Quality & Safety Committee

Tue 21 November 2023, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:05
5 min

1.
PRELIMINARY MATTERS

1.1.
Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2.
Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3.
Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

09:05 - 09:35
30 min

2.
SHARED LISTENING & LEARNING

2.1.
Listening & Learning Story - Bereavement Services

For Discussion and Shared Learning *Donna Walker, Bereavement Clinical Lead*

Strategic Goal: Improving Care

Domains of Quality: Person Centred, Effective, Equitable

2.1 Bereavement presentation QSC 21 November 2023.pdf (11 pages)

2.2.
Spotlight Presentation - Frailty

Discussion *Dom Hurford, Medical Director*

Strategic Goal:

Domains of Quality:

2.2 Spotlight Presentation Frailty QSC 21 November 2023.pdf (17 pages)

09:35 - 09:40
5 min

3.
CONSENT AGENDA

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

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

09:40 - 09:45
5 min

4.
MAIN AGENDA

4.1.
Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

09:45 - 10:30
45 min

5.
SETTING THE SCENE - SERVICE DELIVERY

5.1.
Report from the Clinical Executives

Discussion *Greg Dix, Deputy Chief Executive/Director of Nursing*

Strategic Goals: Improving Care, Inspiring People, Sustaining our Future

Domains of Quality: Safe, Effective, Efficient, Equitable, Person Centred, Timely

5.1 Report from the Clinical Executives QSC 21 November 2023.pdf (14 pages)

5.2.
Care Group Highlight Reports

Discussion *Care Group Nurse Directors*

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

Strategic Goals: Improving Care, Creating Health, Inspiring People

Domains of Quality: Effective, Efficient, Timely, Equitable, Person Centred, Safe

5.2a Planned Care Group Highlight Report QSC 21 November 2023.pdf (5 pages)
5.2b PC C Highlight report October 2023 QSC 21 November 2023.pdf (9 pages)
5.2c Children Families Care Group Highlight Report QSC 21 November 2023.pdf (6 pages)
5.2c Appendix 1 Maternity & Neonatal Metrics QSC 21 November 2023.pdf (24 pages)
5.2d MHLD Highlight report for QSC 21 November 2023.pdf (7 pages)
5.2e Unscheduled Care Highlight Report QSC 21 November 2023.pdf (7 pages)
5.2e Unscheduled Care Appendix 1 QSC 21 November 2023.pdf (2 pages)

10:30 - 11:15
45 min

6.
GOVERNANCE, RISK AND ASSURANCE

6.1.
Organisational Risk Register - Risks Assigned to the Quality & Safety Committee

Discussion *Gareth Watts, Director of Corporate Governance/Board Secretary*

Strategic Goals: Improving Care

Domains of Quality: Effective

6.1a Org Risk Register -November - QSC 211123.docx (6 pages)
6.1b Appendix 1 - Master Org RR - November 23 - QSC 211123.xlsx (6 pages)

6.2.
Healthcare Inspectorate Wales Improvement Plan Tracker Report

Discussion *Greg Dix, Deputy Chief Executive/Executive Director of Nursing*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Equitable, Safe, Timely

6.2 HIW Tracker Inspection Improvement Plans-Nov 2023 QSC 21 November 2023.pdf (6 pages)

6.3.
Update on Mental Capacity work

Discussion *Claire O Keefe, Head of Safeguarding*

Strategic Goals: Improving Care

Domains of Quality: Person Centred

6.3 Mental Capacity Act Report QSC 21 November 2023.pdf (5 pages)

6.4.
Health, Safety & Fire Sub Committee Highlight Report

Discussion *Nicola Milligan, Independent Member/Chair of the Health, Safety & Fire Sub Committee*

Strategic Goals: Improving Care

Domains of Quality: Safe

6.4a Health Safety & Fire Sub Committee Highlight Report 9 November 2023 QSC 21 November 2023.pdf (4 pages)
6.4b Appendix 1 Fire Policy QSC 21 November 2023.pdf (33 pages)

11:15 - 11:30
15 min

7.
DELIVERING OUR PLAN

7.1.
Patient Safety & Quality Dashboard

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

Strategic Goals: Improving Care

Domains of Quality: Safe

7.1a Quality & Safety Dashboard Report QSC 21 November 2023.pdf (15 pages)
7.1b Appendix 1 Compliance summary Alerts QSC 21 November 2023.pdf (2 pages)
7.1c Appendix 2 Compliance summary Notices QSC 21 November 2023.pdf (4 pages)
7.1d Appendix 3 ED & IM Walkround Report-May-Oct 23-Draft v1 QSC 21 November 2023.pdf (14 pages)
7.1e Appendix 4 Patient Experience report- QSC-Aug-Sept 23 QSC 21 November 2023.pdf (8 pages)

11:30 - 11:50
20 min

8.
DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1.
Mental Health Adult Inpatient Improvement Programme

Discussion *Ana Llewellyn, Care Group Nurse Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Person Centred, Timely, Safe

8.1 MH In-patient Improvement QSC 21 November 2023.pdf (7 pages)

8.2.
Stroke Services Progress Report

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

Strategic Goals:

Domains of Quality:

8.2 Stroke Progress Report QSC 21 November 2023 v2.pdf (27 pages)

11:50 - 11:55
5 min

9.
CONSENT AGENDA

9.1.
FOR APPROVAL

9.1.1.
Unconfirmed Minutes of the meeting held on 21 September 2023

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

9.1.1 Unconfirmed Minutes Quality & Safety Committee 21 September 2023 QSC 21 November 2023.pdf (20 pages)

9.1.2.
Unconfirmed Minutes of the In Committee meeting held on 21 September 2023

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

9.1.2 Unconfirmed Minutes Quality and Safety In Committee 21 September 2023 QSC 21 November 2023.pdf (2 pages)

9.1.3.
Violence Against Women, Domestic Abuse and Sexual Violence Policy

Decision *Claire O Keefe, Head of Safeguarding*

Strategic Goals: Improving Care

Domains of Quality: Safe, Timely, Effective

9.1.3a CTMUHB Domestic Violence and Abuse Policy CoverPaper QSC 21 November 2023.pdf (4 pages)
9.1.3b CTM VAWDASV Final Policy V0.2 (003) QSC 21 November 2023.pdf (33 pages)

9.1.4.
Measles Policy

Decision *Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director*

Strategic Goals: Improving Care

Domains of Quality: Effective

9.1.4a Cover Report - Measles Policy QSC 21 November 2023.pdf (4 pages)
9.1.4b IPC25 - Measles Policy V3 Final - April 2023 QSC 21 November 2023.pdf (13 pages)

9.1.5.
Meningitis Policy

Decision *Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director*

Strategic Goals: Improving Care

Domains of Quality: Effective

9.1.5a Cover Report Meningitis Policy QSC 21 November 2023.pdf (4 pages)
9.1.5b IPC21 - Meningitis Policy V3 Final - April 2023 QSC 21 November 2023.pdf (9 pages)

9.1.6.
Safeguarding Annual Report

Decision *Claire O'Keefe, Head of Safeguarding*

Strategic Goals: Improving Care

Domains of Quality: Safe, Timely, Effective

- 9.1.6a Safeguarding Annual Report cover report QSC 21 November 2023.pdf (4 pages)
- 9.1.6b New CTMUHB Safeguarding Annual Report 22-23 QSC 21 November 2023.pdf (32 pages)

9.2.
FOR NOTING

9.2.1.
Action Log

Information *Carolyn Donoghue, Independent Member/Committee Chair*

- 9.2.1 Action Log QSC 21 November 2023.pdf (8 pages)

9.2.2.
Committee Annual Cycle of Business

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

- 9.2.2a Committee Annual Cycle of Business QSC 21 November 2023.pdf (3 pages)
- 9.2.2b Quality Safety Committee Cycle of Business QSC 21 November 2023.pdf (5 pages)

9.2.3.
Committee Forward Work Programme

Information *Gareth Watts, Director of Corporate Governance/Board Secretary*

- 9.2.3 Quality & Safety Committee Forward Work Programme QSC 21 November 2023.pdf (7 pages)

9.2.4.
Infection, Prevention & Control Report - Mid Year Update

Information *Greg Dix, Deputy Chief Executive/Executive Director of Nursing*

Strategic Goals: improving Care

Domains of Quality: Effective

- 9.2.4a Cover Report - IPC Report QSC 21 November 2023.pdf (3 pages)
- 9.2.4b IPC Report - October 2023 QSC 21 November 2023.pdf (21 pages)

9.2.5.
Prescribing Annual Report

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe Care

- 9.2.5 Annual Prescribing Report 2023 Final QSC 21 November 2023.pdf (44 pages)

9.2.6.
RADAR Committee Annual Report

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Timely, Safe, Equitable, Effective, Efficient

9.2.6 RADAR Report QSC 21 November 2023.pdf (26 pages)

9.2.7.
Clinical Audit Quarterly Report

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Safe

9.2.7 Clinical Audit Quarterly Report QSC 21 November 2023.pdf (8 pages)

9.2.8.
Clinical Education Annual Report

Information *Greg Dix, Deputy Chief Executive/Executive Director of Nursing*

Strategic Goals: Inspiring People, Improving Care, Sustaining our Future

Domains of Quality: Safe

9.2.8 Clinical Education annual report 22-23 QSC 21 November 2023.pdf (52 pages)

9.2.9.
Radiation Safety Committee Annual/Mid Year Updates

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

No report on this occasion - next report will be available in January 2024

9.2.10.
Covid 19 Inquiry Preparedness

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

Strategic Goals: Sustaining our Future

Domains of Quality: Effective

9.2.10 C19 Inquiry Preparedness QSC 21 November 2023.pdf (7 pages)

9.2.11.
Human Tissue Act (2004) Compliance and Progress Report

Information *Gethin Hughes, Chief Operating Officer*

Strategic Goals: Improving Care

Domains of Quality: Safe

9.2.11 HTA compliance Progress Report QSC 21 November 2023.pdf (9 pages)

9.2.12.
Organ Donation Committee Annual Report

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Safe, Timely, Person Centred

9.2.12 Organ Donation QSC 21 November 2023.pdf (5 pages)

9.2.13.
Cwm Taf Morgannwg Maternity Metrics - An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022

Information *Suzanne Hardacre, Director of Midwifery*

Strategic Goals: Creating Health, Improving Care

Domains of Quality: Safe, Equitable, Efficient, Effective, Person Centred

9.2.13a Maternity Birth Statistics Wales 2022, CTM Self Assessment QSC 21 November 2023.pdf (4 pages)
9.2.13b QSPE for Sept Board QSv2 3.10.23 QSC 21 November 2023.pdf (19 pages)

11:55 - 12:00
5 min

10.
ANY OTHER BUSINESS

10.1.
Highlight Report to Board - Verbal

Information *Carolyn Donoghue, Independent Member/Committee Chair*

10.2.
How did we do in this Meeting - Verbal

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

10.3.
Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

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

At present we do not have any items requiring discussion at the In Committee session

12:00 - 12:00
0 min

11.
DATE AND TIME OF NEXT MEETING - TUESDAY 23 JANUARY 2024 AT 9:00AM

12:00 - 12:00
0 min

12.
CLOSE OF MEETING

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

Bereavement services update for 2023

Where we were in October 2022

- No Bereavement lead
- Pregnancy loss under Gynae
- No single point of contact
- All hospital funded funerals agreed with pathology
- Outdated communications
- No representation in focus groups
- No staff bereavement lead support

Since October 2022

- Bereavement Link meetings
- Staff support
- Point of contact
- Booklet revision
- Signposting improved
- PRUDIC representation
- Liaison for families
- Staff training
- Notified of all sudden deaths
- Working alongside WAG
- 3RD Sector engagement

SharePoint

Generic email address

Hospital funded funerals

- Everyone has the right to a final resting place
- Either no family and no finance or family and no finance
- Previously completed by bereavement officers
- A Basic burial over £4000 (in Bridgend) and approx £1500 in Llantrisant plus a £75 chaplaincy fee from a 3rd party chaplain.
- In 2022 we facilitated 9 contracted funerals at a cost of over £26,000

Changes to Hospital funded funerals

- I am now informed of all hospital funded funerals
- All burials moved to Llantrisant saving £2700 per Burial
- Facilitated by hospital chaplain at no charge to health board
- All paperwork is now thoroughly checked for finance
- Savings made of over £20,000 since January
- Reunited families that had been estranged
- Taken away financial stress
- Bereavement support payment

A Patient story

Finally I have had the chance to grieve & my pregnancy did matter. You have made my experience so much better

What you are doing will change lives. People need to grieve and this is the perfect start

When I came to see my little girl at the chapel, you held her until I arrived so she wasn't so cold, that isn't a job that is an angel

You looked after my uncle with such care and compassion and then in turn looked after all of us…so grateful

My Auntie's partner was an organ donor and when we couldn't attend the funeral arranged by the hospital, you arranged for the organ donation team to attend the graveside- as a family we thank you and he would have loved that

I am so moved by the care and attention that you are giving to pregnancy loss. I wish I had this when I lost my baby, it may have helped prevent my PTSD.

I stood at the funeral by myself to say goodbye to my son as my family & partner didn't come, you put your arm around me and you became my family

What you do is amazing and without you I would have fallen apart

You are all invited


Thank you

Acute Frailty

Overview of current service at:
Princess of Wales Hospital, Royal Glamorgan Hospital & Prince Charles Hospital

Quality & Safety Committee
21st November 23

PRINCESS OF WALES HOSPITAL

OBJECTIVES

- Previous & current structure of COTE within AMU
- Aims
- Data pre & post commencement of the unit
- Development of the service

FORMATION OF THE ACUTE CARE OF THE ELDERLY (ACE) UNIT

BEFORE	AFTER
COTE patients scattered throughout AMU template	COTE patients cohorted to 2 bays + 3 SRs
Shared ward manager with AMU	Dedicated ACE ward manager
Consultant r/v if new or unwell	Consultant ward round Mon/Wed/Fri, with r/v Tues/Thurs if unwell
11.30am Lengthy AMU & COTE board round (predominantly clinical)	9am Focused board round using EWB (therapy & discharge focused)
COTE band 5&6 nurses asked to rotate on to AMU due to vacancies	COTE band 5&6 nurses working alongside AMU staff on ACE (2 Band 6s on 3/12 secondment)

AIMS

1) Aiding flow & ensuring right patient in the right bed

- Directly pull COTE patients from A&E & AMU side to ACE in order to maintain flow & cohorting
- Highlighting patients:
  - Short stay/early discharge
  - Downstream wards (inc GP led wards/repatriation)
- Reducing length of stay

AIMS

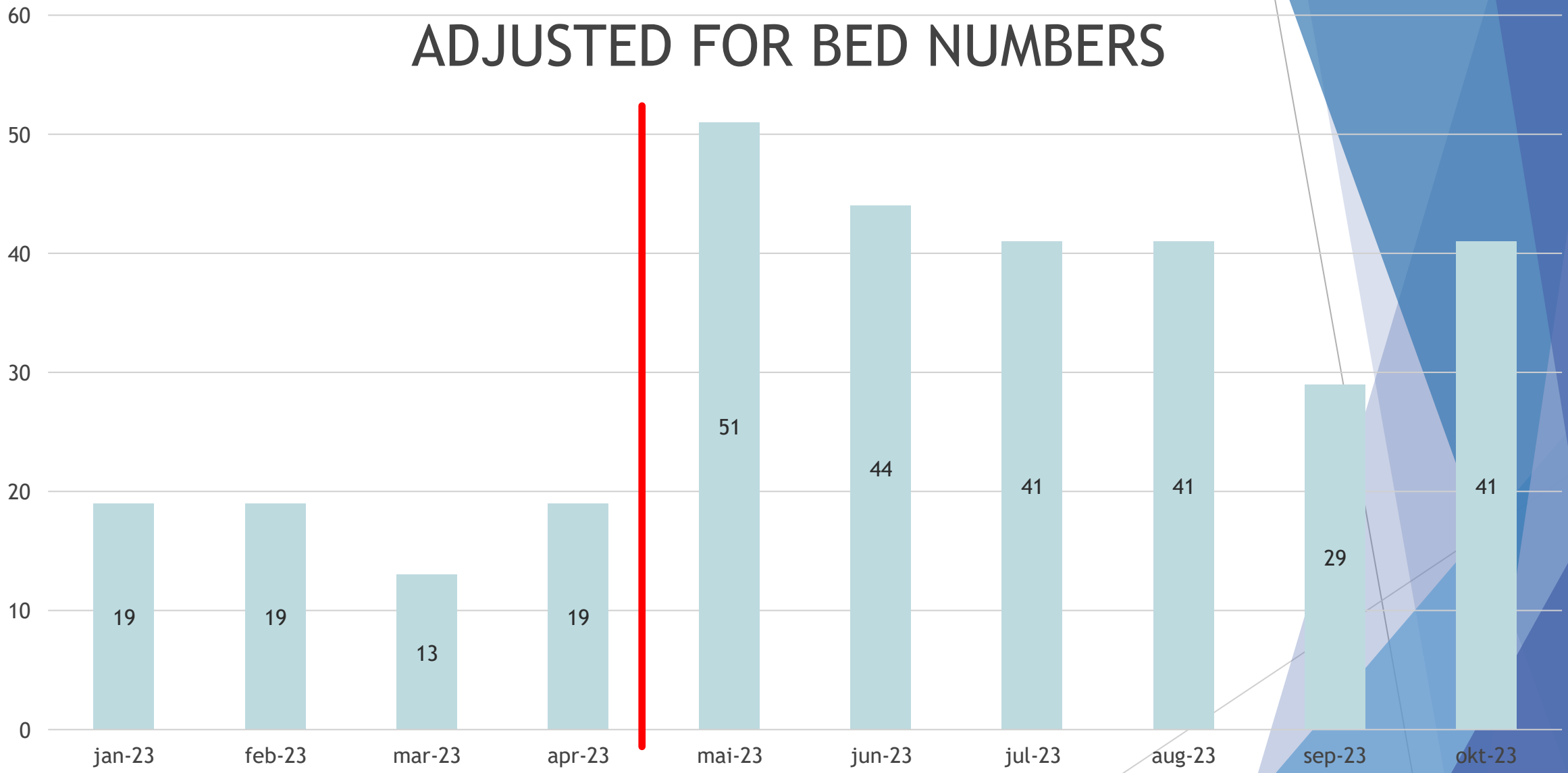
2) Providing the right environment for COTE patients

- Nursed together, calmer environment
- Staff experienced in prevention/recognition & management of delirium (fewer 1:1 requests)
- Reducing inpatient falls

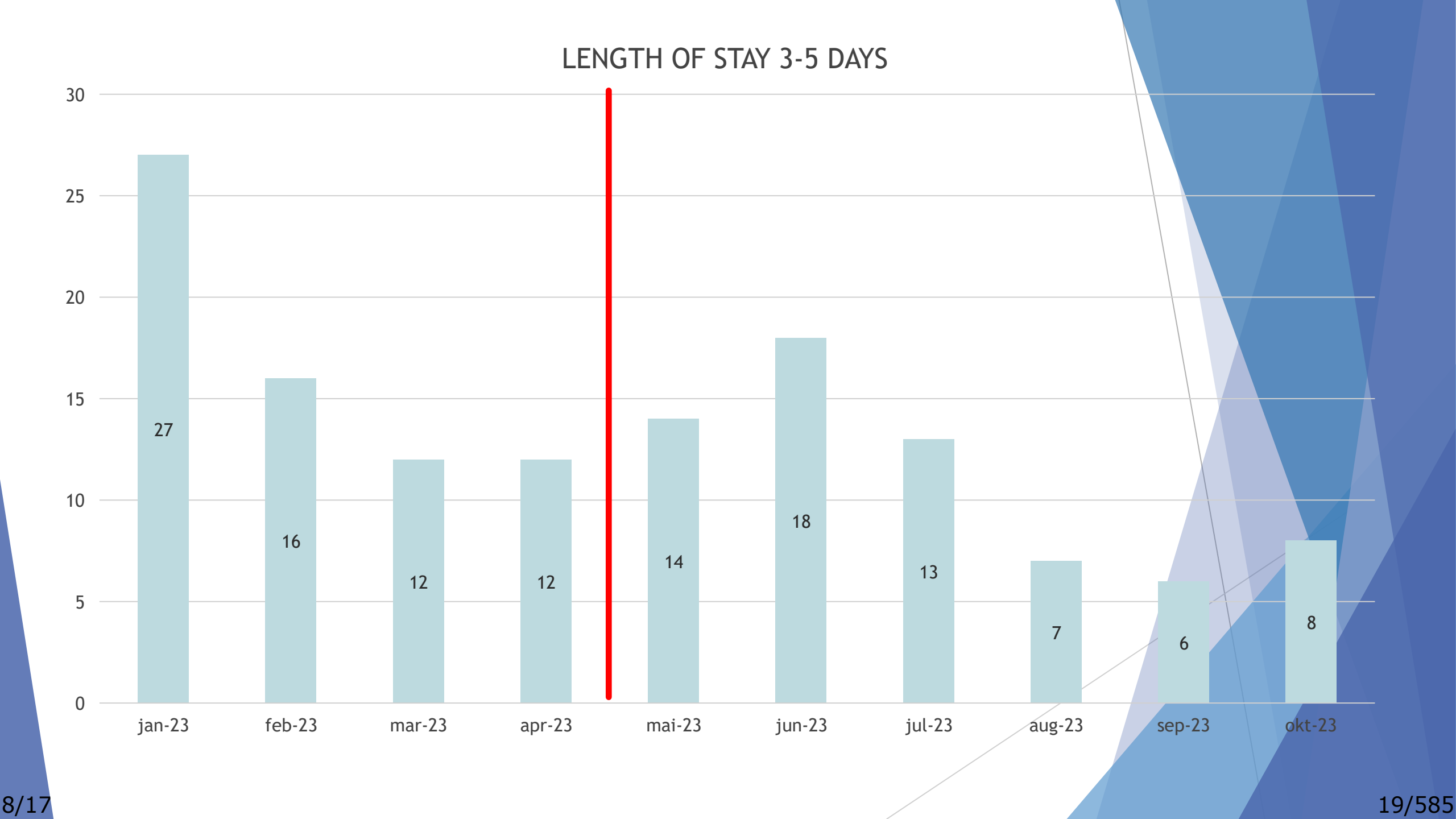
3) Maintaining & improving mobility/reducing deconditioning

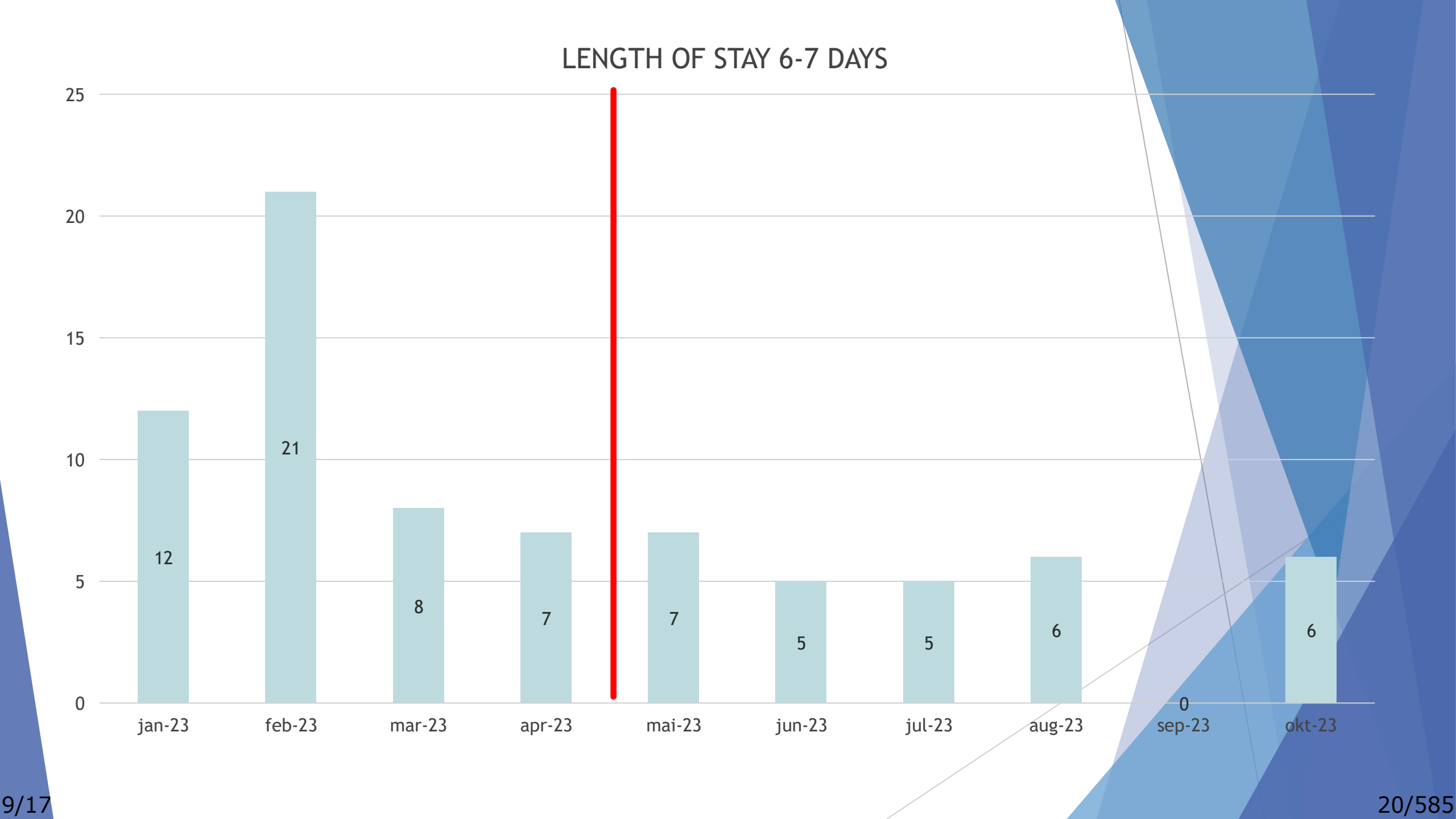
- Ensuring patients are dressed & out of bed, mobilising early
- Daily input at board round with therapy team & appropriate patients highlighted for review

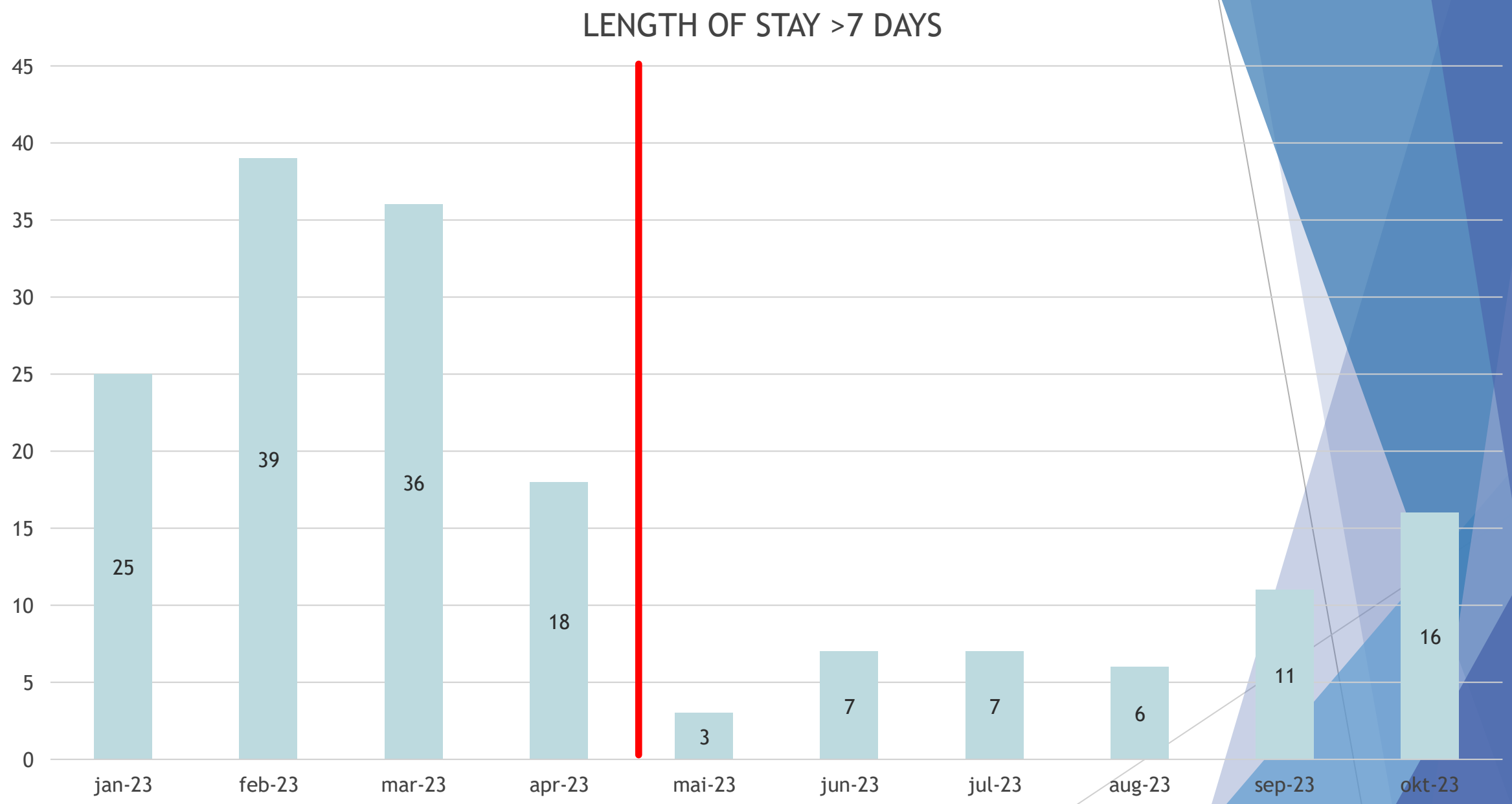
TOTAL NUMBER OF DISCHARGES FROM ACE ADJUSTED FOR BED NUMBERS



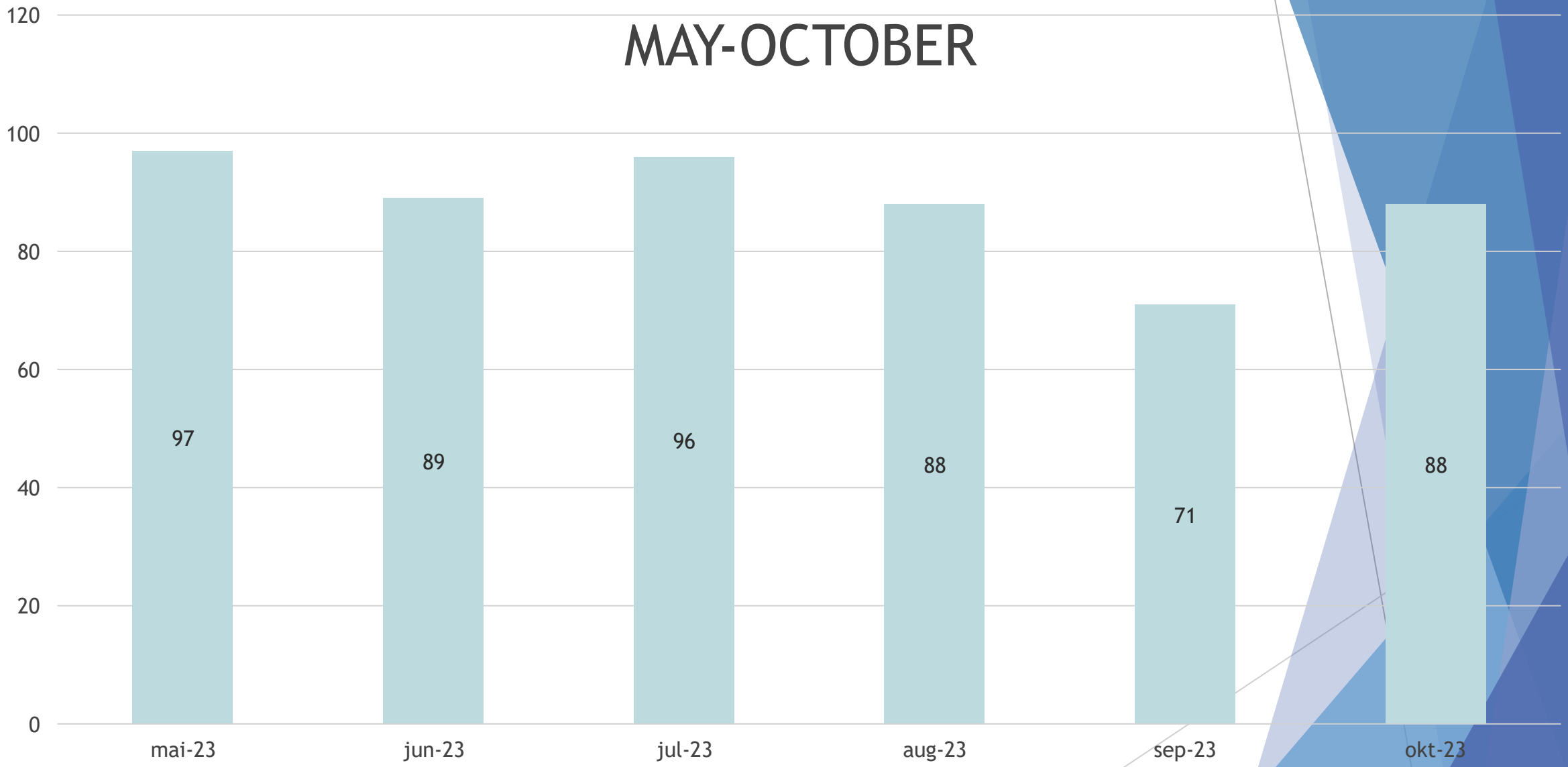

LENGTH OF STAY 0-2 DAYS
30
25
20
15
10
5
0
20
8
12
6
27
14
16
22
12
13
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23
okt-23

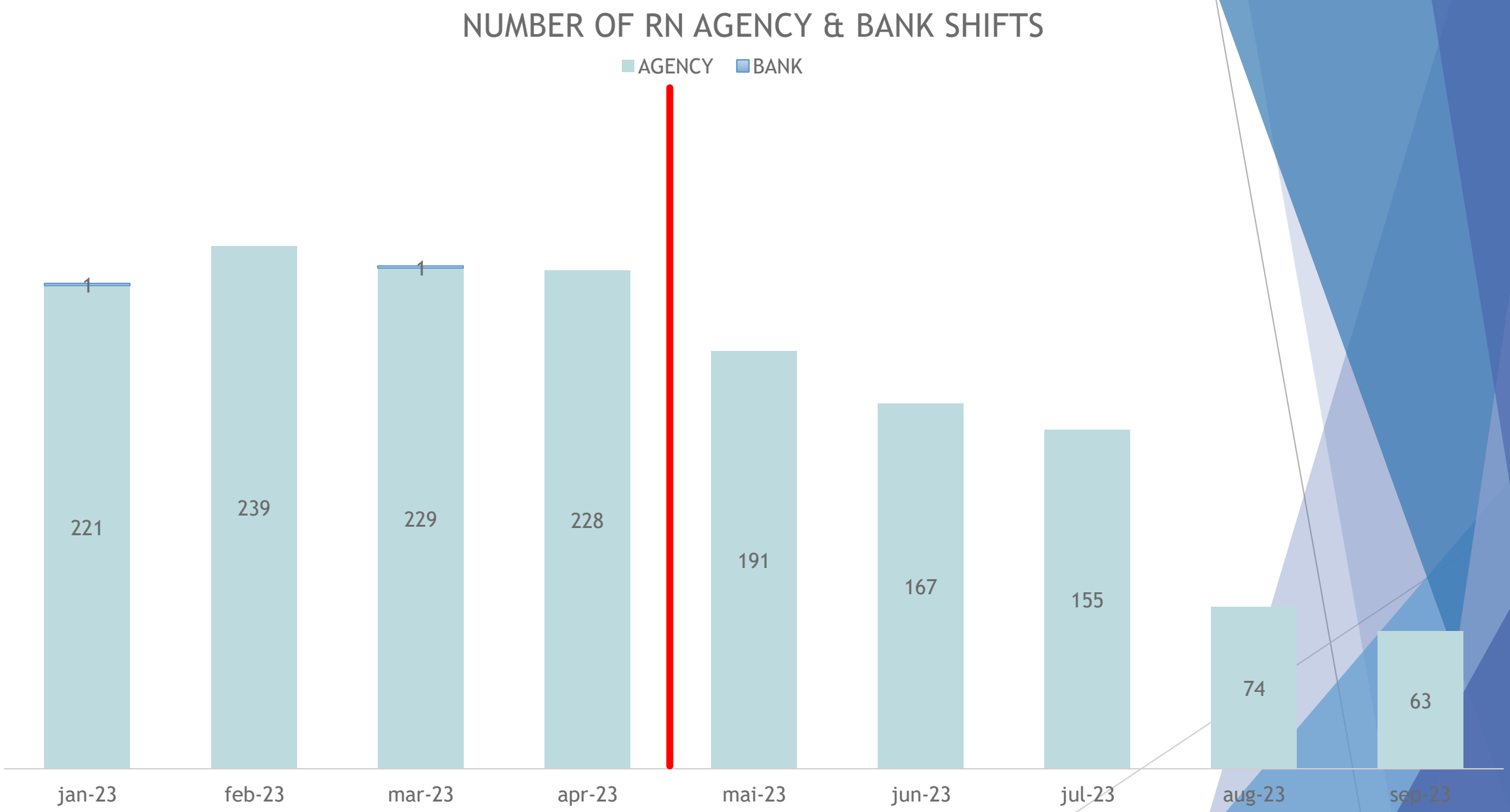

LENGTH OF STAY 3-5 DAYS
30
25
20
15
10
5
0
27
16
12
12
14
18
13
7
6
8
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23
okt-23

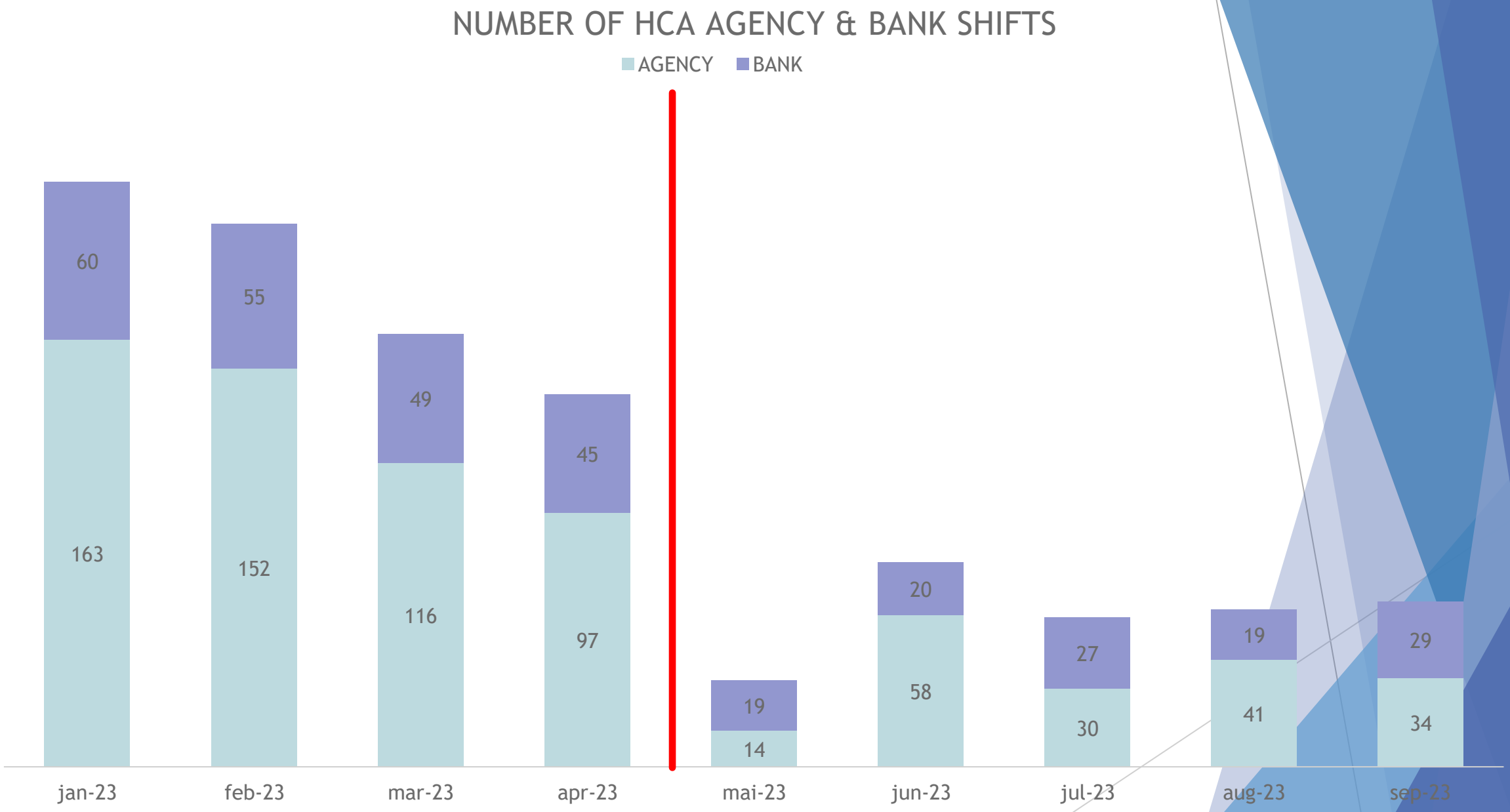

LENGTH OF STAY 6-7 DAYS
25
20
15
10
5
0
12
21
8
7
7
5
5
6
0
6
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23
okt-23


LENGTH OF STAY >7 DAYS
45
40
35
30
25
20
15
10
5
0
25
39
36
18
3
7
7
6
11
16
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23
okt-23

NUMBER OF PATIENTS THROUGH UNIT MAY-OCTOBER



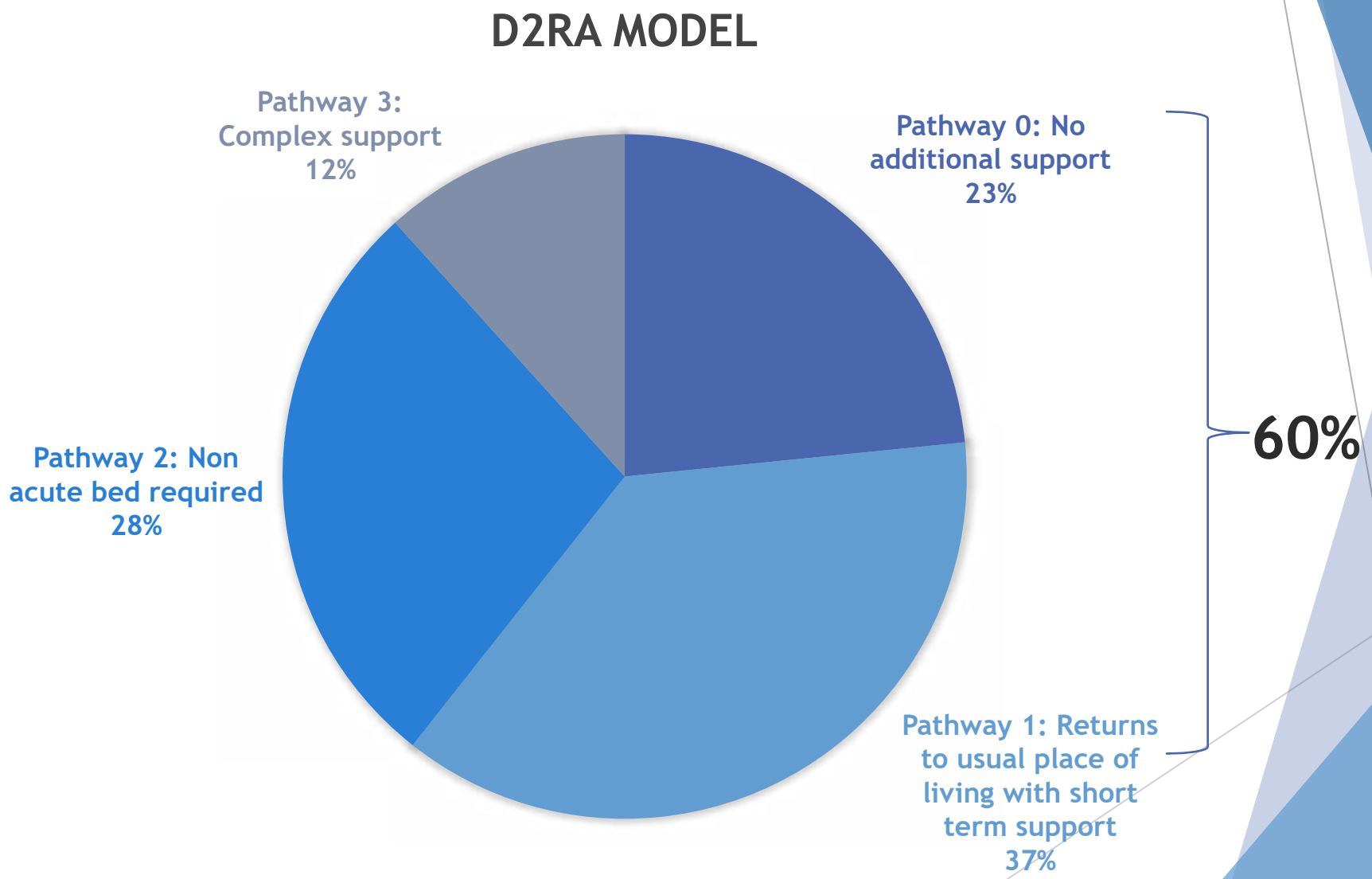

NUMBER OF RN AGENCY & BANK SHIFTS
AGENCY
BANK
1
221
239
1
229
228
191
167
155
74
63
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23


NUMBER OF HCA AGENCY & BANK SHIFTS
AGENCY
BANK
60
163
55
152
49
116
45
97
19
14
20
58
27
30
19
41
29
34
jan-23
feb-23
mar-23
apr-23
mai-23
jun-23
jul-23
aug-23
sep-23

CURRENT WORKING MODEL

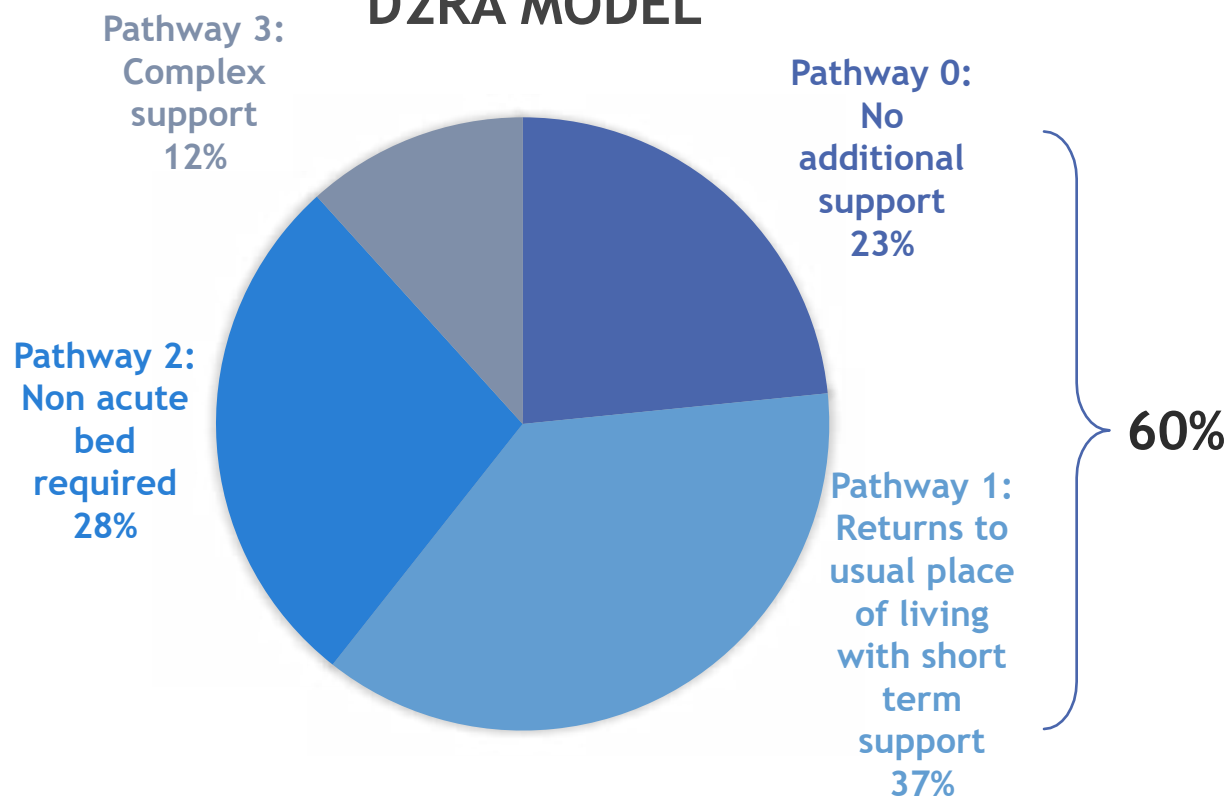
- 15 bed ACE unit
- Additional 10-15 COTE patients within the template
  - Dedicated ACP support inc presence at AMU board round
- COTE follow up clinic weekly

Scope for SDEC within COTE cohort

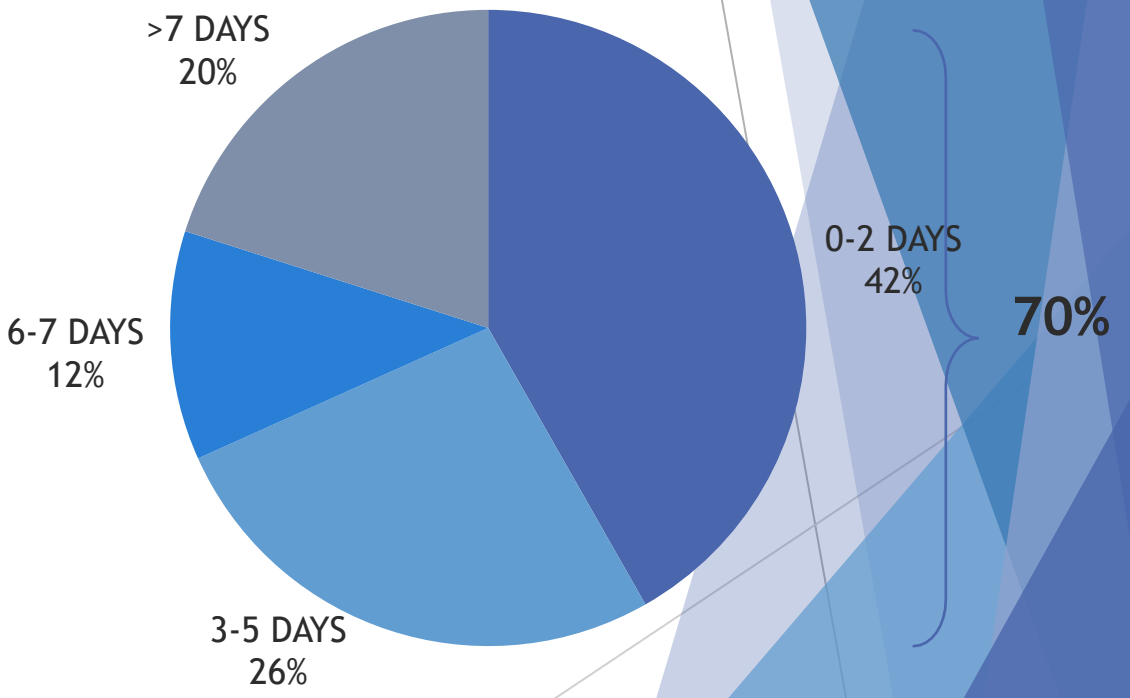


Scope for SDEC within COTE cohort

D2RA MODEL



LENGTH OF STAY



MOVING FORWARD

- ACE UNIT
  - Extend number of cohorted beds to 21
  - Dedicated ACE therapists
- DIRECT REFERRALS
  - Direct GP referrals (either for Inpt Ax or HOT clinics)
  - Would require assessment space
- SDEC & HOT clinics
  - For both internal & external referrals
- WORKING MORE CLOSELY WITH ACT
  - How can we support keeping their pts at home?
  - How can they support us discharging pts earlier?

Agenda Item
5.1

Quality & Safety Committee

Clinical Executive Directors Report

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dom Hurford, Executive Medical Director Lauren Edwards, Executive Director for Therapies and Health Sciences, Greg Padmore-Dix, Executive Director for Nursing and Midwifery
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director Lauren Edwards, Executive Director for Therapies and Health Sciences, Greg Padmore-Dix, Executive Director for Nursing and Midwifery
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director Lauren Edwards, Executive Director for Therapies and Health Sciences Greg Padmore-Dix, Executive Director for Nursing and Midwifery

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms

INNU	Interventions Not Normally Taken
TUG	Theatre User Group
WCCIS	Welsh Community Care Information System
ICU	Intensive Care Unit
ENT	Ear, Nose and Throat
CTM	Cwm Taf Morgannwg
AHP	Allied Health Professions
HCS	Healthcare Science
ELG	Executive Leadership Group
DTPS	Diagnostics, Therapies, Pharmacy and Sciences
PDR	Personal Development Plan
NMC	Nursing & Midwifery Council
GIRFT	Getting it Right First Time

1. Situation /Background

This paper provides an overarching update on the achievements, projects and current challenges within the portfolio of the three Clinical Executive Directors, Medical Director, Executive Director of Therapies and Health Science and the Executive Director of Nursing, Midwifery and Patient Care.

Medical Directorate

This section of the report covers the following achievements:

- Theatre User Group (TUG)
- Mortality
- Safeguarding

This section of the report also covers the following issues/challenges and how the Medical Directorate aim to address them:

- Interventions Not Normally Taken (INNU) Lists
- Appendicitis Guidelines
- Welsh Community Care Information System (WCCIS) ICU System

2. Specific Matters for Consideration for the Medical Directorate

2.1 Recent Achievements

Theatre User Group (TUG)
Established a Pan-health Board group to focus on efficiency and productivity within theatres, supported by GIRFT team and Welsh Government. This includes identifying reasons for reduced efficiency and tackling them as a Health Board. Issues include: on the day cancellations, standardisation of processes, sharing good practice, reducing fallow lists. We have received much praise from WG for our rapid adoption and progress.

Morbidity Reviews
Our process for stages 1 to 3 reviews continues to garner much praise for its approach, and our update newsletter is being adopted across Wales. This is run by our Senior Clinical Audit lead and Assistant Medical Director for Quality and Safety.

Safeguarding
We recently delivered a Level 3 session for Senior Leaders. This was very well attended and the learning for those leading across the HB was very informative. We have been standardising the approach and level of scrutiny across CTM. Our Hub model for reviewing cases has been reported by the Safeguarding lead for Wales as the best model in Wales. We would wish to record our thanks to our Named Doctor lead for Safeguarding within CTM who has now stepped down from this lead role

2.2. Current Issues/Challenges for the Medical Directorate

Interventions Not Normally Undertaken (INNU) lists
Each Health Board has an Interventions Not Normally Undertaken (INNU) list. Over the years there has been variation across hospitals and health boards as to the exact procedures included and adherence to the criteria set out in it. The NHS Executive for Wales has tasked the Health Board with conforming to our INNU list and reviewing compliance.

Our new INNU Oversight Group has developed a strategy for CTM. We started by focussing on key (high frequency cases) specialties. The challenge is approaching this considerately as some patients have been, in the past, listed for a procedure that is now regarded as having no benefit to them. We need to evaluate all cases to ensure that patient safety and there is a benefit to them before we proceed or not. This requires a high level of sensitivity as well as for our colleagues who may have performed a procedure for many years that is now not indicated.

Appendicitis Guidelines
After recent Ombudsman and Coroner cases we have revisited our Appendicitis guidelines to ensure they are followed across CTM. We have had different approaches. The General Surgery Clinical Directors have this as a priority. Am assured that there is a CTM Guideline that is being implemented. *Edit post Q&S Committee meeting on 21st November - confirmation of the guidelines will happen at the next surgical meeting in 2 weeks' time. This will be the NICE guideline that we will have adopted as CTM guideline*

Welsh Intensive Care Information System (WICIS) ICU System
The IT systems across CTM remain a challenging area. Currently PCH/RGH utilise a system called CareVue, whereas POW does not use an IT system. DHCW are currently completing development of an ICU system which is due to be rolled out sequentially across Wales, commencing in a few months' time. As we have a system of very high quality already in use in CTM we need to ensure the new Welsh system is functionally as good as, or better than, the current system.

3. Executive Director of Therapies and Health Science (DoTHS)

This section of the report provides an update from the Director of Therapies and Health Science on ensuring that quality and safety is delivered now and going forward.

3.1 Specific Matters for Consideration for the Director of Therapies and Health Science (DoTHS)

CTM AHP and HCS Delivery Plan launch

On 30th September, the CTM Allied Health Professions (AHP) and Healthcare Science (HCS) Delivery Plan was launched. Drawing on local and national priorities and following engagement across the organisation, the Delivery Plan outlines our ambitions and how CTM AHP and HCS colleagues will contribute to the delivery of CTM 2030 and the CTM Quality Strategy.

One of the 6 priorities in the Delivery Plan is Quality and Safety, with target areas of focus to improve the quality of care.

How we ensure quality & safety now	What we will do in the future
• Established governance structures in place • Regular quality & safety meetings • Timely responses to incidents and complaints • Production of monthly performance and governance reports • Risk management • Compliance with national standards	• Audit against national guidelines • Increase patient engagement • All clinical areas to use appropriate clinical outcome measures • Develop and implement processes to ensure registration of all qualified staff

What we will do in the next year	Our measure of success
• Develop and establish a process for mandatory registration of all qualified staff starting with new recruits • Where required, update job descriptions for qualified AHP & HCS roles to include registration requirements (mandatory/voluntary) • All AHP & HCS colleagues to have participated in a PDR for 2023/24 • Monitor and demonstrate improvements in Quality and Safety • Record compliments and messages of gratitude	• All new starters employed after September 2024 will have an up-to-date job description and a clear understanding of registration requirements • AHP & HCS services will be 85% compliant for PDR • Services reporting patient experience/safety data consistently (concerns/compliments/incidents)

Professional groups have been tasked with identifying the key metrics that will evidence success for their areas. The Assistant Director of Therapies and Health Science (ADoTHS) is co-ordinating this work.

Professional Accountability

Robust clinical governance and accountability structures are essential to assure the delivery of high-quality care. Last year, the Directors of Therapies and Health Science (EDoTHS) Peer Group identified a concern regarding inconsistencies in the governance of AHPs and HCS in Wales. Innovative clinical models, new roles, and recognition of the transferability of core skills has resulted in increasing numbers of AHPs and HCS working in non-traditional roles, structures, and/or being managed by a leader from other professional backgrounds. The document '*Professional Accountability and Use of Professional Title in the Therapy and Health Science Professions - All Wales Guidance*' was developed as a result. Last month, CTM's ADoTHS contributed the development of an infographic to support operational and professional managers and clinicians to understand their responsibilities in relation to role development, recruitment, use of protected titles, registration and supervision.

Quality Strategy Action Plan

CTM's Quality Strategy outlines our quality ambitions and strategic quality goals. Work is underway to collate the baseline progress against key indicators, collected as part of the Annual Quality Plan that sits underneath the Quality Strategy. Following a discussion in the Executive Leadership Group (ELG), a template was

developed to capture progress against the Quality Strategy deliverables. This has been shared with the Chairs of each strategic portfolio board (Creating Health, Improving Care, Inspiring People, and Sustaining our Future). Responses will evidence the progress made in year 1 and will inform the deliverables for the Annual Quality Plans for years 2 and 3. Detail will be provided within a Quality Strategy update paper to the Quality and Safety Committee.

Phase 2 of the Operating Model

Following Phase 1 implementation in autumn 2022, the Phase 2 Implementation Document was released in October 2023 following a consultation period. Phase 2 will see the welcome addition of further AHP and HCS services to the Diagnostics, Therapies, Pharmacy and Sciences Care Group (DTPS). These groups share many similar opportunities and challenges, along with professional accountability to the DoTHS, and so further alignment within DTPS is beneficial. During the consultation, there was strong feedback regarding the correct professional and operational line management for the Healthcare Scientists. As a result, a part-time Clinical Director for Healthcare Science, the first in Wales, will provide professional and operational support to this group. The time available to the Assistant Director of Therapies and Health Science has been reduced as a result. Although not perfect, these changes provide a good solution in our current context. Future consideration will be given regarding opportunities to increase the resource available to support the AHP and HCS strategic portfolio.

4. Executive Director Nursing, Midwifery and Patient Care

4.1 Specific Matters for Consideration for the Nursing, Midwifery and Patient Care Directorate

This section of the report provides an overview and assurance on a number of projects which are ongoing across the organisation together with informing the committee of the aim of the project, the impact to patients and/or organisation if the project is not implemented and associated risks to the delivery of these projects.
These projects are managed under the leadership of the Assistant Director of Nursing and People's Experience on behalf of the Executive Director of Nursing, Midwifery & Patient Care and includes:

1. Ward Accreditation Programme
2. Establishment of an Education Academy
3. Recruitment and Retention
4. International Nurse Recruitment
5. Bank Modernisation
6. Advanced Clinical Practice Assurance
7. Bereavement
8. People's Experience
9. Improvement for the Front Entrance of our Hospitals
10. Peoples Experience Dashboard
11. Nursing Staffing Act
12. Lead on using immersive Learning Opportunities to develop workforce

13.Clinical Leadership Programme

4.2 Overview of the aims of each project, potential impact if not implemented and associated risks to the project delivery.

Ward Accreditation Programme

The aim of the project is:

- To have an overview of ward-level quality and safety
- Drive ownership of quality and safety at the ward level
- Lower incidents and potential harm to patients
- Early identification of areas for improvement
- Drive a culture of safety

The impact of this project if not implemented:

- Increase in concerns, complaints, and safety issues
- Loose opportunity to have early identification of "hot spots"
- Harm to patients due to missed opportunity for early identification of near misses and shared learning
- The board will not have consistent timely data due to a lack of consistent data to ensure timely and ongoing assessments of areas

The risk(s) associated with this project delivery:

- lack of system integration for data retrieval and evaluation
- Lack of staff for peer review and clinical assessments
- Staff who have digital and data knowledge to build dashboards and data analysis

Establishment of an Education Academy

The aim of the project is:

- Provide high-quality, cost-effective, training for all staff for CTM
- Ensuring staff have the skills and education in turn building a skilled workforce and supporting career progression
- Supporting diversity and equity for access to education
- Support attraction, recruitment and retention agenda
- Opportunities for Income generation
- Promotes team working

The impact of this project if not implemented:

- Education provided at various points and can lead to duplication and ownership
- Solo professional education can affect teamwork and the provision of safe timely care
- Solo professional education gives duplication and missed opportunities for shared learning and development
- Financial impact of duplication of education sessions

The risk(s) associated with this project delivery:

- Timely establishment of Education academy

Recruitment and Retention National

The aim of the project is

- Deliver HEIW agenda to deliver a suitable, skilled workforce
- Opportunities to influence and review skill mix and new roles to support multi-professional working and new ways to deliver services and care
- Support flexible working and approaches to Nurse education and registration opportunities
- Ensure robust student streaming process is embedded and adhered to and, understand why students do not stay in CTM to influence new opportunities
- Represent nursing in career fairs and engagement events

The impact of this project if not implemented:

- Local services will be affected due to the lack of workforce.
- Patient care compromised due to lack of skilled workforce
- Increased risk and potential harm to service users due to long waiting times for services or services not deliverable locally
- Financial impact due to ad hoc staffing being used via agencies
- Lack of assurance of temporary staff being used and competencies

The risk(s) associated with this project delivery:

- Lack of UK-trained nurses coming into the profession will lead to service realignment and loss of services being provided due to the need to consolidate services
- Due to complexities multiple departments and establishments are involved in the project with varying priorities

International Nurse Recruitment

The aim of the project is:

- Seek and implement opportunities to support the recruitment of international nurses from within the population of CTM
- Supporting staff who are currently working in CTM to be working at their full potentiation
- Create opportunities for staff to move into the CTM workforce supporting a wider population economy

The impact of this project if not implemented:

- Lack of UK-trained nurses coming into the profession will lead to service realignment and loss of services being provided due to the need to consolidate the nursing workforce.
- Need to have monies in advance to support recruitment
- Staff may leave when they have been recruited
- Individuals may take some time to gain access to NMC resulting in unplanned cost pressures
- Delays in staff getting their registration may result in unexpected costs

The risk(s) associated with this project delivery:

- Integration of International nurses into local communicates
- Supply of nurses from International countries.

- Where other counties may be used to support the recruitment, pipeline need to ensure assurance of skills and knowledge
- Potential financial pressures when exploring recruitment opportunities as the need to spend to save

Bank Modernisation in collaboration with Workforce and Organisational Development

The aim of the project is:

- Ensure sustainable availability of competent temporary staff
- Provide a skilled and knowledgeable workforce
- Support opportunities for flexible working
- Ensure staff with Local knowledge of Health Board and policies and procedures
- Ensuring assurance of compliance with policies and processes are consistently met

The impact of this project if not implemented:

- Service delivery will be compromised where the workforce is not available
- Risk to patients of the workforce not available to deliver care
- Increased financial pressures due to accessing high-cost agency
- Lack of assurance of skills and knowledge of agency staff

The risk(s) associated with this project delivery:

- Training delivery for areas such as Manual handling due to limited resources to deliver training
- Time to complete mass recruitment and impact on other areas and departments
- Lack of data to give assurance of links vacancies and demand

Advanced Clinical Practice Assurance Framework

The aim of the project is:

- Embed a governance and assurance framework for advanced practice
- Support individuals to work at the top of their license
- Promote advanced practice and influence new service models going forward
- Support career progression for advanced practice
- Support workforce recruitment and retention

The impact of this project if not implemented:

- Lack of governance of advanced practice across professions
- Lack of opportunity to review Multi-professional working and new service models.
- Patient safety concerns if the Health Board does not have oversight of competencies
- Risk of Staff leaving the organisation if they do not feel valued and supported to progress in their career

The risk(s) associated with this project delivery:

- Digital systems with the ability to capture accurate data for advanced practice.
- Consistency in banding and Job description may inadvertently have an impact on finances

Embed the All Wales Bereavement Framework

The aim of the project is:

- Embed a robust and sustainable bereavement process
- Improve people's experience of bereavement
- Ensure individuals have a dignified death and funeral
- Support education and training for staff in bereavement and end-of-life care

The impact of this project if not implemented:

- Individuals do not have the support they need when planning and making decisions around funerals for their relatives
- Service user experience is not positive concerning bereavement care
- Staff do not have the skills and knowledge to support bereavement and end-of-life
- Increased financial costs for Hospital funerals due to time for an individual to identify relatives or an alternative funding resource

The risk(s) associated with this project delivery:

- Funding to support ongoing costs for Bereavement Clinical lead for CTM
- Lack of staff resources dedicated to bereavement care

Develop and embed Peoples experience Strategy and Peoples stories framework

The aim of the project is:

- Ensure robust people experience strategy is embedded for CTM

The impact of this project if not implemented:

- Providing a framework to ensure patients' voice is heard through patients' stories and experiences
- Miss the valuable opportunities to work with service users to develop service models
- Missed opportunity to improve outcomes

The risk(s) associated with this project delivery:

- Lack of resources to support the implementation of the People Stories framework
- Lack of ownership of people's experience strategy as it sits across values-based Health care and corporate nursing

Enhancing the Front Entrance to our Hospitals

The aim of the project is:

- To provide collaborative oversight of the hospital sites to improve appearance, Branding, Safety elements, and accessibility

The impact of this project if not implemented:

- Increased anxieties when visiting hospital sites
- Missed appointments and lateness due to parking and location of services
- Lack of confidence in the Health Board if the first impression is negative

The risk(s) associated with this project delivery:

- Lack of ownership to implement actions if outside care groups
- Financial constraints due to long-term large maintenance issues

Development of a Peoples Experience Dashboard

The aim of the project is:

- To develop a clear dashboard for Peoples Experience

The impact of this project if not implemented:

- Data is fragmented leading to missed opportunities to identify trends or increased incidents of concerns, outcomes, or feedback
- Missed opportunity to implement changes and improvements due to data being held and reported by a different department

The risk(s) associated with this project delivery:

- Digital systems are difficult to navigate and inability to interface
- Staffing resources

Nurse staffing act and safe care

The aim of the project is:

- Capturing acuity and staffing levels across section 25B areas of CTM
- Adhere to the Law
- Ward-level overview of acuity and staffing and mitigating risk
- Allows for interrogation of data over a period of time and workforce planning
- Support early identification of risk
- Ensuring correct staffing levels are in place to meet workload

The impact of this project if not implemented:

- Lack of staff in place at the patient's bedside to provide care
- Risk to patients due to lack of staffing and skill mix
- Increased risk of harm and subsequent claims

The risk(s) associated with this project delivery:

- Engagement of ward staff due to workload and time to enter the data
- Compliance with the safe care data input
- Compliance with the law as reports are submitted to WG for oversight

In partnership with Institutes for higher education lead on using immersive learning opportunities to develop workforce

The aim of the project is:

- Identify obstacles to HCSW accessing nursing
- Exploring new ways of learning through immersive learning
- Take opportunities for innovative ways of using funding from scholarships and research funding streams

The impact of this project if not implemented:

- Increase the number of registered nurses to provide patient care
- Career options for the wider population of Cwm Taf

The risk(s) associated with this project delivery:

- Time and staff recourses to commit to the programme

In collaboration with Learning and development develop and embed a Clinical leadership programme

The aim of the project is:

- Support staff development and succession planning
- Develop a sustainable program that incorporates all aspects of leadership into one program
- To support retention and recruitment strategy

The impact of this project if not implemented:

- Develop a knowledgeable and skilled workforce
- Have well-led wards and strong leaders who will be the patient's advocate
- Recognise the importance of strong leadership and impact on high-quality, safe care
- Be cared for by teams that are respectful and recognise the importance of each other's skills

The risk(s) associated with this project delivery:

- Time and staff resources to commit to the program

5 Key Risks / Matters for Escalation

5.1 There are no risks for escalation to the Quality and Safety Committee. All matters outlined within this report are being addressed through each of the three reporting teams led by the respective Executive Directors.

6 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Inspiring People Sustaining Our Future
Dolen i Feysydd Strategol BIP	Living Well

CTM / Link to CTMUHB Strategic Areas	Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below: Data to Knowledge Leadership Learning, Improvement and Research
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Effective Efficient Equitable Person Centred Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Quality of patient care at forefront of improvements and decisions made.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Content of this paper is applicable to all patients and provides equal access to healthcare	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	Yes (Include further detail below)
	Providing high quality, safe care is vital to the reputation of the health board. This paper covers items as a broad update for the committee, but under the directorship and leadership of the three Clinical Directors responsible for this report we strive to protect the health board's reputation.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

7 Recommendation

7.1 The Quality and Safety Committee are asked to **NOTE** the contents of this paper.

8 Next Steps

8.1 The Quality and Safety Committee will be updated on progress made, new challenge(s) and new achievements at the next Quality and Safety Committee.

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Planned Care Quality, Safety, Risk & Experience (QSR&E) Committee meeting

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
T&F	Task & Finish
CNS	Clinical Nurse Specialist
RGH	Royal Glamorgan Hospital
POW	Princess of Wales
RTT	Referral to Treatment Targets
ITU	Intensive Treatment Unit
PCH	Prince Charles Hospital
GIRFT	Getting it Right First Time
IP&C	Infection Prevention & Control
HPV	Hydrogen Peroxide Vapor
PALS	Patient Advice Liaison Service

1. Introduction

This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Planned Care Quality, Safety, Risk & Experience Group at its meeting on 17th October 2023

2. Purpose of this Meeting

2.1 This report had been prepared to provide the Committee with details of the key issues considered by the Planned Care Quality, Safety, Risk & Experience Group at its meeting on 17th October 2023

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

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

3. Highlight Report

Alert / Escalate	**Princess of Wales Hospital** • Ward Controlled Access on inpatient wards not in place. CTM UHB T&F group first meeting November 2023. **Urology** • Urology Sustainability Programme Group commenced in October with key focus on the review of medical, nursing and CNS workforce and job plans to support the ability to enable routine cancer care delivery and reduce waiting lists. **Ophthalmology - Glaucoma** Carrying out a stratifying exercise on all referrals to ensure they are vetted and prioritised appropriately. Changes are being made to streamline the RGH referral clinical conditions to align with PoW. This will rationalise the management of the new RTT waiting list from 12 clinical options to 3 pathways.
Advise	**<u>Organisational Risk Register</u>** • 4 Planned Care risks on the organisational risk register scoring 20: ○ 5214 Critical Care Medical Cover in POW - ITU resilience model for Health Board in development and being managed by Unscheduled Care (where ITU is moving to) ○ 4491 Demand for Planned Care services exceeds capacity ○ 4071 Failure to meet Cancer targets – some improvements noted but some service improvements linked to diagnostic capacity ○ 4103 Sustainability of a Safe and effective Ophthalmology service - Ophthalmology Harm review funding agreed up until March 2024.

Escalation of Concern
Escalation of Clinical Concerns poster (Appendix 1) has been created in PCH and has been cascaded widely across the 3 acute sites.

GIRFT visit at Princess of Wales Hospital
As part of the GIRFT Theatre Utilisation, the UK & NHS Executive GIRFT Team visited POW Theatres at the end of September.

- 15 recommendations in report
- High praise for departments/teams for dealing with challenging constraints for Surgery on the POW Site.
- Impressed with PoW current Day Case rates

Royal Glamorgan

- Ward 8 & 9 – IP&C Outbreak concerns. Actions include the ward will undergo urgent estates works and installation of new call bell system during Nov/Dec. This will enable the ward to decant bays and cubicles to declutter and HPV cleaning of all areas.

- New colorectal robot arrived in RGH & assembled. Governance protocols are being produced to ensure speciality training of surgeons and theatre staff.

Overview Incidents (September 23)

	Bridgend	PCH	RGH
Total Number of Incidents Reported	114	59	121
Total Patient Safety	94	52	112
No Harm	11	8	18
Low	74	38	73
Moderate	9	6	16
Severe	0	0	5
Death	0	0	0

Overview Concerns (Sept 2023)

	Bridgend	PCH	RGH
Total Number of Concerns Received	27	8	9
Early Resolution	20	6	9
Formal Complaints	7	2	0
Complaints compliance response rate:	100%	0%	50%
Number Open:	29	13	4

Assure	Patient Diaries have been launched within Critical Care in Princess of Wales as part of an initiative with the unit psychology team. Prince Charles Hospital • Development of a Potential Ligation Risk checklist for general wards. Aim to roll out pan CTM HB. • Creation of patient information leaflet regarding 'How to Safely Obtain Diet and Fluids when Lying Flat' (Appendix 2). Aiming to roll out pan CTM. • PALS service commenced on PCH site • The re-start of Special Care Dentistry lists at PCH. This service has not run since pre-covid and this is a great achievement for care of our patients with learning disabilities.
Inform	**Monthly Ward Assurance** Percentage of compliance against the 10 key ward assurance audits (September 2023) Action Plan created with DoN for Planned Care, Ward Managers and Senior Nurses for Wards 7 & 9 in PoW.
Appendices	Appendix 1 - Escalation of concerns (available on request). Appendix 2 - How to Safely Obtain Diet and Fluids (available on request)

AREA	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	N
PCH Day Surgical Unit	99%	98%	100%	100%	88%	87%		
PCH Endoscopy Unit	62%	85%	34%	86%	83%	72%		
PCH Theatre Department	92%	59%	78%	91%	96%	55%		
PCH Ward 05	92%	90%	93%	96%	93%	94%		
PCH Ward 06	92%	96%	96%	93%	96%	97%		
PCH Ward 07 (formerly ward 3)	94%	92%	94%	93%	86%	96%		
PCH Ward 08	77%	95%	89%	87%	95%	88%		
PWH Day Surgical Ward	64%	99%	83%					
PWH Endoscopy Unit	96%	97%	98%	85%	100%	84%		
PWH Theatre Department		50%	43%					
PWH Ward 07		78%	68%			11%		
PWH Ward 08	92%	85%	80%	82%	94%	89%		
PWH Ward 09	98%	88%	83%	96%		10%		
RGH Day Surgical Unit								
RGH Endoscopy Unit		88%	66%	48%	54%	54%		
RGH Theatre Department	52%	63%	81%	88%	83%	84%		
RGH Ward 02	87%	93%	90%	94%	99%	95%		
RGH Ward 03	94%	94%	95%	97%	96%	96%		
RGH Ward 08	92%	90%	90%	93%	95%	95%		
RGH Ward 09	95%	94%	96%	95%	96%	94%		
RGH Ward 10	97%	96%	97%	88%	99%	77%		
RGH Ward 15	99%	99%	99%	99%	100%	100%		

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Timely Equitable Person centred Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. Recommendation

5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.2b

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Head of Nursing Primary Care and Communities Fiona Wood, Head of Nursing Primary Care and Communities Jane Armstrong, Clinical Director for Primary Care
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
ACT	Acute Clinical Team
ANP	Advanced Nurse Practitioner
CDS	Community Dental Service
COPD	Chronic Obstructive Pulmonary Disease
DIC	Death in Custody
HB	Health Board
HIW	Health Inspectorate Wales
HMP	His Majesty's Prison
HON	Heads of Nursing
OGEP	On The Ground Education Project
POCD	Package of care delay
POW	Princess of Wales
PROMS	Patient reported outcome measures
PRN	Pro re Nata (As and when required)
RGH	Royal Glamorgan Hospital
RN	Registered Nurse
ToR	Terms of Reference
VHBC	Value Based Health Care
WWIC	Welsh Wound Innovation Centre

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Primary Care and Communities Care Group at its meeting on the 20th September.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group 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.

2.2 The Primary Community Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.

- Provide evidence based and timely advice to the Primary Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Primary Community Care Group in relation to the 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.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate	• **Paediatric General Anaesthetic Lists**. Currently on the risk register (score 12) **867** patients are currently waiting for assessment/GA. Conversion rate of children requiring a GA has increased by 26%. This is a risk to patients and there is evidence of harm, due to the extended waiting times. A paper has gone to PC&C Planning, Performance and Finance Board as well as shared at Operational Management Board. The Dental Director and Planned Care colleagues are working together to secure additional theatre lists and a plan to recover the position and a meeting is scheduled for November 9th with planned care colleagues to review and discuss current risk.
Advise	• 3 x ongoing DIC action plans for **HMP Parc Prison.** • **RN Vacancies in Community Hospitals** remains a significant and ongoing risk to patient safety and quality. Action plan in place and daily senior nursing oversight to mitigate risk. Vacancy factor remains 36% at both sites. International Nurses recruitment being explored for Community Hospitals. • **Advance Care Planning (ACP)** a recent mortality review identified a number of missed opportunities to initiate ACP discussions within Older Peoples Mental Health, District Nursing and a Care Home. This demonstrates the need for further training and education in this area, however, there is currently no dedicated resource within the UHB to progress this. • **Specialist Palliative Care Service** reporting problems with management of syringe drivers, administration of PRN medication, and symptom assessments across POW and RGH. New flowchart in the process of being developed to aid assessment and decision making. • **Lymphoedema Service** national team currently use DrDoctor to collate feedback (PROMS) across all UHBs,

	however, DrDoctor contract ends 31st Oct 2023. New supplier has been procured, but will not be operational until early 2024. Work ongoing to identify ways to collect PROMs as this is critical to the VBHC OGEP evaluation. • **Inappropriate Transfers of Care** between POW and Bryn-Y-Cae reablement unit, Bridgend. Following a recent clinical incident (11th October), a retrospective review of transfers has confirmed an increase in the number of clinically inappropriate transfers to the unit. SBAR has been produced to inform meeting between HoNs and ACT Lead ANP. • **Dental Lists,** being monitored due to 3,000 patients required to be added to the list, there is now a risk of a high backlog and not knowing how many of those patients are waiting for a routine dental practice. • **Orthodontics**. 2 CDS Specialist Orthodontists retired at the same time. Most urgent patients have been sent to a provider in Bridgend that has agreed to carry out the treatment. There is an excess of 300 patients that we need to source treatment for, this has a cost implication, and will be one of the priorities from April 2024. • **Glaucoma** – funding has been identified to enable the scheme to restart. • **Spirometry**. Potentially 8,000 patients will need testing by March 2024. Proposed model 2 phased approach. Phase 1 for COPD diagnosis, phase 2 to include asthma diagnosis. This service is placed on the risk register. • **Salus deployment.** The team are still awaiting formal notification regarding this. Adastra contract is due to expire on 31st December 2023, an SBAR highlighting the risks has been completed. • **Home oxygen** – staff shortages in POW are having an impact on the prescribing of home oxygen for hospital discharges. Potential patient safety risk and financial implications. To mitigate this a training plan has been agreed and will likely commence in October.
Assure	• Community Hospitals Bed redesign work commenced. • Medication risks at **HMP Parc** require further review and pathways to be developed to prevent further medication incidents. Task and finish group meeting arranged. • **Nursing workforce** information work commenced across all ward areas. • **POCD** data has significantly improved across Community Hospitals. • **PC&C** Nursing collaborative meetings scheduled from January 2024 onwards. ToR and Agenda to be drafted. • Process now in place to meet with **HMP Parc** team to discuss Agenda for Change contracts.

- Willows Care Home closed and all patients have been rehomed.
- **Autumn/Winter Flu** campaign Care Home and housebound campaign completed. Immunosuppressed on schedule.
- **Staff vaccine campaign** – very high Did not Attend (DNA) rates in Community Vaccination Centres (CVCs). Acute site and Community Sites clinics/walk arounds also showing lower uptake than the same time last year.
- **Fire Safety** Action plan to address works identified through Fire Integrity Surveys at Ferndale, Ynyshir and Maerdy and pan estate Fire Risk Assessments (FRA) are being drafted with input from Health, Safety and Fire team. This work will inform a future Statement of Need (SON) for the Capital works required
- **Insulin transcribing** issue for housebound patients has been resolved. Community teams have been offered transcribing training and competency sign off to be able to transcribe
- **Wellness Improvement Service (WISE)** are currently developing an e-learning platform for the service, which will hopefully be implemented January 2024, and working with Obstetrics Gynaecology and Sexual Health on a women's health programme for to be implemented in November 2023.

- **Concerns**

Complaints	
Number of Formal complaints received	1
Acknowledgement letter sent within 2 working days	1
Number of Early Resolution received	21
Number of Enquiries received	11
Number of Enquiries received via PALS	1
Complaints Closed	0
Of the complaints closed, number responded to with 30 working days	0
Number of complaints final response due this week	0
Of the number due, number closed / closed escalated to redress / withdrawn within 30 working days	0
Open Complaints	5
Complaints Overdue - Over 30 Working Days	2
Complaints Overdue - Over 6 Months	1
Inquest	
New Inquests Received	0
Total number of open inquests	17
Inquests Concluded	1
Regulation 28 Reports received	0
Claims	
Clinical Negligence Claims Received (Actual)	0

Personal Injury Claims Received (Actual)	0
Total Number of Open Claims	19
Number of Case Management Reports Due	0
Number of Case Management Reports Overdue	0
Number of Case Management Reports Submitted	0
Clinical Negligence Claims Closed	1
Redress	
Cases Transferred to Redress	0
Open Redress Cases	18
Number of Case Management Reports Due	0
Number of Case Management Reports Overdue	0
Number of Case Management Reports Submitted	0
Closed Redress Cases	0

- **Amat Audits –** This is discussed at the care groups operational meetings.

AREA	Jul-23	Aug-23	Sep-23
District Nursing Abercynon	50%	50%	
District Nursing Aberdare Team	94%	98%	100%
District Nursing Ashgrove Surgery	98%	91%	91%
District Nursing Cwm Gwyrdd	50%	100%	100%
District Nursing Dowlais	50%	100%	100%
District Nursing East Cluster			
District Nursing Eglwys Bach	99%	100%	100%
District Nursing Ferndale	97%	95%	94%
District Nursing Forest View	98%	97%	97%
District Nursing Foundry Town	100%	100%	50%
District Nursing Hirwaun & Parc	100%	100%	100%
District Nursing Merthyr Town	98%	99%	99%
District Nursing Merthyr Valley			
District Nursing Morlais	99%	100%	100%
District Nursing Mountain Ash	98%	100%	100%
District Nursing New Park	96%	97%	97%
District Nursing North Cluster			
District Nursing Old School	99%	100%	100%
District Nursing Parc Canol	95%	94%	93%
District Nursing Pontcae	98%	98%	99%
District Nursing Pontnewydd	100%	100%	100%
District Nursing St Johns	99%	100%	100%
District Nursing Taff Vale		93%	100%
District Nursing Tonypandy	94%	100%	96%
District Nursing West Cluster			

MCH Ward Llynfi (temp Wd 21 PoW)	93%	92%	97%
YCC Ward 01	60%	66%	77%
YCC Ward 02		55%	99%
YCC Ward 03	99%	88%	88%
YCC Ward 04	99%	100%	77%
YCR Ward A1	88%	88%	86%
YCR Ward B2	96%	98%	98%
YCR Ward C3	92%	95%	94%
YCR Ward D4	96%	99%	95%

INFORM

- Clinical Lead at **HMP Parc** awarded a Chief Nursing Officer (CNO) Excellence Award for her work within Dementia Care.
- **Safe Care Collaborative 14th September 2023** story boards presented by Quality Improvement (QI) team regarding community projects (CAPU and Falls).
- **Community Acquired Pressure Ulcers (WWIC project)** Tissue Viability service in collaboration with Arjo and WWIC undertook a Pressure ulcer Prevalence audit at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda w/c 18th September 2023. The work and resulting outcomes will help drive improvements to patient safety in relation to pressure ulcer prevention.
- **CEO visit** to Rhondda/Taff Ely District Nursing Service 17th October 2023. Informative presentation served to generate meaningful discussion regarding a range of service and workforce development initiatives. Presentation was followed by a home visit.
- **Lymphoedema Service** the National Cellulitis Improvement Programme progress report (available on request) outlines the impact in CTM UHB since the programme was expanded into Primary Care and Community (from August 2022).
- **Bladder & Bowel Service** article published in the British Journal of Nursing 16th October 2023 "Using technology to encourage ward-culture change and provide individualised bladder care", (article is available on request).
- **Nantymoel** received a **HIW inspection**. An immediate improvement notice with 3 areas of concern was issued. A plan has been submitted and approved by HIW. Plan in place for the team to begin their practice development visits and pick up HIW inspections whilst in the practice.

Appendices

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing Well Living Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. Recommendation

5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.2c

Quality & Safety Committee

HIGHLIGHT REPORT FROM THE CHILDREN & FAMILIES CARE GROUP QUALITY & SAFETY COMMITTEE

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre, Director of Midwifery
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

ACRONYMS/GLOSSARY OF TERMS	
ACP	Assurance and Closure Panel
BMI	Body Mass Index

CTM	Cwm Taf Morgannwg
CS	Caesarean Section
CYP	Children and Young People
HIW	Health Inspectorate Wales
MDT	Multi-Disciplinary Team
NMC	Nursing and Midwifery Council
NN	Neonatal
PCH	Prince Charles Hospital
PeriPRem	Perinatal Excellence to Reduce Injury in Premature Birth
POW	Princess of Wales
RCM	Royal College of Midwives
RCT	Rhondda Cynon Taf
RIF	Regional Integrated Fund
SEHS	School Entry Hearing Screening
SON	Statement of Need
SSI	Surgical Site Infection
USW	University of South Wales
WG	Welsh Government

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children & Family Care Group at its meeting on 12th October 2023.

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

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

2. Highlight Report

Alert / Escalate	• Healthcare Inspectorate Wales (HIW) Unannounced inspection to Tirion Birth Centre 19-20th October – no immediate actions • HIW unannounced inspection to Children's Ward at POW 25-26th September. Immediate actions for improvement included out of date medicines, medicine storage and resuscitation trolley checks. The immediate improvement plan has been accepted. Overall feedback from the reviewing team was very positive. • Neonatal Unit (NNU) at Princess of Wales (POW) requires essential electrical work to be undertaken. This will require a 'decant' of approximately four weeks.
Advise	• School Entry Hearing Service (SEHS) – Cwm Taf Morgannwg (CTM) in breach of their responsibility to implement direction from Welsh Government (WG) to handover the governance arrangements of the programme to audiology services • Bespoke service wide manual handling 2 year course agreed with Manual Handling Department. Commenced September 2023 aiming for 100% compliance by August 2024. • Neonatal Nurse orientation plan developed and approved for rotation of staff to PCH/POW to assist with staffing challenges • Gap analysis in progress for POW Neonatal Unit (NNU), will be the focus of further Neonatal improvement work • There have been four avoidable pressure damage incidents in maternity within the last twelve months. Focused work in place around Purpose T, skin bundle (included on mandatory study days) mattress covers changed. • Forty nine Maternity guidelines out of date. This is due to majority of guidelines being written at the same time in 2020. Multi-disciplinary Team (MDT) guideline forum in place with a priority review of national evidence (monitoring via Maternity and Neonatal Safety Board) • Baby Loss Awareness Week commenced 9.10.23 – events held across the Health Board • Elective caesarean section separate lists to commence at the POW site from 16.10.23. Aiming to provide 3 per week by March 2023

Assure	• Multi-Professional Perinatal Morbidity Review almost complete. To be reported at next Care Group QSE meeting in December. • Abduction drill planned for Tirion Birth Centre (HIW recommendation) • Surgical Site Infection (SSI) Reports for 2022-2023 received. Overall Caesarean Section (CS) rates 3.2%. Increased infection rates seen for women and birthing people who have had more than two CS, those with a Body Mass Index (BMI) 25-29.9 (5.6%), BMI > 30 4.3%. Quality Improvement Project underway to improve recognition of infection / digitalization of reporting. • Extra Assurance and Closure Panel (ACP) planned for 20.10.23 to ensure serious investigations are completed as promptly as possible. First Children and Young People (CYP) ACP held October 2023. • Maternity Neonatal National Discovery Report priorities & Bright Spots has been completed. • University of South Wales (USW) have reported an increase in student satisfaction scores this year. • PeriPrem Cymru national team visited Prince Charles Hospital on 12th July 2023. Overall positive visit feedback received 20.9.23
Inform	• Consultant Midwife invited to speak at the British Intrapartum Care Society Conference re 'Birth outside of guidance' and Royal College of Midwives (RCM) UK student midwife conference. Bryany also spoke at a Cross Party working group at the Senedd on 28th September re 1st 1000 days and her role within CTM. • Nursing and Midwifery Council (NMC) members visited PCH site 26.9.23 – very positive feedback via letter, verbal at the time and verbal at NMC committee meeting the next day. • Birthrate + workforce midwifery review almost complete to include priorities for sustainable workforce and future service provision • The Care Group was well represented & spoke at the Early Years Transformation team Parent Infant Responsiveness & Warmth conference at Hawthorn Leisure Centre in September.

