response rates fell in this reporting period and a direct consequence of clinical teams not having capacity to respond, however additional corporate support has now been provided to the ILG's to clear any backlog. The second wave will again have an impact on the timeliness of 30 day responses although historical concerns allocated to the ILG's when they became operational, affect their overall current compliance. As of November 2020, organisational compliance stands at 61% against a target of 75%. As with SI's the corporate team are working with the ILG's on a supported improvement trajectory. Complainants have received acknowledgement and explanation where there are any delays in reply. Learning from complaints is shared via a number of methods and this is strengthened with the locality and organisational governance structure, providing a more streamlined framework for cross pollination of learning and improvement.





Compliments:
During October to November, there were 196 compliments reported to the PALS team, a significant increase from the previous reporting period. The total number of compliments received for the year so far was 865. This is a difficult time for anything other than core business for colleagues however reminders have been sent to colleagues to share any compliments with the PALS team for reporting on Datix. The people's experience module within the new Once for Wales risk management system is anticipated as a method of facilitating standardised meaningful data, allowing for improved triangulation of intelligence on how are services are experienced by those who use them. Patient experience at Appendix 1.

- **Patient Safety Solutions:**

The Health Board currently reports non-compliance in 3 areas.

Summary
The Delivery Unit snapshot review of Serious Incidents in September 2020 identified insufficiencies in our processes for National Safety Standards for Invasive Procedures (NatSSIPs). As a result, internal review within the Patient Care and Safety Unit is underway which will determine the effectiveness of work undertaken to date and implement corrective measures required to ensure a robust process for all invasive procedures.

The internal monitoring and reporting process for NatSSIPs and Patient Safety Notices (PSNs) is currently under review, with a revised process proposal having been approved and implementation imminent. The new process will fall in line with future plans due to be delivered through the 'Once for Wales' project and will therefore reduce the need of significant process change when this is rolled out.

The Health Board currently reports non-compliance in 3 areas:

PSN008
Nasogastric tube misplacement: continuing risk of death and severe harm.
Interim arrangements put in place by the Health Board are supported by the Delivery Unit and Welsh Government patient safety team until an alternative product is sourced for Wales.

PSN030
The safe storage of medicines: cupboards.
Areas of non-compliance have been identified. Advice from the Delivery Unit is to undertake a further risk assessment across the Health Board to check compliance as the Health Board can report compliance if they can demonstrate safe storage of medicines, despite metal medicines cabinets not being available which is recommended within the notice. Pharmacy leads are reviewing the risk assessment on an All Wales basis but this work is delayed due to the Covid-19 outbreak.

PSN046

Resources to support safer bowel care for patients at risk of autonomic dysreflexia.

Health Board policies, procedures and a Standard Operating Procedure have been drafted and the educational programme is being enhanced. The initial anticipated completion date of April 2020 has now been delayed with a new date not yet available. A full action plan and progress mapping is in place.

All Wales compliance data available at: http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data

Patient Experience:

The latest patient experience data is attached as appendix 1. Health Board wide data will be available once the new national 'Once for Wales' system is introduced, this was planned for April 2020, however there is a delay in progressing the project due to Covid-19. A project lead has been appointed for the Health Board.

Medication errors:

The number of medication administration incidents was 90 for October to November a decrease of from 115 for the previous 2 months. The Medication Safety Steering Group produce a regular newsletter to highlight common errors and to raise awareness of safe medication practice.

Mortality rate:

An expected increase in crude mortality rates is as expected in light of covid and winter infections. Stage 1 reviews are continuing. Locality weekly-based stage 2 review sessions have been established to deal with the increased cases for review due to Covid-19.

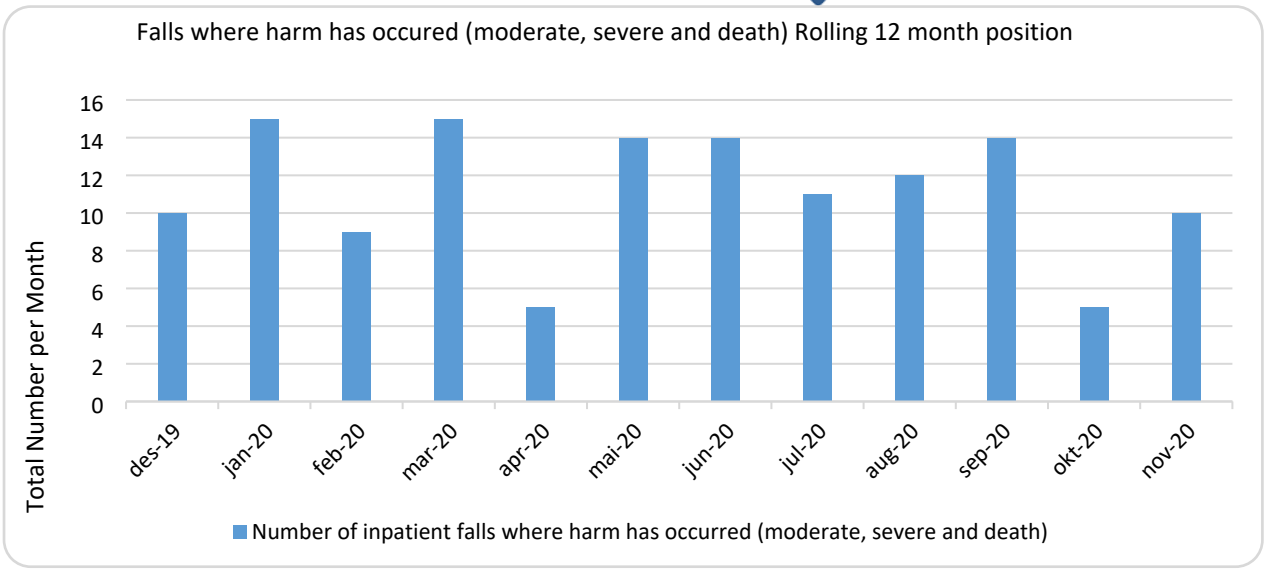
Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Acute Site Metrics													
Total number of inpatient falls **	293	310	278	290	250	282	254	273	269	306	284	**281**	
Number of inpatient falls where harm has occurred (moderate, severe and death) **	10	15	9	15	5	14	14	11	12	14	5	**10**	
Total number of instances of hospital acquired pressure ulcers **	109	137	106	72	70	81	90	96	99	92	100	**88**	
Number of hospital acquired pressure ulcers grade 3 and 4 **	6	4	4	6	1	1	8	4	2	2	2	**3**	
Number of potential Hospital Acquired Thrombosis (HATs)	10	14	13	6	10	4	4	3	2	13	12	**4**	
% VTE risk assessments documented on the med. Chart	90%	96.3%	92.8%	100%	100%	100%	100%	97.3%	100%	94.4%	98.7%	**94.6%**	
Hospital Arrests (2222 calls)	56	NA	49	47	31	98	76	73	95	89	NA	**NA**	
Training % NEWS	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	**NA**	
C.difficile Rate/1000 admissions	0.56	0.92	0.96	1.48	1.98	2.42	2.48	3.36	3.11	3.39	2.28	**1.27**	
MRSA bacteraemia Rate/1000 admissions	0.14	0.31	0.16	0.00	0.00	0.27	0.00	0.21	0.00	0.00	0.25	**0.25**	
MSSA bacteraemia Rate/1000 admissions	2.26	1.53	2.25	1.69	1.98	2.42	2.73	0.84	2.69	1.60	3.30	**2.03**	
E. coli bacteraemia Rate/1000 admissions	4.24	4.13	5.93	6.77	5.28	6.72	8.20	8.19	6.63	6.18	3.30	**7.87**	
% of patients who spend less than 4 hours in A&E from arrival to admission, transfer or discharge	68.36%	71.25%	78.66%	74.10%	92.6%	95.3%	93.1%	89.84%	86.27%	82.66%	79.49%	**78.26%**	

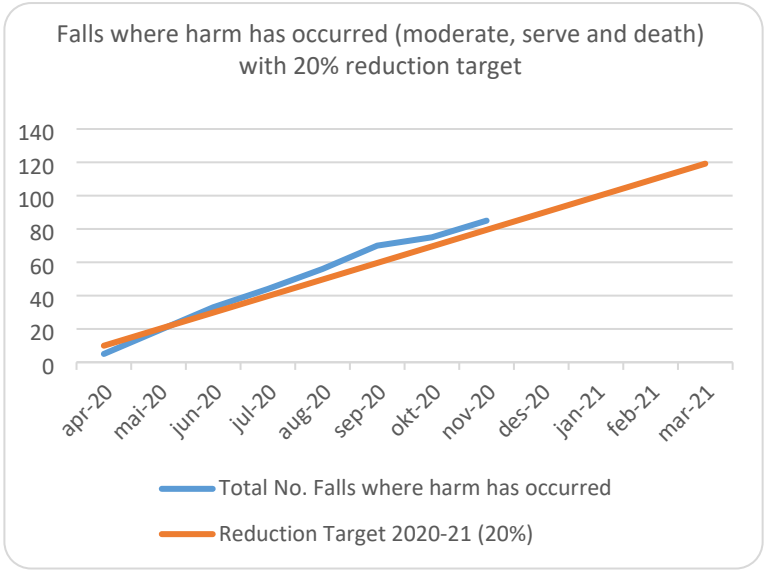
Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Acute Site Metrics													
% of patients who spend less than 12 hours in A&E from arrival to admission, transfer or discharge	93.73%	91.56%	92.77%	88.85%	99.7%	98.9%	99.1%	99.2%	96.79%	96.2%	91.25%	**90.69%**	
AvLOS (based on discharges only)	4.28	4.96	4.71	7.04	9.71	7.41	6.51	6.18	6.56	6.43	6.1	**6.5**	

** The HB and Locality Hospital Acquired Pressure Ulcers and fall data includes all inpatient acute and community hospital sites.

Inpatient Falls:
There was a slight decrease in falls reported for October to November (565) from the previous 2 months (575). The highest number of inpatient falls occurred within medicine and emergency care departments at the Princess of Wales Hospital and Prince Charles Hospital.

Currently only total numbers are reported. The move to add report using 'per 1000 bed days' is under review. Over the past 12 months, a total of 3,370 falls were reported of which, 134 caused harm. An improvement trajectory of 20% reduction in falls with harm is planned. Progress against this will be monitored and supported through the **falls prevention group** which will be re-established when the current demands on staff are less acute. The first step to the improvement will be to ensure that there is data accuracy, however there has been evidence of significant improvement actions to preventing falls within the hospital environment. These have been demonstrated and shared through the quality governance framework deep dive analysis and sub group meetings. Documentation in relation to falls assessment and falls care planning are currently being reviewed by Heads of Nursing to ensure there is organisational understanding and consistency of approach – progress has been stymied by the second wave response.

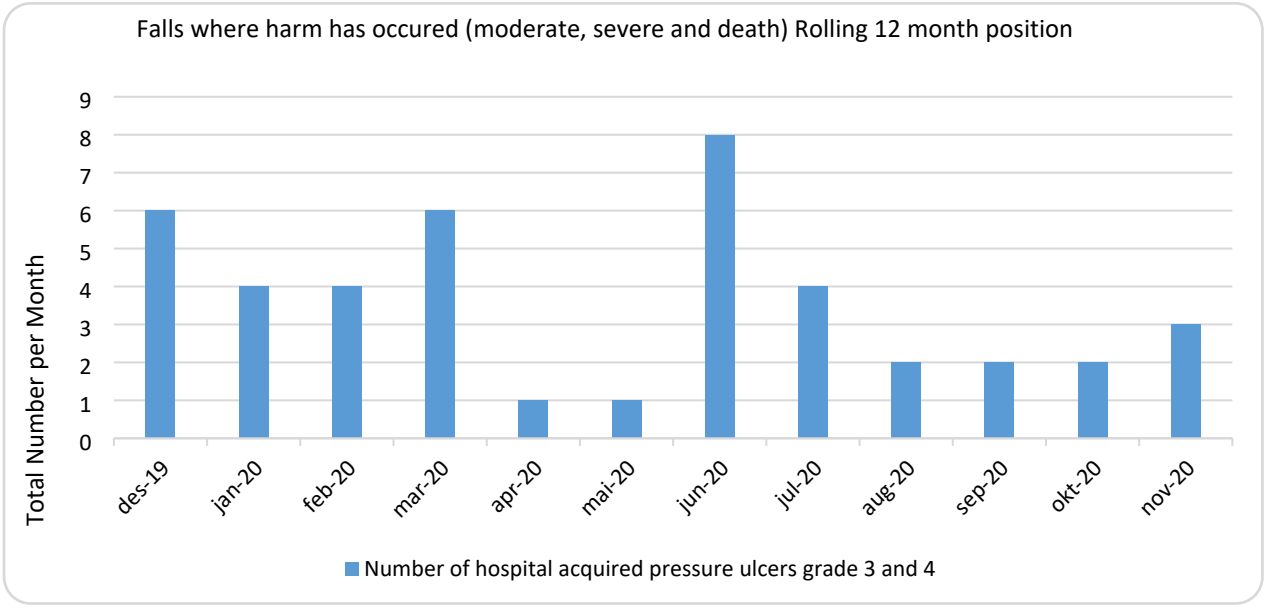


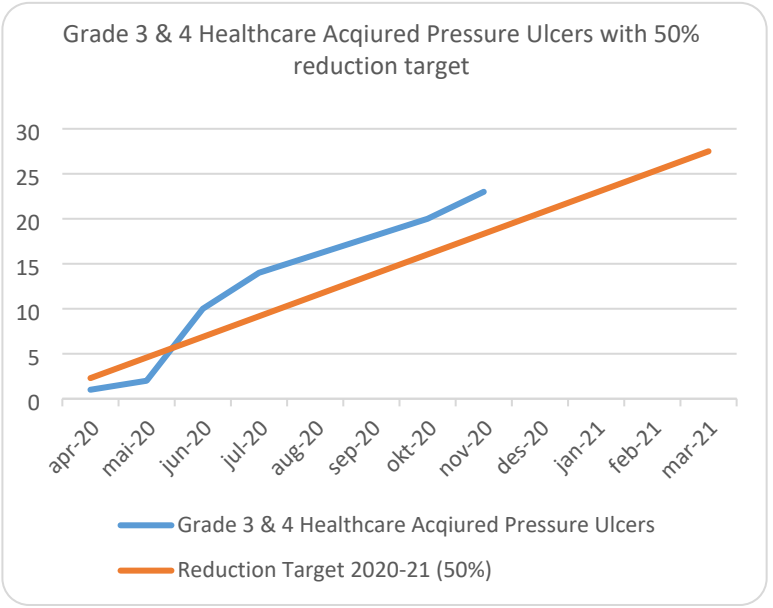


Hospital Acquired Pressure Damage:
The number of reported pressure damage has decreased slightly for October to November (188) compared to 191 for the previous 2 months. The majority of pressure damage occurs within the patient's home (or care placement) and is present on admission or reported by district nursing staff. A review is undergoing by the central team to explore options to improve targeting the community population at risk of pressure damage. Pressure damage incident reporting were equally split across all 3 acute sites within trauma and orthopaedics, acute medicine and the Accident & Emergency department.

Currently, as with falls, only total numbers are reported.

Over the past 12 months, a total of 1,140 hospital acquired pressure ulcers were reported across the Health Board, of which, 43 were Grade 3 and 4s. All avoidable pressure damage is reported to the Multi-Agency Safeguarding Hub (MASH). An improvement trajectory of a 50% reduction in Grade 3 and 4s is planned. Progress against this will be monitored and supported through the **pressure ulcer improvement group** which will also be re-established shortly under the direction of the new Assistant Director of Nursing. The first step to the improvement and learning will be to ensure that there is data accuracy, however the newly established scrutiny panels already provide multi-disciplinary clinical review of departmental pressure damage, holding practitioners to account, taking further action and sharing best practice.





Hospital Acquired Thrombosis (HAT) and Venous Thromboembolism (VTE) assessments:
There were 16 potential HATs identified for October to November 2020 compared to 15 for the previous 2 months.

Hospital Cardiac Arrests and NEWS Training:
The data for October and November 2020 was incomplete, but a revised data source is being identified for the next report. Hospital Cardiac Arrest Calls will remain an important metric as the ultimate goal is cardiac arrests only to occur in the Emergency Department. This is due to strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our DNACPR processes. NEWS scoring, and therefore training, are integral to this goal.

Recognising Acute Deterioration and Resuscitation (RADAR) group has met and in the early stages of forming our cross-organisational programme. We will be expanding our metrics to keep a constant review of our activities.

Infection Prevention and Control (IPC):
Whilst the IP&C team are clearly focussed on COVID-19 work, they continue to maintain a focus on other reportable infections during this period. The Health Board continues to make progress in this area, despite not meeting the required trajectories. This is a similar picture however throughout health boards in Wales.

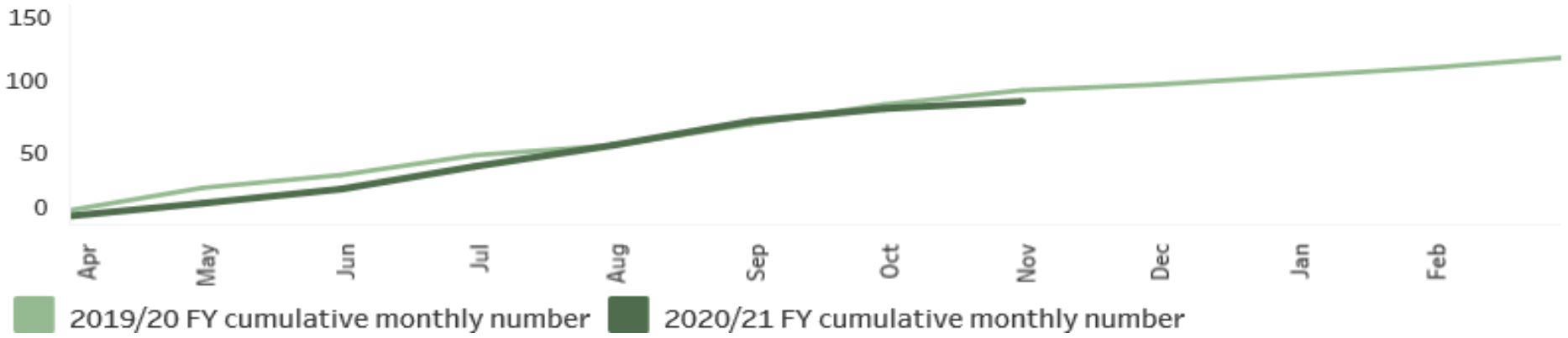
Recruitment is underway to address the current IPC vacancies and long term sickness. Additional IPC staff will directly support the ILG's.

