



AGENDA ITEM

6.4.2

QUALITY & SAFETY COMMITTEE

Bridgend ILG Quality Safety and Experience Report

Date of meeting	24/5/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ana Llewellyn, Nurse Director
Presented by	Anthony Gibson, Group Director
Approving Executive Sponsor	Executive Nurse Director
Report purpose	FOR NOTING

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

Committee/Group/Individuals	Date	Outcome
ILG Leadership Team	6/5/22	APPROVED

ACRONYMS

CSG	Clinical Service Group
CTMUHB	Cwm Taf Morgannwg University Health Board



ILG	Integrated Locality Group
JAG	Joint Advisory Group (accreditation for Gastrointestinal Endoscopic Services)
LFER	Learning From Event Report
POWH	Princess of Wales Hospital
COO	Chief Operating Officer
CAMHS	Child and Adolescent Mental Health Service
FACTS	Forensic Assessment and Consultation Treatment Service
WHSSC	Welsh Health Specialised Services Committee

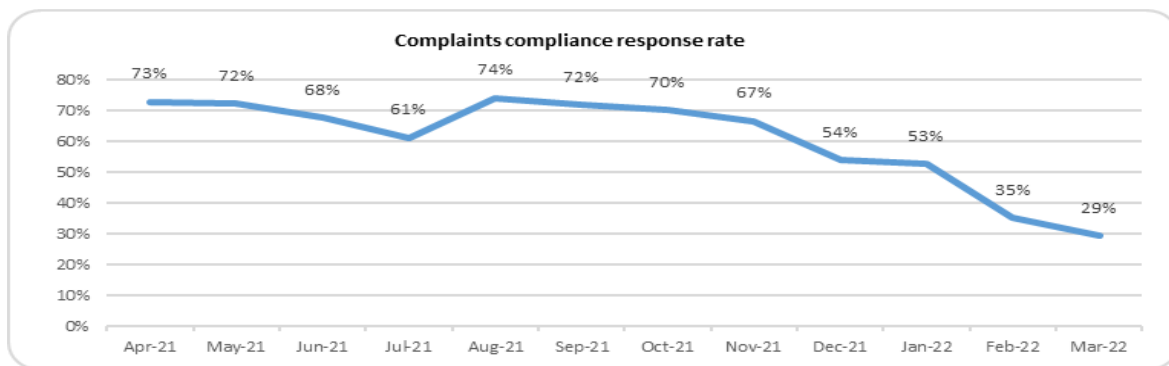
1. SITUATION/BACKGROUND

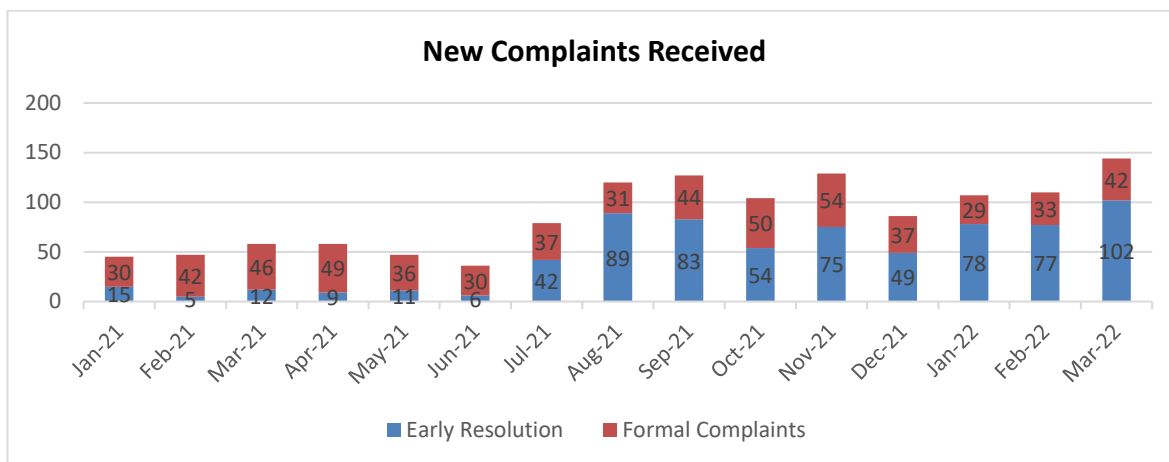
1.1 The purpose of this report is to provide members with an update on quality and safety issues in Bridgend ILG.