<table>
<tr><td></td><td>

Further Care Group Band 7 nursing & midwifery away day held on 18th September at Keir Hardie Health Park
Second ‘Aqua Yoga’ course for pregnant mothers in Rhondda Cynon Taf (RCT) about to start. Thirty participants attended cohort one, evaluation positive ‘Made for Mams’ ‘Water Warriors’.
Vanguard training with WG taking place over next 3 months in relation to continuing care for children & young people
Regional Integrated Funded (RIF) PIR psychologist post agreed to be hosted within Mental Health
Care Group Diverse Cymru training being arranged. Work underway to improve recording of ‘Ethnicity’ for pregnant women and people.
Newly qualified midwives commenced via streamlining September 2023, five more due to start by January 2024.

Risks
<table>
<tr><td>5070</td><td>Staffing in Special Schools</td><td>15</td></tr>
<tr><td>2808</td><td>Waiting times for performance Neurodevelopmental team</td><td>15</td></tr>
<tr><td>5413</td><td>Theatre bed in POW – too old for adequate repairs</td><td>16</td></tr>
<tr><td>3008</td><td>Injury due to manual handling compliance being low</td><td>16</td></tr>
</table>
New colposcopy bed - statement of need (SON) has been agreed and purchase is proceeding.
</td></tr>
<tr><td>Appendices</td><td>Not applicable.</td></tr>
</table>

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /	Starting Well
	If more than one applies please list below:

Link to CTMUHB Strategic Areas	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

4. Recommendation

4.1 The Quality & Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

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

Maternity Metrics:

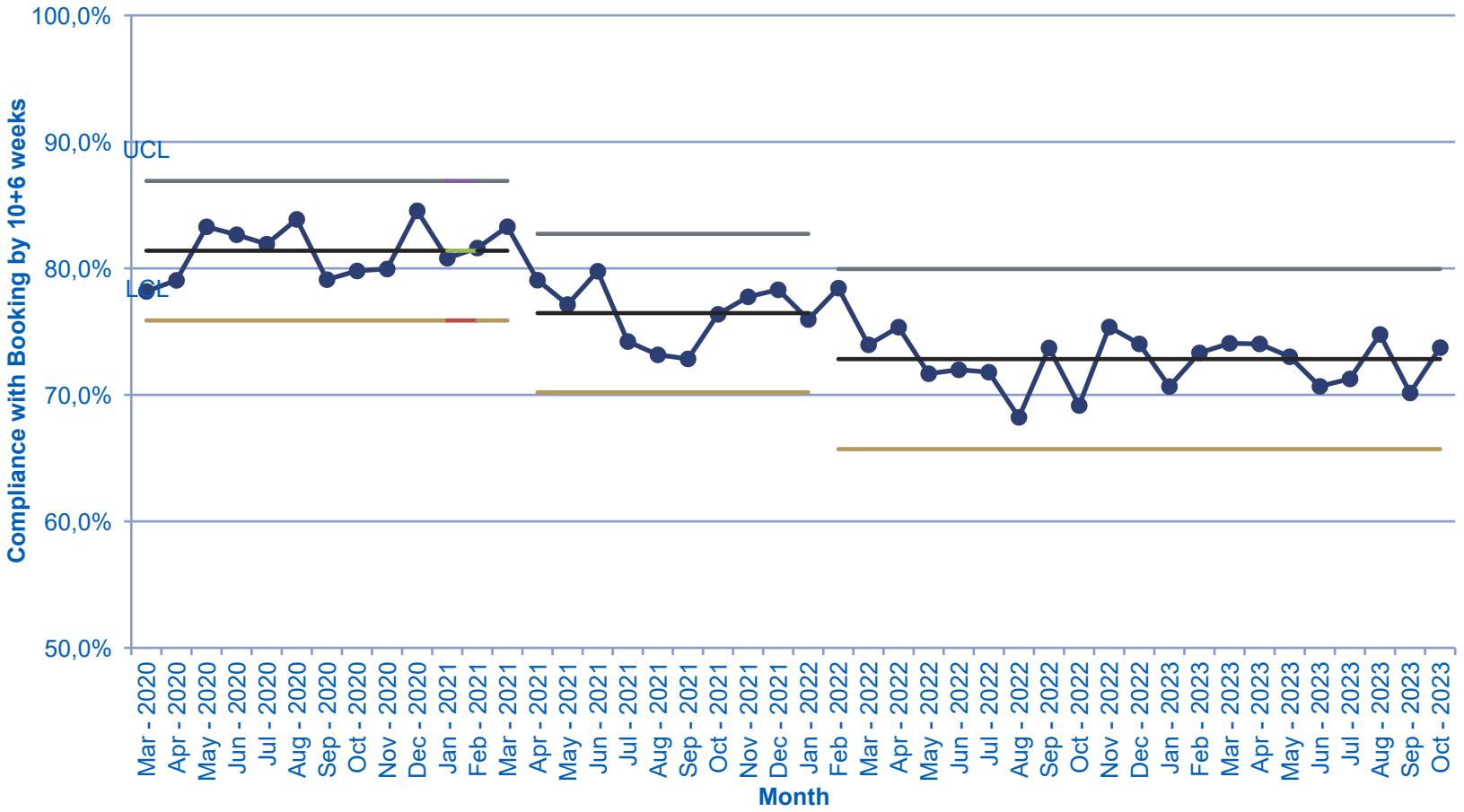
Clinical Dashboard, QI and PREM Signals

October 2023

(Data for October 2020- September 2023 unless otherwise stated)

Elinore Macgillivray, QI Lead Midwife
Bryany Tweedale, Consultant Midwife

Rate of Initial Booking by 10 weeks– October 2023



Median compliance with booking by 10+6 weeks has decreased significantly over the last 3 years.

Median was 81% during COVID, when community services changed significantly due to restrictions.

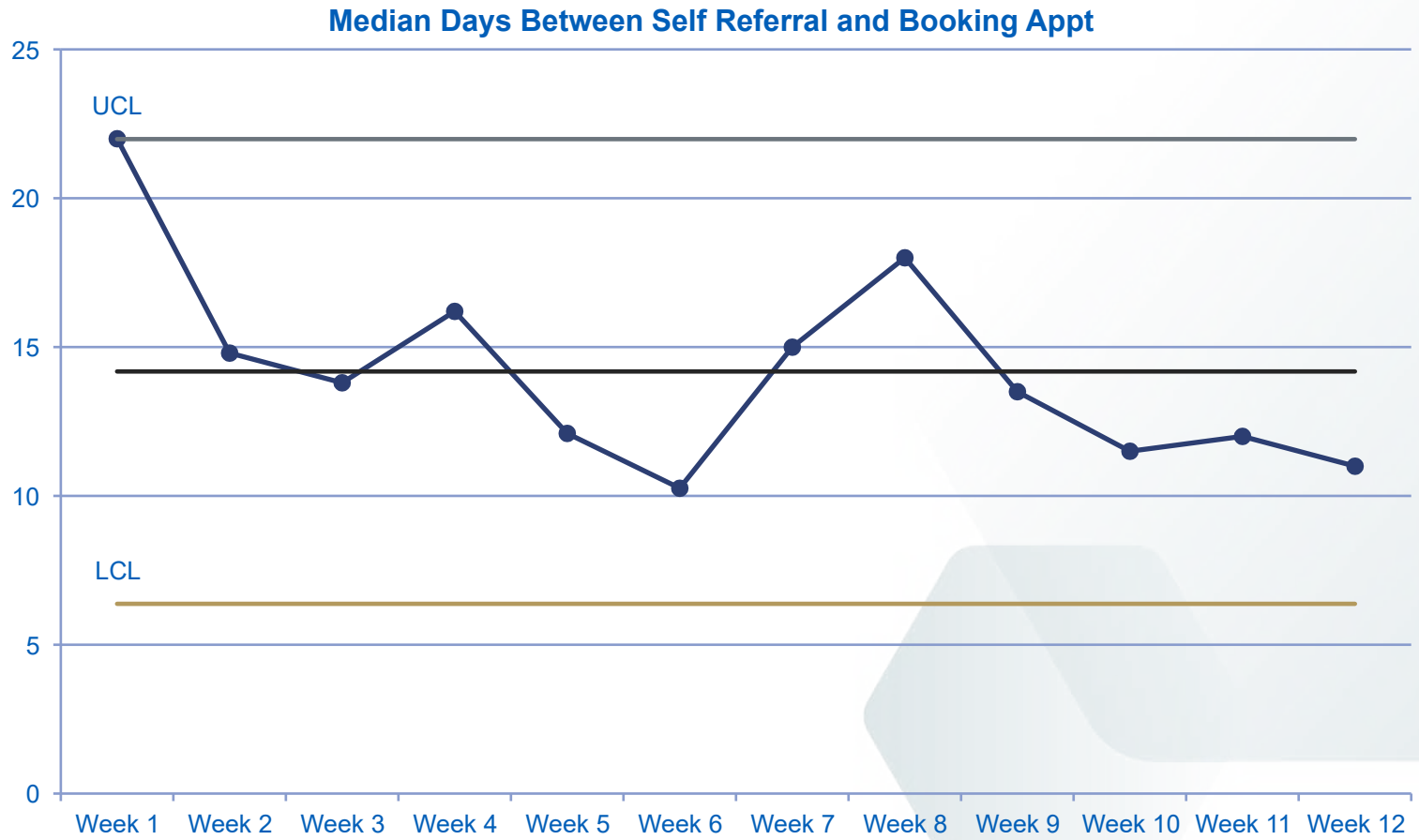
When restrictions eased and home visits resumed, the median fell to 76%.

In March 2022, the median decreased again to 72%, and had been unchanged since.

The digital booking system launched in July 2023.

NB. The Welsh median in 2022 was 77%.

Booking by 10 weeks QI: Process Data



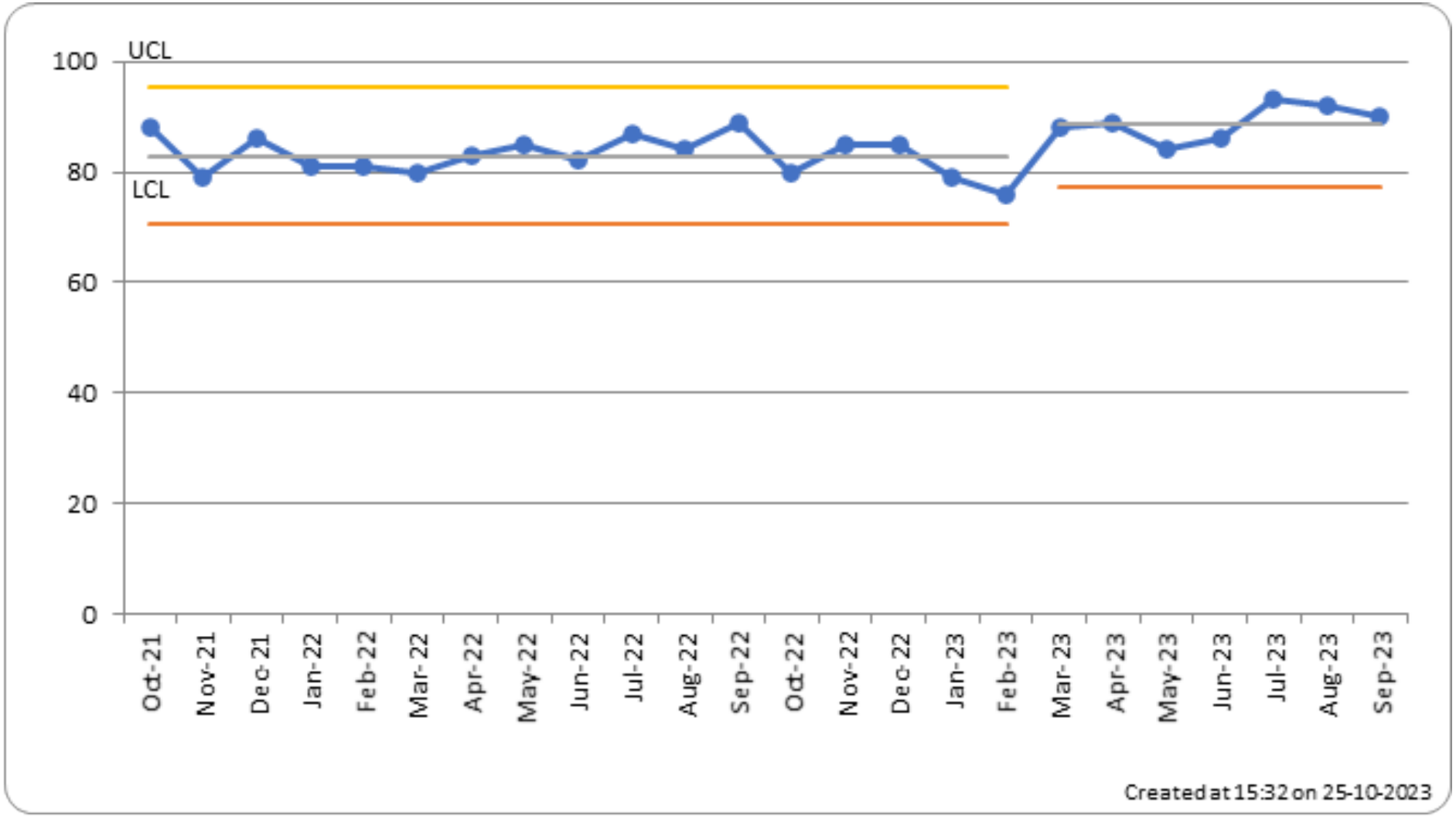
This shows the median days lapsed between date of self-referral and initial booking appointment.

It was only possible to begin collecting this data once the digital system was in place.

There are promising signs of an improvement in the self-referral -> booking appointment interval.

#MatNeoQiCTM

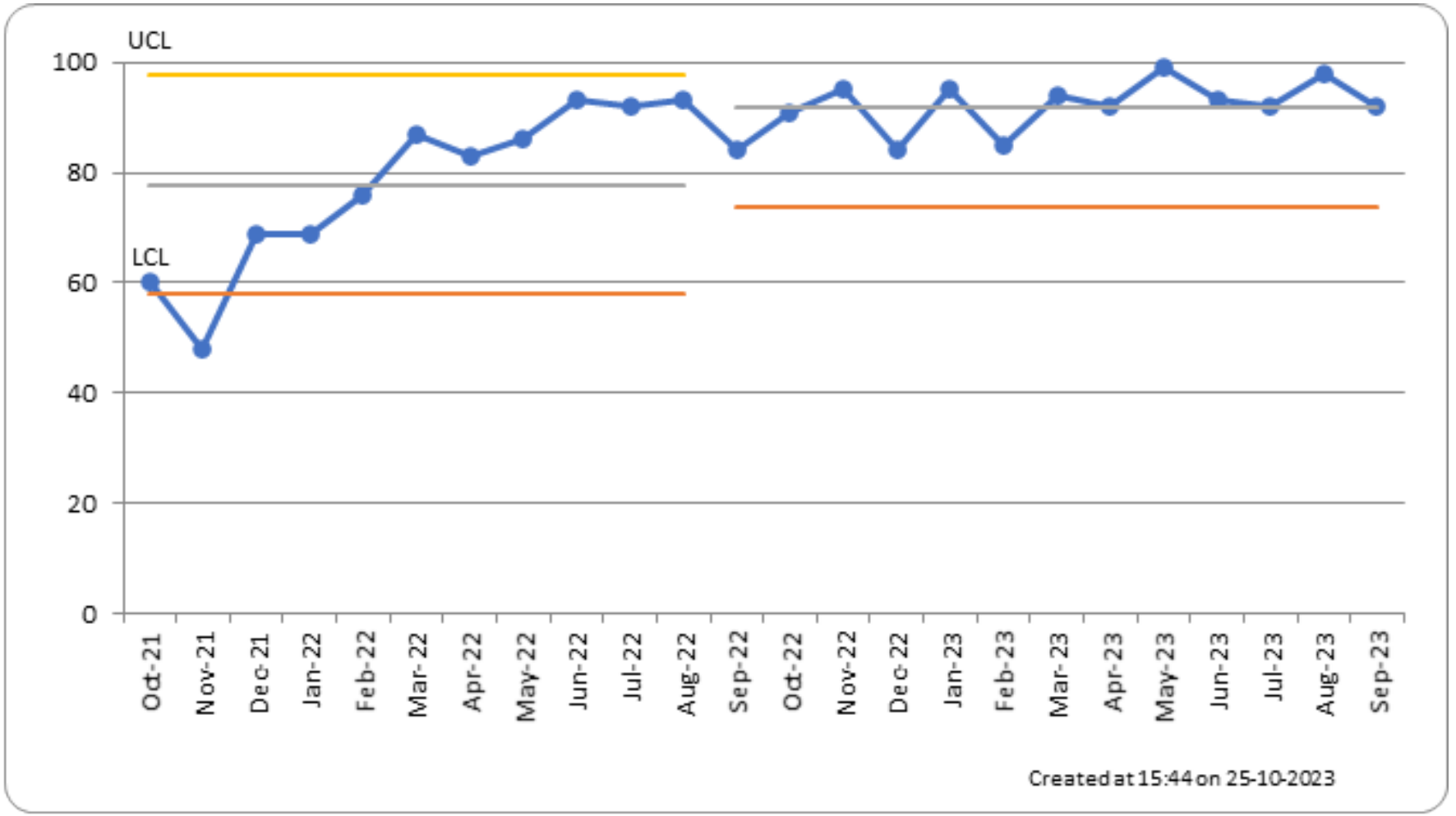
Information in early pregnancy



Thinking about your early pregnancy care, was the information provided easy to understand and were you comfortable to ask questions?

Since implementation of the digital booking system in July 2023 (with key information sent out to women by no-reply email upon notifying the service of their pregnancy), we can see an improvement in women's experience relating to provision of information in early pregnancy.

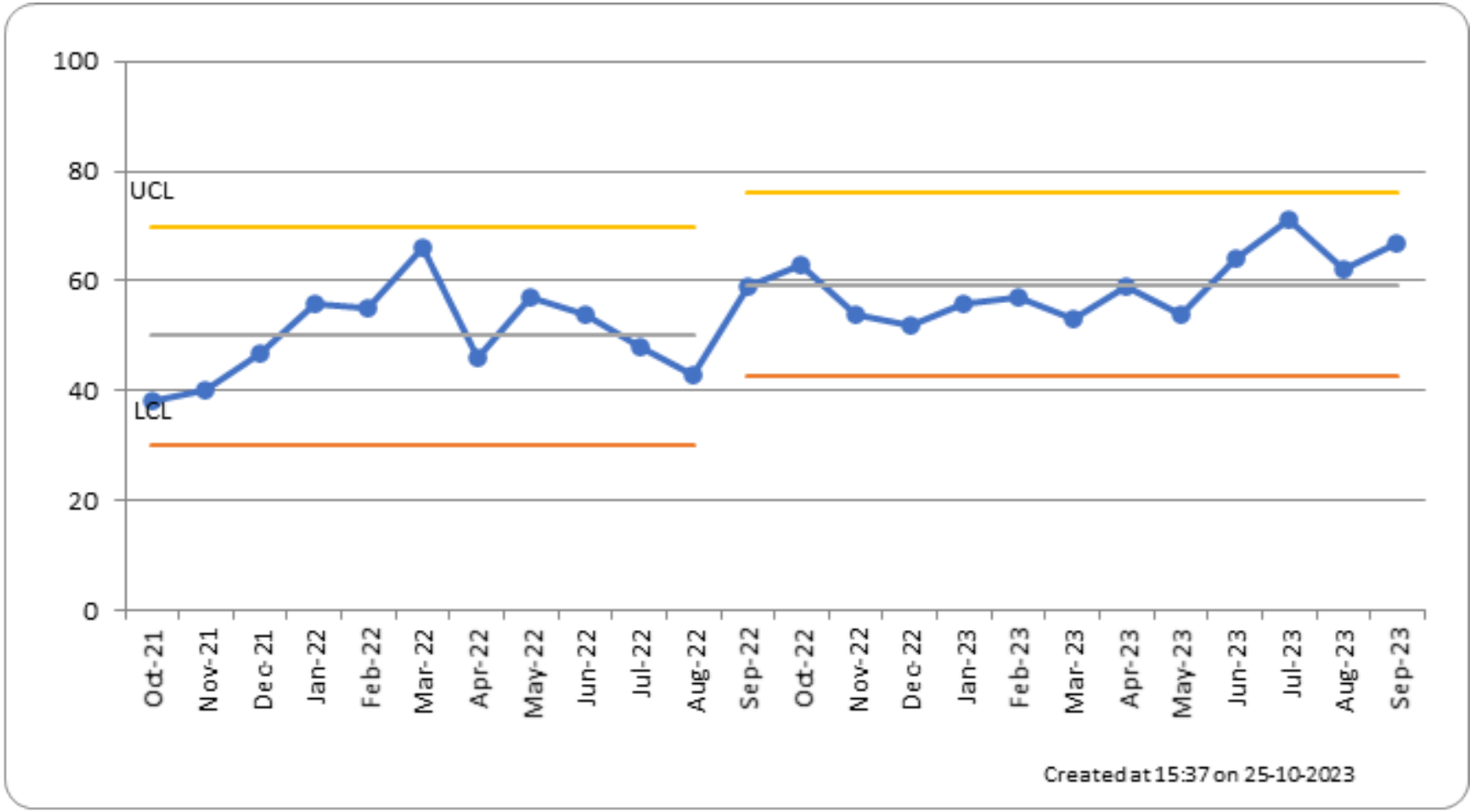
Discussions and Explanations



Throughout your pregnancy, have you been able to discuss and seek explanations about any aspect of your pregnancy, birth or postnatal care?

A significant volume of work has been undertaken across antenatal, labour ward and postnatal forums to design and update patient information, in addition to setting up a centralised birth reflection service, enabling all women and pregnant people to access opportunities to discuss and receive explanations around their maternity and birth experience/s.

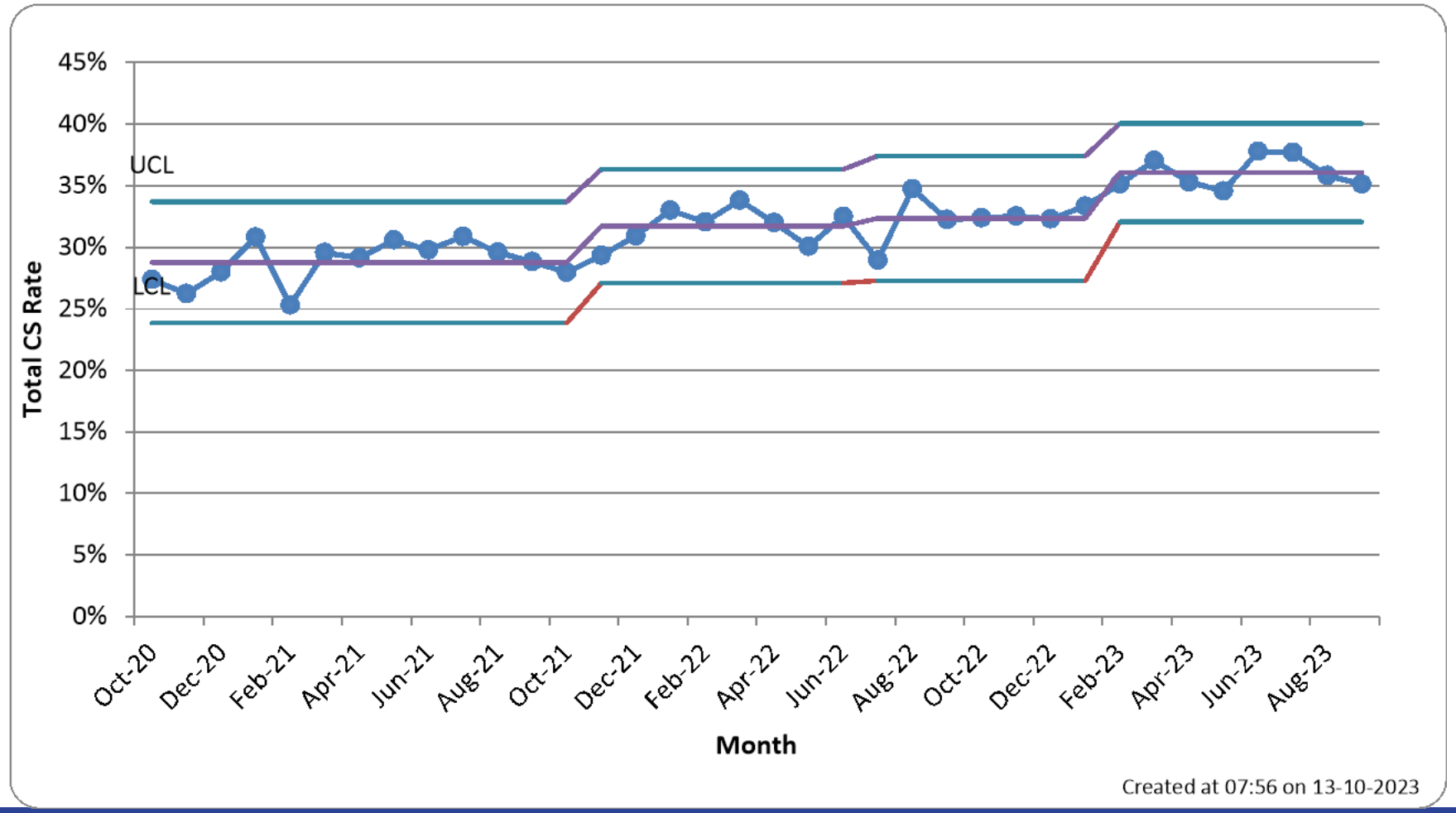
Continuity of Midwifery Care



Evidence shows that women want, and benefit from continuity of carer; the opportunity to develop a trusting relationship with a midwife as a known care-giver.

Recent work around community midwifery transformation has seen improvement in the number of women reporting having seen their named midwife during antenatal care. This remains a key area of focus for improvement.

Rate of Caesarean Section (all categories) – October 2023

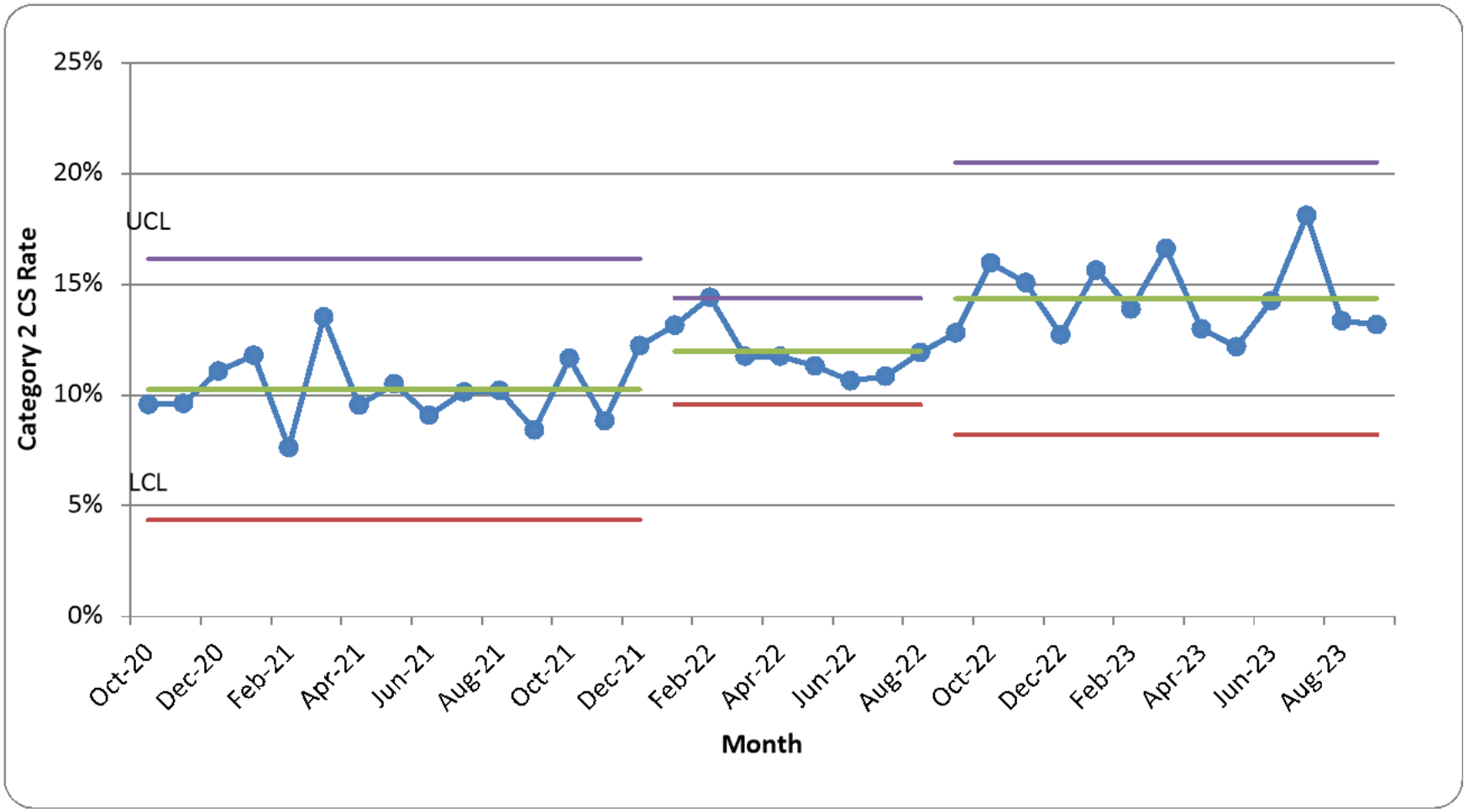


The median CS rate has shifted from 28% to 32% in December 2021 to **36%** in February 2023.

Category 1 CS rate has remained stable for several years.

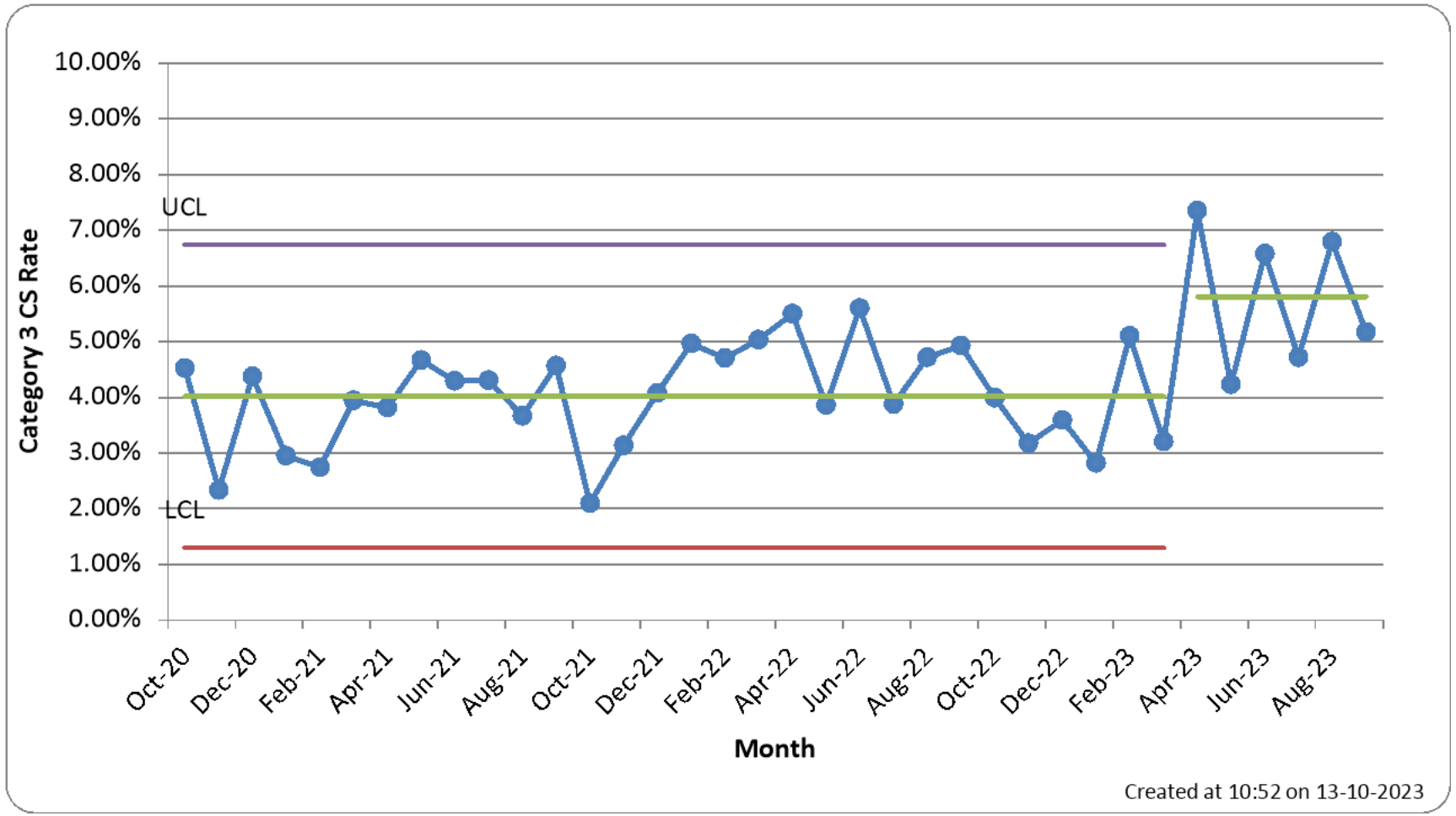
This is a picture of rising intervention that is emerging nationally in Wales.

Rate of Category 2 Caesarean Section – October 2023



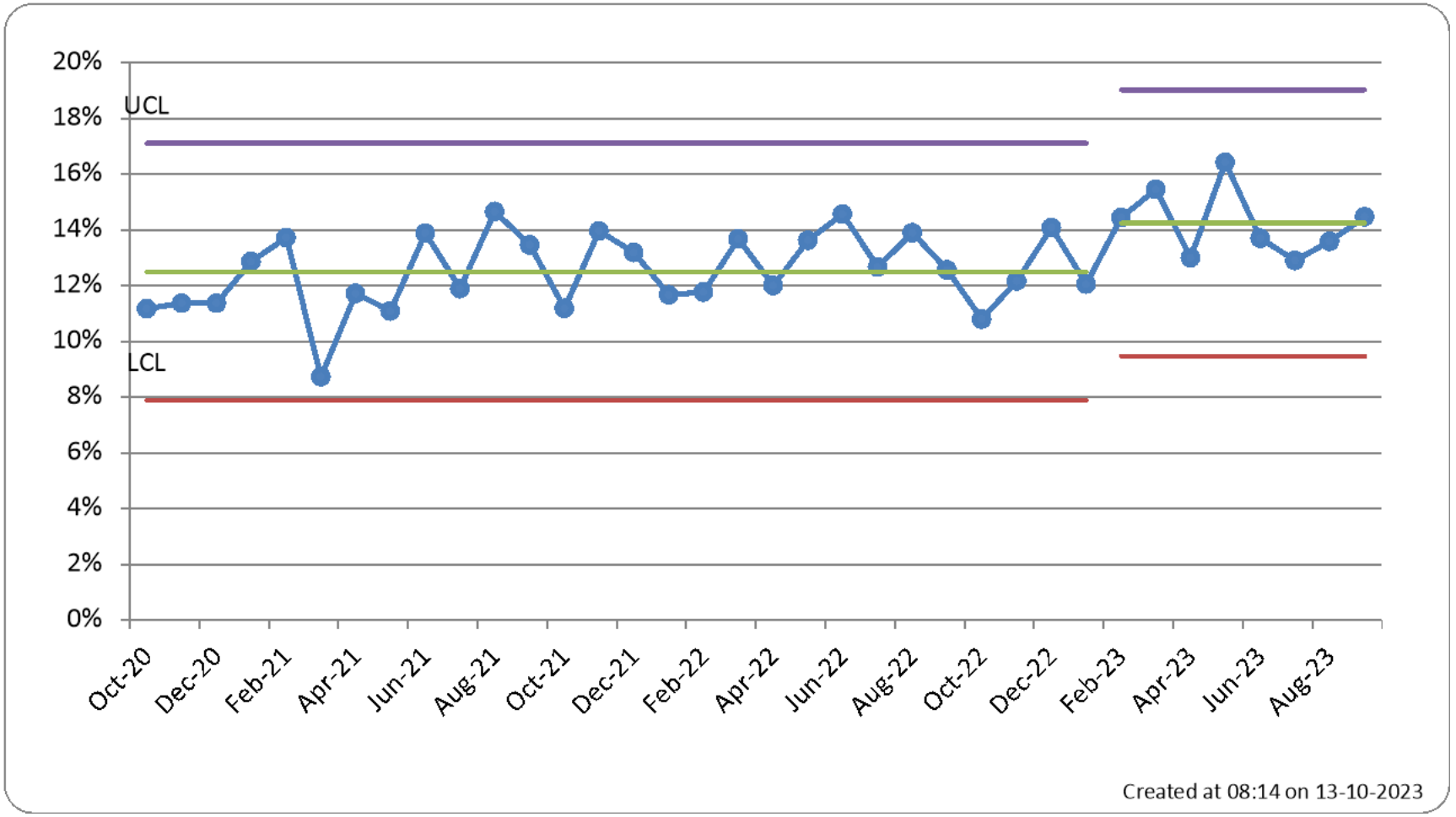
The median rate of category 2 CS has risen twice in the last 3 years. The median rate has increased from just over 10% in 2020 to 14.9% in 2023.

Rate of Category 3 Caesarean Section – October 2023



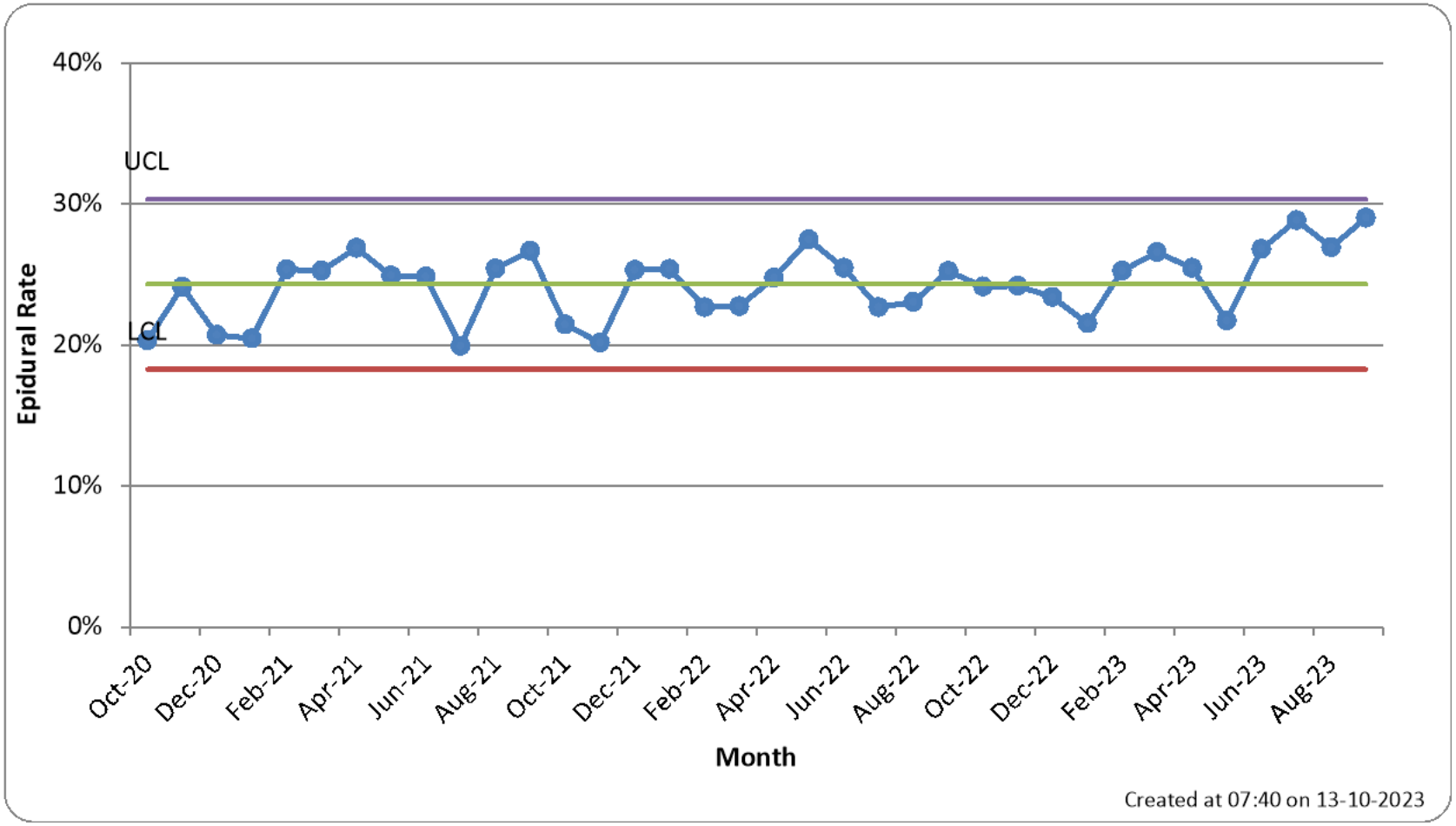
The median rate of category 3 CS has risen from 4% to 5.8% as of April 2023.

Rate of Category 4 Caesarean Section – October 2023



The median rate of category 4 CS has risen from 12.5% to 14.2% as of February 2023.

Epidural Rate– October 2023

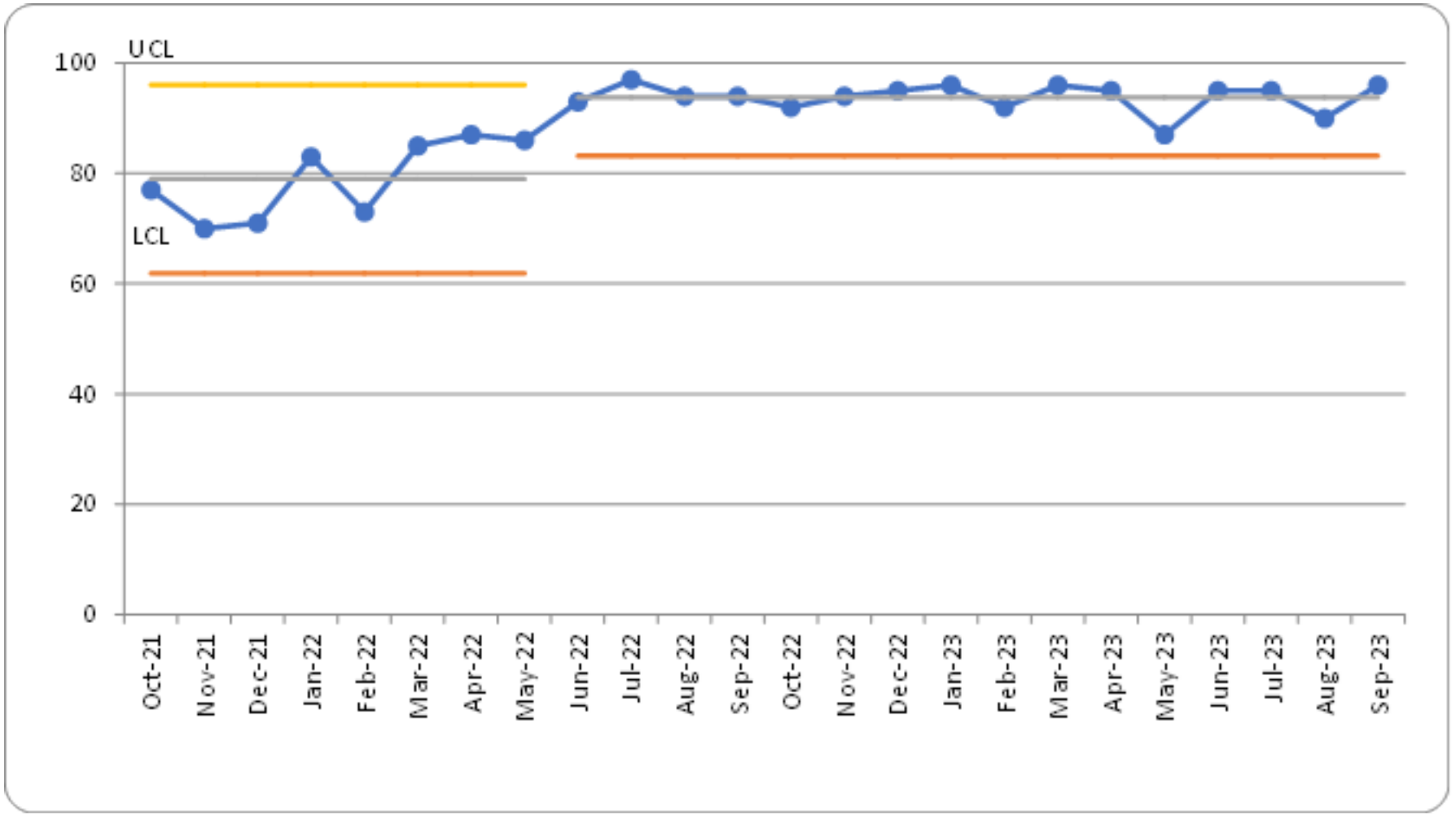


The median rate of epidural usage has not shifted yet, but each of the past 4 months have been above the median line.

July, August and September 2023 saw the highest epidural usage rates in the past 7 years.

This aligns with the overall trend in rising rates of intervention.

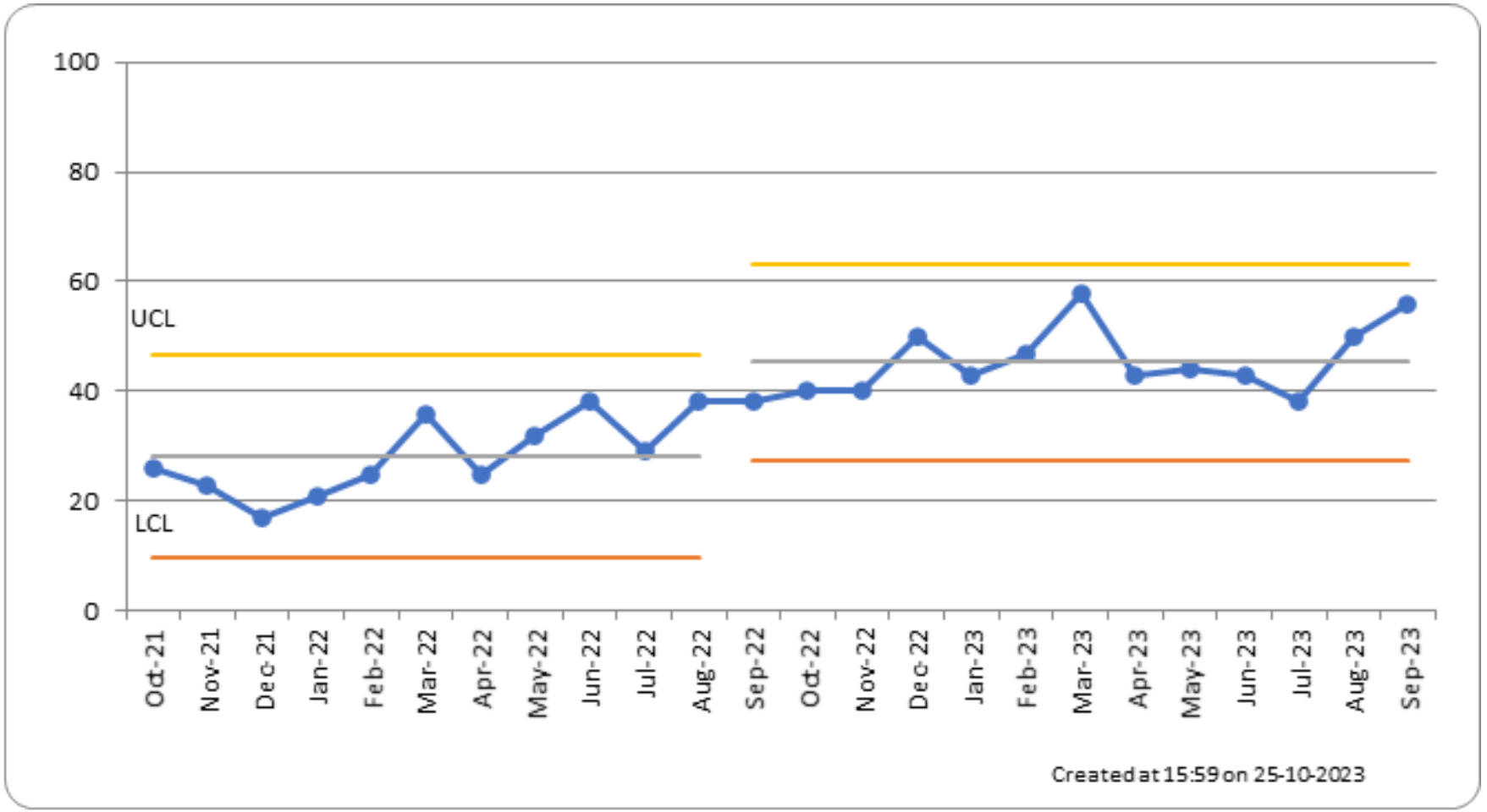
Birth Partner Involvement



If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they had wanted to be?

During the Covid-19 pandemic, there were significant changes in relation to birth partner arrangements; and we have seen a significant improvement in birth partner involvement during admission and care in labour.

Visiting and Partner Involvement



Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted them to?

During the Covid-19 pandemic, there were significant changes in relation to birth partner and wider maternity visiting arrangements; we have seen some improvement in terms of visiting, however this remains an area of poor families' experience.

Continuing Monthly Trends October 2023

Decreasing:
Home birth rate- median 1.8%
Spontaneous vaginal birth rate- median 58%

Increasing:
OU birth rate – median 86.7%

Stable:
Total number of births – median 394/ month
Freestanding midwife led birth rate – median 2.8%
Induction of labour rate – median 37.6%
Instrumental birth rate – median 7%

NB. All medians are for the 12 months October 2022- September 2023

QI Work in Progress– October 2023

Developing a postnatal contraception service. Plan to launch in January 2024.

Drymester: supporting women and pregnant people to remain alcohol free in pregnancy (launch November 23)

Self-referral digital booking system. Test phase 26th June- 23rd July. Full launch 24th July 2023. Some early signs of improvement are being seen.

Induction of labour ongoing QI collaborative, including developing an out of hospital IOL service and digital booking service.

Women's Physiotherapy ante and postnatal education classes. Launch January 2024.

Developing a communication passport for neuro-diverse maternity service users.

PERIPrem Cymru to improve outcomes for babies born below 32 weeks gestation

Improving the Help Me Quit for Baby service, including a digital self-referral pathway

Community transformation programme is ongoing.

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

Neonatal Metrics:

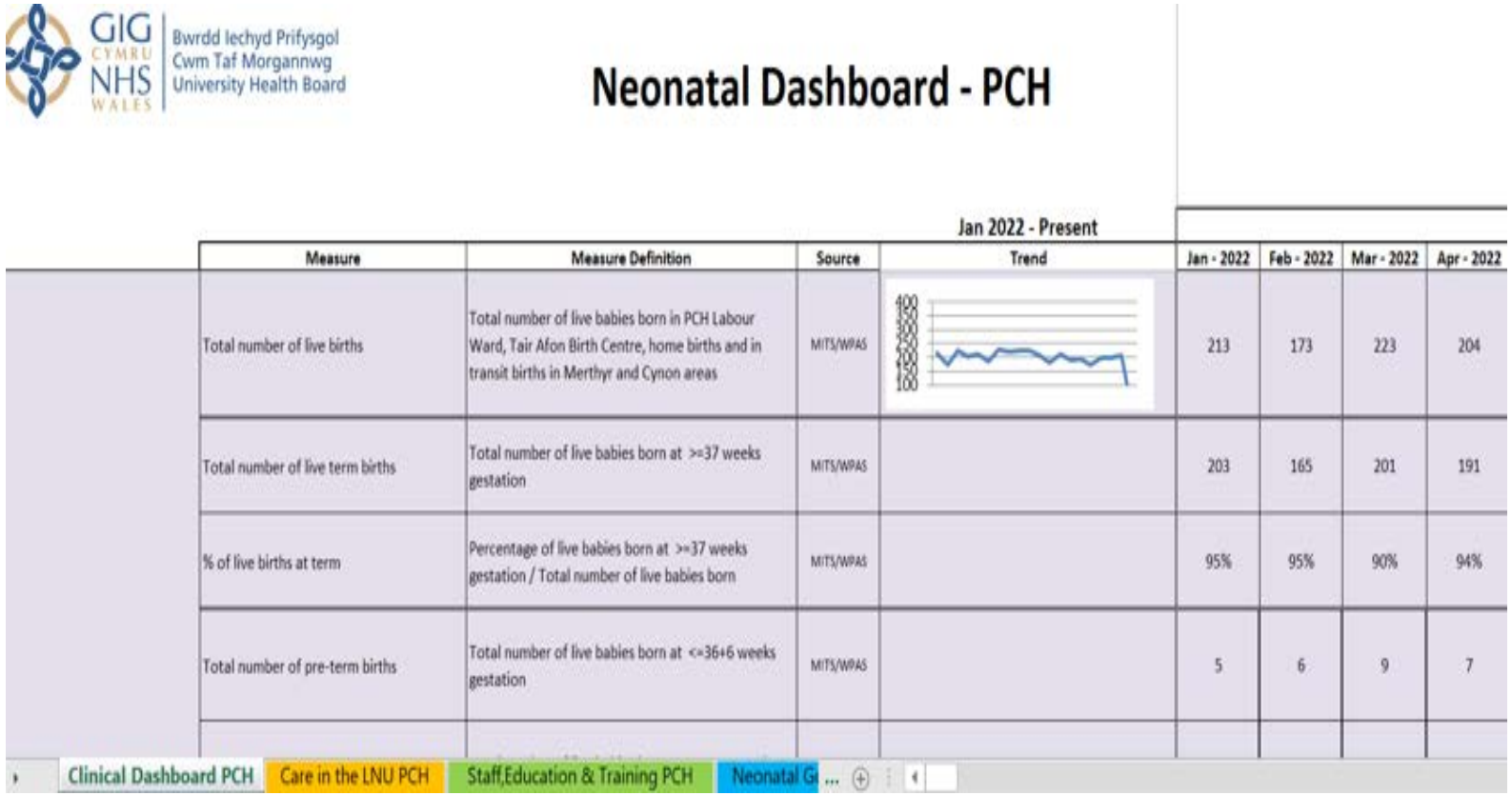
Clinical Dashboard

September 2023

Leanne Richards, Neonatal Improvement Lead Nurse

Neonatal Dashboard Update – September 2023

- The neonatal dashboard is now live in draft.
- The system is being tested against information systems
- Informatics have developed a mostly auto populated neonatal dashboard. However in the current stage will still be reliant on manual input.
- The combined dashboard will be available to all staff on SharePoint and utilised for quality, safety and improvement purposes still on start for an late autumn launch
- Currently there are no examples of this available nationally.
- Clinical improvement nurse to sit on national neonatal data task and finish group.



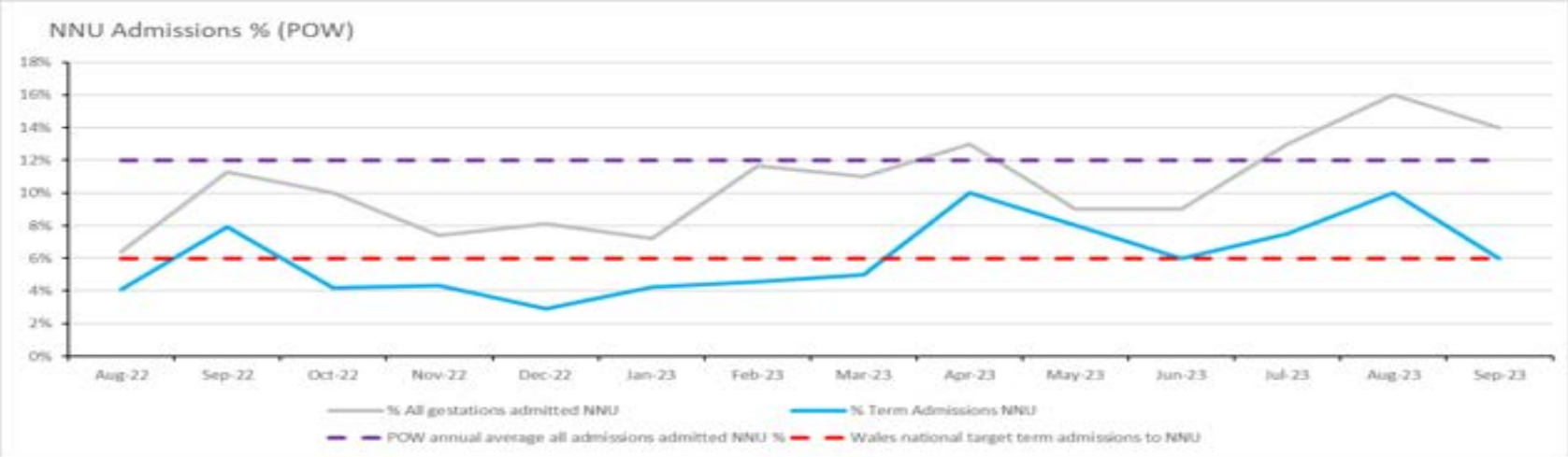
Neonatal Dashboard - PCH

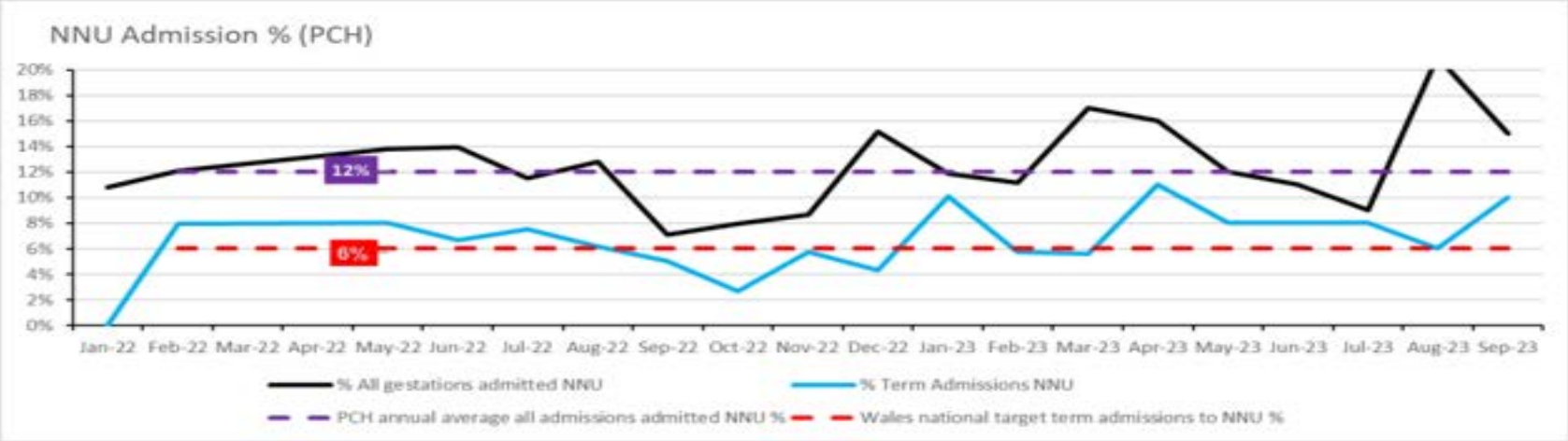
Jan 2022 - Present

Measure	Measure Definition	Source	Trend	Jan - 2022	Feb - 2022	Mar - 2022	Apr - 2022
Total number of live births	Total number of live babies born in PCH Labour Ward, Tair Afon Birth Centre, home births and in transit births in Merthyr and Cynon areas	MIS/WPAS		213	173	223	204
Total number of live term births	Total number of live babies born at >=37 weeks gestation	MIS/WPAS		203	165	201	191
% of live births at term	Percentage of live babies born at >=37 weeks gestation / Total number of live babies born	MIS/WPAS		95%	95%	90%	94%
Total number of pre-term births	Total number of live babies born at <=36+6 weeks gestation	MIS/WPAS		5	6	9	7

Clinical Dashboard PCH | Care in the LNU PCH | Staff,Education & Training PCH | Neonatal G...

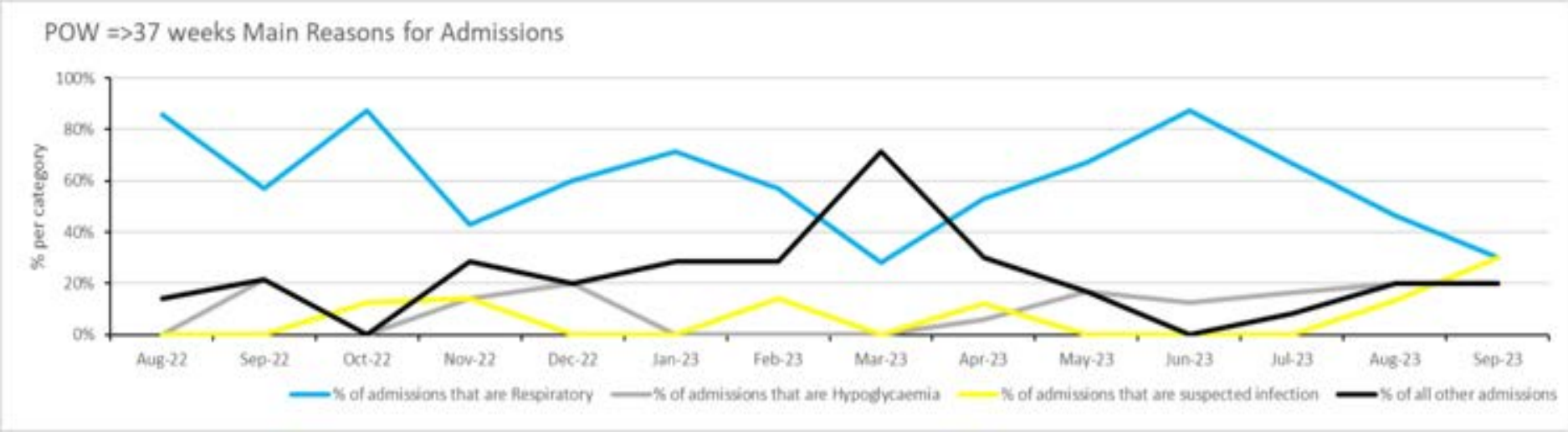
Total Number of admission to the NNU– September 2023

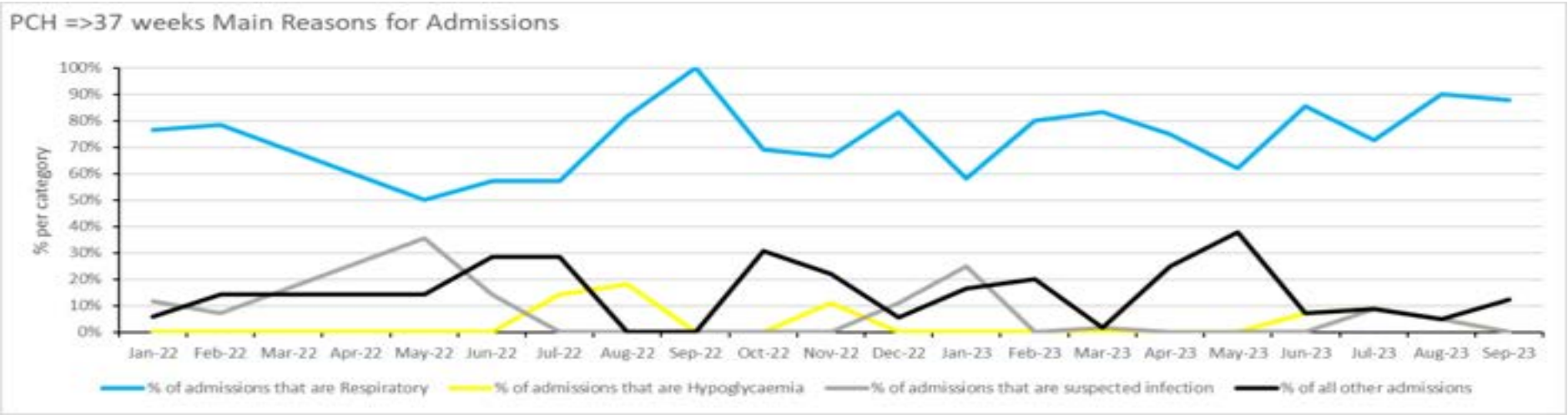




There has been a significant rise in all admissions to the neonatal units in CTM with a notable peak in August and July in 2023. This is reflective of the national pressure on cot capacity across the Neonatal Network. These pressures have continues in Sep/Aug

Primary reasons for term admissions to the NNU – September 2023

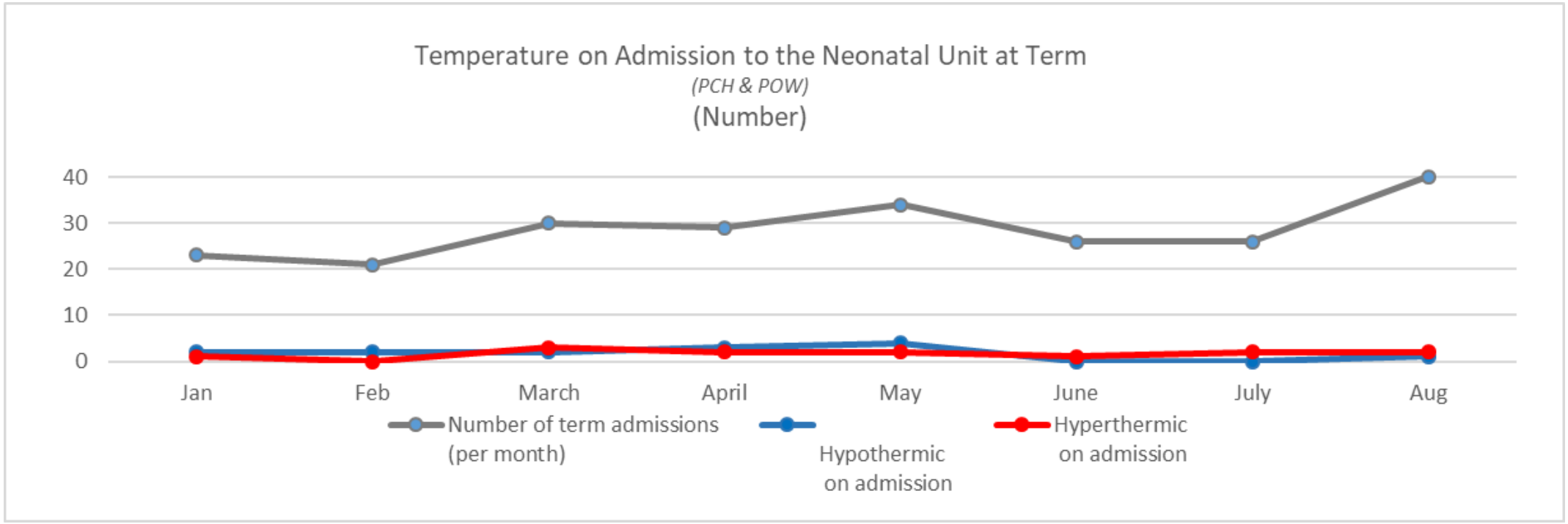




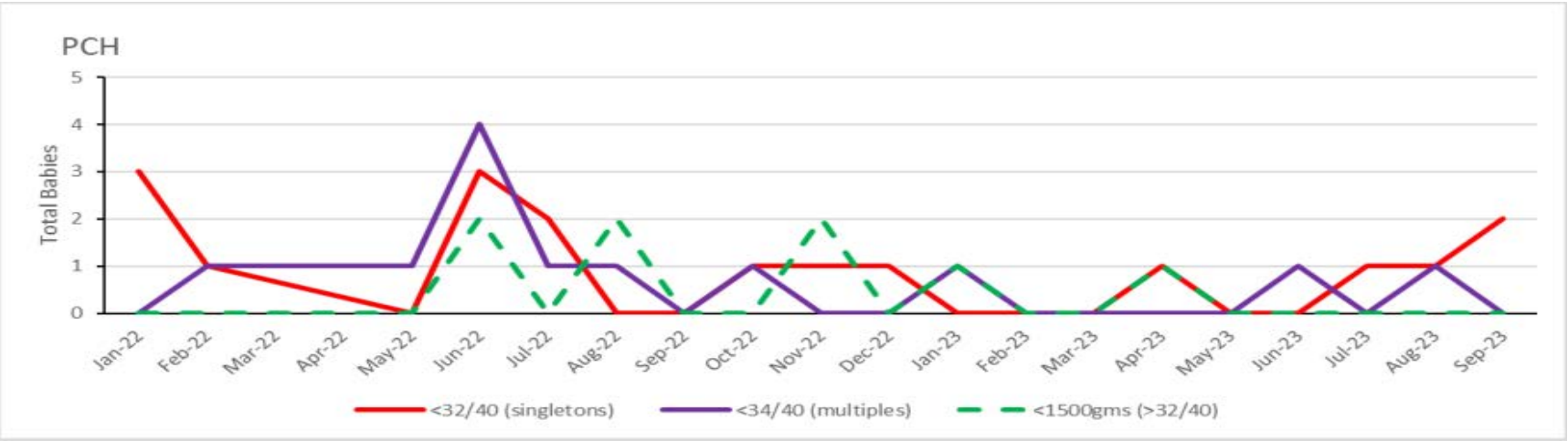
The main reason for term admissions to the NNU remains for respiratory support. On average 80% on both NNU in CTM

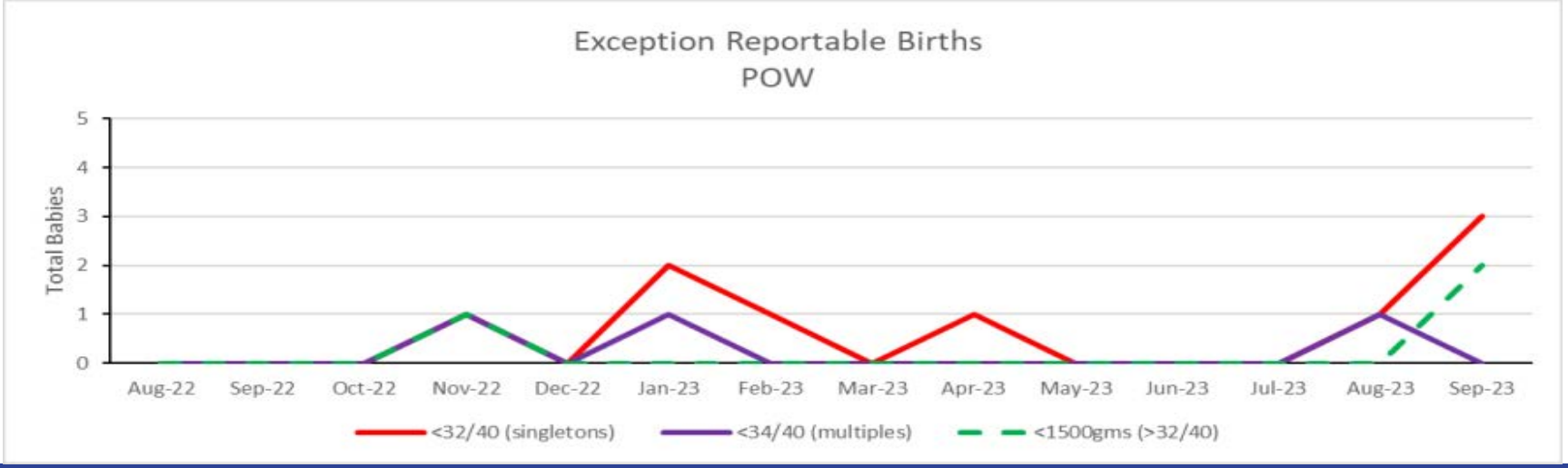
To note All babies admitted in August and Setember were normothermic (2 infants were noted to be above the temperature range were being treated for sepsis)

Temperature on admission to NNU (term) – September 2023



Exception reportable births – September 2023

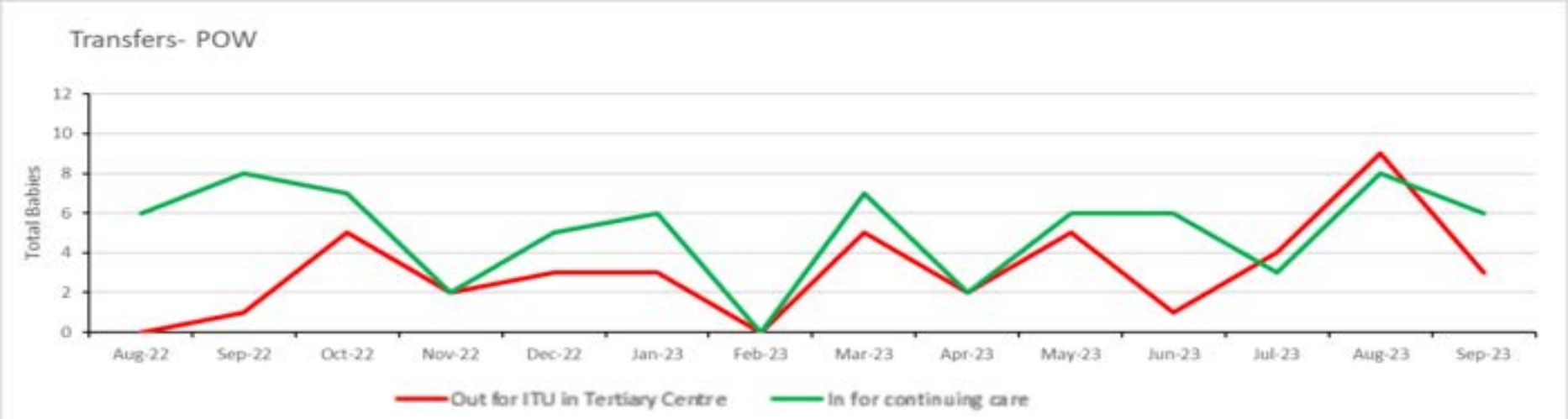


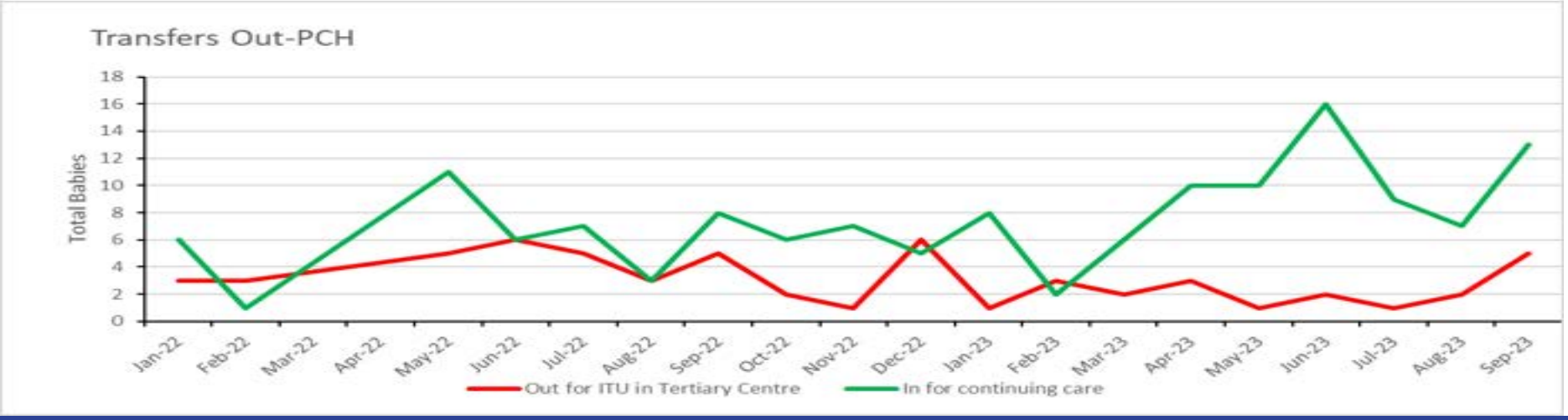


All exception reported births have remained stable. All infants born under 34 weeks gestation have an MDT review as per Peri Prem national work.

NB in July there was one NND in PCH of a 25/40 infant- will be reviewed through PMRT.

Transfers in and Out of the NNU – September 2023

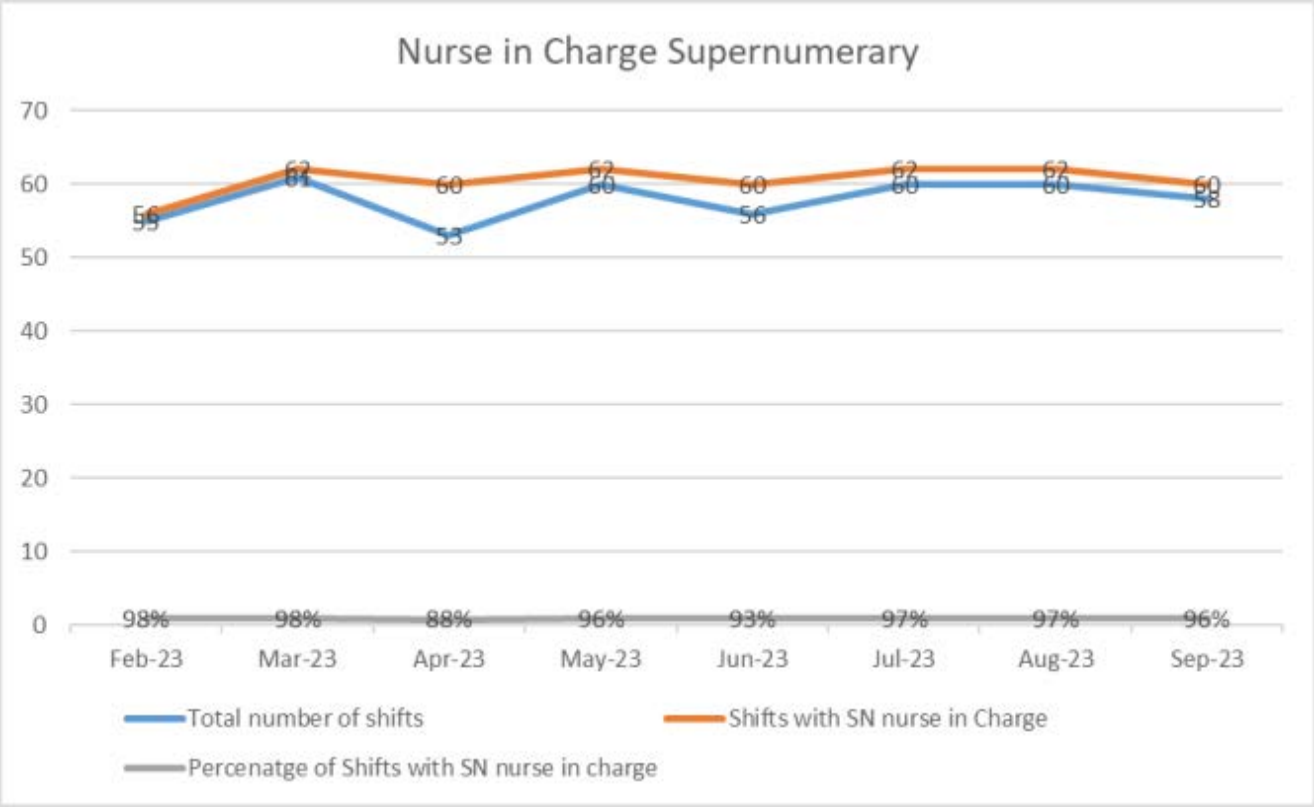




The transfers in the NNU and uplifts of care for transfer out correlate with the high acuity over the last two months and is reflective of the cot demand across the Network.

There were no reports of accidental dislodgement of ETT in this reporting period.

Nurse in charge Supernumerary PCH



- The nurse in charge role to be supernumerary
- Trigger for staffing Datix when not available. To continue to monitor.
- The main cause for the role to be unavailable is when the stabilisation cot is being used.
- The data collection to be retrospectively collected for POW and reported in Oct/Nov

QI Work in Progress– September 2023

Digital checking of resuscitation equipment on the neonatal unit in PCH

Transitional care QI project in POW

Family integrated care

PERIPrem Cymru to improve outcomes for babies born below 32 weeks gestation

Golden drops

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
AMAT	Audit Management and Tracking
CSGs	Clinical Service Groups
NRI	Nationally Reportable Incident
QSRE	Quality Safety Risk and Experience Meeting
RGH	Royal Glamorgan Hospital
WCCIS	Welsh Community Care Information System
WHSSC	Welsh Health Specialised Services Committee

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its meeting on the 10th October 2023.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group 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.

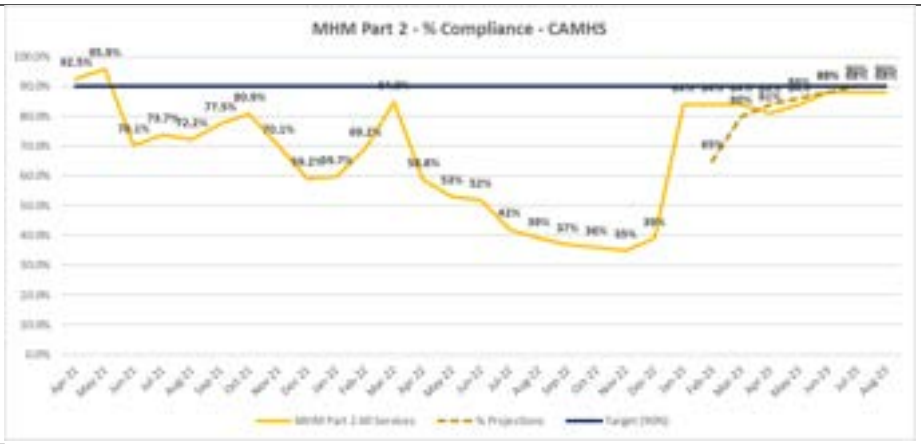
2.2 The Mental Health and Learning Disabilities Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Mental Health and Learning Disabilities Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Mental Health and Learning Disabilities Care Group in relation to the 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.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

ALERT / ESCALATE	• Committee is advised of progress towards a **Single Clinical Record System** (Datix Risk Register ID 3337). The Executive Team and Board have supported the progression toward implementation of WCCIS and an Implementation Board jointly chaired by the Director of Digital and the Deputy Chief Operating Officer is underway. • The **limited availability of CPR and some other face-to-face training** that is outside of the control of the care group is impacting on mandatory and statutory training compliance. • There has been a slight improvement from 37% Band 5 vacancy rates to 32% Band 5 vacancies in the care group, although **Registered Nurse Vacancies** remain a significant challenge and a key area of focus. The RGH Mental Health Unit has 6 wards and it has also had a slight improvement having recruited 2 new registered nurses since the last report to committee. The RGH

	unit has an overall vacancy rate of 41% compared to the previous report to committee which detailed a 47% vacancy rate. A nursing establishment review has recently been completed and its recommendations are currently being considered by the Care Group Senior Leadership Team. • An **anonymous concern** about the Mental Health Unit has been received from a member of staff. A series of confidential conversations have been completed. These conversations highlighted a number of concerns in relation to culture, leadership, estate and staffing levels. The findings have been shared with the Executive Team, trade union colleagues and senior leaders in the care group. A feedback session is planned for staff in the care group on 6th November and the recommendations will be included as part of the In-patient Improvement programme.
ADVISE	• There are a number of estates issues and delays across the Care Group which are impacting on staff and patient safety. There have been increasing failure of the nurse call alarm system at RGH over the last year and while progress to rectify this are underway, mitigating actions are in place including the use of personal alarms being carried by staff on duty. The individual CSGs have developed centralised monitoring systems for estates issues and have intensified their monitoring and relationships with estates colleagues. These issues will be monitored via the Estates, Fire and Health and Safety Group chaired by the Service Director. • The October QSRE received a deep dive and people story into **CAMH Services.** The deep dive highlighted a number of areas of good practice in community services, such as the participation in a child exploitation panel with the local authority in Bridgend as well as the ongoing development of therapy services and service user engagement groups at Ty Llidiard. • The community CAMH service has been focussing its quality improvement on improvement in compliance with **Part 2 of the Mental Health Measure.** Compliance has increased from 35% in November 2022 to 88% in August 2023, further work is needed to get to the desired 90% compliance target.



- It has been identified that current arrangements for **Prevention and management of Violence and Aggression (PMVA) training** do not ensure a sustainable model for regular nor bank staff. Options for sustainable delivery of training programme by "training team" are under development with a proposal paper to be delivered to the next Health and Safety meeting in December 2023.

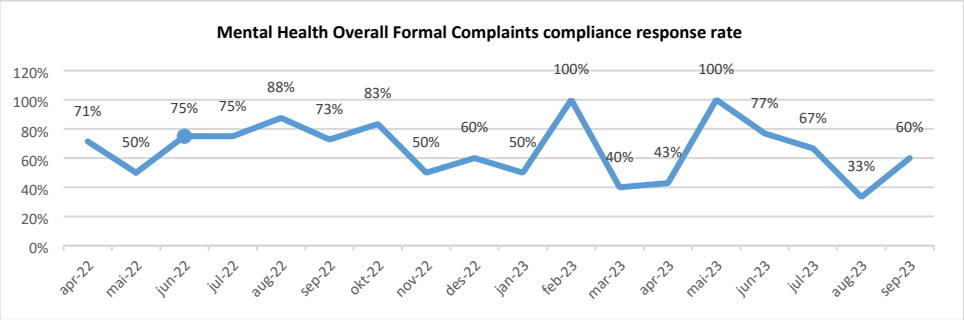
- An externally commissioned safeguarding review into the circumstances around the **Homicide** in Pen y Craig in 2020 was published in May 2023. The Care Group has collaborated with the Local Authority on the multi-agency action plan which is overseen by the CTM Safeguarding Board. The Coroner has re-opened the inquest for the victim and the Health Board is in the process of providing the requested information. This inquest is likely to be heard in late 2024.

- The **111#2** service has moved from project to operational status. A recent peer review has been undertaken alongside the national team and Cardiff and Vale UHB. Very positive initial report particularly in relation to the data being collected.

- Management of a **Smoke Free Environment** and compliance with the smoking legislation from September 2022 remains a challenge in mental health units. A number of challenges include a reported increase in violence and aggression, increased exposure to passive smoking and patient congregation at entrances to mental health units and management of sources of ignition. A benchmarking exercise has been undertaken with other units across Wales and an options appraisal, seeking to balance the legislation alongside the unintended consequences, is being developed for consideration initially by the Care Group Directors and then by the Health Board Health and Safety Group Care Group.

ASSURE

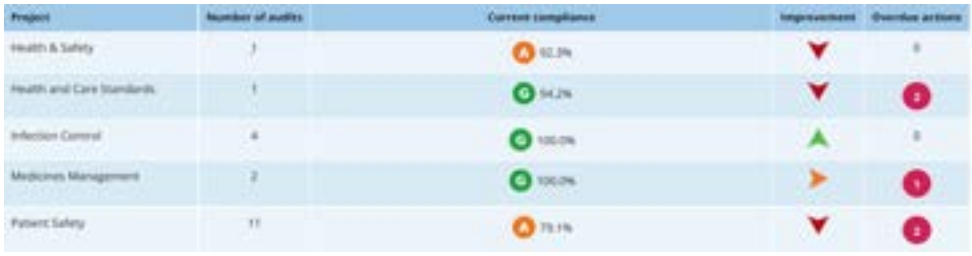
- **Complaint Closure Compliance** is a key priority for the Health Board. Compliance in the MHLD Care Group is 60% in September. The low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.



When reviewed in mid-October when this report was being compiled there were 6 open complaints in MHLD and 1 complex complaint overdue. The care group has sought independent review for the complex complaint and is liaising closely with the complainant.

- There are 7 open **Nationally Reportable Incidents** with 7 of those overdue for completion. These cases are complex, one is being externally reviewed and all are being actively managed.

- The Care Group **Ward Assurance** group have been focussing on the implementation of ward audits on AMaT. Most wards have now received training and are implementing the Health Board core audits where applicable, as well as some specific mental health related audits. The final in-patient rehabilitation service will implement during October and November. The focus will now move to performance monitoring via the care group existing governance arrangements. Compliance with audits in mid October is highlighted below:



INFORM

- There are 4 temporarily **decommissioned beds on Ward 14, POW** due to an infestation and awaiting new flooring. There have been no issues with acuity or demand to date.

	• Two HCSWs have been shortlisted in the Nursing Support Worker category at the RCN Nursing Awards for their work on *Maintaining Standards and Reducing Restrictive Interventions* at Ty Llidiard. They will be attending the awards ceremony in Liverpool in November.
APPENDICES	**NOT APPLICABLE**

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing Well Living Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

5. Recommendation

5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Agenda Item
5.2e

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	23/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma James, Unscheduled Care Nurse Director Alex Brown, Unscheduled care Medical Director & Victoria Healey, Head Of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter	Emma James, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	23/11/2023	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital

POW	Princess of Wales Hospital
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic non touch technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute care of the elderly unit
SALT	Speech & Language Therapy

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 18th October 2023.