Generally there has been a reduction in S.aureus bacteraemia and gram negative bacteraemia (E.coli, Klebsiella and Pseudomonas bacteraemia) compared to the same period last year. There has been a slight increase in the number of C.Difficile cases compared to last year. Almost half of the C.Difficile cases identified in the latter half of 2020 were community acquired infections. This needs to be addressed if we are to see a reduction in overall C.Difficile numbers. In addition, improvements in antimicrobial stewardship and strengthening of the Root Cause Analysis (RCA) processes in secondary and primary care will progress effective management.

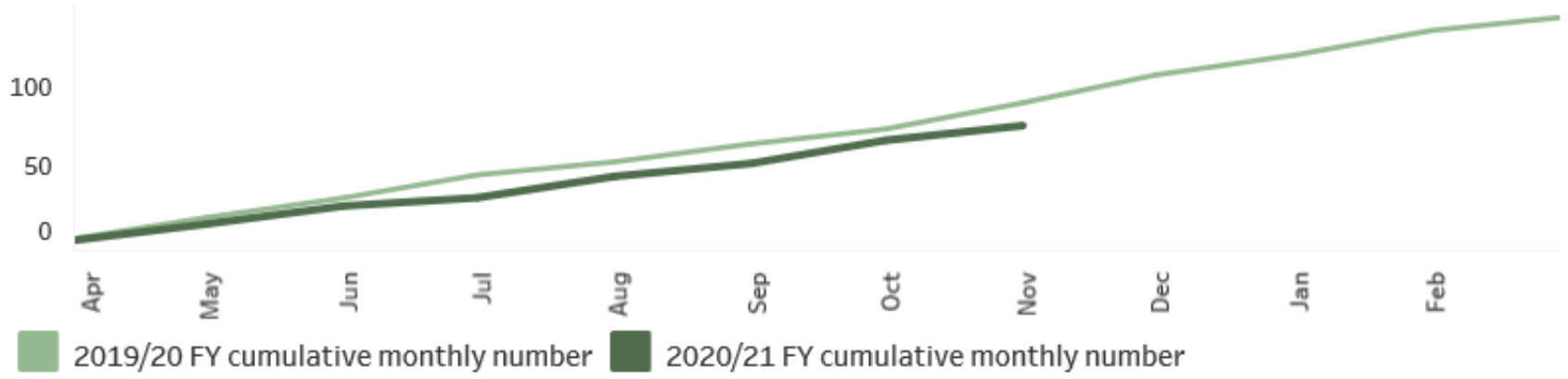
Additional resource is needed to appoint a dedicated IPC team for primary care and to support IPC teams on each of the 3 DGH sites throughout the winter period. Without investment the current team is unable to deliver the targeted interventions needed to improve IPC practice/antimicrobial stewardship which will ultimately benefit secondary care and improve outcomes for patients. We need to introduce a whole system approach for IPC spanning primary and secondary care and community hospitals. This will also help reduce the community acquired S.aurues bacteraemia and E.coli bacteraemia.

Planned improvements to the IPC service:
- Escalate any alert organisms, IPC concerns/issues to the ILGs on a weekly basis.
- Continue to support the COVID response offering additional IPC training/ donning and doffing training
- Reinstate level 2 IPC training in the classroom setting as the COVID situation allows
- Analyse sources of blood-stream infections to introduce targeted interventions
- Learn from incidents/share learning across the organisation.

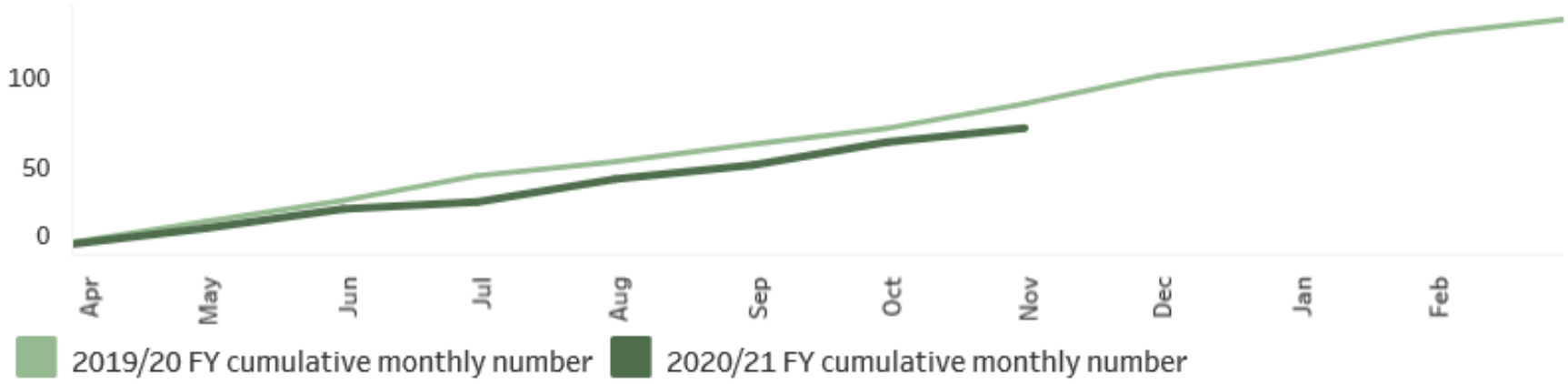
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April to November 2020 against the equivalent period in 2019/20



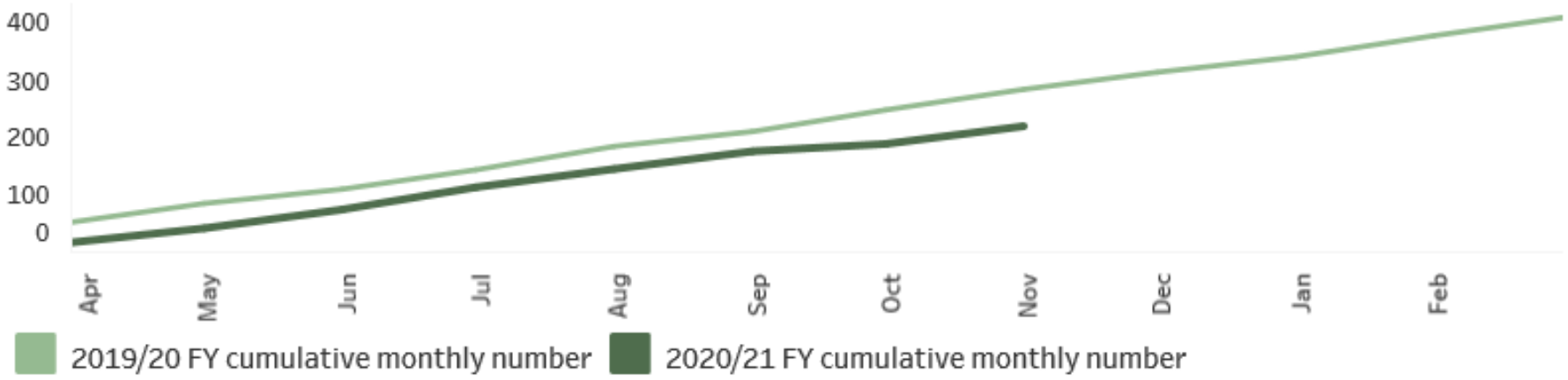
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April to November 2020 against the equivalent period in 2019/20



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April to November 2020 against the equivalent period in 2019/20



Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April to November 2020 against the equivalent period in 2019/20



Emergency Department 4 hour and 12 hour performance:
As a result of the Covid-19 pandemic, attendance at the Health Board's EDs had reduced. Compliance with the 4 hour target has decreased to 78% for October to November compared to 83% for August September due to increased general activity and COVID cases during the 2nd wave. The 12 hour A&E performance has also deteriorated from 97 to 91%.

Average Length of Stay:
The ALoS has remained consistent during the pandemic at approximately 6 days. However, overall ALoS has been affected due to the impact of Covid-19. Further analysis of the Covid-19 period will be undertaken to capture and share good practice.

Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Primary Care Metrics													
Number of out of hours contacts	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Delayed Transfers of Care	5.40%	4.10%	6.30%	7. 1%	NA	NA	NA	NA	NA	NA	NA	NA	

Both these metrics have been identified as initial measures of quality. Further work is required to clarify what these tell us about the quality of care and additional development of meaningful community/primary care data is required and are highlighted in the proposal report (Appendix 2). Primary and community care is central to legislative drive for health improvement and population well-being and this requires more sophisticated indicators of quality, safety and person experience. These are being reviewed and re-designed in conjunction with the three locality Groups and Service Group Directors to attempt parity with the assurance measures of secondary care provision. Covid-19 has significantly impacted on how primary care is working at present however progress is being made in the development of specific subgroups in order to maximise the opportunity for learning, action and continuous improvement of all the services. Monthly Quality Assurance meetings are being put in place for the review of Primary Care contractor incidents and complaints. This will enable themes and trends to be identified, along with building capacity for shared learning.

Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Community Care Metrics													
District Nurse treatments	15186	16203	15779	18356	18832	19699	21290	22908	23706	28447	36940	3507	
Referral to At Home Services (All Referrals)	118	170	144	126	98	66	92	117	91	125	104	122	
Maesteg Hospital (ALOS)	72	54	29	42	47	53	82	40	44	45	48	74	
Ysbyty Cwm Cynon (ALOS)	49	51	63	66	39	45	54	54	50	55	36	44	
Ysbyty Cwm Rhondda (ALOS)	47	56	76	69	57	46	51	67	61	62	49	52	
Palliative Medicine, Bridgend (ALOS)	10	12	11	18	17	13	18	13	10	11	10	10	
Palliative Medicine, Pontypridd/RGH (ALOS)	14	7	17	12	17	7	12	10	11	9	30	10	
Palliative Medicine, YCC (ALOS)	16	25	15	19	28	19	20	15	17	34	17	28	

District Nurse Treatments and at Home Referrals:
All 31 District Nurse teams in CTM are now using the Malinko scheduling and data capture software. Notably this means that the activity levels from Aug/Sept 2020 onwards are being recorded and reported with a very high level of confidence in terms of the true numbers of patients being seen at home. The monthly increase in patient activity is being felt on the ground as a significant pressure in all the teams, especially when taken in the context of a staffing deficit due to Covid related absence. The numbers of referrals for Fast Track end of life care in particular continue to be significant. In order to manage demand the teams have all reduced their patient facing contacts to those that are assessed as most in need/urgent.

GP referrals into the @Home Service continue to account for most of the activity within the team. The service is managing to maintain a timely response despite some staffing deficits.

Community Hospitals Average Length of Stay (ALoS):
The Community Hospitals (Ysbyty Cwm Rhondda (YCR) & Ysbyty Cwm Cynon (YCC)) are continuing to progress patients through to discharge as quickly as possible however the Care Home & domiciliary care sector remain under huge pressure which has an impact on our ability to discharge in a timely way. Close working with our partners in the Local Authority continues daily to support the discharge planning process. YCR in particular has seen two smaller outbreaks of Covid that have had an impact on staff availability as well as ALOS on the affected wards. Maesteg Hospital patients have now been transferred out to Ysbyty Seren as a temporary measure.

The 3 Specialist Palliative Care In-Patient Units have been functioning at full capacity. The spikes in ALOS seen in October and November are attributed to a small number of highly complex and unstable patients who needed to remain within the units themselves for very specialist end of life care.

Indicator Description	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-2020	Trend
Mental Health Care Metrics													
Number of 136 assessments in police cells	0	0	0	0	0	0	0	0	0	0	0	0	
Number of restraints	26	17	18	22	25	32	40	19	32	20	21	19	
Number absconding from wards (overall not just detained) ****	13	9	24	21	10	12	28	26	18	16	11	19	

**** All Wards

Number of 136 Assessments in Police Cells:
None.

Number of Restraints:
Numbers remain relatively low (compared to a peak of 40 in January 2020). Much of this is attributed to relatively low occupancy across this quarter although it should be noted that the people who are admitted are of the highest acuity and risk.

Number of Detained Patients Absconding:
There have been no AWOL's reported from Bridgend services with the absconcions presenting from within RGH. Due to the pandemic there has been urgent development of additional ward space to allow for co-horting and space for the in-patient population. Some of the areas do not provide the same level of security around outside space (and smoking space) that the other wards supply. It is noted that a number of repeated absconcions are by a few patients who have been challenging to manage.

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 impact of the Covid-19 pandemic following the first wave and toward the second wave.
- Data quality and preparation for migrating to the Once for Wales risk management model – changes to dashboard required.
- Gaining health board wide assurance of the breadth of Health Board services and consideration of the four harms.
- Timeliness of availability of data and supporting narrative. This has been an additional challenge since the Covid-19 pandemic.
- IT infrastructure to facilitate effective up to date reporting.
- Quality strategy and priorities for the Health Board.

Actions to address these issues and risks are in place in the improvement action plans relating to the targeted intervention areas.

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)	Choose an item.
	This report applies to all Health and Care Standards.
Equality impact assessment completed	Not required
Legal implications / impact	Choose an item.
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 Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

5.1 **NOTE** the content of the report

5.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

5.3 **NOTE** the risks identified

5.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

Appendix 1:

Patient Experience

Data period – October to November

Cwm Taf Morgannwg University Health Board continues to explore different ways of gaining an insight into patient experience whilst negotiating the restrictions the COVID 19 pandemic places on this. 'Have your say cards', concerns, incidents, CHC feedback from patients, families, and carers continue to provide the Health Board with an opportunity to build on the services we provide to the community.

Communication remains a key factor that contributes to concerns raised across the Health Board. To ensure we provide as much information as possible to our communities the Health Board has developed two patient information leaflets providing an overview of inpatient and discharge advice during COVID. Welsh Government have also reviewed hospital visiting restrictions and these changes are due to be implemented in December 2020 but will allow the Health Board a greater autonomy to meet the needs of patients and their families whilst in hospital. To ensure we continue to provide vital contact with families for patients, the virtual visiting programme is in the process of recruiting more staff to support and pilot sites will be running in Ysbyty Seren and Princess of Wales Hospital.

A Patient Stories project was created in Ysbyty Seren, via the Health Board link with The Voices Project. This is a creative writing for wellbeing project funded by the Arts Council of Wales. The project works with the Arts and Health team and aims to champion patient, staff and community stories and voices through creative writing. The first patient story has been read at Quality & Safety committee, Executive Board and our student appreciation event in November. This emotive narrative has been

well received by its audience and brings into sharp focus that people are at the heart of all we do.

Our volunteering service are currently looking at how they can support the rollout of the community vaccination programme beginning 4th January 2021, working with the project team and third sector colleagues from St John's Ambulance and British Red Cross. To date around 40 volunteers are on standby and 12 new volunteers have been recruited in November. Chaplaincy volunteer support at Ysbyty Seren has been greatly received and helps provide compassionate activity and stimulation for the patients. This is also supported by our virtual volunteers who have been providing crafts for displays and patient activities.

The Chaplaincy & Spiritual Care department continues to work across all sites offering a 24/7 service offering spiritual, pastoral, and religious care to patients, their carers and staff; our focus is currently toward staff support as it is not appropriate to visit patients' bed to bed in this current climate. The numbers of significant encounters recorded are shown below.

October 2020

Patients	Relatives/Carers	Staff	Religious Rites
130	22	301	79

November 2020

Patients	Relatives/Carers	Staff	Religious Rites
148	16	328	96

Alongside this, Chaplaincy produced a video for SharePoint to mark Armistice Day. Ysbyty yr Seren opened its doors to patients and our chaplaincy service are present on site for two afternoon sessions per week. A religious service is offered for anyone who may desire to attend, and spiritual/pastoral support is offered to all.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	Reference Number: QDB1 Version Number:5

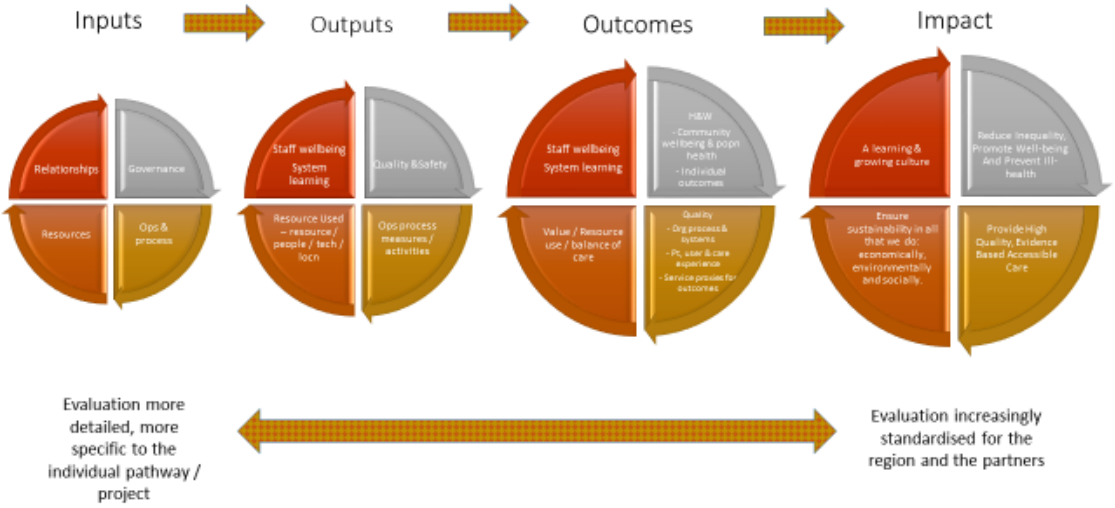
"Integrated Quality Dashboard"
Refreshing the Quality Dashboard for CTMUHB

SITUATION:

CTMUHB has changed the way it is organised to improve the provision of its services through a regional, integrated model, responsive to population need. This is because CTMUHB aims to promote the health and well-being of its population by providing the best quality care, close to home, by valued and motivated staff. With the new model there is a need for greater ambition in terms of quality assurance on all activities and services.

Due to the new ILG and System Group (SG) based structures, and a Population Health approach, the Quality Dashboard (summarising and identifying key areas of focus) needs to adapt to be a useful tool in aiding the HB achieve its vision, legislative, corporate and locality requirements.