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

Quality and Safety Dashboard

2.1 The Bridgend ILG Quality and Safety Dashboard in Appendix 1. The key area of concern continues to be a deterioration in 30 day complaint closure compliance.





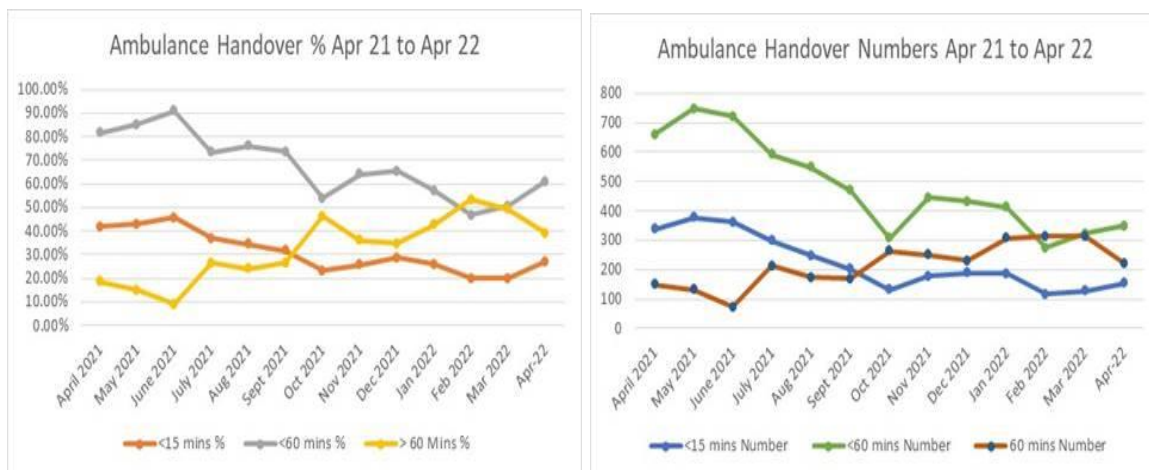
- 2.2 Members will recall that in the previous committee meeting this deterioration was anticipated through April and May due to significant staff depletion in the ILG governance team due to staff sickness and vacancies.
- 2.3 The recruitment to the Head of Quality and Safety post in Bridgend has been paused pending the outcome of the operational model consultation. However all other vacant posts are processing through vacancy control panel and in the interim temporary staff have been sought to support. This and the return of two staff from long term sickness will result in improved compliance from July 2022.
- 2.4 During this challenging period concerns management has focused on casework required to maintain organisational reputation and secure financial reimbursement i.e. information required by external agencies for assurance and legal defence purposes such as LFERs, coroner statements, Ombudsman, Community Health Council, Healthcare Inspectorate Wales responses, and Delivery Unit notifications. As of 6th May 2022 there are 8 open LFERs in Bridgend which are all on track for submission within the requisite Welsh Risk Pool deadlines. There are no outstanding LFERs in Bridgend.

External Quality Assurance

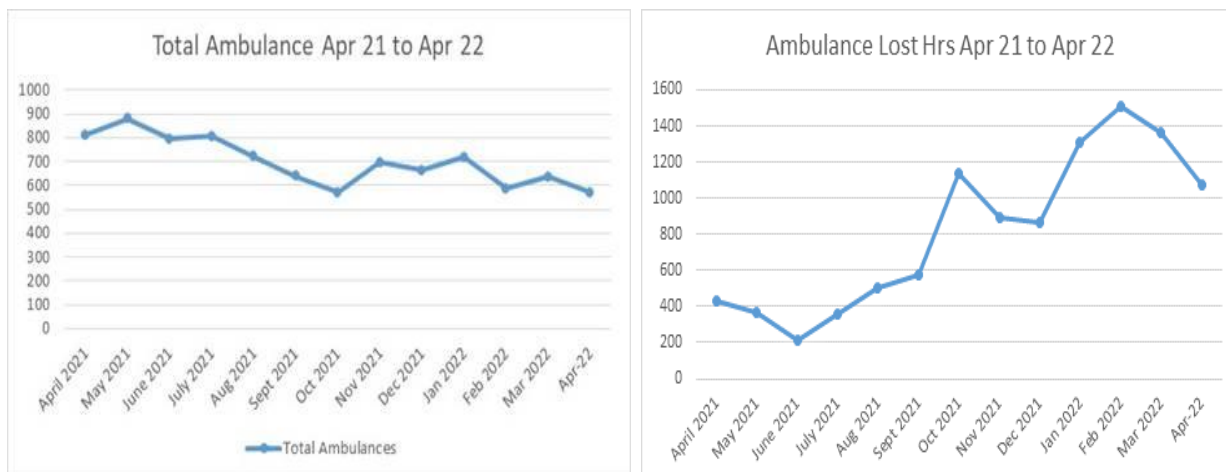
- 2.5 Healthcare Inspectorate Wales undertook an announced inspection of maternity services at POWH between 22nd and 24th March. This report and action plan has not yet been published by HIW. As such, members will receive the full detail in the next committee meeting. For assurance, members are advised that from initial feedback there were a number of security and information governance issues that required immediate assurance and these have been addressed immediately and are being actively monitored by the CSG leadership team.