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

2. Purpose of this Meeting

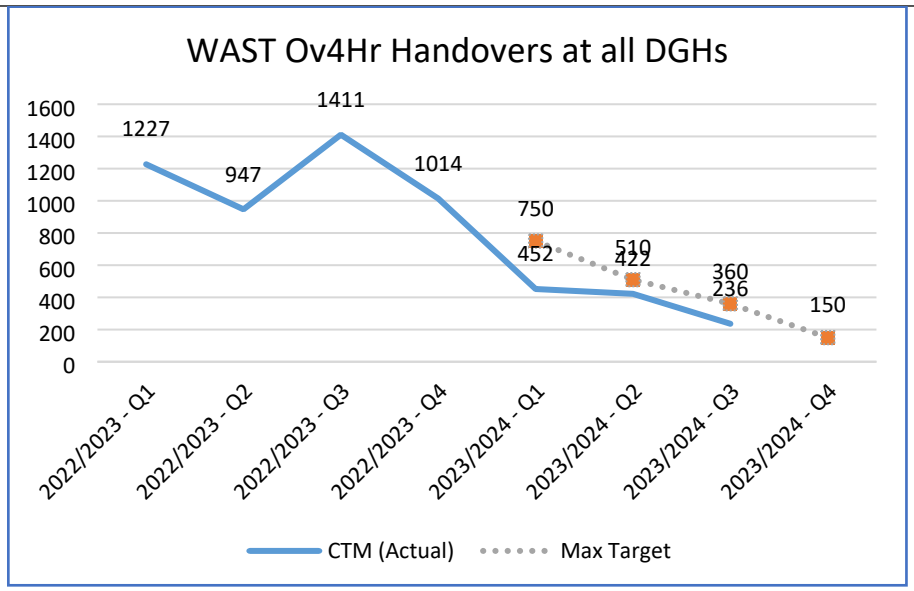
2.1 The purpose of the Quality, Safety, Risk and Experience meeting is to provide assurance to the Care Group and the Health Board's Quality & Safety (Q&S) Committee on the provision of safe and high quality patient care and experience to the population we serve.

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

3. Highlight Report

Alert / Escalate	The Quality, Safety and Patient Experience (QSPE) meeting received an update on a Coroner's Inquest held in September 2023 and sought assurance on the learning and improvement action being taken to mitigate the risk of any similar incidents occurring in future. The learning from the case has led to an urgent review of the catering model within CTM, with the first meeting held in September 2023. A training programme will be developed alongside the revised catering model for the Multi-Disciplinary Team (MDT) - including SALT and Dietetics. An audit tool will also be developed to provide assurances on compliance with the catering model. This will be added to AMaT and Head of Nursing to report in Unscheduled Care (USC) group Assurance meeting.

Advise	Complaints have been transferred to a central quality governance team within the organisation. This will ensure we maintain equity, consistency and strengthen resilience. USC compliance with the 30 day target has increased from 65% in August to 92% in September 2023. Currently there are 32 open complaints and 13 over the 30 day compliance. This is a huge improvement to February 2023 where there were 93 open complaints and 51 over the 30 day compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This has been closely monitored by the USC Senior Leadership Team which has resulted in a significant improvement. An Escalation Procedure is currently in draft with the aim to provide an operational approach to the effective management of capacity and escalation across all areas within CTM. The document will set out the standard triggers and expected response from individuals through to Care Group triumvirates. Where local variances are identified, these will be detailed in the appendices and also held by the individual site management/ bed management teams. The procedures will be designed to enhance the effectiveness of patient flow and maintain patient safety through the implementation of local actions that support best practice through proactive management of increased emergency pressures. All Health Boards across Wales are committed to making improvements in ambulance handover to improve the experience for our patients waiting to transfer into our ED departments and also responsiveness to patients in our communities. In support of this, CTMUHB are moving towards a zero tolerance approach to ambulance handover delays over 4 hours across RGH, POW and PCH. The Unscheduled Care Group leadership team will be spending additional time throughout the early stages of implementation on each site to identify any learning opportunities and obtain feedback from staff across the EDs, patient flow teams, inpatient wards and the wider unscheduled care system within each site. To ensure this support can be appropriately targeted, the implementation of the zero tolerance to ambulance handovers more than 4 hours has been phased in to focus on one acute site at a time. This is now in place across all 3 acute site with The Prince Charles Hospital launched on 4th September 2023. There has been significant improvement during Q1and Q2:



There remains a focus to continue to reduce ambulance handovers on all of the acute sites.

AMaT

Audit Management and Tracking System (AMaT) is an innovative system designed to make auditing easier, faster, and more effective. AMaT is a user-friendly system created with NHS clinical audit teams, it is designed to give users more control over audit activity and can provide real-time insight and reporting for clinicians, wards, audit departments and organisations. AMaT allows clinical teams to register audits, associate related guidance, complete audits online, manage action plans and the scheduling of audits and audit meetings. A high- level report has been produced which gives an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. Attached as appendix 1 is the compliance for all areas within the USC care group to highlight areas which require improvement.

Housekeeping by night across all three Emergency Department sites, is causing concern at present. This has been escalated via the IPC committee and staff have been requested to submit an individual datix report when nursing staff are required to clean areas within the department. This has been previously raised by HIW during inspections within these departments. The Care Group Nurse Director will engage with facilities senior managers to understand current and more substantive options going forward.

Assure	Following the publication of the HIW National Review of Patient Flow a journey through the stroke pathway, an Improvement

Plan was submitted to HIW on 6th October 2023, following approval by the Executive Director lead for stroke services.

The Senior Management Team for USC have undertaken a review of the historical action plan aligned to the stroke strategy group where many of these actions have been closed. Membership and terms of reference have also been reviewed with the Director of therapies and this will be discussed during the next stroke operation group. USC care group are engaging with the stroke regional programme, exploring alternative models of acute stroke care between Cardiff & Vale and CTM. Behind this there is significant modelling work which will feed into review of the whole stroke pathway and Directorate teams exploring feasibility of developing further stroke ANP roles.

Nursing workforce

A joint collaboration with the planned care group has been initiated to review the nursing workforce. Ensuring that the right nurses are in the correct setting and have the correct skills. Statutory and mandatory training is being monitored, allowing a trend analysis and providing a targeted improvement.

RADAR information

Sepsis compliance for Emergency departments is currently 64.5% and NEWS compliance is currently 86%, key areas for improvement

- 12 hr observations as a minimum (some 13-14 hrs)
- Accurate scoring
- Observation as per score or clinical concern
- Alert, Confusion, Voice, Pain, Unresponsive (ACVPU)
- Recording of oxygen

Sepsis champions are now within ED, who undertake regular refresher sessions on the shop floor with staff. All staff have attended or are booked to attend the Acutely Unwell Study Day which is run by the outreach team.

Ward accreditation programme is being implemented in CTM to demonstrate our commitment to provide quality care to our patients against measured standards. This will include patient safety, satisfaction and the well-being of our employees. A pilot phase is scheduled to begin in November 2023 at PCH. Initially, it will focus on three inpatient adult wards which will include acute areas to test and refine the accreditation process. The pilot phase is vital in assessing the program's effectiveness and identifying areas for improvement before expanding to other areas, thereby ensuring a comprehensive and successful integration.

Inform	HIW completed an unannounced inspection on 31st July 2023 at the Emergency department and the Clinical Decisions unit (CDU) at Prince Charles Hospital. Official feedback was received on 19th October 2023, the feedback HIW received from patients and their carers indicated they were generally satisfied with their care and treatment, and the approach of the staff. Challenges with maintaining patient flow through the hospital and the wider health and care system meant patients were waiting in the Emergency Unit (EU) for longer periods than they should expect. They found staff working extremely hard to provide patients with safe and effective care at a time when the hospital was at a heightened level of escalation due to service pressures. A management structure was in place and clear lines of reporting and accountability within the EU and CDU were described and demonstrated. A detailed action plan has been developed in response to the feedback received, immediate concerns during the inspection were addressed and work is ongoing to complete the recommendations in the agreed timeframes. Patient journey signage has been created within the ED at RGH waiting room to support patient understanding of ED attendance and process. There is work ongoing to roll out this signage within the other 2 ED sites.
Appendices	Not applicable.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals	A Healthier Wales
	If more than one applies please list below:

150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Safe Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Choose an item.
	If more than one applies please list below:

5. Recommendation

5.1 The Quality & Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

AREA	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
PCH Cardiac Day Case Unit	99%	98%	99%	98%	100%	99%
PCH Clinical Decision Unit	93%	95%	94%	92%	96%	91%
PCH Emergency Department	68%	58%	82%	77%	95%	50%
PCH ITU	94%	84%	80%	94%	83%	98%
PCH Medical Day Unit	100%	62%		75%	71%	79%
PCH Outpatients Department - Main		94%	100%	97%	95%	99%
PCH Ward 01 CCU	98%	97%	86%	98%	98%	99%
PCH Ward 02	98%	99%	99%	98%	98%	100%
PCH Ward 03 (formerly ward 7)	75%	94%	97%	96%	97%	95%
PCH Ward 09	95%	96%	96%	95%	73%	91%
PCH Ward 10	99%	96%	99%	96%	98%	100%
PCH Ward 11	99%	99%	97%	98%	100%	99%
PCH Ward 12	89%	93%	91%	90%	95%	96%
PWH Acute Medical Unit	86%	89%	95%	94%	84%	87%
PWH Emergency Department	89%	77%	71%	75%	97%	91%
PWH ITU	95%	96%	97%	86%	97%	98%
PWH Outpatient Department	94%	95%	96%	96%	99%	98%
PWH Outpatients - Ophthalmology	96%	100%	90%	84%	94%	94%
PWH Outpatients ENT			64%			
PWH Ward 04	91%	85%	86%	93%	98%	91%
PWH Ward 05	93%	87%	96%	93%	96%	95%
PWH Ward 06	96%	97%	41%	95%	90%	89%
PWH Ward 10	74%	95%	99%	97%	96%	95%
PWH Ward 15	92%	80%	92%	79%	78%	76%
PWH Ward 18	93%	96%	77%	95%	99%	99%
PWH Ward 19	67%	48%	76%	95%	63%	95%

PWH Ward 20	92%	88%	89%	86%	94%	91%
RGH Emergency Department	42%	28%	50%	84%	79%	41%
RGH ITU/HDU	77%	77%	75%	78%	86%	86%
RGH Outpatients - Ophthalmology						
RGH Ward 01 AMU / SAU	94%	39%	85%	30%	78%	
RGH Ward 04 AMU	93%	95%	82%	95%	94%	83%
RGH Ward 05	95%	98%	96%	97%	96%	95%
RGH Ward 06	82%	83%	95%	84%	72%	92%
RGH Ward 12	94%	98%	93%	94%	97%	83%
RGH Ward 14	96%	92%	94%	93%	94%	94%
RGH Ward 19	97%	99%	95%	96%	96%	97%
RGH Ward 20	96%	98%	97%	94%	98%	95%

Agenda Item
6.1

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	October / November 2023	RISKS REVIEWED
Operational Management Board	1st November 2023	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	13th November 2023	MANAGEMENT SIGN OFF RECEIVED

Acronyms / Glossary of Terms	

1. SITUATION/BACKGROUND

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

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

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

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

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **525** members of staff trained to date (Since January 2022). Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID – 5590 - Radiopharmaceutical Business Interruption. New risk escalated November 2023 with a risk score of 20.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Care Group - Unscheduled Care

- Datix ID 3826 - Emergency Department (ED) Overcrowding. With the recent onset of winter pressures the risk rating has been increased from a 16 to a 20, with the likelihood score changing from a 4 to a 5.

- Datix ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). This risk was

re-escalated to the Organisational Risk Register in November 2023 as risk reviewed and score increased from a 12 to a 20.

b) Risks where the risk rating DECREASED during the period

Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID 5304 - The Air Handling Unit (AHU) for the pharmacy aseptic production suite, risk relating to the need for repairs and upgrades has been reduced in terms of scoring this period. Following an independent review of the AHU in July 2023, recommended repairs / upgrades were actioned in October 2023. In light of this mitigation the risk likelihood score has now reduced from a 4 to a 3. This risk is now scoring as a 12 (from 16) and has been de-escalated from the organisational risk register.

Central Function – Corporate Governance

- Datix Risk ID 4922 - Covid-19 Inquiry Preparedness (Information Management), in light of progress in relation to the appointment of a Covid-19 Information Manager and the development of a system for creating a Health Board timeline and archive repository, the risk score has been reduced in terms of likelihood from a 5 to a 4 and therefore the risk has reduced to score of 16 from 20.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Care Group – Diagnostics, Therapies, Pharmacy and Specialties (DTPS)

- Datix Risk ID 5036 - Pathology services unable to meet current workload demands. This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.

- Datix Risk ID 5364 - Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage, risk review undertaken with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new

risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register.

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

Consequence						
	5			4253 3337 4768 3993 4887 4080	5276	
	4				4906 4753 3131 5477 4908 5462 5404 4152 3133 4752 4922 5254 4798 4907	4491 4071 4103 4841 2713 3826 1133 5590
	3					3638 4691 4732 4928 4650 4691 2808 4732
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 Matters to Note

- The Assistant Director of Transformation is currently developing a new risk for escalation relating to the Community Brain Injury Service in Bridgend. It is anticipated that this risk will be escalated to the January 2024 iteration of the Organisational Risk Register.

- In response to discussions at the Population Health and Partnerships Committee on the 7th November 2023, the Interim Executive Director of Public Health is developing a new risk in relation to vaccination uptake.

4. IMPACT ASSESSMENT

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
	A Resilient Wales

Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the Organisational Risk Register.
Cyfreithiol / Legal	Yes (Include further detail below)	
	See detail for each risk	
Enw da / Reputational	Yes (Include further detail below)	
	See detail for each risk	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial*	Yes (Include further detail below)	
	See detail for each risk.	

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

6.1 The Organisational Risk Register will be submitted to the relevant Board and Committees.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Discuss with Radiologists other scan options.	Quality & Safety Committee	20	C4xL5	4 C4xL1	New risk escalated November 2023	23.10.2023	06.11.2023	31.12.2023
3	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	IF there is consistent backlog of Radiology reports THEN there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes RESULTING IN deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Review allocation of reporting and productivity. All further mitigations would require financial resource. WLIs options being considered. Mitigating actions have been discussed through Operational Management Board, Planned care recovery Operational group and have discussed some further options with the Assistant Director of Transformation, Strategic and Operational Planning, Executive Director of Strategy and Transformation and the Chief Operating Officer. Risk score increased and therefore this risk has now been escalated to the Organisational Risk Register due to the current increase in reports outstanding, particularly for MR, USC and concerns raised from internal colleagues and patients. The score is now 20 based on risk being held within the service. Risk reviewed November 2023 - no change to risk score.	Quality & Safety Committee Planning Performance & Finance Committee	20	C4xL5	4 C4xL1	↔	08.02.2017	03.11.2023	11.12.2023
5	5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update November 2023. This risk has been discussed at LDP 19.10.2023, the outcome of the discussion was to keep this risk on the organisational risk register for now. There is a LIMS Programme Board meeting scheduled end of November where the overall RAG rating for the program may be reduced to amber/green. Providing the RAG status is downgraded, we would then look to de-escalate this risk in preparation for the Jan 24 risk submission deadline.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	19.10.2023	01.12.2023
8	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Boards ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focussing on its outcome matrices to ensure it captures investment return effectively. Update November 2023 - due to ongoing pressures risk reviewed and score and mitigation remains unchanged. The following updates are however noted in terms of the Six Goals Plan: 1. Capital work underway in Prince Charles Hospital for Same Day Emergency Care (SDEC) unit completion January 2024. 2. Acute frailty established in Princess of Wales Hospital and Royal Glamorgan Hospital, recruitment completed for service in Prince Charles Hospital awaiting start dates 3. Navigation hub screening calls from nursing homes and pulling proactively from WAST stac (Ambulance demand). Next review 30.11.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	31.10.2023	30.11.2023
9	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update November 2023 - Risk now sits with Planned Care and substantive Director in post. Mitigation work continues, with an increase in straight to test and streamlining of pathways, leading to a small reduction in numbers waiting, a slight improvement in performance	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	03.11.2023	15.12.2023
10	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Update November 2023 - No changes made to scoring or mitigation.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	06.11.2023	30.11.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
11	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	November update new governance arrangements will provide a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • First Board meeting held and monthly meetings to follow from September onwards. • Operational Group being established with first meeting in September with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues. • USC group engaging with stroke regional programme, exploring alternative models of acute stroke care between Cardiff & Vale and CTM. Behind this there is significant modelling work which will feed into review of the whole stroke pathway. • Directorate teams exploring feasibility of developing further stroke ANP roles. • CTM have undertaken a review of the historical action plan aligned to the stroke strategy group where many of these actions have been closed. Membership and terms of reference have also been reviewed with the Director of Therapies and this will be discussed during the next stroke operation group. Risk Remains 20, C4 C5 Review date 31/12/2023. - Pan CTM ESD Service - Staff are coming into post and being inducted and pathways being written, and engagement with key stakeholders. The service will start taking patients when all staff in post.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	02.11.2023	31.12.2023
12	5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	If there is insufficient capacity within the adult weight management service to meet the demand Then patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. Resulting in missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update November 2023 - risk reviewed and risk updates with progress - no change to score 20/10/23 - AWMS Monitor Capacity and Demand Monthly and Review with DHoS. Progressing and first group delivery due to be held. Waiting list continues to increase. Working with Digital Team to identify solution for self referral which will support prudent use of resources and validation for waiting lists to support better C and D management. Timeframe: 11.12.2023 Review NICE Technical Guidance and complete SBAR to consider impact for CTM UHB if applied. Timeframe: 11.12.2023 Review AWMS pathways - 24.10.23 - group now in pilot stage. Evaluation agreed with Research team. Evaluation will take up to 18 months and so local evaluation also planned after first few groups. Next action update to include ongoing plan for groups and likely impact on capacity. Timeframe 09.01.2024.	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	24.10.2023	31.12.2023
14	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director – Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	November update: Unscheduled Care Senior Management Team reviewed risk and met with Emergency Department (ED) leadership teams across CTM, in response to concerns raised including overcrowding. While many of the causes of overcrowding relate to the whole of the acute site, there are actions within ED to help manage risk. The ED teams have for example been asked to develop a protocol for management of an ambulatory stream. This remains an ongoing risk for all three sites and will be reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With the recent onset of winter pressures, risk rating to be increased to 20. C4, likelihood 5. New review date 31/12/2023.	Quality & Safety Committee Planning & Performance Committee	20 ↑ 16	C4xL5	12 (C4xL3)	↑ Risk increased from a 16 to a 20 in November 2023	24.09.2019	02.11.2023	31.12.2023
15	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update November 2023 - risk re-escalated to the Organisational Risk Register in November 2023. November 2023 update: Senior Management Team risk reviewed, nurse establishment review continues in RGH Emergency Department, to support additional capacity within the department. Submitted a full winter pressure plan, decision awaited by the Executive Leadership Group. Risk rating increased C4 & L5, therefore risk now 20. Review date 31/12/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	20	C4xL5	8 (C4xL2)	↑ Risk re-escalated to the Organisational Risk Register in November 2023	20.02.2014	02.11.2023	31.12.2023
18	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2023 Risk Score remains the same. Backlog remains for redress cases: Team Lead triaging backlog of cases, to ensure that cases are prioritised appropriately. Duty of Candour continues to be an area of increased activity. New 'Invest to Save' bid is in final stage of development, prior to submission.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023
21	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	If: The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers Then: the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. Resulting in: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update October 2023 All Claims Investigations Officers have returned to full compliment. Reconciliation of inquest data is currently being undertaken. A Learning Event was undertaken between CTM Legal Services staff and NHS Wales Shared Services Legal & Risk team. The aim of the event was to improve communication and management of legal cases. A meeting has also taken place between senior members of CTM Legal Services and HM Coroner's Office to discuss ways improvements in management of inquest cases. To improve communication, regular meetings between the CTM Legal Services team and Coroners' officer team have been reinstated.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023
22	4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update November 2023 - the system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information. However, in light of progress the risk score has been reduced in terms of likelihood from a 5 to a 4.	Quality & Safety Committee	16 ↓ 20	C4xL4	8 (C4xL2)	Risk score decreased from a 20 to a 16 in November 2023	23.11.2021	18.10.2023	31.12.2023
23	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	IF: the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. THEN: There will be delays in performing and reporting autopsies. RESULTING IN: * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update November 2023 Draft escalation plan currently being approved by FT - this will provide guidance on communication and escalation at various levels of occupancy. This will provide support for escalation throughout the winter months. Awaiting feedback form Paper submitted outlining challenges in PM service/after death service flows. Meeting Coroner weekly to assess situation. Further Winter/Christmas Planning meeting with MES scheduled for end November. Additional staffing requirements to manage winter pressures submitted. Awaiting feedback from Paper submitted outlining challenges in PM service/ after death service flows. Next review 30.11.2023.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	27.10.2023	30.11.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
24	4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	**If** the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), **Then:** the critical service will be unable to meet the need of patients requiring therapy, **Resulting in:** significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	November 2023: The funding released in June 2023 has enabled Speech and Language Therapy (SLT) staffing to be recruited to across all sites, with the Princess of Wales SLT role taking up their post in late October, and the Prince Charles Hospital and Royal Glamorgan Hospital post holders due to commence in November and December. Gaps in funding other Allied Health Professionals (AHPs) remain. The AHP workforce required to address these gaps has been captured within the Critical Care reconfiguration board business case (AHP workforce features as appendix 5 of the business case).	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	16.10.2023	27.12.2023
25	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update November 2023 - Draft escalation plan currently being approved by FT - this will provide guidance on communication and escalation at various levels of occupancy. This will provide support for escalation throughout the winter months. Awaiting feedback form paper submitted outlining challenges in PM service/after death service flows. Next review 30.11.2023	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	27.10.2023	30.11.2023
26	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update October 2023 The OCP has not been fully implemented. The Legal Services team are prioritising other areas of work which have risk of penalties i.e. LFERs and Inquests New invest to save bid has been prepared and due to be submitted.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	07.11.2023	31.12.2023
29	3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update October 2023: Progress made with e-learning ESR package for med gas training to be available via an All Wales agreement, however until attendance/compliance increases significantly, the risk cannot be reduced. Was also raised at MDG Group in September 2023, training compliance provided to Nursing for appropriate circulation. Review again in 3 months(CM/WG 02/10/2023)	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	06.10.2023	29.12.2023
30	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update November 2023: Continued monitoring of waiting lists. Review of demand. Radiology workforce planning.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	3.11.2023	11.12.2023
33	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update October 2023: Risk Score remains unchanged. LFER status is regularly monitored in: - Weekly Patient Safety, Complaints and Legal Services data meeting, - Weekly Executive Patient Safety Meeting and Quality & Safety Committee. Weekly meeting to review and monitor all deferred LFERs has been set up and will continue. Members of Quality & Safety team and Legal Services attend this meeting. This meeting has provided support to Care Groups in relation to evidence required for LFERs. This has provided an increase in number of deferred LFERs the Health Board has submitted and approved by the WRP. This process will continue for deferred LFERs. In addition to the Weekly review meetings, noted above, LFER Scrutiny Panels will take place monthly from December 2023, to ensure evidence submitted meets the appropriate standard required to demonstrate learning and provide assurance to the WRP Learning Advisory Panel.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	06.11.2023	31.12.2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
36	4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	November Update: Senior Management Team reviewed, following clarity of ask from executive team. USC will hold responsibility for Consultant orthogeriatrician to be working with the wider COTE team on each site. Funding to be released to create these posts, from T&O budgets. Nursing/junior medical work force to remain responsibility for planned care group. Risk rating to remain unchanged this period, however, will be reviewed once funding released and solutions implemented.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	7.11.2023	31.12.2023
37	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs ·Improving induction and development of new doctors	Update August 2023: Medical Workforce Productivity Programme is fully established. Within this programme are a range of initiatives which are interrelated and mitigate each associated risk one part at a time. Within the initiatives/workstreams, financial aspects are fully considered. Collaborative discussions have been ongoing for CTMUHB to align rates with Aneurin Bevan UHB's rate card. This has been discussed at Executive level and financial controls have been considered. An updated paper is due to be received at Executive Leadership Group in September for formal approval. Update November 2023 - the Health Boards Non Consultant Rate Card is now active. Medical Workforce Productivity Programme continues as detailed in the August update above and at this point risk score remains unchanged. Risk score will be reviewed in January 2024.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	31.10.2023	31.01.2024
38	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023 Update November 2023: Consideration required for further investment in the service - Timeframe 31.3.2024 NDIP Award for funding until 31.3.2025: - B5 Psychology Assistant recruitment - Timeframe for action 31.3.2024. - Speech and Language Therapy post recruitment - Timeframe for action 31.3.2024. - NDIP funding provided 0.8 wte nurse until 31/03/2024 - Timeframe for action 31.3.2024.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	03.10.2023	01.03.2024
39	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023. Update September 2023 - Project board established and at the July meeting discussed all options for earliest decant from POW theatres, including some that have not previously been considered. Full options appraisal is under development for presentation at a future meeting. Review end of October. Update November 2023 - October Programme Board agreed a preferred option, this option requires significantly less capital. The option has been presented to Welsh Government Capital Team, however, there are revenue elements to the option which require further exploration with Welsh Government.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	31.10.2023	31.01.2024
42	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update November 2023: WCCIS Programme Board held on the 7th November and further discussion and exploration required in terms of implementation for MHLD Care Group. Further update to be provided in January.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	7.11.2023	31.12.2023
43	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. SON completed to support strategic and systematic review of inpatient development opportunities. 3. Develop a strategic outline business case following no.2 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Update September 2023 - Statement of Need (SON) completed to support strategic and systematic review of inpatient development opportunities. Develop a strategic outline business case following SON completion. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Review 31.10.2023. Update November 2023 - linked to September update. Feedback is awaited from Planning Colleagues and therefore risk remains unchanged with a review date extended until 30.11.2023.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	30.10.2023	30.11.2023

Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Rating (Target)	De-escalation Rationale
5304	Chief Operating Officer	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	An independent assessment of the unit took place end of July 2023. The review in July recommended repairs / upgrades which have been actioned in October 2023. The risk likelihood score has now reduced.	Quality & Safety Committee	12 Reduced from a 16 in November 2023	4 (C4xL1)	Likelihood score reduced from a 4 to a 3 in November 2023, in light of the repair works that have been completed in October 2023. Risk now de-escalated from Organisational Risk Register and will be monitored via medicines management which is part of the DTPS Care Group.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	5036 Link to RTE 5155	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Update November 2023 This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.	Quality & Safety Committee	Nov-23	Update November 2023 This risk has been discussed internally and DTPS Care Group have reduced the risk score to reflect current Pathology service provision. DTPS Care Group have taken the decision to close this overarching Pathology risk as department specific risks and mitigations are recorded on the Pathology risk register to capture any remaining resource and capacity issues. Where high risk is identified the risk will be escalated accordingly. Current consideration on the escalation of risk 5115 and 3567 risks in relation to cell Path is underway and these risks will be escalated if required.
3	5364	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required.	Update November 2023 - Risk owner undertook a review with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	Nov-23	Update November 2023 - Risk owner undertook a review with the support of the Head of Safeguarding and considered that this risk had been scored too highly and required updating in terms of the risk assessment and mitigating action. This risk (5364) was closed and a new risk opened (Datix Risk ID 5528 - Merthyr Cynon band 6 SCPHN's shortage) which has been scored as a 12. Due to the closure of risk 5364 and the level of risk score now applied to the new risk this no longer requires escalation to the Organisational Risk Register. New risk 5528 will be monitored via the Children & Families Care Group.

Agenda Item
6.2

Quality & Safety Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT SEPTEMBER-OCTOBER 2023

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Allison Thomas Business Manager Patient Care & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking

1. Situation /Background

1.1 The purpose of this report is to present an update to the Quality & Safety Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker following acceptance of the submitted improvement plan(s) to HIW following their Inspection(s) across the organisation for the timeframe September to end October 2023.

1.2 Oversight and continuous review for assurance is reported to the Care Groups Quality, Patient Safety and Experience Committee(s)

1.3 The manual process of updating and monitoring the HIW tracker will be utilised until all open and live HIW inspection improvement plans are recorded on AMaT and the role of providing assurance and compliance for recording and reporting purposes has been transitioned from the Patient Care & Safety team to the Assurance and Compliance team allowing for a systematic and robust process for continuous monitoring of all the HIW inspection improvement plans and activity.

2. Specific Matters for Consideration

2.1 Each iteration of the HIW tracker evolves as actions are completed or the date surpasses as well as following the submission and acceptance by HIW of new inspection improvement plans. Therefore, members will note changes and progress on the actions which remain as open as these turn to closed/completed actions throughout this and future reports.

2.2 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can be kept live and up to date ensuring all actions are completed in a timely manner. Where actions are reported as complete/closed the Care Groups are responsible for ensuring the supporting evidence is available to support the closure and completeness of such actions. Everyday practice where practicably possible.

2.3 A breakdown of the position with regards to all actions as of the end of October is detailed below.

A total of 445 actions are reported with a further breakdown of the stages towards compliance reported in table 1 below.

Out of these the following breakdown is reported as at November 2023

- 17 reported as Red with the actions being those which are incomplete and have passed the agreed due date
- 20 reported as Amber – actions partially complete/ongoing to meet deadline date
- 78 reported as Yellow on target to meet original or revised completion date
- 254 reported as Green - Completed actions
- 76 have no update or are new to the tracker

A high number of actions are assigned to Mental Health improvement plans with progress on these reported separately however, members are asked to note that there is a significant amount of work ongoing by the Care Groups in order to complete all actions. Mental Health improvement plan(s) are overseen by the Improvement Board, with their next meeting scheduled for 21st November 2023 where a number of actions will be approved.

2.3 **Current Position**

Improvement Plan(s) added to the tracker during this reporting period include:

- Ty Llidiard following the inspection which took place on 12 and 13 September 2023 report due to be published 14 December 2023

- National review of Patient Flow- a journey through the Stroke pathway

Good progress has been made in all areas of the improvement plans with the actions outstanding and those ongoing.

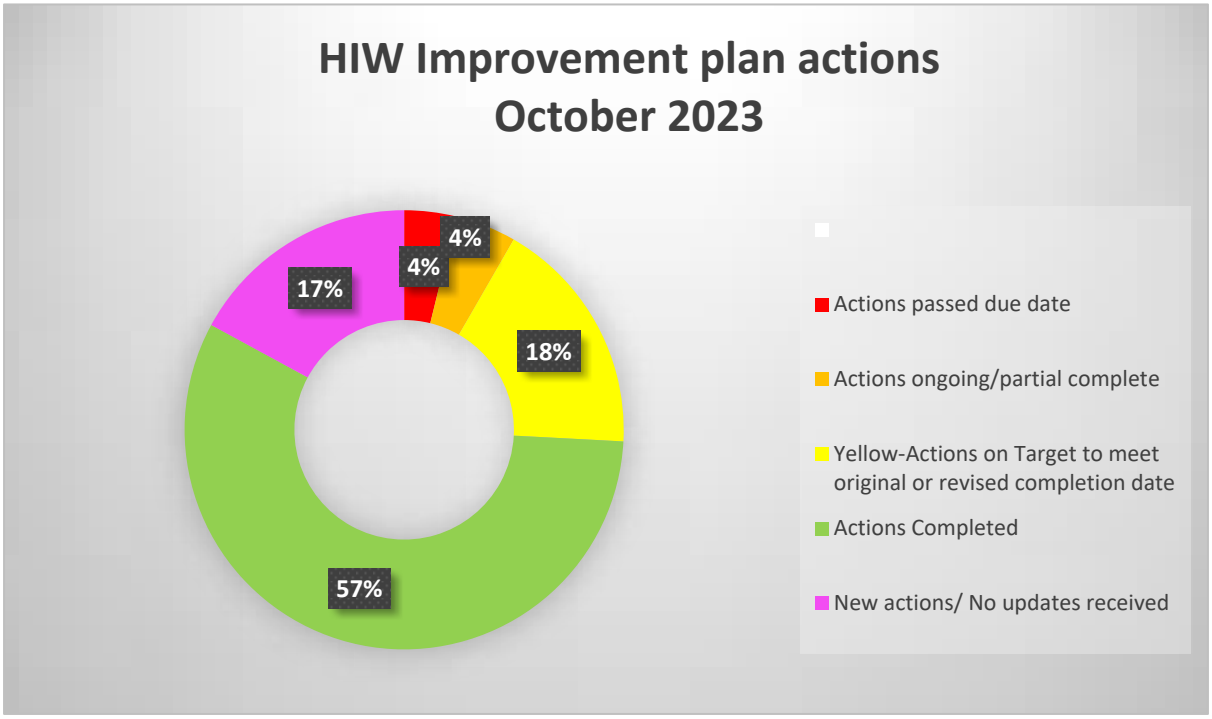
Improvement Plans fully completed/closed during this reporting period

- Angelton Clinic-Glanrhyd Hospital
- Prince Charles Hospital Emergency Department-January 2022

Healthcare Inspectorate Wales request regular three-monthly updates on all improvement plans where ongoing or outstanding actions remain following the initial submission of the improvement plan, these are updated by the responsible Care Group and submitted to HIW following Executive Director review and sign off.

Table 1

Actions by Status-end October 2023					
Total Number of Actions	**Actions passed due date**	**Actions ongoing/partial complete**	**Yellow-Actions on Target to meet original or revised completion date**	**Actions Completed**	**New actions/ No updates received**
445	17	20	78	254	76



3. Key Risks / Matters for Escalation

3.1 As outlined above, the HIW actions tracker will continue to be updated with a targeted focus on actions where the action agreed due by date has passed or no update has been recevied.

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

3.3 HIW Inspection activity work will be transitioning across to the Assurance and Compliance team following agreement of a new and

revised reporting process which is to be proposed to the Audit & Risk committee in December 2023.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies please list below: Efficient, Equitable, Safe, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position update report. If service change arises the specific areas and activity

		impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE** the contents of this report and the activity underway to progress the actions outstanding and ongoing within the improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 Joint work continues to ensure a smooth and robust transition across to the Assurance and Compliance team who will manage the compliance of HIW Inspections.

Agenda Item
6.3

Quality & Safety Committee

Mental Capacity Act

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire O'Keefe – Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter	Claire O'Keefe – Head of Safeguarding
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
MCA	Mental Capacity Act
DoLS	Deprivation of Liberty Safeguards
LPS	Liberty Protection Safeguards

1. Situation /Background

1.1 The Mental Capacity Act (MCA) 2005 is an Act of the Parliament of the United Kingdom applying to England and Wales aged 16 years old and over. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make specific decisions for themselves. It is fundamental to protect and empower our service users who may lack mental Capacity to make their own decisions about their care and treatment and future care decisions.

1.2 The Mental Capacity (Amendment) Act 2019 and the proposed implementation of the Liberty protection safeguards (LPS) led to Welsh Government (WG) providing Health Boards and Local Authorities with funding to allow them to make provisions to ensure their compliance with the amendment Act.

The UK Government on 4th April 2023 advised that they had "taken the difficult decision to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament." Subsequently recommending that all Supervisory Bodies consider how best to strengthen their resources to better meet the needs of those deprived of their liberty.

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

- to address the DoLS backlog;

- to deliver Mental Capacity Act training;

- to improve monitoring and reporting on DoLS, including the collection and quality of DoLS data and supporting systems and processes;

- to embed the principles of the Mental Capacity Act across care, support and treatment planning;

- and to take forward any other work necessary to improve the application of DoLS as we await a future UK Government decision to implement the LPS

2. Specific Matters for Consideration

2.1 The appointment of a MCA Practice facilitator and MCA Practitioner has facilitated a dedicated resource to develop, deliver and oversee MCA training. Mental Capacity Act training is vital in ensuring staff are working within the framework and are compliant with legislation.

2.2 Mandatory MCA training has been updated at level 1, 2 and 3 and has been in place since the 1st of September 2023. Levels 1 and 2 are online learning,

level 3 is face to face. The training aims to ensure that CTMUHB staff are sufficiently trained and competent. To ensure that CTMUHB is compliant and fulfil statutory duties under the Mental Capacity Act (MCA, 2005).

This training also aims to increase staff understanding of the MCA, embed the core principles of the MCA in daily practice, and ensure legislative compliance with mental capacity assessments, understanding of best interest decisions, lasting Powers of Attorney, advocacy service and Deprivation of Liberty Safeguards (DoLS).

2.3 The MCA team have developed a new Mental Capacity Assessment form, this is to ensure compliance with legislation and recent changes. The team are looking to further develop an electronic version of mental capacity assessment form, this version would assist staff with prompts and tips whilst the form is completed. The team are working collaboratively with the Head of Legal and Risk and other health boards in Wales to drive improvements.

2.4 The MCA team has updated and improved information and resources available to staff through a newly developed intranet page. This has ensured that information is accessible to all staff groups.

2.5 Patient and family leaflets have been designed, printed and distributed across sites. Additionally, banner pens and posters have been distributed across sites to highlight the basic principles of MCA.

2.6 The implementation of a dedicated MCA team provides staff in all clinical areas to access support with the management of complex MCA issues and assists in embedding MCA into everyday practice. Support includes, assisting with MCA assessments, best interest decisions and court of protection queries.

3. Key Risks / Matters for Escalation

3.1 In preparation for the implementation of the training packages and to ensure ESR reflects compliance with MCA mandatory training, compliance was reset. Current compliance for all three levels currently sits at 28.1%. The team are working to update ESR with those already compliant prior to the changes.

6136 staff have been identified as requiring level 3 face to face training. 789 have been trained thus far. Bespoke training has been delivered where possible to meet the needs of departments, this has included students, Community Psychiatric Nurses and GP cluster groups in Bridgend.

3.2 The small team are currently funded by Welsh Government, whilst this is recurrent funding from Welsh Government, it is not clear how long this funding will be made available to CTMUHB.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A More Equal Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The roles of the MCA team ensure that through effective processes and pathways equitable care is provided to those who lack capacity. They also ensure through the implementation of the	If no, please include rationale below:

	MCA principles care is timely and person centred.	
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: There are many factors that can affect a patient's mental capacity, this includes age and disability. The work of the MCA team aims to remove barriers for those disproportionately affected.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	CTMUHB have a statutory obligation to adhere to the Mental Capacity Act (2005) and Mental Capacity (amendment) Act (2019).	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Funding for this team currently relies on recurrent Welsh Government funding.	

5. Recommendation

5.1 Quality and Safety Committee members are asked to **NOTE** this report.

6. Next Steps

6.1 MCA training compliance will be monitored through the Safeguarding Executive Group on a quarterly basis.

6.2 A further bid has been made to Welsh Government to extend the MCA team to include an additional Mental Capacity Practitioner.

6.3 The team will continue to work collaboratively with other groups in Wales to ensure good practice is shared and CTMUHB are able to contribute to the development of resources that support practitioners in the implementation of the Mental Capacity Act in practice.

Agenda Item
6.4

Quality & Safety Committee

Highlight Report from the Health, Safety & Fire Sub Committee

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Nicola Milligan, Independent Member/Chair of the Health Safety & Fire Sub Committee
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Hywel Daniel, Executive Director for People

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Introduction

1.1 This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Health, Safety & Fire Sub Committee at its meeting on 9 November 2023.

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

2. Purpose of this Meeting

2.1 The purpose of this Sub-Committee is to:

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

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

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

Highlight Report

Alert / Escalate	• **The Assistant Director of Health, Safety & Fire Report** was received. Members expressed concerns in relation to the Boarding of patients in inappropriate areas, particularly at Royal Glamorgan Hospital, and Members agreed that consideration needed to be given to the potential harm to patients in relation to the types of areas patients were being boarded in. A discussion was also held in relation to the need to risk assess the types of patients being boarded and risk assess against the need to offload patients waiting in ambulances.
Advise	• A report on **Water Quality Issues at Dewi Sant Health Park and Ysbyty George Thomas** was received by Members. The Executive Director for People expressed the importance of ensuring issues such as these were being reported into the Executive Team; • In relation to the **Assistant Director of Health, Safety & Fire Report**, members noted that the under-reporting of Violence and Aggression incidents may be attributed to confusion in relation to entering incidents onto the new Datix System and confusion in relation to coding within the new system;

	• The **Health, Safety & Fire Performance Report** was received. Members expressed concern that staff were finding it difficult to award themselves their own competencies on ESR and noted that the Learning & Development Team were looking at ways in which they could help to improve the position. The Executive Director for People committed to taking forward an action in finding a solution to this issue; • The **Fire Safety Report** was received. Members noted that the Fire Service had recently undertaken a visit to Ysbyty George Thomas where a number of issues were identified and noted that an action plan was now in place to address these. Members noted that at Prince Charles Hospital, deliveries were being left in the central core area which posed as both a fire risk and health & safety risk and Members were assured that this matter was in the process of being addressed; • The **Organisational Risk Register report** was received and noted; • The **Care Group Health, Safety & Fire Report** was received. A discussion was held in relation to future Care Group reporting and representation and it was agreed that in addition to a high level report, deep dives would be received from two Care Groups at each meeting;
Assure	• The **Health Surveillance Programme Progress** report was received. Members advised that they were pleased to see progress being made in this area; • The **Health, Safety & Fire Sub Committee Annual Self-Effectiveness Survey** was received. Members agreed to take forward the actions highlighted within the Areas Requiring Further Action section.
Inform	The following items were approved/noted via the consent agenda: • Unconfirmed Minutes of the meeting held on 15 June 2023 – Approved; • Health, Safety & Fire Sub Committee Forward Work Programme for 2023/2024 – Noted.
Appendices	• Fire Safety Policy for approval

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /	Not Applicable
	If more than one applies please list below:

Link to CTMUHB Strategic Areas	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

4. Recommendation

4.1 The Quality & Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report and **APPROVE** the Fire Safety Policy at Appendix 1.

FIRE SAFETY POLICY

Document Type:	Non Clinical Organisational Wide Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Chris Beadle, Head of Health, Safety & Fire
Executive Sponsor:	Executive Director of Workforce & Organisational Development
Approved By:	**Quality & Safety Committee**
Approval / Effective Date:	(01/09/2021)
Review Date:	(01/09/2024)
Version:	

Target Audience:

People who need to know about this document in detail	Board Level Director for Fire Fire Safety Manager Health, Safety & Fire Teams Capital and Estates Teams Authorised Fire Engineer
People who need to have a broad understanding of this document	Board Members, Management Board, Senior Leaders, Quality and Safety Committee, Health, Saferty and Fire Sub Committee
People who need to know that this document exists	All employees within the UHB, both in CTMUHB & non CTMUHB properties and any organisation working within CTMUHB boundaries.

Appendix A -

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Co-create with staff and partners a learning and growing culture

Appendix B -

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS

Policy Definition iii
1. Purpose 1
2. Policy Statement 1
3. Principles 2
4. Scope 3
5. Legislative and NHS Requirements 4
6. Procedure 4
6.1 Reporting of Fires and/or False Alarms 5
7. Training Implications 7
7.1 Induction 8
7.2 Update / Refresher Fire Training 9
7.3 Responsible Person / Manager / Senior Person Fire Training 9
7.4 Records of Fire Training 10
8. Review, Monitoring and Audit Arrangements 10
8.1 Monitoring of Fire Safety Compliance 10
8.2 Auditing of CTMUHB Fire Safety by External Agencies 10
8.3 Department / Building / Site Compliance 11
8.4 Guidance for Compliance 12
8.5 Contractors, Non Organisation Employees, Voluntary Agenciesand Any Other Users of Organisations Premises 16
8.6 New Builds and Alterations 17
9. Managerial Responsibilities 18
9.1 CTMUHB Board 18
9.2 Chief Executive 19
9.3 Director with Nominated Responsibility for Fire (BLD for Fire): Director of People 19
9.4 Fire Safety Manager (Head of Health, Safety and Fire) 19
9.5 Senior Fire Officer / Fire Officers 20
9.6 Authorised Fire Engineer 21
9.7 Fire Involvement with Groups / Departments / ILG/ Site Fire Safety Groups 21
9.8 ILG leads/ Clinical / Non-Clinical Directors (Responsible Persons) 22
9.9 Service Group Managers / Host Organisation Leads (Responsible Persons) 22
9.10 Department, Line, Ward, Residential, Bank, Agency, Volunteer Managers (Responsible Persons) 23
9.11 Employees, Volunteers, Bank or Agency Staff 25
10. Retention or Archiving 26
11. Non Conformance 26
12. Equality Impact Assessment Statement 26
13. References 26
Appendix A - Major Emergencies 28

1. Purpose

This Policy has been produced by Cwm Taf Morgannwg University Health Board (CTMUHB) to meet the requirements of current fire legislation - Regulatory Reform Fire Safety Order RR(FS)O 2005, NHS Firecode – Welsh Healthcare Technical Memorandum 05 series (WHTM) and codes of practice.It applies to all premises used by CTMUHB and where CTMUHB patients receive treatment.

The aim of CTMUHB is that of the Welsh Government, to minimise the:

- incidence of fire and unwanted fire signals;
- impact of fire on life safety, delivery of service, the environment and property.

CTMUHB has noted the contents of the Welsh Government fire policy issued under cover of WHC [2006] 74.

2. Policy Statement

CTMUHB, as with all NHS organisations in Wales, must comply with legislation relating to fire safety and the Welsh Government policy.

CTMUHB is committed to comply with all the statutory requirements of fire safety legislation, operationally and for existing and new builds. CTMUHB must be satisfied that all buildings within its control meet current legislation, for the protection of the relevant person(s).

Where occupation of other buildings by CTMUHB staff is known the 'responsible persons' for these buildings are made aware of their responsibilities towards fire safety legislation and the safety of the CTMUHB staff and users.

All contracts for health services placed by commissioners must contain clauses to ensure the premises comply with, and will continue to comply with, all statutory fire safety legislation, CTMUHB Fire Policy and associated Fire policy documentation, and provisions relevant to the building and service provided.

When commissioning new buildings, leasing new buildings, or occupying buildings under PPP/PPI contract, the HB must be satisfied that such buildings comply with the legislation relating to fire safety.

Definitions (as defined in the RR(FS)O)
Relevant person: Any person (including the responsible person) who is or may be lawfully on the premises and any person in the immediate vicinity of the premises who is at risk from a fire on the premises.

Responsible person:
(a) in relation to a workplace, the employer, if the workplace is to any extent under his control;

(b) in relation to any premises not falling within paragraph (a)—

(i) the person who has control of the premises (as occupier or otherwise) in connection with the carrying on by him of a trade, business or other undertaking (for profit or not); or

(ii) the owner, where the person in control of the premises does not have control in connection with the carrying on by that person of a trade, business or other undertaking.

3. Principles

This Policy forms part of the CTMUHB health and safety regime and is augmented by other fire safety related documentation and procedures (available electronically via the Fire webpage of the intranet).

The organisation through the Chief Executive will ensure:

- that it creates a safe work environment by undertaking the required risk assessments of the significant findings involved in the work activities of the organisation, implementing the identified control measures and providing relevant fire safety training for all its employees / volunteers based on safe working practices, current legislation and training needs analysis;

- the Board supports the development of appropriate organisational structures and a culture, which encourages risk control and secures the full participation of everyone, in a manner that is consistent with the Regulatory Reform Fire Safety Order 2005 RR(FS)O;

- the commitment of senior managers to workplace fire safety is maintained, ensuring the management of workplace fire safety is given at least equal importance as all other management functions;

- it maintains, improves, monitors and reviews the effectiveness of this Fire Policy, its organisation and arrangements annually;

- the appointment of a Board Level Director (BLD) to champion Fire Safety; *(Director of People);*

- the appointment of a Fire Safety Manager (FSM) *(Head of Health, Safety and Fire)* and the provision of a suitably resourced fire safety function. To meet the requirements of current legislation, and given the authority required to act as the "competent person(s)", Fire Safety Officers (FSO), providing the assistance the organisation requires to comply with current fire safety legislation / WHTM. All employees specifically appointed to assist in the provision of fire safety advice or support will be provided with the necessary fire safety training / qualifications or special expertise and continual professional development to ensure they can carry out their duties, where this can not be provided internally external advice will be outsourced;

- it will establish and maintain effective fire safety group(s) and structure, which meets the requirements of current legislation / WHTM guidance, and the needs of the organisation and its employees;

- it will promote effective cooperation and communication between management, staff and external agencies relative to fire;

- it will provide the facilities, resources and time to enable managers and safety representatives to carry out their tasks and duties;

- the formal delegation of fire safety duties and responsibilities to ILG, Service Group and Departmental Management Teams, via this policy and the issueing of Fire Risk Assessments (FRA);

- the effective control of contractors who may come onto organisation premises, ensuring such contractors are competent;

- this Policy is brought to the attention of all employees.

4. Scope

This Policy is aimed at those who may use CTMUHB premises, especially those who may be classed as the responsible person(s), relevant persons (as defined in the RRFSO 2005) managers, staff, volunteers, and other agencies working, or undertaking duties within CTMUHB.

Independent contractor services are responsible for identifying and managing their own risks, due to the CTMUHB's contractual relationship with them. In order to achieve that, CTMUHB has robust processes in place to identify areas of high risk and address concerns, and are committed to supporting the independent contractor services with risk management.

5. Legislative and NHS Requirements

Fire safety legislation is regulated by the Regulatory Reform Fire Safety Order 2005 RR(FS)O and the associated guidance documents. The NHS has supplementary documents to the Regulatory Reform Fire Safety Order to assist in fire safety within Healthcare, Health Technical Memorandum 05 series - Firecode (within CTMUHB the welsh editions WHTM shall be applied). Reference may be made to other statutory, legislated and guidance documents where necessary.

All NHS organisations in Wales must comply with legislation relating to fire safety and the Welsh Government policy. All NHS organisations in Wales who commission and or lease buildings or occupy buildings under a PPP/PFI contract must be satisfied that they comply with legislation relating to fire safety. Any Service Group undertaking such a commission or lease etc should inform the fire safety manager in writing providing full details of the arrangements prior to completing.

The Department for Health and Social Services will ensure that appropriate advice and guidance on all matters related to fire safety will be available to NHS organisations in Wales through the Firecode suite of documents.

The Government expects that all contracts for health services placed by commissioners will contain clauses to ensure that premises comply with, and will continue to comply with, all statutory fire safety provisions and, where appropriate, Firecode.

Fire safety is a responsibility for all employees, and a duty for all managers to maintain a high standard of fire safety.

CTMUHB is compelled to ensuring the safety of its users (relevant persons) by complying with the statutory fire safety legislation, relevant EU/British standards, WHTM guidance notes and codes of practice.

6. Procedure

The organisation is required to communicate its commitment to fire safety, provide documented evidence to the inspecting authority in relation to its fire safety management and procedures. This will include:

- a current Fire Policy;
- the undertaking, recording and dissemination of fire risks
- a means of accessing fire related information relating to its premises, systems, service or risks*; (CTMUHB intranet – Fire web page);*
- site specific fire relative information - *(located on sites within fire documentation cabinets, and within the CTMUHB intranet fire safety site)*;

- the reporting and investigation of fire / false alarm incident / unwanted fire signals *(CTMUHB intranet Fire / False Alarm / Near miss incident reporting form);*
- demonstrating and evidencing of local management of general fire safety provisions, *(Ward / Departmental Fire Safety Management folders), to include within:*
    - copies of Fire Risk Assessments and actions taken;
    - copy of the local Fire Orientation plan (where applicable);
    - local departmental fire procedures for dealing with a fire emergency;
    - records of training;
    - Ward / Department Checklist;
    - Reference to the location of Planned Emergency Evacuation Procedures (PEEPs) for disabled staff or staff requiring assistance in an evacuation;
    - copies of any correspondence (INO/ENO etc) from the Fire Authority;
    - record of any actions taken to address Fire Safety issues, significant findings from the FRA / ward / departmental checks etc;
- information availability of fire safety provisions and procedures for maintaining fire safety provisions – *(Planned Preventative Measures (PPM) information provided by Estates);*
- procedures for addressing any Fire Authority notices served on the UHB *(Fire Risk Assessment (FRA) – Notice of deficiency (INO) / Enforcement notice procedure (ENO));*
- procedures for addressing building alterations, changes of use, new builds etc *(Fire Build forms);*
- evidence of management / wards / departments and acting upon significant findings from FRAs, INO and ENO notices.

This list is not exhaustive and documentation / procedures will be developed to assist in addressing any issues as they arise.

6.1 Reporting of Fires and/or False Alarms

The Fire Service recommends they are to be called to **all** fires.

All fire related incidents including false alarms **must** be reported to the CTMUHB Fire Safety team within **24** hrs. This must be done via Fire incident reporting system on the Fire Website. This will allow the HB Fire Officers to investigate at the earliest opportunity.

For inpatient sites this must be completed by the Fire Incident Coordinator (Senior / Acting-up Nurse for the site / Site Manager / Hospital at night coordinator / Bed Manager) at the time of the incident.

For all other sites the Fire Incident form must be completed by the senior person present from the department **where** the incident occurred.
E.g. multi use building incident happens within department B the senior person from department B must complete the form, unless the building is served by a reception then the receptionist is to complete the form (if manned at the time of the incident) refer to the site specific documents.

Where the incident occurs outside of normal working hours and HB staff respond to it (e.g. Estates on call, Facilities) these should complete the fire incident form providing as much information as possible.

A copy or notification of the incident should be made known to the Line / Ward / Department / Accommodation Manager for where the incident occurred (if they are not present at the time of the incident).

For an actual fire the area / item must be cordoned off / isolated to allow CTMUHB Fire Officers to investigate and confirm cause etc.
Where the fire area involved is required for urgent operational reasons then only then should photographs be taken to provide the investigating officer with the necessary photographic evidence. Any item involved in a fire should not be reused until CTMUHB Fire Officers have carried out their investigation.

All fires must also be reported to Estates where damage to equipment or fabrication of the building occurs, if the item is clinical then clinical Engineering must also be informed.

Any activation of the fire alarm will require the system to be reset and the cause established. The FIC/NIC, HB Fire Officer, Fire Service may determine the cause and authorise the silencing and reset of the system. The silence of the system must only be undertaken by someone trained in silencing for that particular site / system and resetting **must only** be done by a competent person from either Estates or the alarm maintenance contractor.

All fires / fire alarm activations must be reported to Estates via the Estates helpdesk during normal working hours, or for out of hours to the "Estates Officer on call" via the RGH / PCH /POW switchboard.

Where asbestos is known to exist any in-depth investigation requiring the removal of walls, floors, ceiling panels or tiles is required to ascertain the cause of the activation, then Estates must be informed via the Estates helpdesk during normal working hours, or for out of hours to the "Estates Officer on call" via RGH / PCH /POW switchboards.

Arson: Hospitals and clinics are vulnerable to arson attacks from both intruders, patients or visitors. Within inpatient areas a high level of control of ignition sources should be employed. This is to protect all other occupants from a fire being started deliberatly, and minimise the disruption to inpatient facilities. Even a small fire in a ward area has massive implications to inpatient services.

Also there are areas within our sites such as drug or equipment storage which appeal to the opportunist. These areas should have higher levels of control and management and ensure these areas are locked as an arsonist may set a fire to conceal the theft of goods.

Where arson is suspected this must be made known to the senior management for the area at the time of the incident and cascaded up to senior management, Fire Safety Manager. Arson can be suspected if:

- more than one fire occurs at the same time or reasonably close to each other;
- the fire occurs in a low risk area or improbable location;
- items that would not normally be located where the fire occurs are present (bedding, rags, rubbish);
- there are unusual smells not normally assocated with the area the incident occurred (petrol, thinners);
- the same person appears at more than one fire, or is the same person raising the alarm on different occasions;
- the fire as a whole would not have started on its own;
- anything else unusual about the area, the fire growth gives you reason to suspect arson.

Note if it is known that an arsonist is being treated within our property this must be made known to the managers of the area and additional vigilance employed whilst the patient is within our property.

If arson is suspected the Fire Safety Manager or Fire Officers (during normal working hours), on Call Director (outside of normal working hours) must be informed immediately and the area cordoned off for investigation.

FIRES INVOLVING DEATHS, INJURIES, DAMAGE OR ARE OF SPECIAL INTEREST E.G. ARSON MUST BE PASSED IMMEDIATELY TO THE FIRE SAFETY MANAGER during normal working hours and out of normal working hours the 'ON CALL DIRECTOR' must be informed via the switchboard. Out of hours: this information must then be passed onto the Board Level Director responsible for Fire (BLD for Fire) and the Fire Safety Manager (FSM) who will ensure this information is passed onto the Chief Executive and the persons named in Appendix A. Additionally the BLD for Fire and/or FSM is responsible for ensuring the nearest Health and Safety Executive regional office is informed.

7. Training Implications

Fire Safety training is a STATUTORY requirement under the:

- Regulatory Reform Fire Safety Order 2005;
- Health and Safety at Work etc Act 1974;
- Management of Health and Safety at Work Regulations 1999.

It is mandated under WHTM 05-01 Firecode management of Fire Safety and the organisations Knowledge Skills and Framework.

CTMUHB fire training needs analasis highlights all staff need to have an understanding of fire risks, fire prevention, and fire/evacuation procedures, for within their areas of employment and that no person should exceed a two year period between face to face training by a HB Fire Officer. It is the responsibility of those identified as having responsibility for managing staff under them to ensure their staff / volunteers attend and undertake the relevant training.

7.1 Induction

All staff / volunteers should receive fire induction training on or before their first day of employment or as close to their start date as possible, (not to exceed 1 month from their start date).

CTMUHB fire induction is in two parts 'corporate' and 'local' (ward / departmental). Corporate training is carried out as face to face by a CTMUHB– Fire Officer on the corporate induction program.

Corporate induction must be supplemented by ward or departmental fire / evacuation procedures on commencement of employment in the workplace, by the 'responsible person' for that ward, department or role. This includes CTMUHB staff working in non CTMUHB properties; the CTMUHB manager for the staff working in non CTMUHB property is responsible for ensuring their staff receive local induction. The Ward / Department manger must maintain records of local inductions and update the ESR records.

Non CTMUHB departments, staff or volunteers working in CTMUHB properties must also comply with CTMUHB's protocols of local induction training relative to the department and site. Where staff are employed that cannot immediately on starting attend the corporate induction, local induction relating to fire and evacuation procedures must be carried out and recorded and ESR updated by the Line / Ward manager on the first day of commencing work.

Staff that are employed where there are specific risks, hazards or specialist equipment (i.e. DSEAR, evacuation lifts, evacuation aids etc) or they have a specific role in a fire incident the corporate induction must be supplemented with

specific Ward, Department, equipment and role training. It is the responsibility of the Line / Ward Manager to ensure this is carried out, and recorded. It is the Line / Ward Managers responsibility to ensure that staff are familiar with their roles and responsibilities in relation to fire safety within their workplace environment.

7.2 Update / Refresher Fire Training

All staff, volunteers and frequent users of the organisations premises must attend update / refresher fire training. This is a statutory requirement under the Regulatory Reform Fire Safety Order and WHTM 05-01. This must be undertaken periodically ensuring no staff member exceeds a TWO year period without formal face to face fire training from a CTMUHB Fire Officer.

Additionally where there are specific fire risks, evacuation equipment is provided, or staff have a specific fire role, training is to be undertaken periodically in line with manufacturer's instructions. Where no defined time scales exist from the manufacturer it is recommended the training frequency follows the CTMUHB fire training timescales of not exceeding a TWO year period without this specialist training being undertaken, this training should form part of the local ward / department refresher training.

Local departmental training should be carried out in between the face to face by a CTMUHB Fire Officer. The Ward / Line Manager is responsible for ensuring this training is carried out, and recorded both within the fire file and on ESR. Departmental Fire Procedures and information should be reviewed and updated by managers of wards and departments annually or when a change occurs or a change is made to the physical structure of the area, changes to the operational running of the area or process, or an incident highlights deficiencies or issues. The Manager must consult with the site relative Fire Officer when reviewing the procedure, where changes to the existing procedure are to be made.

The review requirements should be recorded, and any changes should be made known to staff.

7.3 Responsible Person / Manager / Senior Person Fire Training

Any person who has management responsibility for staff or areas must undertake this training. It is designed to meet the requirements of management responsibilities for fire within their workplace. This is a statutory requirement under the Regulatory Reform Fire Safety Order and WHTM 05-01. This must be undertaken periodically ensuring no manager exceeds a TWO year period without this fire training. Note: The Responsible Person, Manager, Senior Person training is provided instead of the update / refresher training and is not additional but counts as attending refresher / update and awards that competency.

Note: Where evacuation equipment is provided for the evacuation of patients, the ward/dept managers must undertake the training in addition to the managers course in order to understand the requirements and process.

Note: Video and computer based fire training should not be used in isolation or as a sole means of induction, but can be used to enhance other forms of fire training *(RRFSO/WHTM 05).* Where the organisations staff are employed in other NHS / private facilities they must adhere to the host organisations policy in relation to training. Any records of training undertaken at these locations must be forwarded to the employing organisations training database holder. Where the host organisations standard or frequency of training is to a lower standard or a frequency exceeding two yearly (i.e. e-learning only as a means of training) then face to face training with a CTMUHB Fire Officer must be undertaken not exceeding two years, and departmental training undertaken in between.

7.4 Records of Fire Training

Irrespective of how training records are maintained (locally or centrally) Managers must have access to, or keep training records of all their staff (and any volunteers that work within their areas) that they are responsible for as having attended fire training, including specialist site or local ward or departmental training and specialist equipment for fire purposes i.e. evacuation lifts, evacuation aids. These records **must** be readily available for inspection when requested by the CTMUHB Fire Officer when undertaking Fire Risk Assessments (FRA) or any inspecting authorities (e.g. Fire Service audit). It is therefore recommended these staff attendance records are kept within the fire file for the area.

Failure to provide information at the time of a Fire Service formal audit could result in enforcement action being imposed on the ward or department for failing to provide the required information.

8. Review, Monitoring and Audit Arrangements

The FSM will ensure that the Policy and Procedures are reviewed in accordance with the timescale specified at the time of approval. Staff who become aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local / national directives that affect, or could potentially affect, the organisations policies and procedures should advise the Fire Safety Manager as soon as possible who will then consider the need to review the Policy or procedure outside of the agreed timescale for revision.

8.1 Monitoring of Fire Safety Compliance

The organisations fire safety compliance is monitored internally by:

- the FSM via the CTMUHB Fire Officers, fire risk assessments and Fire Safety Group meetings;

- ward and departmental checklists, departmental fire procedures, fire incident reports, and training records.

8.2 Auditing of CTMUHB Fire Safety by External Agencies

The organisations fire safety compliance is monitored externally by:

- National Health Wales Shared Services Partnership (NWSSP) - Facilities Services on behalf of the Welsh Government (WG), by means of the annual NWSSP on-line Fire Audit;
- South Wales Fire and Rescue Service by means of audit and inspection visits to sites and departments, inspecting the physical condition of the property or area, records of maintenance, tests, training and questioning staff. The Fire Authority have the powers to inspect at ANY time. Formal audits are arranged giving the HB formal notification of where they wish to audit. Informal audits will be on a **NO formal notice** approach and will normally be out of normal working hours.

8.3 Department / Building / Site Compliance

Each Site / Department Manager is responsible for maintaining workplace fire safety requirements. This can be achieved by utilising a management checklist for fire safety; reporting and chasing up of any defects that compromises the safety from fire of the users and cooperating with other departments where shared or common areas exist.

No new build or alteration to any part of a CTMUHB owned or head leased / managed building should be undertaken without prior consultation with the Fire Safety Manager and/or the Senior Fire Officer / Fire Officers, where requested a Fire Build Form MUST be completed and sent to the relevant fire officer.

When any changes are planned either through capital, virement or any other means the Fire Build Form (available via Fire web page) MUST be completed by the Manager requesting the change or alteration etc and forwarded to the site relevant Fire Officer for comments / advise / information on fire requirements that must be met. This Fire Build Form should then accompany the SON, virement or other request. This will allow the CTMUHB Fire Officers to provide the necessary fire relative information for the build or alteration to those involved.

All building provisions such as fixed electrical, lightning protection, fire hydrants, compartmentation, fire safety provisions, should be maintained and checked in accordance with relevant standards and manufacturers recommendations (this list is not exhaustive). Responsibility for this lies with the Head of Estates for CTMUHB owned properties and Primary Care lead for head leased buildings.

Should the CTMUHB enter into any contract for managing a building e.g. Primary care, the Fire Safety Manager should be consulted prior to undertaking any fire

responsibilities for the building. Copies of the agreement detailing all the fire safety provisions and arrangements for testing and maintaining must be provided prior to becoming the lead / head lease.

8.4 Guidance for Compliance

Housekeeping: It is essential that all areas are kept free from clutter which will reduce the risk of an incident or could affect or impede a fire evacuation such as slips, trips and falls. This can be avoided by regular and frequent workplace inspections by the relevant Manager and ensure issues such as waste collection, cable management, storage etc are addressed. Responsibility for this lies with those responsible persons who have control over the ward, area and/or department, this includes common or shared accommodation such as corridors directly adjacent to their ward or department.

Means of Escape: It is essential that all escape routes are maintained clear of obstructions and available for use at all times. All staff must familiarise themselves with the location and operation of fire exits, and ensure routes to these exits are maintained clear for use. Responsibility for this lies with those 'responsible persons' having control of the ward, area, department and/or process, consideration to where the escape route leads must be taken into account.

Fire Safety Systems (Fire Alarms): It is essential the organisation has an adequate means of raising the alarm suitable for the building and risks. All staff should be aware of the location of the fire safety systems within their working environment. It is essential that these are maintained, clear of obstruction, and available for use at all times, also that they can be heard where sounder alerts are provided or seen where visual indicators are provided. This responsibility lies with the 'responsible persons' for the ward, area and/or department.

Whilst the Head of Estates is responsible for the maintenance of the fire alarm system(s) this may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for in order to meet the British Standards requirements.

Emergency Lighting: Provision of emergency or escape lighting provided and maintained to the relevant BS/WHTM and as required or identified by the Fire Risk Assessment (FRA). Provision and testing of emergency lighting lies with the Head of Estates. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for in order to meet the British standards requirements).*

Fire Fighting Equipment: First aid fire fighting equipment provided in the form of hand held fire extinguishers suitable for the risks. The type will be in accordance with the relevant British/EU Standards. All extinguishers display operating

instructions and application. Suitable suppression systems will be provided where a hazard exists or fire risk assessment identifies the need. All staff must familiarise themselves with the location, operation and application of all. It is essential that these are maintained, clear of obstruction and available for use at all times. Responsibility for this lies with the 'responsible person' for the area having control of the ward, area, department and/or process. Responsibility for the provision and maintenance of fire fighting equipment lies with the Fire Safety Manager and Head of Estates respectfully. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for in order to meet the British standards requirements).*

Fire Action Notices / Signs: Fire action notices should be displayed as near as practically possible to each break glass call point, and where necessary additional areas of high population. These will inform all patients, visitors and staff of the correct action to take on discovering or suspecting a fire, and what action should be undertaken. Directional and exit signage shall be displayed accordingly. These should be visible at all times and not obscured. Fire related notices and signs must conform to WHTM and European standards. Provision of Fire Action notices lies with the Head of Estates. *(This may be delegated to a delegated person within Estates who will have responsibility for the testing and maintaining the system(s) for each site they are responsible for in order to meet the British standards requirements).*

Ensuring they are in position and contain the relevant information it is the responsibility of the 'responsible person' having control of the ward, area, department and/or process that they are located in.

Flammable Substances / Compressed Gasses: All flammable substances / compressed gasses shall be stored and used in accordance with the relevant substance storage and use instructions, and disposed of in the correct manner. Only minimal quantities should be kept within the working area such as required on a day to day basis, relevant signage to indicate flammable substances / compressed gas should be displayed. Under no circumstances should flammable substances or pressurised containers be disposed of through the general waste disposal system. Responsibility for ensuring there is a risk assessment, safe system of work or protocol, and relevant hazard signage is in place and the substances and gases are stored and used correctly and safely lies with the 'responsible person' having control of the ward, area, department and/or process.

Dangerous Substances Explosive Atmosphere Regulations (DSEAR): Managers are responsible to ensure all areas within their responsibility that contain or carry out a process which use dangerous substances, or create an explosive atmosphere, a DSEAR risk assessment is in place, and that they have undertaken or have in place

the recommendations from the risk assessment. Responsibility for ensuring there is a DSEAR risk assessment is in place lies with the "responsible person" having control of the ward, area, department and/or process. Responsibility for ensuring the DSEAR assessment is undertaken lies with Head of Health, Safety and Fire.

Medical Gases: All medical gases should be stored and used in accordance with the relevant British Standard / WHTM 02. Medical gas cylinders within buildings should be stored in fire rated rooms with adequate ventilation direct to outside of the building *(to prevent the build up of gases and explosive atmosphere).* Responsibility for ensuring medical gases are used and stored correctly lies with the 'responsible person' having control of the ward, area, department and/or process.

Electrical Equipment: All electrical equipment must be tested by the Estates Department before use. No extension leads should be used without the Estates Department inspecting the area and determining the reason for use. Departments should attempt to minimise the amount of leads in use where possible. During the festive season all festive lighting and electrical equipment must be of low voltage type and tested prior to use, and display the PAT certificate. The use of cuboids multi plug adaptors is forbidden, these create strain on the plug sockets leading to damage and possible shorting. Responsibility for ensuring electrical items are checked lies with the 'responsible person' having control of the ward, area, department and/or process. Responsibility for the PAT testing of the items lies with the Head of Estates and the Department Managers.

Lithium Ion Batteries: Rechargeable equipment such as E-Scooters, E-Bikes are not permitted within CTM UHB premises, these items must be located within the secure cycle shelters provided. It is not permissbale to charge these items within the work place. The Lithium Ion Batteries pose a significant fire risk to the environment and the safety of staff, patients and visitors. Other recghargebale items such as personal phones , laptops etc pose a fire risk whilst charging and must not be left unattended or in a location where spontaneous ignition may occur. Please seek advice from your local Fire Officer or Senior Fire Officer.

Donated and/or Purchased Equipment: Donated or purchased equipment for use within the organisation should be certified as safe before use i.e. electrical equipment should be tested by Estates before any use. Any furnishings must be of fire resistant material and comply with the current relevant WHTM/BS, and display the furnishings fire safety label indicating its standard of fire resistance, have no signs of damage or internal fillings being open to view or open to ignition sources thus reducing the fire rating. Any items showing inner foam should be repaired or removed from the workplace. All items of furniture and fittings must comply with the current WHTM for furniture and fittings and should be purchased through the CTMUHB procurement process. Responsibility for ensuring donated

or purchased equipment and furnishings lies with the 'responsible person' having control of the ward, area, department and/or process. Responsibility for the procurement of suitable items lies with the Lead for Procurement.

Patients Sleepwear: Patients being admitted should be advised to bring flame retardant nightwear and dressing gowns. Visitors should be also be advised where replacement sleepwear is brought in to ensure they are flame resistant whereever possible.

Access Routes for Emergency Vehicles: All access routes within CTMUHB sites should be maintained clear of vehicles or items that would impede emergency vehicle access. Staff should observe the no parking areas and abide by the site restrictions. These will either be marked with double yellow lines, hatched area or be a recognised no parking area. Responsibility for ensuring access routes are clear lies with the 'responsible person' having control of the parking, area or site.

Lightning Protection: Lightning protection shall be installed and maintained as recommended by the relevant British Standard/WHTM. Responsibility for ensuring lightning protection is provided and maintained lies with the Head of Estates.

Maintenance and Testing: All maintenance and testing of fire related equipment must be undertaken by a competent person. This will either be through direct labour (Estates Department employee) or an authorised supplier or engineer for the product. Responsibility for ensuring fire related equipment is maintained lies with the Head of Estates.

Smoking: The organisation is bound to current legislation regarding smoking and full guidance is contained within the Smoke Free Environmental Policy. Responsibility for ensuring the Smoke Free Environmental Policy is adhered to lies with the 'responsible person' having control of the ward, area, department, process and/or site, and smoking policy lead.

Arson reduction: all staff in all areas must be aware of the potential for arson, and take steps to prevent the occurrence. Such as minimising or controlling the availability of combustibles and flammables or items that would assist a fire etc, ensuring store rooms are locked, combustible and flammable materials are controlled etc. External **skips** should not be sited within **6 metres** of any building or overhang to prevent arsonists utilising the CTMUHB waste as fuel. Responsibility for ensuring wards, areas and departments reduce the possibility of arson lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Shared or Common Areas; Where areas are shared or there are common areas all must cooperate to achieve a fire safe environment.

Shared accommodation is areas used by a number of departments or staff within an area such as a corridor between two departments or a number of departments. This can extend into a common area where rooms used by departments or staff are utilised e.g. disposal hold or rooms in the main hospital street or corridor. Responsibility for this would lie with the users and the Service Group responsible for emptying).

A common area would be somewhere like a main 'hospital corridor or street', or a shared area when primarily used by staff such as in a small building e.g. 'department link corridor'.

Cooking; any form of cooking whether microwave, toaster, gas or electric cooker must be in the recognised purpose built (fire rated) room or designated cooking areas only. Under no circumstances should cooking be undertaken in any room other than the approved designated rooms for cooking (refer to fire site specific documents for accepted areas for cooking). Where cooking is undertaken the process should not be left unattended not even for short periods. Safe systems of work / use should be displayed close to the cooking equipment. Any alarm activation caused by cooking left unattended or the fire door being wedged open could result in the cooking facility being removed. Responsibility for ensuring areas and departments maintain a safe and controlled cooking environment lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Personal Emergency Evacuation Plans Personal Emergency Evacuation Plans (PEEPS) are required to be in place for any staff who are disabled, mobility impaired or have special needs, such as pregnant, hearing, sight, mobility restricted or impaired that may require assistance in leaving the building in an emergency situation. They are to be compiled in conjunction with the individual concerned and based on the knowledge of the building and location of the workplace location within the building. They must explain what methods, routes of escape and assistance is to be in place. Once completed they must be kept in the staff member's or department's confidential file. Where the use of a buddy system is highlighted or the individual is not allowed to work alone or any other issue highlighted requires assistance or the person to carry out a specific role then other members of staff must be made aware of their roles and responsibilities as well as the needs of the individual. Responsibility for ensuring PEEPS are in place lies with the 'responsible person' having control of the ward, area, department, process and/or site.

Note: The PEEP procedure can be utilised for patients in our care or have regular treatment whose condition requires additional non-standard equipment or planning. e.g. bariatric.

8.5 Contractors, Non Organisation Employees, Voluntary Agenciesand Any Other Users of Organisations Premises

Any person using CTMUHB property must comply with the organisations Fire Policy and be familiar with protocols and procedures the organisation employs. This includes the requirement to attend specific fire training or briefings on fire safety relevant to the site or department. The organising department is responsible for ensuring the contractor is briefed in fire safety matters appertaining to the area prior to commencement of work in their area (where the area is still operationally occupied by CTMUHB). Where the area is handed over to the contractor as a whole it is the project leads responsibility to ensure fire information has been given to the contractor.

Under RR(FS)O article 5(3) & (4) the contractor is then responsible for ensuring that the work they undertake relating to fire safety matters within their control are carried out in good order. Therefore any contractor undertaking work must be aware of the working environment and the requirement to maintain the fire safety provisions by liaising with the Estates Department and the Department Manager where the work is to be undertaken. To ensure they are aware of any restrictions measures required before being granted a permit to work (especially where hot work is to be undertaken, or there is to be any interruption or work on the fire alarm system. Emphasis must be made to the need to prevent unwanted fire signals - false alarms). (Refer to the organisations Control of Operational Estates Maintenance Contractors Procedure).

8.6 New Builds and Alterations

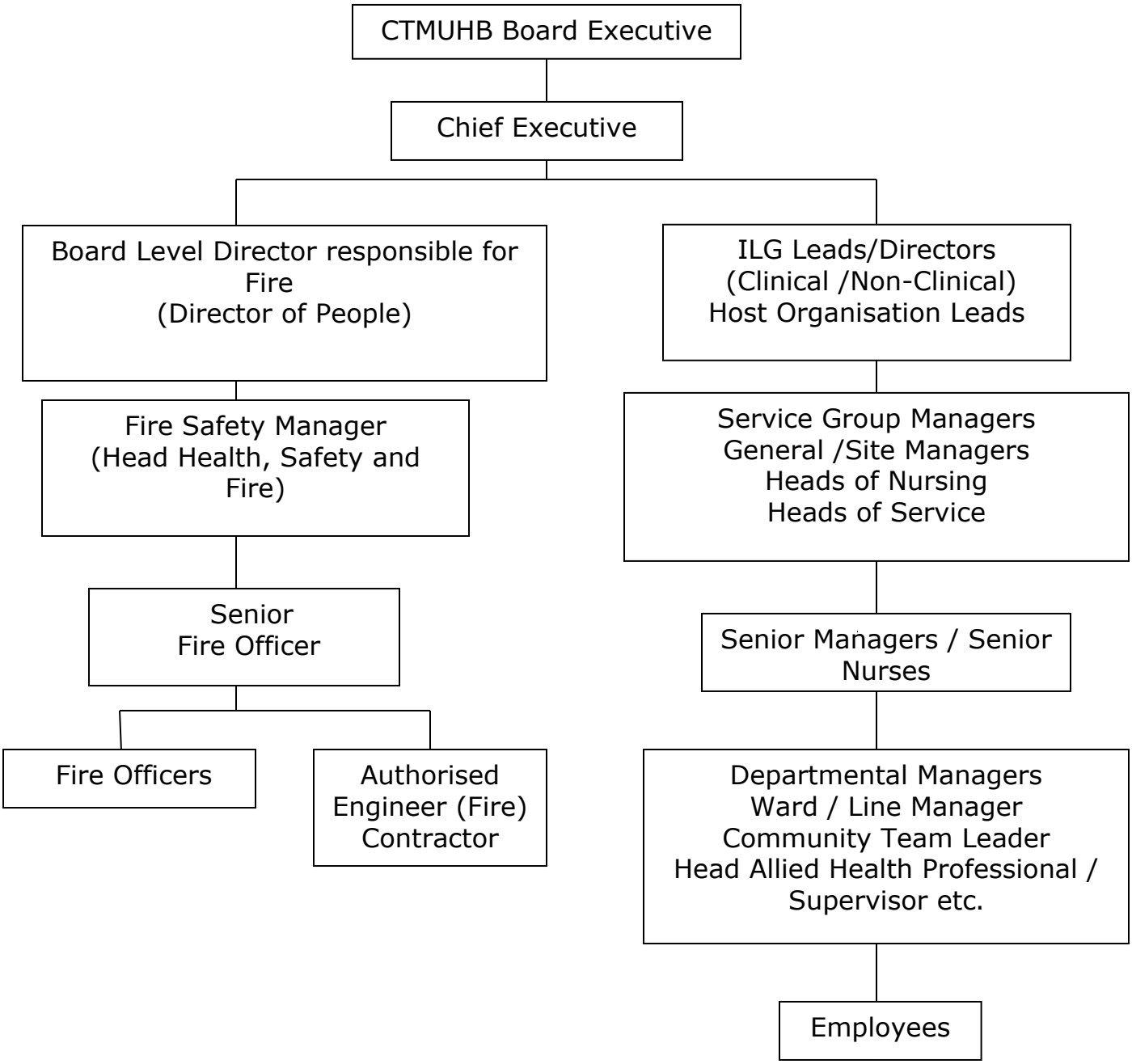
Where new builds or alterations are to be made to existing sites or departments the WHTM 05 Firecode documents provides advice on achieving compliance and must be used for inpatient properties and other relevant guidance as appropriate for non inpatient properties. Whilst there may be alternative ways of achieving compliance or the same objectives, where an alternative approach is to be taken the designers must demonstrate that the approach taken does not result in a lower standard of fire safety than if Firecode had been applied. In all cases the CTMUHB Fire Officers must be consulted from conception to completion including sign off.
The HB utilises a Fire Build form, this must be completed and forwarded to the site relevant Fire Officer prior to any commencement of design or building works. This allows the required fire information to be provided to the user/designer/project lead.

Form available via the Fire website on the HB intranet.

Life safety sprinklers in buildings offer a number of trade-offs and structural relaxations and should be considered and decisions recorded at the outset of design. Close liaison between the Fire Safety Team, Estates (especially where

alarm and detection will be affected) from conception through to completion must be maintained and the development formally discussed and recorded to ensure fire safety is not compromised. Responsibility for this lies with the Director of Finance and the delegated project leads.

9. Managerial Responsibilities



9.1 CTMUHB Board

It is the responsibility of the Board to ensure that the organisation meets its legal obligations under the current fire legislation.

The Board must ensure adequate funds and resources are available to meet the organisations fire safety requirements and periodically review the effectiveness of

the Policy and personnel under their control to whom fire safety responsibilities have been assigned.

9.2 Chief Executive

The Chief Executive shall have overall responsibility for the Policy and fire safety within all CTMUHB owned / head leased premises, and for staff occupying other buildings for CTMUHB business purposes. The Chief Executive shall ensure:

- all statutory requirements are observed and implemented;
- the implementation of Firecode or any fire safety legislation applicable to organisations premises;
- the provision of appropriate fire safety policies and programmes of work for maintaining and improving precautions at all the organisations premises;
- that an Executive Director shall be appointed with nominated responsibility for fire safety matters;
- the appointment of a Fire Safety Manager for the organisation.

9.3 Director with Nominated Responsibility for Fire (BLD for Fire): Director of People

The Director of People is responsible for leading fire safety issues and will assist the Chief Executive and Board in their responsibilities for fire safety. They will ensure that fire safety issues are brought to the attention of the Board and the Chief Executive. The Director of People in conjunction with the Fire Safety Manager will be responsible for the upkeep of the Fire Policy, the coordination of fire safety management and be the point of contact for any fire safety issues for the organisation. As nominated Director they will ensure:

- a Fire Safety Manager is appointed;
- the relevant authorities are informed (see Appendix A) for serious or untoward fire related incidents;
- the organisation obtains suitable and sufficient competent advice regarding fire safety from either within or external sources where appropriate;
- the organisation obtains competent advice regarding Dangerous Substances Explosive Atmosphere Regulations;
- the development and implementation of the Fire Policy in line with the organisations Risk Management Strategy;
- a procedure is in place for the supervision of contractors carrying out work in the organisations premises.

9.4 Fire Safety Manager (Head of Health, Safety and Fire)

It is not possible or desirable to fully define the roles and responsibilities of the Fire Safety Manager. However, they should be responsible for the following:

- an awareness of all fire safety features and their purpose;
- sufficient and suitable resources to address fire safety compliance are available;
- fire safety risks particular to the organisation;

- requirements for disabled staff and patients (relating to fire procedures);
- ensuring appropriate levels of management are always available to ensure decisions can be made regardless of the time of day;
- compliance with legislation;
- development of the organisation's fire safety documentation;
- development of an effective training programme;
- cooperation between other employers where two or more share the premises;
- the reporting of fire incidents in accordance with current practice;
- monitoring and mitigation of unwanted fire incidents;
- liaison with enforcing authorities;
- liaison with other managers;
- monitoring of inspection and maintenance of fire safety systems.

Whilst these roles have been noted these roles may be encompassed in other Service Group responsibilities such as maintaining fire safety provisions, such as extinguishers, alarms, compartmentation, fire safety manuals. The upkeep of records relating to these provisions lies with the Director of Finance

Compliance with Fire Risk Assessments and findings lies with the persons identified in the Fire Risk assessment significant findings action plan.

9.5 Senior Fire Officer / Fire Officers

It is not possible or desirable to fully define the roles and responsibilities of the Fire Safety Officers. However, they will have responsibility for assisting the Fire Safety Manager in the following:

- providing professional and technical advice to the Fire Safety Manager and Board Level Director responsible for fire (Director of People) and to all levels of the organisation;
- providing guidance and direction to all levels of the organisation in relation to fire safety;
- devising, developing, managing and delivering fire safety training to all staff within the organisation;
- development of strategies, policies, protocols and procedures to ensure fire safety;
- undertaking and compiling Fire Risk Assessments (FRA) for all departments and organisations premises in conjunction with the appropriate departmental or premises responsible person(s);
- undertaking and compiling Fire Risk Assessments or providing guidance to hosts of CTMUHB staff in relation to workplace fire safety for premises outside the organisation where organisation staff are employed in conjunction with the appropriate organisational or premises responsible person;

- undertaking and monitor by means of audit, Fire Risk Assessments, and the organisations performance against legislative guidance;
- liaison with various external authorities and agencies where fire safety issues may be involved;
- monitoring compliance with general fire safety duties outlined in relevant fire legislative or guidance documents and the organisations fire policy;
- organising and supervision of CTMUHB evacuation exercises;
- monitoring all fire safety systems provided to ensure compliance to statutory and mandatory legislation;
- analysing building development plans and alterations for the organisation to ensure compliance to various statutory requirements;
- investigation of all fires and false alarms, and ensure the organisation meets statutory requirements to reduce unwanted fire signals (false alarms);
- researching products that will be of benefit to the organisation or improve fire safety within the organisation.

Whilst this list is not exhaustive other areas of expertise and knowledge in associated fire relative subject matter may be required. Where the expertise and knowledge is beyond the Health Boards Fire Safety Officers remit external specialist advice will be outsourced, such as fire engineering, smoke control / fire suppression system expertise, Dangerous Substances Explosive Atmosphere Regulations specialists.

9.6 Authorised Fire Engineer

CTMUHB does not employ a full time Fire Engineer but utilises the organisations Fire Officers, Estates Officer's and NWSSP – Facilities Services experience and knowledge for operational areas. If other specialist advice is required this will be outsourced.

9.7 Fire Involvement with Groups / Departments / ILG/ Site Fire Safety Groups

Fire Safety management does not exist in isolation, many decisions are made at all levels without the thought of what implications they would have on fire safety, the management of fire safety, or the threat of fire to life or property. Any groups or departments making decisions on structural, staffing or operational issues must consider fire implications. Therefore the fire safety management processes must involve either the Fire Safety Manager, the Senior Fire Officer, or the site relative Fire Officer.

Combined involvement internally and externally with authorities and services such as Local Authorities, Fire, Police, Community Partnerships, Local and Government Services, will ensure that fire safety for the patients, visitors, staff and anyone who uses the organisations property is maintained to a high standard.

A Strategic Health, Safety and Fire Safety Committee will review and address the operational and organisations provisions, alterations, provisions and fire safety issues. This group is a sub group of the Quality and Safety Committee. Each ILG has its own Health Safety and Fire Group which reports to the Health, Safety and Fire Committee.

A Building Development Fire Safety Group will review and address the CTMUHBs Estate structural provisions, alterations, provisions fire safety issues. This group will feed into the CTMUHB Strategic Health, Safety and Fire Committee.

Fire safety will be a standing agenda item at the Health and Safety Coordinating Group meetings to ensure any issues can be addressed and discussed at Service Group, Management, staff level, groups or committees. This list is not exhaustive and fire safety can be involved in other group meetings.

9.8 ILG leads/ Clinical / Non-Clinical Directors (Responsible Persons)

Within their sphere of responsibilities, under the RR(FS)O article 5(3) ILG Leads and Service Group Managers are responsible for:

- staff and departments within their remit and maintaining the required level of compliance of fire safety;
- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report upwards onto the Service Group risk register;
- act upon Fire Service notification (INO/ENO) issued on their areas of responsibility and report on the corporate risk register;
- acting upon any departmental fire issues raised;
- cooperating with others where areas of responsibility are shared, ensuring levels of compliance are maintained;
- the safety of patients under their control and ensuring that there is a system or local procedure in place to ensure the safe evacuation of all users of their areas of responsibility, a means of identifying persons missing, and where applicable these systems or procedures take into account highly infectious, contagious disease or bariatric requirements;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed through their Service Group carrying out work in organisations premises;
- staff under their control have the required fire training and have access to up to date training records for audit purposes.

9.9 Service Group Managers / Host Organisation Leads (Responsible Persons)

Within their sphere of responsibilities, under the RR(FS)O article 5(3) Service Group Managers / Host Organisation Leads are responsible for:

- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report upwards onto the Service Group / organisational risk register;
- act upon Fire Service notification (INO/ENO) issued on their areas of responsibility and report on the Service Group / organisational risk register;
- ensuring compliance with general fire safety duties outlined in relevant fire legislative / guidance documents and the CTMUHB Fire Policy;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed by their Service Group carrying out work in organisation premises;
- staff under their control have the required fire training and have access to up to date training records for audit purposes;
- ensuring that satisfactory written arrangements (local ward / dept fire procedures) are in place for the safe evacuation of all staff, patients and visitors including, if appropriate, the safe evacuation and housing of the disabled, highly infectious / contagious disease or bariatric patients;
- ensuring any building leased or utilised for the Service Groups use must have clear documented definitive fire responsibilities. To include the named responsible person for the building, a FRA, fire plan, and information on maintaining and testing of the structural fire systems and fire provisions, prior to occupation. If already occupied this information must be obtained and available for inspecting authorities.

9.10 Department, Line, Ward, Residential, Bank, Agency, Volunteer Managers (Responsible Persons)

Within their sphere of responsibilities under the RR(FS)O article 5(3) Department, Line, Ward Managers are responsible for:

- ensuring that satisfactory written arrangements (local ward / dept fire procedures) are in place for the safe evacuation of all staff, patients and visitors including, if appropriate, the safe evacuation and housing of the disabled, highly infectious / contagious disease or bariatric patients;
- ensuring that their workplace area is checked, inspected and maintained to ensure a fire safe environment is maintained. However the role and tasks of the Department or Line Manager in relation to fire can be, if required, delegated to another staff member. Whilst the role can be delegated, the Department or Line Manager is still responsible for the fire safety issues within their remit;
- ensuring they are aware of all electrical equipment that is to be used in their sphere of responsibility and that it is tested by Estates or Clinical Engineering dependant on equipment classification prior to its use;

- ensuring that where any cooking takes place, e.g. toasters, microwaves, is in a recognised and dedicated room for cooking and a safe system of work is in place to mitigate the chances of unwanted fire signals (false alarms);
- acting upon Fire Risk Assessments (FRA) issued on their areas of responsibility, and report on the department risk register;
- acting upon Fire Service notification (INO/ENO) issued on their areas of responsibility and reporting deficiencies upwards to senior management and ensuring the department risk register is up to date;
- reporting any fire related issues to their Service Group Manager;
- staff under their control have the required fire training and have access to up to date training records for audit purposes;
- ensuring they are familiar with fire procedures for their area and the site;
- ensuring that staff are appropriately trained in the use and location of specialist equipment such as evacuation aids and
- ensuring that staff are appropriately trained in the use and location where there are specific risks such as oxygen and/or medical gases;
- cooperating with others where areas of responsibility overlap;
- the safety of patients under their control and ensuring that a system or local procedure is in place and up to date to ensure the safe evacuation of all users of their areas of responsibility, a means of identifying persons missing, and where applicable these systems and procedures take into account highly infectious or contagious diseases and bariatric requirements;
- the supervision of the evacuated ward or department and account for staff, patients and visitors at the assembly point in a fire emergency situation;
- disseminating local ward and department procedures to all staff on a regular basis including new starters or bank staff, and this training is recorded and available;
- attending fire training specific to their role and level of responsibility, and ensuring all staff under them attend fire training specific to their role and responsibility;
- the supervision of contractors employed by their department carrying out work in organisation premises.