Recent papers to Board have approached this same area from a different angle and we need to do just what is suggested and create an "integrated dashboard", which encompasses the quadruple aspects of value (sustainability and resources), quality, activity and staff wellbeing and learning.
The model proposed is based on a 4 stage process:



Looking at this purely from an "integrated *quality* dashboard" perspective, all teams within CTM need a useful tool for monitoring good practice, to present information and assurance on a wide range of health board services, triangulate and validate hard and soft data, and highlight areas that need greater focus.

This SBAR is intended to cover how we will meet both the requirements placed on CTMUHB for reporting key metrics (as set out by WG) but it also how an integrated quality dashboard, adaptive to the needs of the ILGs, SGs and Corporate teams, can be developed and utilised effectively. The basic -how it is generated, who uses it and what is it telling us.

BACKGROUND:
The 4 stage model for an integrated dashboard process mentioned above, needs to be adapted specifically for Quality aspects the healthcare in CTM.

Outcome level represents the strategic vision of the four System Groups (SGs) and three ILGs. There will be a lot of overlap but also different focusses.

- The SGs and ILGs strategic visions are where our ambitiousness for the health of our population starts.
- Each may develop a set of visionary goals to be aimed at, but they also need the steps needed to be achieved along the way to be able to meet that goal. As such each SG and ILG will decide what information (Output Level data – see below)is needed to demonstrate them achieving their ultimate vision, but also what information is needed to reflect the attainment of the steps taken along that path. *An example; vision is to reduce childhood obesity by 80%, one of the steps towards that might be better dental hygiene with number of community dental reviews being the metric.*
- SGs and ILGs will have visions broader than just hospital based initiatives with Population Health being central, as community initiatives, care homes and mental health (and others) all need to be addressed.
- Each SG and ILG will need a dashboard based upon what they need to help guide them in reaching their goals.
  - Each SG dashboard would be relevant to all 3 ILGs, enabling the ability to compare and contrast the ILGs attainment of these goals, and ultimately achieving the vision.
  - ILGs, with their locality unique population issues, are likely to have differing strategic visions (essence of having 3 localities) so they will each need a uniquely tailored ILG + SGs dashboard to meet their specific needs.

Output level produces information for different asks:

1) High level output measures or information, which relate to the SG and ILG steps and goals
2) Metrics that WG want regular sight of (pressure sore rates for example). These values are important to all – corporate provision of safety metrics to WG as well as to the SGs and ILGs as essential steps along their vision journey.
3) External bodies and audit requests. Information at this level is also provided to external asks such as national audits (e.g. National Emergency Laparotomy Audit, NELA). The informatics team need to be sighted on what data is needed in order to meet these externally (and internal) set criteria, the required metrics.

- As the ILGs are responsible for all activity in their locality these data sets represent important areas that they will be monitoring, along with their internally set focusses.
- Reports within CTM, to the oversight committees, from the SGs and ILGs would need to include this data – as a comparison and assurance process. This make the case strongly for a standardised report template for all ILGs to allow for comparison and scrutiny.

Challenge is for ILGs and SG to see and respond to both their own Outcome and Output dashboards.

Informatics support

- Integral to all the above are the informatics team who maintain all data within CTM. CTMUHB needs one data set from which all variables and metrics can be taken from. This prevents confusion and inaccuracies in data.

Quality Dashboard need
The dashboards we develop need to be wide ranging (to meet the needs of the SGs and ILGs) as well as responsive to external asks (WG safety metrics).
As such there is a need for multiple quality dashboards to be produced for the right arena:

1) Corporate essential quality dashboard for external reporting
2) ILG specific dashboards
3) SG specific dashboards

Each group should be able to view all other dashboards relevant to their activities and needs.

Dashboards are the tool to monitor our steps in the right direction as well as our assurance of meeting targets set, but they are only useful if they are appropriate to the needs of the using group. This is the challenge when developing them and where the informatics team are invaluable.

ACTION
Two stages to the dashboard process:

Stage 1 – Central essential Quality Dashboard

- This is the first quality dashboard that needs to be developed.
- Ongoing dashboard for external asks of our performance and to maintain oversight by any group feeding into the Q&S committee
- Agree a standardised dashboard approach for central use (Q&S Committee) and the format that all ILGs use.
  - Include a Statistical Process Chart (SPC) for each metric (mean for all data) to allow for a meaningful comparison.
- To provide assurance on the quality of our processes suggest addition of limited expansion of metrics (to aid better understanding and explanation to Q&S committee of the data quality and service we provide to our population:
  include: number of complaints (inc. closure compliance and percentage of re-opened complaints) and compliments received, SI numbers and number of cases referred to Ombudsman.
- Trajectories for continuous improvement.
- ILG reports standardised into the same format to enable direct comparisons and ease of understanding the picture across CTMUHB, again with SPC charts.
- Benchmarking in relation to other Health Boards enables us to compare our performance nationally.
- Person experience reporting via a standardised system – Once for Wales will allow a single system to be used across all services to help shape services according to feedback.

Stage 2 –SG / ILG developed Dashboard

- This is where each groups (ILG & SG) ambitious vision (and the individual steps to get us there) for CTM's healthier population is monitored.
- These would be the Outcome and Output level measures discussed in the background section.
- Where "focus pieces" can be represented, such as the ICHOR specific approaches.
- As these dashboards are for the use of ILGs/SGs they would not necessarily be reported to corporate committees, but could be included in an Annual Quality Statement.

Automatic Data capture

- Need to develop our data capture and automatic analysis. QLIC dashboards can provide a useful opening page of the metrics needed but also allow for more in depth analysis. The interface with the Once for Wales datix system will be crucial to the integrity of source data. We need to be able to have a broad view of healthcare across CTM and up to date dashboards would allow for a continual oversight by the ILGs and CSGs.
- In order to achieve this the dashboards need to be in real time so at any point we can see an accurate overview of all areas. Also would allow for a more comprehensive report to be developed for the quarterly Q&S committee and not a last minute analysis.
- Data Validation, process to ensure accurate and representative data.

Integrated Dashboard

- ILGs using the same data presentation format and view, including SPC charts. Integration would mean ILGs could compare themselves and allow for a mature conversation, learning and help between the localities where there is any variation.

Live dashboards

- Currently no continual live data to allow ILGs to access and interrogate the data whenever they need, only review at end of 3 month cycle.
- ILGs need time to see the data, reflect on it, intervene at any time needed and develop well-defined plans to tackle any issues raised before they submit their reports to Q&S.
- Everyone in the organisation needs to be able to review up to date information to aid efficiency.

Data presentation

How data is presented needs addressing, having Statistical Process Charts (SPC) to show a national, and CTM, mean for each ILG / SG would allow for a mature discussion between ILGs as to why they are at the level they are relative to other ILGs and nationally. Allows for better sharing of ideas and initiatives across sites.
Data and the way it is presented needs to be more useful and meaningful to everyone; ILGs, SGs and front line healthcare professionals.

RECOMMENDATIONS

- Multiple group specific Quality Dashboards are needed
- Central metrics (WG reported) and SG / ILG self – identified focussed metrics
- ILGs/CSGs same opening dashboard page, including three ILGs data to allow comparison
- Standardise report formats
- Timely data to allow monitoring of metrics trend
- SPC charts (generated automatically from data set) for all metrics

Distribution	Clare Williams ILG Director teams Greg Dix Alan Roderick
To be read by	Above Planning teams
Date	23rd November 2020

Accountable Executive / Lead Director	Greg Dix Executive Director of Nursing
Author / Clinical Lead	Dom Hurford Louise Mann
Freedom of Information Status	Open
To avoid use of out of date policies please do not print and then store hard copy of this document. **Out of date policies cannot be relied upon.**	

Amendment Record

If a change has been made to the document, the changes must be noted and circulated to the appropriate colleagues.

Detail of change	Why change made?	Page number	Date of change	Version	Name of Policy Author

AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

NeonATAL Services: An update of Perinatal mortality reviews

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	David Deekollu Clinical Director Leanne Richards Senior Nurse Neonatal Service Prince Charles Hospital Jane O'Kane Systems Director preconception to 1000 days & Neonatal Service Improvement Director
Presented by	Jane O'Kane Systems Director preconception to 1000 days & Neonatal Service Improvement 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	
NNU	Neonatal Unit
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
RCOG	Royal College of Gynaecologists
IMSOP	Independent Maternity Oversight Panel
PMRT	Perinatal Mortality Review Toolkit

1. SITUATION/BACKGROUND

1.1 Following the review of Health Board Maternity services by RCOG in January 2019, IMSOP extended their activity to include NNU services in June 2020.

1.2 Activity progressed to respond to actions identified within the RCOG report against a series of recommendations that encompassed clinical and professional governance priorities. The programme of work has been closely aligned with the Maternity services approach, management and methodology for consistency.

1.3 In addition, the Neonatal Network carried out a Peer Review of the NNU at PCH in September 2019 and a report into that review was received in November 2019. Whilst the report was positive about many aspects of care it highlighted some deficiencies in service provision including the fact that the unit was not using the nationally recommended PMRT.

1.4 The Directorate produced an action plan in response to the Peer Review which was submitted and accepted in January 2020 and included an action to start reviewing all neonatal deaths using the PMRT. There was also a commitment to undertake a "look back" exercise, reviewing all neonatal deaths using the PMRT from 2018 onwards.

1.5 PMRT is a national UK wide tool launched in 2018 to standardize perinatal mortality reviews. It was designed following a collaboration led by MBRRACE-UK (*Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK*) and incorporated parental involvement in its design.

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

2.1 The following provides the detail of the Health Board PMRT activity specifically:

- The number of PMRT reviews carried out 2018 – 2020 and those that remain in progress
- Key themes issues and concerns and actions undertaken to address the same to date

2.2 PMRT Activity

Year: 2018/2019

	Completed	In progress
Prince Charles Hospital	10	0
Princess of Wales Hospital	0	2

Year: 2020

	Completed	In progress
Prince Charles Hospital	0	4
Princess of Wales Hospital	1	0

2.3 Themes, lessons learned and actions for neonatal services following the PMRT reviews

1.0 Documentation standards
Key Theme/s: To improve documentation around resuscitation **Actions:** This has been actioned with a checklist developed and in place for clinical use.
2.0 Thermoregulation
Key Theme/s: Some cases have been graded as grade C due to the infant's temperature on admission to the neonatal unit being below the target range. This has been disappointing as the grading of care episode otherwise, would have been A or B. **Actions:** To improve team awareness of factors influencing thermoregulation of newborn baby at birth, this is being addressed through education and training and included in the Neonatal Audit Plan.
3.0 Transport incubator
Key Theme: Requirement for documentation of incubator use **Actions:** The safest mode of transfer for a baby requiring respiratory support is on the transport incubator. There needs to be clear documentation of a clinical decision not to use it. Compliance with this practice is raised on a safety briefing and is highlighted on the Resuscitation documentation sheet.

4.0 Communications
Key Theme: Requirement for a structured debrief approach **Actions:** Team debrief approach supported by development of a template has been ratified and in use.
5.0 72 Hour Review
Key Theme: Some infants did not have a 72 hour review in medical notes. **Actions:** Neonatal Network have a template for the review and this is now embedded into SI process
6.0 Consultant Availability
Key theme: **Consultant availability and timely escalation of concerns** Requirement for increased consultant presence and clear systems of accountability (as in consultant of the week system) **Actions :** A Consultant of the week system is now in place for the neonatal unit. This is currently operational Monday – Friday 8:30 hrs to 12:30 hrs. There is a proposal now to expand this service to a full day, and a bid for resources is underway. Policy is now in place to 'jump call' and to contact consultant on-call if clinical concerns arise

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

3.1 Neonatal Service Model

Concerns about the status of the former neonatal unit at the RGH site was raised within an investigation into the death of a specific infant at RGH.

3.1.1 Regional Approach

The movement of neonatal care to a reduced number of units had been discussed as part of the then South Wales Programme going back as far as the early 2010s and is widely visible in public Board papers. This had also been reviewed as part of the work of the Neonatal Network for South Wales.

3.1.2 Governance and standards of Care

Neonatal provision prior to the amalgamation of the 2 Units in the former CTM Health Board was as a Level 2 Unit as defined below (BAPM):

- Level 1 – special care Units (SCU): These units provide special care for their own local population. They also provide, by agreement with their

neonatal network, some high dependency services. In practical terms, this would mean, provision of service for babies born after 32 weeks gestation.

- Level 2 – local neonatal unit (LNU): These units provide special care and high dependency care and a restricted volume of intensive care (as agreed by local neonatal network) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit. Usually this would mean provision of service for babies born 28 weeks of gestation and above.

- Level 3 – Neonatal Intensive Care Unit or NICU: These are larger intensive care units that provide the whole range of medical (and sometimes surgical) neonatal care for their local population and additional care for babies and their families referred from the neonatal network in which they are based, and also from other networks when necessary to deal with peaks of demand or requests for specialist care not available elsewhere.

The British Association of Perinatal Medicine (BAPM) issued a Framework for Practice in 2010 and in June 2013, WHSSC produced the second Edition of All Wales Neonatal Standards. These were intended to provide a framework for delivery of neonatal care and assessing the quality and safety of services which included the staffing requirements. The compliance responsibility lay with the Wales Neonatal Network (WNN) from Autumn 2010. These have now been superseded by the 2018 BAPM Framework for Practice, and the 3rd Edition of All Wales Neonatal Standards.

3.1.3 Local Provision and models of care

It is evident within Health Board papers that the services in each Health Board needed to be flexible to support the needs of premature and sick babies in South Wales. Cardiff and Vale for example did not have sufficient cots to take all level 3 babies, and were often unable to accept transfers from level 2 units, which led on some occasions to families being separated when babies had to be moved to units in England or North Wales.

It is evident that there was an acceptance that what should have been level 1 or 2 units were routinely taking babies from the next level of care up in order to protect the most ill babies and dependent families. Any change in service for the Royal Glamorgan for example was dependent on the development of cot capacity at Cardiff & Vale (C&V) and in Prince Charles. The consolidation of cots was made in February 2020 when the unit at RGH closed and transferred to Prince Charles Hospital and the Princess of Wales in the recently amalgamated CTMUHB following the expansion of cot space in C&V.

There is no evidence that there was any action or inaction by current or former Boards which could have influenced the well-known capacity issues which were being addressed by the Neonatal Network and the South Wales Programme at a national level.

References:

https://www.bliss.org.uk/

https://www.bapm.org/resources/32-service-standards-for-hospitals-providing-neonatal-care-3rd-edition-2010

http://www.wales.nhs.uk/documents/All%20Wales%20Neonatal%20Standards%202nd%20Edition%20v2%2005.08.13.pdf

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe care, Effective care Timey care, Dignified care
Equality impact assessment completed	Not required
Legal implications / impact	Yes (Include further detail below)
	Pending advice from the Coroner
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	See details of revenue within the body of the report
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

The Committee are asked to **NOTE** the progress as identified; notably with the establishment of the PMRT and the associated ongoing activity to improve services, including the development of a business case to support the enhancement of the Neonatal Team.

AGENDA ITEM
6.5

QUALITY & SAFETY COMMITTEE

DELIVERY UNIT BRIEFING DOCUMENT - REVIEW OF CANCER SERVICES CTMUHB - Q4 UPDATE JANUARY 2021

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	BENJI WILLIAMS, SENIOR MANAGER, CANCER BUSINESS UNIT
Presented by	DR NICK LYONS, 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	
CBU	Cancer Business Unit
CTMUHB	Cwm Taf Morgannwg University Health Board
DU	Delivery Unit
ILG(s)	Integrated Locality Group(s)
SRO	Senior Responsible Officer

1. SITUATION

In Q4 2019 the DU was invited into CTMUHB by the then Chief Operating Officer, to carry out a review of cancer pathway issues as a result of non-compliance against national cancer waiting time measures. The terms of reference were to make systemic improvements, specifically for Urology pathways and Radiology Service constraints, which are the leading causes of cancer breaches for the Health Board.

In scoping the review the DU met with the then Chief Operating Officer and agreed two defined and challenged areas where the DU would support the Health Board as follows:

- Confirm and identify clearly the perceived capacity gap in Radiology at the Health Board where it contributes to the failure to achieve the Cancer targets.
- Review and assist in the development of the Urology plans, providing challenge, assistance and best practice advice.

The DU carried out their review by interviewing staff and by observation during meetings. The DU were due to present the Board with a full review of cancer performance in April 2020. Due to the COVID-19 pandemic and availability of staff from both organisations the completion of the review has been delayed. In order to share the findings to date, a holding document was produced by the DU for action by the Health Board which is attached as Annex 1.

2. BACKGROUND

The DU report identifies six areas for focus by the Health Board with a specific recommendation for each:

1. Executive support for improving performance and the importance of cancer care.
2. Directorates (now ILG) priority of Cancer and ownership of target achievement.
3. Role of Cancer Multi-Disciplinary Coordinators and tracking personnel.
4. National Optimum Cancer Pathway compliance (Urology).
5. Data system compliance and subsequent information processing delays.
6. Staffing capacity in Radiology and MRI processes.

The DU holding report was initially tabled and discussed at the Cancer Programme Board on the 10/06/2020, where it was agreed it should be shared with ILGs for them to respond formally.

An action plan and briefing document was presented to the Management Board on the 27/07/2020. Progress against the action plan is attached as Annex 2.

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

2 actions have now been completed and 4 are behind scheduled because of limitations in DU support capacity and staff shortages/availability due to the Covid pandemic. The recommendations in full and actions taken can be seen in Annex 2.

3.1 COMPLETED ACTIONS

Recommendation number	Status update
1	Dashboard implemented and now tabled at UHB Board meetings and consistent with WG monitoring arrangements. Management Board to review performance monthly. Significant investment released for the Cancer Team (now named Cancer Business Unit) with Deputy Chief Executive Officer and Medical Director SRO Cancer supporting – budget awaiting management board sign off 27/01/2020.
2	ILG cancer management leads identified in April 2020 to lead weekly performance meetings, which will include a review of cancer performance. Senior Cancer Manager to attend and to ensure cancer tracker attendance. Outputs from the meeting will include a high level report which will be distributed by each ILG lead to key stakeholders to provide assurance of performance management activity and to support monthly reporting to WG. This will include mitigating actions to progress patient pathways'.