Internal Quality Assurance

2.6 The Acute Services have continued to manage concerning ambulance offload delay issues through April and May 2022. This is consistent with the profile and pressures for all Health Boards in Wales. POWH, in particular had significant delays most notably over the Easter bank holiday period.



2.7 The performance against the 15 minute and 1hr ambulance handover indicators has been steadily declining over recent months as a result of crowding within the Emergency Department resulting in 27% of patients being handed over within 15 minutes of arrival and 61% of patients being handed over within 1 hour of arrival.



2.8 The volume of ambulance conveyances has seen a reduction over the time period whilst handover delays have been increasing. This a symptom of increased levels of crowding within the Emergency Department as a result of



exit block into the hospital. It should be noted that this increases the number of patients self-presenting due to unavailable ambulance resources in the community (e.g. the demand has not reduced but arrival method changed) which puts a further pressure on the Emergency Departments ability to handover ambulances in a timely way due to a competing stream of unwell self-presenting patients needing urgent treatment and trolley space. The number of hours lost with ambulances waiting outside POWH ED is in excess of 1000 hours per month over the last 4 months.

- 2.9 The front door pressures are associated with poor patient flow through the hospital due to the high numbers of patients awaiting social work allocation, placement or packages of care. As of 5th May there were 117 medically fit patients between POWH and Ysbyty'r Seren which is a concerning deteriorating position. Of these, 22 patients were awaiting health action including therapy intervention; 44 people were awaiting allocation or assessment by a social worker; 32 patients were awaiting a package of care to start and 19 patients awaiting placement. The 95 patients occupying hospital beds but not requiring hospital intervention are utilising approximately 30% of the overall bed capacity.
- 2.10 The ILG has appointed a Head of Patient Flow who is working in partnership with the local authority to expedite the process. A new red release protocol has been introduced to ensure senior oversight of risk based decision making at times of pressure and allow staff to follow a consistent process in terms of ensuring every opportunity is explored and appropriate escalation is undertaken. A revised escalation tool has been drafted in line with the national triggers and a pan-CTM Emergency Pressures meeting is held weekly to maximise opportunities for improvement.
- 2.11 When a patient is unable to be admitted and is held on an ambulance, this is always due to patients with higher clinical need being prioritised. The ILG recognise that patient experience and quality is compromised when patients are required to wait. In these times of acute pressure, patients are always assessed by the ED clinical teams and nursing staff monitor medication, undertake skin checks and ensure that patients have adequate nutrition and fluid intake.
- 2.12 Committee members are also advised that the required closure of the Maesteg Hospital Llynfi Ward at Ysbyty'r Seren at the end of May will have the impact of reducing bed capacity for the locality and will further compromise patient flow issues. POWH has had additional surge bed capacity open with temporary staffing since winter 2019/20 due to the need for additional beds during the pandemic. This is Ward 21 at POWH (a 14 bed unit). This ward will now be required for the Maesteg Hospital Llynfi Ward to transfer to with patients and staff and will have the impact of reducing core bed capacity by 20 beds.