Should the Ward or Department Manager wish to pass these responsibilities onto a member of staff to act on their behalf (fire warden/marshal role) the manager must be fully aware of their roles and requirements of that role still lies with them as the manager and the responsibility lies with that relevant manager to ensure there is no conflict in the managing fire safety. The Ward or Department Manager is still the responsible person as defined under the RRFSO and is accountable at all times. They will be responsible for ensuring there is clear written guidance for the role of the 'Fire warden/member of staff' looking after duties for fire. They will also be responsible for training them in their roles and duties they require them to undertake, as the role of fire warden/marshal is not a recognised role within this organisation).

9.11 Employees, Volunteers, Bank or Agency Staff

All employees have a personal responsibility and a statutory duty of care in respect of fire safety, must maintain high standards and vigilance at all times in order to reduce the risk of fire. All employees must:

- read and sign to state they have read and understood their ward / dept local procedures for where they are employed;
- raise specific fire hazards and or fire safety issues directly with their Line Manager or via their staff side H&S rep before escalating to the HB Fire Officers;
- strictly adhere to risk assessments and safe systems of work;
- respond to incidents as appropriate;
- attend fire training specific to their role and level of responsibility;
- cooperate with management on Fire Risk Assessments issued on their areas;
- cooperate with management on Fire Service notification (INO/ENO) issued on their areas;
- cooperate with all other employers and employees in relation to fire safety matters;
- report to Line Manager any fire safety concerns or issues;
- not interfere with provisions provided for fire safety.

Specifically in relation to this Policy, Safety Representatives are entitled to:

- make representation to Managers on general matters affecting the health, safety or welfare at work of any employee;
- represent employees in consultations at the workplace with inspectors of the Health and Safety Executive, or with any other enforcing authority, in relation to health and safety matters affecting any employee;
- undertake training and receive accreditation from the organisation;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;
- carry out inspections of the workplace in accordance with Regulations 5, 6 and 7 of the Safety Representative and Safety Committee Regulations 1977;
- be represented at, or attend, meetings of the Quality and Safety Committee and Service Group Safety Groups.

Specifically in relation to this Policy, Safety Representatives are entitled to:

- make representation to Managers on general matters affecting the health, safety or welfare at work of any employee;
- represent employees in consultations at the workplace with inspectors of the Health and Safety Executive, or with any other enforcing authority, in relation to health and safety matters affecting any employee;
- undertake training and receive accreditation from the organisation;
- investigate potential hazards, dangerous occurrences, causes of incidents and complaints by employees, at the workplace;

10. Retention or Archiving

In cases of complaints and/or claims and other legal processes it is often necessary to demonstrate the policy in place at the time of the investigation or incident. The Board Level Director for fire must therefore ensure that copies of policies and procedures are archived and stored in line with the organisations Records Management Strategy and are made available for reference purposes should the situation arise.

11. Non Conformance

There is a requirement of all staff to comply with the provisions of this Policy and, where requested, to demonstrate such compliance. Failure to comply will be dealt with in accordance with the appropriate organisations Human Resources policy.

12. Equality Impact Assessment Statement

This Policy has been subject to a full equality assessment and no impact has been identified.

13. References

Statutory Documents
Regulatory Reform (Fire Safety) Order 2005;
Building Regulations;
The National Health Service and Community Care Act (current edition);
Health and Safety at Work etc Act (current edition);
Management of Health and Safety at Work Regulations 1999 (current edition);
Registered Homes Act (current edition);
The Housing Act (current edition);
Furniture and Furnishings Fire Safety Regulations (current edition).

Mandatory Documents
Welsh Health Technical Memorandum (WHTM) 05 – suite of documents – Firecode.

Legislative Documents
There are a number of other WHTMs that have fire implications that relate to fire contained within them. Care should be taken ensure that the fire safety is not compromised by other WHTM guidance's.

Internal Health Board Fire Documents
Fire False Alarm incident reporting form;
Site Specific operational documents;
FRA/INO/ENO Procedure;
Building Alteration / Development Procedure.

This list is not exhaustive and other legislation may apply in varying circumstances. Internal documentation will be developed as and when identified as being required.

Appendix C - Major Emergencies

For any fire related major emergency the Senior CTMUHB manager in charge should follow the major incident procedure and contact those listed on the major incident action card.

Also the **nearest Health and Safety Executive office:**

Health and Safety Executive
Government Buildings
Ty Glas
Llanishen
Cardiff
CF14 5SH
Tel: 02920 263028

Agenda Item
7.1

Quality & Safety Committee

PATIENT SAFETY & QUALITY DASHBOARD

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities	Various dates	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PTR	Putting Things Right
PSOW	Public Service Ombudsman for Wales

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.09.23 to 31.10.23 taken from systems on 07.11.23, unless otherwise specified.

The report contain the following appendices:

- Patient Experience Report
- Executive Director and Independent Board Members Walkround Report

Key areas to note in this reporting period are:

- Decrease in the number of formal complaints received.
- Compliance with the 30 working day target for responding to complaints remains over 70%
- Number of PSOW full investigations has decreased
- Section 23 (Public Interest Report) issued by the Public Services Ombudsman for Wales during October 2023
- Increase in Nationally Reportable Incidents linked to change in reporting process for incidents relating to Infection, Prevention & Control
- Trajectory plan in place to reduce the number of overdue Nationally Reportable Incidents
- Decrease in the number of medication incidents reported
- Increase in Patient falls incidents reported
- Opportunities for benchmarking quality indicators across NHS Wales being explored

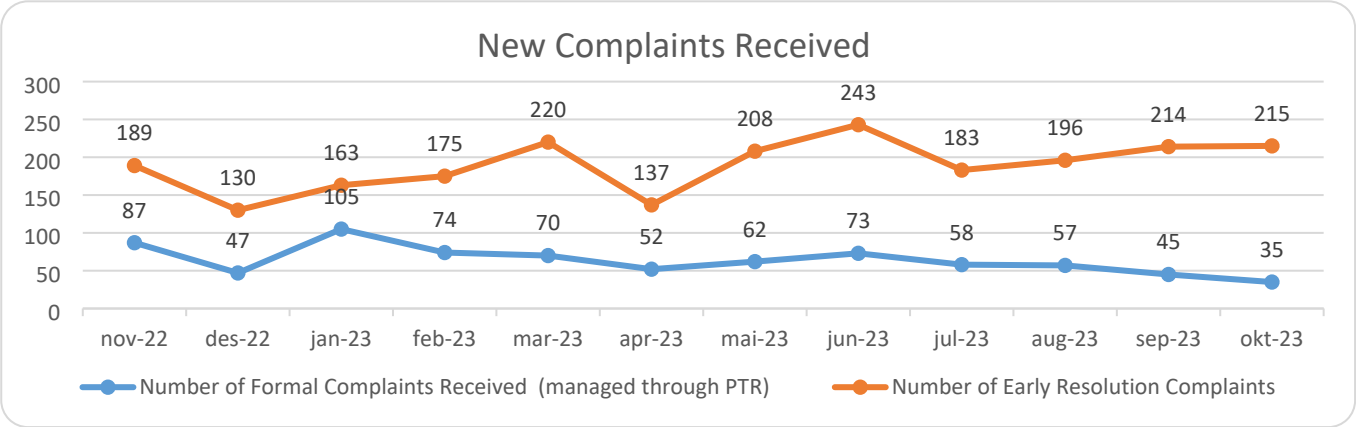
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

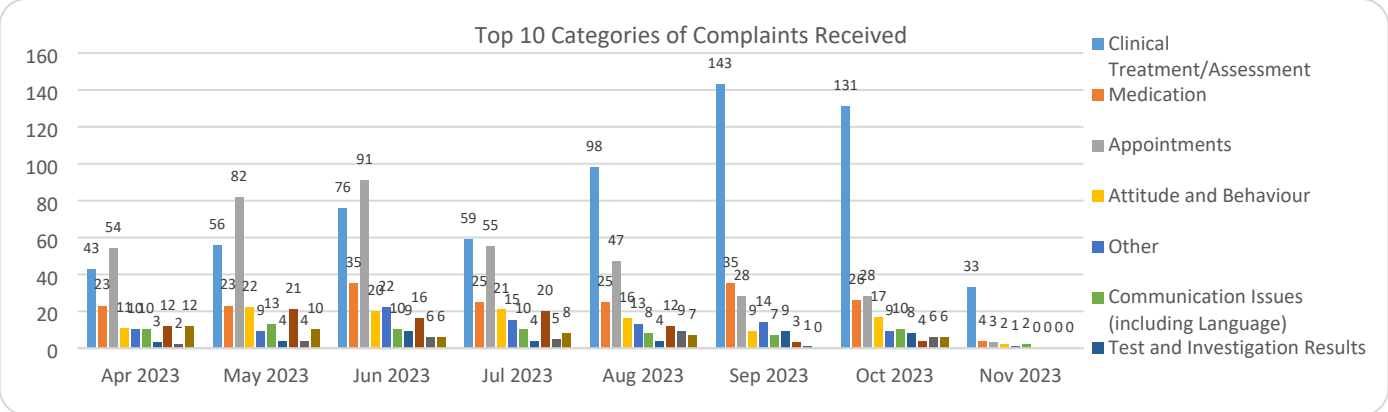
Complaints

New Complaints Received

Between the 01.09.23 and 31.10.23 the Health Board received a total of 509 complaints. Of these, 80 were categorised as formal and managed under the Putting Things Right Regulations (PTR). This represents a continuation of the decrease in the number of formal complaints highlighted in the last report to Committee. The decrease in complaints is reflective of embedding of the improved triage process, realignment of the recording of complaints relating to Primary Care in line with the All Wales process and proactive management of queries relating to waiting times.

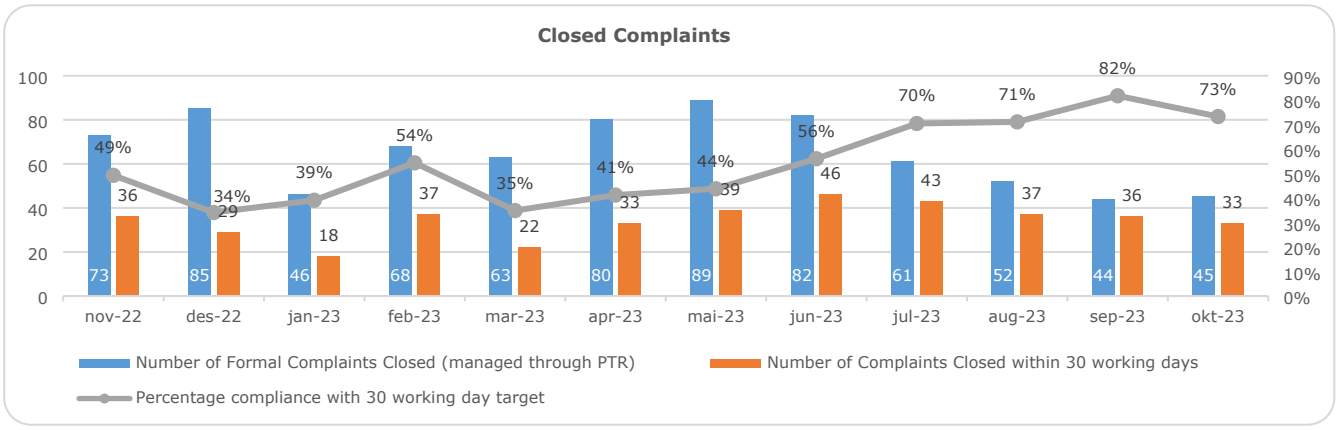


For all complaints received in September and October 2023, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (274), Medication (61) and Appointments (56).



Closed Complaints

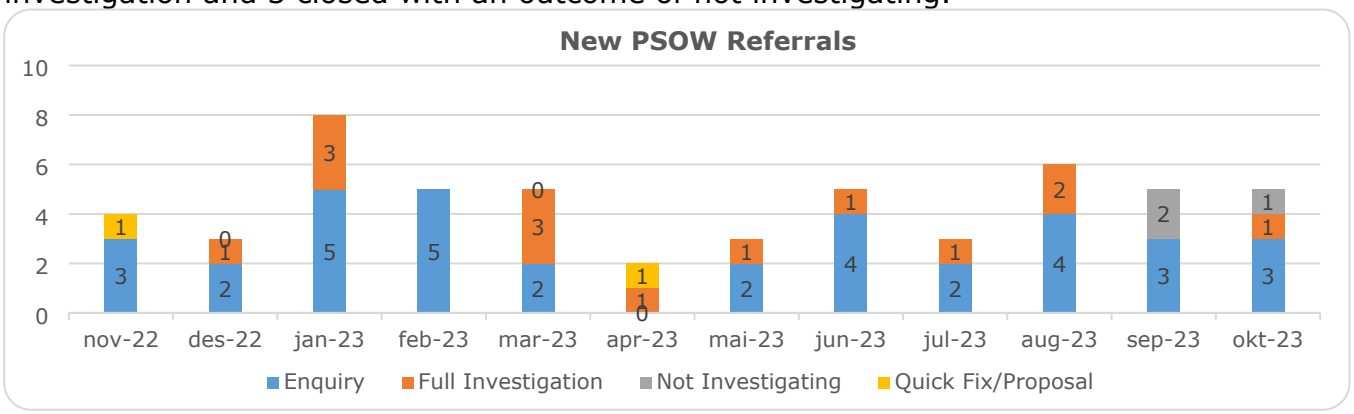
Within the period of 01.09.23 to 31.10.23, the Health Board closed a total of 89 formal complaints (managed through PTR). Following an increase in compliance with the 30 working day target during June 2023, compliance remained above 70%. The decrease in compliance during October 2023 was impacted by the closure of historic complaints.



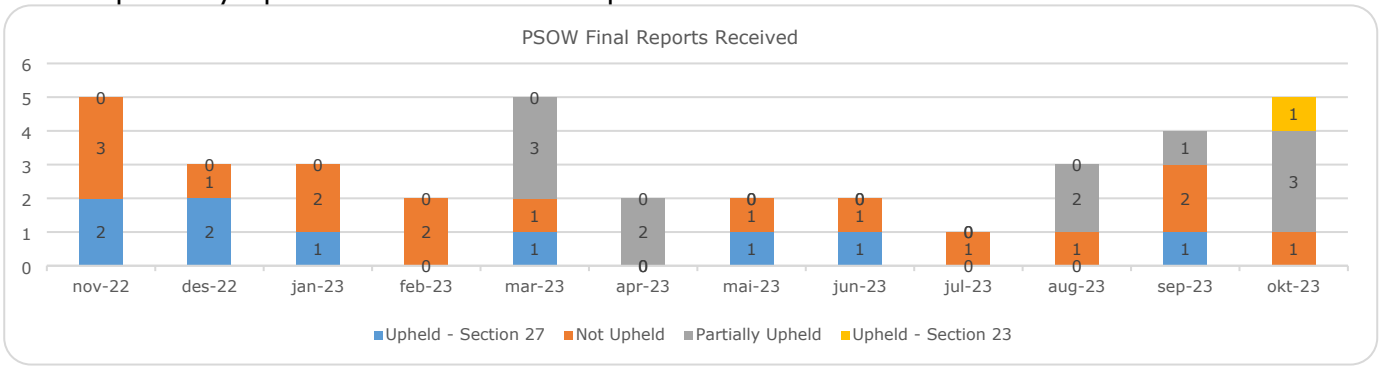
As at 03.11.23 the Health Board had 100 open formal complaints. Of these 62 complaints were open over 30 working days. A trajectory plan is in place to continue to improve compliance and address open complaints over 30 working days. A number of actions are being embedded which include daily Complaint Team Huddles to review cases and support the embedding of the early escalation process, along with reallocation of cases to ensure a focus remains on the concluded cases within time as well as addressing those over 30 working days.

Public Services Ombudsman for Wales

The Health Board received notification of 10 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.09.23 and 31.10.23. This remains relatively consistent with previous months. Of the 10 referrals, 6 were received as enquires, 1 as a full investigation and 3 closed with an outcome of not investigating.



During the same period, the PSOW issued 9 final reports to the Health Board, 2 were upheld, 4 were partially upheld and 3 were not upheld.



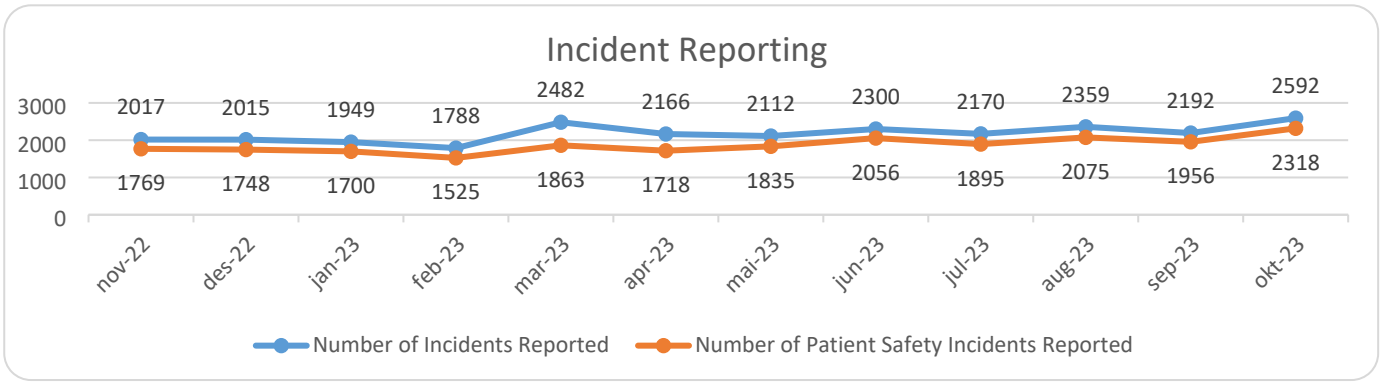
A breakdown of the type of PSOW final reports by Care Group is provided in the table below:

		Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Total
Diagnostics, Therapies and Specialist Care	Not Upheld	0	0	0	0	1	0	0	1
	Upheld	0	1	0	0	0	0	0	1
	Total	0	1	0	0	1	0	0	2
Families and Children	Partially Upheld	1	0	0	0	0	0	0	1
	Total	1	0	0	0	0	0	0	1
Mental Health	Not Upheld	0	0	0	0	0	1	0	1
	Total	0	0	0	0	0	1	0	1
Planned Care	Partially Upheld	0	0	1	0	1	1	0	3
	Not Upheld	0	0	0	0	0	0	1	1
	Upheld	0	0	0	0	0	1	0	1
	Total	0	0	1	0	1	2	1	5
Primary Care	Not Upheld	0	1	0	0	0	0	0	1
	Partially Upheld	0	0	0	0	0	0	1	1
	Total	0	1	0	0	0	0	1	2
Unscheduled Care	Not Upheld	0	0	0	1	0	1	0	2
	Partially Upheld	1	0	0	0	1	0	2	4
	Upheld	0	0	1	0	0	0	1	2
	Total	1	0	1	1	1	1	3	8

The upheld report for Planned Care in October 2023 was issued as a Section 23 Public Interest Report. The complaint relates to missed opportunities to effectively diagnose, manage and treat a patient attending the Princess of Wales Hospital with bleeding from the umbilicus (navel) between December 2019 and January 2021. An action plan addressing the recommendations is currently being implemented.
As at 03.11.23, the Health Board currently has 51 Open PSOW cases, of these 31 are awaiting a response from the PSOW to instigate any further action required. Compliance has been submitted and confirmation of closure is awaited on 10 of the 31 cases. 7 are at final report stage with actions being implemented by the Care Groups.

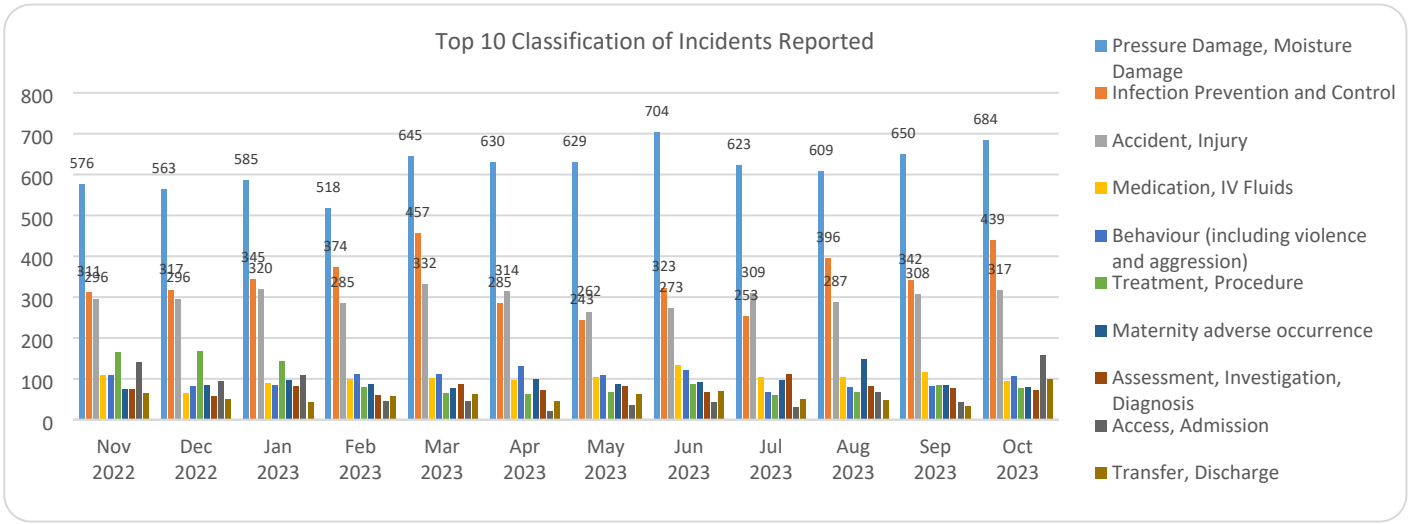
2.2 Patient Safety Incidents

Total Patient Safety Incidents
A total of 4,784 incidents were reported between 01.09.23 and 31.11.23, this represents an increase of 255 when compared with the previous 2 months (4,529).



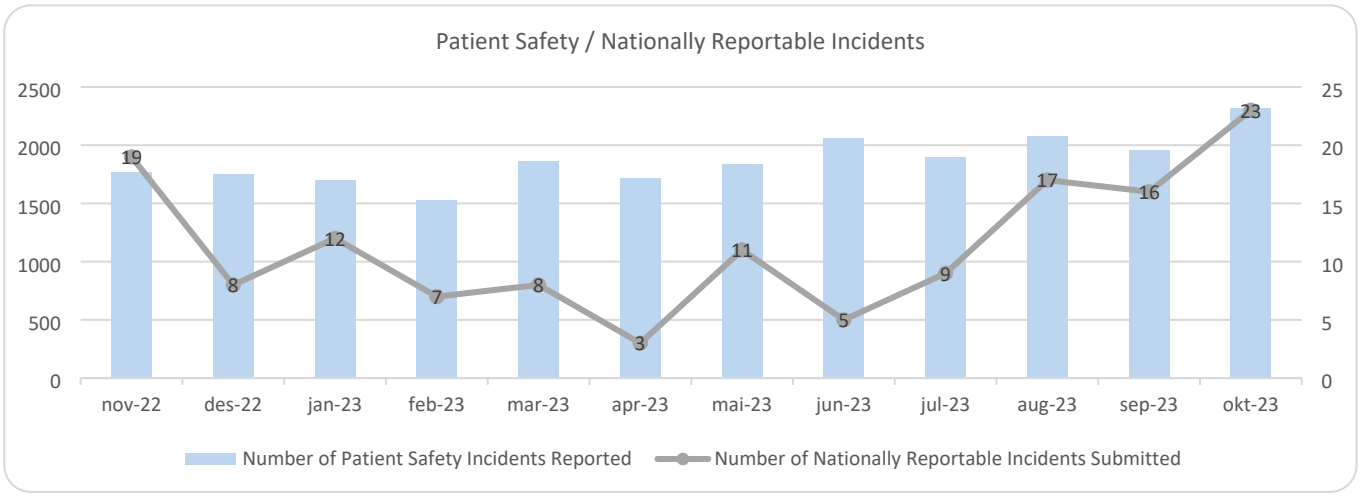
Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has continued to increase. Of the 4,784 incidents reported, 89% (4,274) were reported as the patient affected.

The top 3 types of incidents reported for September and October 2023, linked to a patient affected are Pressure Damage /Moisture Lesion (1334), Infection, Prevention & Control (781) and Accident, Injury (625).



Nationally Reportable Incidents

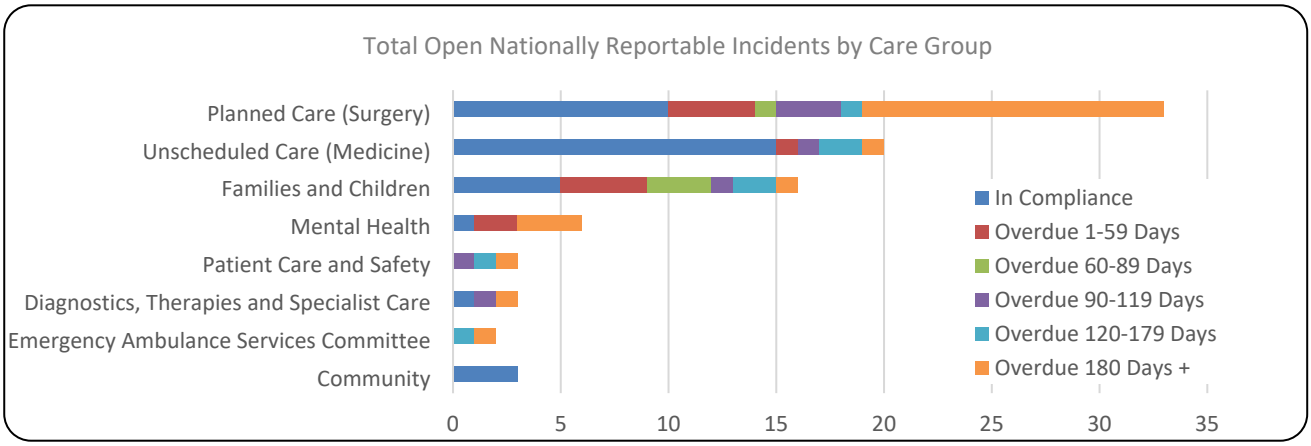
Between 01.09.23 and 31.10.23, 39 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



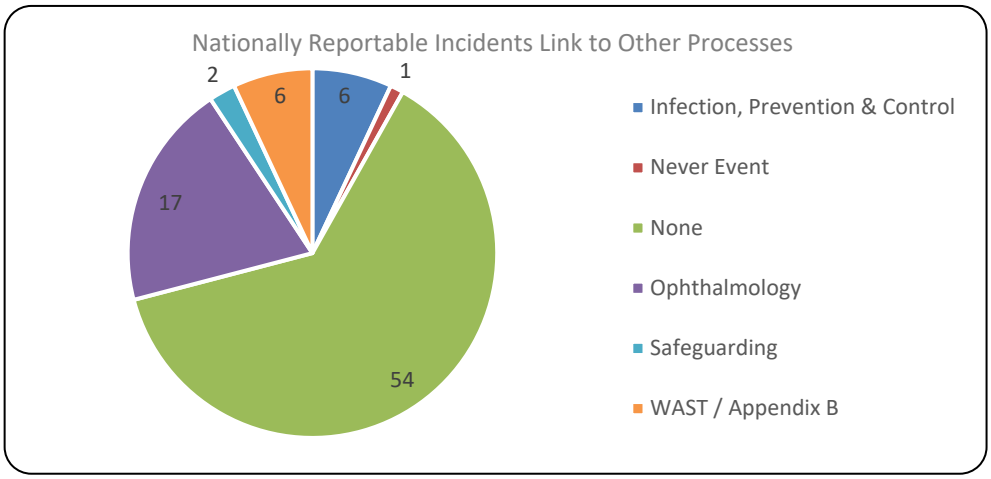
As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive (formerly known as the "Delivery Unit"). This is reflected in the increase in both November 2022 (19), January 2023 (12) and May 2023 (12) is linked to the submission of legacy ambulance delays and notification of Ophthalmology incidents, following completion of the harm review process that occurred prior to the reporting period and pressure damage deemed avoidable following review at scrutiny panel. The increase in Nationally Reportable Incidents since August 2023 can be attributed to change in reporting requirements for infection, prevention and control related incidents, i.e. outbreaks and ward closures. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
Access, Admission	7	1	5	0	1	0	0	0	1	0	0	1
Accident, Injury	2	0	0	1	0	0	0	0	0	0	0	0
Assessment, Investigation, Diagnosis	2	1	0	0	1	0	1	1	2	1	3	0
Infection Prevention and Control	0	0	0	0	0	0	0	0	0	6	10	13
Maternity adverse occurrence	0	1	1	2	1	0	2	0	1	4	0	0
Medication, IV Fluids	0	1	0	0	0	1	0	0	1	0	0	1
Patient/service user death	2	0	0	1	1	0	3	1	0	1	0	0
Pressure Damage, Moisture Damage	1	2	2	2	2	1	5	3	2	5	2	7
Safeguarding	0	1	1	0	0	0	0	0	0	0	0	0
Transfer, Discharge	5	0	0	0	0	0	0	0	0	0	0	0
Treatment, Procedure	0	1	3	0	2	1	0	0	2	0	1	1
Total	19	8	12	6	8	3	11	5	9	17	16	23

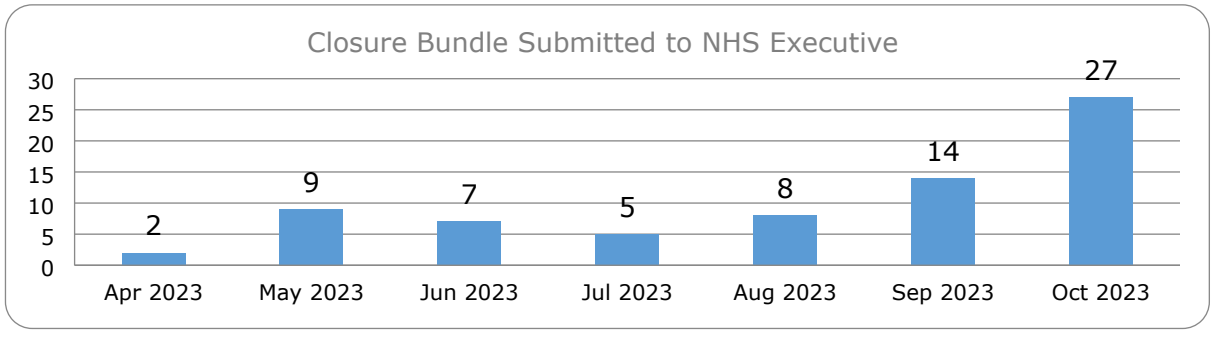
As the 03.11.23 the Health Board currently has 86 open Nationally Reportable Incidents, of which 51 are overdue the timescale for completion. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Of the open Nationally Reportable Incidents, 32 are linked to other processes which are reflected in the chart below:



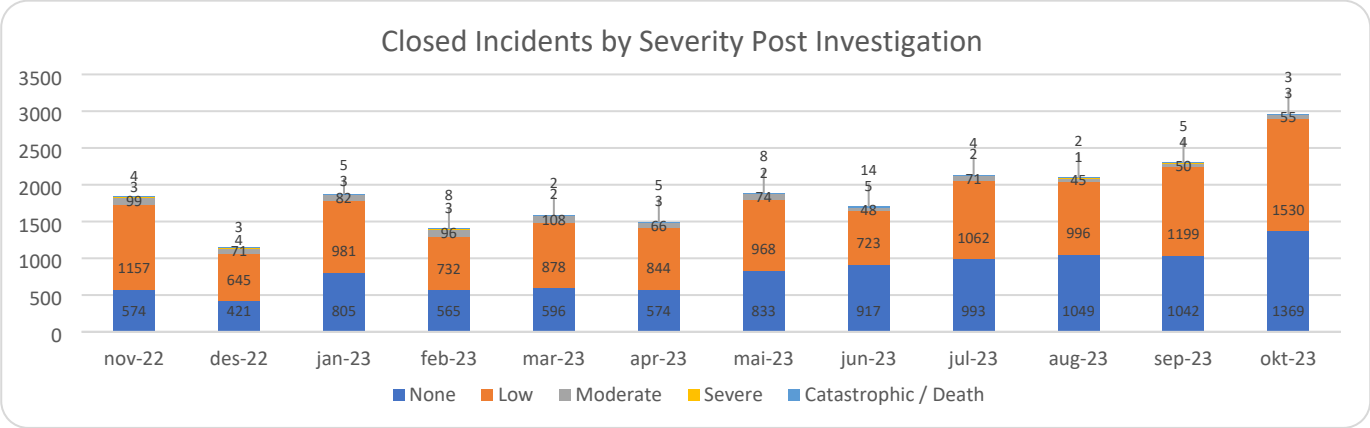
A consolidation exercise of all open Nationally Reportable Incidents was undertaken and a trajectory plan established to address the number of outstanding Nationally Reportable Incidents. This is reflective in the increase in the number of closure bundles submitted during September and October 2023.



Closed Patient Safety Incidents

Between the 01.09.23 and 31.10.23 a total of 5,260 patient safety incidents were closed. Of the 45,260 patient safety incidents closed, 15 were closed with severity post investigation of severe harm (7) or catastrophic/ death (8). It should be noted, however, that an outcome of catastrophic / death may not be directly caused or attributable to an intervention

(action/inaction) by the Health Board (e.g. an unexpected Mental Health death). The 12 month trend is reflected in the table below.



Duty of Candour

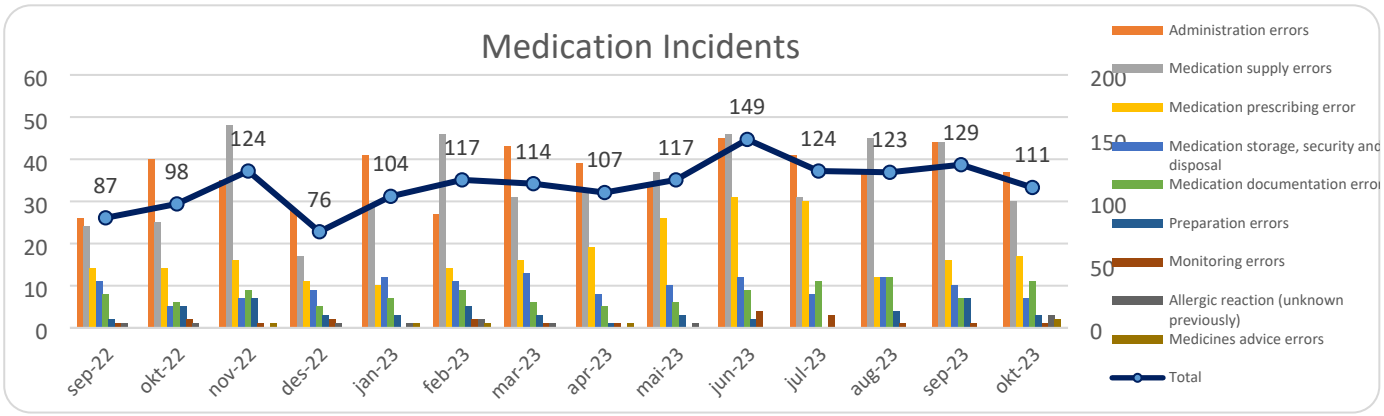
The Duty of Candour regulations where implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have ben devised, which are summarised in the table below. As the implementation of the Duty of Candour progresses, further analysis of the data can be undertaken and included within this report.

Number of Incidents	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept -23	Oct-23
Occurring during the month	1718	1835	2056	1895	2075	1956	2318
Initial Management Review Completed	1546	1445	1532	1468	1285	1579	1691
Identified as Moderate/Severe/Death following Management Review	44	45	64	52	72	55	81
Where Duty of Candour Triggered	13	7	12	10	12	8	10
Where In-person notification completed	5	4	7	3	11	6	7
Where letter of notification sent	1	3	4	1	6	3	4

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

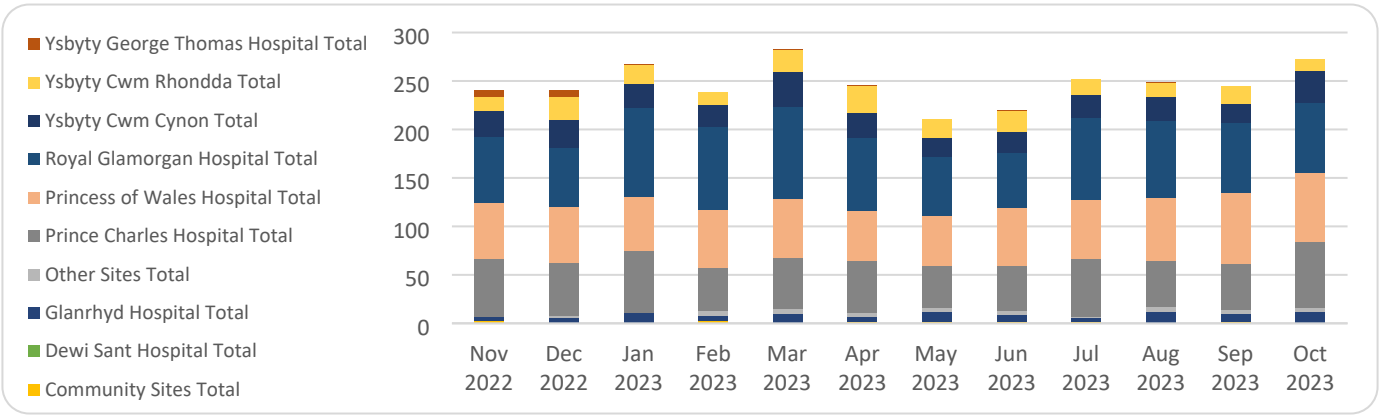
A total of 240 medication incidents were reported as occurring between 01.09.23 and 31.10.23. This is a decrease of 7 when compared with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (81), supply errors (39), and prescribing (33).



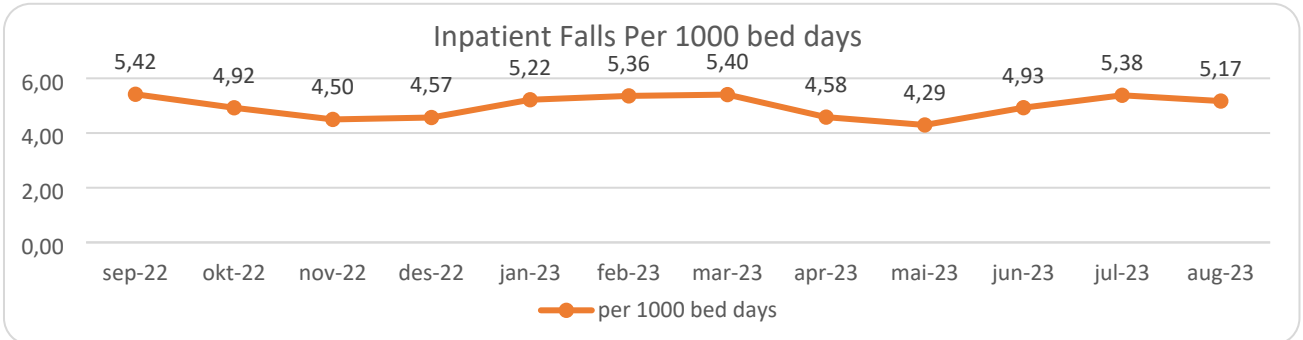
84% of the medication incidents were reported as resulting in no (108) or low (94) harm, with the remaining reported as resulting in moderate harm (35) and severe (3) harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 517 falls, where the person affected was a patient, were reported during September and October 2023. This represents an increase of 16 in the number of falls reported in comparison to the previous 2 month period. Of the falls incidents within the time period, 91% were reported as no (143) or low (328) harm. The remaining incidents were reported as moderate (43) and severe (3) harm. No incidents relating to patient falls were reported as resulting in death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



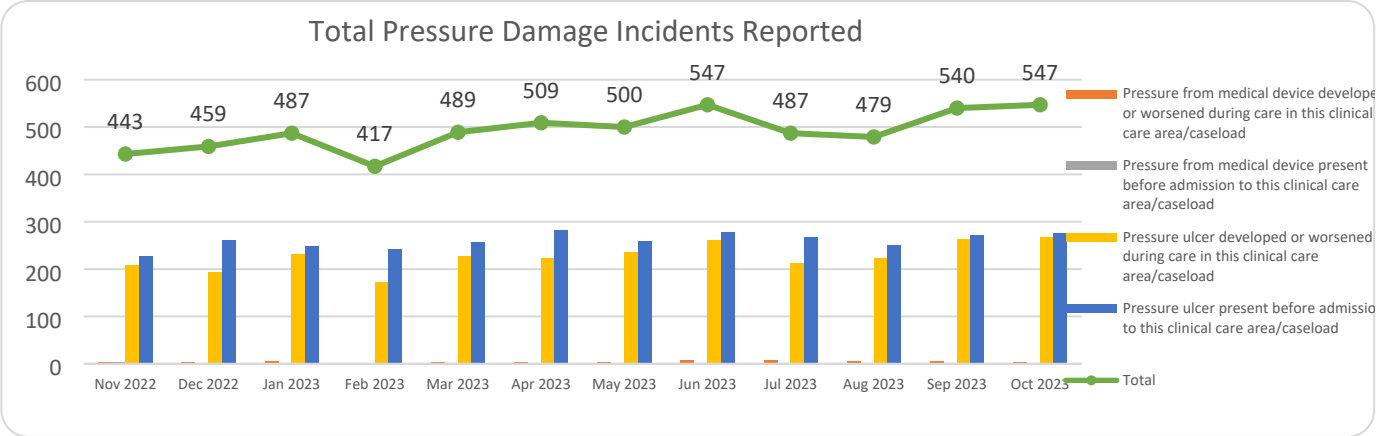
During the time period, the highest number of inpatient falls occurred on Ward 7 at Ysbyty



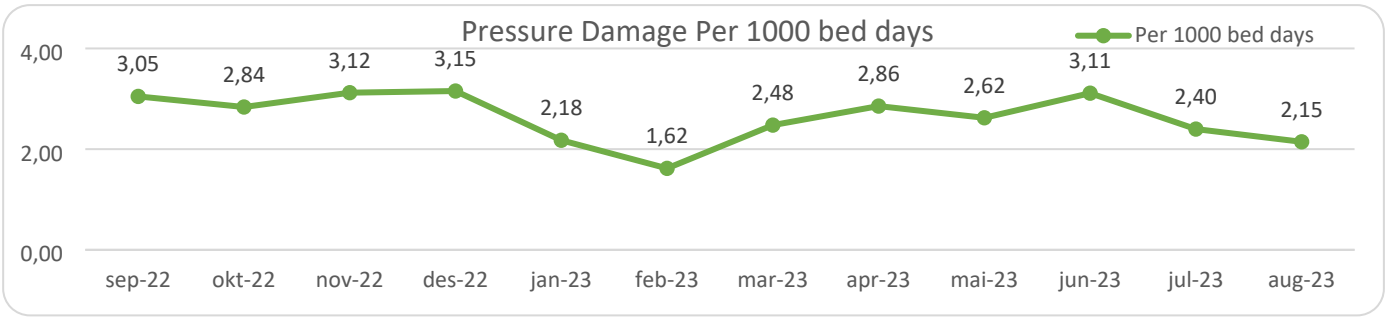
Cwm Cynon (23), Ward 2, Glanrhyd Hospital (16) and Ward 15 at Princess of Wales Hospital (16).
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.3.3 Pressure Damage

Between the 01.09.23 and 31.10.23, a total of 1,087 pressure damage incidents were reported, of which 538 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (549) were reported as being present before admission to this clinical care area/caseload.



Of the 538, identified as developing or worsening during current caseload, 231 were identified as occurring within the community. This represents an increase of 51 when compared with the previous two months.

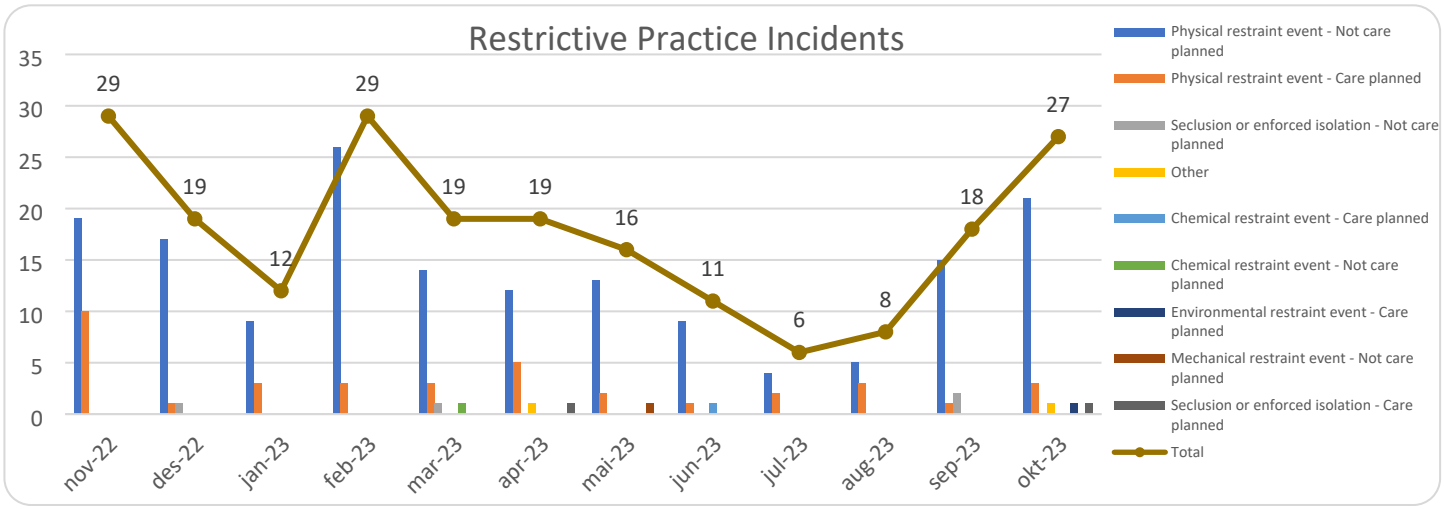


The pressure damage improvement programme continues to progress with a particular focus on grading of pressure damage and completion of required documentation.

2.3.4 Mental Health Metrics

<u>Number of Section 136 (Mental Health Act 1983) Assessments in police cells</u>
The number of Section 136 assessment in police cells remains at 0 (Health Board wide), which demonstrates good compliance with the Crisis Care Concordat, ensuring that those who require mental health assessment are not detained in custody suites.

<u>Restrictive Practices</u>

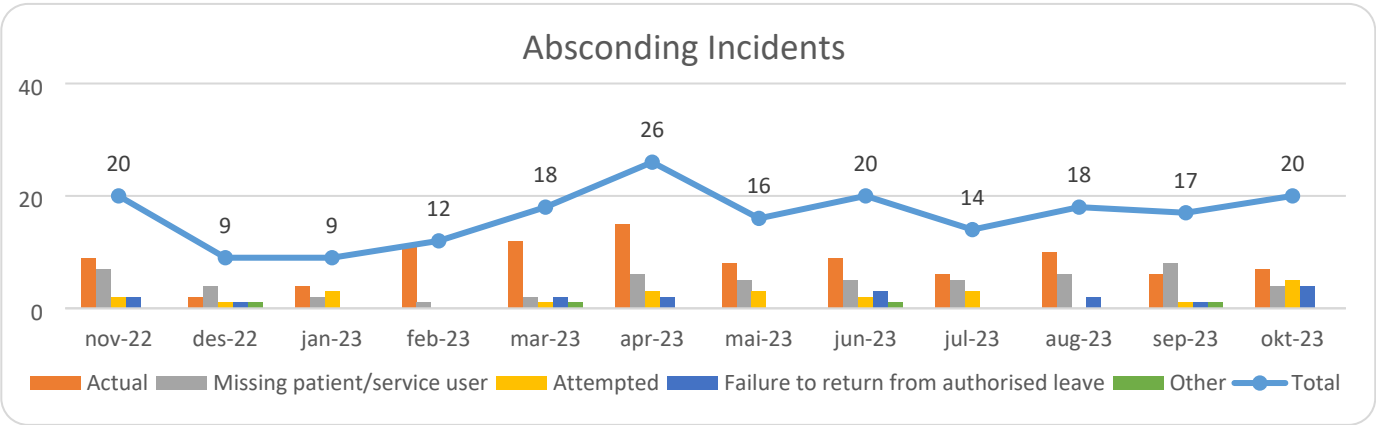


Between 01.09.23 and 31.10.23, a total of 45 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 31 incidents when compared to the previous two months. The increase in incidents during the period is partly associated with multiple incidents being reported for the same patients (4 patients on Ward 14 at the Princess of Wales Hospital).

Of the 45 incidents, 37 were reported as not care planned, 7 were reported as care planned and 1 as other. The highest number of incidents were reported as occurring on Ward 14 at Princess of Wales Hospital (20).

<u>Absconding incidents</u>

During September and October 2023, a total of 37 Absconding incidents were reported, an increase of 5 when compared with the previous 2 month period. 13 were recorded as actual absconding, with the remaining recorded as missing patient / service user (12) attempted (6), failure to return from authorised leave (5) and other (1). The highest number of incidents were reported as occurring in the Emergency Care Department at Prince Charles Hospital (8).



2.4 Benchmarking

At the last Committee meeting a query was raised in relation to the ability to benchmark quality indicators across NHS Wales. The following information is currently collated by the NHS Wales Executive:

- Complaints data including new, subject, closed and compliance with the 30 working days target. This information is obtained from the Organisations quarterly Putting Things Right.
- Nationally Reportable Incidents including new, classification and number currently open.

Discussions are being instigated with the NHS Wales Executive to establish accessibility of the information and potential for presentation at future meetings.

In addition to the above the Public Services Ombudsman for Wales provides an annual report which provides information in relation to complaints management across NHS Wales.

3. Key Risks / Matters for Escalation

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

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Work is required to ensure data included in this report are consistently captured and appropriately validated.
- Improving and maintaining compliance with the 30 working days complaints response rate.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Choose an item.
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.	
Effaith Adnoddau *(Pobl /Ariannol) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

5. Recommendation

Members of the Quality & Safety Committee are asked to:

- **NOTE** the content of the report
- **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required
- **NOTE** the risks identified
- **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

6. Next Steps

Improvement actions identified within the report to continue to be monitored via the Quality & safety Committee and Weekly Quality & Safety Executive Meeting.

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

11/09/2023

	Alerts as at: 11/09/2023	NOTE: THERE IS AN ALL WALES ISSUE REGARDING PSA008 DUE TO NG TUBE COMPETENCY BASED TRAINING FOR MEDICAL STAFF. SOME ORGANISATIONS TO WHICH THIS ALERTS APPLIES ARE NON-COMPLIANT. All Wales approach to support organisations to meet the requirements of PSA008 - Comliance date extended to 29/09/2023										
PSA No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSA001	Legionella and heated birthing pool filled in advance of labour in home settings.	**30/06/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA002	The prompt recognition and initiation of treatment for sepsis for all patients.	**28/11/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSA003	Update to the NPSA alert for safer spinal (intrathecal), epidural and regional devices	**01/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA004	Ensuring the Safe Administration of Insulin	**28/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA005	Minimising the risk of medication errors with high strength, fixed combination and biosimilar insulin products	**14/10/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA006	Risk of death and severe harm from error with injectable phenytoin	**10/03/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA007	Restricted use of open systems for injectable medication	**01/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSA008	Nasogastric tube misplacement: continuing risk of death and severe harm	**30/11/2017**	Non-compliant	Compliant	Non-compliant	Non-compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA009	Wrong selection of orthopaedic fracture fixation plates	**15/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA010	Interruption of high flow nasal oxygen during transfer	**10/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA011	Blood control safety cannula & needle thoracostomy for tension pneumothorax	**15/04/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSA012	Deterioration due to rapid offload of pleural effusion fluid from chest drains	**01/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSA013a	Ligature and ligature point risk assessment tools and policies	**07/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA013b	Ligature and ligature point risk assessment tools and policies	**01/09/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSA014	Inappropriate anticoagulation of patients with a mechanical heart valve	**28/10/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSA015	Safe use of oxygen cylinders in areas without medical gas pipeline	**27/01/2023**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	Non-compliant

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

11/09/2023

Notices as at: 11/09/2023												
PSN No:	**Title of Safety Solution**	**Compliance Date**	**ABHB**	**BCUHB**	**C&VU**	**CTMUHB**	**HDHB**	**Powys**	**PHW**	**SBUHB**	**Velindre**	**WAST**
PSN001	Risk of harm relating to interpretation and action on Protein Creatinine Ratio (PCR) results in pregnant women. NB not part of returns compliance.	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN002	The Surgical Management of Urinary Incontinence (UI) and Pelvic Organ Prolapse (POP)	**31/07/2014**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN003	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN004	Risk of death and serious harm from delays in recognising and treating ingestion of button batteries	**19/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN005	Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment	**30/01/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN006	Risk of hypothermia for patients on continuous renal replacement therapy	**30/04/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN007	Risk of death or serious harm from accidental ingestion of potassium permanganate	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN008	Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder	**28/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN009	Awareness of NICE clinical guidelines on head injuries	**31/05/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN010	Failure to act on known contraindications to Low Molecular Weight Heparins	**25/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN011	Risk of associating ECG records with wrong patients	**18/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN012	Adrenal insufficiency (addison's disease) in adults - information for general practitioners	**12/06/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN013	Managing risks during the transition period to new ISO connectors for medical devices used for enteral feeding and neuraxial procedures	**13/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	Compliant	N/A
PSN014	Residual anaesthetic drugs in cannulae and intravenous lines	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN015	The storage of medicines: Refrigerators	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN016	Risk of inadvertently cutting in-line (or closed) suction catheters	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN017	Risk of using vacuum and suction drains when not clinically indicated	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN018	Risk of severe harm and death from unintentional interruption of non-invasive ventilation	**31/08/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN019	Harm from delayed updates to ambulance dispatch and satellite navigation systems	**30/09/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN020	Minimising risks of omitted and delayed medicines for patients receiving homecare services	**27/11/2015**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN021	Risk of death and serious harm from falling from hoists	**15/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN022	Risk of death from the inappropriate use and disposal of fentanyl patches	**31/01/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN023	The importance of vital signs during and after restrictive interventions/manual restraint	**12/02/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN024	Risk of using different airway humidification devices simultaneously	**01/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN025	Risk of death or severe harm due to inadvertent injection of skin preparation solution	**04/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN026	Positive patient identification	**13/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN027	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN028	Medicine Reconciliation - Reducing the risk of serious harm	**31/03/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN029	Standardising the early identification of acute kidney care	**08/04/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN030	**THIS HAS BEEN REPLACED BY PSN055** **The safe storage of medicines: Cupboards**											
PSN031	Risk of Patient Safety Incidents resulting from errors in the British National Formulary for Children 2015-16 and British National Formulary 70	**31/05/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN032	Risk of Patient harm from an interaction between miconazole and coumarin anticoagulants	**10/06/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN033	Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	**29/07/2016**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN034	Supporting the introduction of the National Safety Standards for Invasive Procedures	**28/09/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A
PSN036	Reducing the risk of oxygen tubing being connected to airflow meters	**04/08/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN037	Resources to support the safety of girls and women who are being treated with Valproate	**06/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN035	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**16/10/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN038	Risk of severe harm and death from infusing Total Parenteral Nutrition too rapidly in babies	**08/12/2017**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN039	Safe Transfusion Practice - Use a bedside checklist	**15/02/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN040	Confirming removal or flushing of lines and cannulae after procedures	**12/09/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN041	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders harm	**23/04/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN042	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	**11/06/2018**	N/A	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	N/A
PSN043	**THIS HAS BEEN REPLACED BY PSN049 Supporting the introduction of the Tracheostomy Guidelines for Wales**											
PSN044	Resources to support safer care for full-term babies	**21/10/2018**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN045	Resources to support safer modification of food and fluid	**01/04/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN046	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	N/A
PSN047	Management of life threatening bleeds from arteriovenous fistulae and grafts	**26/05/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN048	Risk of harm from inappropriate placement of pulse oximeter probes	**29/03/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN049	**THIS NOTICE REPLACES PSN043 Supporting the introduction of the Tracheostomy Guidelines for Wales - Adults & Children**	**01/07/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN050	Assessment and management of babies who are accidentally dropped in hospital	**08/12/2019**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN051	Depleted batteries in intraosseous injectors	**28/08/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	N/A	Compliant	N/A	Compliant
PSN052	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	**31/08/2020**	Compliant	N/A	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN053	Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices	**05/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN054	Risk of death from unintended administration of sodium nitrite	**12/11/2020**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN055	THIS NOTICE REPLACES PSN030 Safe Storage of Medicines: Cupboards	**30/09/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
PSN056	Foreign Body Aspiration during intubation, advanced airway management or ventilation	**01/07/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	**31/01/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN058	Urgent assessment/treatment following ingestion of 'super strong' magnets	**13/10/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant

PSN No:	Title of Safety Solution	Compliance Date	ABHB	BCUHB	C&VU	CTMUHB	HDHB	Powys	PHW	SBUHB	Velindre	WAST
PSN059	Eliminating the risk of inadvertent connection to medical air via a flowmeter	**16/12/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN060	Reducing the risk of inadvertent administration of oral medication by the wrong route	**20/12/2021**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	Compliant	Compliant
PSN062	Elimination of bottles of liquefied phenol 80%	**25/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN061	Reducing the risk of patient harm - standardised strength of phenobarbital oral liquid	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN064	Handlebar injuries in the paediatric abdomen	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	Compliant
PSN063	Deployment of NRFit (ISO 80369-6) compliant devices in Wales (2021)	**31/03/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A	Compliant	N/A	N/A
PSN065	The safe use of ultrasound gel to reduce infection risk	**28/02/2022**	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	N/A

Agenda Item
7.1 Appendix 3

Quality & Safety Committee

Executive Director & Independent Member
Quality & Patient Safety Walkrounds
May-October 2023

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Allison Thomas, Business Manager, Patient Care and Safety
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix, Deputy CEO/Executive Director Nursing, Midwifery & Patient Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
PoWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda

WHSSC	Welsh Health Specialised Services Committee
RITA	Rehabilitation & Interactive Therapy Activities
NHFD	National Hip Fracture Database
#NoF	Fractured neck of femur
SoN	Statement of Need
MDT	Multidisciplinary Team
WNCR	Welsh Nursing Care Record
MAU	Medical Admission Unit
HCAs	Health Care Assistants

1. Situation /Background

1.1 Executive Director and Independent Member Quality & Patient Safety Walkrounds continue to take place across the whole of the organisation to gain assurance of the quality of care delivered to our patients. The team engage with patients/carers/families and staff as the Walkrounds provide an opportunity for engagement with all present at the time of the Walkround. The Executive Director & Independent Member listen to and provide support with any patient safety issues faced by all sectors of front-line staff together with having a clear focus on both patient safety and well-being whilst in our care and the health and well-being of our staff.

1.2 An electronic feedback summary form has been developed and is in its early stages of testing however, initial feedback received is that the form is too complicated, therefore the format of the electronic form will be revisited in order to look at how it can be simplified, following which further testing will continue as we work towards ensuring all of the relevant feedback is captured on the feedback form in order for the agreed responsible leads to take forward any actions arising from the Walkround.

1.3 Immediate verbal feedback takes place at the end of the Walkround providing assurance on all findings and at this time any required actions are agreed with the clinical team supporting the walkround together with agreeing who the nominated responsible person and the timeframe for taking forward any actions. Any urgent matters will be escalated by the site/area/ward lead to the Care Group triumvirate as a matter of urgency.

1.4 Continuous monitoring and reporting on the actions identified during the Walkrounds are managed and monitored through the Care Group Quality, Safety and Patient Experience group meetings for assurance and improvements where such actions have been identified and agreed together with areas of excellence being shared for learning across the wider organisation to support cross pollination of excellence.

2. Specific Matters for Consideration

The table below details the walkrounds completed for the period May-October 2023

Date of Walkround	Site/Area/Location	Executive Director and Independent Member 'Buddy Team'
10th May	RGH Emergency Department	Linda Prosser & James Hehir

31st May	Glanrhyd Hospital, Ward 15, Prescribing Ordering Hub	Lauren Edwards/Melanie Barker & Ian Wells
20th June	PoWH-Emergency Department	Greg Dix & Patsy Roseblade
27th June	RGH Theatres	Dom Hurford & Dilys Jouvenat
14th July	PoWH Neonatal	Hywel Daniel & Carolyn Donoghue
27th July	RGH Therapies Team	Paul Mears & Lynda Thomas
8th August	RGH Ward 16	Stuart Morris & Jayne Sadgrove
15th August	RGH Ward 1	Dom Hurford & Dilys Jouvenat
7th September	PoWH Ward 9	Lauren Edwards & Ian Wells
29th September	YCR D4	Hywel Daniel & Carolyn Donoghue
2nd October	Homeless & Vulnerable Adults	Greg Dix & Patsy Roseblade
24th October	YCR Ward B2	Linda Prosser & James Hehir

2.1 Below is a summary of feedback and comments noted during the Walkrounds:

Areas of Good Practice and Positive findings for RGH Emergency Department

- Great staff involvement, inputs, responses with effective feedback loops.
- Good sense of being a close-knit team
- Well connected to the rest of the hospital teams for more effective flow
- Recent works have improved capacity and patient care conditions.
- Training room well utilised

Areas for Improvement include:

- Additional spaces created above require additional staffing and a proposal has been submitted.
- Outstanding minor works
- Process for referring patients on to clinics and other services outside of the hospital

Areas of Notable Practice includes:

- No 4-hour ambulance holds for last 10 days
- Positive impact of Safe to Start

Areas of Good Practice and Positive findings for RGH Theatres

- Clear team ethos
- Robust approach to Health & Safety
- Safe areas for storage clearly marked
- Introduction of 'blue blankets' to assist with moving patients to reduce harm from moving and handling
- Regular fire and risk assessments carried out
- Work closely with the Health & Safety Team
- Each Theatre has its own board displaying metrics monitoring start times, incidents and any issues
- Positive indication of the approach to quality and compliance
- Datix incidents recorded and learning pathway in place
- Regular huddles during the day
- Team 'Greatix' Board introduction
- Cards of thanks displayed
- You suggest we did" board full and updated regularly
- Suggestions board in place which includes responses as to what has been done and explanations given if there are limitations to enabling the suggestion
- Paediatric area
- Flow through theatre
- Fire plan and attention to detail
- Team all very welcoming and smiling
- Real sense of team in the department, a friendly caring place which was felt to be very reassuring to nervous patients
- Patient dignity – monitoring patient experience

Areas for Improvement:

- Key issues of risks raised includes:
  - Staffing, recruitment, retention and sickness levels
  - Increasing number of sessions and lists at RGH but workforce levels remains static
  - Need to update theatres

- Need full IT overhaul to ensure up to date information systems

Areas of Notable Practice includes:

- Health Care Support workers are allowed 23 hours release to attend university, it is a 4-year course and it is hoped that staff will stay in the Theatres once qualified

Assurance received from the department includes:

- DATIX reporting and follow up
- Never events are treated very seriously and analysed
- Learning from all incidents shared
- WHO checklist approach
- Good learning cycles
- Department is run very efficiently and with an effective service led by the senior Nurse for Theatres, Pre-assessment and Pain
- The Senior Nurse for Theatres, Pre-assessment and Pain demonstrates excellent leadership and a one team ethos which shone throughout the department
- All of the team very welcoming and smiling

Areas of Good Practice and Positive findings for PoWH Neonates:

- Recent closure for upgrade was managed extremely well with staff being flexible and ensuring care could be provided as appropriate
- Exceptional commitment to ensuring the decant happened on time

Areas for Improvement:

- Difficult environment with limited space and cramped conditions however, it was noted that the recent refurbishment has helped but it is a small area and lots of equipment is needed due to the intensity of the case and the need to accommodate families
- The overnight stay areas and room for staff to have breaks are very cramped
- Staffing issues result in it being difficult for staff to leave the ward for their breaks
- Staff morale was described as very low although commitment to supporting babies and their families was very evident

- Vacant nurse posts not being approved as they are secondments event though it is highly likely they will not return to the ward
- Using agency to cover which impacts on continuity
- WHSSC review of neonatal beds is causing concern

Areas of Notable Practice includes:

- The team have responded to the recent infection outbreak extremely professionally and have worked very hard to deal with the closure, decant and reopening with as little disruption to families and babies as possible

Areas of Good Practice and Positive findings for RGH Ward 1:

- MAU staff working across 3 wards
- Very high standard and quality of patient care delivered by nurses
- Visible dedication of all team members with often quite challenging patients
- Medical Optimised Patients, cohorted and therefore care specific to their needs in one area

Development of a less medical intervention space will allow for:

- Focus on care and in a calm environment
- Lots of positive ideas, initiatives and plans to make this ward the perfect place for Medically Optimised patient(s) who are in hospital for protracted periods whilst their care packages are sorted out
- Sense of calm on entering
- Can see how this ward and its environment differs form a normal acute hospital ward
- Ward and staff delivering what our patients need – tailored care
- YCC more set up or longer-term stay, needed a place for these patients to be cared for in a specific tailored unit
- Patient flow noted to have improved across the hospital site

Patient Experience

- Vision to make stay calm and less confusing for the patient(s)
- Expand activities so that patient(s) can do puzzles, cards, iPad (donated during COVID) and potentially RITA.

Areas for improvement:

- Need to review and revise the model of using cubicles within the ward area, to include appropriate funding as outcome of review requires
- Use icons for ongoing care/assessments needed in order to ensure confidentiality is met at all times on whiteboards
- Social Care teams written board to be improved with the use of icons for confidentiality of ongoing care / assessments needed
- Swipe access to ward to ensure confused patients do not go wandering off ward (team are already addressing this area of improvement)

Medical Model

- Need to review and look at the benefit of reducing the Consultant ward round sessions so that medically optimised patients are only reviewed if they become unwell or observations flag a concern, 2 proposed options are:
  1) Single ward round per week
  2) No medical intervention /review unless flagged, whilst ensuring the availability of a team to review immediately as needed.

Funding the establishment

- need to set up an establishment for running the ward. Currently using MAU staff on rotation
- ratio aim: 2 qualified and 4 HCAs
- Need to expand roles– volunteers, Dementia workers
- Sufficient staff as high falls risk in this population
- Dementia nurse training

Areas of Notable Practice include:

- Excellent vision of the team
- Many great ideas and plans to make this ward the perfect place for Medically Optimised patients who are in hospital for protracted periods whilst their care packages are sorted out
- Ward Manager deserves much praise for the development of the ward so far, and for the future improvement plans
- Excellent MAU nursing team, and Ward Manager who are taking this ward on as well as their acute roles
- Experience of patient care is clearly paramount

Areas of Good Practice and Positive findings for PoWH Ward 9

- Warm welcome to the ward
- All members of the MDT were keen to share their thoughts
- MDT working – all members of the team and all professions appeared valued and respected
- Above bed signs updated with key individualised patient information, including physio mobilisation recommendations
- Member of the Trauma Network and contributor to National Hip Fracture Database (NHFD)
- Benchmarking with other Health Boards and sharing of local NHFD performance
- Improvements noted in performance data and patient/family satisfaction (reduction in complaints/concerns) seen since establishment of orthogeriatric pathway
- Bay with enhanced supervision for at risk patients and an Acute bay in sight of Nurses Station
- Ring-fenced #NoF (fractured neck of femur) bed
- Theme regarding pressure ulcers has been identified and actions already taken/underway include training and a SoN for equipment
- Digital Whiteboard in use
- MDT presence at all Board Rounds
- Hearing loop equipment on orthogeriatric trolley
- Recent safety alert on display on staff noticeboard

Areas for improvement

- Ring-fenced #NoF (fractured neck of femur) bed challenging to maintain when site is under pressure
- Medications/flammable items not consistently secured
- Digital infrastructure challenges impacting roll-out of WNCR
- Delayed transfers of care: delays in Social Worker allocation and social care provision
- Challenges providing equitable service to patients who are outliers on other wards – options being explored e.g. therapy clinics, cohorting, etc.

Areas of Notable Practice include:

- Lots of plans to explore further improvements/developments:

- space for confidential conversations with families
- ward move to increase capacity, provide space for group therapy, promote flow, etc; ward environmental sustainability champion
- volunteers for social engagement/activity

- Trauma Study Day development and delivery:
  - 2-part session for RGNs
  - 1-part session for HCSWs

  With the above resulting in increased confidence and improvements in patient experience

- Lack of Fracture Liaison Service, resulting in challenges with proactive bone protection treatment and also meeting follow-up standard within NHFD (120 days)
- Medical staffing numbers – locum usage and difficulties with sufficient capacity
- Physio team keen to agree mobilisation protocols pre-op in order to avoid delays
- No dedicated space for patient mobilisation- work noted as ongoing in order to explore options
- Add space for staff to change clothing

Areas of Good Practice and Positive findings for YCR Ward D4

- Clean and modern environment
- Good facilities and good provision of therapy support
- All staff welcoming and patients happy with their care
- Good support for visitors with more open visiting hours
- Enormous commitment to patient care and holistic approach

Areas for Improvement

- A number of vacancies for registered nurses which results in not being able to offer continuity of care
- Inability to take on international recruits due to lack of accommodation on site or locally
- Improve the consistency of consistent physio cover and increasing standards of the NHFD over weekends
- Review the withdrawal of funding for psychological support for stroke patients resulting in a poorer service and in some cases an extended length of stay for patients

- There are examples of patients having an extended length of stay due to lack of support in the community for administering medications to those who are unable to self -medicate
- The acuity level of patients on the ward is not always recognised as this is a community setting
- Delay in making referrals for social work, housing etc. which can lead to an extended length of stay

Areas of Good Practice and Positive findings for YCR Ward B2

- A consistent and comprehensive focus on excellent personalised care which was evidenced by the testimony of one family in particular whose EOL father had excellent care for 24 hours per day 7 days per week over a period of several months
- Account of proactive care of an individual in anaphylactic shock
- All patients appeared to be well cared for
- High levels of Patient Care and a positive culture
- Cohesive committed teams
- The ward area was clean and tidy

Areas for Improvement:

- Point of delivery of food differs from the theoretical offer and is not responsive to individual patient needs- need to achieve patient centred catering
- Distant relationship with Mental Health teams and a lack of response to support in times of crisis-these concerns have already been escalated
- Call Bell supplier difficulties noted however, it is understood that the estates team are proactively looking for a solution
- High number of vacancies-work has commenced to look at this area with the Assistant Director of Nursing and Peoples Experience

Throughout the walkrounds completed to date there are a number of trends and themes emerging through these walkrounds which include both areas of excellence and areas for improvement

- Positive patient care
- Positive team ethos and leadership
- Excellent Improvement ideas, initiatives and positivity
- Values and Behaviours

- Culture
- Impact due to the number of vacancies, recruitment and retention
- Environment both excellent and in need of review
- Number of estates issues

3. Key Risks / Matters for Escalation

Immediate verbal feedback is shared by the Executive Director and Independent Member to the clinical team who have been supporting the walkround immediately at the conclusion of the Walkround. Any areas of excellence for wider learning and sharing and any actions identified during the walkround are fed back and an action plan developed for improvement following the agreement of the team for the actions to be addressed, noting the named responsible person and agreed appropriate timescale for completion of all actions on the summary feedback form.

In order to further enhance and support the formal feedback process we are looking at a way to improve and streamline the electronic feedback summary report which is in its pilot stage and is available via access to a link or a QR code which can be accessed by any device at any time during or after the Walkround to allow for timely formal feedback reporting.

The Care Group Quality Patient Safety & Risk groups should be monitoring the summary feedback from these walkrounds and feeding in the required improvements to their overarching action plans together with sharing the learning for improvement and areas of excellence.

The next twelve months scheduled is being prepared with a minimum of one Walkround per buddy team of an Executive Director and Independent Member.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:

Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: Aging Well Dying Well Growing Well Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Leadership Culture and Whole-systems perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Equitable Person Centred Care Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This report is about the feedback and findings and is for the Committee to note.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This report is about the feedback and findings and

Have you undertaken an Equality Impact Assessment Screening?		is for the Committee to note.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Some of the findings and agreed actions may be impacted by the need for recruitment and retention and also an element of funding requirements.	

5. Recommendation

The Quality and Safety Committee is asked to **NOTE** the report and continue to support future Executive Director and Independent Member Quality and Patient Safety Walkrounds.

Agenda Item
7.1 Appendix 4

Quality & Safety Committee

People's Experience Activity Report – August – September 2023
Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon, Assistant Director of Nursing & People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Patient Experience Team	Click or tap to enter a date.	Noted

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
PALS	Patient Advisory Liaison Service
RPB	Regional Partnership Board
CBL	Clinical Bereavement Lead
BAME	Black Asian & Minority Ethnic
POW	Princess of Wales Hospital
PCH	Prince Charles Hospital

USW	University of South Wales
SCBU	Special Care Baby Unit
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
RGH	Royal Glamorgan Hospital

1. Situation /Background

1.1 The purpose of this report is to provide an overarching update on the work that has been undertaken by the People's Experience Team and the areas that fall within this remit.

People's Experience Team continues to explore ways to engage with our communities to ensure that the patient's voice remains at the heart of the services we provide. Working in conjunction with colleagues in the Values Based Healthcare Team to create a Framework that involves internal/external stakeholders that drives a learning ethos to support service improvement and shared learning.

2. Specific Matters for Consideration

Population Engagement

The team has engaged in a number of engagement events such as International Day of Older Persons, World Patient Safety Day and Women's Health engagement event. These events are valuable opportunities so the team can gain a better understanding of what matters to our population and support directly or signpost to other services where necessary. Since the Older People Safety Day, the team has been asked to present to the Rhondda Cynon Taf (RCT) over 50's Forum to provide an overview of the projects undertaken.

November 7th a collaborative event between People's Experience, Values Based Healthcare (VBHC), and 3rd Sector, will facilitate a roadshow in Princes of Wales Hospital. This will give an opportunity to engage with the public and staff to highlight the services on offer to support within the hospital and community settings. This will then be rolled out across the HB on the acute sites initially and then community sites.

Patient Feedback/Civica system

The HB continues to utilise feedback through the Civica system which is being rolled out across departments/specialties across the HB and captures patent-reported experience measures (PREMS) which are shared with service leads. Posters containing information and QR codes to encourage feedback from service users are displayed across all sites. Work is ongoing to increase engagement with the system amongst service users as well as

those responsible for service planning and delivery. 'Have Your Say' cards continue to be distributed across all acute sites by colleagues in the People's Experience Team. November 1st will see the launch of a texting feedback service available for all service users in Emergency care as part of an all-Wales survey going live across Cwm Taff Morgannwg.

August-September, 1,002 responses were recorded across all surveys within Civica, of which there were 86 responses were from CTM-wide surveys. It should be noted that due to resources there is a backlog of "Have Your Say" information being uploaded onto the digital system the number of responses for Have Your Say (only) will increase once the surveys have been uploaded onto the system (Appendix1)

Appendix 2, gives a high-level overview of feedback data captured currently across CTM within the Have Your Say and All Wales surveys.

Chaplaincy

Significant Spiritual and pastoral care contacts from August to September
Patients 931
Relatives/carer's 237
Staff 253

Religious rites
235

Out-of-hours requests for support equating to 25.75hors

Three pregnancy loss cremation services were facilitated at Coychurch, Glyntaf, and Llwydcoed Crematoriums, which were well attended by bereaved parents. The Clinical Bereavement Lead also officiates HB contract funerals in collaboration with the Chaplaincy Team and has been instrumental in coordinating these on behalf of the HB. This has had a hugely positive impact ensuring the process is equitable for all and where there are no next of kin ensuring they can lay their loved one to rest.

The Bereavement and Loss Workshops are going from strength to strength with these being facilitated by the Health Board 'At a loss Cafes' are being held across the HB with over 62 patient contacts. Facilitator training has been cascaded to community leaders who attended the CTM 2030 Leadership Event to those who wished to take this forward so workshops and cafes can be facilitated independently with support at a distance by the HB chaplain. This work will expand into areas covering 'loss' from several perspectives such as dementia, end of life, diagnosis of life-changing condition, and bereavement from loss of parent.

The creation of end-of-life volunteer companion roles within the chaplaincy service is proving to be well-received by staff and families. This can be seen in the thank you received below:

Good Afternoon Hilary,

- *"I am just emailing to let you know Mr X has passed away, and a big Thank you and all the chaplaincy Volunteers in supporting Mr X's Daughter.This has been a difficult anxious time for her. However your teams support for her welfare at this sad time has been really fantastic and positive outcome, she has been more relaxed and calm and accepted her father's death , she also has a strong faith which has given her the strength along with by your team to cope,"*
  Kind Regards David

The team is always looking for new ways to enhance their services and one area under review is to explore how they can support where patients have no family/friends to support or families who are struggling to visit loved ones in a hospital setting due to commitments at home/work.

One such extension to the service is setting up a new In Reach service to Pinewood Mental Health Unit (MHU) in Treorchy on a monthly basis to support the inpatients and staff.

To promote equality, there are conversations underway with other faith leaders, about how we as a HB can extend our services across other faiths to support access to leaders across our community as well as ensure our multi-faith centres are accessible.

Bereavement

The clinical Bereavement Lead (CBL) is being contacted and required to support in many arenas across the HB, such as facilitating the funeral of a baby from the Black Asian & Minority Ethnic (BAME) with greater support in relation to their religious needs and supporting Paediatrics, POW, to provide on-site support for family and staff following the sudden death of a young boy. Also taking on the role of Family Liaison Officer to support families providing a point of contact to improve communication.

CBL undertakes training and teaching sessions in collaboration with the University of South Wales (USW) and student nurses relating to bereavement care and last offices, taking every opportunity to promote the service and role to colleagues inside and outside the HB. More recently being filmed on ITV News relating to the butterfly garden in PCH. In collaboration with USW, the clinical lead has led on a unique training opportunity utilising HYDRA (Immersive simulation training) system to create the first bereavement module in the UK. This was well received with staff and there is ongoing work to explore how this can be expanded into other arenas.

Volunteers

Volunteers contribute considerably to supporting our patients and their families, as well as an essential addition to our workforce with unique skills and knowledge.

The "Good to grow" project continues to run at Y Bwythyn Newydd Day Unit and volunteer drivers transport patients attending the weekly sessions.

Volunteers across our maternity areas are proving to be a huge success. Alongside midwifery colleagues who are offering breastfeeding peer support for new mothers with new opportunities being identified, volunteer maternity support roles will be offered at future volunteer information sessions. In September 2023, several "BLISS" (Baby Life Support Systems) Volunteers provided support to the neo-natal Special Care Baby Unit (SCBU) at Prince Charles Hospital (PCH) as requested by the Senior Midwife for Neo-Natal Services helping families of sick babies with companionship and support services/signposting.

Ward befriender and activities volunteers continue to support wards at Princess of Wales Hospital (POW) and Ysbyty Cwm Rhondda (YCR), with a further volunteer undertaking their local orientation at Ysbyty Cwm Rhondda (YCR) in October 2023 with an extension to Ysbyty Cwm Cynon (YCC) in September 2023. Meet and Greet Volunteers support with wayfinding, signposting, and providing information at POW, RGH and Dewi Sant Health Park (DSHP), with the addition of a new volunteer starting in YCC, September 2023. The Emergency Department Volunteer project continues to run successfully at POW and extended to Royal Glamorgan Hospital (RGH) in September 2023 with further plans to undertake a local orientation for a further six volunteers in October 2023.

Cariad Pet Therapy Volunteers continue to visit sites across CTM which include, Ty Llidiard POW, Palliative Care, POW & RGH, Seren & St David's Wards RGH and Angleton Dementia Unit, Glanrhyd Hospital which are well received with positive feedback.

New training opportunities are being explored for the volunteers to access Dementia training and Welsh Language training.

Veterans

Collaborative projects are being undertaken with the HB and the Armed Forces Covenant and Employer Recognition Scheme with Workforce to reapply for the Silver award.

The team again collaborating with colleagues from the Regional Innovation & Co-Ordination Hub has linked in with the Bridgend Military College and the company "ARM" to support the clearing of spaces to create reflective gardens across CTM. The project has started with a space in POW to clear and repurpose the areas for reflective spaces for staff and service users, see Appendix 3.

Patient Advisory Liaison Service (PALS) Team

The PALS Team has extended across all acute sites and community hospitals to proactively work with patients, families, carers and staff to resolve any queries or concerns or signpost at the point of contact.

The PALS teams throughout this period have made 238 contacts with patients, families, and carers (Appendix 4). These contacts are made via several avenues i.e.: telephone, email, staff referrals, care-to-share clinics and third-sector referrals. Reports are provided weekly to the senior nursing team and care group Directors of Nursing to action/disseminate as they feel appropriate.

Evaluating the data from these contacts the key themes identified are

- Clinical Treatment/Assessment
- Communication Issues
- Patient Care

The HB recognizes the importance of good communication and as this is a common theme is an area that is being prioritised to identify areas for improvement. Linking in with USW we are exploring if we can again utilise the Hydra system to create a communication training program that can be rolled out across CTM as an immersive training tool.

To support the ongoing learning and training for the team all staff are being offered to complete a Level 4, Information Advice and Guidance qualification to ensure that they are able to continuously improve on their skills to support our patients, families, and communities.

3.0 Key Risks / Matters for Escalation

2.1 Not applicable.

4.0 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	Choose an item.

Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	Yes (Include further detail below)
	Activity where performance falls short within the areas that the PALS support may impact on trust and confidence in the Health Board's service provision.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.
	As the PALS service evolves there may be an ask that the HB looks to expand the service to proactively support, patients, families and unpaid carers.

3. Recommendation

3.1 The Quality & Safety Committee is asked to **NOTE** the contents of this report and the activity underway to progress the People's Experience Team and ensure patients, and families remain at the centre of the services we provide.

Appendices referenced below are available on request

Appendix 1 – Civica data

Appendix 2 - Civica poster Have Your Say and All Wales surveys

Appendix 3 – Veterans Reflection Garden support

Appendix 4 – PALS data

Agenda Item
8.1

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023	
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable	
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director	
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director	
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science	
Pwrpas yr Adroddiad / Report Purpose	For Noting	
Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
MHLD	Mental Health and Learning Disabilities
QSRE	Quality Safety Risk Experience
SRO	Senior Responsible Officer

1. Situation /Background

1.1 This report provides committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.

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

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

1.4 In June 2022 HIW identified a number of significant patient safety concerns and issued an immediate assurance improvement plan relating to: discharge governance; communication arrangements between teams (including the issue of the lack of a single electronic record); significant limitations in the involvement of patients and carers; and risk management and discharge arrangements.

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

2. Specific Matters for Consideration

2.1 The Health Board Improvement Plan was published by HIW on 6 September 2023: CTMUHB MH Discharge Review - Improvement Plan Final EN.pdf (hiw.org.uk)

2.2 As part of HIW's Local Review process a further improvement plan will be submitted to HIW three months and eighteen months after acceptance of the initial improvement plan.

2.3 A Mental Health Inpatient Improvement Programme has been developed with a number of work streams. The HIW actions and the four improvement themes referenced above are aligned to these work streams.

2.4 The scope of the Adult Inpatient Improvement Programme is broader than the HIW Discharge Review. However, given the timescales the first phase of the improvement programme will be to deliver the 40 recommendations. These 40 recommendations are made up of 145 individual actions. Of the 9 work streams, the 8 work streams with HIW recommendations are currently active.

2.5 The work streams have been allocated to a Care Group Director who acts as the Senior Responsible Officer (SRO) role for quality assuring the evidence before submission to the Improvement Board.

2.6 The 40 recommendations are made up of 145 individual actions. Recommendations are only put forward to the Improvement Board for ratification when all of the actions relating to that recommendation are complete and have supporting evidence that has been approved by the SRO.

2.7 The Improvement Board, which is chaired by the Executive Director of Therapies and Health Science last met on 10th October 2023. The completion dates in the improvement plan submitted by the Health Board should have resulted in 36 of the 40 recommendations being completed at this stage. The remaining 4 recommendations have later dates for completion.

2.8 However only four fully completed recommendations were approved by the Improvement Board in October.

Recommendations	Number completed and approved by Improvement Board	Number declared completed by action holder (Evidence requires QA'ing by SRO)	Number with planned later timescales	Number with slipped timescales
40	4	**8**	**4**	**24**

2.9 Eight recommendations were reported as complete by action owners but had not had evidence reviewed by SROs prior to the Improvement Board meeting. These will be considered by the Improvement Board in November.

2.10 Of the remaining 24 recommendations with slipped timescales there is evidence of significant progress with their associated actions but not all of the actions had been completed. Sixteen of the recommendations have completed actions but require cycles of audit to ensure that these actions are embedded in to practice.

2.11 All 16 of these recommendations have audit tools that have been developed. They are awaiting digitisation with the intention that they will be recorded on AMaT. In the interim audit results are being recorded manually on excel spreadsheets. An aggregated audit report for all 16 recommendations will be reported to Improvement Board in November to support approval of the closure of these recommendations.

Rec 1	Physical Health Checks
Rec 2	Risk assessment standards
Rec 3	Mental Capacity Assessment
Rec 4	Carers Assessment
Rec 5	CTP Standards
Rec 6	Ward Round structure (Patient Discussion)
Rec 7	Discharge Communication
Rec 9	MDT Records
Rec 11	Patent and Carer views
Rec 12	Crisis Contingency plans
Rec 13	Discharge communication standards
Rec 14	Expedited Discharge arrangements
Rec 21	Discharge letter content
Rec 22	Discharge letter timescale
Rec 23	Discharge Summary Timescale
Rec 24	3 day Follow up

2.12 Five of the 24 recommendations with slipped timescales are also on track for completion by the November Improvement Board.

2.13 However there are three recommendations that will not be completed by November. Two of the recommendations relate to training, with compliance of 85% required before they can be regarded as complete. Delays in training compliance are associated with challenges in staff release. The other outstanding recommendation is associated with the datix reporting system and has been delayed due to prioritisation given to core business in the health board following the implementation of the new datix system in

the Health Board. Revised completion dates of end of January 2024 have been determined for these recommendations.

Rec No.	Recommendation	Deficit/ What is required to complete
2	The health board must ensure that when staff complete patient risk assessments, the method should reflect the requirements set out within national guidance	• WARRN training to be delivered to all new staff within 8 weeks of commencement with a target of 85% for all staff who require the training. (Compliance 57.2% as at 01/10/23)
8	The health board must ensure that all relevant staff complete appropriate training for timely and effective communication and information sharing relating to the discharge process.	• The Care Group will achieve and sustain 85% training compliance in these core skills training domains. o WARRN (Compliance 57.2% as at 01/10/23) o PMVA (Compliance 79.6% as at 01/10/2023) o CTP (Compliance 55.2% as at 01/10/23) o IG (Compliance 81% as at 16/10/23)
38	The health board must consider how it can audit the process in place for social worker identified incidents, which are documented within Datix, and that feedback, learning and actions are shared with them as applicable.	• Discussions are ongoing between the Head of Quality and Safety and the Head of Concern and Business Intelligence as to how social worker identified incidents can be extracted from Datix and audited and a mechanism put in place for multi-agency incident reporting. The Revised timescale of 31/01/2024 is for the mechanism to be in place.

2.14 It is now anticipated that the Health Board will be in a position to submit an updated improvement plan to HIW at the three month interval with 33 completed recommendations rather than the 36 that were originally planned.

3. Key Risks / Matters for Escalation

3.1 Committee members are asked to note the slippage on fully completed recommendations and to also note that 3 recommendations have revised completion dates of January 2024.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol	Living Well

BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Leadership Data to Knowledge Culture and Valuing People
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Person-centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service provision
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality**	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Have you undertaken an Equality Impact Assessment Screening?		No change to service provision
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There are public and stakeholder concerns about the quality and safety of in-patient mental health services	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Improving mental health services is dependent on people – there are challenges to recruitment and retention in in-patient mental health services.	

5. Recommendation

5.1 Members are asked to note the progress of the Inpatient Improvement Programme to date and the plans in place for the outstanding recommendations.

6. Next Steps

6.1 The Adult Mental Health Inpatient Improvement Board, chaired by the Executive Director of Therapies and Health Science next meets on 21st November 2023 and will review progress and evidence against the HIW recommendations.

Agenda Item
8.2

Quality & Safety Committee

STROKE SERVICES – PROGRESS REPORT

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kevin Duff, Head of Strategic Planning and Commissioning Sarah Follows, Unscheduled Care Group – Service Director Sian Bingham, Interim Clinical Group Service Manager
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards, Executive Director of Therapies and Health Science Alex Brown, Care Group Medical Director - USC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
	PCH – Prince Charles Hospital RGH – Royal Glamorgan Hospital POWH – Princess of Wales Hospital ESD – Early Supported Discharge SSNAP – Stroke Sentinel National Audit Programme WAST –Welsh Ambulance Service Trust CTM UHB – Cwm Taf Morgannwg University Health Board QIMs – Quality Improvement Measures FAST – Face, Arm, Speech, Time AI – Artificial Intelligence EDI – Equality, Diversity and Inclusion

1. Situation /Background

1.1 Stroke remains the fourth leading cause of death in Wales and can have significant long-term effects on survivors and their families. The prevalence of people living with the impacts of stroke is increasing due to a decrease in mortality from stroke and an ageing population.

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

2. Specific Matters for Consideration

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

2.2 Some service developments have been achieved, but progress is limited due to availability of investment and wider acute service pressures.

South Central Wales Regional Stroke Network Programme

2.3 Welsh Government's Quality Statement for Stroke emphasises the importance of collaborative work to address all aspects of the stroke care pathway. To address challenges faced by our current services, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards, along with key

stakeholders, have established the South-Central Wales Stroke Delivery Network. A governance and programme structure is in place as well as a small programme team, including a programme manager but there is currently a vacancy for a clinical lead. The structure includes a programme board involving key stakeholders, including WAST, Public Health colleagues and the Third Sector.