3.2 UNCOMPLETED ACTIONS

Recommendation number	Status update	Outstanding actions
3	A joint report has been developed by the DU and the Senior Cancer Manager and will be presented to Cancer Steering Group in January 2021. Investment proposal for increased tracker and MDT investment in development.	Action plan will be developed by the Data Quality and Assurance and Information Technology sub-group with a preliminary target date of February 2021. Investment proposal to Management Board Feb 2021. Timeline for implementation - June 2021.
4	Consultant leads identified and leading. Task and Finish Group to commence in Jan 2021. Work Programme will take 6-9 months, Covid-19 dependent.	Action Plan to be developed from this first meeting.
5	NWIS have agreed to work with Senior Cancer Manager and Information team to develop current Cancer Tracker 7 system and to devise training programme to support more effective use of Cancer Tracker. Link to review of MDT Coordinators and Tracker role and skills/capacity gaps within services to update cancer tracker. The CBU are working with ABUHB to develop a service specification for the CTMUHB information team to commission a user friendly	The training programme will be taken forward by the Data Quality and Assurance and Information Technology sub-group with a preliminary target date of February 2021. Awaiting Investment Proposal for increased cancer informatics support – January 2021.

	and accessible cancer information system. In line with ABUHB programme of development this process may take 12 months to complete. Newly appointed SCP Improvement Cancer Manager tasked with taking this work forward through the sub-group of the CSG. Cancer Business Unit Investment Proposal to Management Board in Jan 2021 which will hopefully approve increased cancer informatics support – FTE Band 7 Cancer Information Manager to support this work stream.	
6	DU unable to support this review at the current time. Review on hold after prioritising Urology and MDT/Tracker reviews in agreement with the Cancer Director.	Identify resource to undertake the radiology review when Covid-19 pressures permit.

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

The delays in addressing recommendations 5 and 6 are resulting in ongoing sub optimal cancer waiting time performance across urology and the radiology service.

5. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The recommendations provide a platform for improving the timeliness and effectiveness of key cancer pathways
Related Health and Care	Governance, Leadership and Accountability

standard(s)	Safe, timely and effective care
/Equality impact assessment completed	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 Well-being Objectives	Ensure sustainability in all that we do, economically, environmentally and socially

6. RECOMMENDATION

The Quality & Safety Committee are asked to **NOTE** the DU update and suggested implementation plan to be overseen by the Cancer Business Unit and Cancer Steering Group.

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Support to Cwm Taf Morgannwg UHB in providing a Focussed Review of Agreed Cancer Performance Dependencies

INTRODUCTION AND SCOPE

This is a short briefing document generated due to the break in the work scheduled to be completed by the NHS Delivery Unit (DU) in support of Cwm Taf Morgannwg UHB. The prioritisation of duties of the DU as a direct result of the 2020 COVID -19 pandemic coupled with availability of key staff from both organisations has resulted in an unavoidable delay in the work required to be done to undertake the full review and thereby the provision of a full report, originally planned to be produced in April 2020. As a result and in order that the findings to-date can be shared, has it has been agreed that this document will serve as a holding document with assessment of the need and ability to complete the review, to be discussed at a later date, should this still be required.

ORIGINAL PURPOSE AND OBJECTIVES

The overall aim for the health board must be to achieve sustainable and efficient systems, and to deliver improved quality of care for the patients of the Health Board in the short, medium and long term. The aim of the DU within this work, is to ensure that, in areas as identified in discussion with the Chief Operating officer and lead Cancer Manager, the DU will support improvement against Cancer standards in two discrete areas as follows:-

- **Confirm and identify clearly the perceived capacity gap in Radiology at the HB where it contributes to the failure to achieve the Cancer targets.**
- **Review and assist in the development of the Urology plans, providing challenge, assistance and best practise advice.**

FINDINGS (TO MARCH 2020)

Cancer in General

1. Executive support for improving performance

It was felt by staff that the significance of the performance of Cancer in the HB was not given a sufficiently high profile. As a result many of the priorities for improvement in Cancer performance were delayed or indeed not actioned at all. Data available to populate visible tools such as a functioning dashboard with detail of stages in pathways and priority of cases, is lacking and therefore, meaningful escalation of key performance issues appears not to be available in sufficient and regular relevant detail to support executive decision making.

Recommendation: Appropriate importance at executive level must be given to Cancer performance. An intuitive and flexible dashboard view of cancer data must be made available to be viewed at all levels. Analysis of this data should make clear to executives with the source of any failures in the Cancer pathway at service level and by tumour site level included with sufficient granular data to ensure effective targeting for solutions to be considered and actioned.

2. Directorates priority of Cancer and ownership of target achievement

We found that there appeared to be a lack of ownership for patients with Cancer among the directorate management. Little of the directorate managers appear to perceive that they had responsibility for cancer patient's performance in those processes in areas under their control, which clearly affect the achievement of the Cancer target. There was little evidence of Directorate scrutiny at individual patient level.

Recommendation: A reiteration of the need for Cancer performance to be a clear directorate responsibility is required. While Cancer management roles are undoubtedly fundamental in the achievement of Cancer standards, the clear interdependencies of other systems and pathway elements mean that this has to be seen as a joint responsibility. A review of the accountability of the Cancer performance responsibility is required where directorates play their role in ensuring appropriate pathway compliance for Cancer and other urgent patients.

3. Role of Cancer Coordinators/trackers

The lack of coordinators input in key performance management meetings was a concern. This would inhibit their ability to sufficiently influence the process of ensuring that patients are pushed through the pathway. Also their awareness of optimal pathways appeared inconsistent, which is crucial in ensuring they have confidence to and are supported in, challenging the 'system'.

They reported that they were not clear on the escalation processes in order to facilitate the prioritising of cancer patients where appropriate.

Recommendation: A review of the coordinator/tracker role is required. Clear levels of accountability and effective methods for escalation should also be part of this as well as consideration of attendance at review meetings. Furthermore, consideration should be given

to training needs and educational sessions to ensure that these staff are up-to-date with latest pathway changes.

Urology and Radiology Specific Issues

4. National Optimum Pathway Compliance

Within Urology, the National Optimum pathways were not in place in CTMUHB (and other tumour sites). These include key elements (such as 'straight to test') which will enhance the capacity utilisation of the system as well as improve compliance against the national target. More importantly, improve patient care.

Recommendation: A full review of the current pathways for Urology across the HB is required with a view of their compliance against the national pathways steps. Plans should be drawn with clear timescales and actions to bring the pathways into line with the nationally agreed, Optimal Pathways and timings within.

5. System Compliance and subsequent delays

Staff reported that the Radis system and Cancer tracking system's lack of interoperability was resulting in the manual transfer of data between platforms. It was reported that this caused delays and was inefficient. Furthermore, the results were still being sent via internal mail to sites across the HB, taking up to 3 days to arrive.

Recommendation: A full review of data needs and connectivity of systems should be undertaken. Informatics staff should provide assistance devising a system which allows a reduction in manual inputting and the digital transfer of information should replace any manual 'posting' immediately, using server areas or other electronic platforms.

6. Staffing capacity in Radiology and MRI processes

In relation to the haematuria pathway, staff in Radiology reported a lack of sonographers to sufficiently review cases releasing Radiologist time. It was suggested some cases could go straight to CT and that this would negated the requirement for ultrasound.

Staff in Radiology reported that a process whereby there was a wait for MRI to be reported before a Radiology clinic appointment was booked was, in operation. This created an unnecessary delay. Furthermore concerns were raised about high levels of delayed reporting of non-urgent cases.

Recommendation: A full review of Radiology staff capacity should be undertaken. Where replacement of traditional functions are inefficient or unlikely to yield appropriate value, new innovative solutions must be considered or functions reviewed to ensure timely pathway flow.

ACTION PLAN FOR IMPROVEMENT

Reference (Claim / Incident / Complaint)	Delivery Unit Interim Report – Cancer Performance Dependencies (to March 2020)
Medical Director's Office	Cancer SRO
Executive Director of Operations	
Date action plan commenced	August 2020
Synopsis of Concern	Delivery Unit Review of Cancer Services (Urology and Radiology).

Area of focus	**area**	**Recommendation**	**Progress & Evidence**	**Monitoring Arrangements** (State HB group where progress is reported)	**By who**	**Deadline date for completion** (Use traffic light system to indicate status) **& insert date of completion**
1. Executive support for improving performance and the importance of cancer care.	Corporate	Appropriate importance at executive level must be given to Cancer performance. An intuitive and flexible dashboard view of cancer data must be made available to be viewed at all levels. Analysis of this data should make clear to executives with the source of any failures in the Cancer pathway at service level and by tumour site level included with sufficient granular data to ensure effective targeting for solutions to be considered and actioned.	Dashboard implemented and now tabled at UHB Board meetings and consistent with WG monitoring arrangements. Management Board to review performance monthly. Significant investment released for the Cancer Team (now named Cancer Business Unit) with Deputy Chief Executive Officer and Medical Director SRO Cancer supporting – budget awaiting management board sign off 27/01/2020.	Management Board. WG.	CTMUHB Performance and Information team	August 2020

2. Directorates' (now ILG) priority of Cancer and ownership of target achievement.	Operations	A reiteration of the need for Cancer performance to be a clear directorate responsibility is required. While Cancer management roles are undoubtedly fundamental in the achievement of Cancer standards, the clear interdependencies of other systems and pathway elements mean that this has to be seen as a joint responsibility. A review of the accountability of the Cancer performance responsibility is required where directorates play their role in ensuring appropriate pathway compliance for Cancer and other urgent patients.	ILG cancer management leads identified in April 2020 to lead weekly performance meetings, which will include a review of cancer performance. Senior Cancer Manager to attend and to ensure cancer tracker attendance. Outputs from the meeting will include a high level report which will be distributed by each ILG lead to key stakeholders to provide assurance of performance management activity and to support monthly reporting to WG. This will include mitigating actions to progress patient pathways'.	Locality Monthly Performance arrangements by EDO	Executive Director of Operations	Leads appointed April 2020 Meetings initiated December 2020
3. Role of Cancer Multi-Disciplinary Coordinators and tracking personnel.	Operations	A review of the coordinator/tracker role is required. Clear levels of accountability and effective methods for escalation should also be part of this as well as consideration of attendance at review	A joint report has been developed by the DU and the Senior Cancer Manager and will be presented to Cancer Steering Group in January 2021. Investment proposal for increased tracker and MDT investment in development.	Cancer Steering Group	Senior Cancer Manager	Action plan to be developed February 2021 Investment proposal to Management Board Feb 2021. Timeline for

		meetings. Furthermore, consideration should be given to training needs and educational sessions to ensure that these staff are up-to-date with latest pathway changes.				implementation - June 2021.
4. National Optimum Cancer Pathway compliance (Urology)	Planning	A full review of the current pathways for Urology across the HB is required with a view of their compliance against the national pathways steps. Plans should be drawn with clear timescales and actions to bring the pathways into line with the nationally agreed, Optimal Pathways and timings within.	Consultant leads identified and leading. Task and Finish Group to commence in Jan 2021. Work Programme will take 6-9 months, Covid-19 dependent.	Cancer Steering Group	Urology pathway improvement group (sub group of the Cancer Steering Board)	First meeting of the task and finish group to take place 01/21 Action Plan to be developed from this first meeting. Estimated date of completion: July/Oct 21 (Covid-19 dependent)

5. Data system compliance and subsequent information processing delays.	IT and Information	A full review of data needs and connectivity of systems should be undertaken. Informatics staff should provide assistance devising a system which allows a reduction in manual inputting and the digital transfer of information should replace any manual 'posting' immediately, using server areas or other electronic platforms.	NWIS have agreed to work with Senior Cancer Manager and Information team to develop current Cancer Tracker 7 system and to devise training programme to support more effective use of Cancer Tracker. Link to review of MDT Coordinators and Tracker role and skills/capacity gaps within services to update cancer tracker. The CBU are working with ABUHB to develop a service specification for the CTMUHB information team to commission a user friendly and accessible cancer information system. In line with ABUHB programme of development this process may take 12 months to complete. Newly appointed SCP Improvement Cancer Manager tasked with taking this work forward through the sub-group of the CSG. Cancer Business Unit Investment Proposal to Management Board in Jan 2021 which will hopefully approve increased cancer informatics support – FTE Band 7 Cancer Information Manager to support this work stream.	Cancer Steering Group	Date Quality Assurance and Information Technology group (sub-group of the Cancer Steering Board)	The training programme will be taken forward by the Data Quality and Assurance and Information Technology sub-group with a preliminary target date of February 2021. Awaiting Investment Proposal for increased cancer informatics support – January 2021.
6. Staffing capacity in Radiology and MRI processes.	Planning	A full review of Radiology staff capacity should be undertaken. Where replacement of traditional functions are inefficient or	DU unable to support this review at the current time. Review on hold after prioritising Urology and MDT/Tracker reviews in agreement with the Cancer Director.	Cancer Steering Group	Executive Director of Operations	Q4 – escalate

		unlikely to yield appropriate value, new innovative solutions must be considered or functions reviewed to ensure timely pathway flow.				

Status of action:

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

AGENDA ITEM
6.5.2

QUALITY & SAFETY COMMITTEE

UPDATE ON DELIVERY UNIT REPORT ON CARDIOLOGY TO CARDIAC SURGERY FOLLOW UP REVIEW 2

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Head of Business Support
Presented by	Gareth Robinson, Executive Director of Operations
Approving Executive Sponsor	Chief Operating Officer
Report purpose	FOR APPROVAL

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

ACRONYMS	

1. SITUATION/BACKGROUND

The purpose of the report is to update the Quality & Safety Committee for a second time on progress with the Delivery Unit Report on Cardiac Services Waiting Times and to demonstrate the actions that the Integrated Locality Group (ILG) and Clinical Service Groups (CSGs) are undertaking to address issues raised.

The Report itself is attached at **Appendix 1**.

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

A Delivery Unit Follow Up Review of Cardiology to Cardiac Surgery was published in August 2019. This was as a result of a Welsh Health Specialised Services Committee (WHSSC) commissioned review of the interface between Cardiology and Cardiac Surgery which included a focus on the accurate reporting of waiting times.

In October 2018, the Welsh Government asked all Health Boards to self-assess their services. This process did not provide the appropriate level of assurance and so the Delivery Unit was asked to undertake a Follow Up Review.

The Health Board provided partial assurance to the Delivery Unit and a number of recommendations were made – the Action Plan was produced as a response to this.

The Action Plan was on the agenda at a meeting of the Quality and Safety Group in November 2020, and a number of questions were raised by the Independent Members. This paper includes specific answers to those issues as follows:

Timescales in the action plan would be welcomed for further assurance and scrutiny.	Further timescales have been included.
Rag rating on the plan is not correct for some actions.	The rage ratings have been reviewed and changed and updated where necessary.
There appears to be huge onerous tasks and responsibilities on the Cardiac Nurse Facilitator. What or are there plans to engage more Consultants in the process.	A decision has been made that the Cardiac Nurse Facilitator model does need additional Consultant involvement and practices have been changed to reflect this.

What are the future plans for resourcing in PCH and RGH to drive the improvement plan?	Investment has been made in administrative staff. The individual ILGs will make bids for additional resources as part of the preparations for the new financial year.
The ICT issues re merger of PAS systems and the WPAS interface should this be referred to the Digital Committee?	Yes it will be as part of the processes underway currently.

This follow up paper provides an update to that reported in December 2019 and November 2020.

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

The Action Plan outlines the risks in the area that the Delivery Unit reviewed and the mitigations and plans to address them.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Identified within the report attached
Related Health and Care standard(s)	Safe Care
	All Health and Care Standards apply
Equality impact assessment completed	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 Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

5. RECOMMENDATION

5.1 **ENDORSE** the action plan and the report.