- 2.13 The ILG leadership team have held two engagement sessions with Maesteg staff at Ysbyty'r Seren with another planned for 12th May.
- 2.14 The JAG accreditation for the Endoscopy Service at POWH was reviewed in May 2022. The report is awaited but members are advised that this accreditation is at risk due to delays in the new build central decontamination unit related to business case approvals at Welsh Government level. The Health Board has put forward a request for a further extension. The final report is awaited.
- 2.15 Ophthalmology delays continue to concern the ILG. Monthly monitoring meetings continue with the service. Members are advised that a detailed report will be provided to a future in-committee meeting as planned and a brief update on demand and capacity is included in the COO's report for this committee meeting.
- 2.16 Proposed changes to the operating model are likely to impact on the transition of the **Maternity and Neonatal Improvement** to ILGs. This was initially proposed for June 2022 but is being re-considered due to the potential of operating model changes in July 2022. It is now proposed that leadership for the improvement activities will transition to the proposed pan-CTM care group post implementation of the new operating model in order to ensure a seamless transition for the clinical teams and for external stakeholders.
- 2.17 The **Mental Health Measure** is relevant to both Adult Mental Health and to CAMHS. In brief Part 1 relates to access and Part 2 relates to the provision of a care and treatment plan for patients receiving secondary care services. Performance is monitored by the Performance Planning and Finance Committee of the Board but issues of performance do impact on the quality of services, hence advising members of particular issues in the CAMH service in this committee meeting.
- 2.18 CTMUHB provide CAMH services to CTMUHB and Swansea Bay UHB residents. There are issues of access in both services which link both to increased demand and to capacity issues.



Measure	Target	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Part 1 Cwm Taf Morgannwg CAMHS													
The percentage of MH assessments undertaken within (up to and including) 28 days from date of receipt of referral	80%	62%	40%	17.6%	15%	12%	20%	32%	32%	38%	28%	50%	47%
The percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS	80%	65%	54%	76.9%	58%	42%	50%	71%	38%	70%	39%	43%	56%
Part 2													
The percentage of HB residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan	90%	74%	96%	70.1%	74%	72%	78%	81%	70%	59%	59%	69%	85%
Measure	Target	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Part 1 Swansea Bay CAMHS													
The percentage of MH assessments undertaken within (up to and including) 28 days from date of receipt of referral	80%	0%	0%	0%	5%	37%	89%	65%	36%	43%	28%	24%	36%
The percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS	80%	49%	68%	60%	100%	82%	35%	0%	64%	50%	39%	67%	78%
Part 2													
The percentage of HB residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan	90%	82%	82%	81%	81%	65%	84%	82%	84%	84%	89%	88%	100%

- 2.19 A number of actions have been taken to date including validation of waiting lists, the implementation of additional sessions, a clinical assessment of the evidence base for group therapy sessions, the realignment of assessment to treatment sessions and active recruitment to new posts. An action plan is in place with plans that include but are not limited to the roll out of group interventions where appropriate in each locality, the provision of additional assessment capacity from crisis teams and the provision of pathway support to referrers.
- 2.20 A review of care and treatment planning has revealed that there are low numbers of children and young people being considered as receiving secondary care mental health services. As part of the improvement work this number is going to increase and it is therefore expected that for a short period there will be issues of compliance for Part 2. A full training exercise is also underway to ensure that all new staff are skilled in this area.
- 2.21 **CAMHS** continues to be in escalation with WHSSC for Ty Lliard for issues of culture and leadership and for FACTS for issues of service sustainability. Monthly escalation meetings are held with WHSSC. De-escalation for FACTS is dependent on medical leadership recruitment. The job description is currently being reviewed by the Royal College and it is anticipated that the post will be out to advert by the beginning of June. Ty Lliard has received

additional investment from WHSSC and is progressing recruitment to key leadership and therapies posts. These posts are key to providing enhanced therapeutic support and will address a number of findings from external reports. Members will note that a more detailed Ty Llidiard report will be provided as planned to a future committee meeting.

People's Experience

2.22 **Mental Health** CSG have been working in partnership with an ex-service user to co-produce a training package on Personality Disorder. The first cohort received training in April and this was delivered by the ex-service user with positive feedback from participants in the training.

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

3.1 Members are asked to note the risks associated with the closure of Ysbyty'r Seren and the anticipated impact on patient flow at POWH.

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 (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.



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

5. RECOMMENDATION

- 5.1 Members are asked to **NOTE** the progress outlined in this report and **DISCUSS** the matters for escalation.