2.4 To achieve our goals of sustainable and effective services, it is crucial to understand the perspectives of stroke patients who have received care from us. A three phase communication and engagement plan has been established for the regional programme, led by our region, and implementation of the plan is underway.

2.5 Phase one involved the completion of a patient experience survey inviting all stroke patients from the past year to provide feedback on their care, establishing a baseline understanding of experience of our current services. The survey is complete and there is ongoing analysis of the initial findings. This has also been accompanied by a survey of colleagues working in stroke services across both health boards to gain an understanding of their experience in providing care.

2.6 Phase two will involve the hosting of in-person and virtual listening events across the CAV/CTM footprints. This phase will involve conversations with local leaders and formal events at community spaces (as well as options for digital involvement) which are structured and provide very clear next steps. An engagement schedule has been drawn-up and implementation of phase 2 is in progress.

2.7 There is ongoing liaison with communication and engagement teams in both CTM and CAV Health Boards around phase three which is public engagement. Regular touchpoint meetings have been established with Llais and the Stroke Association to ensure good governance in the public involvement aspect of the regional programme.

2.8 A well-attended regional summit across CAV and CTM Health Boards was held on 10th October when potential options for the development of regional integrated stroke services were presented. This enabled consideration of the options by colleagues from both Health Boards and WAST.

2.9 The National Stroke Programme will become an implementation network for stroke, sitting under the Cardiovascular Strategic Network. A number of subgroups are being established to assist networks within the cardiovascular strategic network, with support from the Stroke Association, Health Education and Improvement Wales (HEIW) and Public Health Wales (PHW). Good progress is being made in the operational delivery network, including; development of a thrombectomy oversight group which has seen significant increase of referrals in Wales, the rolling out of AI for stroke imaging, and piloting a pre-hospital video triage service.

2.10 Recent collaborative and successful research grants include Health and Care Research Wales for Public and Patient Benefit (RfPB) (Cardiff University), Medical Research Council (Cardiff University) and Stroke Association (Cardiff Metropolitan University). Progress of the stroke related PREDICT – EV study is attached at **Appendix 1**.

CTM UHB Strategic and Operational Development of Stroke Services

2.11 The Stroke Operational Programme Board, developed under the remit of the CTM UHB Unscheduled Care Group, has been meeting every other month since its first meeting in July 2023. The Programme Board involves key stakeholders from across the acute and rehabilitation stroke pathways and enables the further development of the stroke action plan and the operationalisation of quality and safety improvements. The Programme Board is supported by a Stroke Operational Group, which is able to make a more granular analysis of the acute stroke pathway and identify opportunities for improvement in its day-to-day running.

2.12 The above improvements to the operational governance of acute and rehabilitation stroke services in CTM UHB has enabled the Stroke Strategy Group to return to its originally-intended strategic oversight and co-ordination role, meeting on a 6 monthly basis. The Stroke Strategy Group will continue to keep oversight of the development of stroke services across the whole pathway from prevention and early intervention, through to life after stroke. It will also ensure an appropriate fit between the development of stroke services in CTM UHB and the emerging regional model across CAV and CTM Health Boards.

Service developments and improvements

2.13 **What actions are we taking & when is improvement expected?**

- Referrals to Bristol for thrombectomy are limited by both Bristol's opening hours and CTM consultant staffing levels. The Bristol service has extended its opening hours from 8 am to midnight (need to be in Bristol by 10 pm) and hope to extend to 24/7 thrombectomy in the autumn. There is a clinical risk in supporting 24/7 thrombectomy locally due to a 1 in 4 Stroke Consultant rota and conversations are continuing regarding a regional rota.
- Work is ongoing to improve scanning times. CTM have implemented Radiographer-approved CT and CT angiograms to minimise delays in getting CT angiograms for patients presenting with acute strokes. Work is ongoing to implement Brainomix AI software reporting for CT and CT angiograms, in order to minimise delays in referral for thrombectomy, with Year 1 funding agreed via Therapies.
- Recruitment has been progressing to facilitate the development of a pan-CTM Early Supported Discharge team. Additional therapies colleagues are being inducted into post and pathways are being written/revised, with engagement from key stakeholders. Plans are underway for the wider service to commence as soon as all key staff are in post.

- CTM has contributed to the national review of Stroke Self Presenters and the outputs from this are awaited.
- The USC Care Group Stroke Programme Board is now established and the first Stroke Operational Group was held in September, with a focus on analysis of the data and updating the programme of improvement actions to feed into the Programme Board e.g. actions identified to respond to the increase in delayed requests at PCH from ED upon patient admission/medical clerking.
- Work is underway to explore extending Stroke Clinical Nurse Specialist (CNS) hours to 18:30 to cover more of the window for thrombectomy referral/transfers. Results will be reported back to Stroke Operational Group and fed up to Stroke Programme Board at next meeting. Without an additional CNS, this would only be viable when both nurses are on duty and there is no annual leave/sickness.
- The Operational Group is in the process of updating the Improvement Plan with the actions identified via the data and which will address the performance indicators.

Quality Improvement Measure performance

2.14 The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides an overview to the Health Board against 6 national Quality Improvement Measures (QIMs) which are part of the suite of improvement measures in the SSNAP:

- direct admission to an acute stroke unit within 4 hours
- thrombolysis with a door to needle time within 45 minutes [1]
- CT scan within 1 hour
- assessment by a stroke consultant within 24 hours
- Patients assessed by one of OT, PT, SALT within 24 hours
- Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team

2.15 The latest performance report against the four QIMs is attached at **Appendix 2**. Performance remains low against some key indicators, and sadly this is a picture that is replicated across Wales.

What are the main areas of risk?

- 5 day clinical model. There is concern regarding clinical capacity to ensure service resilience and improved outcomes for patients regardless of the day or time of their admission.
- There are only 2 CNS roles at PCH and funding is required for a 3rd, which would significantly enhance the service for patients and performance.
- Small inpatient therapies resource.
- There were no applicants for the 3rd Consultant vacancy at PCH. Scoping is underway regarding the possibility of employing two SAS doctors using this funding.

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

- There is currently no administrative/systems support at POW, required to further develop processes for managing and improving the data quality.
- Regional development discussions are progressing with significant clinical engagement, but no confirmed WG funding for any potential developments.

Organisational Risk Register

2.16 Demand, capacity and performance challenges across the stroke pathway are recognised as a risk in the CTMUHB Organisational Risk Register. The risk is included at **Appendix 3**.

Next steps

2.17 Based on feedback from discussions in both Quality and Safety Committee and also Planning, Performance and Finance Committee, the Stroke Strategy Group will continue to oversee progress against stroke action plan **(Appendix 4)**, informed by updates from the Stroke Programme Board**.** The group will regularly assess performance and progress, and review the plan to ensure it incorporates current and newly-identified actions with clear Action owners and delivery dates.

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

3 Key Risks / Matters for Escalation

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

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

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

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

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: • Effective Care • Dignified Care • Timely Care • Staying Healthy • Staff and resources
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Significant challenges delivering a consistent high-quality stroke pathway across CTM.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: EIA to be undertaken as part of further work if required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	SSNAP data is reported nationally and is below the standards at which we strive to perform	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Service improvements required to meet the QIM standards that we aspire to is associated with significant additional resource that it has not been possible to identify.	

5 Recommendation

5.1 The Quality and Safety Committee are asked to:

- Note the ongoing significant challenges faced across CTM stroke services, reflected in the QIM performance data
- Note that the identification of a small amount of additional resource to support stroke service developments. It has not been possible to identify the large-scale funding required to deliver improvement across all 4 QIMs due to the challenged financial position across CTM
- Note the developments made in some aspects of the stroke pathway and the updated action plan.
- Note the focused work on the stroke pathway undertaken through the revised governance structure.
- Note the regional and national work being undertaken to develop high quality prevention, identification and treatment for stroke.

6 Next Steps

- Ongoing targeted focus on stroke pathway service developments and quality improvement by Stroke Operational Group, Programme Board and Stroke Strategy Group.
- Ongoing active engagement with regional and national stroke programme.

Appendix 1

PREDICT-EV Stroke Study: Collaboration between Cardiff Metropolitan University and Cwm Taf Morgannwg Health Board. Funded by the Stroke Association UK

In England, Wales and Northern Ireland, over a quarter of people who have a stroke have had a previous stroke or Transient Ischemic Attack (TIA). Experiencing a TIA increases your risk of a subsequent stroke and patients who have suffered a TIA are at the highest risk of suffering a stroke 24 hours post TIA.

A problem for stroke physicians and nurse practitioners who evaluate TIA patients, is to identify and to stratify risk those patients requiring rapid intervention to prevent a stroke. The development of a risk stratification pathway involving blood biomarkers could be helpful in clinical decision making.

The PREDICY-EV study is investigating whether the risk of clotting and profile of circulating extracellular vesicles (EV) population can be used as potential biomarkers in predicting the risk of a future stroke in patients who have suffered a TIA. Patients with suspected TIA are being recruited from the TIA OPD clinic, Accident and Emergency Department and Stroke unit at Prince Charles Hospital. Patients are approached and after giving consent, are asked to provide a blood sample at baseline for EV, coagulation and other routine blood tests. These patients are followed up for the duration of the study to monitor future clinical presentation, to include stroke. Blood Samples are also being collected from a subgroup of consented non-TIA patients as a control group.

The primary outcome measure is a comparison of coagulation screen and clot structure/lysis measurements in TIA patients before and after suffering a stroke versus TIA patients that do not go on to experience a stroke within the study timeframe. The secondary outcome measures are to compare circulating EV profile and activation state in TIA versus non-TIA patients and those who do and do not go on to suffer a stroke. The laboratory analysis will also seek to understand if the EV's contribute to the coagulation status, clot stability, clot lysis and inflammatory processes that could all contribute to stroke severity and recovery. In addition, the project team through analysis of a 20 year population wide data set available through SAIL, will retrospectively explore whether the prothrombin time, not currently a routine test for stroke patients, can also help in the assessment of thrombotic risk and future development of a stroke in TIA patients.

Recruitment of the study is ongoing with 119 patients and 24 controls having been recruited to date. The study target is 270 TIA participants, all of which will require follow-up for the term of the study. Dedicated Research Officer support continues to be provided by the CTMUHB Research & Development (R&D) team and Cardiff Metropolitan post-doctoral researchers, funded by the successful Stroke Association UK grant (£240K). As a result of the PREDICT-EV project and partnership, other stroke related

collaborative research ideas are being developed with Cardiff Metropolitan University colleagues.

Early results from the study have been presented at the Artery conference (Bonn 2023) and the CTMUHB R&D conference last year and at this year's upcoming event.

The CTMUHB research team and Cardiff Metropolitan University research group have met with the UK Stroke Association research lead and CEO and provided updates on the study's progress and preliminary data. It is anticipated that this study could help bring further Stroke Association UK research funding into Wales.

Professor John Geen: BSc(Hons), Dip.Med.Tox.,FIBMS,EuSpLM,CSci,MSc,PhD,FRCPath

Clinical Lead: Clinical Biochemistry Service and Point of Care Testing Service

Assistant Director for R&D

Visiting Professor of Clinical Science (University of South Wales)

Professor (Hon) of Clinical Biochemistry (Cardiff Metropolitan University)

Appendix 2

Quality Improvement Measures across PCH and POWH

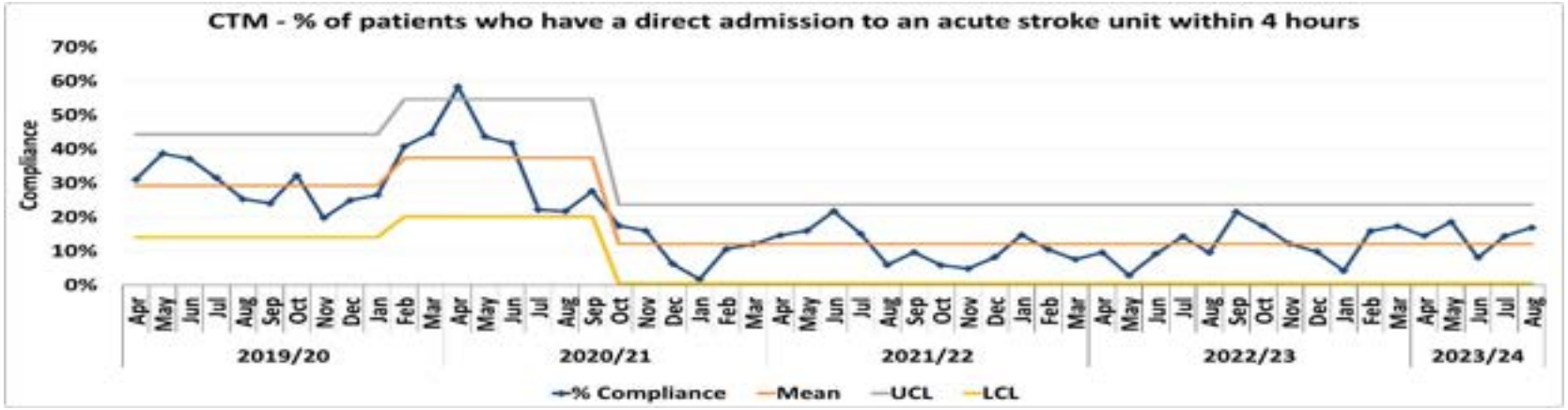
The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides the Health Board with an overview of 6 national Quality Improvement Measures (QIMs), which are part of the suite of improvement measures in the SSNAP:

- Direct admission to an acute stroke unit within 4 hours
- Thrombolysis with a door to needle time within 45 minutes
- CT scan within 1 hour
- Assessment by a stroke consultant within 24 hours
- Patients assessed by one of OT, PT, SALT within 24 hours
- Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team

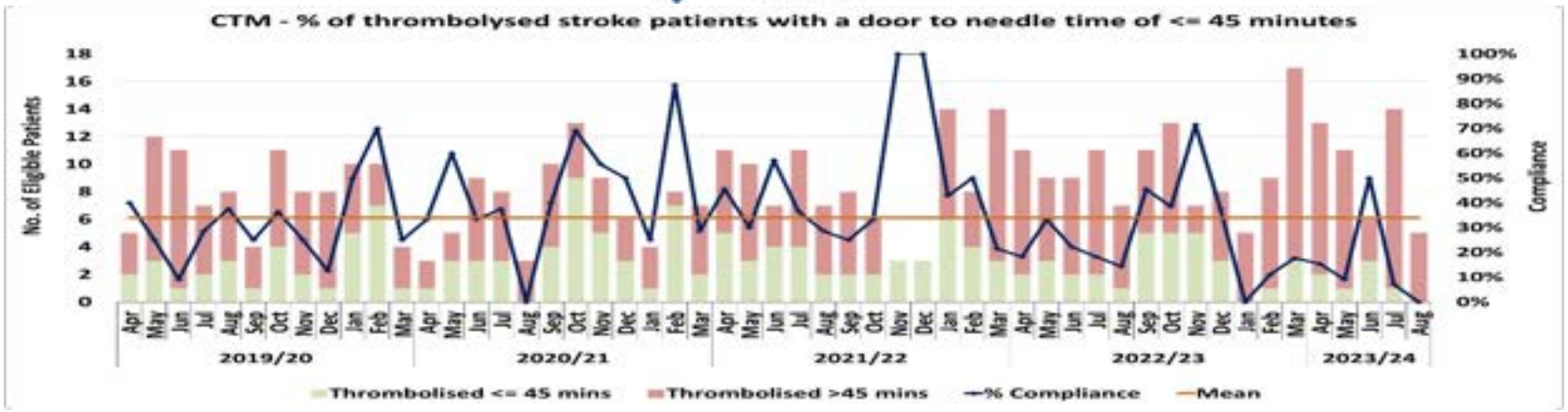
Overall, patient flow challenges on both the POWH and PCH sites have had a direct impact upon the ability to admit people to a stroke ward within 4 hours. In addition, increased length of stay for stroke patients at the POWH site is linked to the lack of access to ESD and community rehabilitation beds to support flow.

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

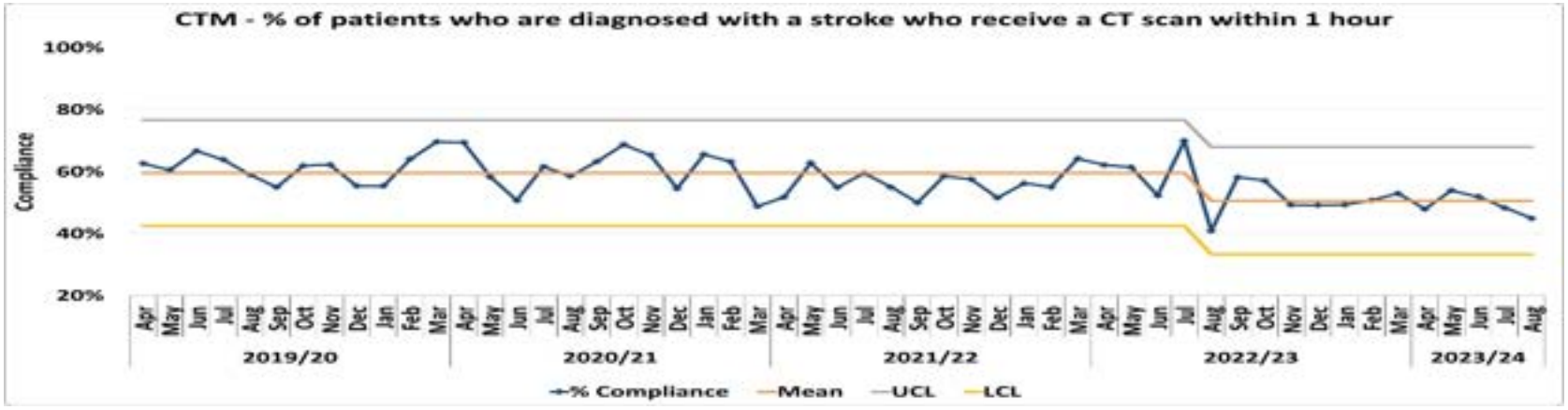
% compliance with direct admission to an acute stroke unit within 4 hours



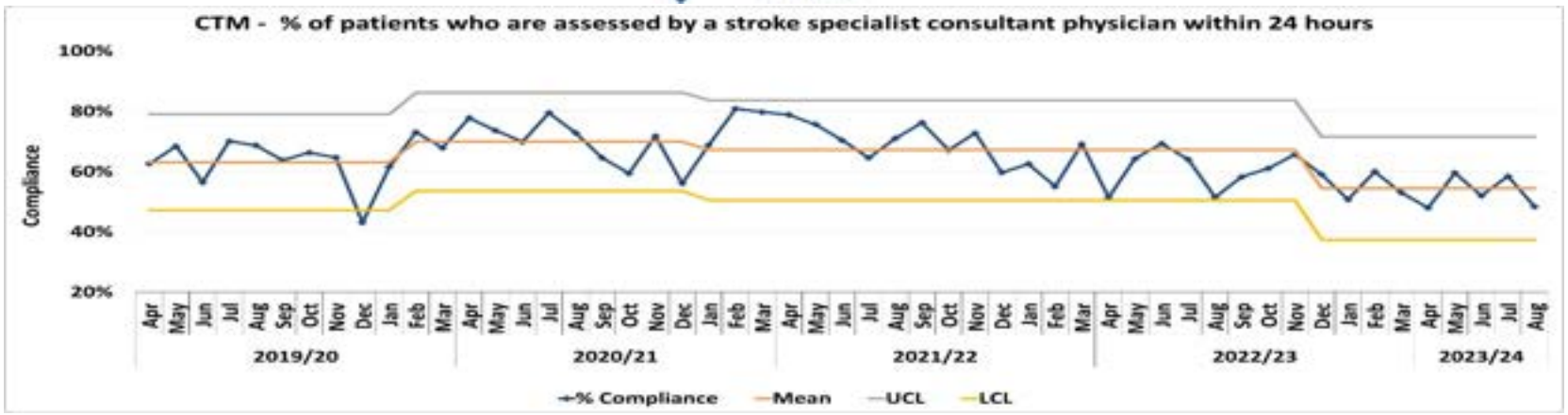
% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes



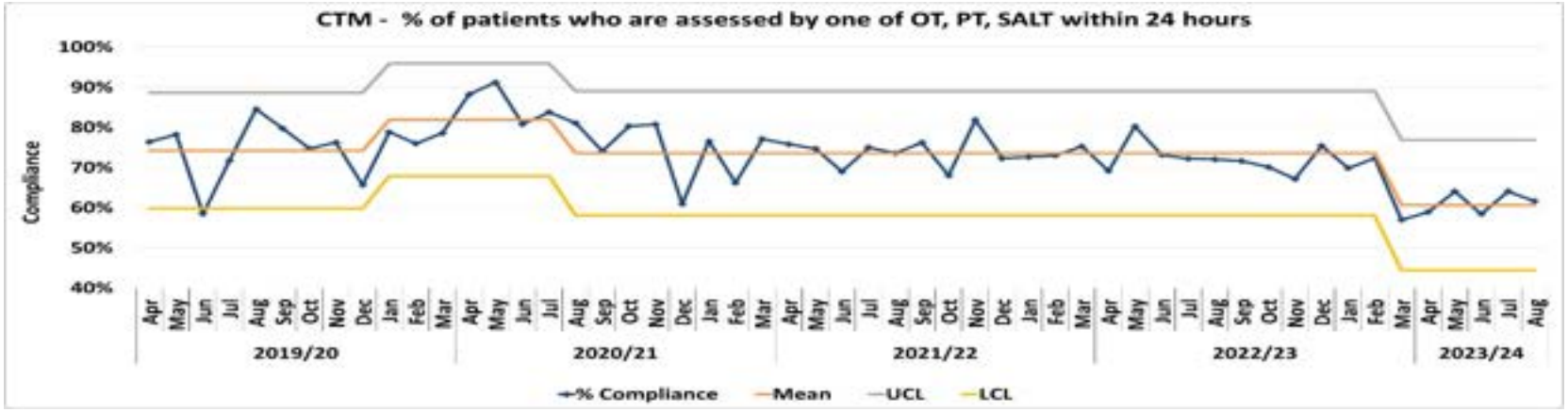
% compliance of patients diagnosed with stroke received a CT scan within 1 hour



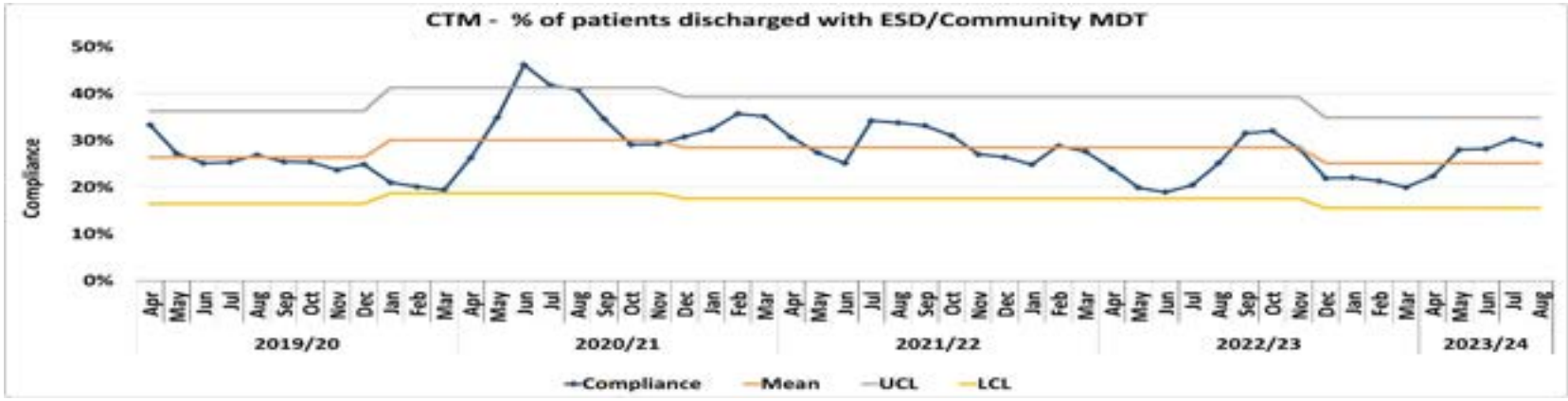
% compliance assessed by a stroke consultant within 24 hours



% of patients assessed by one of OT, PT, SALT within 24 hours



Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team



Appendix 3

Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	Update 4th September 2023: It is the expectation that the new governance arrangements will give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • 1st Board meeting held and monthly meetings to follow from September onwards. • Operational Group being established with 1st meeting in September with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues. • The risk level will need to remain high as Medical and CNS staffing levels at PCH continue to be a challenge relating to maintaining services however also relating to service improvement i.e providing services outside 8-4 during the working week. Review date 31/10/23

Appendix 4

CTM UHB STROKE ACTION PLAN

KEY TO RAGG RATING

Red = No Progress
Amber = Work progressing with issues to address
Green = Complete
Grey = Ongoing Monitoring

KEY TO LEAD

SOG = CTM UHB STROKE OPERATIONAL GROUP

6 GOALS = CTM UHB UEC 6 GOALS PROGRAMME

RSPB = SOUTH CENTRAL REGIONAL STROKE PROGRAMME BOARD

SSG = CTM UHB STROKE STRATEGY GROUP

SPB = CTM UHB STROKE OPERATIONAL PROGRAMME BOARD

Short Term

	Action	Review Date	Lead	RAG Rating	Progress
1.	Review policy for transfer of acute stroke patients from RGH to PCH	~~November 2022~~ ~~May 2023~~ ~~July 2023~~ December 2023	SOG		Fortnightly Task & Finish Group developed proposal to ring fence acute stroke beds on both sites unless under Business Continuity. Daily reviews by Head of Flow to improve stroke transfers. Design of a formal protocol and Standard Operating Procedure for transfers of acute stroke patients presenting at RGH. WAST to review recommendation regarding presenting

					to nearest acute stroke unit vs nearest ED. SOP to be formalised and go to the Board before sharing with care groups for implementation. This action has moved to an ongoing monitoring phase so the review date has moved accordingly.
2.	Check use of WAST/CTMUHB Pathway for Stroke	~~November 2022~~ ~~May 2023~~ ~~July 2023~~ December 2023	SOG		Copy of WAST protocol/pathway received. Currently under review. Establishment of USC Care Group enables singular focus on stroke across CTM UHB and review date has moved accordingly.
3.	Use of electronic whiteboard to review therapy activity, caseload, numbers awaiting transfer in order to aid flow and transfer of care between PCH and YCR.	~~August 2023~~ December 2023	6 Goals		In January 2023, Cwm Taf Morgannwg University Health Board launched a new digital enabler known as the E Whiteboard List View. As staff embed and increase the usage of this digital enabler, there is an aspiration that we will see a median reduction in the length of stay on our acute sites and we will be able to demonstrate the patients experience as a measure of value rather than time as we move forward. Refer to CTM UHB 6 Goals Programme - review date moved accordingly
4.	Provision of Therapy Space at POWH	~~July 2023~~ December 2023	SOG		Covered via a risk assessment submitted to the previous pathways task and finish group. There has not been any change in the risk since then,

					and accommodation for therapy at PCH and POW is still significantly limited. Operational system pressures meant the identified space was re-purposed. Review date has moved to enable the allocation of the space to be revisited.
5.	Provide ring-fenced beds on Stroke Wards	Ongoing	SOG		Action taken forward from Stroke and Bed Management Task and Finish Groups to re-start ring fencing stroke capacity on a daily basis. Daily plan to create a ring fenced bed for stroke in PCH and POW to be confirmed through daily flow calls. Complete – monitor use of plan on daily flow calls.
6.	Development of single evidence-based care pathways across both sites	~~November 2022~~ July 2023	SOG		Work progressing to develop a single operating procedure of how patients are handled from when they are assessed as having a stroke, from ambulance control or from home, and how handover is progressed to the stroke team. Continued work ongoing with clinicians across both acute hospital sites (PCH and POWH) to improve the stroke pathway looking at CT scanning, 7 day therapy and access to stroke unit (November 2022).

					Radiographer approved CTAs are now operating on all 3 acute sites, to minimise delays in thrombectomy. Following publication of new stroke guidelines in April will need to develop new thrombolysis pathways and CT perfusion scanning.
7.	Development of single evidence-based care pathway for thrombolysis	September 2022	SOG		Unified criteria for thrombolysis agreed across both sites. As above.
8.	Review and development of stroke pathway to include:		SOG		Work to address these actions is progressing through the Stroke Operational Group and progress reviewed through the Stroke Operational Programme Board.
	There is a clinical risk in supporting 24/7 thrombectomy locally due to a 1 in 4 Stroke Consultant rota and conversations are continuing regarding a regional rota.	January 2024			
	Work is ongoing to implement Brainomix AI software reporting for CT and CT angiograms, in order to minimise delays in referral for thrombectomy, with Year 1 funding agreed via Therapies.	January 2024			

	Recruitment has been progressing to facilitate the development of a pan-CTM Early Supported Discharge team. Additional therapies colleagues are being inducted into post and pathways are being written/revised, with engagement from key stakeholders. Plans are underway for the wider service to commence as soon as all key staff are in post.	January 2024			
	CTM has contributed to the national review of Stroke Self Presenters and the outputs from this are awaited	January 2024			

	Work is underway to explore extending Stroke Clinical Nurse Specialist (CNS) hours to 18:30 to cover more of the window for thrombectomy referral/transfers. Results will be reported back to Stroke Operational Group and fed up to Stroke Programme Board at next meeting. Without an additional CNS, this would only be viable when both nurses are on duty and there is no annual leave/sickness.	December 2023			
9.	Review current pathway for Orthoptics and explore potential for unification of service across CTMUHB	~~November 2022~~ ~~July 2023~~ December 2023	SSG		Attend anywhere video consultations and additional phone consultations have been put in progress to address W/L in North CTM. Training of staff in these localities has also commenced, which should lead to a more aligned service across localities. Head of Orthotics post remains vacant. Lack of Head of Orthoptics in post challenge to development of service – review date has moved accordingly.
10.	Optimisation of medication and compliance for patients on Primary	~~November 2022~~ July 2023	SSG		CTM UHB Value Based Health Care Business case successful as part of Regional Business Case. Work progressing on implementation.

	Care Atrial Fibrillation (AF) and Hypertension Registers. Case Detection of patients with AF and Hypertension.				This action has moved to an ongoing monitoring phase so the review date moves accordingly.

Medium Term

1.	CTM UHB Stroke Programme Board to scope clinical pathway across CTM UHB, develop workforce model and associated Business Case / Investment Plan to include consideration of:	March 2024	SPB		These actions are complete but the additional resource required is not available for these developments other than for point *v. provision of ESD service across the CTMUHB footprint*. The Stroke Task & Finish Group, using previous Stroke information from other forums, undertook a further risk assessment of the pathway. The T&F Group ranked and rated the risks to prioritise the top risks and then identify elements of the pathway that require further investment in order to best mitigate the risk(s), make the stroke pathway safer and more resilient for patients, and optimise both short and longer term clinical outcomes.
	i. development of a single specialist bedded stroke rehabilitation unit for CTM to support flow from the acute sites and so increase acute stroke bed availability				
	ii. 7 day working of stroke teams (inc. medics, nurses and therapists) additional Junior Doctor hours, including 7 day working				
	iii. provision of additional Advanced Nurse Practitioners to support the stroke pathway				

	iv. consider requirement for additional Stroke Consultant Capacity				
	v. provision of ESD service across CTMUHB footprint				
	vi. explore potential for increased inpatient stroke rehabilitation capacity in YCR				
	ii. appointment of a co-ordinator at YCR to improve communication with patients and families and free up medical, nursing and therapy time.				
2.	Develop ability to transfer patients with nasogastric tubes to YCR	September 2022	SSG		Protocol established and 2 recent admissions accepted. Complete.
3.	Explore reasons for delay in accessing help and arriving at PCH. In some cases this delay is a median time of 15 hours if travelling by own transport.	November 2022	SSG		Work has been undertaken to validate the data on the delays. It appears that delays have increased to both units but particularly in arriving at PCH when using own transport. Despite efforts to understand the reasons for protracted delay in attendance at PCH with stroke, there does not appear to a single reason for this. It is most likely to be multifactorial ranging from a lack of recognitions of symptoms and signs of stroke, particularly in waking strokes to an intrinsic stoicism to not trouble acute services.

					Funding was agreed to run the F.A.S.T. campaign in Wales, commencing 27th April 2023 In addition, a social media campaign has been funded by public health to run locally. Furthermore, as part of the AF/BP prevention work, a primary care nurse will work with those at risk to raise awareness of the signs and symptoms of stroke locally. Furthermore, as part of the AF/BP prevention work, a primary care nurse will work with those at risk to raise awareness of the signs and symptoms of stroke locally.
4.	Improve access to thrombectomy at Bristol.	~~November 2022~~ Awaiting go-live date from Bristol	SOG		Bristol thrombectomy service to go 24/7, improving access for both PCH and POWH. No definitive date on Bristol providing 24/7 thrombectomy service for South Wales. However, CTM UHB continue to develop structures that will enable this to be delivered when able, including radiographer approved CTAs, urgent Everlight reporting of CTs and implementation of AI software.

Long Term

1.	Work with Cardiff and Vale UHB to explore potential for regional	Q1 2024	RSPB		South Central Stroke Delivery Network (SCSDN) Programme Board now in place. Phase

	working and regional enhanced stroke unit				one of the programme, scoping and discovery, is now drawing to a conclusion as we prepare to work with key stakeholders to develop a new model for the delivery of our services. There are ongoing delays in the ability to initiate phase two fully, as capacity constraints within the National Stroke Team are leading to delays in the development of required service specifications, optimal pathways and demand/capacity modelling. It is envisaged that the business case for the new clinical model will be completed by the end of Q1 2024. A meeting is being arranged between CTM and C&V therapy staff - to get to know each other, roles and how current services are run.

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 21 September 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member (Committee Chair)
Dilys Jouvenat	Independent Member (Vice Chair)
Nicola Milligan	Independent Member (In part)
Patsy Roseblade	Independent Member
James Hehir	Independent Member

In Attendance:

Sallie Davies	Deputy Medical Director
Lauren Edwards	Executive Director of Therapies & Health Science
Gethin Hughes	Chief Operating Officer (in part)
Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Hywel Daniel	Executive Director for People (in part)
Gareth Watts	Director of Corporate Governance & Board Secretary
Emma James	Care Group Nurse Director
Adrian Clarke	Deputy Director & Head of Nursing NCCU (In part)
Jo Lines	Lead Nurse, Scheduled Care
Sharon O'Brien	Care Group Nurse Director
Suzanne Hardacre	Head of Midwifery
Mohamed Elnasharty	Consultant Obstetrician & Gynaecologist
Nigel Downes	Assistant Director of Quality & Safety
Richard Hughes	Deputy Director of Nursing
Stephanie Muir	Assistant Director of Concerns & Claims
Julie Denley	Deputy Chief Operating Officer (in part)
Lisa Love-Gould	Care Group Director
Sally Bolt	Consultant Radiologist
Samantha Connell	Senior Project Manager, Programme Management Office
Kellie Jenkins Forrester	Head of Concerns and Business Intelligence
Esther Flavell	Consultant Anaesthetist (In part)
Debbie Bennion	Head of Nosocomial Investigation Team (In part)
Paul Dalton	Head of Internal Audit
Emma Walters	Head of Corporate Governance & Board Business
Tyler Lewis	Corporate Governance Officer (Observing)
Emma Jerwood	Medical Secretary (Observing)
Kelly Eddington	Quality Assurance and Compliance Officer (Observing)
Sheiladen Aquino	Speech & Language Therapist Clinical Lead (Observing)

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

1.2 Apologies for Absence

Apologies for absence were received from:

- Nicola Milligan, Independent Member
- Dom Hurford, Medical Director
- Cally Hamblyn, Assistant Director of Governance & Risk
- Stephen Sarasin, Care Group Director
- Mary Self, Care Group Director
- Hannah Wilton, Chief Pharmacist
- Ana Llewellyn, Care Group Nurse Director
- Gaynor Jones, Staff Side Representative

1.3 Declarations of Interest

There were no additional interests declared.

2.0 SHARED LISTENING AND LEARING

2.1 Listening & Learning Story- Snowdrop Breast Centre

J. Lines (Lead Nurse) shared the listening and learning story which related to a patient's experience of receiving treatment from the Snowdrop Breast Centre. Members noted that the Unit opened on 20 February 2023, with the official opening taking place on the afternoon of 21 September 2023.

The Committee Chair welcomed the story which she found to be emotional and inspiring and added that the patient had clearly expressed how important this service was which highlighted how patient stories could be so powerful.

G Hughes extended his thanks to J Lines and the patient for sharing the story and added that the story had highlighted how the environment was so crucial for patients when they were feeling vulnerable. G Hughes advised that listening to this feedback was crucial and important when taking into consideration the design of a building, for example, the Llantrisant Health Park, and added that having an environment that supports patients during difficult times was paramount.

The Committee Chair extended her thanks to all staff involved in the development and operation of the Snowdrop Breast Centre and added that she hoped the official opening goes well.

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

2.2 Care Group Spotlight Presentation – Planned Care – Focus on Ophthalmology Backlog

Sharon O Brien shared the presentation and highlighted the key matters for Members attention. G Hughes advised Members that a presentation had also been shared with the Planning, Performance and Finance Committee in relation to the performance aspects.

The Committee Chair welcomed the presentation which highlighted the significant amount of work being undertaken in this area.

G Hughes advised that in relation to ophthalmology as a whole, the area which was causing the most concern was in relation to Glaucoma, primarily as this would lead to irretrievable sight loss should a patient not receive the appropriate treatment. Members noted that the Getting it Right First Time (GIRFT) report had identified the need to follow up the patients with high-risk glaucoma at regular interventions and had also identified the cohort of patients who could be followed up within the community. In this respect, the Team were in the process of changing the operating model and were also considering the good practice that had been identified by GIRFT across both Ophthalmic departments, with an ambition to move to a single specialist eye care unit for the population of Cwm Taf Morgannwg, based at the Princess of Wales Hospital.

G Hughes extended his thanks to the Planned Care Team for the work undertaken to date and advised members that whilst there would be patients that would be identified where harm had occurred during this period of time, the Team were working really hard to manage this risk and move the Health Board towards an Ophthalmic service it should be proud of.

J Hehir extended his thanks to S O'Brien and G Hughes for sharing the report which he found to be interesting and candid and made reference to the referrals being made to Vanguard and sought clarity as to how performance was being monitored to ensure the treatment being provided to patients was being delivered in the appropriate way and with the expected outcomes. S O'Brien advised that the Health Board had been working with Vanguard for a significant amount of time and provided assurance that governance processes were already in place. Members noted that patients were still being followed up within Health Board clinics by Health Board Clinicians. S O'Brien added that the referrals were being made to ensure the Health Board was maximising the best service for its population in relation to reducing the amount of time patients needed to wait for treatment. J Hehir extended his thanks to S O'Brien for the assurance provided.

P Roseblade advised that the verbal update provided appeared to be much more positive than the information that had been contained within the presentation and added that given the presentation would be made available within the public domain following the meeting, there were a number of acronyms contained within the presentation which needed explanation. She added that the presentation needed to be strengthened to provide more assurance to members of the public that focus was now being placed on identifying the patients most at risk of harm.

P Roseblade advised that the presentation made reference to the creation of a business case and added that on page 5 reference was made in relation to appointing additional glaucoma consultants. P Roseblade sought clarity as to whether funding was already available for this given the current financial position. G Hughes confirmed that funding had been secured on an interim basis for the additional Glaucoma Consultants and added that in light of some maternity leave within the Team, the consultant resource was being reconfigured to provide additional capacity. Members noted that work was being undertaken with the Independent sector to ensure the patients waiting for first assessment were being seen promptly and noted that the additional Locum Consultants would focus on clearing the backlog of Glaucoma patients requiring follow up. P Roseblade extended her thanks to G Hughes for the update provided.

The Committee Chair advised that she found the update provided to be more reassuring compared to what had been reported in the presentation and advised that the trajectories included in the presentation looked positive and questioned what level of confidence was in place in maintaining this moving forwards. The Committee Chair noted that resource was in place for the additional staff required and questioned whether there was an opportunity to highlight to the Board the positive steps that had been taken in this area. G Hughes advised that he would be happy to prepare a report for a future meeting of the Board.

The Committee Chair extended the Committee's congratulations to all staff involved in this piece of work which had been an area of concern for the Committee for some time. The Committee Chair advised that Committee Members had been provided with assurance that relevant action was being taken and that there was enough in the system to maintain improvement and added that the position would still need to be closely monitored given the potential harm to patients.

Resolution: The presentation was **NOTED.**

Action: Report to be prepared for a future meeting of the Board highlighting the positive steps that had been taken to address the backlog within Ophthalmology

3.0 CONSENT AGENDA

The Committee Chair asked Members if there were any items on the consent agenda (Item 9) that they wished to move to the main agenda for discussion. There were no items identified.

4. MAIN AGENDA

4.1 Matters Arising not considered on the Action Log

There were none.

5.0 SETTING THE SCENE – SERVICE DELIVERY

5.1 Report From the Chief Operating Officer

G Hughes presented the report and highlighted the key matters for Members attention.

P Roseblade made reference to page 2 of the report which referred to concerns raised in relation to Safeguarding at the Princess of Wales Hospital and advised that she was unsure what this related to and added that she felt this was a concerning statement to make within a public document. G Hughes advised that a case had been identified where it was thought a safeguarding alert should have been raised and added that this was being led by the Medical Director. S Davies advised that the case had been reviewed and added that work was being undertaken with Teams to learn lessons from this matter. S Davies advised that the Health Board had recently had its Safeguarding Hub reviewed which had been held up as an exemplar across Wales.

P Roseblade made reference to page 7 of the report which referred to a Stroke Programme Board being established and added that she thought that this had been established and in place for some time in order to deliver the current action plan, which she could not recall receiving at the Committee recently. L Edwards advised that the Stroke Strategy Group had been in place for some time and added that the Stroke Improvement Board, which sits underneath the Stroke Strategy Group, had recently been established, with the first meeting taking place in July 2023. L Edwards advised that a Stroke Progress report was presented to the Committee on a quarterly basis, with the next report due to be presented at the November 2023 meeting.

The Committee Chair advised that she felt as a Member of the Committee, updates were being provided on Stroke and progress against action plans but she did not get a feel for who was undertaking the actions and the results of the actions being undertaken and suggested that consideration may need to be given as to how progress against stroke actions were being presented. The Committee Chair added that she wouldn't want officers to feel that the Committee were negating the work being undertaken, she just felt concerned how progress was being reported back to Committee members. E James

advised that she would be happy to encompass progress being made around the stroke action plan within the Unscheduled Care Group Highlight report moving forwards.

The Committee Chair referred to the Phase 2 Consultation in relation to the Operating model and sought an update as to the current position. G Hughes advised that the Phase 2 Consultation was running until 29 September 2023 and added that a number of comments had been received which the Team were working through in detail. Members noted that once the consultation had closed any proposed changes based on the feedback provided would need to be shared within two weeks from consultation closure. G Hughes advised that internal recruitment would be undertaken via an Assessment Centre process in the latter part of October with any remaining gaps being filled via an external recruitment process. Members noted that positive engagement had taken place with Care Groups to date, and it was hoped that in eight weeks there would be clarity as to where the gaps were, and the process required for filling these.

The Committee Chair advised that she felt it was timely for a discussion to be held on Sepsis and requested that this was added to the agenda for the next meeting.

Resolution: The report was **NOTED.**

Actions: Consideration to be given as to how progress being made against Stroke Actions were being presented to the Committee

Report on Sepsis to be presented to the next meeting of the Committee

5.2 CARE GROUP HIGHLIGHT REPORTS

Diagnostics, Therapies, Pharmacies and Specialties

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

J Hehir welcomed the report which he had found to be candid and made reference to the Controlled Drugs licences at HMC Parc and noted that the Home Office would be undertaking a visit in November 2023. J Hehir advised that this seemed to have created a significant work around for the Health Board and sought clarity as to when the issues would be resolved. L Love-Gould provided assurance that all the licences were now up to date and advised that she would be happy to ask H Wilton, Chief Pharmacist to provide an update on the current position if required. Members recognised that this had created increased pressure on staff and the increase on resource requirements had been significant which had not been anticipated. S Bolt also provided assurance that full compliance was in place in relation to controlled drugs licences. D Jouvenat advised that she had recalled a discussion taking place at

Board where assurance had been provided that compliance was now in place in relation to controlled drugs licences.

P Roseblade made reference to the Planned Care Recovery Business Case and questioned whether this was a Business Case that had been submitted against the funding that had already been allocated to Planned Care. L Love-Gould advised that she would need to confirm this outside the meeting and added that funding had been allocated for a short period of time and given the effectiveness of the funding the Team were hoping this funding would continue. G Hughes noted that he had advised the Team that the outsourcing for Pathology would continue within the current financial run rate for the remainder of the year and added he would discuss further with the Team outside the meeting.

N Milligan made reference to the statement made within the report regarding the recruitment freeze on administration vacancies having an impact on the therapy profession, and questioned what impact this was having on patients. L Love-Gould advised that the position had changed since the report was produced and added that some higher priority posts had now been approved. Members noted that complaints were being received that patients were unable to reach the Physiotherapy Department by telephone as staff were having to prioritise tasks. There were also issues being experienced in relation to the timely production of reports and letters that needed to be sent to patients. Members noted that the Team were trying to manage the position and were monitoring the position closely. N Milligan advised that patient communication was important and added that as patients were having difficulties contacting departments this would result in patients becoming anxious and was likely to increase the number of complaints being received.

G Hughes advised that the freeze was not a blanket freeze on administration posts and advised that this process provided an opportunity to review areas where there was poor utilisation of admin resource and utilisation of admin agency. Members noted that consideration was being given to how technology could be deployed appropriately, for example, digital dictation. G Hughes agreed that it was not acceptable that patients could not access services and make telephone calls and added that consideration needed to be given to what the best service model would be that would meet the needs of our patients to ensure they can access service promptly.

S Bolt provided Members with an update in relation to the Radiology backlog and advised that meetings had been held with the Teams to discuss the best ways of reducing the backlog, which included a review of structures to ensure the appropriate resource was in place.

In relation to administrative posts, H Daniel advised that the Health Board had quite a large administrative resource and there were some opportunities to review this. H Daniel provided assurance that posts had been prioritised where there was an urgent clinical need and would potentially impact on patient care. Members noted that Care Groups had been asked to prioritise their vacancies

that had been submitted for approval. Members also noted that it was appropriate that a review of admin agency and admin overtime was undertaken given the current financial spend in these areas.

Unscheduled Care

E James presented the report and highlighted the key points contained within the alert escalate section. E James made reference to the work being undertaken in relation to Frailty and the Committee Chair advised that the Committee would welcome a Spotlight Report on Frailty at a future meeting.

In response to a query raised by the Committee Chair as to whether the issues regarding major trauma related to Cwm Taf Morgannwg or the wider network, E James advised that work had been undertaken with the network and advised that patient flows were agreed when the trauma units went live with the Centre being based in Cardiff. Members noted that the Health Boards were now starting to get a feel for where patients would flow to which had identified that there would not always be a need for the heightened skill sets to be based in all three areas. Members noted that further work was required to determine which area would be best to house the Trauma Unit which would need to be undertaken in collaboration with the network and patient flow teams.

P Roseblade made reference to the redesign of the repatriation policy and questioned whether this was a Wales wide policy which was being developed jointly with other Health Boards. E James confirmed that the redesign being undertaken was specific within the CTM cohort of patients being repatriated as opposed to an overarching review of the policy which would not be in the Health Board's gift to undertake.

The Committee Chair noted the significant improvements made in the Infection, Prevention and Control work and the work being undertaken on the Emergency Department development.

Children & Families

S Hardacre presented the report and highlighted the matters for escalation.

N Milligan advised that she had recently sat on the appointment panel for the Head of Midwifery, Gynaecology & Integrated Sexual Health post in which there were two service users who were also on the panel. N Milligan advised that she had found their input to be helpful and refreshing and suggested that consideration be given to involving service users in future stakeholder panels for key posts. S Hardacre confirmed that she had found their feedback valuable in terms of making a decision. The Committee Chair welcomed this involvement and agreed that it would be worth considering replicating this across the Health Board as a learning tool.

Mental Health & Learning Disabilities

J Denley presented the report and highlighted the items contained within the alert escalate section.

The Committee Chair advised that the issues in relation to the Registered Nurse vacancies had caused some significant concerns for Committee Members and added that Members would welcome sight of the update being prepared on this matter which should hopefully provide Members with assurance.

Primary Care & Community
J Denley presented the report and highlighted the areas contained within the alert escalate section.

The Committee Chair made reference to Parc Prison and advised that this seemed to feature heavily in reports being presented and sought clarity as to whether the work involved in taking over this service had been significantly underestimated. J Denley advised that this had been underestimated in some areas and added that one the of areas of learning was that standards within the private sector provision were significantly different to standards within the NHS, particularly in relation to the management of concerns.

N Milligan advised that she was disappointed to see that General Anaesthetic Paediatric referrals were increasing and questioned whether the children were having issues accessing a dentist. J Denley advised that there were less issues with children being able to access a dentist and advised that these referrals related to patients with additional vulnerabilities and needs.

Planned Care

S O Brien presented the report and highlighted the areas contained within the alert escalate section.

J Hehir made reference to the incidents that had been reported as moderate harm for July and questioned whether there were any themes or trends that Members needed to be made aware of. S O'Brien advised that this mostly related to Ophthalmology and advised that themes had been identified in relation to escalation of care, escalation at Ward level in relation to NEWS reporting and medicines errors which related to prescribing. Members noted that the Care Group was undertaking a joint piece of work with the Unscheduled Care Group in relation to escalation of care and steps were being taken to introduce a Health Board wide Jump Call.

The reports were **NOTED.**

Resolution:

Action: Spotlight report on Frailty to be presented to a future meeting of the Committee.

6.0 GOVERNANCE, RISK AND ASSURANCE

6.1 CTMUHB Staff Process for Raising Concerns

G Watts presented the report and highlighted key matters for Members attention. The Committee Chair recognised that this was a critical piece of work that needed to be taken forward.

D Jouvenat advised that a report had also been presented to the People & Culture Committee and added that she had agreed to be the champion for this piece of work and advised that she would welcome involvement from other Independent Members in this area of work.

In response to a question raised by J Hehir as to what engagement had been undertaken with staff networks, members noted that existing staff networks were being used to undertake engagement and noted that staff networks were also members of the Speaking Up Safely Group.

P Roseblade made reference to paragraph 2.3 which stated that it was not the role of the Speaking Up Safely Group to investigate and added that within the key risks and matters for escalation section it stated that matters needed to be taken seriously and investigated, which appeared to be contradictory. H Daniel advised that normal mechanisms would be in place for undertaking investigations and disciplinaries and added that the Speaking Up Safely process would be a route to signpost staff to existing processes, which needed to be made clearer within the report.

G Watts advised that he would be undertaking the role of designated Executive Lead in this area and added that he will be working with Members of this Committee and other Committees to take this piece of work forward. G Watts assured Members that engagement would be undertaken with various networks within the Health Board and added that Welsh Government had asked all Health Boards to undertake a self-evaluation which needed to be completed by end of October 2023. Members noted the self-evaluation would be shared with Board Members prior to submission.

The Committee Chair welcomed the update on the work being undertaken and advised that she looked forward to a further update being received at a future meeting.

Resolution: The report was **NOTED.**

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

G. Watts presented the report and highlighted key items for Members attention.

P Roseblade made reference to Risk 5036 which stated that the risk score had been reduced and also stated that the Pathology Service was unable to meet current workload demands and questioned why the risk had been reduced if this was the case. G Hughes advised the risk was an inherent risk which related

to a Demand & Capacity shortfall within Pathology, which had been driven by a number of reasons, including workforce. G Hughes advised that the reason the risk score had reduced was as a result of mitigating actions being put into place on a non-recurrent basis and outsourcing on a recurrent basis which had resulted in waiting times being brought back to reasonable levels. Members noted there had been a significant reduction in the level of incidents being reported in relation to long waits and G Hughes advised that he was content with the reduction in risk score as a result of the mitigating actions that had been put into place. L Love-Gould advised that in relation to this risk, there had been an initial error in the grading of the risk which had resulted in the risk being re-graded following the Team receiving risk training.

P Roseblade made reference to risk 4148 (Deprivation of Liberty Safeguards which had a reduction in risk score from 16 to 12 and advised that it was not clear as to why this risk score had reduced. G Dix agreed that this needed to be better articulated in the mitigating action section of the report and added that the risk score had reduced because of a reduction in the authorisation of backlog cases and as a result of improved processes being put into place for managing the DOLS procedure through an alternative platform.

P Roseblade made reference to Risk 4907 (Redress) and the reduction in risk score from 20 to 16 and advised that whilst she recognised that there was an Invest to Save bid, there was no guarantee that this funding would be approved given the current financial position and added that there did not seem to be any rationale provided for reducing the score. N Downes advised that alternative processes had to be put into place as a result of sickness absence within the Team and added that as staff return to work he was confident the risk score would reduce further.

The Committee Chair advised that it would be helpful if future reports could include an explanation as to why the risk scores had been reduced to enable Committee Members to accept the reductions being proposed.

The Committee Chair welcomed the recruitment of Therapy staff and noted that the impact on winter planning was referenced against some risks but not others. The Committee Chair recognised that mandatory training compliance appeared to be a common theme and questioned whether this was being discussed at People & Culture Committee. H Daniel confirmed that this matter was being discussed strategically at People & Culture Committee and was being considered daily at an operational level.

The Committee Chair made reference to risk 4217 (No Infection Control resource within Primary Care) and advised that she did not understand why this risk had been reduced as it appeared to make reference to reporting frequency and could not understand how reporting frequency reduces the risk. The Committee Chair requested an update against this risk for the next meeting.

Resolution: The report was **DISCUSSED** and **REVIEWED**

Actions: Future reports to include an explanation as to why the risk scores had been reduced

Update to be provided against Risk 4217 at the next meeting to explain why reporting frequency would have reduced the risk score

6.3 Healthcare Inspectorate Wales Improvement Plan Tracker Report

G. Dix presented the report and highlighted the key matters for Members attention.

D Jouvenat made reference to the 40% of Improvement Actions which had been recorded as unknown status which she found to be concerning and sought assurance as to how confident the Team were that the information required would be received. G Dix advised the 40% largely related to the Mental Health Improvement Programme and added he was confident that these were on track to be addressed.

Resolution: The report was **NOTED.**

6.4 Learning From Events Reports

S. Muir Presented the report and highlighted the key matters for Members attention.

The Committee Chair welcomed the report which she found to be positive and added that it provided assurance that good systems were in place to manage the backlog of work that needed to be addressed. Following a query raised by the Committee Chair, S Muir confirmed that resource was now in place to deliver this piece of work.

Committee Members confirmed that they felt content that robust processes were now in place and noted that a further update on progress would be presented as an appendix to the Quality Dashboard at the January 2024 meeting.

Resolution: The report was **NOTED.**

Action: Further update on progress to be presented to the January meeting of the Committee as an appendix to the Quality Dashboard report.

6.5 CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unity Interim Learning Report

D Bennion presented the report and highlighted key matters for Members attention. Members noted that as at the end of August, 75% of the 3233 total

investigations had been completed and noted that as at the end of September 175 letters and reports had been sent out to families which had resulted in five family meetings. Members noted that no cases had been referred to the Ombudsman. Members noted that the programme was due to come to an end at the end of March 2024.

Following a query raised by the Committee Chair as to whether it was felt that Committee Members needed to be provided with further assurance on this matter, G Dix advised that whilst he felt that regular updates were not required, Committee members may find it helpful to be provided with the outcome of the Demand & Capacity work that would be undertaken by D Bennion post April 2024. The Committee Chair agreed to receive a further update once the Demand & Capacity work had been completed.

Resolution: The report was **NOTED.**

Action: Outcome of the Demand & Capacity work to be presented to a future meeting of the Committee

6.6 Quality & Safety Committee Annual Self Effectiveness Survey

The Committee Chair presented the survey and highlighted the key items for Members attention. The Committee Chair advised that it would be helpful if Members could identify their training needs so that training could be provided to the Members who requested further training.

P Roseblade made reference to the suggestion made to hold at least one future meeting as an in-person meeting and added that she struggled to understand the value of this, given that Board and Board Development sessions were now taking place in person. P Roseblade advised that she felt the virtual format of this meeting worked well and added that consideration would need to be given to the time constraints involved in relation to travelling to meetings. The Committee Chair recognised that there was good attendance at the Committee meeting virtually and added that she had found hybrid meetings to be difficult.

D Jouvenat advised that the People & Culture Committee had held mainly in person meetings which had worked well and added that whilst she totally understood the points made by P Roseblade, she felt that it was important for Board members to be at meetings in person as opposed to a hybrid approach.

J Hehir advised that consideration would need to be given to the opportunity costs and added that Members should be mindful of the time pressures on staff given that they were being asked to attend a number of meetings. J Hehir added that asking people to travel to attend an in-person meeting may be a challenge for some and added that he felt that whilst he felt that virtual meetings worked well, he could also see the benefits of in person meetings.

N Milligan advised that only one in person meeting was being suggested and added that given that a request had been made for members to complete the

survey, it was important to follow through what had been highlighted in the survey outcome. N Milligan added that she felt that in person meetings allowed for wider discussions to be held and felt that at least one in person meeting needed to be held each year.

The Committee Chair advised that following the discussions held, the Committee would commit to holding one in person meeting in 2024 and suggested that a review was undertaken following that meeting to determine whether it worked well.

In relation to the greater use of Welsh language, the Committee Chair advised that she would take steps to ensure she moves towards providing a Welsh introduction and advised that she would welcome support from the Welsh Language Team in achieving this.

Resolution: The report was **NOTED.**

Action: One in person meeting to be held in 2024 to determine its effectiveness.

6.7 Summary of Irradiated Blood Alerts incorrectly added to Digital Patient Records

S. Davies presented the report and highlighted the key matters for Members attention. Members noted that the report had also been discussed at the Digital & Data Committee where it was identified that no specific episodes of harm had occurred and noted that the issues related to patient records being incorrectly labelled as opposed to blood samples. Members noted that processes had been put into place to prevent re-occurrence.

Resolution: The report was **NOTED**.

7. DELIVERING OUR PLAN

7.1 Patient Safety & Quality Dashboard – to include an update on CIVICA

N. Downes presented the report and provided an update on key matters for Members attention.

N Downes provided Members with a verbal update on the action contained within the action log in relation to the Public Services Ombudsman for Wales Report about care and treatment in relation to a missed appendicitis. Members noted that this had now progressed to a Claim and in this respect had been closed by the Ombudsman. Members noted that required actions were being put into place to ensure learning was being shared.

N Downes provided Members with a verbal update on the action in relation to what percentage of incidents classed as catastrophic or death were directly attributed to the Health Board and what percentage were not directly attributed. Members noted that due to issues with the system it would not be

easy to run a report off the system in relation to this data at present. Members noted that it was hoped that issues would be resolved in January 2024 and a report could be provided in March 2024.

In response to a question raised by J Hehir as to whether the Health Board benchmarks against other Health Boards in relation to activity and performance, N Downes advised that benchmarking could be undertaken against areas available within the public domain and advised that he would be happy to include some narrative on this in the next Quality Dashboard report.

In response to a question raised by P Roseblade as to whether the categorisation of incidents was subjective or whether there was clear guidance in place as to how an incident should be categorised, particularly in relation to falls, N Downes advised that in relation to falls, a Falls Panel would undertake a review of each incident and added that if an incident had been categorised as moderate and above, a rapid review of the incident would be undertaken to ensure it had been categorised appropriately. G Dix added that the Health Board categorised incidents by using the National Patient Safety Agency descriptors of harm (from no harm to severe harm) and advised that at the point of incident the severity was not always known immediately. G Dix provided assurance that the Patient Care & Safety Team undertakes a review of all Duty of Candour incidents classed as moderate and above to ensure they complied with the descriptors within the framework. G Dix added that there was an element of subjectivity assessment within the framework, particularly in relation to incidents where a fracture had occurred.

G Dix asked Members to note the CIVICA update which had been included as an appendix to the report which included outputs from the 2021/2022 survey. Members noted that an aggregate score of satisfaction of 87% had been achieved across the Health Board and noted that work continued to be undertaken to ensure more timely patient feedback was being presented to the Committee.

Resolution: The report was **NOTED.**

Action: Narrative to be included in the next iteration of the report in relation to what areas benchmarking could be undertaken against.

8.0 DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1 Closure of the Maternity & Neonatal Improvement Programme

S. Hardacre presented the report and highlighted key matters for Members attention. Members welcomed the report and were pleased to note that the service had been de-escalated from Targeted Intervention to Enhanced Monitoring.

Members endorsed the closure of the Maternity & Neonatal Programme Board and extended their congratulations to the Team for this achievement.

Members agreed that they would be happy to receive future updates within the Care Group Highlight Report.

S Hardacre presented the Maternity Metrics report which was welcomed by Members.

Resolution: The Closure of the Maternity & Neonatal Improvement Programme Board was Endorsed for Board Approval.

8.2 Tŷ Llidiard Tier 4 CAMHS Inpatient Unit Report

L. Edwards presented the report and highlighted the key matters for Members attention. Members welcomed the news that the service had now been completely de-escalated by the Welsh Health Specialised Services Committee to Level 0 – Routine Monitoring. Members noted that Healthcare Inspectorate Wales had recently undertaken a visit to the Unit and provided positive feedback.

The Committee Chair advised that this was a positive achievement by the Team who had worked hard to achieve this and added that she was pleased to note that two of the Team had been shortlisted in the nursing support worker category which was encouraging. Members agreed that they would be happy to receive future updates within the Care Group Highlight Report.

Resolution: The report was **NOTED.**

8.3 Mental Health Adult Inpatient Improvement Programme

L Edwards presented the report and highlighted the key matters for Members attention. Members noted that the Team were on track to respond to the 36 recommendations that had been included within the improvement plan. Members agreed to continue to receive further updates until the recommendations had been responded to.

Resolution: The report was **NOTED.**

8.4 National Collaborative Commissioning Unity (NCCU) Quality Improvement and Assurance Service Annual Position Statement

A Clarke presented the report and highlighted the key items for Members attention.

The Committee Chair noted the issues highlighted within the report in relation to eating disorders and the pressures within that service in relation to lack of provision.

L Edwards welcomed the report and extended her thanks to A Clarke and his Team for the support they had provided to the Team at Ty Llidiard.

Resolution: The report was **NOTED.**

9.0 CONSENT AGENDA

The Chair asked Members if there were any items from the Consent Agenda (Item 9) that they wished to bring forward.

9.1 FOR APPROVAL

9.1.1 Unconfirmed Minutes of the Meeting Held on 25 July 2023

The Minutes of the meeting held on 25 July 2023 were **APPROVED.**

9.1.2 Unconfirmed Minutes of the In Committee Meeting Held on 25 July 2023

The Minutes of the In Committee meeting held on 25 July 2023 were **APPROVED.**

9.1.3 Use of Medicines Policy

The Use of Medicines Policy was **APPROVED.**

9.1.4 CTMUHB Safeguarding Policy

The CTMUHB Safeguarding Policy was **APPROVED.**

9.1.5 Clinical Policies Approval Process

The Clinical Policies Approval Process was **APPROVED.**

9.2 FOR NOTING

9.2.1 Action Log

The Action Log was **NOTED.**

P Roseblade made reference to the action related to the Medical Staff Rate Card and advised that this matter appeared to being discussed at a number of Committee meetings, including Audit & Risk Committee. G Watts agreed to undertake a review as to which Committee this matter should be discussed at to ensure there was no Committee cross over.

Action: Review to be undertaken in relation to discussions being held in regards to the Medical Staff Rate Card to determine which Committee remit this matter falls under.

9.2.2 Committee Annual Cycle of Business

The Committee Annual Cycle of Business was **NOTED.**

9.2.3 Committee Forward Work Programme

The Forward Work Programme was **NOTED.**

9.2.4 WHSSC Quality & Patients Safety Committee Chairs Report

The report was **NOTED.**

9.2.5 Infection, Prevention & control Report Annual Report 2022-2023

The report was **NOTED.**

9.2.6 Regulatory Review Recommendations Update Relating to Healthcare Inspectorate Wales

The report was **NOTED.**

9.2.7 Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2022/2023

The report was **NOTED.**

9.2.8 Public Services Ombudsman For Wales A Year of Change – A Year of Challenge Annual Report and Accounts 2022/2023

The report was **NOTED.**

9.2.9 Incident Management Internal Audit Report

The report was **NOTED.**

9.2.10 A National Review of Consent to Examination & Treatment Standards in NHS Wales – Final Welsh Risk Pool Report

The report was **NOTED.**

9.2.11 Public Services Ombudsman for Wales Groundhog day 2: An Opportunity for Cultural Change in Complaints Handling

The report was **NOTED.**

10.0 ANY OTHER BUSINESS

The Committee Chair extended her thanks to J Hehir for all the support he had provided to the Committee and wished him all the very best for the future.

10.1 Highlight Report to Board – Verbal

G Dix requested that it was noted within the Highlight report to Board that Quality Governance had also been de-escalated in addition to Maternity & Neonates.

Action: Committee Highlight report to reflect that Quality Governance had also been de-escalated in addition to Maternity & Neonates.

10.2 How Did we do in this meeting – Verbal

The Committee Chair advised that she would welcome feedback outside the meeting as to how Members felt the meeting went.

10.3 Identification of Future Spotlights and Thematic Presentations

The Committee Chair asked Members to consider any themes or discussion points that would support a targeted presentation or a focus at the Committee and added that a couple of areas for spotlight reporting had been identified during the meeting.

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

Members noted that the following items would be discussed at the In Committee Session:

- Stillbirth Thematic Review 2022;
- MBRRACE-UK Perinatal Mortality Report – 2021 Births.

11.0 DATE AND TIME OF NEXT MEETING – TUESDAY 21 NOVEMBER 2023 AT 9:00AM

12.0 CLOSE OF MEETING

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 21 September 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member (Committee Chair)
Dilys Jouvenat	Independent Member (Vice Chair)
Patsy Roseblade	Independent Member

In Attendance:

Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Lauren Edwards	Executive Director of Therapies & Health Science
Sallie Davies	Deputy Medical Director
Suzanne Hardacre	Director of Midwifery
Mohamed Elnasharty	Consultant Obstetrician & Gynaecologist
Bryany Tweedale	Consultant Midwife
Emma Walters	Head of Corporate Governance & Board Business (Committee Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

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

1.2 Apologies for Absence

Apologies for absence were received from:

- Hywel Daniel, Executive Director for People
- Cally Hamblyn, Assistant Director of Governance & Risk
- Nicola Milligan, Independent Member
- James Hehir, Independent Member
- Gareth Watts, Director of Corporate Governance/Board Secretary

1.3 Declarations of Interest

There were none.

2 MAIN AGENDA

2.1 Unconfirmed Minutes of the In Committee held on 25 July 2023.

P Roseblade advised that she was present at the In Committee session held on 25 July and asked for her attendance to be added to the list of attendees.

The Minutes were **APPROVED** subject to the suggested amendment.

Resolution:

2.2 Action Log

The action log was received and discussed.

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

2.3 MBRRACE-UK Perinatal Mortality Report: 2021

B. Tweedale presented the report and highlighted key matters for Members attention.

Resolution: The report was **NOTED.**

2.4 Stillbirth Thematic Review 2022

B. Tweedale presented the review for Members attention.

The Committee Chair welcomed the update provided and extended her thanks to the Team for the work being undertaken in this area.

Resolution**:** The report was **NOTED.**

3. ANY OTHER BUSINESS

G Dix advised Members that a review was being undertaken of the procedures in relation to the reviewing of unexpected Neonatal deaths.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on – Monday 27 November 2023 AT 13:30PM

Agenda Item
9.1.3

Quality & Safety Committee

CTMUHB SAFEGUARDING POLICY

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Nadine Long – Deputy Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Safeguarding executive Group	26/10/2023	Endorsed for Approval

Acronyms / Glossary of Terms	
VAWDASV	Violence against Women, Domestic Abuse and Sexual Violence

1. Situation /Background

1.1 In view of the new Domestic Abuse Bill 2021 and VAWDASV Strategy 2022-2026, the Cwm Taf Morgannwg University Health Board Domestic Violence and Abuse policy has been revised to ensure all adjustments are incorporated. Revisions have been made to ensure that colleagues managing both staff and patients who are experiencing any concerns in relation to domestic abuse will have access to up to date guidance and contacts. It also describes individual responsibilities to adhere to legislation and guidance.

2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with Directors and managers of all care groups, safeguarding specialists, People Services, and through the Safeguarding Executive Group.

2.2 The policy contains information on domestic abuse, with guidance on appropriate recognition, support and referral of safeguarding concerns. VAWDASV predominately identifies women as the victim; however, the Health board recognises that all genders are at risk of domestic abuse. This policy is aimed to recognise and report abuse, which will subsequently reduce discrimination and harassment of women. It is considered that this policy will compliment future policies targeting sexual safety and gender based violence.

2.3 This policy will be used in conjunction with the Workforce/People Services Domestic Abuse Policy.

Name Title	***Date Consulted/Completed***
Equality Impact Assessment	06/11/23
Informal Consultation with interested parties	August 2023
Formal Consultation	September 2023
Committee – For approval	Safeguarding Executive Group 31/10/23

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

Organisational values and behaviours have been reflected within the policy.

3. Key Risks / Matters for Escalation

As Welsh Government progress with the Blueprint work streams, this policy may need to be revised earlier than the anticipated three year date.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe Safe, timely and effectiveness is required to safeguard the community accessing our services.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Quality Impact screening has identified no indicators for a full QIA.	If no, please include rationale below:
Cydraddoldeb	Yes: ☒	No: ☐

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome: This policy has been developed in line with Welsh Government VAWDASV policy and recognises women to be disproportionately affected by domestic abuse. However, this policy is relevant to all practitioners and members of our community. It does recognise abuse can occur in any person's life at any age.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	The health board and its employees have a 'duty to report' any related safeguarding concerns in line with the Social Service and Wellbeing (Wales) Act 2014.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality and Safety Committee are asked to approve the revised Domestic Violence and Abuse Policy.

6. Next Steps

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

Domestic Violence and Abuse Policy

Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015

Ref:	Non Clinical Organisational Wide Policy
Document Author:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Executive Sponsor:	Claire O'Keefe – Head of Safeguarding & Nadine Long - Deputy Head of Safeguarding
Approval / Effective Date:	Executive Nurse Director
Review Date:	**Management Board (Non Clinical Procedures Only)**
Version:	11/08/2023
	(00/00/0000)
	1

Target Audience:

People who need to review this document in detail	All employees of Cwm Taf Morgannwg Health Board.
People who need to have a broad understanding of this document	All employees who have contact with patients, families and carers. All line managers.
People who need to know that this document exists	All employees within the UHB, both in CTMUHB & non CTMUHB properties and any organisation working within CTMUHB boundaries.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	00/00/2023
Aligns to the following Wellbeing of Future Generation Act Objective	Co-create with staff and partners a learning and growing culture

Approval Route:

Where	When	Why
Safeguarding Executive Group		Endorse for Board Approval
Quality and Safety Committee		Approved

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

CONTENTS

	Domestic Violence and Abuse Policy Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015	Page
1	**Policy Statement**	4
2	**Scope of Policy**	5
3	**Aims & Objectives**	5
4	**Definition of Domestic Abuse**	6
5	**Definition of Gender Based Violence**	7
6	**Definition of Sexual Violence**	7
7	**Responsibilities** **All Employees** Safeguarding children Safeguarding Adults at Risk **Line Manager** Employees who are victims of abuse Employees who are perpetrators of abuse	8 8 8 9 10 10 10
8	**National Training Framework for Ask & Act' Training** **Group 1** **Group 2** **Group 3**	11 11 11 12
9	**'Ask & Act' Referral Pathway** 9.1 Risk Identification and Assessment 9.2 Online Multi-Agency Risk Assessment Conferences (MARAC) Referral Process 9.3 'Ask and Act' and Safeguarding Process 9.4 All Wales Minimum Standards Routine Enquiry into Domestic Abuse, Pregnancy and Early Years 9.5 Health Based Independent Domestic Violence Advocate (IDVA) 9.6 Identification and Referral to Improve Safety (IRIS)	12 12 13 13 13 14 14
10	**Confidentiality**	15
11	**Information Sharing**	15
12	**Male Victims**	15
13	**Ethnic Minorities and Sanctuary Seekers**	15
14	**Getting Help**	16
15	**Legislation/Policies**	17

16	**References**	18
	Appendices Appendix 1 - Definitions Appendix 2 - Key Indicators Appendix 3 - Pathway Appendix 4 – MARAC Referral Form	 19,20,21 22 23 24

1. POLICY STATEMENT

Violence against women, domestic abuse and sexual violence (VAWDASV) has a significant impact on those who use the services provided by the Health Board. It is important that relevant staff roles, working within the Health Board are skilled to recognise potential indicators of violence and abuse against any person and take appropriate action (Appendix 1).

Cwm Taf Morgannwg University Health Board (CTMUHB) have adopted "Ask and Act". "Ask and Act" is a Welsh Government policy for targeted enquiry to be practiced across all public service for violence against women, domestic abuse and sexual violence. The approach is further defined in this policy. This policy outlines the commitment of the Health Board and its agreement that professionals will be able to identify violence against women, domestic abuse and sexual violence and be confident to ask about these issues, in a private setting, to ensure an appropriate response and referral. The process of "Ask and Act" must be implemented within a culture and environment where the confidentiality, privacy and data of victims is respected and treated carefully.

Anyone can be a victim of domestic abuse, regardless of gender, age, ethnicity, religion, socio-economic status, sexuality or background.

This policy is for both men and women.

The Health Board will:

- Promote awareness of violence against women, domestic abuse and sexual violence.
- Promote working practices which will decrease those experiencing violence.
- Work in partnership with other statutory agencies and voluntary organisations within Wales and other areas as required.
- Fulfil its obligations in relation to the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 and Domestic Abuse Act 2019.
- Actively listen and seek the voice of the survivor to shape its services in the future.

The Health Board is committed to the health and well-being of its patients and staff and recognises that domestic abuse is a crime, which adversely affects the health of individuals, families and communities. Identifying abuse and/or violence at an early stage can be an effective measure in preventing an escalation in severity and frequency, and can assist to ensure appropriate and expedited support is provided. Taking a responsive and enabling approach is fundamental in encouraging individuals who are experiencing violence, threats, intimidation, and other abuse to disclose.

2. SCOPE OF POLICY

This policy applies to:

- EMPLOYEES IN ALL SETTINGS ACROSS THE HEALTH BOARD.
- ALL PROFESSIONALS AND PUBLIC CONTACTS WITH THE HEALTH BOARD.
- ALL SERVICE USERS AND PARENTS/CARERS

3. AIMS AND OBJECTIVES OF "ASK & ACT"

"Ask and Act" is a process of targeted enquiry to be practiced across all public services to identify violence against women, domestic abuse and sexual violence. The term-targeted enquiry describes the recognition of indicators of violence, domestic abuse and sexual violence as a prompt for a health professional to ask their client whether they have been affected by any of these issues. This policy recognises that anyone (women, men, older people, children and young people) can experience and be affected by violence and abuse. This can happen in any relationship regardless of sex, age, ethnicity, gender, sexuality, disability, religion or belief, income, geography or lifestyle.

The aims of "Ask and Act" are:

- To increase identification of those experiencing violence, domestic abuse and sexual violence.
- To offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client.
- To offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client.
- To begin to create a culture across the public service where addressing violence, domestic abuse and sexual violence is understood in the correct context, where disclosure is accepted and facilitated and support is appropriate and consistent.
- To improve the response to those who experience violence, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and
- To pro-actively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm.

Posters are displayed throughout the Health Board providing information in relation to Domestic Violence and Abuse helpline numbers. The Health Board's intranet page has information, links and contact numbers.

4. DEFINITION OF DOMESTIC ABUSE

Domestic abuse is not just physical violence, but can also take other forms such as emotional, controlling and coercive behaviour and economic abuse between two people aged 16 years or over who are personally connected. Section 3 of the Domestic Abuse Act 2021, recognises children as victims. Not all victims of VAWDASV are women. VAWDASV can affect men and those with a non-binary identity. However, the vast majority of those who commit abuse are male. Our policy recognises that male violence defines VAWDASV even more strongly than the gender of the survivor.

'Abusive behaviour' is defined in the act as any of the following:

- physical or sexual abuse
- violent or threatening behaviour
- controlling or coercive behaviour
- economic abuse
- psychological, emotional, or other abuse
- For the definition to apply, both parties must be aged 16 or over and 'personally connected'.
- 'Personally connected' is defined in the act as parties who:
- are married to each other
- are civil partners of each other
- have agreed to marry one another (whether or not the agreement has been terminated)
- have entered into a civil partnership agreement (whether or not the agreement has been terminated)
- are or have been in an intimate personal relationship with each other
- have, or there has been a time when they each have had, a parental relationship in relation to the same child
- are relatives

5. DEFINITION OF GENDER BASED VIOLENCE

Gender-based violence is a phenomenon deeply rooted in gender inequality, and continues to be one of the most notable human rights violations within all societies. Gender-based violence is violence directed against a person because of their gender. Both women and men experience gender-based violence but the majority of victims are women and girls.

Gender-based violence and **violence against women** are terms that are often used interchangeably as it has been widely acknowledged that most gender-based violence is inflicted on women and girls, by men.

The United Nations defines gender-based violence in the following way:

"The definition of discrimination includes gender based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."

https://www.who.int/news-room/fact-sheets/detail/violence-against-women

6. DEFINITION OF SEXUAL VIOLENCE

Any sexual act which has not been consented to can be classed as sexual violence and can include: rape; sexual assault; child sexual abuse; incest; sexual harassment; female genital mutilation; forced marriage; trafficking; sexual exploitation; ritual abuse.

The World Health Organization (WHO) defines **sexual violence** as: 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'(2)

https://www.who.int/news-room/fact-sheets/detail/violence-against-women

7. RESPONSIBILITIES

ALL CTMUHB EMPLOYEES

All Health Board employees are accountable for their own practice and must be aware of the legal and professional responsibilities relating to their role. All staff within Health Board must be familiar with the procedures detailed in this document and other related policies. This will be assured through induction, supervision and appraisal. All staff who receive a disclosure of domestic abuse or sexual violence must follow this policy. All staff must act in the best interests of the patient (victim) and any children involved. A child's welfare is paramount. The Social Services Well-Being Act 2014 places a statutory responsibility for professionals to refer an adult/child who is at risk.

Staff are required to discuss any concerns around domestic abuse with their line manager or safeguarding lead. They can also access advice and support from the Multi-Agency Safeguarding Hub (MASH). In addition, if a disclosure is made, staff are required to complete the Domestic Abuse, Stalking and Honour Based Violence Risk Assessment (DASHRiC) (Appendix 2) and utilise the "Ask and Act" VAWDASV Pathway to identify the most relevant support service (Appendix 3).

SAFEGUARDING CHILDREN

There is considerable overlap between violence against women, domestic abuse and sexual violence and the abuse of children. According to child protection experts, there is significant evidence that demonstrates that men who are abusive to their female partners are more likely to cause physical abuse their children. In some instances, the children may also be injured in the course of an assault on their mother (Stanley 2011, Safe Lives 2015).

The Health Board recognises the serious and adverse effect that Violence against Women, Domestic Abuse and Sexual Violence has on children as both direct victims and witnesses. Since the **Domestic Abuse Act 2021**, children that have been exposed to domestic abuse are now recognised as victims of domestic abuse in their own right, rather than just witnesses.

Children may be directly, indirectly or accidentally involved in violence against women, domestic abuse and sexual violence. Additionally, many children witness and/or hear the violence directed towards their mother (or father) and all children, however young, are likely to be aware of their mother or father's distress. These children will also be aware of the non-physical forms of abusive and controlling behaviour that are very much part of the dynamics of abuse (Jaffe et al 2007). Even in these situations, where the child is not physically abused they can be suffering significant harm (Kitzman et al 2003, Melter

et al 2009). The issue of safeguarding children is everyone's business and is a shared responsibility.

The perpetrator may use the threat that their children will be taken into care, if the abuse is reported. Consequently, it is essential to deal with child protection issues sensitively when discussing suspected abuse with patients or employees. When dealing with suspected cases of domestic abuse and sexual violence the manager must establish if the employee has any children living at home and, if so, consider whether they are in imminent danger and take appropriate action to ensure their safety. The Wales Safeguarding Procedures 2019 must be adhered to.

The NSPCC identified how young people are the group most likely to be in an abusive relationship. A survey of 13 to 17-year-olds found that a quarter (25%) of girls and 18% of boys reported having experienced some form of physical violence from an intimate partner, a child can also be identified as a perpetrator of domestic abuse in addition to being a victim.

Cwm Taf Morgannwg MASH Team can provide support and advice. The contact details for the team can be accessed within the 'Getting Help' section.

SAFEGUARDING ADULTS AT RISK

Section 128 of the Social Services and Well-being (Wales) Act introduces a duty to report adults at risk. Section 126 of the same Act defines an "adult at risk" as an adult who: -

- Is experiencing, or is at risk of abuse or neglect.
- Has needs for care and support (whether or not the authority is meeting any of those needs.
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it relevant agencies and their staff should understand their statutory duty to inform the local authority where there is reasonable cause to suspect that a child or an adult is at risk.

If an adult is at risk due to Violence against Women, Domestic Abuse and Sexual Violence, the Wales Safeguarding Procedures are to be followed in addition to the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

LINE MANAGER

Line managers are responsible for ensuring all staff have an awareness and understanding of this policy and other related policies and that all staff have undertaken the appropriate level of training for their role.

All new staff to Health Board will be informed how they can access this policy during their induction programme. Health Board managers also have a duty to ensure their staff fulfil their statutory responsibilities to safeguard and promote the welfare of children and adults at risk of abuse and neglect.

EMPLOYEES WHO ARE VICTIMS

It is acknowledged that some staff will experience Vicarious Trauma because of working with victims of abuse. The implementation of "Ask and Act" may increase the likelihood of this. It is important that senior managers are aware of this risk as the Health Board has a responsibility to limit the impact of this difficult work for staff. Staff are encouraged to access additional support from the Health Board's Well-Being Service.

Within the workplace, employers must support employees who may be experiencing VAWDASV. Whilst domestic abuse is the most prevalent form of violence, it is important to recognise that rape, sexual violence and harassment including stalking are often inter linked with domestic abuse.

Employers have a responsibility to provide all staff with a safe and effective work environment. Identifying an employee experiencing domestic abuse at an early stage, may result in the offer of timely and appropriate support.

Managers should offer employees the opportunity to discuss personal issues which may be affecting their health and work performance during each stage of the Health Boards Sickness & Capability Policies e.g. during Return to Work interviews.

EMPLOYEES WHO ARE PERPETRATORS

Domestic abuse and / or sexual violence perpetrated by employees will not be condoned under any circumstances nor will it be treated as a purely private matter. Employees should be aware that misconduct inside or outside of work (whether or not it leads to a criminal conviction) is viewed seriously and can lead to disciplinary action and referral to a relevant professional body. Allegations against employees of the Health Board may be subject to the Cwm Taf Morgannwg Safeguarding Board's policy '**RESPONDING TO SAFEGUARDING CONCERNS ABOUT INDIVIDUALS WHOSE WORK BRINGS THEM INTO CONTACT WITH CHILDREN AND ADULTS AT RISK**'.

https://www.cwmtafmorgannwgsafeguardingboard.co.uk/En/Professionals/JointPoliciesandProcedures/J12RespondingToSafeguardingConcernsAboutIndividualsWhoseWorkBringsThemIntoContactWithChildrenAndAdultsAtRiskEndorsedSept2018.pdf

Managers can seek additional advice from People Services concerning an employee's fitness for work or necessary adjustments for example safety concerns including temporary role changes.

8. NATIONAL TRAINING FRAMEWORK FOR "ASK AND ACT" TRAINING

"Ask and Act" is a form of targeted enquiry, which requires relevant practitioners to apply a "low threshold for asking" whether the individual is experiencing violence and abuse when the individual presents certain indicators of such abuse. "Indicators" are used to describe all of the signs, symptoms, cues or settings through which Violence against Women, Domestic Abuse and Sexual Violence can be identified.

Within the healthcare setting, Group 1, 2 and 3 of the National Training Framework promotes a consistent standard of care for those who experience Violence against Women, Domestic Abuse and Sexual Violence.

Supporting staff to access "Ask and Act" Training Group 1

All staff within the Health Board are required to complete the online Group 1 "Ask and Act" training available on ESR. All staff are required to complete their Mandatory Training, including completing training within six weeks of induction and refresher training every three years.

Group 1 "Ask and Act" Training includes:

Basic awareness of what Violence against Women, Domestic Abuse and Sexual Violence

How to recognise Domestic Violence, Abuse, and Sexual Violence

The help available to victims.

Group 2

All staff that have regular contact with patients, their families, carers or the public will receive are required to complete Group 2 Training, National Training Framework, and Violence against Women, Domestic Abuse and Sexual Violence (Welsh Government, 2019)

The aim of the training is to support the learner to:

Recognise the signs and indicators that someone is being abused

Talk to that person sensitively (if appropriate)

Offer options and services to them quickly and efficiently.

Group 3

Aimed at individuals in roles that require them to do more than "Ask and Act" and those who perform a champion's role.

The training will enable people to:

Support colleagues as they make difficult decisions in relation these subject areas, help offer services to all family members affected by Violence against Women, Domestic Abuse and Sexual Violence

Act as a champion within their organisation.

Meeting the aims of "Ask and Act" does not require Health Board staff to become "experts" in VAWDASV. The aim is for staff to be able to identify indicators and to sensitively as the question (Appendix 2).

9. "ASK AND ACT" REFERRAL PATHWAYS

When a disclosure is made, staff should follow the multiagency "Ask and Act" Referral Pathway (Appendix 3)

9.1 Risk Identification and Assessment

The main purpose of risk assessment is to identify the need for immediate Safeguarding and interventions for families who are experiencing Domestic Violence and Abuse. Health Board staff will be expected to make an assessment of immediate risk based on the likelihood of serious harm following their observations and discussions with the patient. This will include:

- Whether the person who has disclosed is at immediate risk to harm
- Whether there is an immediate threat to life.
- Whether there is a strong possibility that the individual is at risk of serious immediate harm.

9.2 Online Multi-Agency Risk Assessment Conference (MARAC) referral process

The MARAC aims to share information to increase the safety, health and well-being of victims/survivors and their children and to determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community.

At the beginning of June 2021, the Western Domestic Abuse Unit (West DAU) modified the way in which MARAC referrals were completed and processed. Referring agencies are directed to the link below that will take you to the Online MARAC Referral Form. This form guides you through the referral process step-by-step and includes the DASH RIC – so there is no requirement to submit this separately. The form is available in both English and Welsh.

Online MARAC Referral Form - English (south-wales.police.uk) Online MARAC Referral Form - Welsh (south-wales.police.uk)

All Health staff to complete the MARAC referral form (Appendix 4) and send to CTHBMASHReferrals@wales.nhs.uk

In an emergency, always dial 999.

MARAC Referral Form

CTM MARAC Referral Form 2023.docx

9.3 "Ask and Act" and Safeguarding process

All staff have a professional duty if they;

- Witness abuse
- Receive information about abuse, suspected abuse or concerns about the care of or treatment of an adult or child at risk
- Have concerns or suspicious about possible abuse or inappropriate care.

9.4 Routine Enquiry into Domestic Abuse

'Routine enquiry' involves asking all women at each assessment about any potential abuse, regardless of whether there are any indicators or suspicions of abuse. It was established in maternity, sexual health, health-visiting settings. This was due to the disproportionate number of women accessing these services, making a disclosure when they have experience of abuse.

Frontline staff are not expected to be experts in dealing with abuse, but through implementing routine enquiry, they can provide a supportive environment to help and encourage disclosures and gather information. Assessing immediate and long-term

health and safety needs to provide information/signpost and refer on where appropriate and to document the disclosure of abuse and actions taken.

All women should be routinely asked about domestic abuse at every contact with practitioners in pregnancy and early years.

The All Wales Minimum Standards Routine Enquiry in to Domestic Abuse, Pregnancy and Early Years 2021 defines a minimum set of standards that are intended to guide practitioners in the identification and support of those individuals experiencing domestic abuse. Please remember that the situation may change at any point throughout the individuals' journey within health services. People may be put off by the word 'abuse' and may not use that word themselves to describe behaviours that they are experiencing. Whatever words you use to ask, it is important to do so in a safe and private environment where the person can speak freely and feel comfortable, without the abuser present.

9.5 Health Based Independent Domestic Violence Advocate (IDVA)

The Health based IDVA acts as a resource and point of contact for staff across Cwm Taf Morgannwg UHB where patients or staff disclose, identify as or are likely to be experiencing domestic violence and abuse.

The Health based IDVA is based in the Royal Glamorgan Hospital and available on: Kristy Davies 07824 541716.

9.6 Identification and Referral to Improve Safety (IRIS)

IRIS is a general practice-based Domestic Violence and Abuse (DVA) training, support and referral programme, which is a collaboration between primary care and third sector organisations specialising in DVA. The IRIS programme allows GP practice staff to refer directly to a specialist advocate if a disclosure is made. The Advocate Educator offers specialist support to GP practices and women that have been referred, as well as providing specialist DVA support and delivery of training to the practices. Staff in GP practices that have received the IRIS training can make referrals.

The purpose of IRIS is:

- To improve health responses to victims and increase practitioner's confidence to ask the question and report appropriately.
- Meet the statutory requirements of VAWDASV (Wales) 2015 within a primary health care setting.

10. CONFIDENTIALITY

Individuals have a right to confidentiality but this right is not absolute. There may be occasions where an individual makes a disclosure as a result of targeted enquiry and a practitioner will have to make a judgement about whether to share some or all of the information and if so, what details to share.

Any decision to share information must be informed by the relevant data sharing legislation and the common law duty of confidentiality. It is imperative that each individual is aware of their rights to confidentiality and where these rights change; to be able to make informed decisions about what information they choose to share with the practitioner they are working with and have reasonable expectations of how this information will be treated.

11. INFORMATION SHARING

The process of "Ask and Act" will inevitably lead to disclosures of personal and sensitive information, which will lead staff to decide whether this information can be shared.