Action Plan in Response to DSU Cardiac Waiting Times Follow Up Review Report (August 2019)
Updated for January 2021

RECOMMENDATION	OWNER	ACTION(S) TO BE TAKEN	PROGRESS	RAG RATING & TIMESCALE
The Health Board should develop further training to reinforce the latest Cardiac RTT rules for secretaries as well as clinicians to ensure that there is consistency, and to improve the percentage of correct PSDs, particularly reducing potential for delay to patients. This should include staff at the Princess of Wales Hospital.	Admin Lead for Merthyr Cynon Clinical Assurance Group Medicine / Clinical Services Support Manager, Medicine/A&E RT ILG - Deputy Service Group Manager / Medicine & CoTE PoWH	Provide training for the secretaries to reinforce the latest cardiac RTT rule	Training and retraining has been provided for the Medical Secretaries on all sites. In Merthyr Cynon and Rhondda Taf Ely, a specific training plan and manual has been developed and at the Princess of Wales Hospital is currently undertaking a pilot on the management of follow up patients to ensure lessons are learned and shared with Medical Secretaries. To ensure that any new staff are made aware of the rules and to maintain the standards of the staff already in post, training is continually ongoing.	Complete
The process of referral, with cardiac referrals going through the health board's referral centre, should be revisited and better understood, particularly with a view to the time that this adds to the pathway.	- Medical, Records Manager	Move to electronic Hospital to Hospital (H2H) referrals	The referral process within the RTE and MC ILGs has been undertaken and better understood and there are no delays in sending referrals to the tertiary centre. The move to an electronic system has been delayed by the implications of Covid-19. This should be resolved in xyz.	Delayed by COVID 19 activity

RECOMMENDATION	OWNER	ACTION(S) TO BE TAKEN	PROGRESS	RAG RATING & TIMESCALE
			The referrals from the PoWH do not use the Referral Centre. The Cardiac Surgery Nurse Facilitator and the named consultant of the week at the Princess of Wales Hospital send the referrals either to the Cardiac Surgery Pool or to a named Consultant and these referrals are monitored to ensure they are received and discussed.	
The Health Board should also ensure that there are clear communications with Morriston Hospital as well as Cardiff & Vale, to ensure that the flow of patients from Princess of Wales Hospital to Morriston is covered.	- Deputy Service Group Manager / Medicine & CoTE PoWH	Introduce electronic referral system	The Cardiac Surgery Nurse Facilitator and the named Consultant of the week at the Princess of Wales Hospital ensure that all patients awaiting outpatient surgery / TAVI and inpatient work are recorded and liaise daily with the Morriston and the University Hospital of Wales Cardiac Centres. The pilot Swansea Bay UHB was going to undertake has been put on hold due to COVID 19, however the system is robust.	Delayed by COVID 19 activity, robust intermediate system in place
Administrative capacity to process echo referrals should be reviewed to ensure that patients can follow a lean pathway, including tests before first outpatient appointment.	- Head Cardiopulmonary Diagnostic Unit PCH / RGH	Increase admin team support and set up booking room to improve efficiency	Within the RTE and MC ILGs, administrative staffing levels have been increased as recommended which supports the lean pathway. Space for the administrative hub has been identified but is currently on hold as a consequence of the accommodation needs of COVID 19 activity.	Complete

RECOMMENDATION	OWNER	ACTION(S) TO BE TAKEN	PROGRESS	RAG RATING & TIMESCALE
	- Deputy Service Group Manager / Medicine & CoTE PoWH.		A review of the administration support within the Cardiac Physiology Department will be undertaken along with the other staff groups to ensure there is sufficient support for the echo pathway. This should be complete by the end of Quarter 1 2021 – 2022.	Ongoing, target date June 2021
Variation in managing triage between Prince Charles Hospital and Royal Glamorgan Hospital should be reviewed, in light of the fragile (single point of failure) arrangement in place in the Royal Glamorgan.	- Consultant Cardiologist and clinical lead PCH / RGH	Introduce a senior nurse referral process on the PCH site	The ILG Clinical Lead regards the Consultant of the week reviewing referrals electronically on WPRS is the most clinical safe, efficient and elective process currently available to us. This model is the one used at PCH. This will mean that the referrals are always processed in a timely manner with no single point of failure. Access to WPRS for GPWSI and CNSs has been increased to triage their own referrals again, sharing the workload and ensuring a robust referral management system.	
The Health Board should work with the Cardiac Network to promote a transparent system to identify the stage of the pathway for each patient. This will allow early identification of pathway constraints.	- Clinical Lead at Cardiac Network	Engagement with Cardiac Network through participation in network meeting and working groups	In the MC and RTE ILGs, there is clinical and operational management representation all Cardiac Network Meetings including HCIG, Cardiac Network Managers Meeting, SE Wales Collaborative. In response to this recommendation we have Directorate Support Manager (DSM) representation the Health Board on the Cardiac Network Component Working Group. The DSM working	

RECOMMENDATION	OWNER	ACTION(S) TO BE TAKEN	PROGRESS	RAG RATING & TIMESCALE
			with performance and information in order to submit component information to WAG by the November deadline. Key staff from all three CTM sites are regular participants in the Cardiac Network meetings with representation from clinicians and managers. Our ITMP priorities for cardiology are based on the HCIG priorities for 19/20. We are currently engaged in the various cardiac network work steams including all Wales cardiac pathways including ACS.	
The Health Board should expedite work to merge the two PAS systems, so that patient records are visible on each site. This is a potential clinical risk that goes beyond the scope and remit of the current review.	- Deputy ADI ICT, ICT Department	Disaggregation of POWH from the Swansea Bay WPAS system	Business case has been developed for the disaggregation of POWH from the Swansea Bay system. Disaggregation depends upon all the other clinical systems that are interfaced into WPAS. The business case will require Welsh Government funding of in excess of £1 million and will be discussed by Digital Committee as part of this process. Alternative solutions to move both HB to a National WPAS that has been developed for Velindre has been proposed to NWIS. Discussions are awaited and it is anticipated that this will be a priority when the response to the second wave of covid is over.	April 2022 as part of business case development and approval

AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

DIRECTION OF CARE – RESETTING CTM 2020-2021: OPERATING FRAMEWORK QUARTER 3/4

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dom Hurford Interim Deputy Medical Director
Presented by	Dom Hurford Interim Deputy Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Individuals	**Date**	**Outcome**
Richard Lee Anthony Gibson Stuart Hackwell	Oct 2020	NOTED

ACRONYMS	
WG	Welsh Government

CTMUHB/ CTM	Cwm Taf Morgannwg University Health Board
HCAI	Health Care Acquired Infection
SOP	Standard Operating Procedure
EIDO	All Wales approved consent to treatment information leaflets
ED	Emergency Department
HDU	High Dependency Unit
ICU	Intensive Care Unit
OPD	Operating Department Practitioner

1. SITUATION/BACKGROUND

1.1 The resurgence of COVID-19 during December – January 2021 is being predicted to exceed the demand placed on health services in Wales during the first April 2020 wave.

1.1.1 Workforce constraints will limit our ability to continue with full services whilst dealing with the increased emergency care demand.

1.1.2 There will be a need to redeploy staff towards emergency and urgent care. This means that we will not, in common with other Welsh Health Boards, be able to deliver our full range of services.

1.2 An Operating Framework for Quarter 3-4 was produced in October 2020.

1.3 This report sets out the reasons for deviating from these established plans, as we cannot meet the aims of the Q3&4 framework now due to the latest COVID-19 resurgence. Predictions of when we will be able to recommence services as normal are at present uncertain.

1.4 There will be a larger backlog of cases to tackle, on top of the already high number of delayed surgical cases since April 2020.

1.5 Compared with the first COVID-19 wave in April 2020, we are intending to continue with as many cancer and urgent elective surgical cases as possible, within resource constraints, throughout the next few months. These will be undertaken within green islands on the acute hospital sites, and in external facilities, private hospitals and Neath Port Talbot, where able.

1.6 The need to divert away from the Q3&4 plans are primarily due to:

- A revised prediction of need from essential services (especially Critical Care and Respiratory / medical teams) across December 2020 and January 2021, highlights a significant increased demand on CTM resources, with an associated need to ensure sufficient

staff capacity to meet the forecast demands of critical care and respiratory care.

- There is a need to ensure we have developed a realistic plan to meet the elective demands on CTM due to a deterioration in the COVID-19 pandemic situation.
- Staffing is the major constraint
  - We predict higher staff sickness rates due to staff burnout after 9 months of extremely stressful pressures on our hardworking caring staff, and the need for staff to self-isolate.
  - As seen over the course of this pandemic, workforce has been the biggest challenge – maintaining staffing of key areas and required skill mix as well as maintaining the health and wellbeing of our workforce.
- WG have set out potential options for CTMUHB to consider in order to maintain staffing of key areas. This will of course reduce availability of care in other areas of the Health Board.
- There is ongoing review of potential to suspend other services to support acute and critical care
- CTM approach to maintain equity to emergency / cancer surgery needs to be considered. There are limited resources to continue and these are regarded as essential.

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

2.1 Reasons for continuing with Cancer and urgent elective surgery:

Patient Safety

• There is already a considerable back log and increased waiting time for all elective surgical cases after the complete cessation of services in the first pandemic wave.

• Cancer services were previously significantly affected and there was potential patient harm in delaying urgent surgical (and non-surgical) diagnosis and care.

• Further delay to urgent cancer care would certainly be high risk for all CTM patients already diagnosed with cancer requiring surgery.

• Delaying surgical care will increase the very real risk of cancer growth and metastasis and it is likely that some patients will move from curative to palliative care.

• Delays also cause psychological harm especially in cancer and urgent need patients. The impact of anxiety by having cancer and urgent care delayed cannot be underestimated.

• Urgent elective care has similar implications to cancer care. This relies on surgeons deciding a case warrants urgent treatment. This is decided in the awareness of surgical risk increasing significantly in a COVID positive patient.
• Patients will become more debilitated as they are unable to exercise or function normally, adding to that disease progression, and overall the patient's risk of complications rises. Surgeons will be operating on sicker patients than they would have done initially, and the impact on need for HDU / ICU post-operation will increase.
• Demand on Critical Care will rise.
• We will reach a stage where all COVID-19 patients are prioritised over other illnesses. There needs to be a balance across all urgent care – cancer patients are also urgent.

Patient Experience
Negative aspects
• Anxiety and mental wellbeing will be severely impacted if cancer and urgent elective care is suspended.
• There will be longer waits for urgent needed surgery.
If we suspend the elective urgent case service then the risk of HCAI is reduced.
However steps to mitigate this risk are in place with SOP for green surgery.
• Patients are concerned about HCAI from coming in to hospital – the reassurance of green surgical areas is needed along with (EIDO) appropriate consent process.

Whole system impact
• Patient physical and mental health implications – high risk to suspend care for this patient group
• Morbidity and Mortality incidence is highly likely to rise if delays occur.
• Increased post-operation Critical Care demand due to debilitated more unwell patients undergoing surgery (higher risk surgery to patient)
• Extension of urgent waiting lists and impact on purely elective operating lists.
• This will further increase elective waiting time as time spent re-starting elective services will be needed for urgent and cancer cases.

2.2 **Overall impact of suspending cancer and urgent elective care was scored as 25, equates to very high risk.**

- This is based upon an assessment of the above factors likelihood and the negative impact if they did occur.

- 25 is the highest score possible indicating very high risk serious consequences of cancelling this service.

2.3 Reasons for suspending non-urgent elective surgery

Patient Safety

• There is already a considerable back log and increased waiting time for all elective surgical cases after the complete cessation of services in the first pandemic wave.
• Delays cause psychological harm – anxiety and depression.
• Despite surgery not being urgent or for cancer, patients still need surgery and care. The disease process requiring surgery may be causing pain and physical symptoms that limit the activities of our patients.
• Balance of risks:
Proceed with surgery when the known surgical risk is significantly higher in COVID positive patients versus the impact of living with the condition deemed to be requiring surgical intervention.
• Defining urgent and non-urgent surgery is guided by national and specialist surgical societies. This does rely on surgeons deciding if a case warrants urgent treatment.
• Patients have the potential to become more debilitated, depending on their condition, as they are unable to exercise or function normally, add to that disease progression and overall the patient's risk of complications rises. Operating on sicker patients than we would have done initially could mean that the need for HDU / ICU post-operation will increase. It may also increase rehabilitation time.
• This population have been determined not to need urgent surgery at a point in time, however this may change if a disease or condition progresses or the patient develops complications.
• These need to be monitored and there will need to be an acceptance that some patients will move between categories of need.

Patient Experience

• Anxiety of people attending acute hospitals due to COVID-19 risk. Expecting surgery and stay for non-urgent care has potential to cause anxiety and stress.
• Balance of risks:
  - COVID-19 HCAI risk is low but is perceived as high by the population contributing to higher stress.
  - Many people wish to avoid hospital care at present, Primary Care teams have reported this to us.
  - Others are desperate for their surgery to proceed, orthopaedics for example.
  - Overall balance in favour of waiting for surgery.

• Longer waits for needed surgery.

If we suspend the elective urgent case service then the risk of HCAI is reduced.

However steps to mitigate this risk are in place with SOP for green surgery.

• Other side concern of HCAI from coming to hospital – reassurance of green surgical areas is needed along with (EIDO) appropriate consent process.

Clinical Effectiveness

• Use of theatre teams clinical expertise in other clinical areas

• Surgical team roles in ward and ED care.

• Extension of waiting lists and impact on purely elective operating lists in the post-peak COVID times.

• Increase further elective waiting time as there will need to be time spent re-starting elective services when it is deemed safe to do so (after a COVID peak).

Whole system impact

• This will increase the number of available clinicians and nursing teams from theatres and recovery to assist in patient care elsewhere in response to COVID-19 admission rises

• Anaesthetists and ODPs skill sets can support ICU demand, Theatre & recovery teams can assist Critical Care

• Surgical teams are able to assist in ward based care and ED

• Patient physical and mental health implications – there is a risk in suspending care for this patient group

• Morbidity and Mortality incidence has the potential to rise if delays occur.

• Complications, morbidity and mortality have the potential to rise by suspending elective surgery

• Extension of waiting lists and impact on purely elective operating lists.

- There is a potential for increased post-operation Critical Care demand due to debilitated more unwell patients undergoing surgery (higher risk surgery to patient)

• Increase further elective waiting time as time spent re-starting elective services will be needed on urgent and cancer cases.

• This will generate more pressure in the post-COVID period to operate and the pressure on already stressed workforce can be detrimental to patient care.

2.4 Non-urgent surgery decision, based on all factors:

- Understanding and appreciation of the impact which suspending non-urgent care would entail (outlined above).

- Appreciate the need to increase available workforce pool and ability to redeploy teams to support and treat emergency admissions. Without this ability we will reach capacity rapidly and be unable to care for emergency immediate need patients.
- As such the overall balance (taking into account both of these opposing viewpoints) the decision was made to suspend non-urgent care. QIA score was 12, highlighting a moderate risk.

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

3.1 Continue cancer and urgent elective care, as we are able to with available resources over the next few months.
3.2 Suspend non-urgent care, including non-urgent outpatient care, to enable response to emergency and urgent care needs.
3.3 Appreciation of need to move away from Quarter 3 & 4 framework from October 2020.
3.4 Support need to redeploy and utilise skill set of our workforce to meet emergency demand.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	Staff and Resources, Governance, Leadership and Accountability.
Equality impact assessment completed	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 Main Strategic Objective	To protect and improve population health
Link to Main WBFG Act Objective	Commitment to corporate social responsibility and improving health & social equity, work with our staff, partners and communities to build strong local relationships and solid foundations of the past

5. RECOMMENDATION

- **NOTE** the report and the reasons for the need to move away from the planned Q3&4 activity due to clinical need from COVID-19 resurgence.

AGENDA ITEM
6.7

QUALITY & SAFETY COMMITTEE

Royal College of Anaesthetists & Royal College of Surgeons Invited Service REview On the Intensive Care Service for General surgery patients at princess of wales

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dr R Alcolado, Deputy Medical Director / Mrs Leanne Baylis, Business Manager
Presented by	Dr Nick Lyons 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**
Carl Verrecchia, Anthony Gibson, Cheryl Hucker – Bridgend ILG		SUPPORTED

ACRONYMS	
	RCS – Royal College of Surgeons RCoA - Royal College of Anaesthetists POW – Princess of Wales IRM – Invited Review Mechanism ASGBI - Association of Surgeons of Great Britain and Ireland FICM - Faculty of Intensive Care Medicine ICNARC - Intensive Care National Audit & Research Centre GI – Gastrointestinal MDT – Multidisciplinary Team QSE – Quality, Safety & Experience ILG – Integrated Locality Group TCM – Total Conflict Management

1. SITUATION/BACKGROUND

1.1 On 11 July 2019, the then Medical Director for Cwm Taf Morgannwg University Health Board wrote to the Chair of Royal College of Surgeons (RCS) Invited Review Mechanism (IRM) to request an invited service review of the Princess of Wales Hospital's intensive care service for general surgery patients.

1.2 The request was considered by RCS and Royal College of Anaesthetists (RCoA), also representatives of the Association of Surgeons of Great Britain and Ireland (ASGBI) and the Faculty of Intensive Care Medicine (FICM). A review team was appointed and an invited review visit was held on 12 and 13 September 2019.

1.3 In particular, the request highlighted concerns regarding intensive care processes and team-working between clinical teams.

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

2.1 The action plan was considered at the May 2020 Quality & Safety Committee meeting.

2.2 The update to the action plan since the last Quality & Safety Committee review is attached (Appendix 1).

2.3 The RCS have been monitoring our progress against our action plan and are satisfied that good progress is being made and have now ceased active monitoring following our last update.

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

3.1 A number of the actions are noted in the action plan to be delayed due to the COVID pandemic and the fact that much elective surgery is on hold. The risk / issue that each of these carry are explained below:

- ***Recommendation 2*** - The ILG will review the available audit results and the action plan at its next QSE meeting on 11 February 2020. The ILGs QSE will also give consideration to closing the action once the audit cycle has been included in the ILG's audit programme for 2021/22 to facilitate future monitoring. Any arising associated risks identified via the audit cycles will be escalated via the ILG's/CTM QSE & R framework appropriately. However current risk associated with non-compliance to the audit cycle is considered to be low due to the current cessation of elective surgery, and relatively low volume emergency surgery being undertaken during the second COVID 19 Pandemic Wave.

- ***Recommendation 4 –*** Due to COVID 19 impacts on ability to release staff it has not been possible to complete the programme within the stipulated timeframe. However the action has been initiated and progressed as per recommendation requirement and consideration to closure will be taken at the ILG's next QSE meeting. Pending resolution of the current COVID 19 pandemic wave it is aimed to complete the TCM work by September 2021
- ***Recommendation 5*** **-** Current risk associated with non-compliance to the audit cycle is considered to be low due to the current cessation of elective surgery, and relatively low volume emergency surgery being undertaken during the second COVID 19 Pandemic Wave.
- ***Recommendation 16 –*** As per recommendation 5 all data to be collected to become a standing item on Bridgend ILG's Annual Clinical Audit programmes for implementation and monitoring via the ILG's QSE Framework. Current risk associated with non-compliance to the audit cycle is considered to be low due to the current cessation of elective surgery, and relatively low volume emergency surgery being undertaken during the second COVID 19 Pandemic Wave.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Risks identified are being managed via the action plan (Appendix1)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	All standards apply
Equality impact assessment completed	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 Well-being Objectives	Provide high quality, evidence based and accessible care.

5. RECOMMENDATION

5.1 To **NOTE** the contents of the report.

5.2 For the Committee to **RECOMMEND** whether this action plan can now return to Locality Governance for ongoing monitoring or whether it needs to be brought back to the Committee at a future date.

Health Board response to joint RCoA and RCoS invited Service Review at the Princess of Wales Hospital
January 2021.

Joint College report recommendation	Key actions	Completion date	Lead responsible	Comments
Recommendation 1: The Health Board should ensure as a matter of urgency that there is an agreed protocol for the management of post-operative pain which is evidence based, following the guidelines of best practice, and applied consistently by all clinicians of every discipline.	Review / redraft post-operative pain protocol incorporating WHO pain ladder. Share with all consultants at audit meetings.	16th January 2020 October 2020	Consultant Anaesthetists Clinical Service Director	Draft shared at February audit meeting.
Recommendation 2: The Health Board should ensure that all general surgery patients have equitable access to the specialist pain team throughout their admission. This should be subject to regular audit and any deviation from the agreed protocol should be acted upon appropriately.	Audit of access to pain team and adherence to agreed post-operative pain protocol to be completed quarterly and fed back through Bridgend Locality governance structures and escalated if any noncompliance noted.	Due to COVID 19 impacts on implementation the potential closure has been revised to 11th February 2021 (next BILG QSE meeting)	Consultant Anaesthetist / Deputy General Manager / ILG Head of Quality and Safety	Main action Completed. Baseline audit completed and shared with CSG as per attachment. It has not been possible complete the agreed on going audit cycles due to service pressures and elective surgery being adversely impacted by COVID. However the ILG remains committed to commencing this work as soon as practicable. To facilitate this a suite of audit tools to monitor compliance to colorectal / pain management protocols has been developed as attached below. The ILG has established its QSE meetings and will review this action and the plan at its next meeting, therefore this action will be closed through QSE.

Health Board response to joint RCoA and RCoS invited Service Review at the Princess of Wales Hospital
January 2021.

Recommendation 3: The Health Board should ensure that the conduct and behaviour of all ITU and General Surgery consultants is compliant with organisational and professional standards, and that deviation from these standards is acted upon in a timely and appropriate way. A code of conduct document should be drafted explicitly outlining expected behaviour in meetings, towards colleagues and all other staff. It should be clearly stated that failure to adhere to an agreed standard of conduct may result in disciplinary action.	Copy or link to Guide to good medical practice to be sent to all colleagues from the Medical Director with Accompanying letter once the Pain protocol has been completed. Also to be discussed through the February CD meetings	February 2020	Medical Director ILG Director	15th Jan 2020: Nick Lyons emailed all medical staff in HB re Duties of a doctor, professional standards and behaviours. Considered that explicit 'code of conduct' is comprised in GMC's Duties of a Doctor Discussion at Medical Leadership Forum with all CDs 22/1/2020 - completed
Recommendation 4: It is recommended that the Health Board initiate a facilitated process to repair relationships between General Surgery and ITU consultant teams. It is recommended that there be a neutral professional facilitator and this is a sustained process over at least 12 months. The review team consider that facilitation needs to address views expressed regarding decisions to withdraw care in the ITU.	Medical Director to explore options to commission a professional facilitator then notify the POW Triumvirate to organise.	Due to COVID 19 impacts on implementation the potential closure has been revised to September 2021	Medical Director/Director of Workforce ILG team	Update Dec 2020 TCM have offered 1:1 meetings with all staff members involved. Key themes of meetings to date have been discussed and there are two more 1:1 meetings scheduled. We have discussed a number of next steps which are likely to include joint training sessions on Human Factors Training, Civility Saves Lives campaign and effective team working. Small group facilitated sessions are likely to be the next step

				forward but a formal proposal will be agreed with TCM once all 1:1s are complete and a write up of themes and finding has been shared.
Recommendation 5: Clinical outcome data should be collected prospectively by the Health Board, and made available to all General Surgery and ITU consultants. Service and individual date should be audited and analysed at least every six months to ensure that any concerns are highlighted at an early stage. If any concerns are raised from the data they should be investigated promptly and appropriate measure implemented to ensure patient safety is maintained.	Medical Director to speak to Mark Townsend and clinical audit team to establish what data can be collected and whether this can be incorporated into the annual clinical audit plan.	Due to COVID 19 impacts on implementation the potential closure has been revised to June 2021	Medical Director Head of Quality and safety, Clinical Service Director and Informatics colleague	Delayed due to pandemic, A Qlik App is in development with KPIs by surgeon for a variety of specialties. This will include some of our regular audit data as well as generic fields showing quality indicators. Each surgeon will be able to identify their own data and will be able to compare themselves against other surgeons whose data will be anonymised. This will be taken forward through Clinical Audit and monitored locally.
Recommendation 6: The review team considered that there should be an agreed process developed for escalation of disagreements on patient management, and this process should allow for appropriate input from a family or patient advocate that is compliant with the Mental Capacity Act (MCA).	Clinical Director for ACT to review protocols in use elsewhere and draft a locally applicable process that can be shared, agreed and implemented	February 2020	Clinical Director	HB wide policy is in place in line with the national consent policy. A local policy to escalate conflicting opinion regarding patient management has been developed and implemented within ICU POWH. Action Complete.

Recommendation 7: The Health Board should review the MDT and pathway arrangements for upper GI cancer patients to ensure that there is appropriate MDT input into decision making and a standardised pathway for every patient that is compliant with the Association of Upper Gastrointestinal Surgeons (AUGIS) guidelines.	Medical Director to liaise with Medical Director for Swansea Bay UHB where the Upper GI cancer MDT is held and outcomes agreed. In addition, chase up outcomes from independent regional Upper GI cancer surgery review	31st January 2020 14th July 2020	Medical Director ILG Operations Director	A draft specification has been received for a regional UG Cancer service.
Recommendation 8: Given the apparent distress caused to medical and nursing staff as a result of the breakdown of relationships between critical care and general surgery, the Health Board should ensure that there is external pastoral and psychological support made available to all staff members in these departments.	Medical Director to establish external pastoral / psychological support links and share with POW Triumvirate. Signposting and dialogue to appropriate colleagues to be implemented once links identified.	31st January 2020	Medical Director ILG Operations Director	There is a psychologist now working in the HB and as part of the COVID work there has been additional psychology and wellbeing support provided to the critical care teams across the HB including POW. Signposting now provided locally to all teams regarding psychological support. Dec 2020 update: The work with TCM under section 4 will also provide more targeted support. Small facilitated discussion groups which are likely to be the next step will also continue to support those who remain hurt by all that they have been through.

Recommendation 9: The Health Board should have a mechanisms that enables them to provide assurance that all staff adhere to organisational policies. Where clinicians are considering adopting practices that diverge from the organisations formally agreed procedures, there should be a process whereby new approaches should be considered and ratified by appropriate organisational governance structures.	Medical Director to review processes for new procedures / equipment introduction across Health Board. Also need to establish within new Operating model how the localities will feed into this.	31st March 2020	Medical Director	CESG (Clinical Effectiveness Steering Group) would previously have been the mechanism in the former organisation. Any new procedures would now need to be discussed through Clinical Service Group and ILG quality and Safety meetings. New Equipment Process is now embedded and is a statement of need through Capital management groups for equipment. New procedures will need to be brought through the Quality and Safety group in the ILG with relevant Clinical Directors present. To be reiterated through new medical leadership model. (Standing agenda item of ILG Q&S group).
Recommendation 10: The Health Board should undertake a comprehensive review of clinical governance processes in order to ensure that they can monitor performance more robustly and detect any issues as early as possible. The clinical governance structure needs to be robust and adhered to so that issues are escalated through appropriate	Comprehensive review to be undertaken to provide assurance on clinical governance processes.	February 2020	ILG Director	Intention to document description of current governance processes at POW, directorate and specialty level. Reporting line of QPS or its subcommittees to be discussed with exec team in line with new operating model implementation.

channels. This will also inspire confidence through transparency and accountability.				New governance framework and structure now aligned with Integrated Locality Groups.
Recommendation 11: The Health Board should address and investigate allegations of inaccuracies in incident reports. Incident number 81997 was specifically raised to the review team as divergent views exist on the events that occurred. The Health Board should consider investigating this incident and addressing any other staff reports of factual inaccuracies in incident reports.	Reopen and review the incident fully	February 2020	Deputy Nurse Director / Unit Medical Director / Clinical Director	Royal College review undertaken on this incident
Recommendation 12: The Health Board should ensure that the feedback from incident reports is fully analysed and then fed back to relevant staff. The review team observed that trends should be identified to highlight risks to patient care and improve the standard of conduct and behaviour.	Further dialogue through local POW QPS and taskforce around feedback assurance and closure of incidents and identification of trends that can impact on patient care.	1st February 2020. 1st July 2020	Unit Nurse Director ILG Team	'Governance Memory' introduced in QPS late 2019, further work to embed regular use and evidence actions. Wider feedback mechanisms will now feature through the ILG Quality and Safety committee and ILG board. ILG newsletter now in place with learning from incidents and reports
Recommendation 13: It is imperative that all general surgery patients undergoing acute or elective surgery have reasonable	Check the All Wales informed consent Policy is up to date, and look at a mechanism to start to audit this.	10th February 2020	Clinical Service Director	On agenda and discussed at POW Surgical Management Board 24/1/2020

treatment options, along with their potential implications explained. This discussions should also include material risks for each option. The Health Board should ensure all consultant general surgeons consent practices are compliant with the Montgomery Ruling. It is recommended that the Health Board undertakes an audit of these practices, to ensure there is appropriate consideration of risks and benefits of surgery, included in the associated consent taking.	To be discussed through February Audit meeting including how we measure Montgomery Principles are being used.			Discussed further at February audit on how colleagues are using Montgomery principles in informed consent. Directive received from Welsh Risk Pool to use EIDO patient information (where available) as they have been approved with plain English and plain welsh translation
Recommendation 14: The Health Board should benchmark the Princess of Wales Hospital against the Faculty of Intensive Care Medicine (FICM) guidelines for the Provision of Intensive Care Services (2019) and address any areas of non-compliance.	Review Peer review submission with FICM standards section and identify any deficits. Recommence Critical Care Implementation Group with Critical care lead to feed into to local POW QPS agendas and specifically undertake Gap analysis against FICM standards and work towards full compliance.	17th January 2020 February 2020	Clinical Director / Deputy General Manager Clinical Director / Deputy General Manager	Favourable peer review for Bridgend in September 2018. Ongoing regular engagement with peer review and there is currently an ongoing service redesign process across the health board
Recommendation 15: Concerns regarding unexpected or negative trends with this data should be discussed with the relevant clinician, and highlighted within their appraisal to provide an adequate opportunity for	This will be picked up through the benchmark against FICM standards and taken through the local CCIG. Evidence of closing the loop will be required	February 2020	Clinical Director / Deputy General Manager Clinical Service Director	FICM reviewed by the Clinical Director. No outstanding actions It is the Health board intention to mandate that all surgery outcome data is entered onto

reflection. Such learning should then be used to drive and deliver service improvements.				recognised national databases e.g. NHS Hip fracture, NELA etc.
Recommendation 16: Data should be analysed and presented at a joint anaesthetic and surgical audit meeting, where all of the clinicians are present. Ideally this data analysis should be overseen, validated and presented by an independent consultant colleague. The data to be presented at this meeting should be anonymised.	Review of data to be discussed between clinical Directors and presented at Joint Audit meetings	Due to COVID 19 impacts on implementation the potential closure has been revised to June 2021	Clinical Service Director / Clinical Director	Needs further discussions through Audit meetings. On hold as pandemic has prevented joint meetings being undertaken As per recommendation 5 all data to be collected to become a standing item on annual audit programmes
Recommendation 17: Anaesthetic and general surgery departments should use the RCS recommended M & M good practice guide and continue to comprehensively minute the meetings with documented learning points and action plans. These minutes should be circulated to all attendees. The Health Board should ensure that all necessary cases are discussed and incorporates as appropriate into any other organisational mortality reviews. It is also recommended there is a joint M & M meeting dealing with general surgery patients in the ITU.	This action point to be taken through General Surgery and ITU / Anaesthetic colleagues and incorporated into natural audit cycle going forward in 2020	February 2020	Clinical Service Director / Clinical Director	Minutes of meetings and audit plan as evidence to be fed through the CSG Quality and safety meetings The action plan was presented and discussed at the ILG QSE meeting in October 2020 Section The action plan was also discussed at the ILG QSE meeting 2020.

Recommendation 18: The Health Board should ensure that medical leadership positions are adequately supported and that there is appropriate time allocated in job plans to effectively manage their area of responsibility.	New locality structures and operating model is expected to address this recommendation	August 2020	Medical Director	Consistent approach to ILG clinical leadership model has been agreed. Appointments made through November and Dec 2020 and clinical leaders in post with agreed tariff of time in their job plans
Recommendation 19: The review team recommends that the Upper GI surgery clinical lead role is reviewed. In particular it is recommended that this role does not undertake review of incidents or appraisals for upper GI surgery. The review team consider that neutral, external input on these matters would contribute to resolving team working issues. The college document "Surgical Leadership: A guide to best practice" can provide guidance on good surgical leadership.	Clinical Director and Unit Medical Director to meet with individual with HR and staff members representative with accurate minute taking. Letter to be drafted to invite and offer the individual the right to be accompanied to discuss the clinical lead role	By January 17th 2020	ILG Director / Clinical Service Director	Upper GI Clinical Lead has been formally written to, to inform that he will no longer be undertaking incident review of UGI incidents or appraisal of UGI colleagues. The Clinical Director will allocate incident reviews accordingly. The RCS document was circulated to all colleagues. The clinical leadership model has been concluded will result in a new clinical lead being appointed
Recommendation 20: The Health Board should consider reviewing procedures undertaken in the Private Setting at the Princess of Wales Hospital, and benchmark practice against GMC Good Medical Practice and RCS Good Surgical Practice.	Immediate review of procedures being planned and undertaken through Bridgend clinic. Review of users immunisation status and individual indemnity Paper to be drafted for exec team with recommendations	By January 17th 2020 By January 17th 2020 By January 31st 2020	ILG Director / Operations Director	'No clinical activity without indemnity' in place. Requirement for revised 'Practising privileges' authorisation to include immunisation status, DBS, appraisal/revalidation, complaint/claim/concern declaration. To be considered in line with revised BC Framework

	Nursing staff indemnity with Welsh Risk Pool to be confirmed	By January 17th 2020	Deputy Head of Nursing	document to include governance processes. DB clarified nursing staff indemnity. Procedures undertaken in BC list is available (activity as coded): review against Good Medical/Surgical practice outstanding (SS). Paper provided for executive team and discussed on 3rd February 2020.
Recommendation 21: Consideration should be given to review local appraisal processes to ensure that all consultant anaesthetists and general surgeons are compliant with NHS Medical Appraisal guidance (MAG) and GMC Good Medical Practice Framework for appraisal and revalidation. In particular, the Health Board should consider reviewing appraiser allocation and the inclusion of private practice in the appraisal process.	Letter to be sent out to all consultants to remind them of the need to be fully compliant with appraisal and revalidation. All job planning discussion to specifically document dates of appraisal and revalidation as evidence. Review of process	By January 31st 2020 February 2020 April 2020	Medical Director ILG Operations Director MARAG	Need to share this action across the HB via appropriate AMD and all CDs who undertake job planning. Review of whole practice appraisal guidance as should already include private practice. All job plans going forward in Surgery and CSS since December 2019 have been documenting appraisal and validation. Reviewed an in line with all wales guidance. COMPLETED
Recommendation 22: It is recommended that the Health Board audit the case mix of the CEPOD lists to establish if the	Retrospective Audit of cepod list usage over the last year both in and out of hours. Report through QPS.	17th January 2020	ILG Operations Director	Data has been extracted no obvious problem identified. The required parameters will be

order of patients is appropriate for patient acuity.	Discussion with theatre team to establish how we can prospectively capture changes in cepod prioritisation and whether clinical priority rationale was used appropriately.	31st March 2020 30th September 2020	ILG Operations Director / Clinical Service Director	captured more robustly prospectively. Review in 3 months – not completed due to COVID and change in processes for CEPOD activity scheduling. Since the COVID 19 Pandemic, We now have a dedicated emergency cepod list and separate trauma lists. There have been no reported issues with emergency list prioritisation since the lists have been separated. No Datix incidents recorded on this during the review period.

AGENDA ITEM
6.8

QUALITY & SAFETY COMMITTEE

Ophthalmology position statement

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Paula Pearce, Clinical Services Group Manager, Deb Matthews, Head of Nursing and Alix Hayman, Ophthalmology Service Manager
Presented by	Dr Stuart Hackwell, RTE ILG 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**
Ophthalmology Harm Review MDT	Fortnightly	NOTED

ACRONYMS	
RTE	Rhondda Taff Ely
ILG	Integrated Locality Group
FUNB	Follow up not booked
AMD	Age Related Macular Degeneration
PDR	Prolific Diabetic Retinopathy
RCA	Root Cause Analysis
SI	Serious Incident

1. SITUATION/BACKGROUND

At the outset of 2019, the Health Board set out to reduce its overall number of patients waiting for follow up without an appointment.

In March-April 2019 the plan to address the FUNB issues within Ophthalmology was to outsource the work to a private company. The outsourcing work enabled the speedy discharge of those patients who did not require hospital based care and early identification of those follow ups that required ongoing health assessment and therefore were potentially at highest risk of harm.

Following this work the Directorate were able to identify those patients at risk and redesign the service accordingly to prevent any ongoing delays for these patients.

Following the FUNB validation work in September 2019, the Head of Nursing, Ophthalmology Consultant and other members of the multi-professional team developed a Multi-Disciplinary Team (MDT) Harm Review meeting that initially met weekly, now fortnightly, to review all retrospective and current ophthalmology incidents.

As of the last Harm Review MDT (29/11/2020) the outcomes to date are:

Number of Incidents Reviewed	**225**
Severe Harm	46
Moderate Harm	13
Low/No Harm	151
Harm review in progress	15

Patients continue to be reviewed through MDT Harm Review and since July 2020 five incidents have been identified as severe harm. A further six incidents were confirmed to have caused moderate harm. Patients within the 'Harm Review in progress' section are patients whose treatment is still underway, completion of which is required to determine whether the patient has come to severe harm/irreversible sight loss.

To date a total of 42 Serious Incidents (Sis) have been identified/reported within the service, including eight identified during the Covid-19 response which have not been reported to Welsh Government (WG) in line with WG's relaxation of its national SI reporting requirements (subsequently reinstated in August 2020).

All seven SIs reported prior to the establishment of the MDT Harm Review in September 2019 have been referred to the MDT Harm Review to revisit the initial harm assessment and ensure consistency of process. Upon review at MDT, five have been identified as not severe, one has been

confirmed as severe; and the remaining SI has been referred for further clinical opinion from the relevant specialty Consultant. SIs subsequently downgraded upon review by the MDT reflect the fluctuating nature of the disease and the requirement to await completion of treatment before the level of harm resulting from follow up delays can be accurately determined.

Two cluster Root Cause Analysis (RCA) Reports have been developed; these are for the Glaucoma and Macular service. The Macular service RCA and action plan has been finalised and approved by the Rhondda Taf Ely Integrated Locality Group (ILG) and the Executive Directors. The Glaucoma service RCA has been drafted and referred to Ophthalmology Consultants/SAS doctors for clinical input. It was anticipated that this would be completed by the end of November 2020, however this was not completed due to delays in securing clinical input needed to finalise this work. This has been escalated to the ILG Director and Deputy Medical Director.

Four patient specific Root Cause Analysis reports have been developed for patients with Proliferative Diabetic Retinopathy (PDR). One RCA has been finalised and the investigation findings shared with the patient and the Health Board's claims team. Two PDR RCAs are now near to completion and the fourth one was wrongly categorised and recently transferred for individualised investigation.