The Health Board is a signatory of the Information Sharing Protocol for Cwm Taf Morgannwg Regional Safeguarding Board. The Information Sharing Policy allows the sharing of reciprocal information and is supplementary to the Wales Accord on the Sharing of Personal Information (WASPI). Under the Data Protection Act 1998, the Health Board is legally able to share data with the police if there is a threat to life (vital interests) of the patient, without the consent of the patient against whom the offense has been committed.

Good practice would require the professional to inform the individual that they will be contacting the police. If disclosing without consent, the reasons for disclosure need to be clearly documented. Advice on information sharing can be sought for the Health Boards Corporate Safeguarding Team/ Information Governance Team.

12. MALE VICTIMS

Male victims of Domestic Violence and Abuse and Sexual Violence, may be reluctant to disclose their experience due to fear of being ridiculed, not being believed or being treated unfairly by agencies. They may have misguided notions of masculinity, which cause additional feelings of shame and embarrassment. People of all ages, ethnic backgrounds, genders, gender identities and sexualities experience abuse. It affects people of different abilities, and happens across every class background.

13. ETHNIC MINORITIES AND SANCTUARY SEEKERS

There is under-reporting of Violence against Women, Domestic Abuse and Sexual Violence by people from ethnic minorities' communities in the general population. Some of the additional barriers to reporting could be:

- Language barriers - interpretation;
- Immigration status and no recourse to public funds;
- Racism (either a perception or fear of a racist response or an actual racist response from a service provider)
- Assumptions made by practitioners, based on appearance or skin colour; Cultural beliefs and practices; fear of rejection by their community; and mistrust of authorities.
- Violence in the country of origin - Asylum-seeking and refugee people may have experienced abuse or violence prior to their arrival in the UK

Bawso | Supporting ethnic minorities affected by violence and exploitation

14. GETTING HELP

The Multiagency Safeguarding Hub **(MASH)** Safeguarding Health Team are available for advice Monday-Friday from 9.00am – 5.00pm (excluding Bank Holidays)

MASH Health Team - 01443 743730 / 01656 643630
Health Independent Domestic Violence Advisor (IDVA) – Kristy Davies 07824541716
Head of Safeguarding – Claire O'Keefe 07557 549634
Deputy Head of Safeguarding – Nadine Long 07786 660415

Additionally, you can email:
CTHBMASHReferrals@wales.nhs.uk for advice and submission of all health safeguarding referrals.

SUPPORT SERVICES

Rhondda Cynon Taf (RCT)
Oasis Centre – 01443 494190
famouspeoplerct.co.uk

RCT Domestic Abuse Services - 01443 400791
wa-rct.org.uk

Bridgend
Assia Domestic Abuse Service – 01656 815919
assia@bridgend.gov.uk

Merthyr
Domestic Abuse Resource Team (DART)
01685 388444
07539170396
Freephone 0800 389 7552
www.smt.org.uk

All Areas

Live Fear Free Helpline:
0808 8010 800
Text 078600 77333
info@livefearfreehelpline.wales

New pathways 01685 379310 – sexual violence and abuse
newpathways.co.uk

Black and Asian Women Step Out (BAWSO) 24 Hour Helpline 08007318147 – BAME Service
bawso.org.uk

Broken Rainbow – 08452 604460 - lesbian, gay, bisexual & trans people
broken-rainbow.org.uk

15. LEGISLATION AND POLICIES

This policy should be used in conjunction with:

Wales Safeguarding Procedures (2019)

CTMUHB Safeguarding and Public Protection Policy

Cwm Taf Morgannwg VAWDASV Strategy 2023-2026

J12 Professionals Concerns Protocol 2023 'Responding To Safeguarding Concerns About Individuals Whose Work Brings Them Into Contact With Children and Adults At Risk.

CTMUHB Special Leave Policy

Domestic Abuse Act 2021

Violence Against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015

Social Services and Wellbeing (Wales) Act 2014

16. References

- http://www.nspcc.org.uk/
- Jaffe S.R., Morfitt T.E., Caspi A., Taylor A. (2007) Influence of adult domestic violence on children's internalizing and externalizing problems: An environmentally informative twin study Journal of American Academy of child and adolescent psychiatry 41 (9) 1095-1103.
- Kitzmann K.M, Gaylord N.K., Holt A.R and Kenny E.D (2003) Child witnesses to domestic violence, a meta-analytic review. Journal of consulting and clinical psychology 71, 339-352.
- Melter H., Doos L., Vostaris P., Ford T and Goodman R (2009) The mental health of children who witness domestic violence. Child and family social work 14 491-501.
- Safe Lives (2015) Getting it right first time: policy report. Bristol. Safe Lives.
- Stanley N. (2011) Children experiencing domestic violence: a research review Totnes, Devon. Research in practice.
- Violence against women, domestic abuse and sexual violence (Wales) Act 2015 Available at:- www.legislation.gov.uk/anaw/2015/3/contents/enacted. Wales Safeguarding Procedures (2019) available at http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

APPENDICES

Appendix 1 – Definitions

Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 provides the following definitions:

Abuse: Physical, sexual, psychological, emotional or financial abuse.

Accreditation: For the purposes of this guidance, the term "accreditation" describes authority or sanction to a training course provided by an official body when recognised standards have been met.

"Ask and Act": A process of targeted enquiry across the Welsh public service in relation to violence against women, domestic abuse and sexual violence and a process of routine enquiry within maternal and midwifery services, mental health and child maltreatment settings.

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

Client: Client is used here as a term to describe a person experiencing violence against women, domestic abuse and sexual violence. The term encompasses the terms "victim", "survivor", "service user" and "patient". Different partners use different words to define their relationship to the person at risk and so the guidance reflects this. In practical terms, it is suggested a person experiencing violence against women, domestic abuse and sexual violence selects the term they prefer, where a term is required. It should generally be possible to use a client's name rather than other descriptive terms.

Domestic abuse: Abuse where the victim of it is or has been associated with the abuser. A person is associated with another person for the purpose of the definition of "domestic abuse" if they fall within the definition in section 21(2) or (3) of the Violence against women, domestic abuse and sexual violence (Wales) Act.

Female Genital Mutilation: An act that is an offence under sections 1, 2 or 3 of the Female Genital Mutilation Act 2003 (c. 31).

Gender-based Violence
(a) violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation; female genital mutilation;

(b) forcing a person (whether by physical force or coercion by threats or other psychological means) to enter into a religious or civil ceremony of marriage (whether or not legally binding);

Harassment: A course of conduct by a person, which he or she knows or ought to know amounts to harassment of the other; and for the purpose of this definition:

(a) a person ought to know that his or her conduct amounts to or involves harassment if a reasonable person in possession of the same information would think the course of conduct amounted to or involved harassment of another person, and

(b) "conduct" includes speech;

Independent Domestic Violence Adviser: Trained specialist worker who provides short to medium-term casework support for high-risk victims of domestic abuse.

Independent Sexual Violence Adviser: Trained specialist worker who provides short to medium-term casework support for victims of sexual abuse.

Local Authority: A county or county borough council.

Practitioner: a professional employed to work directly with a client group; a proportion of whom are likely to be experiencing a form of violence against women, domestic abuse or sexual violence, whose role and relationship to the client provides an opportunity to "Ask and Act".

Public service: Public services are services delivered for the benefit of the public. This can include services delivered through the third sector, through social enterprise or through services that are contracted out. In the context of the National Training Framework (of which "Ask and Act" is an element) the public service is defined based on an estimate of 'devolved public sector workers' in Wales – this includes the devolved civil service, local authorities, health, education authorities and WGSBs.
Although not devolved, Police Authorities are included as they are partly funded by WG. 'Devolved public sector workers' excludes non-devolved civil servants (such as those working for HMRC and the DVLA), military personnel and people employed by Public Corporations (such as S4C and Cardiff Bus etc.) in Wales.

Region: Local authorities are expected to work with neighboring local authorities

and across Local Health Board areas for the purposes of dissemination of the VAWDASV Services Grant (from March 2018). Local authorities will have the autonomy to align as they see best for this purpose. For the purposes of this guidance the partnership with other Local Authorities and Local Health Boards is referred to as a region. The Train the Trainer course which supports "Ask and Act" will be delivered within this region.

Relevant authorities: county and county borough councils, Local Health Boards, fire and rescue authorities and NHS trusts.

Sexual exploitation: Something that is done to or in respect of a person which

(a) involves the commission of an offence under Part 1 of the Sexual Offences Act 2003 (c. 42), as it has an effect in England and Wales,

(b) would involve the commission of such an offence if it were done in England and Wales.

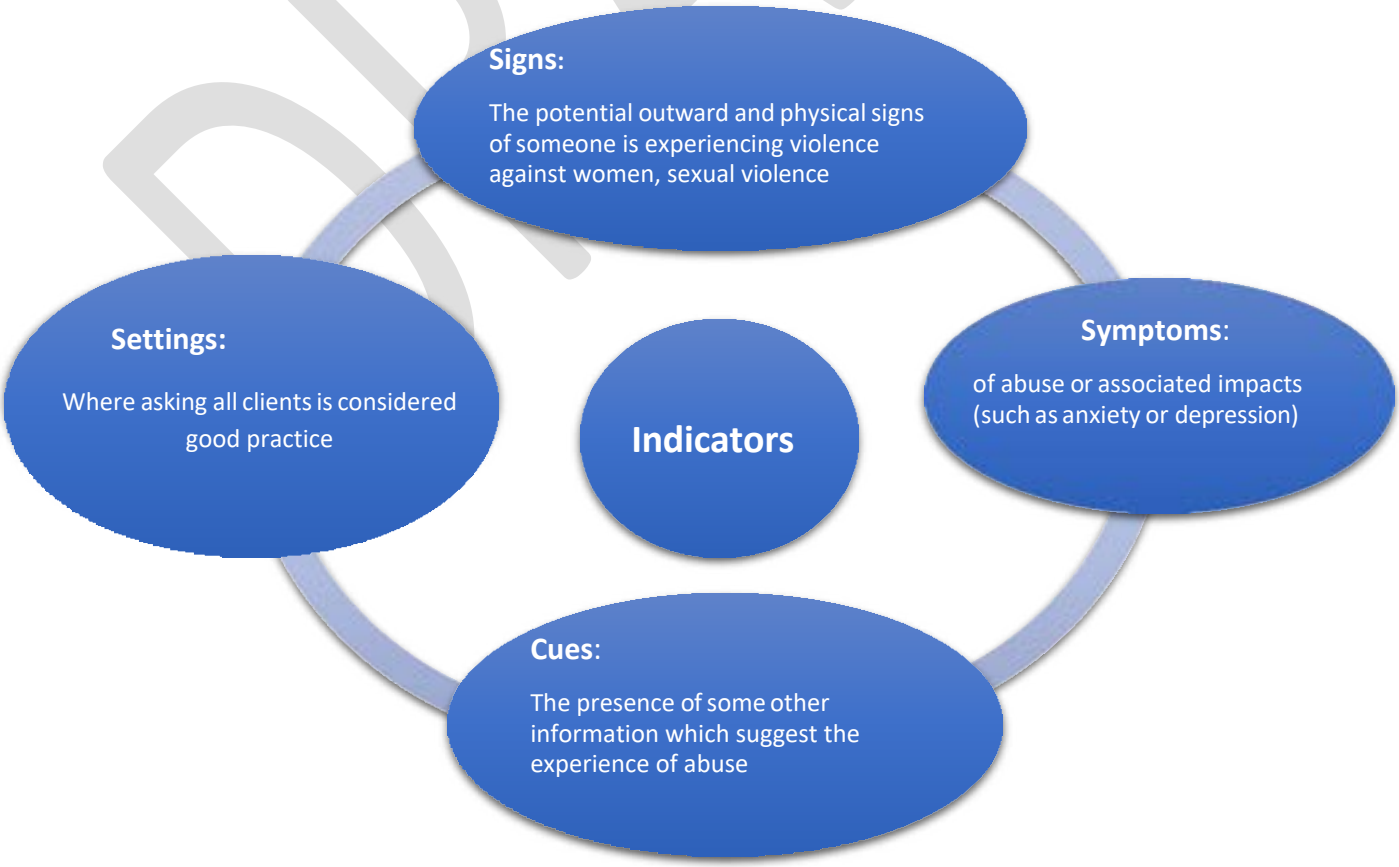
Sexual Violence: Sexual exploitation, sexual harassment, or threats of violence of a sexual nature.

The Act: The Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.

Appendix 2

Key indicators (NICE, 2014)

- Depression, anxiety, sleep disorders
- Suicidal tendencies or self-harming
- Alcohol or other substance misuse
- Unexplained reproductive symptoms, including pelvic pain and sexual dysfunction
- Adverse pregnancy outcomes, i.e. multiple unintended pregnancies or terminations, miscarriage, pre-term labour and stillbirth
- Frequent bladder or kidney infections
- Vaginal bleeding or sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic injury, particularly if repeated with vague or implausible explanations.
- Repeated health consultations with no clear diagnosis
- Appointments missed or frequently rescheduled
- Intrusive "other person" in consultations, this can be partner, parent, grandparent or an adult child (abuse of the older person)
- Partner or other person's behaviour: aggressive, overly dominant, doesn't let their partner / family member speak for themselves.



Appendix 3

"Ask and Act": Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Pathway

VAWDASV Health Pathway

Tick boxes as appropriate and insert in patient record/ maternity department in maternal safeguarding folder

VAWDASV Identified

Contact Police Emergency Services (999) if you have a serious concern regarding immediate patient / child safety

Ask the patient / person the following questions:	Yes	No
Do you feel threatened or been physically hurt in your current relationship or at home?		
Does your partner or anyone else insult, talk down to you, or control you?		
Does your partner, ex-partner or anyone else shout or swear at you so that you feel unsafe?		
Are there any physical visual injuries		

No to all 4 questions

No current risk to safety.
Live Fear Free Helpline number given:
0808 80 10 800
Text: 07860077333
Email: info@livefearfreehelpline.wales

Yes	No

YES to 1 or more questions. DASH RIC to be completed by either:	Yes	No
Health Professional (preferable)		
With verbal consent for patient to speak to Live Fear Free Helpline 0808 80 10 800 for referral and support		

Are there children under 18 or adults at risk who;	Yes	No	If Yes, follow CTMUHB Safeguarding Procedures i.e. C1 / A1
Live at the property?			
Have significant contact with the patient or perpetrator?			

DASH RIC completed by Health Professional	Yes	No
Low / Medium Risk (score less than 14)		

With consent offer a MARAC referral to local services.
(Pontypridd Safety Unit / Dart / Assia)

Use professional judgement to identify any risk for referral without consent

HIGH RISK IS 1 OR MORE BOXES TICKED	Yes	No
DASH RIC score is 14 or more		
You are aware of 3 or more incidents in the past 12 months		
Professional judgement (essential to record your reason for MARAC referral)		

DASH RIC and MARAC form completed by CTMUHB Health Professional to be emailed to: CTHBMASHReferrals@wales.nhs.uk

For any advice, please contact MASH Health in working hours or Out of Hours team after 5pm and weekends

In working hours:
Cwm Taf MASH – 01443 743730
Bridgend MASH – 01656 643630
Health IDVA – 0782 4541716

Out of hours: Emergency Duty Team: 01443 743730

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Appendix 4

MARAC Referral Form

MARAC (Multi-Agency Risk Assessment Conference) is a meeting where information is shared on the highest risk domestic abuse cases.

The "4" Aims of MARAC:

1. **Safeguard Victims (and their Children)**
2. **Manage Perpetrator Behaviour**
3. **Safeguard Professionals**
4. **Make links with other safeguarding processes / agencies**

This form should be completed by the member of staff identifying the risk and emailed via secure email address and / or password protected to:
CTHBMashreferrals@wales.nhs.uk

For Completion by the MARAC Co-ordinator			
Date Received		**If repeat, date of previous MARAC(s)**	
MARAC Date			

Please indicate the type of referral being submitted to MARAC

HIGH RISK MARAC ☐ **D.V.D.** ☐ (Claire's Law) **D.V.P.N.** ☐ (Domestic Violence Protection Notice)

AGENCY DETAILS	
The following details MUST to be completed before a referral can be made	
Referring Agency	
Contact Name	
Contact details of agency (phone number and email)	
Date of referral	

DETAILS OF VICTIM			
Please supply all of the information below, if available			
Name			
DOB		**Age**	
Address			

Is the victim pregnant (if so, date due)				
Safe contact number / time to contact				
What is the status of the tenancy	Private owned	Private rented	Shared tenancy	Landlord details if relevant

Diversity Data This information will help to better support victims and monitor reporting levels from particular communities. Please complete as fully as possible based on information that **you might already hold** about that person. If information is unavailable, you **MUST select unknown**.

Gender	Male / Female / Other	Comments:				
Does the victim identify as transgender?	Yes / No/ Unknown					
Is the victim in a same gender relationship?	Yes / No / Unknown					
Sexual Identity/sexual orientation	Gay / Lesbian / Homosexual	Bisexual	Heterosexual	Other (specify)	Unknown	
Ethnicity	White	Black	Asian	Mixed race	Other (please specify)	Unknown
Is the victim disabled?	Yes /No	Learning disability	Physical disability	Sensory impairment	Other	Unknown
Are there any specific religious or cultural considerations to be made?	Yes (please give details) No Unknown					
Religion (Please state)						

DETAILS OF PERPETRATOR

Please supply all of the information below, if available

Name				
DOB		**Age**		
Address				
Relationship to Victim				
What is the status of the tenancy	Private owned	Private rented	Shared tenancy	Landlord details if relevant

Diversity Data This information will help to better support victims and monitor reporting levels from particular communities. Please complete as fully as possible based on information that **you might already hold** about that person. If information is unavailable you **MUST select unknown**.

Gender	Male / Female / Other	Comments:
Does the perpetrator identify as transgender?	Yes / No / Unknown	
Is the perpetrator in a same gender relationship?	Yes / No / Unknown	

Sexual Identity/sexual orientation	Gay / Lesbian / Homosexual	Bisexual	Heterosexual	Other (specify)	Unknown	
Ethnicity	White	Black	Asian	Mixed race	Other (please specify)	Unknown
Is the perpetrator disabled?	Yes/No	Learning disability	Physical disability	Sensory impairment	Other	Unknown
Are there any specific religious or cultural considerations to be made?	Yes (please give details) No Unknown					
Religion (please state)						

CHILDREN'S DETAILS

Please supply all of the information below, if available

Name	DOB	Relationship to Victim	Relationship to perpetrator	Address	School

Was the child at the premises when the incident occurred	Yes / No	**Did the child witness the incident**	Yes / No
Do you consider that there are grounds for a Child Protection referral	Yes / No	**If so, have you made such a referral**	Yes / No

REFERRAL TRIGGERS

Please select at least one option below

Visible high risk (14 ticks or more on Safe Lives DASH)	
Professional Judgement (If using professional judgement, please explain in 'Reason for Referral' why you feel the victim is at risk of murder or serious harm)	

Potential escalation (ie: 5 incidents and/or 3 crimes in a rolling 12-month period between the same perpetrator and victim)	Yes / No
MARAC repeat (ie: further incident between same victim and perpetrator within 12 months from last referral)	Yes / No
ADDITIONAL VICTIM INFORMATION:	
Is the victim aware of the referral	Yes / No
If not, why	
Has the victim consented to this referral (if not, please refer to the MARAC Operating Protocol and complete the **Information Sharing without Consent Form**)	Yes / No
Who is the victim afraid of (to include all potential threats, and not just primary perpetrator)	
Who does the victim believe it safe to talk to	
Who does the victim believe it NOT safe to talk to	

REASON & RISKS IDENTIFIED FOR REFERRAL
Use this space to provide a CONCISE summary as to why you are making this referral incl seriousness / frequency, risks identified, and victims view of risk. (Police - Provide a BRIEF summary of the incident and outcome) – Please include when the Victim was last sighted (date) and by whom

DETAIL THE SAFETY PLAN / MEASURES YOU HAVE PUT IN PLACE TO REDUCE THE RISK.
Please detail what actions have already been done and what still needs to be actioned?

WHAT ARE THE VICTIM'S WISHES /NEEDS
Consider what the victim wants for themselves, the children, other dependants and the perpetrator, and what agencies may need to be involved. (What more can MARAC do?)

SafeLives Dash risk checklist (Guidance Only)

Aim of the form

- To help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence.
- To decide which cases should be referred to Marac and what other support might be required. A completed form becomes an active record that can be referred to in future for case management.
- To offer a common tool to agencies that are part of the Marac[1] process and provide a shared understanding of risk in relation to domestic abuse, stalking and 'honour'-based violence.
- To enable agencies to make defensible decisions based on the evidence from extensive research of cases, including domestic homicides and 'near misses', which underpins most recognised models of risk assessment.

How to use the form

Before completing the form for the first time we recommend that you read the full practice guidance and FAQs. These can be downloaded from: http://safelives.org.uk/sites/default/files/resources/FAQs%20about%20Dash%20FINAL.pdf. Risk is dynamic and can change very quickly. It is good practice to review the checklist after a new incident.

Recommended referral criteria to Marac

1. **Professional judgement:** if a professional has serious concerns about a victim's situation, they should refer the case to Marac. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. ***This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence.*** This judgement would be based on the professional's experience and/or the victim's perception of their risk even if they do not meet criteria 2 and/or 3 below.

2. **'Visible High Risk':** the number of 'ticks' on this checklist. If you have ticked 14 or more 'yes' boxes the case would normally meet the Marac referral criteria.

[1] For further information about Marac please refer to the 10 principles of an effective Marac: http://safelives.org.uk/sites/default/files/resources/The%20principles%20of%20an%20effective%20MARAC%20%28principles%20only%29%20FINAL.pdf

Please pay particular attention to a practitioner's professional judgement in all cases. The results from a checklist are not a definitive assessment of risk. They should provide you with a structure to inform your judgement and act as prompts to further questioning, analysis and risk management whether via a Marac or in another way. **The responsibility for identifying your local referral threshold rests with your local Marac.**

What this form is not

This form will provide valuable information about the risks that children are living with but it is not a full risk assessment for children. The presence of children increases the wider risks of domestic violence and step children are particularly at risk. If risk towards children is highlighted you should consider what referral you need to make to obtain a full assessment of the children's situation.

SafeLives Dash risk checklist for use by Idvas and other non-police agencies2 for identification of risks when domestic abuse, 'honour'- based violence and/or stalking are disclosed

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.** **It is assumed that your main source of information is the victim. If this is <u>not the case</u>, please indicate in the right hand column**	**YES**	**NO**	**DON'T KNOW**	**State source of info if not the victim** (eg police officer)
1. Has the current incident resulted in injury? Please state what and whether this is the first injury.	☐	☐	☐	
2. Are you very frightened? Comment:	☐	☐	☐	
3. What are you afraid of? Is it further injury or violence? Please give an indication of what you think [name of abuser(s)] might do and to whom, including children. Comment:	☐	☐	☐	
4. Do you feel isolated from family/friends? I.e, does [name of abuser(s)] try to stop you from seeing friends/family/doctor or others? Comment:	☐	☐	☐	
5. Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
6. Have you separated or tried to separate from [name of abuser(s)] within the past year?	☐	☐	☐	
7. Is there conflict over child contact?	☐	☐	☐	

[2] Note: This checklist is consistent with the ACPO endorsed risk assessment model DASH 2009 for the police service.

8. Does [name of abuser(s)] constantly text, call, contact, follow, stalk or harass you? Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.	☐	☐	☐	
9. Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
10. Is the abuse happening more often?	☐	☐	☐	
11. Is the abuse getting worse?	☐	☐	☐	
12. Does [name of abuser(s)] try to control everything you do and/or are they excessively jealous? For example: in terms of relationships; who you see; being 'policed' at home; telling you what to wear. Consider 'honour'-based violence (HBV) and specify behaviour.	☐	☐	☐	
13. Has [name of abuser(s)] ever used weapons or objects to hurt you?	☐	☐	☐	
14. Has [name of abuser(s)] ever threatened to kill you or someone else and you believed them? If yes, tick who: You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	
15. Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	☐	☐	☐	
Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	**YES**	**NO**	**DON'T KNOW**	**State source of info**
16. Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	☐	☐	☐	
17. Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	☐	☐	☐	
18. Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
19. Has [name of abuser(s)] ever mistreated an animal or the family pet?	☐	☐	☐	
20. Are there any financial issues?	☐	☐	☐	

For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?				
21. Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. Drugs ☐ Alcohol ☐ Mental health ☐	☐	☐	☐	
22. Has [name of abuser(s)] ever threatened or attempted suicide?	☐	☐	☐	
23. Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. Bail conditions ☐ Non Molestation/Occupation Order ☐ Child contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐	☐	☐	☐	
24. Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: Domestic abuse ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

Agenda Item
9.1.4a

Quality & Safety Committee

Measles Policy

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Dr M Abrishami, Consultant Microbiologist / IPC Doctor
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Infection Prevention & Control Committee	18/04/2023	Endorsed for Approval
The policy has been reviewed and is consistent with the approach across NHS Wales.		
The HARP team, PHW have been engaged in the consultation		

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
UHB	University Health Board
HARP	Healthcare Associated Reduction Programme
PHW	Public Health Wales

1. Situation /Background

1.1 This policy provides information on measles and the infection prevention and control management of patients and/or staff who are suspected or known to have this infection.

Cwm Taf Morgannwg University Health Board's (CTMUHB) aim is to provide optimum management for patients with known or suspected measles and ensure staff are aware of the required infection prevention and control procedures. Cwm Taf Morgannwg University Health Board's (UHB) measles policy will be continually monitored and updated in line with current legislation and guidelines.

2. Specific Matters for Consideration

2.1 Engagement on this Policy has taken place with the Infection Prevention and Control Committee,

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

2.3 The HARP team, PHW have been engaged in the consultation

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

3. Key Risks / Matters for Escalation

Only minor typographical amendments were made as a result of the various consultation stages.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies, please list below:
Dolen i Feysydd Strategol	Not Applicable

BIP CTM / Link to CTMUHB Strategic Areas	If more than one applies, please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable If more than one applies, please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable If more than one applies, please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective If more than one applies, please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies, please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: No adverse quality issues have been identified.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: No adverse equality issues have been identified.	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

5.1 The Quality and Safety Committee are asked **APPROVE** the Measles Policy.

6. Next Steps

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

(Measles Policy)

Document Type:	Clinical Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Mohammed Abrishami, Consultant Microbiologist/IPC Lead Doctor
Executive Sponsor:	Executive Nurse Director
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(18/04/2026)
Version:	3

Target Audience:

People who need to know about this document in detail	All Clinical Staff in CTMUHB
People who need to have a broad understanding of this document	Service Managers, Head of Nursing, Deputy Head of Nursing, Senior Nurses
People who need to know that this document exists	All Clinical Staff within the Care Groups

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: 02.05.23** **Outcome: No impact identified.**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Contents

1. **Purpose** 3
2. **Policy Statement** 3
3. **Principles** 3
   - 3.1 **Definitions of Terms Used** 3
   - 3.2 **Introduction** 3
   - 3.3 **Transmission/Infectivity** 4
   - 3.4 **Prevention/Immunity** 4
   - 3.5 **Susceptible High risk Groups** 4
   - 3.6 **Diagnosis** 4
   - 3.7 **Laboratory Test** 5
   - 3.8 **Post Exposure Prophylaxis** 5
4. **Scope** 5
5. **Legislative and NHS Requirements** 5
6. **Procedure** 5
   - 6.1 **Communication of Case** 5
   - 6.2 **Admission of a known or suspected case** 5
   - 6.3 **Inpatients who develops measles** 6
   - 6.4 **Contact Tracing** 6
   - 6.5 **Transfer of patient/visit to other departments** 7
   - 6.6 **Personal Protective Equipment (PPE)** 7
   - 6.7 **Cleaning/Linen Procedures** 8
   - 6.8 **Out-Patient Department** 8
   - 6.9 **New Employee Measles Screening** 8
   - 6.10 **Staff** 8
7. **Training Implications** 9
8. **Review, Monitoring and Audit Arrangements** 9
9. **Managerial Responsibilities** 9
10. **Retention or Archiving** 10
11. **Non-Conformance** 10
12. **Equality Impact Assessment Statement** 10
13. **References** 10

Appendix A - Summary Action Sheet 11
Appendix B -Contact Tracing for Measles – Patients 10
Appendix C - Contact Tracing for Measles – Staff 10

1. Purpose

This policy provides information on measles and the infection prevention and control management of patients and/or staff who are suspected or known to have this infection.

2. Policy Statement

Cwm Taf Morgannwg University Health Board's (CWMUHB) aim is to provide optimum management for patients with known or suspected measles and ensure staff are aware of the required infection prevention and control procedures. The University Health Board's (UHB) measles policy will be continually monitored and updated in line with current legislation and guidelines.

3. Principles

3.1 Definitions of Terms Used

Measles:	acute viral illness caused by measles
Susceptible:	Person who has not had measles or MMR vaccine
Immune:	Person who has had measles or has received complete course of MMR vaccine

3.2 Introduction

Measles is one of the most highly infectious diseases known. It is an acute viral illness characterized by prodromal stage of fever, malaise, coryza, conjunctivitis and cough. Koplik spots (small spots with white or bluish white centres on an erythematous base) may appear on the buccal mucosa. The prodromal stage is followed by appearance of an erythematous maculopapular rash which usually begins on the face and behind ears, spreading to the trunks and limbs over 3-4 days.

Complications includes otitis media, bronchitis, pneumonia, diarrhoea, convulsions and encephalitis. Measles can be particularly severe in susceptible infants, pregnant women, and immunocompromised individuals. The most effective way to control measles is by active immunisation of a high proportion of the population.

Clinicians, making a clinical diagnosis of measles are responsible to inform the Consultant in Communicable Disease Control (CCDC) as soon as possible via telephone.
The contact number for the CCDC is via the AWARE team – 0300 003 0032.

This notification is a statutory requirement and must be undertaken even if the diagnosis is suspected. Refer to Notifiable Infectious Disease and Notification Procedure (IPC 08). Once notified, the Consultant in Communicable Disease Control (CCDC) will follow up all appropriate contacts and provide advice on chemoprophylaxis if needed.

3.3 Transmission/Infectivity

Transmission of infection is via respiratory droplets or direct contact with nasal or throat secretions of infected person. The incubation period is about 7-18 days. Individuals with primary measles infection are infectious from approximately 4 days before rash onset until 4 full days after the rash appears.

3.4 Prevention/Immunity

The most effective way to control measles is by active immunisation of a high proportion of the population. Vaccination against measles was introduced in 1968 but coverage was sub-optimal up to the late 1980s. MMR vaccine was introduced in October 1988. In general, those born before 1970 would have been exposed or have had measles and therefore developed natural immunity.

3.5 Susceptible High risk Groups

Measles can cause severe illness in some adults and susceptible high risk groups. These high risk groups are:

- Susceptible pregnant women
- Immunocompromised patients, including:
    a. Patients on long term steroids / immunosuppressive treatment
    b. Patients with immunodeficiency conditions
    c. Persons on chemo or radiotherapy; those who have received a bone marrow transplant
- Neonates / Infants
- Children with chronic illness eg cystic fibrosis, congenital heart or kidney disease, failure to thrive, Down's syndrome.
- Malnourished children

3.6 Diagnosis

Clinical diagnosis of measles will be based on a combination of epidemiological and clinical factors.

The following features are strongly suggestive of measles:

- Rash for at least 3 days that starts on the face and spreads to the trunk
- Fever for at least 1 day
- At least one of the following - cough, coryza or conjunctivitis

3.7 Laboratory Test

Salivary kits are available from the Public Health Team for PCR test. Oral fluid (OF) is the optimal sample for measles surveillance. These samples are minimally invasive and are more acceptable than serum for confirming cases in infants and children. Importantly, OF can be tested for IgM, IgG and measles RNA.

Serum is the most appropriate sample to assess the immune status of contacts.

3.8 Post Exposure Prophylaxis

Susceptible individuals who have had significant exposure to measles should be offered post exposure prophylaxis of either MMR vaccine or Human Normal Immunoglobulin (HNIG). To be effective, vaccine must be administered promptly, ideally within 3 days. In individuals where vaccination is contraindicated or not effective (e.g. immunosupressed, pregnancy, infant), Human Normal Immunoglobulin (HNIG) should be considered as soon as possible, ideally within 72 hours although can be given within 6 days. Consider testing for immunity (antibody) in at risk exposed individuals where appropriate. Any severely immunocompromised patients should be given HNIG regardless of their history. Do not wait for laboratory diagnostic confirmation of the index case as this may delay administration of prophylaxis where needed. Risk assessment of the likelihood of measles should be based on clinical and epidemiological grounds. Please discuss with Microbiologist if advice is needed.

4. Scope

This policy is directed to any healthcare professionals who may provide care to a patient with known or suspected disease caused by measles virus and to reduce the risk of staff developing or spreading the measles virus.

5. Legislative and NHS Requirements

It is the policy of the UHB to comply with NHS, UK and EU statutory and other legislative requirements in relation to the prevention of healthcare associated infections.

6. Procedure

6.1 Communication of Case

In the event of a case of measles being admitted to or identified in hospital, **it is essential that early communication be made to the Infection Prevention and Control Team (IPCT)** so that necessary precautions can be taken immediately. The patient should be isolated into a side room immediately and transmission based precautions applied.

6.2 Admission of a known or suspected case

- All patients admitted with clinically suspected measles must be isolated in a single room in respiratory isolation. Where possible, admit into rooms with negative pressure suite ventilation.

- Please refer to the Isolation Guidelines (IPC 12). The door should be closed where possible to avoid drift of virus into other areas.

- Patients with measles should not be hospitalized unless absolutely necessary. Nor should susceptible persons known to have been exposed within the previous 18 days.

- Exposed susceptible patients requiring hospitalization should be nursed in respiratory isolation with airborne precautions from 5 days after their earliest exposure to the source until 21 days after their most recent exposure.

6.3 Inpatients who develops measles

- Isolate the patient immediately in single room with airborne precautions. Where possible, admit into single room with negative pressure ventilation. The door to the room must be kept closed if possible.

- Inpatients who develop measles and susceptible patients exposed in the healthcare setting should be discharged as soon as possible if their clinical condition permits.

- Contact tracing must be carried out to determine whether significant exposure to others has occurred (refer to section 6.4)

6.4 Contact Tracing

- High-risk individuals such as susceptible patients, neonates and the immunocompromised should be protected from exposure.

- **RISK ASSESSMENT** - made based on immuno-compromised status of patient, nature of exposure and immunity status.

- Exposed high-risk patients should be risk assessed by the Doctor looking after these patients. Check immunity status if possible but do not delay administration of post exposure prophylaxis if appropriate. Offer Immunoglobulin's (HNIG) or MMR Vaccine if indicated in liaison with Microbiologist (refer to section 3.8).

- Ward/department managers are responsible for coordinating contact tracing for all susceptible staff and high risk patients on their ward who have had a significant exposure to the infected patient or member of staff with measles. This process includes completion of the "Contact Tracing for measles" forms, Appendix B for patients and Appendix C for staff. Liaise with Infection Prevention and Control team (IPCT) and the Occupational Health Services (OHS).

- The ward manager must notify the OHS department and forward a

completed copy of the Contact Tracing Form (Appendix C) to the department

- Following a review/risk assessment, the OHS team will advise staff of any further actions required and to advise on their fitness to remain in work.

- Staff members with a documented history of 2 measles containing vaccines, laboratory confirmed immunity or clear confirmed history of past measles infection that has been accepted as such by an assessing Occupational Health professional may carry on with their normal duties.

6.5 Transfer of patient/visit to other departments

- As with all Infection Prevention and Control matters, the Nurse in Charge of the ward has the responsibility to ensure that the necessary information regarding an infected patient is passed to a senior member of staff of the receiving ward/department prior to transfer.

- Inter-ward transfer of the infectious patients should be avoided unless absolutely necessary, but should not jeopardise clinical management. Discuss with the IPCT if necessary.

- Visits to other departments should be kept to a minimum.

- The staff in the receiving department must be informed prior to the visit so that only staff members who are known to be immune to measles will look after the patient.

- Prior arrangements should be made with the senior staff of the receiving department and the Portering Supervisor to ensure staff protection (appropriate use of PPE) and awareness.

- Infected patients should be treated at the end of the working session and they should spend the minimum time in the department.

- They should only be sent for when the receiving department is ready and not left in a waiting area with other patients.

- If possible, the patient should wear a fluid resistant surgical mask during transfers to other areas eg. CT scan or Xray.

- This policy should never jeopardise clinical management.

6.6 Personal Protective Equipment (PPE)

- Use appropriate PPE as per PPE Policy (IPC07). Staff entering the room must wear a FFP3 mask and eye protection in addition to other PPE (aprons/gown/ gloves) as required.

6.7 Cleaning/Linen Procedures

- Please refer to Isolation Guidelines (IPC12).

6.8 Out-Patient Department

- Patients with suspected/confirmed measles should be advised not to attend appointment if possible.

- If unavoidable or patient attends, place the individual in an empty consultation room immediately. The patient should be seen and discharged as soon as possible.

6.9 New Employee Measles Screening

- New employees with patient contact or a potential to be exposed to measles, including virology laboratory staff, are required to provide documented evidence of measles immunity (two documented doses of MMR vaccine or laboratory confirmed evidence of immunity/infection).

- OHS advisers will as part of the new starter employment health screen identify susceptible staff

- If documented evidence cannot be provided, the staff member should be considered as susceptible and MMR vaccination must be offered (vaccinations will be administered if consent is given and there are no contraindications). Staff born before 01/01/70 will be considered to be protected/immune.

  Blood tests for measles IgG will only be undertaken in exceptional circumstances (e.g. if MMR immunization is medically contraindicated) and this will be at the discretion of the Occupational health professional.

- OHS advisers will advise ward/department managers of the measles status of new staff who have completed a full new starter health questionnaire and clinical contact is indicated on the form, as part of the recruitment process.

- Where internal forms have been used for recruitment, it is the responsibility of the ward/department manager to ensure they know the measles status of their staff.

6.10 Staff

- Staff whose measles status is unknown and not confirmed by OHS should ideally not have contact with patients with known or suspected measles.

- Susceptible staff identified by ward/department manager (using Appendix C form) who have had significant exposure to an infected patient must have their immunity status checked by OHS. If a susceptible member is deemed to have had significant exposure, post-exposure MMR vaccination or Immunoglobulin prophylaxis should be discussed with the

Microbiologist. Immunoglobulin prophylaxis can be administered in the Accident and Emergency department, in primary care or an area identified by the microbiologist or a member of the health protection team, Public Health Wales. This will be determined as part of the contact tracing procedure.

- Following contact tracing from OHS, susceptible staff with significant exposure may be excluded from work 5 days following the exposure until 21 days after latest exposure, even after receiving post exposure prophylaxis. If agreement is made with Public Health Wales, it may be appropriate to undertake measles IgG within 7 days of exposure and a positive result would be deemed as immune and the staff member would be able to return to work.

  OHS will advise both the employee and manager of decisions regarding fitness to work.

- If staff develop any symptoms suggestive of measles (see 3.2) they should seek advice from their GP. (They should ring the surgery and advise of potential infectious disease – to enable the practice staff to determine suitable arrangements for consultation)

- Any staff member thought to have measles should contact OHS by telephone stating potential infectious disease and advice should be given about their fitness to work. They should not attend OHS in person. Consent should be obtained by OHS to discuss fitness to work with their manager, or person in charge of shift and IPCT. If consent is not given and the member of staff has highly suggestive symptoms or measles diagnosis, OHS nurses should seek advice regarding breaching confidentiality.

- Staff with measles should not be at work until a full 4 days has passed after the rash appears when they should no longer be infectious.

7. Training Implications

No specific training required. All staff should be aware of this Policy.

8. Review, Monitoring and Audit Arrangements

An audit of the application of the policy or procedure may be undertaken, monitored and overseen by the Infection Prevention and Control Committee.

9. Managerial Responsibilities

There are detailed responsibilities in the main Infection Prevention & Control Strategy (IPC01).

- Managers as per Control of Substances Hazardous to Health (COSHH) Regulations, should keep a record of the measles status of their staff with patient contact or who have a potential to exposure to measles, e.g. laboratory staff.
- Managers should encourage their staff without measles protection/immunity to attend OHS for vaccination/screening.

- Staff identified as susceptible/not protected to measles should not be exposed to patients/specimens with known or suspected measles.

10. Retention or Archiving

The responsible Lead Infection Prevention and Control Nurse must ensure that copies of policies and procedures are archived and stored in line with the Organization's Records Management Policy and are made available for reference purposes should the situation arise supported by IP&C Coordinator.

11. Non-Conformance

If there has been any non-conformance identified with this policy, incident forms may be completed.

12. Equality Impact Assessment Statement

This Policy has been subject to a full equality assessment and no impact has been identified.

13. References

- HPA National Measles Guidelines, Nov 2019 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/849538/PHE_Measles_Guidelines.pdf

- Immunisation against infectious disease, Department of Health, Chapter 21, Dec 2019 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/855154/Greenbook_chapter_21_Measles_December_2019.pdf

- Post exposure prophylaxis for Measles: Revised Guidance, HPA June 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814203/Guidance_for_measles_post-exposure_prophylaxsis.pdf

- Joint Public Health Wales and NHS Wales Occupational Health Forum Group October 2017

Appendix A - Summary Action Sheet

ROLES

Ward Managers

When a patient is clinically suspected of having measles, the nurse in charge of the ward should:

- Institute appropriate isolation/ infection prevention and control precautions immediately.
- Inform the Infection Prevention & Control Team (IPCT).
- Ask medical team to risk assess exposed patients. Complete patient contact tracing from (Appendix B) and share with Infection Prevention and Control Team. Dr to inform Public Health.
- Ensure only staff known to have immunity for measles care for the patient if possible.
- Inform the Occupational Health and Wellbeing Department (OHS). Make a list of staff with significant contacts (Appendix C: Contact Tracing Form) & forward a copy to OHS.

Infection Prevention and Control Team

- Liaise with Ward Manager & OHS to ensure all infection prevention and control measures are in place.
- Liaise with medical team and Microbiologist to risk assess susceptible patient contacts to determine whether post exposure prophylaxis is required.

Occupational Health and Wellbeing Service

- Be informed of members of staff who are identified as a significant contact of measles.
- Assess immunity status of staff who have been exposed.
- Assess the need for temporary removal (medical suspension) from clinical duty of susceptible staff if appropriate in discussion with Ward Manager and IPC.

Appendix B -Contact Tracing for Measles – Patients

INDEX CASE

Name : Ward :

DOB : Consultant :

Hosp No : Date :

Date of onset of rash :

Date of admission :

Bed location : Bed _____ Bay _____ or Side room: _____

Relevant Medical History/risk factors:

Patient transferred to side room on:
Infection, Prevention & Control Team informed on:

Patient's Name	DOB	Bed Location: Bed _ Bay_	Risk factors	Documented History of Measles /MMR - Y/N	Blood results Measles IgG Date, Pos/Neg

Appendix C - Contact Tracing for Measles – Staff

INDEX CASE

Name : Ward :

DOB : Hosp No :

Date of onset of rash: Date of admission:

Ward/dept person responsible for liaising with OHS: Contact No:

Infection, Prevention & Control Team informed on :

Name of Occupational Health and Wellbeing nurse informed: Date

Date form received in OHS:

Staff Full Name	DOB	Contact Number	OHWB Use	Documented measles vaccine x 2 (Yes/No)	Documented measles IgG positive (Yes/No)	Pregnant or Immunoco-mpromised (Yes/No)	Further Action

Date contact tracing complete and ward/department advised of actions:

Name of OHS adviser:

Agenda Item
9.1.5

Quality & Safety Committee

Meningitis Policy

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr M Abrishami, Consultant Microbiologist / IPC Doctor
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Infection Prevention & Control Committee	18/03/2023	Endorsed for Approval
The policy has been reviewed and is consistent with the approach across NHS Wales.		
The HARP team, PHW have been engaged in the consultation		

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
UHB	University Health Board
HARP	Healthcare Associated Reduction Programme
PHW	Public Health Wales

1. Situation /Background

1.1 This policy provides information on the infection, prevention and control management of patients who are suspected or known to have meningitis. This is to ensure Healthcare Workers are aware of the actions and precautions required to minimise the risk of transmission between patients, staff and visitors.

2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with the Infection Prevention and Control Committee,

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

2.3 The HARP team, PHW have been engaged in the consultation

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

3. Key Risks / Matters for Escalation

3.1 Only minor typographical amendments were made as a result of the various consultation stages.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	Not Applicable

Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: There are no specific legal implications related to the activity outlined in the report.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /*	There is no direct impact on resources as a result of the activity outlined in this report.	

Resource Impact *(People / Financial)*	

5. Recommendation

5.1 The Quality and Safety Committee are asked **APPROVE** the Meningitis Policy.

6. Next Steps

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

(MENINGITIS POLICY)

Document Type:	Clinical Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Mohammed Abrishami, Consultant Microbiologist/IPC Lead Doctor
Executive Sponsor:	Executive Nurse Director
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(18/04/2026)
Version:	3

Target Audience:

People who need to know about this document in detail	All Clinical Staff in CTMUHB
People who need to have a broad understanding of this document	Service Managers, Head of Nursing, Deputy Head of Nursing, Senior Nurses
People who need to know that this document exists	All Clinical Staff within the Care Groups

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: 03.05.23** **Outcome: No impact identified**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

1. Purpose 3
2. Policy Statement 3
3. Principles 3
3.1 Introduction 3
3.2 Transmission/Infectivity 4
4. Scope 5
5. Legislative and NHS Requirements 5
6. Procedure 5
6.1 Communication of Case 5
6.2 Admission of a Known or Suspected Case 5
6.3 Contact Tracing 6
6.4 Chemoprophylaxis for Staff 7
7. Training Implications 7
8. Review, Monitoring and Audit Arrangements 7
9. Managerial Responsibilities 8
10. Retention or Archiving 8
11. Non-Conformance 8
12. Equality Impact Assessment Statement 8
13. References 8
Appendix A - PEP Risk Assessment for Staff Exposure to a case of Meningococcal Disease 9

1. Purpose

This policy provides information on the infection prevention and control management of patients who are suspected or known to have meningitis. This is to ensure healthcare workers are aware of the actions and precautions required to minimise the risk of transmission between patients, staff and visitors.

2. Policy Statement

Cwm Taf Morgannwg University Health Board's (CTMUHB) aim is to provide optimum management for patients with known or suspected meningitis infection and ensure staff are aware of the required infection prevention and control procedures. The Health Board's Meningitis Policy will be continually monitored and updated in line with current legislation and guidelines.

This document does not cover the treatment (clinical management) of Meningitis, please discuss with Microbiologist for advice or refer to CTMUHB's "Guidelines for Antimicrobial Therapy for Adults in Secondary Care" (available on share point).

3. Principles

3.1 Introduction

Meningitis occurs when the meninges, the membranes that line the brain and spinal cord, become infected. The meninges act as a barrier to stop infection reaching the central nervous system.

Types of Meningitis

Meningitis can be caused by a number of organisms, viruses, bacteria, fungi and even amoeba.

- **Viral**
  The most common cause of meningitis is a viral infection. It causes a wide spectrum of conditions, only a minority of individuals will get meningitis. Although viral meningitis is a less severe illness than bacterial forms of the disease, it can still be very debilitating and, in very rare cases, can progress through headache, fever and drowsiness to deep coma. Viral infection can also affect the substance of the brain (encephalitis). The commonest forms of viral meningitis are caused by the coxsackie virus and echoviruses (or enteroviruses). Infection with measles, chickenpox, mumps, and herpes simplex can also lead to viral meningitis.

- **Bacterial**
  Bacterial meningitis, the less common form of the disease, is always associated with serious and severe illness.

  Meningococcal and pneumococcal infections are the most common causes of bacterial meningitis. They can also cause septicemia (blood poisoning), which can spread through the body, causing very serious illness. Other forms of bacteria that can cause meningitis include Haemophilus influenza, Streptococcal Group B, listeria, E.coli and tuberculosis.

  Many people who get the infection have some symptoms of both meningitis and septicemia. People can have predominantly symptoms of meningitis (e.g. neck stiffness, sensitivity to light), septicemia (e.g. red or purple spots that do not fade, cold hands and feet and rapid breathing), or symptoms of both meningitis and septicemia.

  Vaccines are available for certain pathogens to prevent meningitis.

  Patients with bacterial meningitis need urgent attention and immediate antibiotics. Please refer to the Health Boards Antimicrobial Guide or discuss with Microbiologist if required.

3.2 Transmission/Infectivity

Viruses are shed in respiratory secretions and/or faeces, and therefore can be transmitted by the faecal-oral route, respiratory route or by direct (or close contact) from person to person. The incubation period for viral meningitis can be up to three weeks. Viral meningitis cannot be treated with antibiotics although anti-viral treatment may be required for some forms of encephalitis.

Meningococcal bacteria are very common and are usually carried harmlessly in the nose and throat of individuals, particularly teenagers and young adults. The bacteria can be spread by these carriers through prolonged close contact by droplets/secretions from the upper respiratory tract via coughing, sneezing and kissing. In a small number of individuals, the bacteria overwhelm the body's defenses to cause meningitis or septicemia.

Period of communicability: transmission can occur until after 24 hours of treatment with appropriate antibiotic therapy. After this time, the carriage rate of meningococci falls dramatically. Colonisation clearance may also be necessary depending on which antibiotics have been used for treatment.

Many people carry the **Streptococcus pneumoniae** bacteria in the throat without resulting in illness. However, occasionally they penetrate the body's defenses causing a range of conditions from earache to bronchitis or pneumonia. Pneumococcal infection can develop into septicemia and meningitis. It does not usually spread from person to person.

4. Scope

This policy is directed to any healthcare worker who may provide care to a patient with known or suspected meningitis.

5. Legislative and NHS Requirements

It is the policy of the CTMUHB to comply with NHS, UK and EU statutory and other legislative requirements in relation to the prevention of healthcare associated infections.

6. Procedure

6.1 Communication of Case

In the event of a case of meningitis being identified, it is essential that early communication of cases be made to the Infection Prevention and Control Team (IPCT) so that necessary precautions can be taken immediately. The patient must be isolated into side room immediately.
Clinicians, making a clinical diagnosis of meningitis are responsible to inform the Consultant in Communicable Disease Control (CCDC) as soon as possible via telephone. This notification is statutory and must be undertaken even if the diagnosis is suspected. Refer to Notifiable Infectious Disease and Notification Procedure (IPC 8). Once notified, the Consultant in Communicable Disease Control (CCDC) will follow up all appropriate contacts and provide advice on chemoprophylaxis if needed.

The contact number for the CCDC is via the AWARE team: 0300 003 0032.

6.2 Admission of a Known or Suspected Case

Isolation

- All patients admitted with clinically suspected meningitis must be placed in respiratory isolation.
- Please refer to the IPC Isolation Guidelines (IPC 12).
- Isolation should be maintained until a clinical or laboratory diagnosis has been confirmed.
- Decision of discontinuing isolation will depend on the type of organism isolated.

- General guidance on the duration of respiratory isolation is listed below once infective agent has been identified:

ORGANISM	DURATION OF ISOLATION
Enterovirus	Up to 7 days after onset of illness
Meningococcal	Up to 24 hrs after start of effective antibiotic therapy
Haemophilus	Up to 24 hrs after start of effective antibiotic therapy
Pneumococcal	Isolation Not required

For other organisms not listed, please discuss with the IPCT if required.

Protective Clothing

- During the isolation period, it is not necessary to wear face protection/masks for general healthcare duties unless exposure to large particle droplet/secretions from the respiratory tract is anticipated or other situations are present such as other respiratory viruses eg. COVID or Influenza

- Full-face protection must be employed for direct close contact with the patient when carrying out airway management procedures and during resuscitation.

- Standard infection prevention and control precautions apply for dealing with all other body fluids.

- Please refer to the Personal Protective Equipment Guidelines (IPC 13).

Decontamination Advice

- Standard precautions apply for the cleaning of isolation rooms. Deep or additional cleaning is not required.

6.3 Contact Tracing

This is undertaken by the Communicable Disease Team (Health Protection Team).

6.4 Chemoprophylaxis for Staff

For Meningococcal meningitis:

The risk of transmission to healthcare workers during work activities is significantly lower than that of household contacts. Transmission is extremely rare. Therefore prophylaxis is NOT REQUIRED for staff involved in the general medical or nursing care of a suspected or confirmed case of meningococcal sepsis. Staff who have been directly exposed to large particle droplets/secretions from the respiratory tract around the time of admission to hospital will be at greater risk. This type of exposure is most likely to occur in staff who undertake airway management during resuscitation without wearing a mask or other mechanical protection.

Under those circumstances, the Ward/Department Manager should contact Occupational Health and Wellbeing (OHS) to carry out a risk assessment (during working hours). The OHS staff will work to a departmental meningitis exposure standard operating procedure.

The accident and emergency departments will work in liaison with Occupational Health Services in relation to prophylactic treatment, if indicated.

If exposure is out of hours, contact the on call Microbiologist for advice. (Refer to Appendix 1 for PEP Risk Assessment protocol).

OHS to advise CTMUHB in relation to the Reporting of Diseases and Dangerous Occurrences Regulations as appropriate.

7. Training Implications

No specific training required. All staff should be aware of this Policy.

8. Review, Monitoring and Audit Arrangements

Approval will take place at the Quality and Safety Committee following consultation and agreement at Infection Prevention and Control Committee.

An audit of the application of the policy or procedure may be undertaken via the following mechanisms and monitored and overseen by the IP&C Committee for example:-

- Monitoring of the clinical incident reporting system
- Monitoring of the complaints and claims system

9. Managerial Responsibilities

There are detailed responsibilities in the main Infection Prevention and Control Strategy - IPC 01.

10. Retention or Archiving

The responsible Lead Infection Prevention and Control Nurse must ensure that copies of policies and procedures are archived and stored in line with the Trust's Records Management Policy and are made available for reference purposes should the situation arise supported by IP&C Coordinator.

11. Non-Conformance

If there has been any non-conformance identified with this policy, incident forms may be completed.

12. Equality Impact Assessment Statement

This Policy has been subject to a full equality assessment and no impact has been identified.

13. References

- Cwm Taf University Health Board. Secondary care antimicrobial guidelines.

- Department of Health. Preventing Meningitis, July 2018

- Public Health Wales | Meningitis Public Health Wales website accessed April 2018

  http://www.wales.nhs.uk/sitesplus/888/page/43792

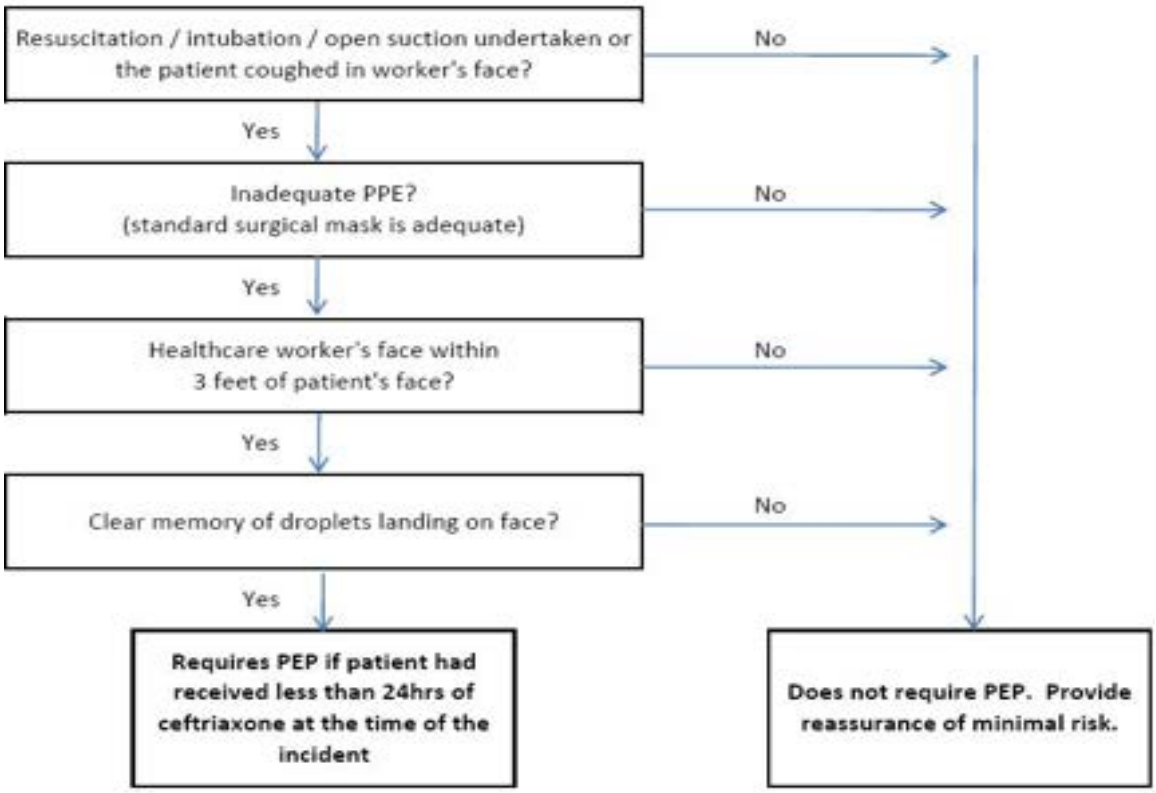
- Guidance for the public health management of meningococcal disease in the UK Public Health England Updated May 2022 (accessed online January 2023)

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/554011/Green_Book_Chapter_22.pdf

Appendix A – PEP Risk Assessment for Staff Exposure to a case of Meningococcal Disease

Protocol for Post Exposure Prophylaxis (PEP) for healthcare workers exposed to a case of Meningococcal disease

NB: General nursing and medical duties are not an indication for PEP



Notes:

1) Vomiting by the patient near a healthcare worker is not normally an indication for PEP. In the rare instance that the patient vomits in the face of the healthcare worker, discuss PEP with on call consultant microbiologist or CCDC.

2) Exposure of the eyes to respiratory droplets is not an indication for PEP. There is a low risk of developing conjunctivitis. Staff should be counselled about this and strongly advised to seek early treatment if conjunctivitis develops within 10 days of exposure. Public Health should be notified promptly of any case of meningococcal conjunctivitis.

3) Chemoprophylaxis is not recommended without a clear history of exposure as above. General medical or nursing duties should not be considered an indication for prophylaxis.

Based on HPA Meningococcus Forum (2006) "Guidance on management of meningococcal disease in the UK"

Source & Acknowledgment: Public Health Wales - Dr Gwen Lowe (Consultant Communicable Disease Control) & Dr Thom Waite (Specialty Registrar in Public Health), Feb 2011.

Agenda Item
9.1.6

Quality & Safety Committee

SAFEGUARDING ANNUAL REPORT 2022/2023

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Claire O'Keefe – Head of Safeguarding
Cyflwynydd yr Adroddiad / Report Presenter	Claire O'Keefe – Head of Safeguarding
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	Endorse for Board Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Safeguarding Executive Group	26/10/2023	Endorsed for Approval

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 Each year the corporate safeguarding team provides an annual report to demonstrate the progress and accomplishments made within safeguarding across Cwm Taf Morgannwg University Health Board. This report identifies areas of work undertaken through care groups during April 2022 – March 2023 in respect of child and adult safeguarding. In addition captures work undertaken with regards to domestic abuse and other public protection matters.

2. Specific Matters for Consideration

2.1 This annual report is in addition to the CTMUHB annual report and Cwm Taf Morgannwg Safeguarding Board annual report that the team have contributed to.

2.2 Clinical nurse specialists along with the corporate safeguarding team have contributed to work undertaken with the health board services. This is demonstrated within the child safeguarding section.

2.3 During this year focus has been given to sharing and embedding learning with respect to child and adult practice reviews. Ongoing work is reflected in the health boards Safeguarding maturity Matrix.

Name Title	***Date Consulted/Completed***
Equality Impact Assessment	01/11/2023
Informal Consultation with interested parties	July and August 2023
Formal Consultation	October 2023
Committee – For approval	Safeguarding Executive Group 26/10/2023

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

3. Key Risks / Matters for Escalation

3.1 The results and subsequent actions of the inspections will be included within the 23/24 annual report. However, assurance is provided that these recommendations form part of the health board's improvement plan.

3.2 In response to Child T's practice review, work has been undertaken jointly with partner agencies and the safeguarding board to drive improvements in all services. Much of the work undertaken this year has focussed on sharing learning from this review and strengthening the health board's recognition

and response to physical injuries in children. This work continues and will be reflected within the 23/24 annual report.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe Safe, timely and effectiveness is required to safeguard the community accessing our services.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Quality Impact screening has identified no indicators for a full QIA.	If no, please include rationale below:

Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This report is designed to provide assurance to CTMUHB colleagues and those accessing its services that safeguarding is given priority in all of its services.
Cyfreithiol / Legal	Yes (Include further detail below)	
	The health board and its employees have a 'duty to report' in line with the Social Service and Wellbeing (Wales) Act 2014.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The Quality and Safety Committee are asked to Endorse for Board approve the Safeguarding Annual Report.

6. Next Steps

6.1 Once approval is sought the author will share the Annual Report with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Safeguarding & Public Protection Annual Report 2022 /2023

Claire O'Keefe, Head of Safeguarding

Annual Report 2022/2023


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

Contents

Safeguarding & Public Protection Annual Report 2022/2023	Page
Assurances	3
Safeguarding & Public Protection	4-5
Lead Roles	5-6
Safeguarding Children	7-9
Child Sexual Exploitation	10-11
Looked After Children	11-13
Adults at Risk	13-15
Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)	15-17
Deprivation of Liberty (DoLS)	18-19
Mental Capacity Act (MCA)	20-21
Allegations made against Professionals	21-23
Training & Learning	23-26
Multi-Agency Safeguarding Hub (MASH)	26-28
Radicalisation & PREVENT	28-29
Offender Management	29-30
CTM Safeguarding Board	30-31

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

Assurances:

- To ensure that UHB meets its duties under Part 2 of the Well-being of Future Generations (Wales) Act 2015, in that the Sustainable Development Principle is applied and consideration is given to the impact of current decision making on people living their lives in Wales in the future.

- To ensure the UHB discharges its duties under the Social Services & Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 [Looked After Children] & Part 7 [Safeguarding Children & Adults at Risk].

- To ensure the UHB complies with section 47 [child protection investigations] of the Children Act 1989 and sections 25,27 and 28 [duty to cooperate to safeguard & promote welfare children] of the Children Act 2004;

- To ensure the UHB complies with the requirements as the Supervisory Body and Managing Authority for the Deprivation of Liberty Safeguards (DoLS) as outlined in the Mental Capacity Act 2005, amended in the Mental Health Act 2007 and Mental Capacity (Amendment) Act 2019;

- To ensure the UHB discharges its duties as a Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency under s325 Criminal Justice Act 2003;

- To ensure the UHB discharges its duties under the Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 [develop and implement a local strategy with the Local Authority] and Domestic Abuse Act 2021

- To ensure the UHB complies with s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police].

- To ensure the UHB discharges its duties under the Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour].

- Oversee an on-going process of self-assessment and improvement against Safe Care Standard 2.7 of the Health & Care Standards in Wales;

- To provide assurance to the Board that arrangements to secure governance, risk management & internal control are suitably designed and applied effectively.

What does Safeguarding & Public Protection look like in CTMUHB?

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

- **Safeguarding** in Cwm Taf Morgannwg involves working with our partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm and actively prevent them from becoming at risk of abuse, neglect or other kinds of harm.

- **Public Protection** seeks to protect, promote and improve the health, safety and well-being of our population across Cwm Taf Morgannwg.

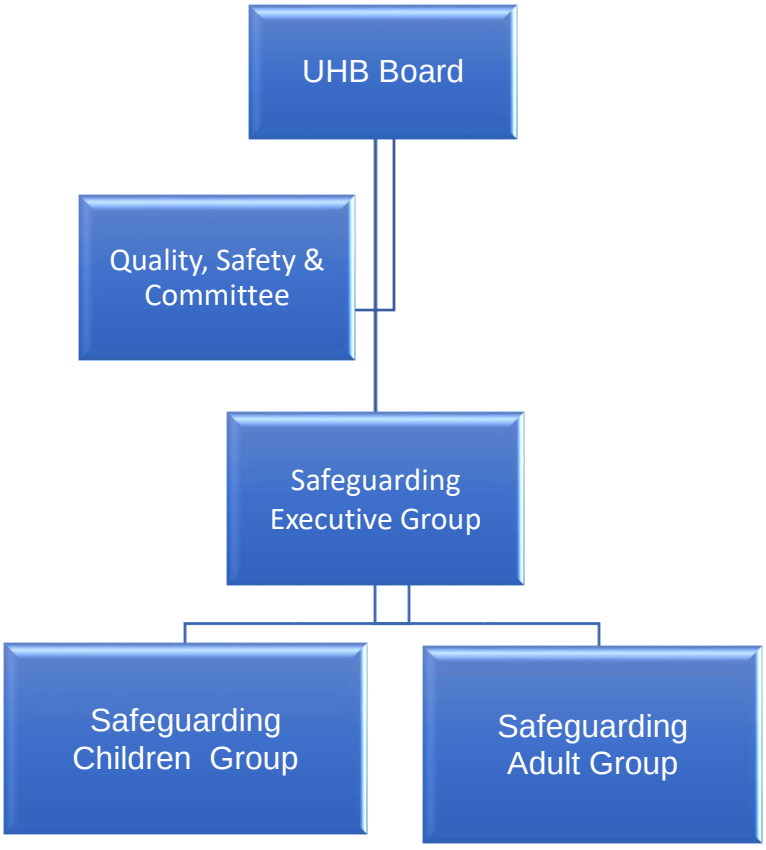
Strategic Objectives for Safeguarding and Public Protection:

- There are effective measures in place to safeguard people and protect children and adults at risk.

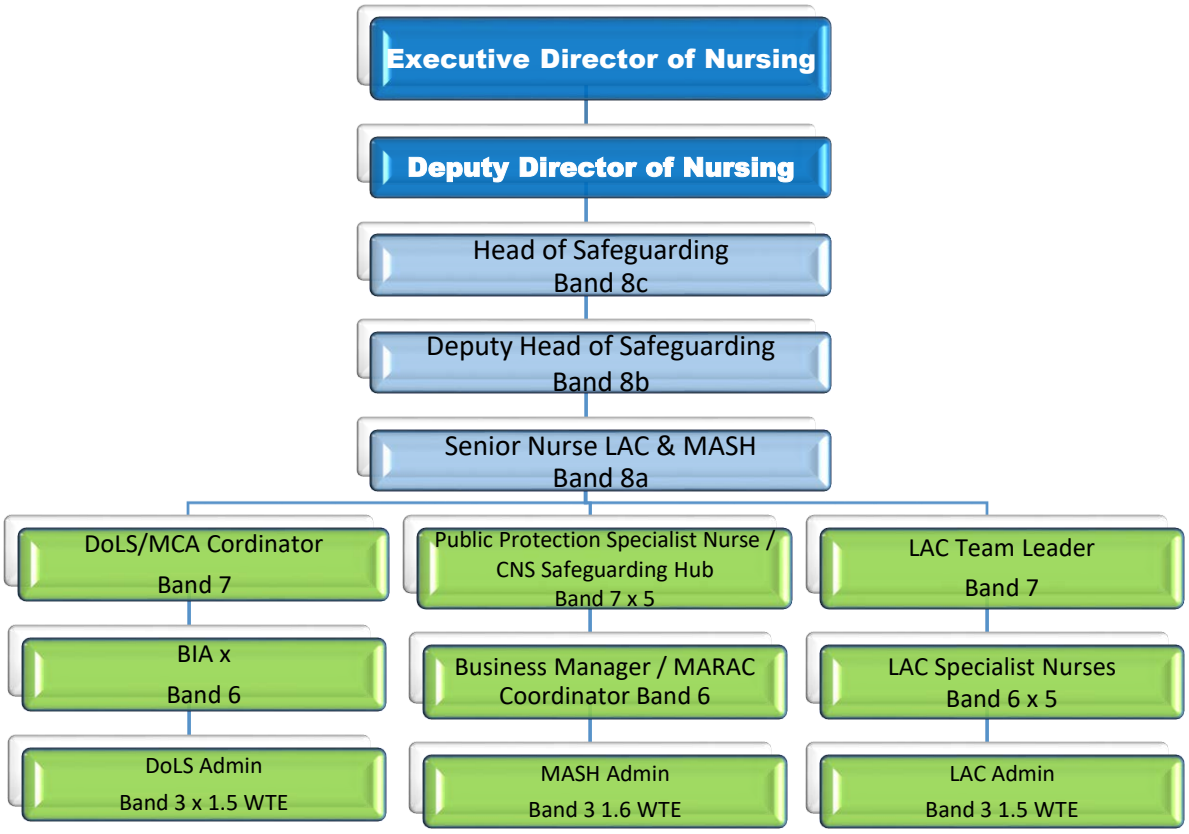
- There is effective inter-agency co-operation in planning and delivering safeguarding and public protection services and in sharing information.

The UHB works within regional partnership arrangements.

CTMUHB Governance Arrangements & Reporting Structure UHB Board



Corporate Safeguarding Team



Lead Roles in Safeguarding within CTMUHB

Executive Director of Nursing: UHB Executive lead for safeguarding

Deputy Director of Nursing: Assistant to the Director of Nursing and UHB executive lead for quality, patient safety and safeguarding.

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

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

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

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

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

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

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

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

Safeguarding Midwife: Midwife for Safeguarding Children.

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

Clinical Nurse Specialist for adoption.

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

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

CAMHS: The Head of Nursing and the Senior Nurses across the Network have lead safeguarding responsibilities for their areas. CAMHS colleagues also receive ad hoc supervision and safeguarding support from the corporate safeguarding team.

Mental Capacity Act Team: To teach and underpin the principles and application of the Mental Capacity Act into daily working practice.

Safeguarding Children

Our Aim

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

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

How Will We Do This?

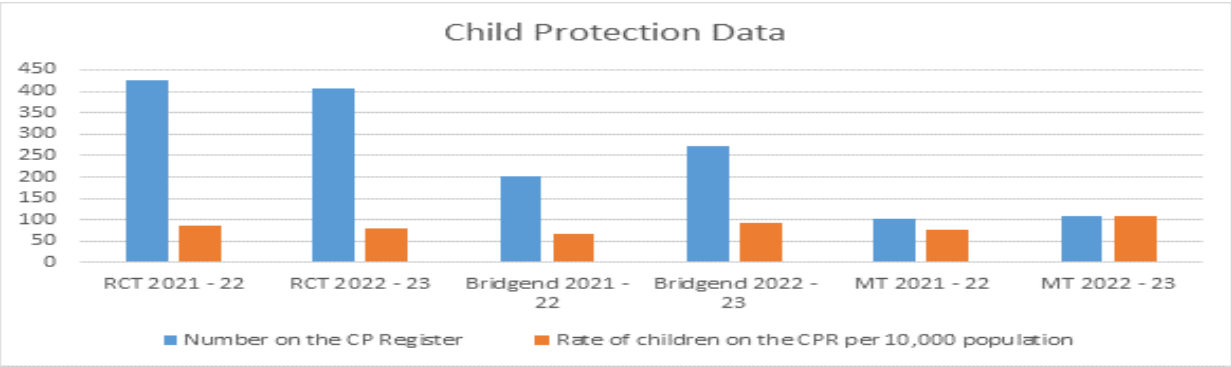
By ensuring that there are effective interagency safeguarding processes and practice in place, supported by robust quality assurance and information sharing systems.

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

What Did We Do?

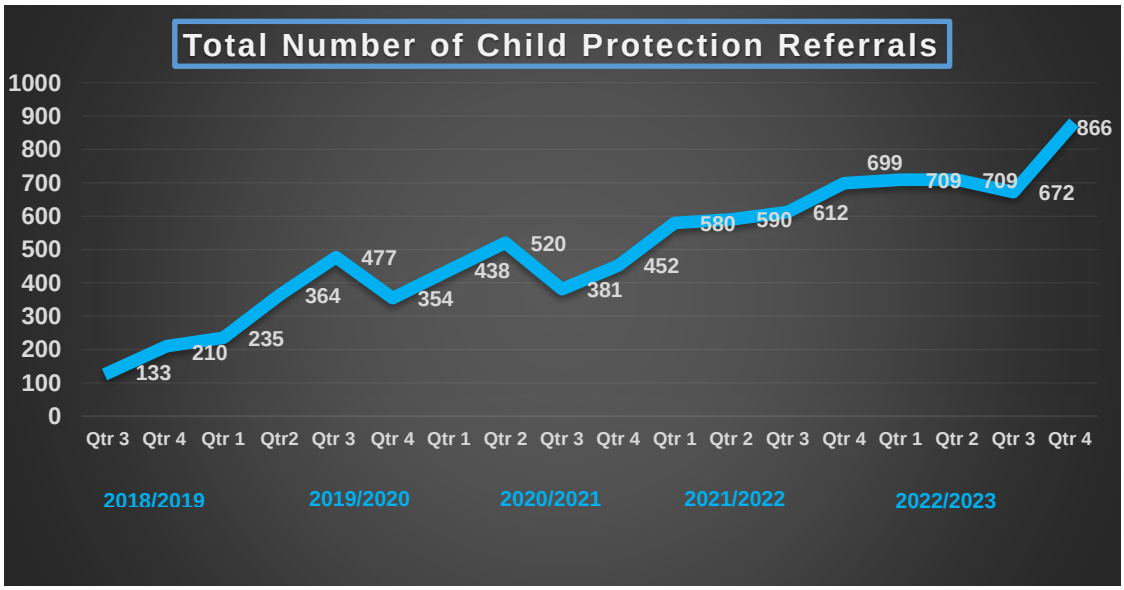
All three Local Authorities have reported an increase in safeguarding activity at front door services and those families accessing Local Authority early help services.

Bridgend has seen a significant increase in demand in child protection assessments, enquiries and cases proceeding to an initial conference. This is reflective of the increased professional and public awareness following the publication of the Child T Child Practice Review and factors associated with the increased cost of living crisis.



Data for 2022-2023 above is taken from local performance reports provided on a quarterly basis from the Local Authority to the Regional Safeguarding board.

All areas within CTM have seen an increase in referrals and strategy meetings. There have been 2956 health referrals submitted to Children Services, this is a 19% increase from 21/22. A large proportion of the referrals continue to be submitted from Emergency departments across the three general hospital sites. It is considered that this may be attributed to additional training and awareness in respect of children/young people presenting with physical injuries and concerns with their mental health and wellbeing.



In 2022/23, 293 child protection medicals were undertaken compared to 270 in the previous year, this is consistent with the increase in safeguarding activity observed across CTM. The Child Protection Medical Hub undertakes approximately two thirds of the overall medicals. Children aged 2 – 17 years are seen at the Hub, all children under two years old or those accessing health care through Accident and Emergency are seen on Paediatric wards.

This year has tragically seen fourteen cases of unexpected child deaths, whereby the Procedural Response to Unexpected Deaths in Childhood (PRUDiC) has been initiated. The process has been utilised to ensure effective information sharing and partnership working to support those families and professionals affected by the sad passing of these infants and children.

In response to sudden infant deaths, the health board's safeguarding midwife led on the revision of the regional safe sleep policy, developed a 7 minute briefing and video to support practitioners and families in reducing the risks of sudden infant death.

What Did We Learn?

From multi-agency audit and reviews, the following learning themes were identified and shared through communications and learning forums:

- The importance of effective multi-agency working and effective communication between professionals when there are concerns for suspicious or unexplained injuries in children.

- The importance of professional curiosity when working with children and families where there are safeguarding concerns.

- The importance of escalating concerns regarding inter-agency safeguarding practice. When children are identified as being at a continued risk of harm despite professional involvement.

- The importance of capturing the voice of the child and young person in safeguarding and utilising this to shape the health board's services.

Good Practice themes identified:

- Increased awareness and appropriate referral among frontline staff to recognise children who are suffering with poor mental health or at risk of self-harming behaviours.

- The emergency department safeguarding meetings have consistent attendance from both medical and nursing colleagues across CTMUHB three emergency departments. There is a commitment to delivering safe care and a consistent approach to managing safeguarding concerns.

- Lunch and learn session utilised by Clinical Nurse Specialists to share learning and themes from reviews.

Next Steps

Maintain effective safeguarding practice in Cwm Taf Morgannwg:

- To continue to embed learning from past and current child practice reviews, this will ensure that improvements in practice are sustained.

- Development of an audit plan that ensure quality improvement in all community and acute settings.

- Continue to work closely with frontline services and facilitate improved information sharing in a timely manner.

- The revision of the current bruising and injuries in immobile children will be reviewed and strengthened to ensure it guides all frontline practitioners in the management of concerns. In addition, in response to Child T's practice review, this policy will include guidance on the management of bruises and injuries in older, mobile children.

- Opportunities to capture the voice of children and their families who experience child protection processes will be gathered to further enhance services provided to them.

Child Sexual Exploitation (CSE)

Our Aim

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

How Will We Do This?

Prevent and protect children and young people from sexual exploitation;

- Provide responsive, appropriate and consistent support to those identified as being subject to or at risk of Child Sexual Exploitation
- Contribute to the identification, disruption and prosecution of perpetrators.
- Provide education and training to health professionals in a position to identify children at risk.

What Did We Do?

The lead for CSE within the Corporate Safeguarding Team has developed partnerships with other professionals and agencies. Attending regional multi-agency exploitation meetings.

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

- Undertaken an audit in respect of referrals assessed within the Multi-Agency Safeguarding Hub, to ensure appropriate action and support was provided from agencies in response to exploitation, child sexual abuse and harmful sexual behaviour.
- Contributed to Individual Risk Management plans within Multi-Agency CSE meetings.
- Participated in the planning and implementation of the multi-agency process for pooling intelligence in relation to perpetrators, and contextual safeguarding with view to enhancing the focus of criminal and safeguarding interventions.

- Through the Emergency Safeguarding Group established links to explore the use of the Child Sexual Exploitation Risk Questionnaire (CSERQ) assessment tool within all three general hospitals.

- Working with partners of the Cwm Taf Morgannwg Safeguarding Board to develop a regional exploitation strategy.

What Did We Learn?

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

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

- Exploitation is now seen more widely; it is no longer a forum for reviewing only sexual Exploitation. This facilitates wider networking and joined up working with statutory and third sector services to recognise and respond to all forms of exploitation.

Next Steps

- Further encourage the use of the CSERQ across all services in CTMUHB, to aid in identification and risk assessment for those at risk of CSE.

- Ensure consistent health representation at all CSE strategy meetings, to include representation from Child and Adolescent Mental Health Services (CAMHS) and Emergency Departments.

Looked after children

Our Aim

To ensure that Children Looked After have their physical, emotional and mental health needs met, through timely assessments, referral and access to health care services that they may need.
To ensure compliance with related legislation:

- Social Services & Well-being (Wales) Act 2014 – Part 6
- Toward a Stable Life and Brighter Future 2007 [statutory health assessments]
- The Care Planning, Placement and Case Review (Wales) Regulations 2015

How will we do this?

Undertake timely assessments and health planning for children within CTMUHB footprint

- Ensuring equal access to relevant universal and specialist health services and meeting statutory requirements for health provision.

- Supporting and participate in effective interagency CLA processes and practices in place to support health needs

- Robust quality assurance and information systems

What do we know?

The ONS latest figures indicate that November 2022 there were 7,080 children 0-18 years of age in Wales who were Looked after by Local Authority. CTMUHB had approximately 1446 children who were looked after during 22/23, covering three local authorities within its footprint, this number also includes children placed by other local authorities. Following a change in the law, every local authority will now have unaccompanied asylum-seeking children placed with them. This has resulted in CTMUHB providing a variety of additional services to support these young people.

The social services and well-being act (2014) places a statutory duty to provide health services for care experienced children this included completion of statutory Health Assessments. All assessments for children over 5 years of age are undertaken by the specialist nursing team, or are commissioned from the placing health authority. CTMUHB undertake all assessments for children and young people placed within CTMUHB, irrespective of local authority of origin.

Children and young people who have been exposed to adverse childhood experiences and trauma are at an increased risk of poor mental health. CTMUHB Looked after children's team and CAMHS are working collaboratively to develop a process that supports timely and seamless transition when children and young people are moving across different health boards.

What did we learn?

- The team continue to make every attempt to ensure health assessments are undertaken within statutory timescales. Where there are service pressures, the team prioritise those most vulnerable utilising a risk assessment. Ensuring their physical, emotional and mental health needs are met through services.

- Unaccompanied asylum-seeking children and young people require a coordinated health response as they may not have had access to health care for a long period of time. CTMUHB services are working together to ensure their provision of care is holistic and meets the needs of this cohort of young people.

- This year has seen an increase in the movement of placements for children and young people, this has been evidenced by the increased use of the notification

pathway. The notification pathway ensures effective information sharing between areas, ensuring that health needs are identified timely and seamless delivery of care.

Next Steps

- To consider the development of clinics to undertake review health assessments. This will ensure that any backlog is kept to a minimum and children/young people are seen within statutory time frames.
- To develop opportunities for children and young people to express their views and have their voice included in health decisions. This feedback will be utilised to develop the service.
- Develop a standard operating procedure jointly with CAMHS to reduce inequalities and provide a seamless transition when children/young people are moving between health boards.
- To collate meaningful data that can be shared with partners and analysed to identify themes and the needs of the children/young people.

Adult at Risk

Our Aim

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

To ensure that the UHB complies with the related legislation:
Social Services & Wellbeing (Wales) Act 2015 – Part 7

How Will We Do This?

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

What Did We Do?

- All Adult Safeguarding Reports are made to the Local Authority to decide if the threshold for enquiries is met.

- There have been 501 adult at risk referrals in 2022/2023. This is a significant increase on the previous year.

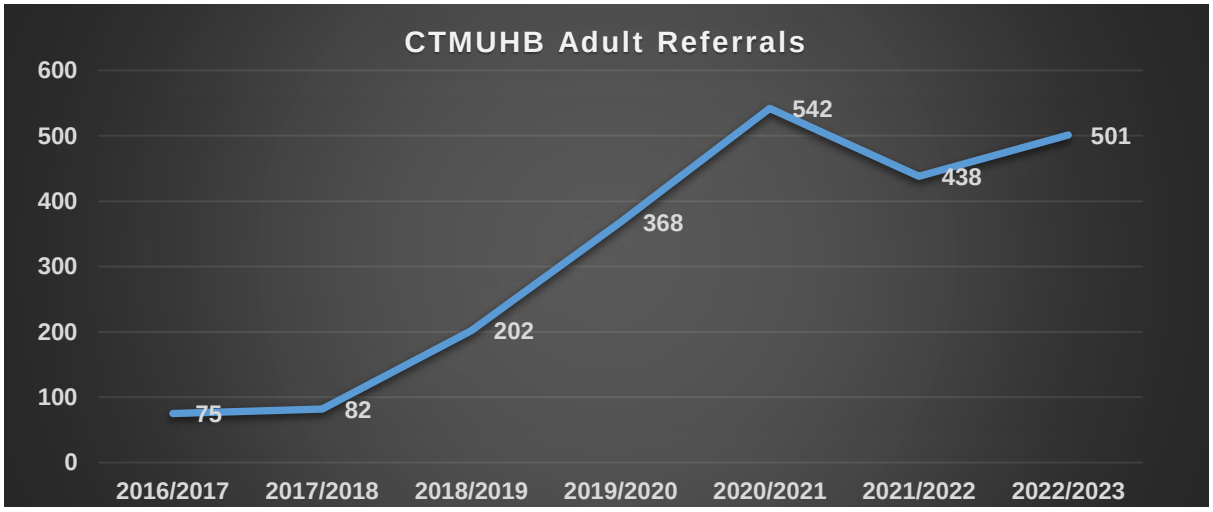
- The highest category of abuse reported continues to be Neglect. Pressure Damage being the highest percentage of all neglect safeguarding referrals. The second highest is for physical abuse.

Avoidable Pressure Damage

- There has been a reduction of Grade 3 or above referrals submitted. The quality of referrals has improved, now including action plans to overcome any issues, allowing the Local Authority to be able to threshold without any delays. This may be due to shared learning within training and discussion within scrutiny panels. The Royal Glamorgan Hospital have also appointed Pressure Ulcer champions for each ward, which appears to be working well.

- Tissue Viability Nurses (TVN) in Bridgend have devised a booklet around Pressure Damage for Agency staff in order that they are familiar with pressure ulcers management within CTM. This together with the ward workbooks that have been designed and distributed by TVN's for general use throughout CTMUHB for Registered Nurses and Health Care Support Workers, is welcomed.

Number of referrals received from CTMUHB



Cwm Taf Morgannwg Safeguarding Board published two Adult Practice Reviews during the year 22/23, these are available on the Cwm Taf Morgannwg Safeguarding Board website.

What Did We Learn?

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

- CTMUHB to review the arrangements in place for Mental Health Clinical Services to comply with the National Reportable Incidents process, to ensure that they are aware of Nationally and Locally reportable incidents and comply with the

agreed timescales.

- A review of the arrangements for offering individuals timely Independent Professional Advocacy.

- Agencies to review the arrangements for risk assessments for those with developing dementia to ensure there is an understanding of the potential harm and emerging risks.

- Evidenced based practice and intervention should always be adopted to ensure a consistent approach and provide the appropriate evidence to support step downs from care delivery. This approach will also support the individual and support to manage and minimise any areas of risk.

Next Steps

Maintain effective safeguarding practice in Cwm Taf Morgannwg:

- CTMUHB are key partners in the multi-agency suicide prevention group, learning from these groups needs to be disseminated across the health board. Work is ongoing to learn from 'near misses', this will enable services to work together to provide ongoing support to those identified at risk.

- To continue to drive improvements in the management of pressure damage across the health board, ensuring timely, effective referral pathways to Local Authorities in line with the Wales Safeguarding Procedures.

- The Self-neglect policy was implemented across all authorities in CTM, continued awareness of this forum needs to be raised within the health board.

Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)

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

Our Aim

Individuals who are victims of violence against women, domestic abuse and sexual violence are treated and supported in a way that optimises their potential and life chances.
To ensure the UHB complies with the related legislation:

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

How Will We Do This?

- Continue to develop and implement the Cwm Taf Morgannwg Violence Against Women Domestic Abuse Sexual Violence (VAWDASV) strategy with regional partners.

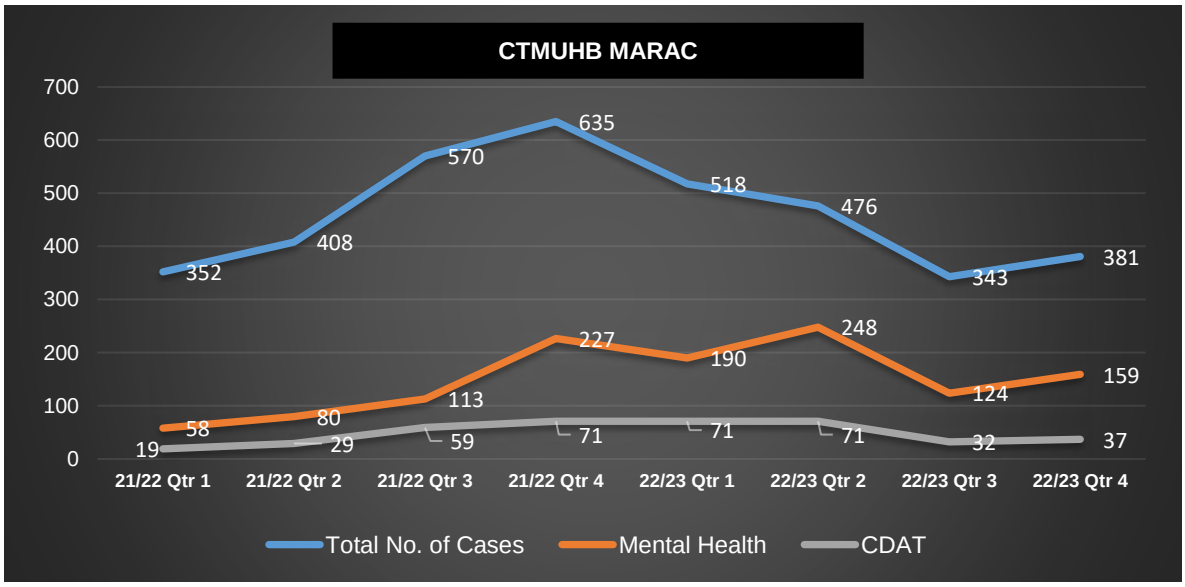
- Ensure compliance and reporting in line with the VAWDASV National Training Framework.

- Ensuring that there are effective interagency processes and practice in place throughout health services, to safeguard both women and men who experience domestic abuse.

What Did We Do?

- 1718 cases have been assessed at daily domestic abuse discussions held in the Multi Agency Safeguarding Hub as opposed to 1965 in 2021/2022. Through the implementation of the Multi Agency Risk Assessment Conference (MARAC) Coordinator role, CTMUHB ensures it has appropriate health representation at daily and MARAC discussions to enable effective information sharing and development of safety plans.

- Although the number of cases discussed at MARAC is lower for 22/23 than 21/22. There is an increase in those children linked to incidents discussed at MARAC. In addition, there is a significant increase in those victims and perpetrators open to mental health services. 721 adults identified with mental health issues as opposed to 478 in 2021/2022.



- In February 2022 a new Health Independent Domestic Violence Advisor (IDVA) was appointed, funded by the Police Commissioners office until April 2025. The appointment of this IDVA has enabled both staff and patients to access timely, appropriate advice and support. Ensuring the safety of those experiencing domestic abuse is prioritised, with victims having opportunities to access services to reduce risks on discharge.

- In March 2023 Mental Health services commenced attendance at MARAC for Rhondda Cynon Taf County Borough Council (RCTCBC). This ensures that CTMUHB are compliant with Safe Lives guidance and are able to respond appropriately to the increasing numbers of victims and perpetrators discussed at MARAC. The expertise of Mental Health practitioners will also facilitate a wider safety plan for victims of domestic abuse.

- Training packages have been reviewed and amended to include learning from practice reviews and domestic homicides.

What Did We Learn?

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

- There is an increase of 21.4% in those persons 60 years and older experiencing domestic abuse and being discussed at MARAC. With increasing numbers and the added health and social care concerns within this age group, there needs to be an increased awareness in those health practitioners working with them.

- This year saw an increase of 38.1% in health referrals, with the highest number being referred from A & E and the Health IDVA. This evidences the benefits of a health IDVA within the emergency departments, raising awareness and identifying those at risk of harm.

- Routine enquiry audits across Health Visiting and Midwifery services demonstrate evidence of the health board's compliance with the All Antenatal Domestic Abuse Pathway.

Next Steps

- Mental health representation at MARAC for all three regions within CTMUHB.

- Bespoke training will be delivered to mental health colleagues across CTMUHB services. This will ensure that themes from practice reviews are shared and influence an increased awareness in the safety planning of those affected by domestic abuse.

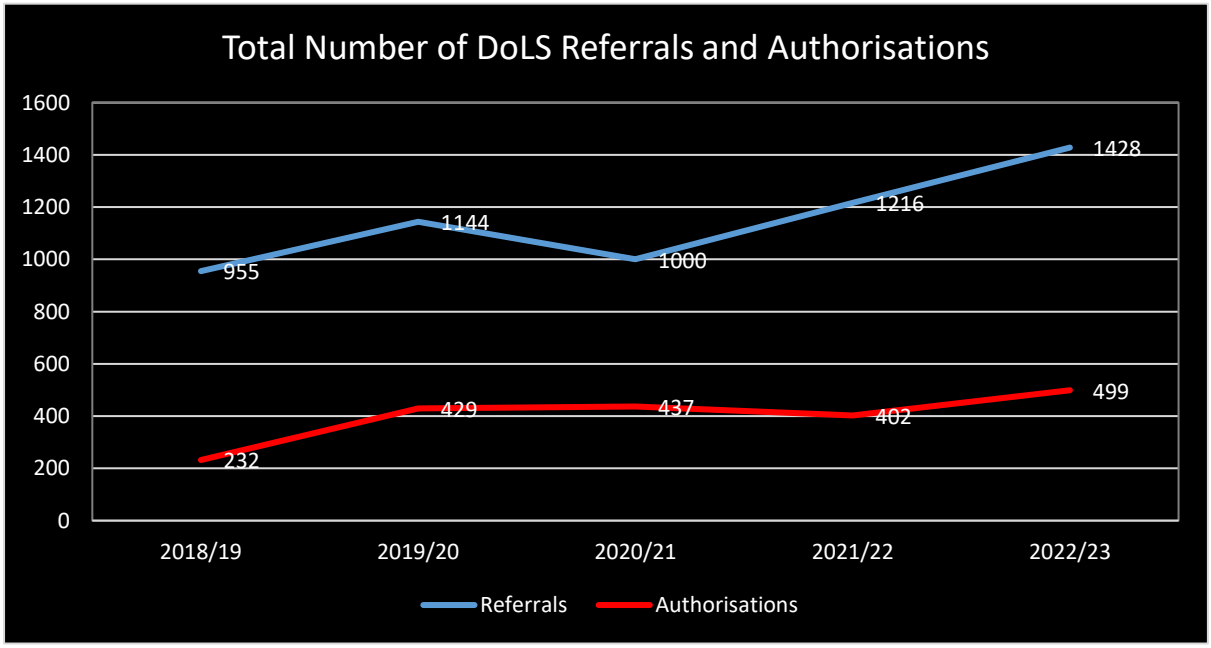
- CTMUHB will contribute to the ongoing commissioned Domestic Homicide Reviews. Incorporate the learning from practice reviews and Domestic homicides into future learning.

Deprivation of Liberty Safeguards (DoLS)

Our Aim

Ensure that the UHB follows the defined legislative processes and discharges the functions of the Supervisory Body and the Managing Authority.
To protect people who for their own safety and in their own best interests need care and treatment that may deprive them of their liberty but who lack the capacity to consent and where detention under the Mental Health Act 1983 is not appropriate at that time.

What Did We Do?



- 1428 DoLS Applications were made. An increase of 15% on the previous year.
- 499 DoLS authorisations were completed.
- CTMUHB has been represented in All Wales Liberty Protection Safeguards (LPS) Steering Group and LPS National Minimum Dataset Group. As well as the regional steering group for Cwm Taf which included Merthyr Tydfil, Bridgend and Cwm Taf County Borough Councils.
- Utilising Welsh Government funding the health board has appointed and trained additional Best Interest Assessors to reduce the backlog of authorisations.

What Did We Learn?

- 539 applications were withdrawn – linked to patients regaining capacity, detention under the Mental Health Act 1983, transfer to another Managing Authority, discharge of patients or sadly patient's death. This evidences how changeable the wait lists are for patients awaiting assessment.

- The waiting list this year has increased by 25%, this is reflective of the increased awareness and subsequent referrals. Performance management has allowed the team to identify themes, trends and barriers, assisting in the quality improvement of service delivery.

- The team has been working consistently to raise awareness and reduce the backlog in readiness for the implementation of the Liberty Protection Safeguards. However on the development of this report the government had announced their intention to step away from the introduction of the Liberty Protection Safeguards (the LPS) and the implementation of the Mental Capacity (Amendment) Act 2019 (the 2019 Act).

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

Next Steps

- To continue to reduce the DoLS waiting list, further funding will be utilised to commission an agency to clear the current backlog, allowing the health board to further explore what resource is required to provide a sustainable model that reduces the risk of further backlogs.

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

- In partnership with the Mental Capacity Act team, provide workshops to colleagues and improve the information provided on share point to assist wards with Mental Capacity Assessments, Court of Protection cases and how to manage their DoLS authorisations.

Mental Capacity Act

Our Aim

MCA: To ensure staff understand the implications of Mental Capacity Act 2005 and can implement it in their practice.
To ensure that the UHB complies with the related legislation:
Mental Capacity Act 2005 (amended in Mental Health Act 2007)

How will we do this?

By embedding the five key principles of the **Mental Capacity Act (MCA):**

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done or decision made, for on behalf of a person who lacks capacity must be done, or made in their best interests.
- Before a decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

What Did We Do?

- The implementation of a Mental Capacity Act team that will be available to all clinical areas throughout the hospitals, will assist in further embedding the MCA into everyday practice and support staff with complex MCA issues that arise on the ward.
- Participation in focus groups designed to improve and raise awareness of the importance of the Mental Capacity Act and its delivery to patients that are currently in hospital.
- Using Welsh Government funding a Mental Capacity Act Practice facilitator was employed to oversee MCA awareness and Liberty Protection safeguards (LPS) transition. Due to the delay in LPS implementation this role has focussed on

embedding the MCA into everyday clinical practice, through bespoke training and support in many speciality areas.

- Mental Capacity Act principles resources; including banner pens, posters and leaflets have been designed and distributed across all sites to raise awareness amongst staff and community sites.

What Did We Learn?

- CTMUHB employs in excess of 12,000 people. All levels of staff have been assessed and an appropriate level of competency assigned to each role for MCA training. Training has been combined with DoLS to ensure a comprehensive learning experience that demonstrates how the key principles should be applied to practice.

- Awareness raising needs to be delivered in a variety of forms to ensure all staff and patients have a clear understanding. Resources need to be provided to carers and colleagues to promote MCA.

Next Steps

- CTMUHB will continue to embed the Mental Capacity Act principles across services. This will be achieved through training, education and awareness raising.

- In collaboration with the training department staff will be allocated to groups dependent on their roles. These competencies will be allocated on ESR in three levels.

- MCA training compliance will be monitored through the safeguarding operational and executive groups.

Allegations Made Against Professionals

Our Aim

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

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

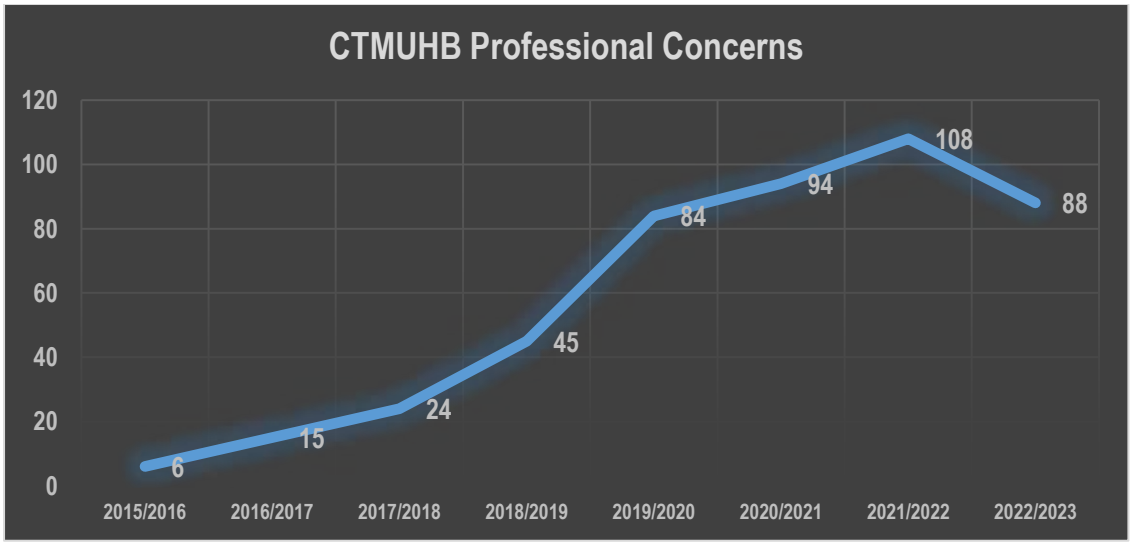
How Will We Do This?

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

What Did We Do?

There were 88 health board staff implicated in allegations of abuse or cause for concern about a person who works with children or adults at risk, this is compared to 108 in 2021/2022.

- 17 related to child protection concerns
- 31 related to adult protection concerns
- 33 were due to professional conduct concerns
- Training has been delivered to managers and workforce colleagues by the Disclosure Barring Service (DBS) to ensure the health board makes appropriate referrals when the criteria is met.



What did we learn?

- Many of the professional concerns raised have been in regard to both professional and personal conduct. There has been a decrease in referrals in 2022/23.
- Several professional concerns have also been in relation to incidents of domestic violence. There has been a national increase in cases of domestic violence, alcohol misuse and poor mental health since the COVID pandemic. Since many of our CTMUHB workforce also reside within the CTM footprint, it is not unreasonable to consider the impact of the community issues identified, including the increased cost of living and pressures presenting in line with this.

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

Next Steps

- All risk management documentation and guidance to be reviewed in line with the new Cwm Taf Morgannwg Safeguarding Board Professional Concerns Policy. A CTM standard Operating Procedure will be developed to streamline the process across the Health Board.

- The revision of the CTM Domestic Abuse Policy to ensure the process for supporting staff identified of experiencing domestic abuse, is consistent and robust within the workplace.

- Development and delivery of bespoke training to managers throughout the health board to ensure appropriate and consistent management of concerns for professionals.

Training & Learning

Our Aim

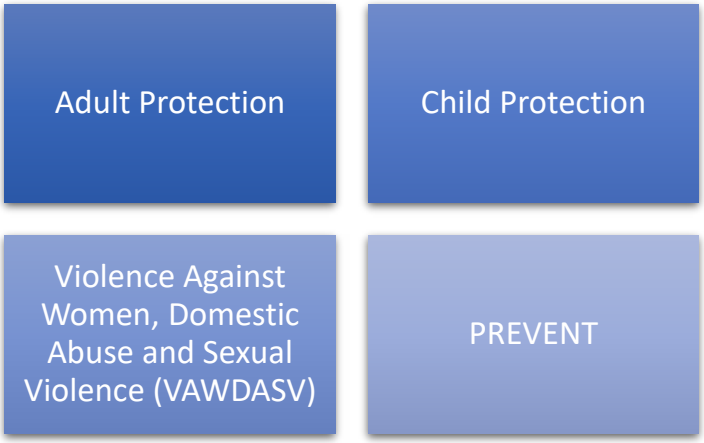
To ensure CTMUHB staff are sufficiently trained and competent to be alert to the potential indicators of abuse, including concerns about behaviour of staff, and know how to act and report on those concerns in order to fulfil statutory safeguarding duties under the Children Act 1989 & 2004, the Social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

How Will We Do This?

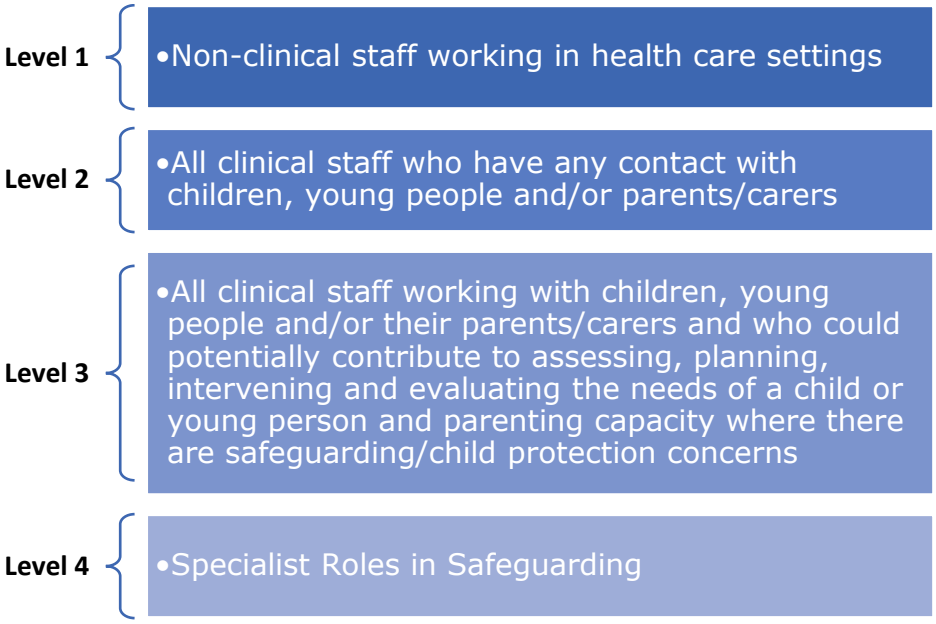
Safeguarding and Public Protection training is vital in protecting our service users, their families and our communities from harm. Safeguarding Children and Safeguarding Adult training is identified as two of the Mandatory training requirements in the NHS UK Core Skills Training Framework. All staff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

VAWDASV and PREVENT training are also statutory for all staff in Wales.

- There are four key dimensions of Safeguarding Training:



- The CTUHB Safeguarding Training Strategy has been updated in light of the new **National safeguarding training, learning and development standards.** It describes the level of training competency required for each role in relation to children or adults at risk & these have been assigned to each role on ESR. The strategy is in line with the Royal Colleges Intercollegiate Safeguarding Children Training Document and Adult Safeguarding Levels and Competencies for Health Care Professionals 2019. This strategy incorporates both medical and nursing staff competencies.



Violence Against Women, Domestic Abuse and Sexual Violence

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

- The Group 2 Ask and Act package is regularly reviewed to ensure it reflects identified learning from practice reviews and domestic homicides. The Group 2 Ask and Act has been revised in an all Wales group for use across Wales health boards. This training is delivered monthly, with additional bespoke sessions provided to areas such as emergency departments and mental health.

What Did We Do?

- Training continues to be delivered by virtual means to enable health board staff to have an ease of accessibility. In addition, bespoke training has been delivered to several services groups, particularly those working with children. This has included emergency departments, CAMHS, acute and community children's teams, General Practitioners and students.

- Monthly training sessions were delivered in partnership with tissue viability nurses to raise awareness of the safeguarding implications and management of avoidable pressure damage.

- Learning events have been delivered across health visiting and midwifery to share learning from child practice reviews, leading to improvements in processes and practice.

- The learning from Child T's practice review, a young 5 year old who died in July 2021 has been shared through a multitude of forums, to both nursing and medical staff. Particular emphasis has been given to the recognition of suspicious physical injuries, professional curiosity and the importance of multi-agency decision making.

- 7 minutes briefings have been shared through the health board's intranet, listening and learning forums, operational groups and care group meetings in respect of safeguarding learning and practice.

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

What Did We Learn?

- From available data reviewed Children and Adult at risk safeguarding compliance is increasing slowly. Safeguarding training compliance was significantly impacted by the pressures of the COVID pandemic and subsequent training priorities associated with infection control and re-deployments.

- Compliance for medical colleagues accessing level 3 training outside of the health board is not currently reflected on the health board's ESR.

- Level 3 training compliance is much lower than national requirements. The challenge for the next year is to achieve above 85% compliance.

- Safeguarding Children & Adult training continues to be well evaluated. However, many groups have expressed their prefernec for besoke training specific to their area of work.

Next Steps

- All clinical nurse specialists for safeguarding will be delivering level 3 training to become confident and competent in delivering training across children and young people services. This will widen the availability of trainers for level 3 safeguarding.

- To continue to target key areas who work with children, parents and carers, this will ensure colleagues are trained to contribute to the assessing, planning, intervening and evaluation of the needs of the child or young person and parents capacity.

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

- In order to firmly embed a safeguarding culture and practice within the organisation it is imperative that alternative methods of raising awareness and learning are utilised appropriately, therefore webinars and short videos will be developed to enhance learning.

- Monitoring the uptake of safeguarding training of CTMUHB staff and targeting areas of low engagement and departments making high numbers of safeguarding referrals.

- Improved monitoring of training compliance for Doctors and Registrars. ESR is not currently used by Doctors, resulting in difficulties in identifying those that require updates.

Multi-Agency Safeguarding HUB (MASH)

Our Aim

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

How Will We Do This?

- MASH facilitates safeguarding by working together, in one place, sharing information and making collaborative decisions. Through MASH, a more timely

and proportionate approach to the identification, assessment and management of safeguarding, child and adult protection enquiries can be achieved.

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

- COVID required changes in practice, with partner agencies moving to home working through periods of lockdown and in line with Government guidance. The MASH within Cwm Taf region continues to be facilitated on a virtual platform.

What Did We Do?

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

- Following the rapid review report and due to Cwm Taf MASH continuing with a virtual approach, all public protection nurse were co-located at Bridgend MASH. This enabled them to support new social work teams and develop good working relationships. Whilst ensuring a consistent response to health referrals across the three local authorities.

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

- Through the MASH operational group, health have participated in joint audits, task and finish groups to identify areas of good practice and learning.

What Did We Learn?

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

- Following the Bridgend Rapid Review and subsequent audits, work has commenced to improve information sharing within the Bridgend MASH. Several information sharing platforms are being explored with partners for implementation across both MASH.

- Co-location has facilitated improved working relationships within the Bridgend region, with timely communication and information sharing with partners.

- The significant increase in safeguarding activity has resulted in an increase in strategy meetings. Sharing information is a key priority for all partners based in

MASH. To meet the demand the public protection nurse have invited key health professionals working with the child to strategy meetings. This has ensured that health have been part of multi-agency decision making.

Next Steps

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

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

- To participate in forums to improve the quality of child protection referral forms submitted by health to MASH.

Radicalisation and PREVENT

PREVENT
Terrorism Strategy

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

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

The challenge is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly, and is aware of and can locate available support through their organisation.

What Did We Do?

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

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

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

What did we learn?

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

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

Next Steps

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

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

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

Offender Management

Our Aim

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

To ensure the UHB complies with the related legislation:

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

How Will We Do This?

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

systems.

Participate in MAPPA meetings and implement health actions.

Participate in the work of the relevant regional partnerships:

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

Next Steps

Maintain effective inter-agency offender management practice in Cwm Taf Morgannwg, ensuring appropriate representation from CTMUHB at all level 2 and 3 MAPPA meetings.

Cwm Taf Morgannwg Safeguarding Board

Our Aim

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

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

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

How Will We Do This?

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

- There are effective measures in place to protect children and adults at risk who are experiencing harm or who may be at risk as the result of abuse, neglect or other kinds of harm.

- There is effective inter-agency co-operation in planning and delivering protection services and in sharing information.

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

What Did We Do?

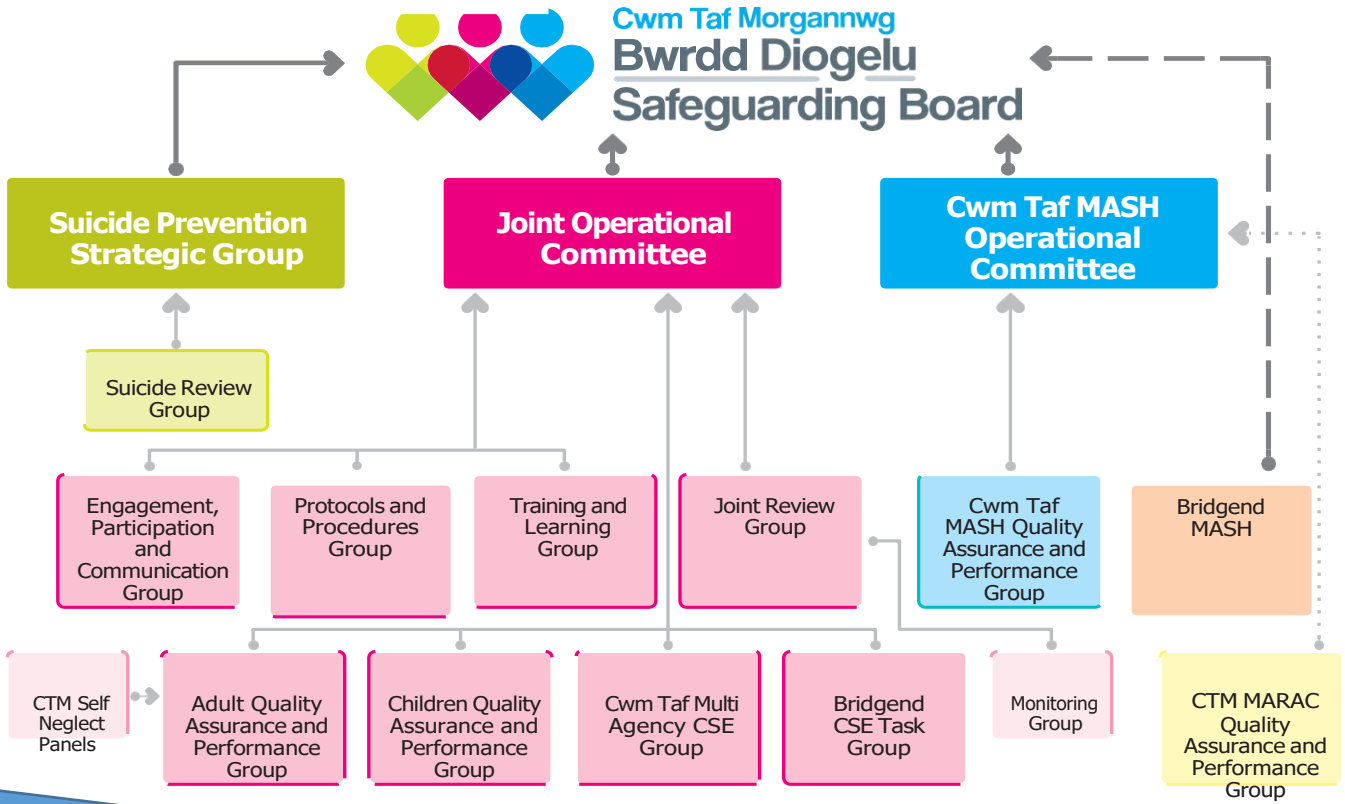
- The UHB is represented on the Safeguarding Board by the Deputy Director of Nursing and the Head of Safeguarding.

- Individuals from the Corporate Safeguarding Team represent the UHB on the committees and subcommittees that implement the functions of the Safeguarding Board.

- The collaborative work undertaken between Health, partner agencies and the Regional Safeguarding Board is documented in the Cwm Taf Morgannwg Safeguarding Board Annual Report.

- The UHB makes a financial contribution to supporting the effective working of the Board as required in the statutory regulations.

The Board has published its Annual Plan for 2022/23. These priorities were agreed by all Board partner agencies at a Board Development Day earlier in 2022. The Annual Plan can be accessed at;
www.cwmtafmorgannwgsafeguardingboard.com



ACTION LOG QUALITY & SAFETY COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at November 2023)
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	January 2024	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
2.1	24 January 2023	**Listening & Learning Story** Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Director of Nursing	January 2024	**In progress** Date to be agreed. Being considered alongside other Listening & Learning stories that need to be scheduled into the programme.

2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Data to be shared with Members outside the meeting in relation to ambulance handovers to include the data for each individual hospital for the numbers for requested for immediate release and number agreed.	Care Group Nurse Director – Unscheduled Care	24 May 2023 Now 25 July 2023	**In Progress** The report currently received in relation to ambulance handovers is for the whole of CTM. The Team have started to interrogate this data and will have to start manually recording at each front door. The Unscheduled Care Senior Management Team are also working collaboratively with WAST to ensure transparent and robust processes are in place. Once this is completed the data will be shared and presented to the Quality & Safety Committee. **Status as at 21 November 2023 - Awaiting a revised action log update from the Chief Operating Officer**
5.2d	25 July 2023	**Mental Health & Learning Disabilities Care Group Highlight report** Update to be provided to the next meeting in relation to the outcome of the Demand & Capacity exercise undertaken by the	Executive Director of Nursing	21 September 2023 Now 21 November 2023	**In progress** Demand and capacity assessment is near completion. Alongside the review, the resuscitation training and clinical education team are creating an immediate training

		Resuscitation Team in relation to CPR training compliance			strategy for basic adult life support training across the care groups which is due for completion by 15th November 2023. The Deputy Executive Director of Nursing will review and move to approve the plan and engage with Care Group Nurse Directors regarding plans for implementation and on-going surveillance.
6.1	25 July 2023	**Quality Dashboard** Response to be provided outside the meeting as to what percentage of incidents classed as catastrophic or death was directly attributed to the Health Board and what percentage was not directly attributed	Assistant Director of Quality & Safety	21 September 2023 **Now 14 March 2024**	**In progress** A verbal update was provided to Members at the meeting held on 21 September. Members noted that due to issues with the system it would not be easy to run a report off the system in relation to this data at present. Members noted that it was hoped that issues would be resolved in January 2024 and a report could be provided in March 2024.
8.3	25 July 2023	**Mortality Assurance Report**	Medical Director	21 November 2023	**In progress** Further report to be presented to the Committee at its meeting on 21

		Further update on progress to be presented to the Committee in three months		**Now 23 January 2024**	November 2023. **This has now been deferred to January 2024**
2.2	21 September 2023	**Care Group Spotlight Presentation – Planned Care – Focus on Ophthalmology Backlog** Report to be prepared for a future meeting of the Board highlighting the positive steps that had been taken to address the backlog within Ophthalmology	Chief Operating Officer	Date to be confirmed	**In progress** To be scheduled into the Forward Work Programme for Board
5.1	21 September 2023	**Report from the Chief Operating Officer** Consideration to be given as to how progress being made against Stroke Actions were being presented to the Committee	Executive Director of Therapies & Health Sciences	21 November 2023	**In progress** Review of the action plan is in the process of being undertaken and a copy of the action plan will be presented to Committee Members at the November 2023 meeting. An update on progress against the stroke action plan will also be included in the Unscheduled Care Group Highlight report when there isn't a specific update on Stroke on the Quality & Safety Committee agenda.
5.1	21 September 2023	**Report from the Chief Operating Officer**	Medical Director	21 November 2023	**In progress** This was originally scheduled for the 21

		Report on Sepsis to be presented to the next meeting of the Committee		**Now 23 January 2024**	November meeting. This has now been deferred to the meeting taking place on 23 January 2024
5.2	21 September 2023	**Unscheduled Care Group Spotlight Report** Spotlight report on Frailty to be presented to a future meeting of the Committee	Unscheduled Care Group Nurse Director	21 November 2023	**In progress** Spotlight report on agenda
6.2	21 September 2023	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Update to be provided against Risk 4217 at the next meeting to explain why reporting frequency would have reduced the risk score	Assistant Director of Governance & Risk	21 November 2023	**In progress** Update requested from the risk owner and once response is received this will be shared with committee members.
6.4	21 September 2023	**Learning From Events Reports** Further update on progress to be presented to the January meeting of the Committee as an appendix to the Quality Dashboard report.	Assistant Director of Concerns and Claims	23 January 2024	**In progress** Will be presented the 23 January 2023 meeting
6.5	21 September 2023	**CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unity Interim Learning Report** Outcome of the Demand & Capacity work to be	Head of Covid19 Nosocomial Investigation Team	TBC (post April 2024)	**In progress** To be scheduled into the forward work programme once date agreed

		presented to a future meeting of the Committee			
6.6	21 September 2023	**Quality & Safety Committee Annual Self Effectiveness Survey** One in person meeting to be held in 2024 to determine its effectiveness.	Head of Corporate Governance & Board Business	To be confirmed – likely to be July 2024	**In progress** Corporate Governance Team are in the process of sourcing a suitable venue
7.1	21 September 2023	**Quality Dashboard Report** Narrative to be included in the next iteration of the report in relation to what areas benchmarking could be undertaken in	Assistant Director of Quality & Safety	21 November 2023	**Completed** Update included in the November iteration of the Quality Dashboard report.
9.2.1	21 September 2023	**Action Log** Review to be undertaken in relation to discussions being held in regards to the Medical Staff Rate Card to determine which Committee remit this matter falls under.	Director of Corporate Governance/Board Secretary	21 November 2023	**In progress** It has been agreed that this would fall under the remit of the People & Culture Committee.

PREVIOUSLY REPORTED Completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at November 2023)
6.1	25 July 2023	**Quality Dashboard** Public Services Ombudsman for Wales Report in relation to care and treatment in relation to a missed appendicitis to be shared with Members at the September meeting	Assistant Director of Quality & Safety	21 September 2023	**Completed** Verbal update provided by the Assistant Director of Quality & Safety Committee at the meeting held on 21 September 2023. Members noted that this had now progressed to a Claim and in this respect had been closed down by the Ombudsman
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Medical Director to ensure interim timelines were put into place for the Task & Finish Groups referred to in relation to Risk 4080.	Medical Director	January 2023 Was August 2023 Now September 2023	**Completed** Risk 4080 no longer refers to Task and finish groups and the narrative has been updated in the risk to reflect the action from November 2022. The Medical Rate Card for Non-Consultant Staff was approved at the Executive Leadership Group and is now active.
10.1	21 September 2023	**Highlight Report to Board** Committee Highlight report to reflect that Quality	Head of Corporate Governance & Board Business	30 November 2023	**Completed** This has been included in the escalation section for

		Governance had also been de-escalated in addition to Maternity & Neonates.			the Committee Highlight report being presented to November Board as a positive escalation.
6.2	21 September 2023	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Future reports to include an explanation as to why the risk scores had been reduced	Assistant Director of Governance & Risk	21 November 2023	**Complete** Assistant Director of Governance & Risk highlighting through training and communication with Care Groups and Directorates. Datix Risk Module now includes a specific section to capture the rationale if a change to risk score is made. This will be an ongoing improvement action.
6.1	16 March 2023	**Maternity Services & Neonates Improvement Programme** Review to be undertaken of the metrics included within the report to ensure they aligned with data contained within other reports, for example, the number of concerns and incidents being reported.	Director of Midwifery	24 May 2023 Now 21 September 2023	**Complete** Team are continuing to review the quality of information through the Patient Safety Meetings.

Agenda Item
9.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	

1. Situation /Background

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

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

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

2. Specific Matters for Consideration

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

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd	Safe

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

6. Next Steps

6.1 There are no next steps required.

Quality & Safety Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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

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

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

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

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

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Action Log	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Committee Annual Report	Director of Corporate Governance	Annually					⚑							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually	⚑											
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually					⚑ Deferred to July 2023		⚑ Deferred to Sept 2023		⚑			
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	⚑		⚑ Deferred to May. Report will not be approved until 15/03/23		⚑		⚑		⚑			
WHSSC Quality & Patient Safety Committee Annual Report	Director of Corporate Governance	Annually							⚑					
Putting Things Right Annual Report	Director of Corporate Governance	Annually							⚑					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually	⚑										⚑	
Health & Care Standards Annual Report To be removed from the cycle of business as no longer applicable	Director of Nursing	Annually											⚑	

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Welsh Ambulance Services NHS Trust Patient Experience Report Update has been included in the Unscheduled Care Group Highlight Report for July 2023	Director of Nursing	Quarterly	⚑				⚑ Deferred to July 2023		⚑				⚑	
Infection, Prevention & Control Committee Exception Reports	Director of Nursing	As and when required												
Infection, Prevention & Control Report (Annual Report and Mid-Year Update)	Director of Nursing	Bi-Annually					⚑ End of year update				⚑ Annual Report		⚑ Mid Year update	
Quality Governance – Regulatory Review Recommendations and Progress Updates (to include Healthcare Inspectorate Wales, Delivery Unit, Community Health Council) This report has now been superceded by the Healthcare Inspectorate Wales Action Plan Tracker report	Director of Nursing	All regular meetings when needed	⚑		⚑		⚑		⚑		⚑			
Healthcare Inspectorate Wales Action Plan Tracker	Director of Nursing	All regular meetings (from May 2023 onwards)					⚑		⚑		⚑		⚑	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					⚑ Will be discussed at In Committe e QSC 31/5							
Cancer Services Annual Report	Medical Director	Annually					⚑							
Prescribing Annual Report	Medical Director	Annually											⚑	
RADAR Committee Highlight Reports (Annual Report and Mid-Year Update) – to include updates on Sepsis Compliance – Quality Improvement	Medical Director	Bi-Annually			⚑ Deferred to May 2023		⚑						⚑	
Clinical Audit Quarterly Report	Medical Director	Quarterly			⚑				⚑				⚑	
Clinical Audit Annual Plan	Medical Director	Annually			⚑									
Clinical Education Annual Report	Director of Nursing	Annually											⚑	
Individual Patient Funding Request Annual Report	New Chair being appointed	Annually							⚑ Deferred to Sept		⚑			
Health, Safety & Fire Sub Committee Highlight Reports	Director for People	Quarterly			⚑				⚑				⚑	
Radiation Safety Committee Annual and Mid Year Updates	Director of Therapies & Health Sciences	Bi-Annually			⚑ Deferred to May		⚑ Deferred to July		⚑				⚑	
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			⚑ Deferred to May		⚑ Deferred to July		⚑				⚑	
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	⚑						⚑					
Ombudsman's Annual Letter and Annual Report	Director of Nursing	Annually									⚑			

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					⚑						⚑	
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually							⚑					
GOVERNANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
IMPROVING CARE														
Maternity & Neonates Services Improvement Programme Agreed at the September 2023 Quality & Safety Committee that progress in relation to Maternity & Neonates would now be reported via the Children & Families Care Group Highlight report from November onwards given recent de-escalation	Director of Nursing/Medical Director	All regular meetings	⚑		⚑		⚑		⚑		⚑			
Quality Dashboard to include: • Delivery Unit Performance Dashboards; • Care Group Quality & Safety Highlight Reports; • Updates from the Shared Listening & Learning Forum	Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Care Group Spotlights Presentations	Director of Nursing/Chief Operating Officer	All regular meetings *(2x Care Groups per meeting)*	⚑		⚑		⚑		⚑		⚑		⚑	
Thematic Spotlight Presentations	Director of Nursing/Chief Operating Officer	All regular meetings as required	⚑		⚑		⚑		⚑		⚑		⚑	
Report from the Chief Operating Officer *(to include Planned Care Improvement Programme Progress Report (to include Follow Up Outpatients Not Booked and Harm Reviews)* Agreed at the Agenda Planning meeting for the November meeting that this report would now be titled the Report from the Clinical Executives	Chief Operating Officer Executive Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Stroke Services Progress Report	Director of Therapies & Health Sciences	Bi-Annually Now Quarterly			⚑				⚑				⚑	
Mortality Indicators and Mortality Reviews	Director of Public Health/Medical Director	Bi-Annually			⚑								⚑ Defer to Jan 24	
Ty Llidiard Progress Reports Agreed at the September 2023 Quality & Safety Committee that progress in relation to Ty Llidiard would now be included in the Mental	Director of Therapies & Health Sciences	All regular meetings	⚑		⚑		⚑		⚑		⚑			

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Health & Learning Disabilities Care Group Highlight report from November onwards given recent de-escalation														
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually							Defer to Sept 2023					
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Director of Nursing	Annually												
Mental Health In-Patient Improvement Progress Reports Agreed following discussion at the In Committee Quality & Safety Committee that this matter would need to be reported to all regular meetings from May onwards.	Director of Nursing	All regular meetings												

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email Request from the Patient Care & Safety Team	Additional Item	Concerns Policy	Director of Nursing	Planned for May 2023 – Deferred to 25 July 2023. Deferred to 21 September 2023. **Now deferred to 23 January 2024**
Request made by the Chair and Vice Chair at the agenda planning session for the July Board	Additional Item	Mortality Report	Medical Director	Report presented to the meeting held on 25 July 2023. Further report to be presented to the 21 November 2023 meeting. **Now deferred to 23 January 2024**
Request made by the Quality & Safety Committee Chair	Additional Item	Annual Quality Work Plan	Director of Nursing	Discussion held at agenda planning. Noted that an Annual Quality Report would need to be produced as opposed to an Annual Quality Work Plan. Date for presentation of the Annual Quality work plan to be confirmed
Action agreed at the July meeting of the Quality & Safety Committee	Additional Item	Update on Liberty Protection Safeguards	Director of Nursing	Planned for 21 November 2023 – **Now deferred to 23 January 2024 as agreed with the Executive Director of Nursing. A report on Mental Capacity work will now be presented to the November meeting instead**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Identified as an agenda item at the Hosted Bodies Audit & Risk Committee held on 16 August 2023	Additional Item	EASC Quality & Safety Composite Report	Chief Ambulance Services Commissioner	Was planned for 21 November 2023 – **Now 23 January 2024**
Request received from the Head of Nosocomial Investigation Team	Additional Item	CTMUHB Nosocomial Covid 19 Incident Management Programme - Delivery Unit (NHS Executive) Interim Learning Report	Executive Director of Nursing	**In progress** Report received at the meeting held on 21 September 2023. Further update on progress to be presented to the Committee in **May 2024.**
Email request received from the Medical Director Business Manager	Additional Item	Organ Donation Committee Annual Report	Medical Director	Planned for 21 November 2023 – **On agenda**
Email Request received from the Senior Nurse Community Children's Nursing Services	Additional Item	Was Not Brought Policy – For Approval	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request received from the Head of Safeguarding	Additional Item	Deprivation of Liberty Protection Safeguards Policy	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**
Email Request from the Lead Infection Prevention & Control Nurse	Additional Item	Measles Policy	Director of Nursing	Planned for 21 November 2023 – **On agenda**
Email Request from the Lead Infection Prevention & Control Nurse	Additional Item	Meningitis Policy	Director of Nursing	Planned for 21 November 2023 – **On agenda**
Additional report received from the Director of Midwifery	Additional Item	Cwm Taf Morgannwg Maternity Metrics - An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022	Director of Nursing	**On agenda**
Item agreed at agenda planning session	Additional Item	Spotlight Presentation on Sepsis	Medical Director	Was planned for 21 November 2023 **– Now 23 January 2024**
Item agreed at agenda planning session	Additional Item	Spotlight Presentation on Frailty	Medical Director	Planned for 21 November 2023 – **On agenda**

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Learning From Events Backlog – Progress Report	Assistant Director of Concerns & Claims	**Completed** Report received at the meeting held on 21 September 2023 where Members received assurance that positive progress was being made to address the position. A further report on progress will be presented to the January 2024 meeting as an appendix to the Quality Dashboard report.
Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report	Executive Medical Director	**Completed** Report received at the meeting held on 21 September 2023.
Assistant Director of Governance & Risk advised of this email verbally	Additional Item	Clinical Policies Approval Process	Medical Director	**Completed** Report received an approved at the meeting held on 21 September 2023
Email request received from the Director of Midwifery	Additional Item	MBRRACE response to the 2021 Perinatal Mortality	Director of Nursing	**Completed** Report received and discussed at the In Committee meeting held on 21 September 2023
Email Request received from the Chief	Additional Item	Ombudsman Wales Report – Groundhog Day 2: An Opportunity for Cultural Change in Complaint Handling	Director of Nursing	**Completed** Report received and noted at the meeting held on 21 September 2023

Executive requesting this item be added to the agenda				
Highlighted within the Diagnostics, Therapies, Pharmacy and Specialties Highlight Report that this policy would be coming forward for approval	Additional Item	Medicines Policy (for approval)	Chief Pharmacist	**Completed** Policy received and approved at the meeting held on 21 September 2023
Request made by the Quality & Safety Committee Chair	Additional Item	Progress on phase 2 of the implementation of the Care Group Model	Chief Operating Officer	**Completed** Update included in the Chief Operating Officers report at the meeting held on 21 September. COO provided a verbal update on progress also.
Email request received from the Patient Care & Safety Business Manager	Additional Item	Safeguarding Policy – For approval	Director of Nursing	**Completed** Policy received and approved at the meeting held on 21 September 2023.
Email Request received from the Head of Concerns and Business Intelligence	Additional Item	Internal Audit Review – National Incident Framework	Director of Nursing	**Completed** Report received and noted at the meeting held on 21 September 2023
Request received from the Medical Director to add	Additional Item	Irradiated Blood Alerts	Director of Digital	**Completed** Report received and noted at the meeting held on 21 September 2023

this to the agenda				
Identified as an item for discussion at the Executive Leadership Group held on 21 August 2023	Additional Item	Raising Concerns Process	Medical Director	**Completed** Report received at the meeting held on 21 September 2023. Members requested a further update during the Autumn. It was agreed at agenda planning held on 11 October 2023 that this can be removed from the agenda given that the full Board will be provided with an update on Speaking Up Safely at the Board Development session being held on 19 October 2023.
Email request from the Assistant Director of Governance & Risk	Additional Item	Quality Governance Arrangements Joint Review Follow-up	Director of Nursing	**Completed** Agreed at the agenda planning session held on 11 October 2023 that this item can be removed from the agenda given that de-escalation has been reported to the Committee and the report has been received by the full Board at its meeting held on 28 September 2023. Progress against outstanding recommendations will be monitored at the Audit & Risk Committee via the Audit Tracker.
Request made by the Chair at the In Committee session of the Quality & Safety Committee held on 31 May 2023	Additional Item	External Review of Practice into Care of a Patient by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council – Action Plan Progress Update	Director of Nursing	**Completed and Ongoing** Agreed at the agenda planning session that updates on progress will be included in the Mental Health & Learning Disabilities Care Group report moving forwards.
Email request from the Medical Directors Office	Additional Item	Introducing the Use of NHS Numbers for Patients Accessing Sexual Health Services	Medical Director	**Completed** Was planned for 21 November 2023. Agreed at agenda planning that given this item was discussed at Digital & Data

Business Manager				Committee and Members were assured that action was being taken it was felt that further scrutiny did not need to be undertaken at Quality & Safety Committee.

Agenda Item
9.2.4

Quality & Safety Committee

Infection, Prevention & Control (IPC) Report – Mid Year Position

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Bethan Cradle, Lead IPC Nurse
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Infection Prevention and Control Committee	17/10/2023	Approved

Acronyms / Glossary of Terms	
CTM	Cwm Taf Morgannwg
IPC	Infection prevention and control
AMR and HCAI	Antimicrobial resistance and healthcare associated infections
JAG	Joint advisory committee

1. Situation /Background

The IPC report was prepared and presented to IPC Committee in October 2023. It describes the HBs mid-year position against the Welsh Government AMR and HCAI Improvement Goals for 2023-24, provides compliance data for IPC training, demonstrates progress against the IPC audit programme and provides an update on the decontamination agenda.

2. Specific Matters for Consideration

2.1 Six months into the year, CTM is not on trajectory to meet the reduction expectations for reducing HCAI.

2.2 Further work needed to support the Women and Children's Care Group to improve mandatory surveillance and reporting of C.section surgical site infections.

2.3 A delay in progress of the centralised decontamination unit at the Princess of Wales hospital could affect endoscopy decontamination across various departments leading to service disruption.

2.4 There has been a delay in planned IPC improvement work due to long term sickness absence within the team.

3. Key Risks / Matters for Escalation

3.1 An increase in the number of MRSA, E.coli and Klebsiella bacteraemia has been reported April – October 2023 compared to the same period last year.

3.2 A significant proportion of the blood stream infections are defined as community acquired infections.

3.3 A strategic review of the IPC team is underway to enable the team to provide a comprehensive integrated service for primary, community and secondary care services.

3.4 The IPC team continues to support the Health Boards response to managing patients with acute respiratory infection (including COVID). The IPC advice to close wards to admissions is regularly overruled due to operational pressures.

3.5 Legionella continues to be detected in the water in some areas of the HB despite remedial works. Mitigating actions are in place to reduce the risks to patients.

3.6 The lack of progress with the centralised decontamination unit at the Princess of Wales Hospital will affect JAG accreditation in Endoscopy if significant delays continue.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /	Living Well
	If more than one applies please list below:

Link to CTMUHB Strategic Areas	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Not Applicable
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this report
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this report
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 To accept and note the report.

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

Health and Care Standards
Measurement for Improvement

Infection Prevention & Control Committee

IPC Report




October 2023

Approved by:	Infection Prevention and Control Committee	**Date Approved**	
Report Title:	IPC Report		

Key Executive Summary Statement(s) (key *statement from the Approving Group / Board / Committee / Responsible Lead*)

- Improving infection prevention and control practice **must** be everyone's responsibility and ownership from ward to board is critical to improve patient safety.
- There is a strategic review planned to determine the direction of IPC across the CTM footprint. The aim is for the IPC team to provide an integrated service across primary, community and secondary care services. More emphasis must be placed on making improvements in primary care to improve patient care and safety and influence a reduction in C. Difficile infection, S. aureus and gram-negative bacteraemia. The HB will not achieve the healthcare associated improvement goals without investment in primary care.
- Medical engagement is critical to strengthen the RCA process in secondary and primary care for C. Difficile and preventable infections.
- Support needed to re-establish the IV steering group to improve and standardise management of IV devices across CTM
- Executive steer required on service provision across CTM in order to understand where services will be provided. This will inform the business case to progress with the central decontamination scheme in POW and placement of negative pressure isolation rooms across CTM.
- Clinical engagement required from multi disciplinary colleagues to improve compliance with IPC practices to enhance patient care and safety.

Standard 2.4 Infection Prevention and Control (IPC) and Decontamination

Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice based on the best available evidence so that people are protected from preventable healthcare associated infections.

Number and rate of *C. difficile, S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population, April 2023 – September 2023.

Table: IPC01

	Rate of C. difficile/ 100,000 population		Rate of MRSA bacteraemia / 100,000 population		Rate of MSSA bacteraemia / 100,000 population		Rate of E. coli bacteraemia/ 100,000 population		Rate of Klebsiella sp. bacteraemia/ 100,000 population		Rate of Pseudo aer bacteraemia/ 100,000 population	
	No. of Cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate	No. of cases	Rate
Cwm Taf Morgannwg	62	27.57	5	2.22	71	31.57	207	92.03	54	24.01	8	3.56
All Wales	563	35.53	29	1.83	400	25.24	1190	75.09	356	22.46	82	5.17

Data taken from HCAI mandatory surveillance summary, HARP. April – September 2023.

Lower than the same period of previous FY

Higher than the same period of previous FY

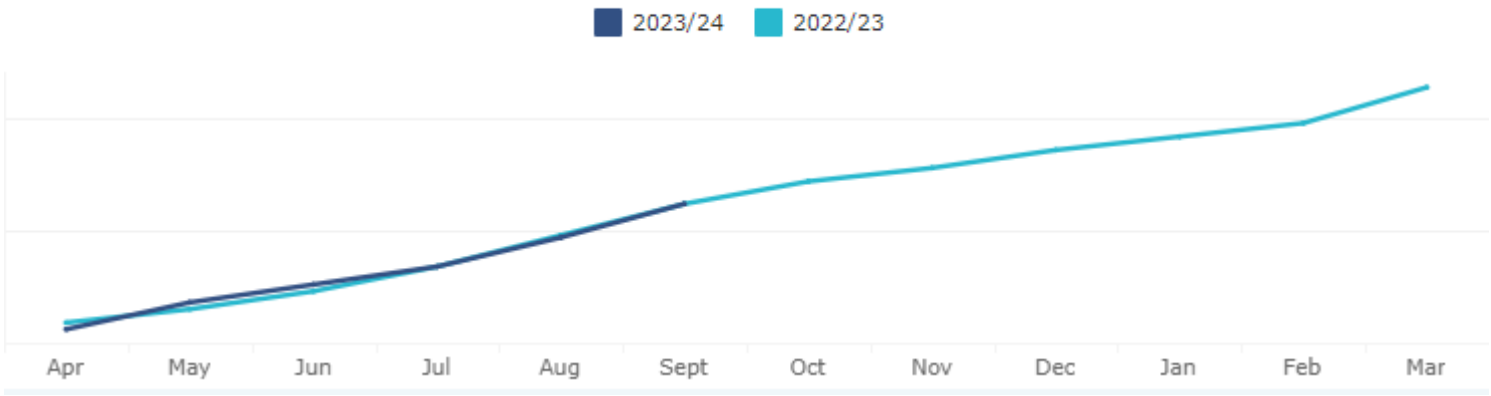
Same as the same period of previous FY

*** The numbers/rates included in the table above have been taken from the HARP database. There are some anomalies compared to the local numbers included in the narrative below due to different cut off dates for collecting information.**

Local reduction expectations have not been calculated based on the new care group model.

Clostridium difficile

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of C. difficile for April – September 2023 against the equivalent period in 2022/23



The WG reduction expectation for 2023/24 is 25 cases per 100,000 population, which equates to no more than 112 cases per year. 62 cases of C.Difficile infection have been reported for April – September 2023 which is the same as the equivalent period in 2022/23.

The provisional rate of C.Difficile infection in CTM is 27.57 per 100,000 population compared to the All Wales rate of 35.53 per 100,000 population.

- 50% of the cases (31/62) are healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or sample sent within 48 hours of admission with a recent hospital admission in the past 4 weeks.
- 26% of the samples (16/62) were sent from GP practices. Only 1 of the 16 cases had a recent admission to hospital.

- 2 deaths reported in RGH where C.Difficile was recorded on the death certificate. One rapid review meeting held, x1 outstanding.

	Total	HCAI	CAI	GP samples - CAIs
RGH	20	9	11	9
PCH	12	5	7	1
POW	29	17	12	4

The RCA process must be reintroduced in primary care to ensure any learning from incidents can be shared widely and used to inform future practice.

The main themes identified from the RCA process in secondary care include delays in sampling, delays in isolation, lack of HPV cleaning and antimicrobial stewardship. There are also recurrent cases who should be considered for faecal transplant but there is currently no service available in POW and RGH.

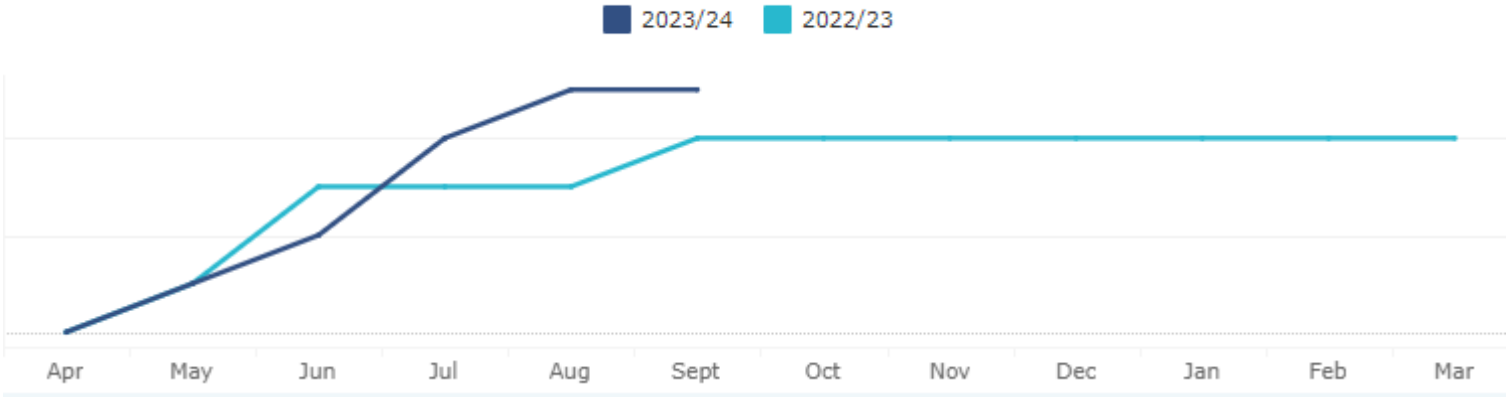
Whole genome sequencing results have alerted the IPC team to transmission of CDI on 2 wards. Two patients were linked on 2 separate wards.

S. aureus bacteraemia

The reduction expectation for 2023/24 is a combined target (MRSA and methicillin sensitive S. aureus) of 20 cases per 100,000 population, which equates to no more than 90 cases per year.

76 cases reported in CTM for April – September 2023 which is 8 less cases than the equivalent period in 2022/23. The current rate of S. aureus bacteraemia in CTMUHB is 33.79 compared to the All Wales rate of 27.07per 100,000 population.

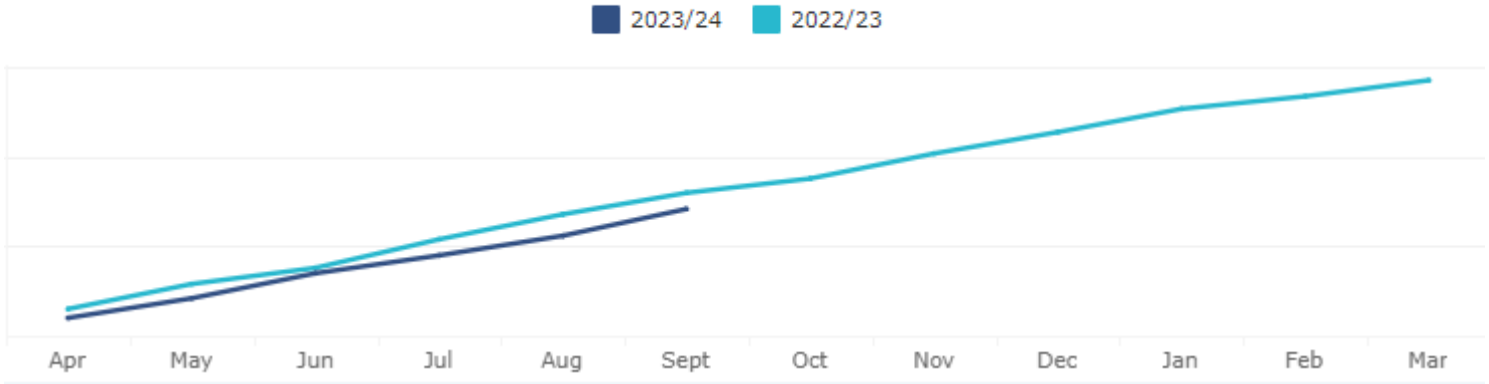
Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MRSA bacteraemia for April – September 2023 against the equivalent period in 2022/23



5 cases of MRSA bacteraemia reported April – September 2023 which is 1 more than the equivalent period in 2022/23. The rate of MRSA bacteraemia in CTM is 2.22 which is higher than the All Wales rate of 1.83 per 100,000 population.

2 of the 5 cases are deemed to be health care associated cases by sample date, no preventable sources identified.

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of MSSA bacteraemia for April – September 2023 against the equivalent period in 2022/23



71 cases of MSSA bacteraemia reported April - September 2023. This is 9 fewer cases compared to the previous year. The rate of MSSA bacteraemia in CTM is 31.57 which is higher than the All Wales rate of 25.24 per 100,000 population.

- 23% (16/71 cases) are healthcare associated infections based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 67% (55/71 cases) are community acquired infections.
- 8% (6/71 cases) are associated with an IV device.

IPC huddles are arranged to discuss preventable infections and the outcome/ learning is discussed and shared at the site IPC meetings. The IPC team requests support to restart the IV steering group to provide a steer for IV line management across CTM. There is currently no training available to support management of PICC lines and support is being sought from a neighbouring HB.

E. coli bacteraemia

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of E. coli bacteraemia for April – September 2023 against the equivalent period in 2022/23

The reduction expectation for 2023/24 is 67 cases per 100,000 population, which equates to no more than 301 cases for the year.

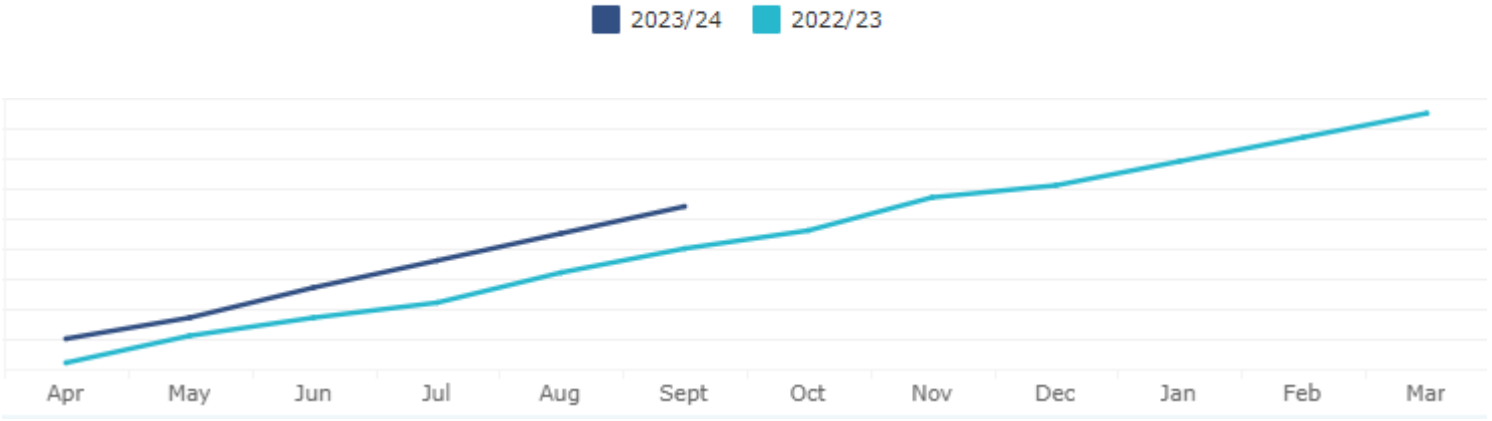
207 cases reported for CTM April – September 2023 which is 14 more cases than the same period last year. The rate of E. coli bacteraemia in CTM for April - September 2023 is 92.03 compared to the All Wales rate of 75.09 per 100,000 population.

- 25% (51/207 cases) are healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 75% (156/207 cases) are deemed to be community acquired infections.
- 10% (21/207 cases) are associated with a urinary catheter (12 HCAI/9 CAI).

IPC huddles are held to discuss urinary catheter related bacteraemia and learning is shared widely to influence and inform practice.

Klebsiella sp. bacteraemia

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of Klebsiella sp. bacteraemia for April – September 2023 against the equivalent period in 2022/23



CTM is expected to achieve a 10% reduction based on 2017/18 numbers which equates to no more than 63 cases in 2023/24.

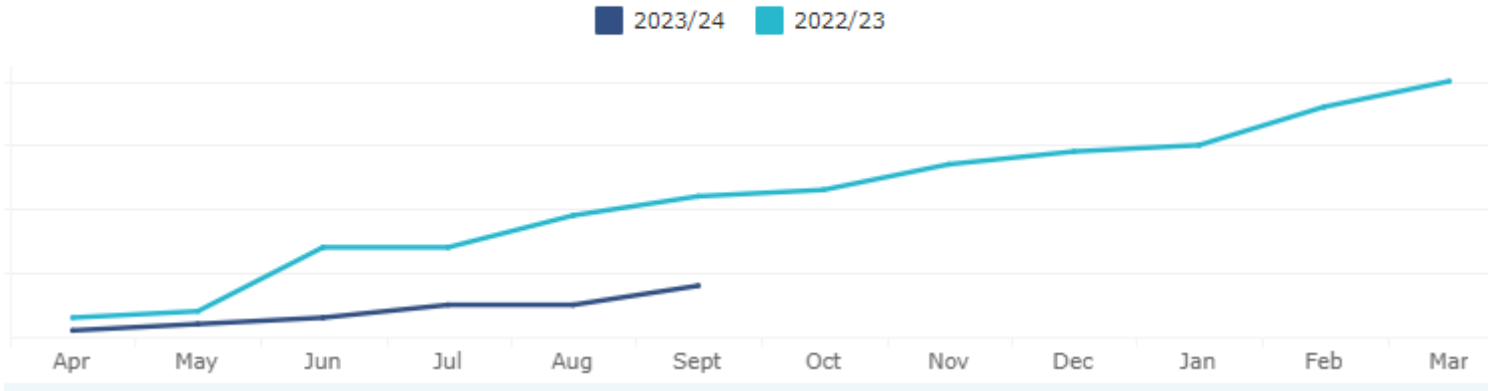
54 cases of Klebsiella bacteraemia (includes E. aerogenes bacteraemia from April 2019 onwards) reported April – September 2023 which is 14 more cases than the equivalent period in 2022/23. The rate of Klebsiella sp. bacteraemia in CTM for April - September 2023 is 24.01 compared to the All Wales rate of 22.46 per 100,000 population.

- 41% (22/54 cases) are healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 59% (32/54 cases) are community acquired infections.
- 15% (8/54 cases) are linked to a urinary catheter (4 HCAI/ 4 CAI).

IPC huddles are held to discuss each urinary catheter related bacteraemia and learning is shared widely to influence and inform practice.

Pseudomonas aeruginosa bacteraemia

Cwm Taf Morgannwg University Health Board cumulative monthly numbers of Pseudomonas aeruginosa for April – September 2023 against the equivalent period in 2022/23



A 10% reduction in cases is expected in CTM in 2023/24 compared to 2017/18 numbers. This equates to no more than 24 cases.

8 cases of P. aeruginosa bacteraemia reported in April – September 2023 which is 14 less compared to the equivalent period in 2022/23. The rate of P. aeruginosa bacteraemia in CTM for April – September 2023 is 3.56 compared to an All Wales rate of 5.17 per 100,000 population.

- 38% (3/8 cases) are healthcare associated infections based on sample date
- 62% (5/8 cases) are community acquired infections.
- 25% (2/8 cases) are associated with a urinary catheter (1 HCAI/1 CAI).

IPC Support for Primary Care

The Executive Director of Nursing has commissioned a strategic review of the IPC team to explore opportunities to provide an integrated service for CTM. There has been long term sickness absence within the team during the summer months which has improved but the clinical elements of the role have taken priority which has delayed progress with planned improvement work.

COVID-19/respiratory illness update.

Please refer to the COVID report for detailed information

There have been no changes to the acute respiratory infection guidance since the last meeting. The IPC team continues to respond to outbreaks of ARI including COVID. Due to bed pressures on the acute sites, the IPC advice to close wards to new admissions is frequently overruled by the operational teams following risk assessment. The IPC team arrange PII meetings to highlight learning from outbreaks of infection.

Boarding of additional patients across the acute hospital sites continues as the number of patients needing admission to hospital exceeds the number of beds available daily.

A revised national testing strategy has been published with no changes no note.

Mandatory Surveillance

C. Section surgical site infections

The senior clinical midwifery team have agreed to drive the improvement work needed to develop a robust surveillance process and reporting system for C.section surgical site infections (SSI).

Work has commenced to use the literature developed by Public Health Wales to support use of standardised definitions, training and protocols to ensure CTM has a system which promotes confidence in the Health Boards SSI data/rates.

Periods of Increased Incidence Meetings (PII)

PII meeting are arranged by the IPC Team to discuss and learn from incidents to inform future practice.

VRE

6 cases of Vancomycin Resistant Enterococcus identified on ward 9 RGH 24/10/22 – 30/07/23, 5 of the 6 cases are healthcare associated cases. Results of whole genome sequencing are identical for 2 of the cases which strongly suggests transmission has occurred. A PII meeting was arranged, actions identified and learning shared.

No further cases reported.

MRSA Neonatal Unit, Princess of Wales Hospital

A closure meeting was held following the MRSA outbreak on NNU POW. No further cases reported.

Legionella – Y Bwthyn Newydd, Princess of Wales Hospital

Legionella (Serogroup 2 – 14) was detected from water samples sent as part of pre contractual work from Y Bwthyn Newydd in March 2023 and continues to be detected in a small number of outlets. Point of use filters have been fitted to outlets across the ward and day unit and only outlets with a point of use filter are being used.

The Estates team and external contractors have completed a variety of remedial works to pressurise and rebalance the water system, remove thermal mixing valves, change taps and wash hand basins, remove dead legs and infrequently used outlets and chlorinate the water system.

The water temperature profiles are being monitored regularly and a programme of repeat water testing on the positive outlets has commenced.

Legionella – Dewi Sant Health Park (DSHP).

Legionella spp. continues to be detected in the water at DSHP. High water temperatures, low water usage in some areas, lack of flushing and the design of the pipework across the site is contributing to the ongoing problem. As a mitigation, point of use filters have been fitted across the site to enable staff to have access to water. Regular flushing and water temperature monitoring continues.

Following discussion at the Water Safety Group, monies have been approved for major capital work to replace and reconfigure the pipework. A contract is being developed to start the tender process.

In addition to this, Capital colleagues are working with water consultants to install a chemical treatment plant.

Air Cleaners

Three companies visited CTM to demonstrate their air cleaning products to the Infection Prevention and Control team, Estates colleagues (AP Ventilation) and Authorised Engineer (Ventilation) Shared Services. Further work is required prior to recommendations being made to the Health Board's ventilation group for consideration.

Cleaning Standards

The team has contributed to a revision of the national cleaning standards. The document is currently in draft form and will be approved in the autumn. Implementing the cleaning standards will have financial implications for the HB and Housekeeping hours have already been reduced to pre pandemic numbers. This has a detrimental impact on maintaining a clean environment especially out of hours when there are no staff available to decontaminate vacated bed spaces and single rooms to admit new admissions.

High Consequence Infectious Diseases (HCID)

Members of the HB team attended an event demonstrating the proposed PPE ensemble for HCID. Once the ACDP guidance is updated to reflect the proposed changes, the HBs procedure will be updated and roll out of PPE training will commence. Some of the PPE is not available to order as yet and procurement are working on this.

Infection Prevention and Control Training - Data up to 08.09.23

Combined compliance %
for all 3 levels of IPC Training

Compliance by subject level

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110|LOCAL|Infection Prevention and Control Management Training - No specified renewal|	1130	1130	359	31.77%	0	31.77%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	4282	4282	3441	80.36%	143	77.02%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	8164	8164	5872	71.93%	1218	57.01%

Combined compliance % by Staff Group

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic	416	536	298	55.60%	46	47.01%
Additional Clinical Services	2415	2417	1848	76.46%	326	62.97%
Administrative and Clerical	2574	2601	2136	82.12%	101	78.24%
Allied Health Professionals	776	859	668	77.76%	220	52.15%
Estates and Ancillary	1367	1368	1036	75.73%	35	73.17%
Healthcare Scientists	200	214	176	82.24%	16	74.77%
Medical and Dental	773	1177	258	21.92%	47	17.93%
Nursing and Midwifery Registered	3890	4398	3248	73.85%	568	60.94%
Students	6	6	4	66.67%	2	33.33%

Combined compliance % by Care Group

ILG	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110 Bank Care Group	1	1	1	100.00%	0	100.00%
110 Chief Operating Officer Care Group	1248	1253	939	74.94%	34	72.23%
110 Children & Families Care Group	1363	1507	985	65.36%	170	54.08%
110 Corporates and Hosted Care Group	1296	1313	1081	82.33%	47	78.75%
110 Diagnostics, Therapies & Specialties Care Group	1552	1700	1257	73.94%	275	57.76%
110 Mental Health & Learning Disabilities Care Group	1174	1298	961	74.04%	166	61.25%
110 Planned Care Care Group	2075	2398	1514	63.14%	224	53.79%
110 Primary & Community Care Group	1565	1673	1333	79.68%	215	66.83%
110 Unscheduled Care Care Group	2143	2433	1601	65.80%	230	56.35%

Face to face training sessions continue for level 2 and level 3 IPC training across CTM. This is in addition to the E-learning training on offer.

ANTT Update

The IPC team has relaunched ANTT training, workshops are being provided on all sites. Ward based training is also offered in areas with low compliance. The All Wales ANTT policy has been updated and will be adopted by the HB. Achieving bronze accreditation is a priority for the IPC team in 2023/24 and re-starting the ANTT steering group will be a critical element part in the process. Improving ANTT compliance amongst medical colleagues is key in order for the HB to achieve accreditation.

The requirement to attend ANTT refresher has been amended nationally and CTM will adopt the revised requirement.

Level 2 training will need to be completed every 3 years

Level 1 & level 3 training will only need to be completed once.

ANTT will be temporarily "unmandated" whilst work is ongoing to review and update roles which need an ANTT competency attached. This will also enable us to update the refresher period for Level 1.

ANTT Combined compliance % for Level 1 (e-learning) & Level 2 (workplace assessment)

ANTT compliance % for each of the three levels of training

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
110|LOCAL|Aseptic Non Touch Technique - Level 2 (Workplace Assessment) - 3 Years|	3439	3439	1351	39.28%	49	37.86%
110|LOCAL|Aseptic Non Touch Technique - Level 3 (Assessor) - No Specified Renewal|	225	225	70	31.11%	1	30.67%
NHS|MAND|Aseptic Non Touch Technique - 3 Years|	3703	3703	2944	79.50%	113	76.45%

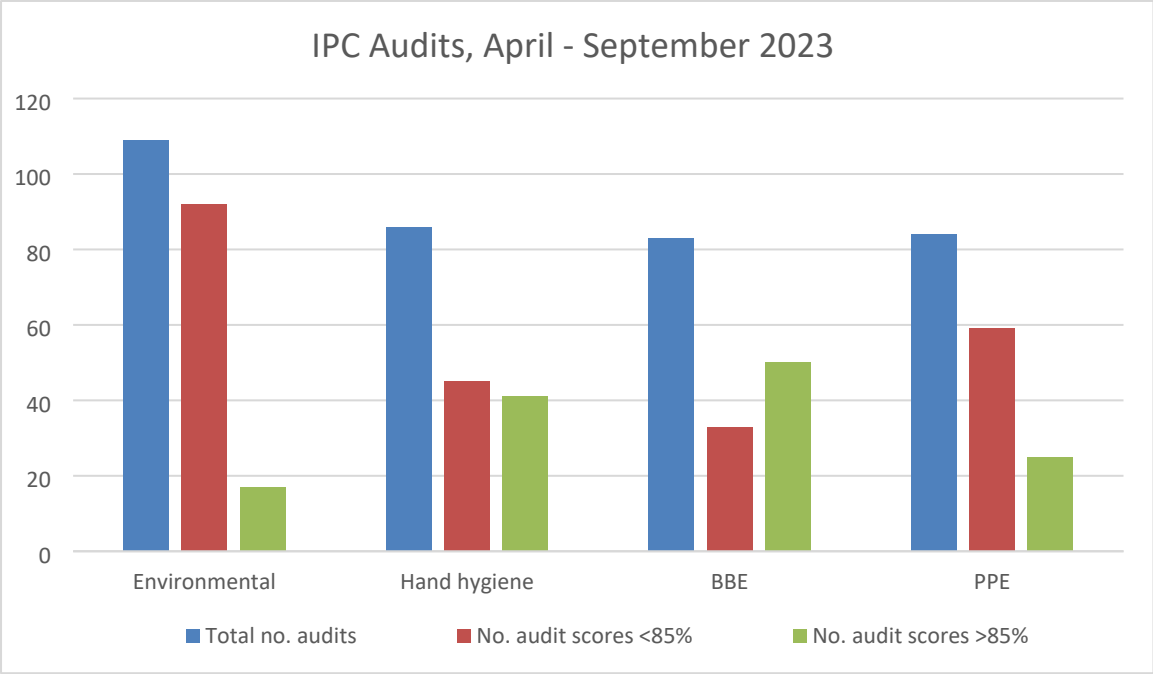
Combined Level 1 and Level 2 compliance % for each staff group

Staff Group			Headcount	Competencies Required	Competencies In-date	Compliance %	Competencies Expiring in Next 90 Days	Predicted % in 90 Days
Add Prof Scientific and Technic			22	44	20	45.45%	1	43.18%
Additional Clinical Services			1006	1938	1137	58.67%	57	55.73%
Allied Health Professionals			305	626	391	62.46%	8	61.18%
Healthcare Scientists			1	2	1	50.00%	0	50.00%
Medical and Dental			361	713	138	19.35%	9	18.09%
Nursing and Midwifery Registered			2018	4042	2677	66.23%	88	64.05%
Students			1	2	1	50.00%	0	50.00%

IPC Audits, April – September 2023.

The IPC team has an annual programme for IPC audits. Additional audits are performed during periods of increased incidence of infection/ during outbreaks. Environmental, hand hygiene/bare below the elbow, personal protective equipment (PPE) and care bundle audits form part of the audit programme. Non-compliance with IPC practice/ policy is highlighted at the time of the audit with the staff member/ ward or departmental manager. An audit report is also shared with the Manager and copied to the Senior Nurse and Head of Nursing or department lead.

IPC audits completed April – September 2023 demonstrate poor compliance with hand hygiene/ bare below the elbow and use of PPE. The environmental audit scores are also poor and issues identified are escalated for action to Nursing, Estates and Housekeeping colleagues.



The IPC team provide ward based training in response to poor audit scores. Any IPC related issues linked to the environment/cleaning are escalated to respective colleagues to action.
IPC audits are also completed by clinical staff and standardised audit tools are available on the AMat System.

DECONTAMINATION

Endoscope Decontamination POW

There is an urgent need for a medium term plan for endoscope decontamination in POW.

Urology

The two decontamination machines (Poka Yoka) in Urology POW are considered obsolete and parts are difficult to acquire when the machines breakdown. The machines are taken out of use on a regular basis following unacceptable weekly TVC water results which has led to initiating the local contingency plan on at least one occasion. The risk has been escalated to the Care Group as this could have a detrimental impact on Urology waiting lists.

Endoscopy

The JAG audit was undertaken in Endoscopy POW on the 24th April 2023 where a red/amber rating was awarded to the department. The AE(D) highlighted concerns regarding the lack of progress with the Central Decontamination Unit and that if significant delays continue, modular solutions/alternative infrastructure changes must be considered as a medium term plan.

The next JAG audit is planned for December 2023, dates to be confirmed.

Central Decontamination Unit

The Capital Planning team are in a position to commence the business case for the Central Decontamination Unit in POW. However, it is not known how Llantrisant Health Park will impact on the decontamination requirements in Bridgend and which site will host specific services within the Organisation. The Capital Planning team are awaiting a steer from the Executive Team.

Steriliser installation RGH & POW

Two new sterilisers have been successfully installed/commissioned in HSDU RGH. The commissioning of two new sterilisers in HSDU POW, will take place in the upcoming weeks.

Internal Decontamination Review

NHS Wales Shared Services Partnership (NWSSP) presented the final report to the Audit and Risk Committee. CTM provided reasonable assurance for three objectives; policies and procedures, roles and responsibilities, monitoring arrangements and substantial assurance for two objectives; decontamination training and governance arrangements. The DLIPCN would like to thank the service users for their support and cooperation during the audit process.

Mobile Endoscopy Unit RGH

There are plans to extend the InHealth contract for an additional 6 months. The quarterly/annual decontamination reports have been requested but have not been received. This has been escalated to the Care Group.

Chemical supply issue

Notification of a chemical supply issue affecting the UK was received in July 2023. The manufacturer (Getinge) detected a quality issue with the Aperlan Poka Yoke Agent A and B chemical bottles. Aperlan is used for the endoscope decontamination process and the shortage would primarily affect Endoscopy, Urology and ENT services across CTM. The care group for planned care arranged daily multidisciplinary operational meetings where updates were received and contingency plans established, to maintain emergency/cancer services across the UHB. Getinge circulated a Field Safety Notice (FSN) for the defective chemical bottles and stock was released in a controlled manner. The supply issue was rectified by mid-August 2023.

Competent Person Decontamination (CPD) Booklet

There is a national request to review qualifications, competency and registration of engineering staff working on decontamination equipment. This will include both internal and external staff. It may involve a national database and routine refresher training based upon a matrix. The AP(D)'s have been asked to lead on this work and the decontamination officer is monitoring progress through the local decontamination groups.

Robotic assisted surgery

A task and finish group has been set up to introduce robotic assisted surgery to CTM. The unit has been delivered to RGH and will initially be used in Theatre 2 for colorectal surgery. A decontamination sub-group has been developed to work through the decontamination elements of the service in preparation for the go-live date which is yet to be announced.

Annual prescribing report	21st November 2023	Quality and Safety Committee	Summary of Performance against National Prescribing Indicators

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	The Senior Pharmacy Leadership Team
Presented By:	Dom Hurford, Exec Medical Director
Approving Executive Sponsor:	Dom Hurford, Exec Medical Director
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	Ongoing engagement with clinical teams in primary and secondary care

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Improved patient quality and safety
Related Health and Care Standard	e.g. Governance, Leadership & Accountability
Has an EQIA been undertaken?	N/A
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes Shift to Soft Mist Inhaler (SMI) from Dry Powder Inhaler (DPI) may increase costs, staff resources
Link to Strategic Goals	Sustaining Our Future Improving Care

Introduction

The All Wales Medicines Strategy Group (AWMSG) has endorsed the National Prescribing Indicators (NPIs) as a means of promoting safe and cost-effective prescribing since 2003.

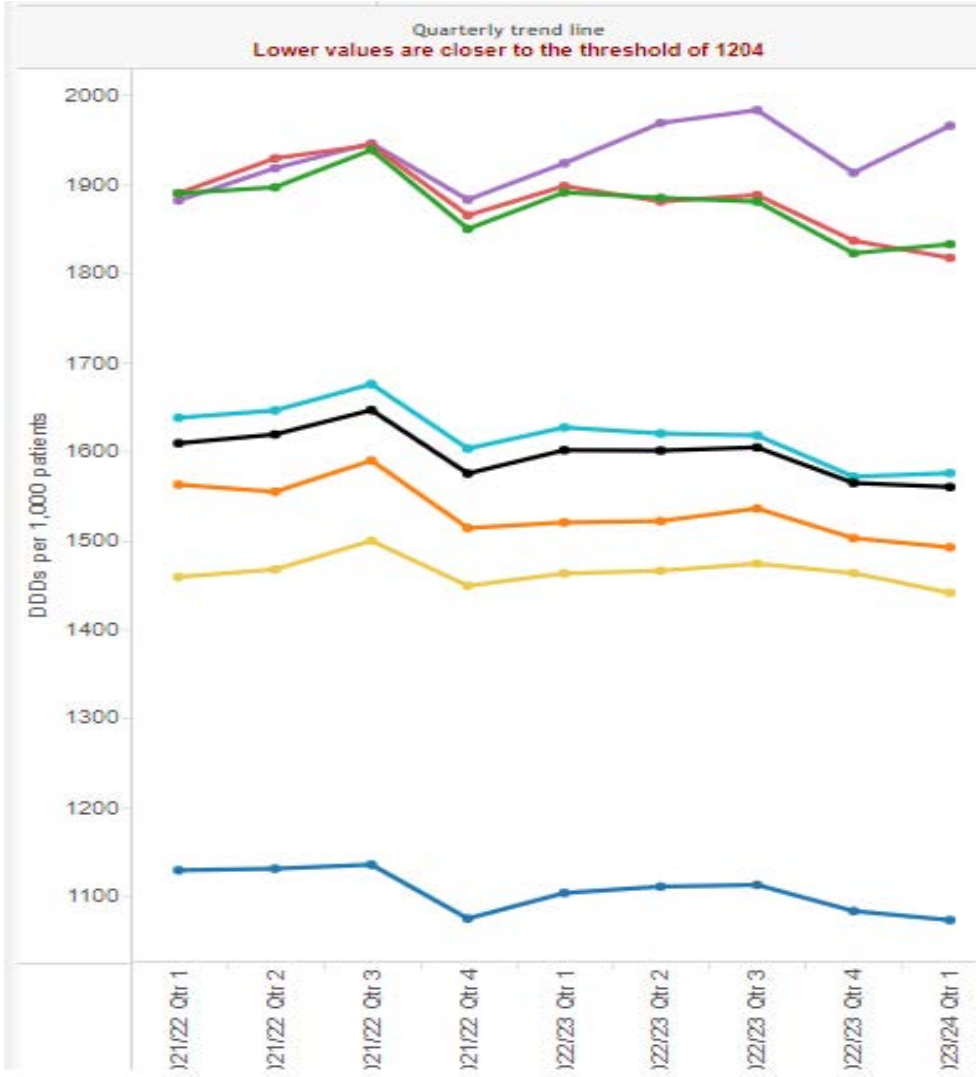
The National Prescribing Indicators 2022-2023: Supporting Safe and Optimised Prescribing focus on four priority areas, supported by additional safety and efficiency domains.

This report contains data relating to the NPIs for the period March 2020- March 2023

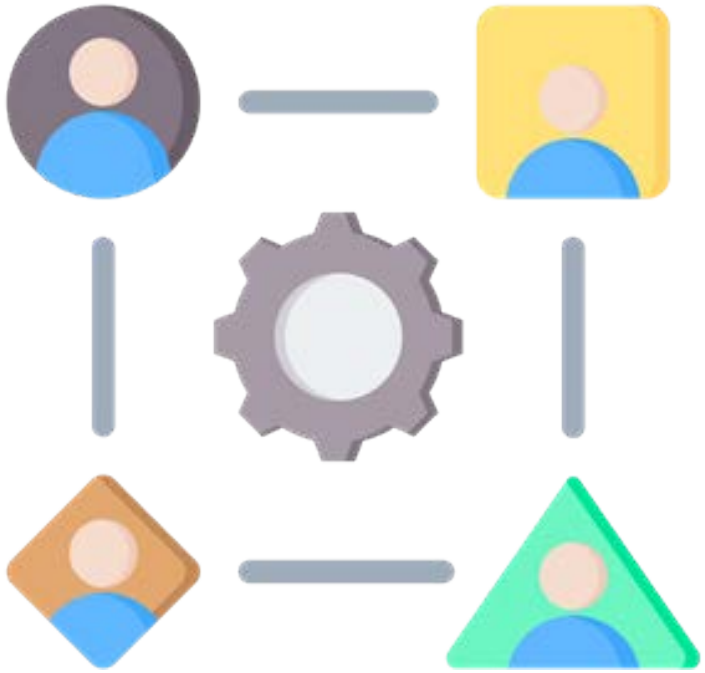
Analgesics

Opioid prescribing

- Overall reduction since 2021
- 0.25% increase in last recorded quarter
- Tramadol has decreased significantly since 2020, although reduction slowed to 0.68% last quarter



Opioid Prescribing



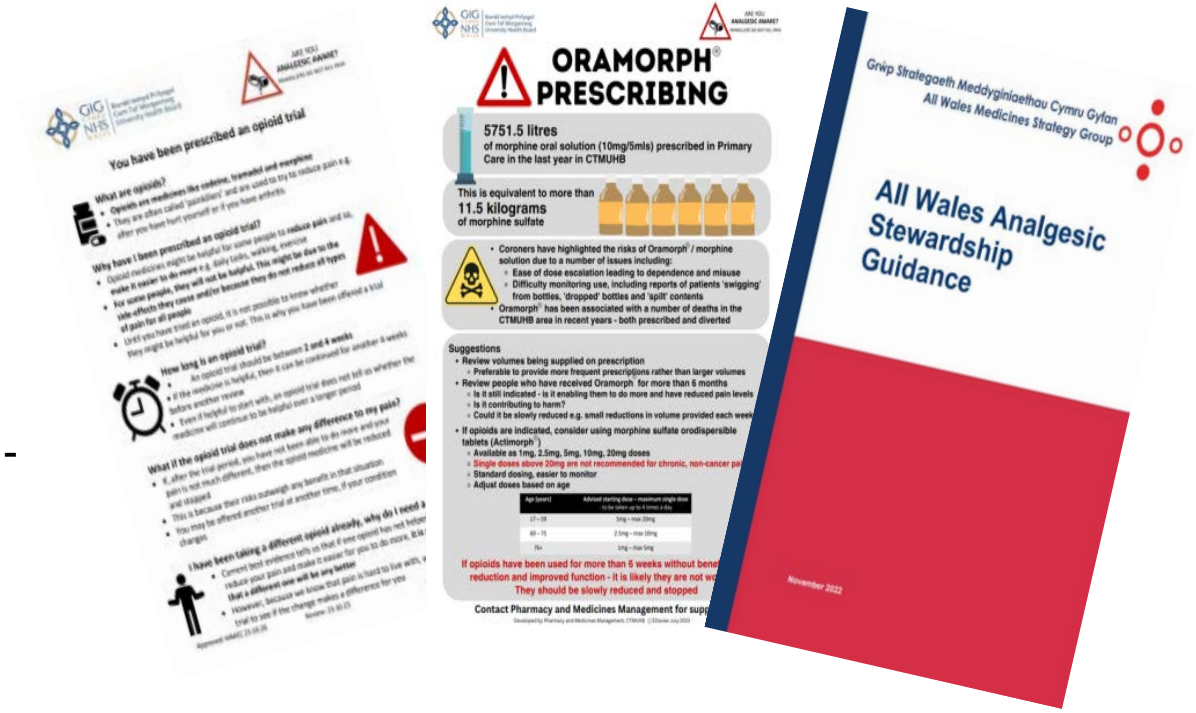
What is still needed?

- Health Board Analgesic Stewardship group
- Support for education and training in Primary Care
- Acute care guidelines
- Regular audit in all sectors
- Specialist service for problematic prescribing
- Improved access to evidence-based pain management

Opioid prescribing

What has been done to address prescribing?

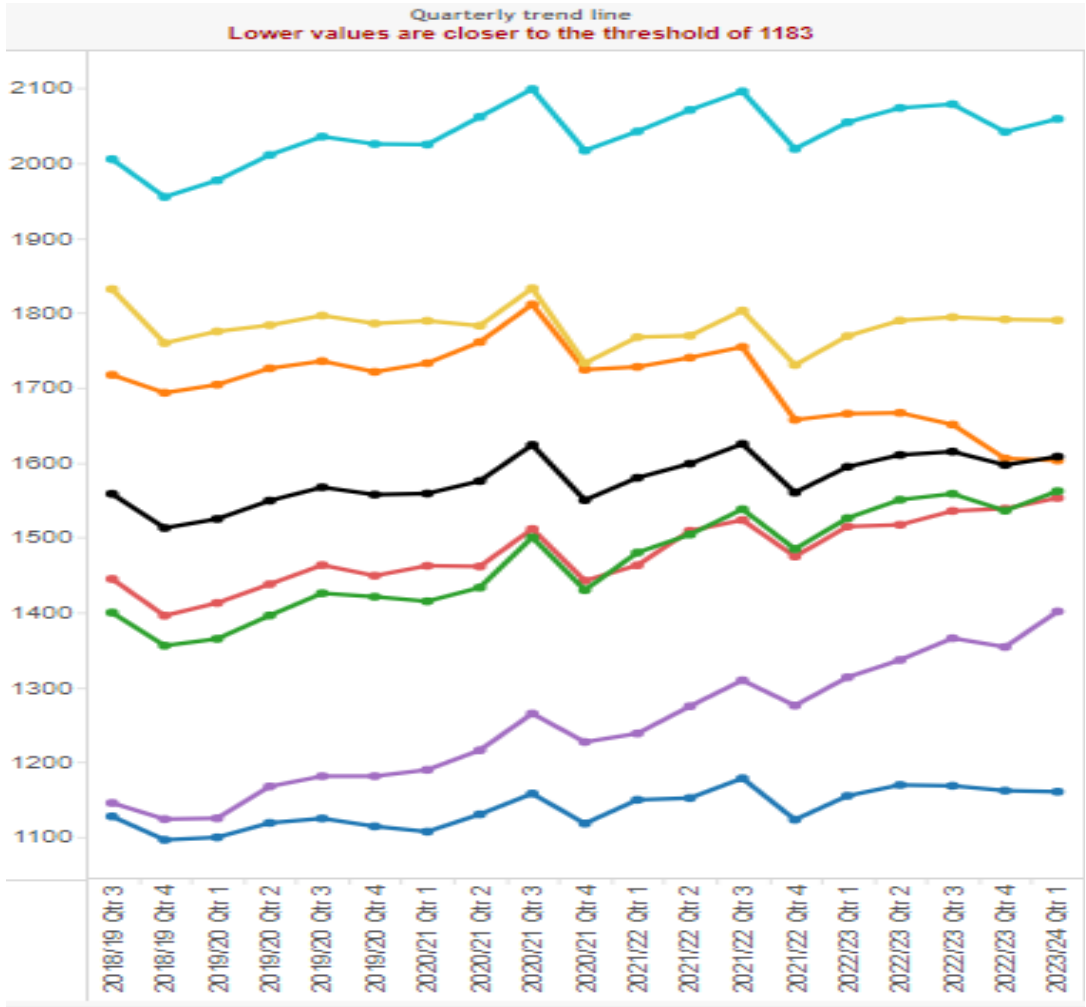
- National prescribing guidelines approved for use in CTMUHB
- Opioid stewardship and prescribing resources circulated - website in development
- Education and training for Primary Care colleagues offered



Gabapentinoid prescribing

Current situation

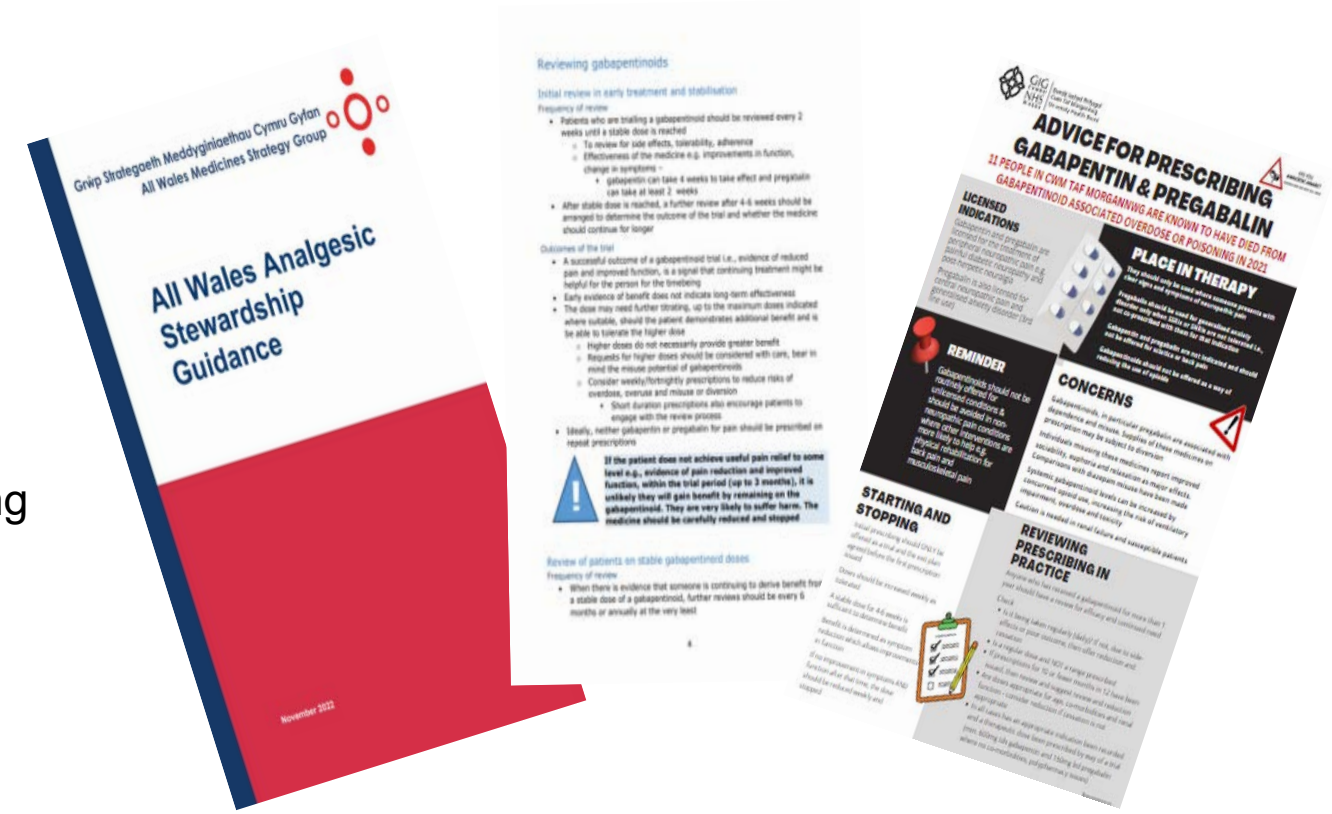
- Highest prescribing rates in Wales
- 0.85% increase in last recorded quarter



Gabapentinoid prescribing

What has been done to address prescribing?