To date three FUNB serious incidents have been the subject of formal complaints; two investigations are complete, findings have been shared with the patients and are being managed by the redress/claims team as appropriate; a third investigation remains under investigation.

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

Patient/family meetings have been held for only two of the 36 severe harm incidents identified by MDT. Both cases have subsequently been referred for ongoing management to the redress/claims team.

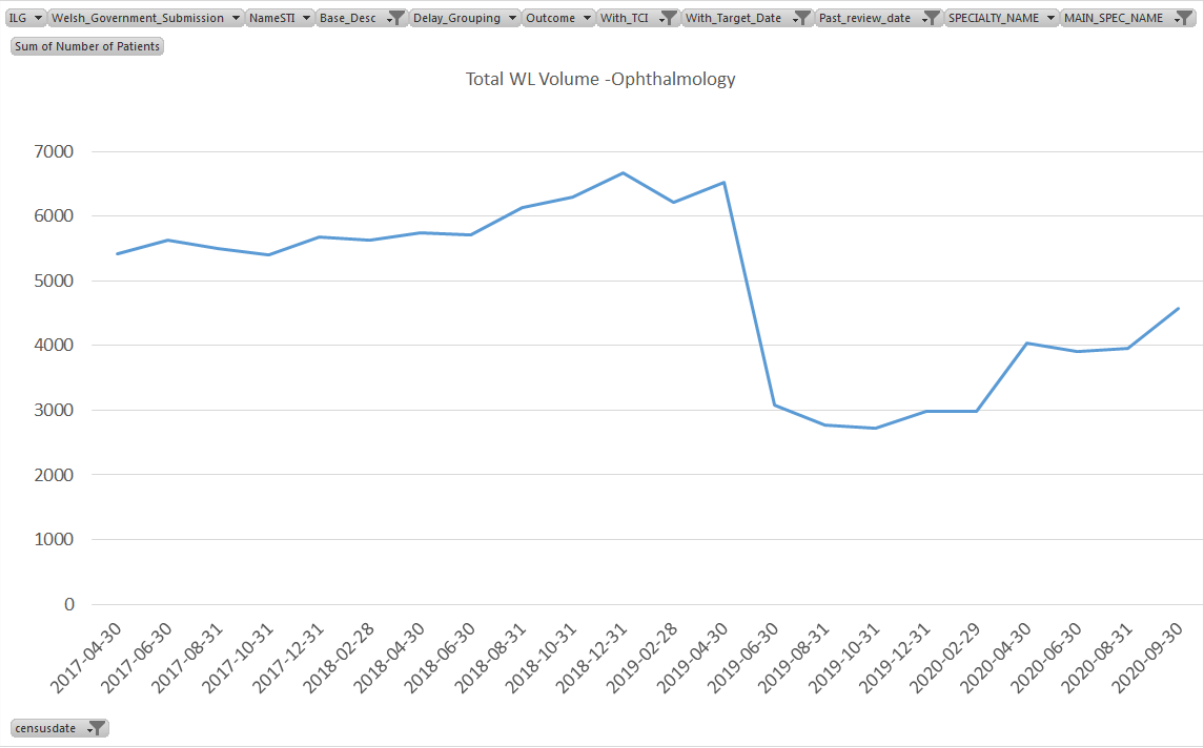
A Senior Nurse for Clinical Governance and Risk within Ophthalmology has been appointed from the 3 August 2020 for six months to continue to lead the MDT Harm Reviews and take the lead with the patient/family meetings. As part of the serious incident process a plan is in development to contact all patients who have come to harm in the next few weeks. We will start with those for whom the RCA has been completed and will arrange specific consultant review where needed.

Details of all affected patients (or their next of kin where the patient is now deceased) have now been established. We await advice and guidance from

the Health Board's Redress team before making contact with them. A meeting between the Central Redress Team, Central Patient Experience Team and ILG team was held on 18 January 2020, where the full details of the completed RCAs (Macular) and individual harm reviews were sent across to the Redress team for a decision to be made regarding each individual case as to whether they would proceed down a Redress or Clinical Negligence route. Contact with the affected patients will be conducted following the decision, and appropriate details given for the Redress team where needed. This is due to commence in January 2021, however, the trajectory for completion of the Programme is flexible due to the high competing demands resulting from pandemic activity.

The Glaucoma Cluster RCA (previously 4 cases of severe harm identified) is still underway by the nominated Consultant. They have now undertaken and completed a review of the grading and severity of harm to the patients and this will inform the completion of the RCA.

Current FUNB situation



Ophthalmology	0-25%	25-50%	50-100%	>100%	Grand Total
Q2	737	487	862	2328	4414
Q3	802	743	1325	3171	6041

There are currently 6041 patients passed their target date for follow up. 3171 (52%) of the FUNB patients are 100% passed their target date, whilst the FUNB position has been impacted greatly by COVID-19 and our ability to see patients. This represents an overall increase of 1394 patients from figures previously reported.

The majority of the serious incidents that have been reported, have derived from the highest clinical risk sub-specialities – Macular and Glaucoma.

Within the cohort of 3171 patients, there are only 77 Macular patients past their target date for follow up and this is due to patient decision not to attend at present due to COVID-19, Consultant Annual Leave and sickness. A major clinical validation has also taken place within our Glaucoma cohort by our Glaucoma lead Optometrist who has reviewed all of the patients and identified the highest risk patients and we have actively continued to review these patients where appropriate through the pandemic. Further administrative and clinical validation took place for the FUNB backlog during the first wave of the pandemic. However, with the re-introduction of services, validation by clinicians has been very sporadic due to clinical requirements and a need for senior cover in Casualty clinic. The Senior Nurse for Governance and Risk is planning to meet with the Consultants to agree a structured plan for the FUNB review and the Ophthalmology Service Manager continues to undertake administrative review and validation.

Whilst we cannot guarantee any more patients within the FUNB cohort won't have come to harm there is a lower clinical risk now sitting within the remaining patients due to their sub-speciality.

To note following this validation work there is still a high volume of FUNB patients for which following this desktop review the consultants have not been discharged and are waiting for an appointment.

Whilst cases of harm continue to be identified through regular MDT harm review panels, the frequency of cases where moderate/severe harm has occurred has reduced significantly. This is indicative of the service improvement work positively impacting outcomes and then the emerging adverse impact of Covid-19 service restrictions. Since November 2020, there have been two SIs reported due to Ophthalmology FUNB delays. Both of these have been Macular-related cases.

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

- The level of harm identified within ophthalmology remains a key risk to the organisation both from patient safety, reputational and financial perspective.

- To need to break the cycle in relation to the lack of consultant clinic capacity to book FUNB patients into clinic and due to this volume and risk, the need to use clinical capacity to risk assess FUNB patients. Dedicated support is need to develop demand and capacity plans.

- The service does not have a consultant clinical lead and this is a historic issue. The need for active consultant led clincial engagement and leadership to implement service re-design and modernisation is essential to develop a longer term sustainability plan and effectively engage in the national planning agenda.

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 completed	No (Include further detail below)
Legal implications / impact	Yes (Include further detail below)
	Harm has been identified from Serious Incident review. Cases likely to warrant form of claim/redress.
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 Well-being Objectives	Choose an item.

5. NEXT STEPS

FUNB Plans

Recent FUNB reviews have been based on the review of medical notes and last clinic letter. This has not resulted in a material discharge rate and so it is important to identify the shortfall in current capacity both to clear the backlog and recurrent capacity to meet demand.

- To develop more robust demand and capacity plans to validate the capacity gap and to develop interventions to close this gap. The Service Group will need dedicated support from Perfomance and Information to work with the Ophthalmology Service Manager to develop detailed localised plans. Initially to focus on outpatients (new and follow up and the FUNB backlog).

- For clinicians to identify the opportunities to utilise alternative communiation with patients such as Attend Anywhere and telephone follow up.

- To consider whether the model used in Cardiff & Vale to manage Orthopaedic FUNBs which was a combination of clinical and administrative validation could be adapted for Ophthalmology

- The Senior Nurse for Governance and Risk, with support from the Ophthalmology Service Manager are planning to meet with the Consultants to agree a structured plan for the FUNB review. This has been delayed due to the high competing demands and staff redeployment resulting from pandemic activity. However, meetings are currently being arranged for January 2021.

- The Ophthalmology Service Manager continues to undertake administrative review and validation.

- The Ophthalmology Service Manager with support from the Directorate Support Manager and Opthalmic Nurse Manager have arranged with the Consultants to run Saturday clinics throughout the month of January 2021.

- Virtual DRS clinics have run during the first week of January 2021 to target longest waits on FUNB list (for new and follow up patients).

Clinical Engagement and Leadership

- The service does not have a consultant clinical lead and this is a historic issue. The need for active consultant led clincial engagement and leadership to implement service re-design and modernisation is well recognised and essential to develop a sustainability plan and ensure proactive engagement in the national planning agenda. This has been escalated to the ILG Group Director and the Deputy Medical Director for support and they are working with the consultant body to develop this approach.

Service Review

- Despite the progress we have made we remain concerned about the capacity of the Ophthalmology Service to meet the future needs of our patient population. We have therefore requested a service review from the Royal College of Ophthalmology. The terms of reference are attached as appendix 1 and we will seek to address the issues identified. An initial meeting with the Royal College of Ophthalmology took place with Dr Nick Lyons, Dr Stuart Hackwell and Dr Dom Hurford and the scope of the review was agreed in line with the terms of reference. The review will take place in 2 parts. The first concentrating on the service in RGH and PCH; the second looking at the future model to match projected demand and capacity.

6. RECOMMENDATION

- **NOTE** the progress made in relation to the Macular service leading to improvements in the delivery of timely appointments;
- **NOTE** the ongoing progress with the harm review and the risks identified to date as a result of this work;
- **NOTE** the ongoing work to risk assess FUNB patients and the lower clinical risk due to sub speciality in this cohort
- **NOTE** the plans to develop a structured approach to further improve the management of FUNBs led by the Ophthalmology Senior Nurse for Governance and Risk with support from the Ophthalmology Service Manager.
- **NOTE** the ongoing key risks to the success of the programme of redesign for ophthalmology services and the opportunities to progress this with the integration of the service in POW and through the strengthening of clinical leadership.
- **NOTE** the date for integration of Ophthalmology Services into a hosted arrangement in the Bridgend ILG will take place on 1st February 2021. Historical concerns that have been identified will remain the responsibility of the RTE ILG to resolve.
- **NOTE** the follow up action to progress the plan to meet with patients & families is awaiting individual case decisions from the Health Board Redress team.
- **NOTE** that a Royal College of Ophthalmology Service Review of the Ophthalmology service in the historical Cwm Taf area will be taking place in 2021 following agreement of the Terms of Reference with the RCOphth.

Terms of Reference for Ophthalmology Service Review

Review of the quality of care provided to patients by the Ophthalmology service at the Royal Glamorgan Hospital and Prince Charles Hospital, including: Quality of the clinical leadership, team-working & inter-professional relationships between the consultant body, and other members of the multidisciplinary team and the level and quality of management support to the service.

Background

Concerns have been raised about the ability of the Ophthalmology Service at the Royal Glamorgan Hospital and Prince Charles Hospital to meet the needs of the community it serves.

At the outset of 2019, the Health Board set out to reduce its overall number of patients waiting for follow up without an appointment. This work was outsourced to a private company in March to April 2019 which allowed the speedy discharge of those patients who did not require hospital based care and early identification of those follow ups that required ongoing health assessment and therefore were potentially at highest risk of harm.

Following this work the directorate were able to identify those patients at risk and redesign the service accordingly to prevent any ongoing delays for these patients.

In September 2019, the Head of Nursing, ophthalmology consultant and other members of the multi-professional team have developed a MDT Harm Review meeting that initially met weekly, but now continue to meet fortnightly to review all retrospective and current ophthalmology incidents.

Thirty-five patients were identified as having suffered severe harm and the MDT Harm Review is ongoing.

The Macular Service has been overhauled and redesigned to match demand and capacity. This is progressing well and we have recently appointed a Medical Retina Consultant to bolster this service.

There has been 2 cluster Root Cause Analysis reports developed and these are in progress – Glaucoma and Macular service. Macular service RCA has been finalised while the Glaucoma RCA is still in draft awaiting clinical input.

The Health Board has recently undergone a merger and reorganisation. The process of merging the Ophthalmology service in the RGH and PCH with the Ophthalmology service in the Princess of Wales Hospital is due to begin on 1st December 2020 with the transfer of management the Bridgend integrated Locality Group.

Given these serious incidents and the merging of the service with the resulting opportunity to radically redesign services we would welcome an external college review.

Review

The review will involve:

- Consideration of background documentation regarding the delivery of ophthalmology care to the patient population described above.

- Interviews with relevant members of staff, including Consultants, Middle and Junior Grade Doctors, Nursing staff, Othoptics and other members of the MDT including the service management team with a specific focus on team working, culture and leadership.
- A review of service redesign that has been undertaken and identification of redesign that remains to be done in the different service areas.
    - Unscheduled care
    - Medical Retina
    - Glaucoma
    - Paediatrics
    - Cataracts
    - Other commissioned services
- A review of the Significant Incident process and delays in completion of the RCA with associated focus on directorate governance.

Terms of Reference

In conducting the review, the review team will consider the standard of ophthalmology care provided by the Ophthalmology team to patients at RGH and PCH, with specific reference to:

- Quality of clinical care, including considering whether satisfactory outcomes are achieved and clinical practice is evidence based, in accordance with recognised standards and national (UK and Welsh) guidance;
- Team-working - considering whether the care provided is facilitated by positive team working relationships and a supported by a framework for engagement.
- Clinical Leadership – effectiveness, engagement and culture within the department.
- Patient experience - considering whether care is patient-centred, founded on good communication and providing a positive patient experience.

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided including whether there is a basis for concern in light of the findings of the review.
- Make recommendations for the consideration of the Medical Director of Cwm Taf Morgannwg University Health Board as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise enhance the care provided to patients and facilitate transformation into a center of ophthalmic excellence.

AGENDA ITEM
6.10a

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE INFECTION PREVENTION AND CONTROL (IPC) COMMITTEE	
DATE OF MEETING	19 January 2021

PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Julie Donovan, IPC Co-Ordinator
PRESENTED BY	Greg Dix, Executive Director of Nursing
EXECUTIVE SPONSOR APPROVED	Executive Director of Nursing
REPORT PURPOSE	FOR NOTING

ACRONYMS	
	None Identified.

1. PURPOSE

1.1 This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Infection Prevention and control Committee at its meeting on 22 July 2020.

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

1.3 The Quality & Safety Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	A dedicated resource to lead on the operational agenda for decontamination is required for the Health Board. This is a risk to the organisation. Members were asked to note that in the former Cwm Taf University Health Board (CTUHB) there has only been one Health and Safety Advisor to undertake FFP3 fit test training. At the start of the COVID19 outbreak, it was difficult to get all staff trained to wear masks. Health and Safety to produce a business case for additional trainers. Members not aware of the outcome of the business case A meeting to be held with the Integrated Locality Director Bridgend to discuss how to take forward the reduced on site Consultant Microbiologist cover. A verbal update was given by the IPC Lead Nurse on the COVID19 position from 1st March to 20th July 2020 where Royal Glamorgan Hospital (RGH) saw a peak of healthcare associated COVID19 cases. To date 22 outbreaks have been reported to Welsh Government (WG). Interventions were put in place which helped to see a reduction in the number of positive cases. Committee members were asked to note the poor quality of the FFP3 masks. This has been added to the risk register.
ADVISE	The reduction expectations for healthcare associated infections (HCAI) set by Welsh Government (WG), have not been published for 2020/21. WG have advised to follow those set for 2019/2020. Investment is needed to provide an integrated whole system approach for Infection Prevention and Control (IPC). The Health Board will not achieve the healthcare associated improvement goals without investment in Primary Care to appoint a dedicated IPC resource. Significant work has been completed to standardise and improve the C. section Surgical Site Infection (SSI) surveillance and reporting systems. Members were asked to note that IPC Level 2 training is mandatory via E. learning on an annual basis.

	CSSD services moved to RGH to allow for the replacement of boilers in Prince Charles Hospital (PCH). This was commissioned on 07.06.20. Due to staff shortages and an issue with the air changes/pressure in the gowning and cleaning room the service continues to operate from RGH. During this time, there has been no disruption to the service in PCH. The AE(D) for Wales carried out the annual JAG audit in the Endoscopy department in Princess of Wales (POW) where an amber rating was achieved. A business case for the centralised decontamination unit was submitted to WG in January 2020. A response has been submitted to WG, but CT have not received any correspondence in relation to this. Local Decontamination meetings have been set up for each Integrated Locality Group which feed up to the Decontamination Committee. An SGS audit was undertaken in POW in October 2019 where the certification was temporarily suspended. The area was re-audited in January 2020 where 7 minors were identified. The SSD Manager is progressing with the corrective actions. A repeat audit to take place September/October 2020.
ASSURE	The Committee received and noted for assurance the Infection Prevention and Control Quality Report which gives an overview of Cwm Taf Morgannwg UHB's position for healthcare associated infections. The Committee received and noted for assurance the contents of the IPC Risk Register. The Committee received and noted the contents of the COVID19 position paper. The Committee received and noted for assurance the Directorate Exception reports. The Committee noted the verbal report given by Occupational Health and well Being. The Committee received and noted for assurance the following Exception reports:

	• Combined Estates (including Critical Ventilation and Water); • Waste; • Housekeeping; • Antimicrobial Resistance (AMR) Delivery Implementation Plan.
INFORM	There has been a delay rolling out ANTT in POW due to COVID19. This will commence in the Autumn. Guidance to be put in place when reintroducing staff back to work when shielding ends following the COVID19 outbreak. Following the approval of the new Visiting Policy there has been an increase in the number of people on site.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
6.10b

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE INFECTION PREVENTION AND CONTROL COMMITTEE	
DATE OF MEETING	19 January 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Julie Donovan, IPC Co-Ordinator
PRESENTED BY	Greg Dix, Executive Director of Nursing
EXECUTIVE SPONSOR APPROVED	Executive Director of Nursing

REPORT PURPOSE	FOR NOTING

ACRONYMS	
	None Identified.

1. PURPOSE

1.1 This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Infection Prevention and Control (IPC) Committee at its meeting on 19 November 2020.

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

1.3 The Quality & Safety Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	IPC Lead Nurse expressed her concerns regarding the lack of Microbiologist cover at Princess of Wales Hospital (POW). This is having an impact on the site as there is no continuity. The Medical Director to be informed of the situation. COVID19 Outbreak Control Meetings are taking place three times a week to discuss the situation across the Health Board. IPC investigate each case in detail to identify the source of transmission. The Integrated Locality Groups (ILG's) continue to work towards implementing the 15-point plan to reduce hospital transmission of COVID19. Committee members were asked to note that IPC have not been able to support the decontamination agenda due to the pressures of COVID19. This is a risk to the organisation with no dedicated resource to undertake the role of Operational Lead for Decontamination. A report to be written to support this resource.
ADVISE	There have been no revised healthcare associated infection (HCAI) reduction expectations published for 2020/21. Welsh Government have advised to follow those set for 2019/20. "Full details of the Health Board's position is available from the IPC Team upon request". An additional IPC Nurse resource is required in Primary Care to achieve the HCAI improvement goals. To be included in the Integrated Medium Term Plan (IMTP). A report to be written to support this resource. Committee members noted there is poor compliance with IPC Training, which ILG's are now taking responsibility for. IPC will deliver face-to-face training when the situation of COVID19 improves. Awaiting approval from Welsh Government (WG) for the funding of the Central Decontamination Unit in POW. In the interim Capital Planning have allocated money to employ a Design Team. This will allow JAG accreditation to continue.

ASSURE	The Committee received and noted for assurance the contents of the IPC Risk Register. The Committee noted the verbal update for Decontamination. The Committee received and noted for assurance the ILG's Exception reports. The Committee received and noted for assurance the following Exception reports: • Combined Estates (including Critical Ventilation and Water); • Waste; • Housekeeping; • Antimicrobial Stewardship.
INFORM	ANTT to be rolled out in POW. Decontamination Risk Register to be developed. Concerns have been raised regarding the different practices that are in place for the decontamination process of the reusable hoods and respirators across the HB. An audit log to be produced to identify what is in use, to ensure a strict Standard Operating Procedure (SOP) is in place and to identify appropriate areas for the decontamination process to take place. Committee members were informed that two of the three antimicrobial pharmacists have been redeployed to other areas due to COVID19 and do not have capacity to carry out antimicrobial stewardship activities at present. This will be documented on the Pharmacy Risk Register. It was noted that the company that provides the clinical waste collections across Wales has had a problem with their plant in Bristol for the last 12 months. CTMUHB are managing the risk and WG and Shared Services are involved. It was agreed to extend the out of date IPC policies to February 2021.

APPENDICES	**NONE**

AGENDA ITEM
7.1

CTM BOARD

UPDATE ON COVID-19 NURSING WORKFORCE PLAN TO SUPPORT INCREASED CAPACITY

Date of meeting	19/01/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Debbie Bennion, Deputy Executive Director of Nursing
Presented by	Greg Dix, Executive Director of Nursing
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**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
NMC	Nursing & Midwifery Council
ILG	Integrated Locality Group
HEIW	Health Education Improvement Wales

1. SITUATION

Covid-19 remains an established and significant pandemic across the UK (and globally). NHS Wales remains under increasing and significant pressure, with direct impact on the staffing resource.

This SBAR report provides an updated positon on the Nursing Workforce plan to support increased capacity which was presented at the May 2020 Quality and Safety Committee.

The Chief Nursing Officer and Deputy Chief Medical Officer issued a Welsh Government letter to Health Boards in July 2020 which outlined papers to support Health Boards with their planning and response to the ongoing provision of critical care to support the outbreak and prepare for any second wave.

The letter highlighted changes to the previous guidance issued in March 2020 in relation to critical care Staffing levels.

The letter gave the following rationale for the review of the guidance:-

"At the start of the outbreak, the UK Chief Nursing Officers in association with a wide number of nursing professional associations issued guidance in relation to appropriate staffing levels for critical care throughout the various surge levels. Lessons learnt across the UK both in terms of the practicality/safety of operating at the higher surge levels/ratios as well as the reality that staffing in most cases has not proved to be the limiting factor for critical care capacity"

The letter outlines the fact that the Critical Care Nursing Exception surge guidance issued in March 2020 would be withdrawn and the Health Boards should seek to meet the requirements set out on page 8 in the Faculty of Intensive Care Medicine's bridging guidance (phases 1 and 2 in the original guidance).

Further detail will be outlined under the Critical Care section of this SBAR report.

Nurse Staffing Act

The Chief Nursing Officer issued a Welsh Government letter on the 24th March 2020 to Health Boards about how the business as usual processes of the Nurse Staffing Levels (Wales) Act 2016 and associated work-streams are affected.

The letter specifically considered the effects of the COVID19 pressures in relation to:

- The ongoing work to extend the Act
- The duty to paediatric inpatient wards

- Compliance with and reporting against the existing duties under the Act.

A separate Nurse Staffing Act report outlining CTMUHB's position in relation to the Nurse Staffing Levels (Wales) Act 2016 was provided to the September 2020 CTM Health Board meeting. A further paper following the July 2020 acuity audit was provided to the November 2020 CTM Health Board meeting. The Chief Nursing officer (Wales) has informed all Executive Nurse Directors that due to the challenges the Health Boards are facing the January 2021 bi- annual acuity audit has been cancelled and will be rescheduled for later in the year.

This SBAR report:

- Sets out CTMUHB's proposed Nurse staffing ratios during the pandemic when surge capacity is required. These ratios have been approved by the Executive Director of Nursing, Midwifery & Patient Care.

- Seeks to ensure all Board members are sighted on the proposed nurse/staffing ratios.

- Provides an update on the nursing workforce plans and agreed ratios used to support the increase in demand described in the May 2020 paper. These include the following :-

  1. Critical care beds (ventilated patients)
  2. Non-Invasive ventilation beds (NIV/CPAP) required to staff the increase
  3. Community Hospital beds with Oxygen provision
  4. Field Hospital beds
  5. General Ward beds (which will be staffed at a reduced Registered Nurse ratio in order to achieve the increased demand as described above)

2. BACKGROUND

During this second wave of the pandemic, the bed modelling and operational pressures remain a shifting picture which impacts significantly on the nursing workforce model and requires a "shift" in actual and planned resources each time changes are made.

In May 2020 the Locality Directors completed and implemented plans where necessary to increase the number of critical care ventilated beds on each acute site and quantified the exact nurse staffing gap that would limit this scaling up.

In addition the guidance for treatment decisions for patients suffering COVID-19 based on expert opinion was changing rapidly. Continuous Positive Airway Pressure (CPAP) remains a valid early treatment for certain patients to try to avoid intubation. CPAP is an Aerosol generating procedure and therefore carries significant risk to staff and non COVID-19 patients.

The Locality Directors developed specific CPAP/respiratory high care areas across all sites to concentrate the expertise in medical and nursing staff to ensure the best outcome for patients and minimize risk to staff. This was supported by the development of Health Board wide protocols for the delivery of these reviewed treatment plans). On this basis the nursing workforce model for the high care respiratory areas on all three sites was been developed.

It is important to note that this requires an extremely flexible approach to the deployment of the nursing workforce across each site and it is essential that the medical and allied health professional workforce deployment dovetails into these plans at Locality level.

3. ASSESSMENT

NURSE STAFFING RATIOS

These proposed ratios have been approved by the Locality Nurse Directors and the Executive Director of Nursing, Midwifery and Patient Care.

When calculating the whole time equivalent staff required a general uplift rate of 26.9% has been agreed (covering sickness, "other leave" and study").

It is evident that these proposed new nursing ratios are a significant move away from our current levels and derogation from the Nurse Staffing Act (which currently applies to general surgical and medical wards).

The Chief Nursing Officer (CNO) for Wales has acknowledged that this is the case during these times of extremis and applies to all Health Boards.

The CNO has specifically asked for Boards to be kept up to date with decisions / actions taken around non-compliance of the Act and her team are currently developing a framework for Executive Nurse Directors to use.

UPDATE ON NURSE STAFFING ACT

On the 15th October 2020 the CNO wrote to Executive Nurse Directors, in which she outlined the fact that the primary purpose of a ward remains the treatment of patients for medical or surgical conditions, and the Welsh Levels of Care tool is still applicable to that setting. The CNO further

outlined, in her view those wards would remain under the auspices of 25B of the Act and if a ward was legitimately repurposed to treat those critically unwell Covid19 patients (as we expected in March to be a more common occurrence); the CNO view remains that those wards would be considered exclusions with an expectation we would follow national advice on staffing critical care areas.

In addition on the 1st July 2020, an updated version of the Healthcare Monitoring System (HCMS) went live for use, this was informed by the All-Wales Adult work-stream, the enhancements were designed to support Health Boards in recording data that the Act lists as being necessary under section 25E (reporting). The CNO expectation was a more detailed reporting picture would be possible from the 1st July 2020 than had previously been possible.

NURSING WORKFORCE PLANNING

The nursing workforce planning remains relatively iterative as the numbers required to support the Critical Care units and High Care Respiratory beds (NIV and CPAP) are co-dependent depending on demand at a given time. There will be a reduction in the Specialist Registered Nurse to Patient ratio when critical care and high care respiratory (NIV/CPAP) bed numbers are increased and field hospitals are utilized for surge capacity.

This will have the consequence of the general wards Registered Nurse to Patient ratio being reduced significantly to enable the redeployment of Registered Nurses to the surge capacity areas.

Work has been undertaken since May 2020 to upskill" our existing nursing workforce to support the Critical Care units and areas designated for Non-Invasive ventilation.

It is important to note that the CTMUHB proposed nurse staffing ratios are the absolute minimum that should be considered and will only be instigated when critical care (ventilators) and respiratory/ high care (NIV/CPAP) are at their peak capacity.

If it becomes necessary to invoke these revised staffing ratios the Locality Nurse Directors will escalate for approval to the Executive Director of Nursing, Midwifery and Patient care. The revised staffing model will be monitored and reported on the weekly Executive Nurse Director calls.

During this time the ward sisters/senior nurses and Heads of Nursing will provide additional oversight and support to the affected areas.

In addition, since December 2020 a daily RAG rated staffing positon is provided to the Executive Director of Nursing and Midwifery and the ILG for each acute site by the Heads of Nursing in each acute site.

The monitoring of nurse sensitive indicators, complaints, incidents etc. will continue during these times and will be carefully monitored by the ILG nurse leadership and quality governance teams.

4. CRITICAL CARE RATIOS

As explained in the earlier section, the proposed and agreed ratios outlined in the SBAR paper presented to the Quality and Safety Committee in May 2020 met the guidance issued in the " Joint Statement on development immediate critical care capacity, March 2020. This guidance has now been withdrawn in Wales and replaced with guidance contained within the "Critical care response to first wave and preparation for second wave of COVID-19" issued on the 28th July 2020.

The guidance issued in July 2020 was for Health Boards to:-

" seek to meet the requirements set out on page 8 in the Faculty of Intensive Care Medicine's bridging guidance which relates to phases 1 and 2 in the original guidance".

It is important to note that the terms phase in the original guidance has been replaced with the term capacity in the July 2020 guidance.

- **PHASE 1 CAPACITY (March guidance) replaced with " APPROACHING BASELINE L3 CAPACITY" (July 2020 guidance)**

The main difference between the March 2020 and July 2020 guidance is as follows:

In March 2020 when critical care capacity was deemed **Phase 1** the required nursing staff ratio **per patient** was:

- 1 Trained critical care registered nurse
- 1 Registered Nurse or allied health professional with recent /previous critical care experience with some transferable skills (Category A nurse)
- 1 Registered Nurse with no critical skills (Category B Nurse)

The July 2020 guidance replaces this Phase 1 ratio with a category described as **"Approaching baseline L3 capacity"** – at this level the required critical care staffing ratio **per patient** is:

- 1 Trained critical care registered nurse
- "Normal HCSW establishment per critical care unit"

- **PHASE 2 CAPACITY (March guidance) replaced with "2 X APPROACHING BASELINE L3 CAPACITY" (July 2020 guidance)**

The main difference between the March 2020 and July 2020 guidance is as follows:
In March 2020 when critical care capacity was deemed Phase 2 (double capacity) the required nursing staff ratio for every 2 **patients** was :

- 1 Trained critical care registered nurse : 2 patients
- 1-2 Registered Nurse or allied health professional with recent /previous critical care experience with some transferable skills (described as Category A nurse in March 2020 guidance) : 2 patients
- Registered Nurse with no critical skills (described as Category B Nurse in March 2020 guidance) : 2 patients

The July 2020 guidance replaces this Phase 2 ratio with a category described as **"2x baseline L3 capacity" –** at this level the required critical care staffing ratio for every **2 patients** is:

1 Trained critical care registered nurse: 2 patients
1 Non- critical care registered nurse: 2 patients
1 HCSW: 2 patients

Non Invasive ventilation (CPAP/NIV)

The agreed staffing ratios for non-invasive ventilation remain unchanged from the May 2020 – these are outlined below:-

Non-Invasive ventilation (CPAP/NIV) i.e. respiratory high care beds

Registered Nurse (NIV/CPAP specialist)	:	**Patient**
1	:	4

HCSW	:	**Patient**
1		2

The Locality Directors have worked together to propose the development of respiratory high care beds across the Health Board which includes a proposed iterative staffing model as the pandemic moves.

The phasing describes the change in skill mix that is required when there is a need to increase the number of respiratory high care beds (NIV/CPAP). The actual increase in beds and phasing of staffing will be dependent on

the geographical layout of the respiratory high care bed provision for each site. The Locality Nurse Directors have bespoke plans to manage this change in skill mix if required to staff increased respiratory high care beds.

	Now	**Phase 3**	**Phase 4/6**
NIV Trained Nurse	3	2	1
Registered Nurse	3	4	3
Non Registered Nurse*	6	6	8
Health Care Support Workers			
Total	**12**	**12**	**12**

* Non Registered Nurses include therapists, army medical team etc.

General ward beds (24- 28 beds)

Registered Nurse: Patient (2 Registered nurses per shift)

1 : 12 or maximum of
1 : 14

HCSW*: Patient

6-8* : 24/28

*The number of HCSW's required would depend on the case mix of the patients and the geographical layout of the general ward e.g. number of single rooms and visibility of patients.

Field Hospital (Ysbyty'r Seren)

In May 2020 our agreed staffing ratio's for our field hospitals were as outlined below.

Registered Nurse: Patient

1 : 21

HCSW : Patient

4 : 21

When Ysbyty'r Seren opened the following criteria on admissions was applied:

- A step-down rehabilitation/re-enablement and discharge pathway for those recovering from Covid-19 (14 days post positive swab).

- A supportive palliative management pathway providing end of life care
- Our patient profile/ criteria for admission is listed below:
    - Covid-19 positive confirmed on testing
    - Day 14 from post positive swab
    - Medically stable
    - Afebrile for at least 48 hours without medications
    - Not oxygen dependent or requiring aerosol generating therapies
    - Not requiring ongoing acute investigations
    - Not EMI/ requiring enhanced level of supervision

A revised nursing workforce model was implemented with the principles outlined below:

- 1wte x 8a Senior Nurse – overarching senior nurse (Mon – Fri 08.00-16.00hrs)
- 1 x Supernumerary Band 7 per shift 7 days a week per 76 beds
- 3 x Registered Nurses per 38 beds (ratio of 1:14nurse/patient ratio)
- 4 x non-registered staff per 19 beds (ratio of 1:5 HCSW/patient ratio)

The nursing workforce remains the same for day and night shifts this is due the large open plan facility with poor visibility between rows of wards and the isolated cubicles.

Band 7 establishment

Each Supernumerary Band 7 will be responsible for 76 beds and the role will include clinical leadership, for the nursing workforce and overarching ward managerial responsibility for these 76 beds and its workforce.

Recognizing the risk to provide a Registered Nursing workforce across the Health Board when triple ITU capacity was required. The registered Nurse/patient ratio could be increased to a 1:19. However due to the layout of the facility as described above this would not be without increased risk to patient safety.

Support staff for all schemes

Support staff, for example therapies and pharmacy will be factored into the nurse staffing models as required. These may be used to assist in filling the gap in HCSW numbers in some areas and to support the Registered nurses, for example pharmacy role in medication administration.

Nursing Students

Between May and September 2020 Health Boards across Wales were fortunate to have the support of student nurses who with the agreement of HEIW and support of Shared Services were contracted to work in Band 3 or

Band 4 roles depending on the date they were due to qualify. Since September 2020 student nurses have returned their university studies.

Registered Health Visitor and Nursery Nurses

Between May and August 2020 many Health visitors and nursey nurses agreed to be redeployed into the acute areas; after undergoing "clinical skills update training". Since August 2020 these have returned to their contracted posts.

Overseas Nurses

In January 2021, the Nursing and Midwifery Council (NMC) confirmed they were opening the temporary register to two additional cohorts of overseas trained nurses.

The nurses in both cohorts are current applicants to the permanent register. The first cohort are those who began their registration applications before October 2019 and who have a valid decision letter. The second cohort comprises applicants who started their registration after October 2019 and from whom NMC have received a registration application and all relevant supporting declarations.

The approach taken with both groups will preserve the 'opt-in' nature of the temporary register. The potential for CTM Health Board will be for an additional 35-37 nurses who could join the temporary register.

The OSCE centres remain open and the NMC has strongly encourage organisations to continue to support overseas-trained nurses in their process to permanent registration.

Ongoing Monitoring and Deployment

The Health and Care Standards Monitoring system along with the Health Board's Datix incident reporting system allow the senior nursing teams to have oversight and upward reporting of any deviation from the identified care indicators.

Further work is being undertaken to refine the Health rosters to ensure deployment of staff across ILGs is managed and monitored effectively by the ILG's and to ensure key performance indicators are clearly articulated to provide assurance regarding the proactive management of rosters and deployment of staff.

5. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Provides an update on the nursing workforce plans and agreed ratios used to support the increase in demand.
Related Health and Care standard(s)	Safe Care
	Staff and resources Timely care Dignified care Effective care more than one Healthcare Standard applies please list below: All HCS apply.
Equality impact assessment completed	No (Include further detail below)
Legal implications / impact	Yes (Include further detail below)
	Nurse Staffing Act applies
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Workforce supply and costs
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

6. RECOMMENDATION

The Quality and Safety Committee is asked to **NOTE** the contents of this report and **APPROVE** the outlined surge ratios (noting the caveats detailed within the report).