- National Analgesic Stewardship and prescribing guidelines approved for use in CTMUHB
- Reviews included in Prescribing Management Scheme
- Resources developed and circulated to Primary Care - website in development



Gabapentinoid prescribing

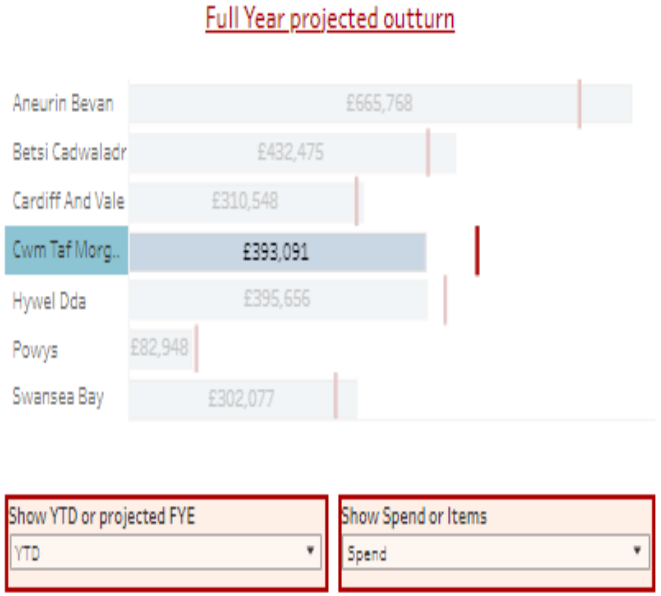
What is still needed?

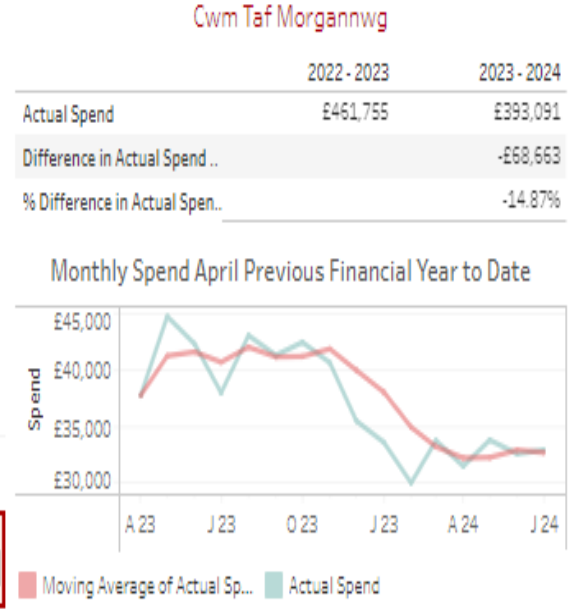
- Health Board Analgesic Stewardship group
- Support for education and training in all sectors
- Acute care guidelines
- Regular audit in all sectors
- Specialist service for problematic prescribing
- Improved access to evidence-based pain management

Lidocaine Plasters 5%

Current position

- 27% reduction in spend and prescriptions compared to 2021/22
- Rate of reduction starting to slow
- Recommendations for prescribing continue to be sent from secondary care, contrary to formulary, evidence and guidance

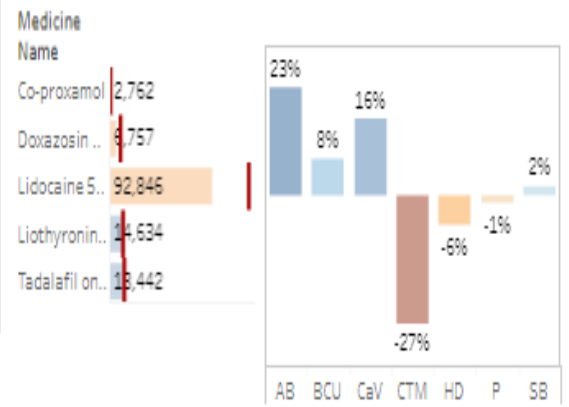




YTD / Spend

Breakdown of Low Value for Prescribing Paper 1 basket for Cwm Taf Morgannwg

Medicine Name	SpendOrItems 22-23	SpendOrItems 23-24	Difference in SpendOrItems from 22-23	Difference in SpendOrItems from 23-24	% Difference in SpendOrItems from 22-23	% Difference in SpendOrItems from 23-24
Co-proxamol	1,125	2,762		1,637		145.6%
Doxazosin modi..	9,742	6,757		-2,985		-30.6%
Lidocaine 5% pl..	126,408	92,846		-33,562		-26.6%
Liothyronine or..	11,931	14,634		2,703		22.7%
Tadalafil once d..	13,098	13,442		345		2.6%
Grand Total	162,303	130,441		-31,862		-19.6%



Lidocaine Plasters 5%

What has been done to address prescribing?

- Standard Operating Procedure (SOP) approved and used in Primary Care by Medicines Management Team to reduce prescribing
- Education resources developed and circulated to primary care
- Draft guidance for secondary care written in 2021 - awaiting consultation

What is still needed?

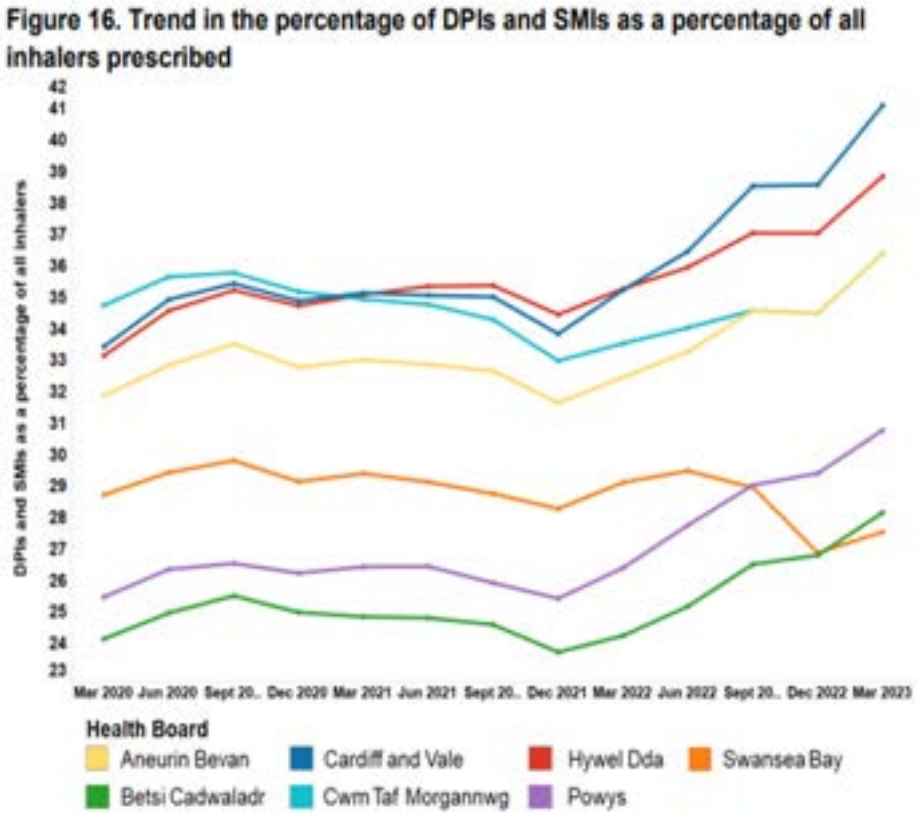
- Secondary Care guidance to be consulted on and implemented
- Formulary compliance regularly audited
- Primary Care practices supported to return requests to initiate prescribing to secondary care

Decarbonisation of Inhalers

AIM – to increase the proportion of Dry powder inhalers (DPI) and Soft mist inhalers (SMI) prescribing to decrease the carbon footprint

Currrent Situation

DPI/SMI usage has been increasing for CTM with the percentage change between March 22 and 23 being 8.54%



Decarbonisation of Inhalers

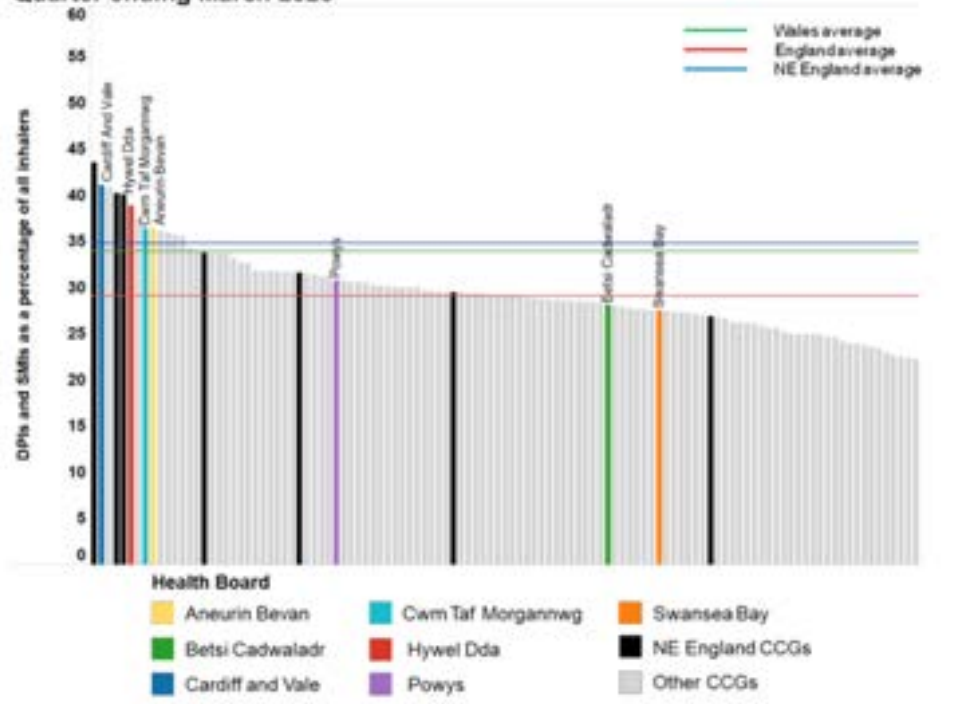
Target

The target is a shift to 80% of inhalers being low Global Warming Potential (GWP) alternatives (for example, DPIs or SMIs) by 2025.

CTM Position

CTM currently percentage is 36.4%. This is the 3rd highest for the HBs in Wales but there is a considerable way to go to reach the target.

Figure 17. DPI and SMI prescribing in Welsh health boards and English CCGs – Quarter ending March 2023



Decarbonisation of Inhalers

What is being done

- Education and training of practice nurses, pharmacists and GPs
- COPD/Asthma projects conducted in primary care
- Annual Prescribing Reports/Visits
- ScriptSwitch messages – chapter currently under review
- Waste reduction and reviews of patients receiving >6 SABA inhalers p.a.

Further Work

- Prescribing Management Scheme (PMS) – no Part 1 quality indicators this year
- Formulary Review

RISKS

- Dry Powder Inhalers (DPIs) are considerably more expensive than Metered Dose Inhalers (MDIs). Switching products **will** result in increased prescribing costs

Anticoagulants in Atrial Fibrillation (AF) stroke prevention : Why?

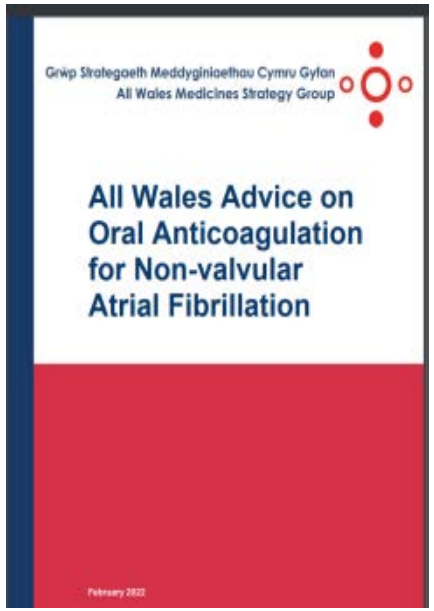
2021/2022

- 11K patients in CTM with AF
- 763 strokes
- 125 (16.4%) had AF prior to stroke
- Average 5 year cost of an AF related stroke: £19k to NHS and £30k to social care
- Prevention vitally important

Anticoagulation in AF National Prescribing Indicators	2021-2022	2022-2023
% of patients with AF, CHA_2DS_2-VASc ≥ 2 on an anticoagulant	90.5% CTM 91.1% Wales	93.4% (↑ 3.16%) CTM 93.3% (↑ 2.48%) Wales
% of patents with AF prescribed an anticoagulant with **documented** review in last 12 months	56.7% CTM 53.7% Wales	57.7% (↑ 1.76%) CTM 55.7% (↑3.82%) Wales
% of patients with AF prescribed antiplatelet monotherapy	4.37% CTM 3.67% Wales	3.85% (↓11.9%) CTM 3.18% (↓13.3%) Wales
% of patients with AF prescribed warfarin	19.6% CTM 16.8% Wales	15.8% (↓3.8%) CTM (1,850 – need to target this) 13% (↓3.8) Wales

What has already been done?

- All Wales medicines strategy group (AWMSG) Guidance
- Enhanced Service provision (93% uptake)
- Cluster pharmacists and pharmacy technicians leading Direct oral anticoagulants (DOAC) initiation and review services
- Leadership and education provided by specialist teams in secondary care



What is still needed?

- Streamline processes to increase capacity
- Improve technology to support audit and outcome reporting
- Introduce systems to ensure cost effective prescribing
- Support from specialist teams to overcome capacity issues
- Showcase and share best practice

Safety Domains-Prescribing Safety Indicators

Purpose: To identify patients at high risk of adverse drug reactions (ADRs) and medicines-related harm in primary care

No target has been set for this NPI and it is not intended that comparisons are made between health boards. However, data can provide a baseline for future quarters to enable monitoring within health boards.

Main themes

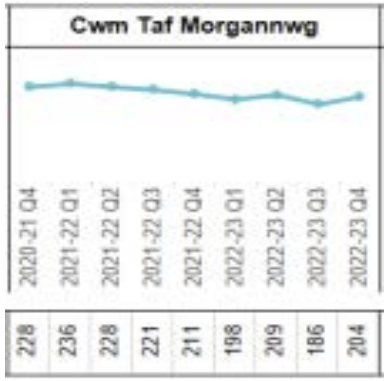
There are 5 main themes of these safety indicators

- Prescribing Safety Indicators related to acute kidney injury (AKI)
- Prescribing Safety Indicators related to bleeds
- Prescribing Safety Indicators related to cognition
- Prescribing Safety Indicators specific to females
- Prescribing Safety Indicators related to 'other'

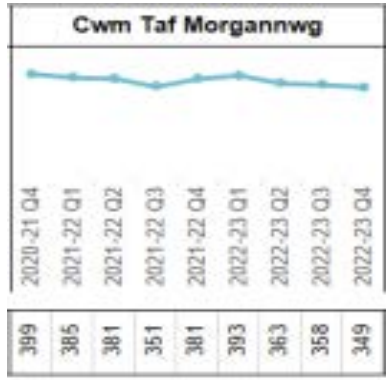
They have been put in full on the following slides for an illustration but cannot be interrogated individually

Prescribing Safety Indicators related to acute kidney injury (AKI)

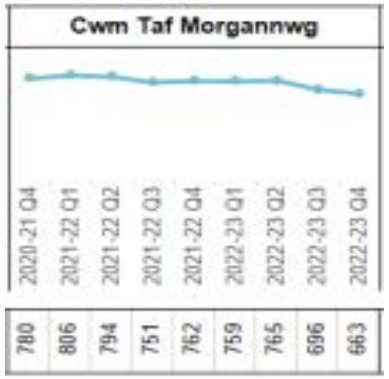
1. Number of patients on the Chronic Kidney Disease register (CKD stage 3–5) who have received a repeat prescription for an non steroidal anti-inflammatory (NSAID) within the last 3 months



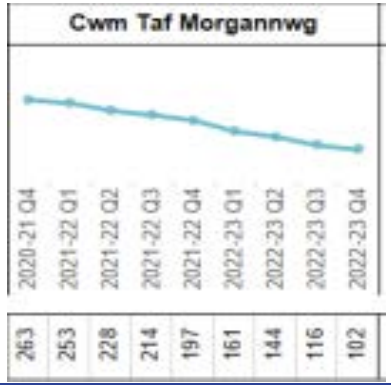
2. Number of patients who are not on the CKD register but have an estimated Glomerular Filtration Rate (eGFR) of < 59 ml/min and have received a repeat prescription for an NSAID within the last 3 months.



3. Number of patients with concurrent prescriptions of an NSAID, renin-angiotensin system (RAS) drug and a diuretic.

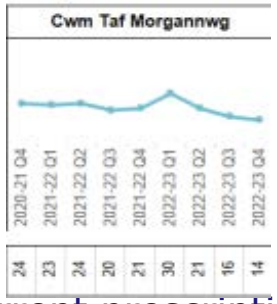


4. Number of patients aged 75 years and over with a current prescription for an Angiotensin-Convertine Enzyme (ACE) Inhibitor or loop diuretic without a check of renal function and electrolytes in the previous 15 months.

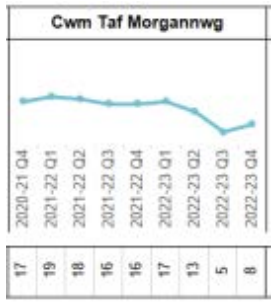


Prescribing Safety Indicators related to bleeds

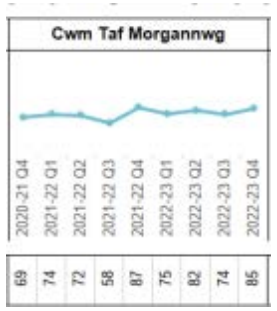
5. Number of patients with a peptic ulcer who have been prescribed NSAIDs without a Proton pump inhibitor (PPI)



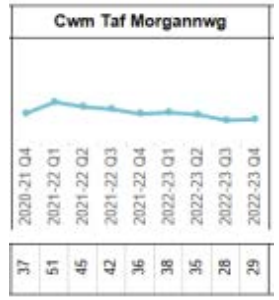
6. Number of patients with concurrent prescriptions of warfarin and an oral NSAID.



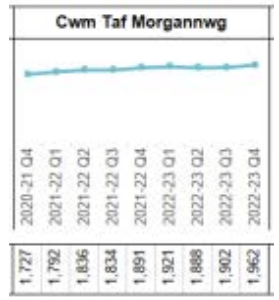
7. Number of patients with concurrent prescriptions for a DOAC and an oral NSAID



8. Number of patients aged 65 years or over prescribed an NSAID plus aspirin and/or clopidogrel but without gastroprotection (PPI or H2 receptor antagonist)

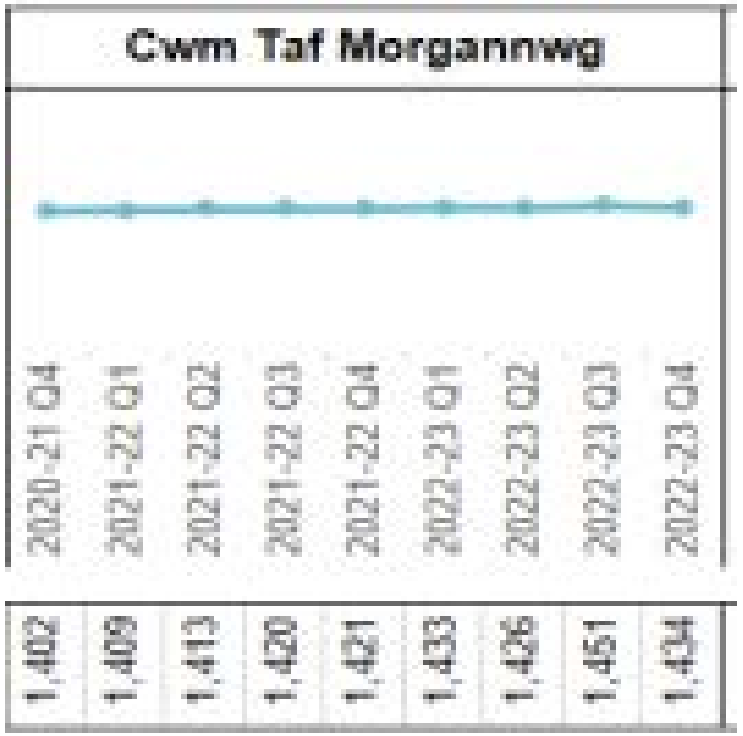


9. Number of patients with concurrent prescriptions of an oral anticoagulant (warfarin or DOAC) and a Selective Serotonin Reuptake Inhibitor (SSRI)

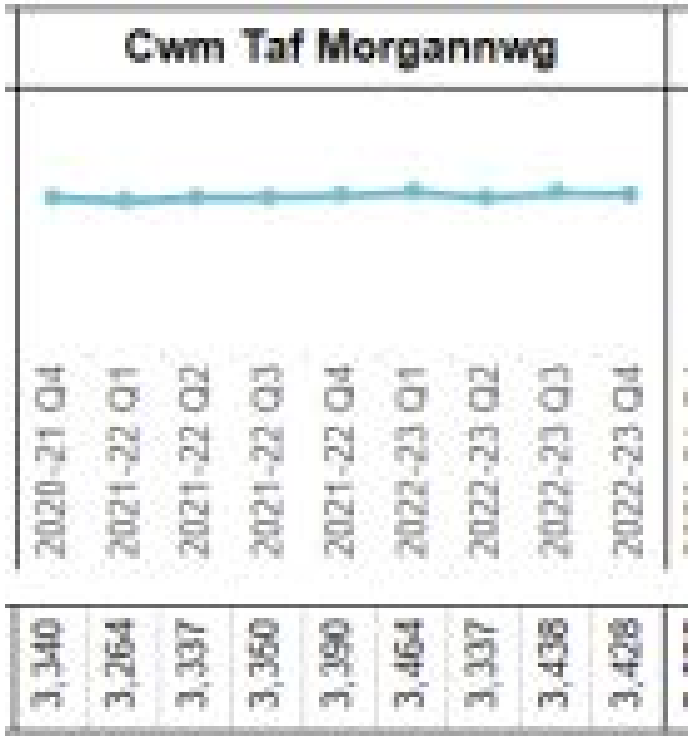


Prescribing Safety Indicators related to cognition

10. Number of patients aged 65 years or over prescribed an antipsychotic

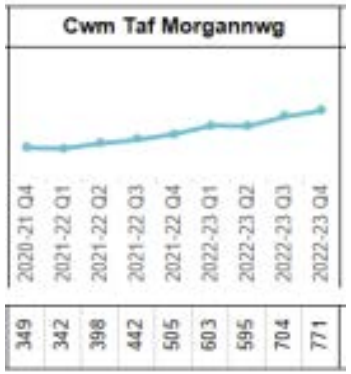


11. Number of patients aged 75 years and over with an Anticholinergic Effect on Cognition (AEC) score of 3 or more for items on active repeat.

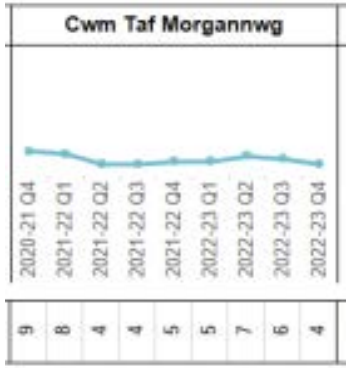


Prescribing Safety Indicators specific to females

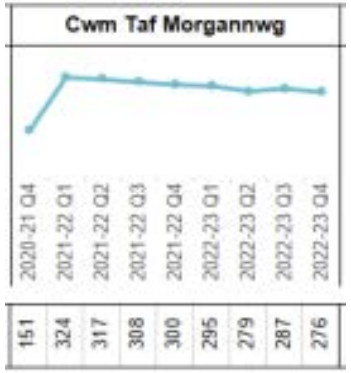
12. Number of female patients with a current prescription of oestrogen-only hormone replacement therapy without any hysterectomy Read/Systematised Nomenclature of Medicine (SNOMED) codes



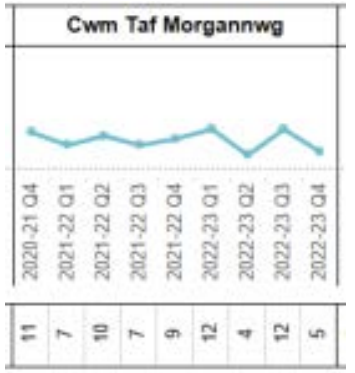
13. Number of female patients with a past medical history of venous or arterial thrombosis who have been prescribed combined hormonal contraceptives



14. Number of female patients aged 14–55 years with a prescription for sodium valproate*



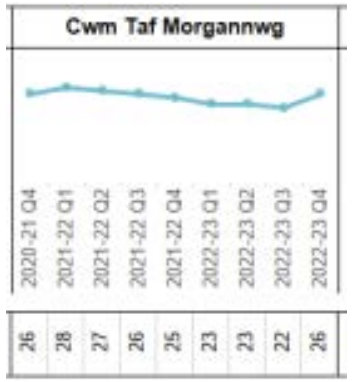
15. Number of female patients aged 14-55 years with a prescription for oral retinoids*



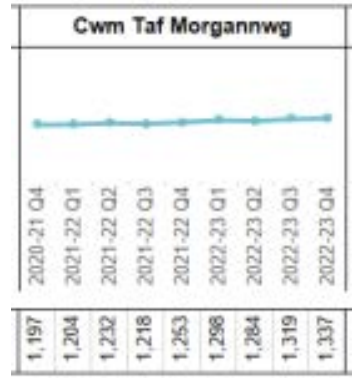
* The search for this Prescribing Safety Indicator was amended from Q1 2021–2022 to include female patients aged 14–55 years. Data prior to Q1 2021–2022 includes female patients aged 14–45 years only)

Prescribing Safety Indicators related to 'other'

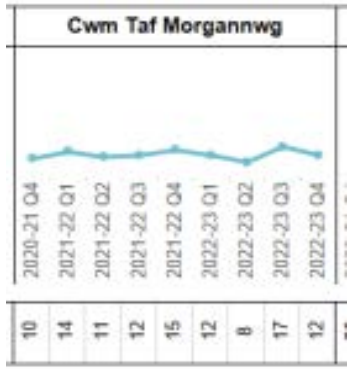
16. Number of patients aged under 16 years with a current prescription of aspirin.



17. Number of patients with asthma who have been prescribed a beta-blocker



18. Number of patients with concurrent prescriptions of verapamil and a beta-blocker



What is being done?

- These indicators don't come with a target but are presented to allow monitoring
- The CTM Medication Safety Group will have first meeting on 8th November. These indicators will be reviewed as part of this with a strategy being established on how to tackle these with multidisciplinary input
- Strategy will be complex and multidisciplinary as this data presented related to patients in primary care, but will generally be initiated in secondary care
- Most indicators are non-specific i.e. relate to multiple disciplines so will need input from many different groups
- Ensuring clinical teams primary and secondary care are looking at these
- Medication safety newsletter/ Sway
- Propose learning at lunch sessions (primary care and secondary care)

Yellow Cards

Purpose: To encourage an increase in the number of Yellow Cards submitted in Wales.

Unit of measure: Number of Yellow Cards submitted per GP practice, per hospital, per health board and by members of the public. Number of Yellow Cards submitted by community pharmacies, by health board.

Aim: To increase reporting

Health Board

- Yellow Card reporting has increased by 31%

Figure 23. Trend in number of Yellow Cards submitted by health boards per 100,000 health board population

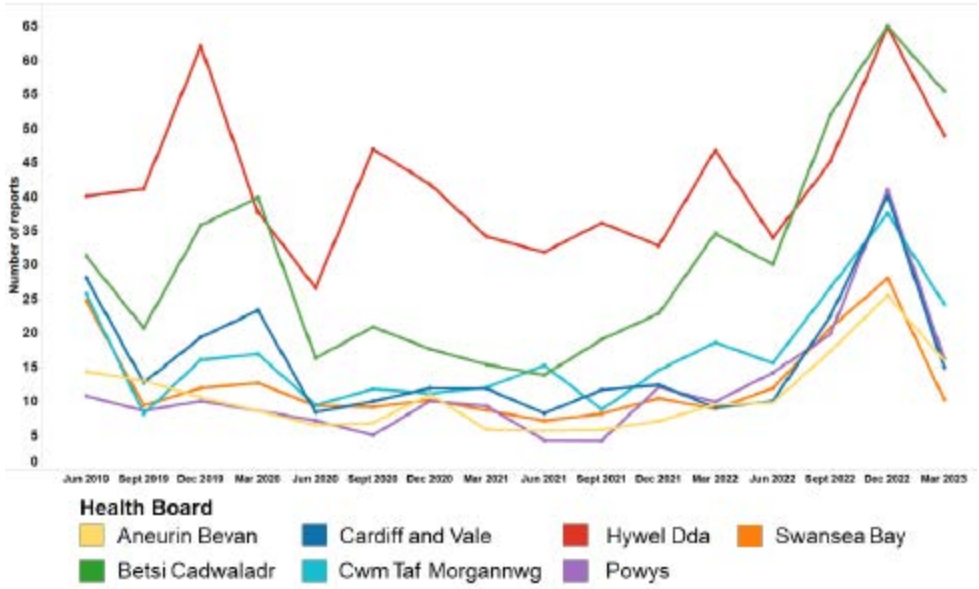


Table 14. Number of Yellow Cards submitted by health board/NHS Trust

	2021–2022 Qtr 4	2022–2023 Qtr 4	% Change
Velindre	1	3	200%
Aneurin Bevan	59	100	69%
Cardiff And Vale	48	80	67%
Powys	14	23	64%
Betsi Cadwaladr	245	395	61%
Cwm Taf Morgannwg	87	114	31%
Swansea Bay	35	41	17%
Hywel Dda	186	196	5%
Wales	675	952	41%

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

GP Practices

Yellow Card reporting has decreased by 24% since 2021-2022

What needs to be done?

- Primary Care Yellow Card Champion
- Facilitate promotional events/awareness days
- Education and training on when and how to report

Figure 21. Trend in number of Yellow Cards submitted by GP practices per 100,000 health board population

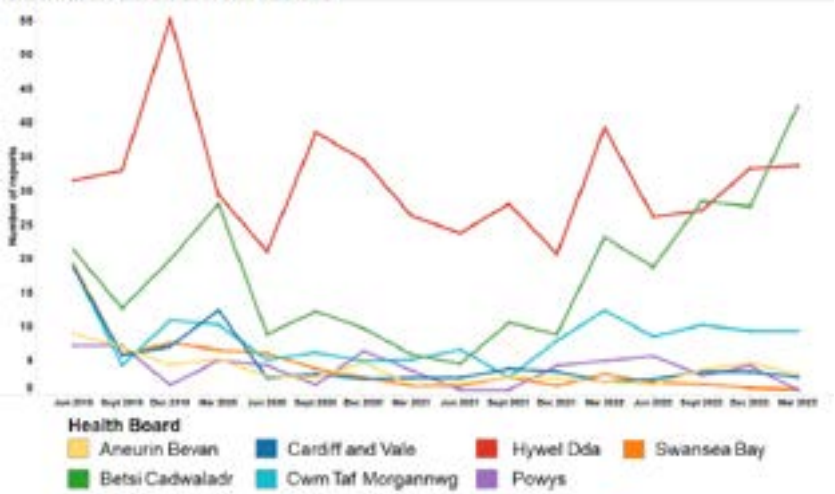


Table 12. Number of Yellow Cards submitted by GP practices

	2021–2022 Qtr 4	2022–2023 Qtr 4	% Change
Betsi Cadwaladr	164	302	84%
Aneurin Bevan	12	19	58%
Cardiff And Vale	10	14	40%
Hywel Dda	156	135	-13%
Cwm Taf Morgannwg	58	44	-24%
Swansea Bay	12	3	-75%
Powys	7	1	-86%
Wales	419	518	24%

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

Secondary Care

Yellow Card reporting has increased by 200% since 2021-2022

What has been done to increase reports?

- Yellow Card promotional events/awareness days
- Yellow Card Champion Teams on each site
- News articles on SharePoint
- Promotional posters in wards/departments

What is still needed?

- Education and training sessions held for A&E & Admissions staff

Figure 22. Number of Yellow Cards submitted by secondary care – Quarter ending March 2023 versus quarter ending March 2022

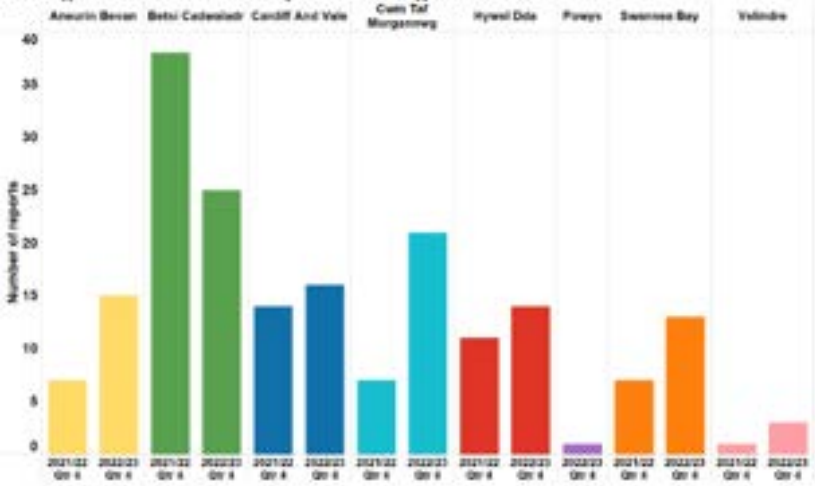


Table 13. Number of Yellow Cards submitted by secondary care

	2021–2022 Qtr 4	2022–2023 Qtr 4	% Change
Cwm Taf Morgannwg	7	21	200%
Velindre	1	3	200%
Aneurin Bevan	7	15	114%
Powys	0	1	100%
Swansea Bay	7	13	86%
Hywel Dda	11	14	27%
Cardiff And Vale	14	16	14%
Betsi Cadwaladr	38	25	-34%
Wales	85	108	27%

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

Community Pharmacies

What needs to be done?

- Facilitate promotional events/awareness days
- Education and training on when and how to report

Figure 25. Number of Yellow Cards submitted by community pharmacy – Quarter ending March 2023

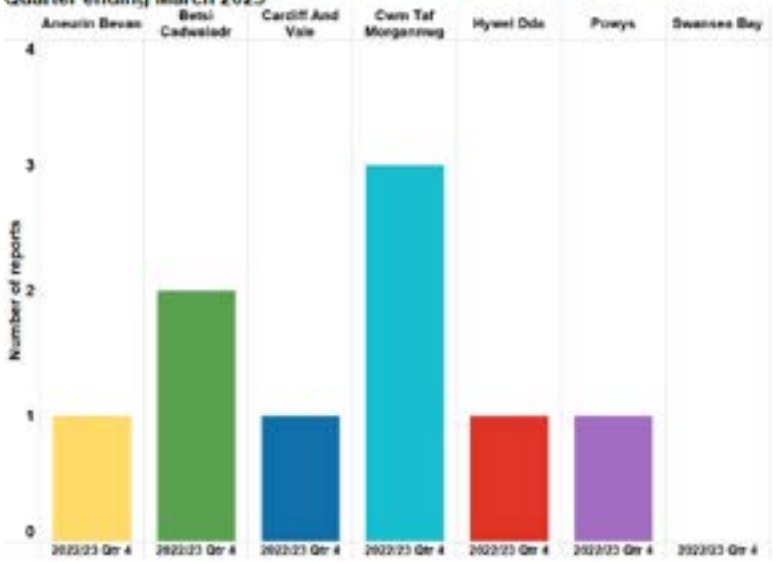


Table 16. Number of Yellow Cards submitted by community pharmacies

	2022–2023 Qtr 4
Cwm Taf Morgannwg	3
Betsi Cadwaladr	2
Aneurin Bevan	1
Cardiff And Vale	1
Hywel Dda	1
Powys	1
Swansea Bay	0
Wales	9

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

Public

Yellow card reporting has increased by 117% since 2021-2022

What has been done to increase reports?

- Yellow Card promotional events/awareness days in secondary care
- Leaflets and posters in outpatient waiting areas in secondary care

What is still needed?

- Promotion of Yellow Card scheme in all sectors
- CTM Yellow Card social media campaign

Figure 24. Number of Yellow Cards submitted by members of the public – Quarter ending March 2023 versus quarter ending March 2022

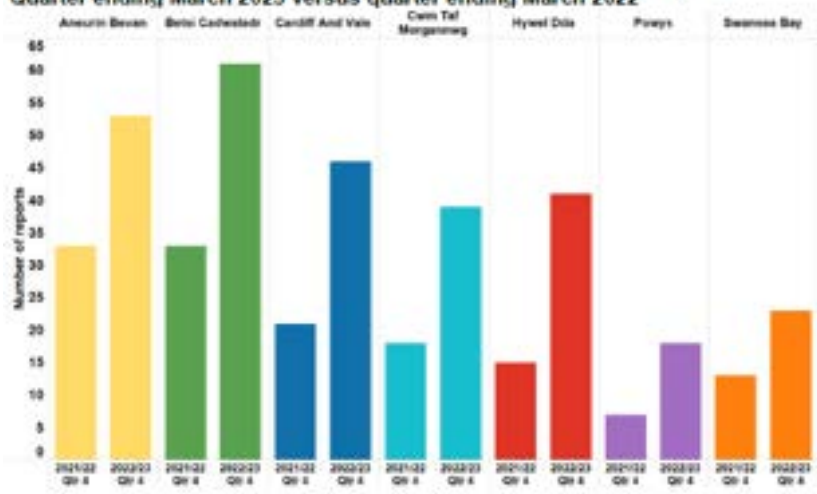


Table 15. Number of Yellow Cards submitted by members of the public

	2021–2022 Qtr 4	2022–2023 Qtr 4	% Change
Hywel Dda	15	41	173%
Powys	7	18	157%
Cardiff And Vale	21	46	119%
Cwm Taf Morgannwg	18	39	117%
Betsi Cadwaladr	33	61	85%
Swansea Bay	13	23	77%
Aneurin Bevan	33	53	61%
Wales	140	281	101%

Best Value Biological Medicines

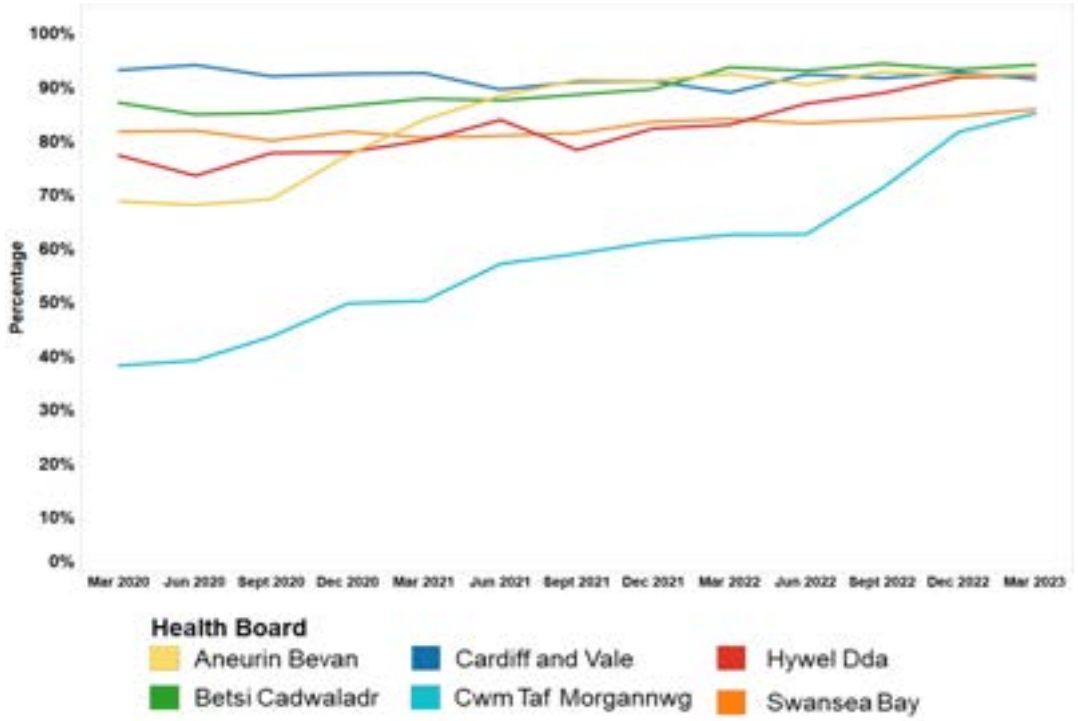
Purpose: To ensure prescribing of best value biological medicines supports cost-efficient prescribing in primary and secondary care in Wales.

Unit of Measure: Quantity of best value biological medicines prescribed as a percentage of total 'biosimilar' plus 'reference' product

Aim: To ensure prescribing of best value biological medicines supports cost-efficient prescribing in primary and secondary care in Wales

Adalimumab 85.2% (end March 2023)

- Lowest percentage adalimumab biosimilar prescribing but largest percentage increase



Ranibizumab

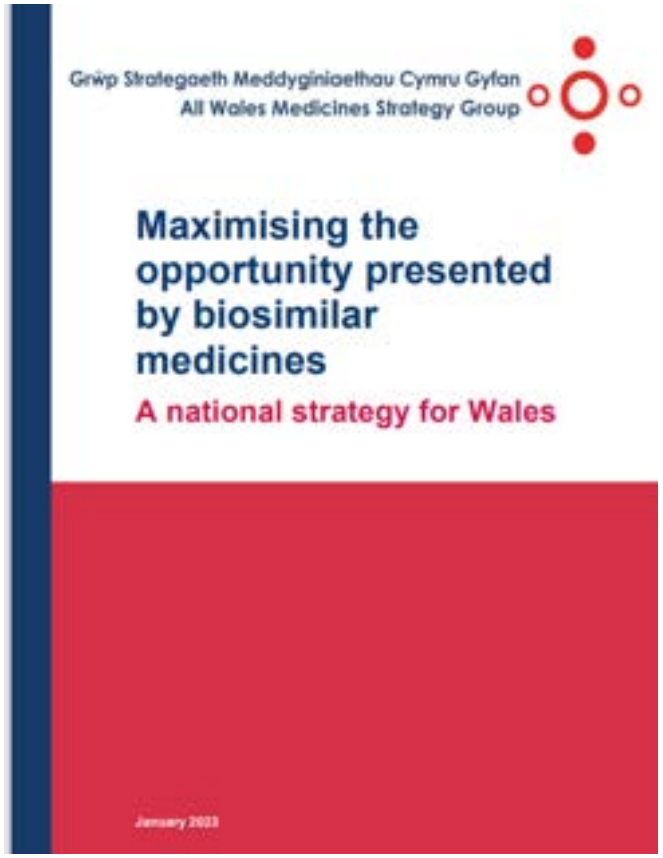
- No biosimilar usage
- Low prescribing activity

2022-23 Quarter 4

	CTM	Wales
Infliximab	97.4%	97.6%
Rituximab	97.9%	99%
Etanercept	90%	85.6%
Transtzumab	Not reported	Not reported

The proportional use of the best value biologic has increased to the point that continued reporting of year-on-year changes has become less valuable

What is being done?



- Biosimilar medicines are therapeutically equivalent and considered to be interchangable with their reference product.
- Patients can be switched under the supervision of a specialist in consultation with the patient
- Needs local endorsement and adoption
- Adalimumab performance:
  - Engagement with clinical teams - PCH rheumatology key area to improve performance
- Key enabler – Specialist Pharmacist

Low Value for Prescribing

Purpose: To drive a reduction in the prescribing of items considered as not suitable for routine prescribing in Wales.

Unit of measure: Low value for prescribing defined medicines spend per 1,000 patients.

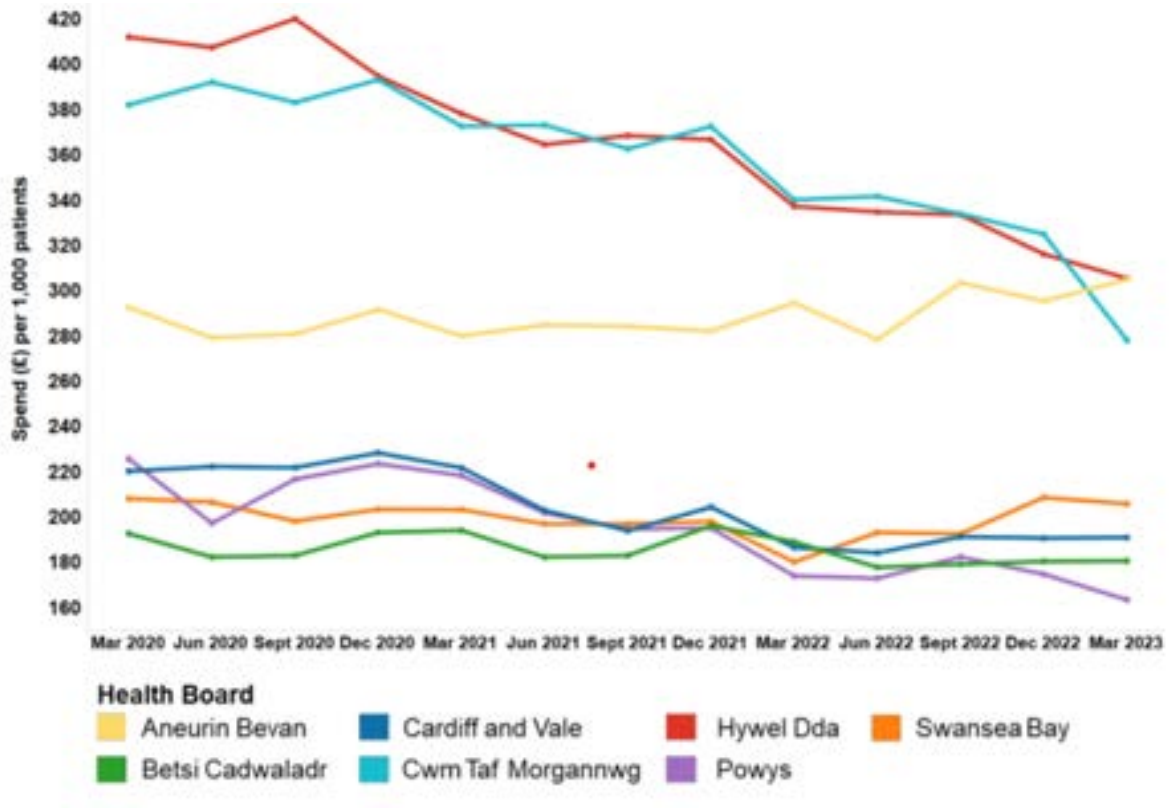
Aim: To reduce prescribing of items considered as not suitable for prescribing in Wales

First phase:

- co-proxamol
- lidocaine plasters
- tadalafil once-daily preparations
- liothyronine
- doxazosin modified release tablets

Second phase:

- omega-3 fatty acid compounds
- oxycodone/naloxone combination
- paracetamol/tramadol combination
- perindopril arginine



Greatest percentage decrease for the quarter ending March 2023, compared with the equivalent quarter of the previous year

Primary care workstreams influencing this

- Prescribing Management Scheme/Incentive Scheme
- General medication reviews
- 'Housekeeping' switches (doxazosin, perindopril)
- Targeted switches e.g. Lidocaine
- Scriptswitch
- Annual visit reports

Other key enablers

- Formulary
- Good secondary care processes – manage patient expectations, good discharge processes
- Guidelines

Hypnotics and anxiolytics – the aims:

- *Maintain performance levels within the lower quartile* ☒
- *or show a reduction towards the quartile below* ☑

Trends and comparisons to other Health Boards

Welsh Analytical Prescribing Support Unit

Figure 19. Trend in hypnotic and anxiolytic prescribing ADQs per 1,000 STAR-PUs

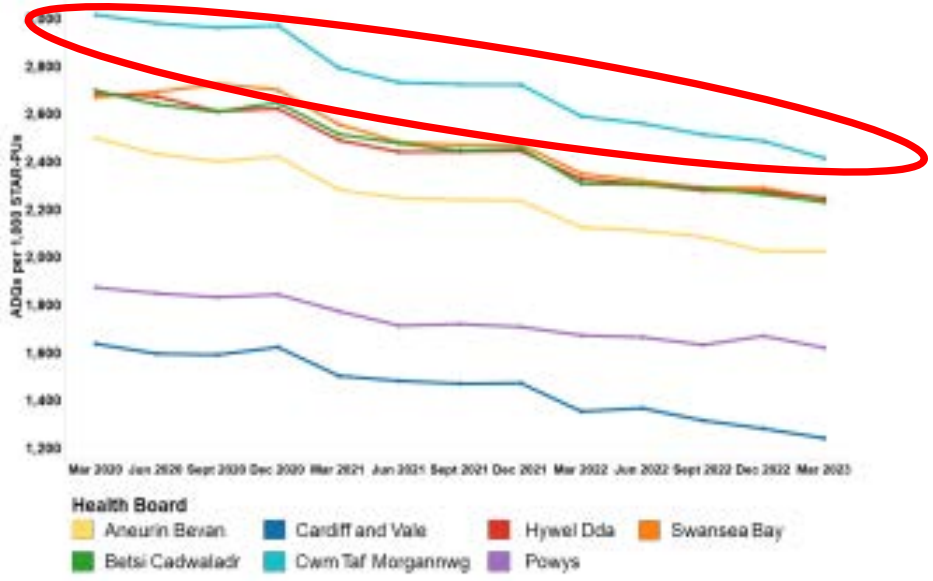
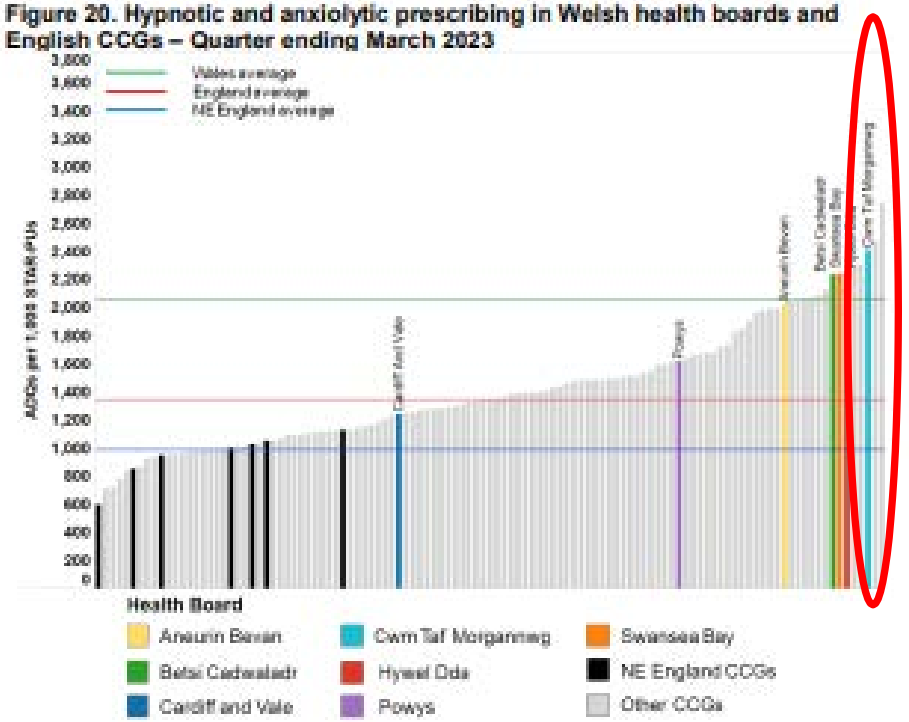


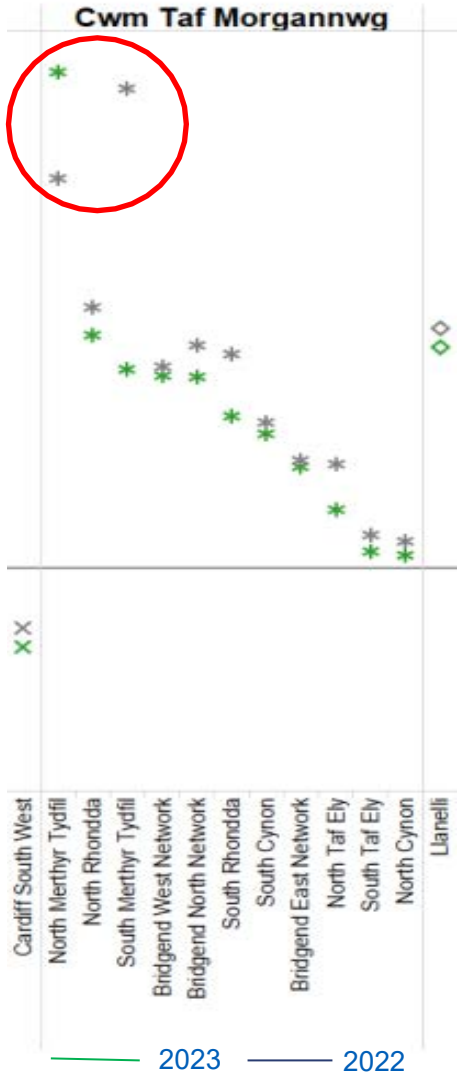
Figure 20. Hypnotic and anxiolytic prescribing in Welsh health boards and English CCGs – Quarter ending March 2023



Highest prescribers BUT going the right way
Above all the averages, including NE England (similar deprivation)

2022 vs 2023

Prescribing of hypnotics and anxiolytics (ADQs per 1,000 STAR-PUs) in primary care **reduced by 4.78% across Wales**, compared with the equivalent quarter of the previous year. This is in line with the aim of the indicator



Q4 21-22	Q4 22-23	% change
2592	2417	-6.74%

Outliers – Merthyr Tydfil high prescribers

South Taf Ely and North Cynon – doing well

Key enablers

- Lead Mental Health Pharmacist – focussed clinics and influencing secondary care
- Pharmacists in practice – see Cynon data
- Secondary care/interface policy
- Scriptswitch messages
- Annual visit reports
- Formulary

Key challenges and barriers

- Prescribing in one area influenced by previous tragedy (Aberfan)
- Lack of engagement with some practices
- Lack of quality PMS/incentive scheme
- Deprescribing hypnotics is a VERY long process –**NEED TO prevent starting them if possible**

Future work:
Audits to identify where they are started
Bespoke clinics – EL return from mat leave
Inclusion in PMS

Recommendation:	The Committee is asked to:
	• *Consider the improvements seen in prescribing indicators over the last year* • *Note the work still to be done* • *Consider whether the Committee can seek assurance from the report that all that can be done is being done to improve prescribing in CTM.*

Agenda Item
9.2.6

Quality & Safety Committee

RADAR COMMITTEE REPORT

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Richard Jones, Clinical Lead for Resuscitation and Acute Deterioration Vanessa Jones, Acute Deterioration Lead Bethan Harding, Resuscitation Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Executive Medical Director Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	7/11/2023	APPROVED
RADAR committee	13/11/2023	NOTED

Acronyms / Glossary of Terms	
RADAR	Recognition of Acute Deterioration and Resuscitation
NEWS	National Early Warning Score

Situation /Background

1.1 The purpose of this report is to provide the Quality and Safety Committee with an overview of governance and activity across CTMUHB of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) over 2023.

1.2 The attached annual RADAR report (appendix 1) describes the CTMUHB approach to Acute Deterioration and Resuscitation with reference to:

- The governance infrastructure in place and progress in the Recognising Acute Deterioration and Resuscitation programme.

1. Specific Matters for Consideration

To note the Governance and quality response:

2.1 Structures

2.1.1 The improvement in CTMUHB governance arrangements since 2019 with the formation of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) and local (previously Integrated Locality Group (ILG)) RADAR subgroups.

2.1.2 Recognition of the impact and progress made with the Acute Deterioration (AD) programme through the appointment of a Clinical Lead (medical) and an AD Lead (nursing).

2.1.3 The essential role of the Critical Care outreach team and the progress made towards establishing 24/7 service equity on all the acute sites across CTMUHB.

2.2 Acute Deterioration Processes

2.2.1 Updating and embedding NEWS Cymru to have a structured and unified approach across CTMUHB in all clinical areas to allow rapid objective detection of deterioration.

2.2.2 Awareness of our NEWS and Escalation Procedure that provides best practice guidance to health care professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

2.2.3 The introduction of a new Sepsis Screening tool via the Sepsis improvement work plan and the Sepsis Working group

2.2.4 Adoption of the All-Wales Treatment Escalation Plan (TEP) as a response to linked work with mortality reviews, where appropriate escalation and de-escalation have been issues in the identified themes.

2.3 Outcomes and assurances

2.3.1 The establishment of audit and feedback processes to monitor and improve performance e.g., NEWS Cymru compliance audit, analysis of Rapid Response and Cardiac Arrest calls to assess the effectiveness of identification, escalation, and response to acute deterioration within CTMUHB

2.3.2 Standardisation of Rapid Response emergency calls throughout CTMUHB.

2.3.3 Progress with the establishment of 24/7 Critical Care Outreach (CCOT) services on each acute site: - Services are now 24/7 at Royal Glamorgan Hospital (RGH) and Princess of Wales (POW). Prince Charles Hospital (PCH)

2.3.4 Establishment of standard operating procedures for CCOT.

2.3.5 Compliance with Welsh Government Sepsis Guidelines 2017.

2.3.6 RADAR care group data reporting established via the care group Quality Safety and Patient Experience/Risk meetings following the organisational restructure.

3 Key Risks / Matters for Escalation

3.1 Structural

3.1.1 Critical Care Outreach teams being pulled/redeployed to cover other areas impacting on clinical rapid response to the acutely deteriorating patient and severe sepsis. Education and training for Sepsis and NEWS Cymru, measurement/audit of sepsis compliance.

3.1.2.1 Challenges in accessing sufficient dedicated accommodation for training in NEWS, Acute Deterioration, Sepsis, Rapid Response and resuscitation

3.1.2.2 Need for Performance and Informatics support to provide meaningful timely data sets to assure Care Groups/Health Board and inform improvement

3.1.2.3 Need for Communications support to promote implementation, engage all staff groups and to advertise good practice.

3.1.2.4 Clinical pressures continue to impact on attendance at training. The Did not Attend (DNA) rate of all resuscitation training currently is 26%

3.1.2.5 Barriers within the electronic staff record (ESR) system exists when aligning the updated matrix with staff resuscitation competences, particular in matching compliance to their job role rather than just a job number

3.1.2.6 Future work: administrative support required to be able to enrol CTMUHB in the National Cardiac Arrest Audit which would give us comparable data to benchmark our systems and training with national

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Timely
	If more than one applies please list below: SAFE, EQUITABLE, EFFECTIVE, EFFICIENT
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* /**Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5 Recommendation

That Quality & Safety Committee

5.1 **NOTE** the content of this report.

5.2 **RECOGNISE** the role of a RADAR Clinical Lead and an Acute Deterioration Lead to drive improvement in this area.

5.3 **RECOGNISE** the essential role that the Critical Care Outreach teams have in both the response to Acute Deterioration and in delivering education to reduce the impact of Acute Deterioration on the patient and on the Health Board.

5.4 **RECOGNISE** the importance of good quality training in Resuscitation to ensure as good an outcome as is possible following Cardiac Arrest.

RADAR COMMITTEE

Cwm Taf Morgannwg

University Health Board

Annual Report 2023

What will this Annual Report tell you?

Our Annual Report provides you with information about the Recognition of Acute Deterioration and Resuscitation (RADAR) Committee within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do and how we work across the organisation to ensure quality and governance in patient care and safety, and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements to date and what we intend to do to build on these.

Contents

Page

1. Introduction and Current Health context in Wales and CTMUHB..... 6-7

2. RADAR Committee Activity..... 7- 21

2.1. Policy and Governance

2.1.1.1 Supporting services

2.2 Quality Improvement

2.2.1 NEWS guidance
2.2.2 NEWS and Escalation Process
2.2.3 sepsis
2.2.4 Acute Kidney Injury
2.2.5 Fluid Balance
2.2.6 Burden of Acute Illness
2.2.7 Resuscitation and Clinical skills
2.2.8 Rapid Response systems
2.2.9 Treatment escalation Plans

2.3 Education and Training

2.3.1 Resuscitation training
2.3.2 Critical Care Outreach

2.4 National Work

Introduction and Background

RADAR Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver *'A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment and resource challenges as healthcare services reset and recover.

Context in CTMUHB

Background

In 2019 CTMUHB received a (Ref 1) Peer Review of Acute Deterioration Services report with a set of recommendations regarding areas for improvement.

The Peer review of Acute Deterioration Services is both a quality assurance and quality improvement programme that assesses the quality of the service being delivered by multi-disciplinary teams and local health boards in Wales. This assessment is set against a framework of local and national guidelines, Patient Safety Alerts and the overall Health and Care Standards for Wales and is underpinned by the principles of Prudent Healthcare.

Sepsis is a specific area of focus of the Acute Deterioration programme.

Also in 2019, the former CTUHB commissioned an external review of Resuscitation Services (Ref 2), where it was noted that governance arrangements regarding the Resuscitation Committee needed to be more robust.

The review team felt that the service should focus more on identifying the organisation's training requirements in relation to the deteriorating patient.

In response to recommendations from both reviews, and practice in other health boards, a new CTMUHB governance infra-structure was created in bringing together resuscitation and acute deterioration (including sepsis) under the consideration of one committee – Recognition of Acute Deterioration and Resuscitation (RADAR) (Ref 3). RADAR reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

Two key clinical appointments were made to lead, direct and co-ordinate RADAR activity:

- Medical Clinical Lead x 2 sessions/ week.
- Acute Deterioration Lead Nurse WTE Band 8A. (*key recommendation from Peer Review)

These posts are currently hosted by Clinical Education.

From March 2023 these 2 posts have been made substantive.

2 RADAR Committee

2.1 Policy and Governance

2.2 Quality Improvement – Acute Deterioration Processes including Sepsis

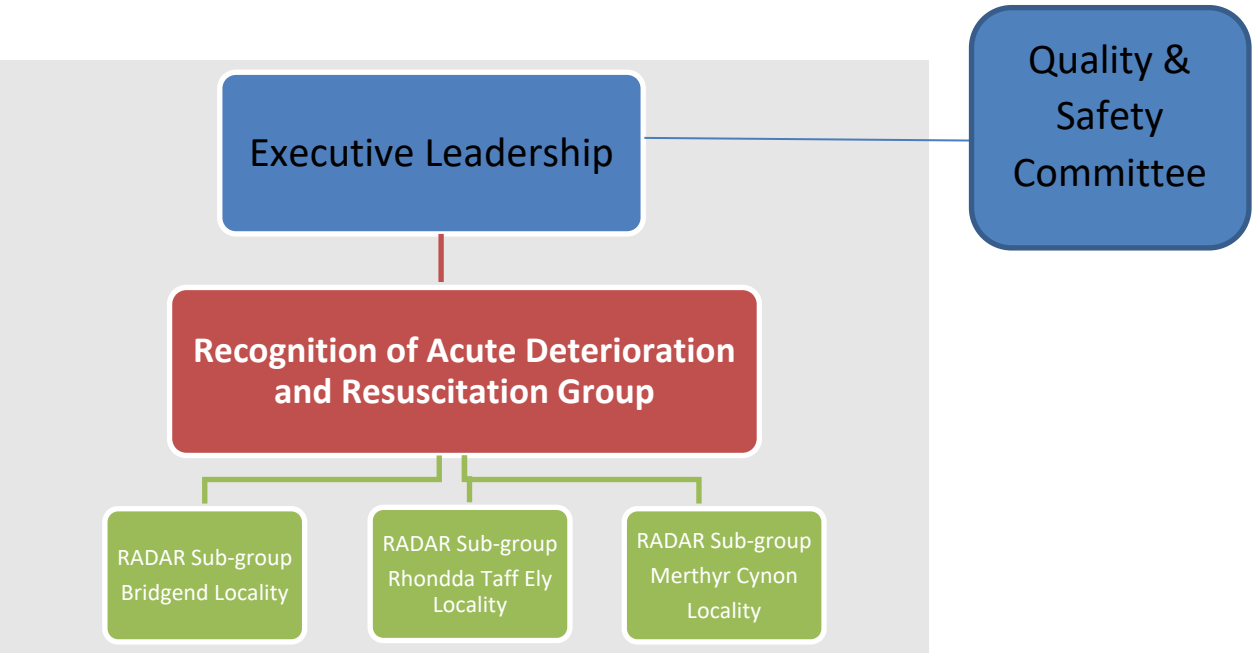
2.3 Education and Training

2.1 Policy and Governance

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Recognition of Acute Deterioration and Resuscitation related issues within the organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It is chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Medical Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 to develop and embed a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the identification, escalation and response to the acutely unwell patient. There is a Resuscitation Lead Nurse who is responsible for providing professional and clinical leadership in all aspects of resuscitation in the health board.

The internal structure of the subgroups of RADAR will be further re-aligned over 2023 with the establishment of the new CTMUHB organisational structure.



2.1.1 **Supporting services**

Resuscitation service

The Resuscitation Service for CTMUHB has a significant focus on providing training to ensure health care professionals are competent and up-to-date with the relevant life support skills for their roles. A training and resuscitation equipment service is also provided to Powys Training Health Board, General Practices and Dentists among other SLAs. This service is also a Resuscitation Council Accredited Training Centre for Level 4 Life support training.

Critical Care Outreach Service

In order to provide a 24-hr response to acute deterioration the Critical Care Outreach teams have been expanded.

Current Outreach establishment

- Princess of Wales Hospital 7WTE (3 x band 7,4 x band 6)24/7
- Royal Glamorgan Hospital 7WTE (7 x band 7)24/7
- Prince Charles Hospital 7WTE (2x band 7, 5 x band 6) 24/7

The expansion of the teams allow a critical care outreach presence at all rapid response calls. The establishment of 7 WTE per site allows for a vital teaching role to be included, which supports the provision of training on acute deterioration, NEWS, sepsis and acute kidney injury (AKI). Due to increased demand for both clinical workload and education, bids have been submitted to expand the teams to 8WTE on each site.
The service continues to face challenges where outreach staff are called back to cover gaps in ITU, emergency departments and areas of high acuity. Strategic direction and leadership are required for this team and service and moving forward could be provided by the acute deterioration lead post.

2.4 **Quality Improvement – Acute Deterioration Processes**

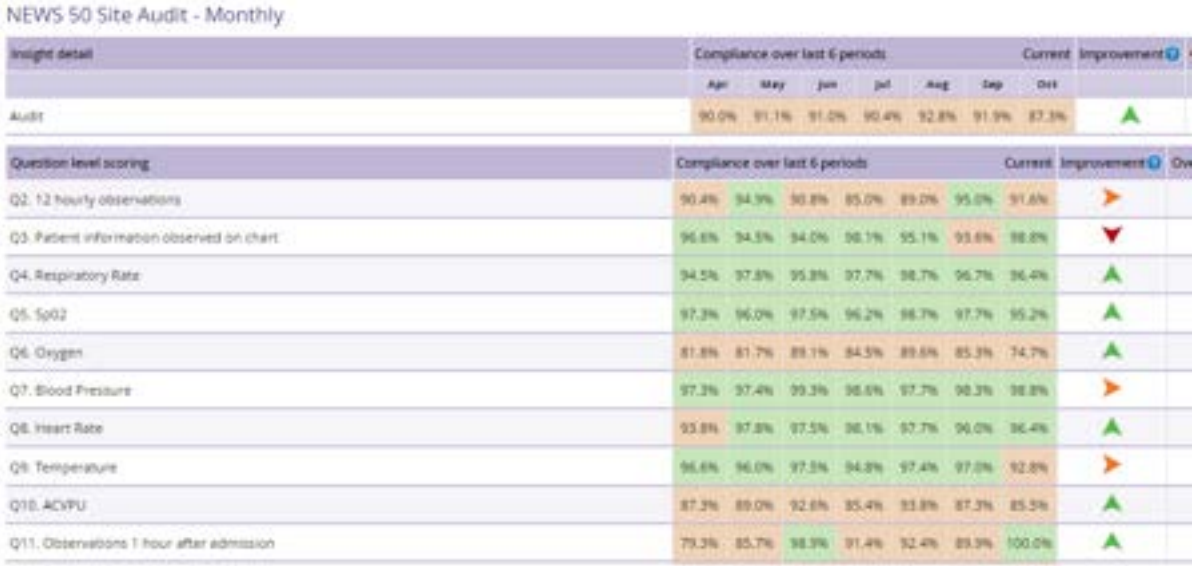
2.2.1 NEWS Guidance

The focus of work is to have a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the areas set out in the Welsh Government (WG) Task and Finish group report on provision of critical care outreach services in Wales Ref and compliance with Welsh Government Sepsis (2017) guidelines (ref 5) including the use of the National Early Warning Score (*NEWS*) in all clinical areas to allow rapid objective detection of deterioration.

As a direct result of the work led by the Clinical Lead and the Acute deterioration lead posts, NEWS charts have been updated in alignment with NEWS2 principles and rolled out as 'NEWS Cymru' charts (ref 7) standardised across all acute and community hospitals in CTMUHB. Specific education and training to support the standardisation has been provided to all staff and incorporated into existing training programmes e.g., Health care support worker induction training and our resuscitation training programmes.

In order to provide assurance within the health board that the NEWS charts are completed accurately and appropriately escalated an audit pro forma has been developed based upon NICE CG50. Data is entered monthly onto the Audit Management and Tracking (AMaT) system. Results are disseminated to all ward managers, senior and head of nursing for review. Any compliance issues are also discussed within the ILG Recognition of Acute Deterioration and Resuscitation RADAR meetings. NEWS audits are used to provide evidence of learning in Learning from events reports (LFER).

Fig 1. CTMUHB Secondary Site NEWS audits April 23-October 23



2.2.2 NEWS and Escalation Procedure

This clinical procedure has been produced to provide Cwm Taf Morgannwg University Health Board (CTMUHB) best practice guidance to health care

professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

The procedure specifically provides a framework through which doctors, registered nurses, healthcare assistants and allied healthcare professionals are informed of their responsibilities in relation to: -

- the minimum standards for monitoring patient's physiological observations
- recording and communicating the results of the monitoring of such physiological observations
- the minimum actions and referral route that must be taken in accordance with the NEWS scoring system

2.2.3 Sepsis Screening Tool

Sepsis
Sepsis is a complication of infection in which a *dysregulated host response is associated with organ dysfunction and increased risk of death.* It is estimated that there are in the region of 500 'suspected sepsis' admissions per year in CTMUHB, with a mortality of about 7%.

Early recognition and response to Sepsis improves outcome.

Sepsis is one of the leading causes of Acute Deterioration and therefore our response to the Acutely Deteriorating patient has Sepsis at its core. Our response to Sepsis is built upon the response to all forms of Acute deterioration i.e., recognition, escalation and timely response by appropriately trained clinicians.

The entry criteria for recognising "Sepsis" are the Suspicion of infection PLUS a NEWS score of 3 or more. This should lead to a patient being screened for sepsis using a *sepsis-screening tool.*
**A note on tools*
Screening tools are used to help clinicians make a judgement on a likely diagnosis at the bedside in a timely manner. Waiting many hours for microbiological confirmation is obviously not an option. There are several tools used for screening a patient for Sepsis. They have varied sensitivities and specificities and no individual tool is ideal. Tools that are too sensitive over-estimate the likelihood of sepsis and lead to many people being over-treated with antibiotics and fluids. This in itself is harmful but added to this is the risk that treating a non-septic patient as septic leads to the true diagnosis being missed e.g.: heart failure, pancreatitis etc. Tools that are too specific under-estimate the likelihood of sepsis leading to patients not receiving essential, early antibiotics. Tools that are overly complicated are difficult for staff to follow and are not practical in most clinical situations as presenting cases seldom conform to rigid protocols.

Sepsis is one of the main causes of acute deterioration and if not identified and treated in a timely manner can lead to multi-organ failure, admission to Intensive Care and death.

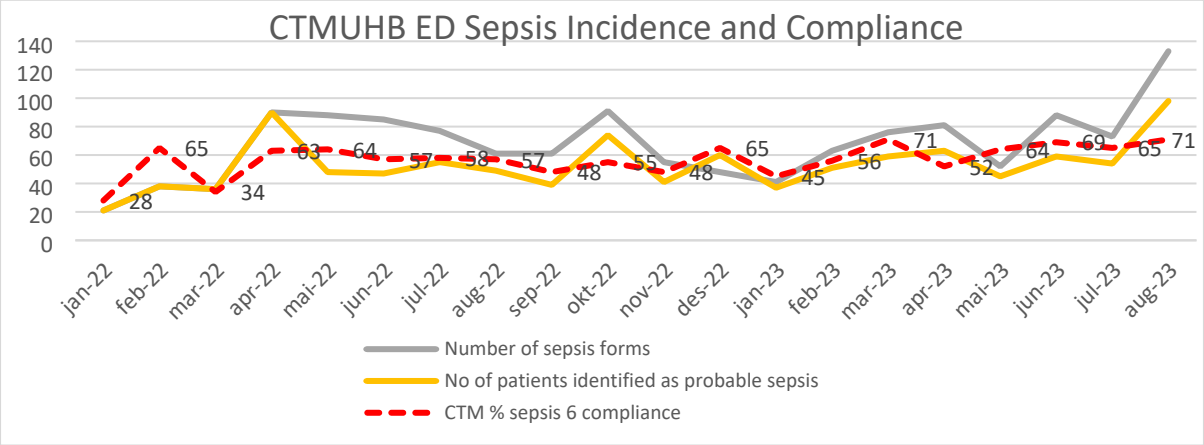
In CTMUHB historically there were several sepsis screening tools in use. To ensure consistency in the identification of sepsis within the hospital setting a new sepsis tool was developed using a collaborative approach between pharmacy, medical

and nursing leads and using the NICE guidelines and the new guidance from the Academy of Medical Royal Colleges. We introduced it into our Emergency Departments (where we see 75% of Sepsis presentations.) Over the course of the year through a great effort in education we have rolled it out to the rest of our hospitals. The new sepsis tool focuses on risk stratifying patients into categories to ensure those at most risk receive timely care. (Ref 4)

To support the timely administration of antibiotics, the first line antibiotics for use within Emergency departments was standardised and a QR code attached to the tool which links to the Antibiotic guidance. This has helped to reduce the time to prescription and administration of antibiotics in the patient with probable sepsis.

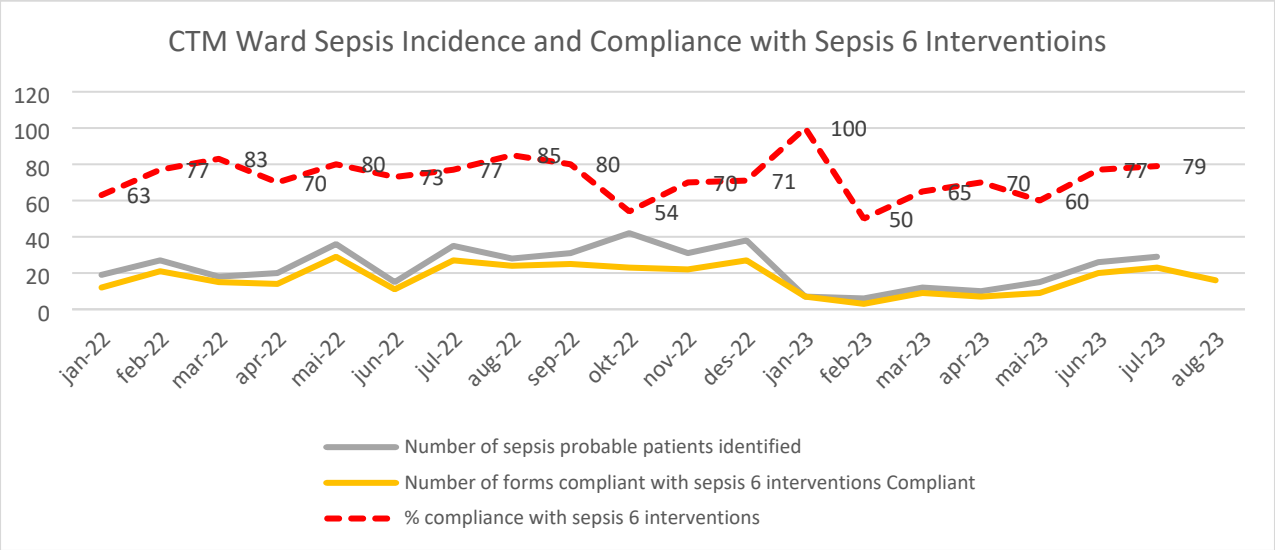
The sepsis tool was trialled within the three Emergency departments for a period of three months. Initial results indicated an increase in the use of screening from 7 screening forms to 90 forms per month and an increase in compliance from 34% to 63% with timely treatment.

Fig 2 CTM Emergency Department Sepsis Incidence and Compliance



Following on from the intial trial in ED the sepsis screening tool has been introduced into *all wards* within RGH/PCH/PoWH. Ongoing work continues on providing meaningful data from all sites

Fig 3 CTM Ward Sepsis Incidence and Compliance



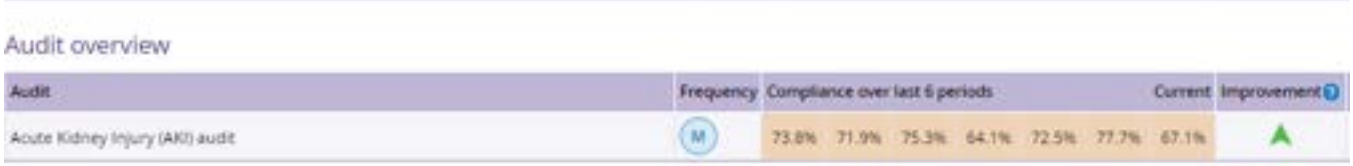
2.2.4 Acute Kidney Injury (AKI)

The National Confidential Enquiry into Patient Outcomes and Death report (NCPOD) in 2009 demonstrated poor management of acute kidney injury (AKI) throughout the UK. In the UK up to 100,000 deaths each year in hospital is associated with acute kidney injury. Up to 30% could be prevented with the right care and treatment. NICE recognises this, and identified only 50% of cases with AKI documented as cause of death received satisfactory or good care (NCEPOD 2009).

In order to improve the management of AKI within CTMUHB an AKI steering group was developed and an AKI sticker bundle was drafted which prompts actions for Medical/nursing staff when patient has an AKI. The AKI steering group reports into RADAR.

The AKI sticker bundle has been introduced into the acute medical wards within RGH, and the care of the elderly wards (COTE) wards in POWH. To measure sticker compliance an audit has been developed on AMaT to ensure that AKI alerts are being managed appropriately and in a timely manner and to identify areas of low compliance to make improvements. Ongoing roll out will take place within all sites in 2023.

AKI Sticker Bundle compliance Audit RGH



2.2.5 Fluid Balance

Fluid balance is an essential tool in determining hydration status. Accuracy in recording fluid intake and output is vital to the overall management of certain patient groups and facilitates the assessment and evaluation of the patient's condition. In addition, accurate fluid balance is an essential component in the prevention and management of an AKI.

In order to improve compliance with recording of a patient's fluid balance status a whole site audit within Royal Glamorgan Hospital and within the Care of the elderly (COTE) wards at POWH were conducted. The results of the audit identified areas for improvement. Ongoing work is being done with the Health Care Support Worker (HCSW) team to develop a fluid balance training session Registered nursing staff are educated via the CCOT within the acutely unwell study days and on the ward teaching. To underpin fluid balance training a procedural document has been written.

The purpose of the procedure is to raise staff awareness by providing a clear set of standards in managing optimal hydration and effective fluid balance. The aim is to guarantee that health care staff apply a consistent and safe approach to maintaining, assessing and recording of individual patient's fluid balance. The intention is to create a set method for recording a detailed and accurate fluid balance by establishing effective standards and management for optimal hydration while supporting staff to determine an appropriate and timely rationale for starting and stopping a fluid balance.

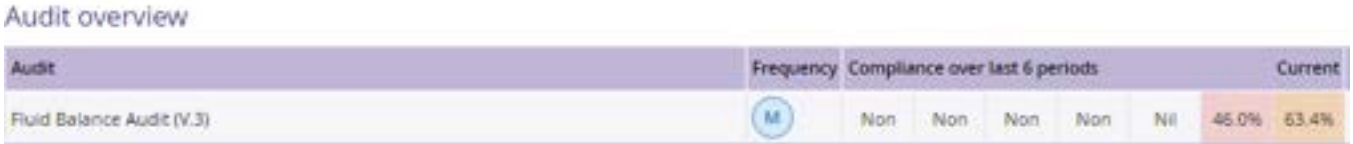
To provide assurance on compliance a monthly fluid balance audit is conducted within RGH site which will be introduced to all sites within 2023.

Fluid Balance Audit (RGH)


Audit overview

Audit	Frequency	Compliance over last 6 periods						Current	Improvement
Fluid Balance Audit (V.3)	M	63.3%	61.0%	71.1%	90.9%	69.3%	69.0%	67.4%	▲

Fluid Balance Audit (Surgery PCH)

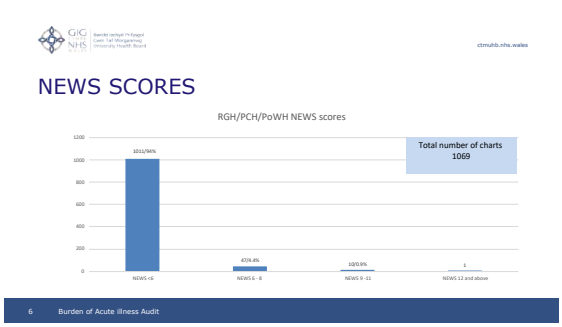

Audit overview

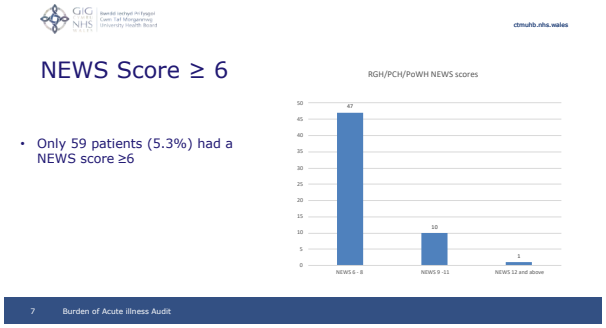
Audit	Frequency	Compliance over last 6 periods						Current
Fluid Balance Audit (V.3)	M	Non	Non	Non	Non	Nil	46.0%	63.4%

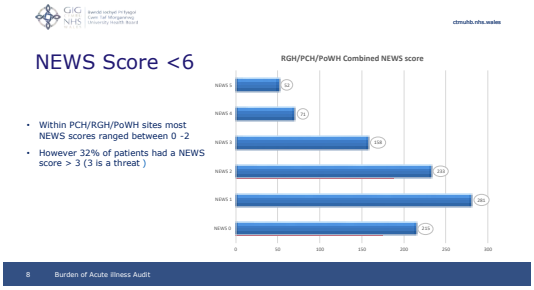
2.2.6 Burden of Acute Illness

Knowledge of how many acutely unwell we have in our acute hospitals in any one period of time is vital to plan provision of services for Acute Deterioration.
We conducted an audit to assess the burden of acute illness within each secondary care hospital over a 24-hour period and to review the escalation process in order

to provide assurance around the management of acute deterioration on each site. (Ref 4)







We looked at these parameters:
The number of NEWS charts in each clinical area
The number of patients scoring NEWS ≥6 in each area
The number of patients who scored ≥6 – 8 who were escalated in line with policy
The number of patients scoring ≥9 in each area who were escalated as per clinical policy

We undertook a separate review into:
The number of rapid responses calls in previous 24 hours
The number of admissions to Critical Care in previous 24 hours
The number and location of cardiac arrest calls in previous 24 hours

2.2.7. Resuscitation and Clinical Skills

The resuscitation service for CTMUHB currently has 12 members. This consists of 1 resuscitation manager, 3 resuscitation practitioners, 3 resuscitation training officers, 3 Clinical skills officers and 2 administrators. Due to maternity leave and the position not being backfilled there are currently 5 members of the team actively training, however, 2 of these have additional managerial responsibilities within the UHB. In addition to this they provide a service to Powys Health Board, GPs, Dentals and other SLAs.

Throughout 2021-22, there was a focus on standardisation of Resuscitation Standards in CTMUHB. This included a complete review of the CTMUHB resuscitation policy, and a renewed resuscitation training compliance matrix for the organisation.

Additionally, the resuscitation equipment was standardised across the health board, with a major change to equipment taking place in Princess of Wales Hospital with the rollout of new resuscitation trolleys across what was then the Bridgend locality group.

The standardisation of equipment, along with the rollout of the Rapid Response Calls, has not only improved patient safety, but has also rationalised equipment with a significant reduction in equipment utilised.

During 2021-22 the Royal Glamorgan Hospital and Prince Charles Hospital received 40 new defibrillators along with the relevant training of staff to ensure competence and safe use.

The service also provided support and training for staff to roll-out a new standard operating procedure in Ty Llidiard, as part of the response to a Welsh Government investigation into a recent incident. This included working closely with Welsh Health Specialised Services (WHSSC) Committee and Welsh Ambulance Service NHS Trust (WAST) to create a hybrid 2222/999 response to emergency calls.

2.2.8 Rapid Response Systems

Clinically significant deterioration of patients admitted to general wards is a recognized complication of hospital care. Rapid Response Systems aim to reduce the number of avoidable adverse events. Over the last 2 years in CTMUHB we have standardised our Rapid Response Call to a NEWS of 9 or over. Rapid arrival at the bedside of the appropriate team has led to patients being seen earlier in their deterioration. Access to Critical Care is enhanced, ward-based treatments are maximised and decisions on further management e.g.: end of life decisions are clarified.

Quality metrics for the evaluation of Rapid Response Systems recommended by the International Society of Rapid Response systems (ref 5)

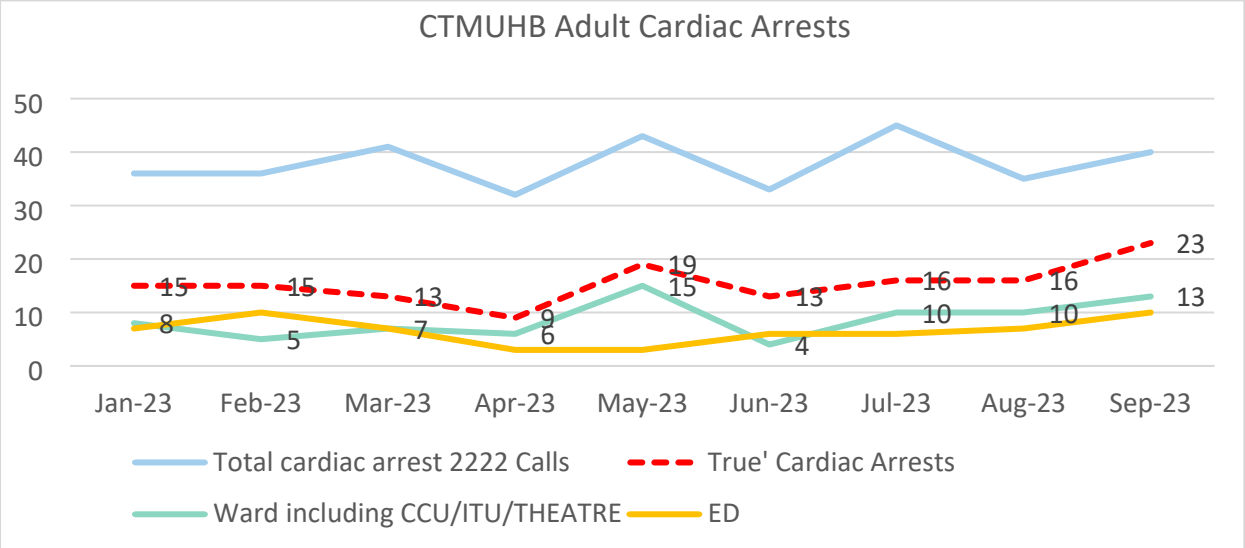
Metrics	Method of data collection	Rationale	How we will do this
Hospitals should measure and track cardiac arrests in regular ward patients	Measure all cardiac arrests occurring within the ward environment	Rates of cardiac arrests on general wards can be seen as an indicator of an organisations ability to appropriately identify and manage patients who deteriorate	We compile a monthly list from switchboard of 2222 calls and input onto AMAT, differentiating which are for Cardiac Arrest and which are for Rapid response

Hospitals should measure predictable cardiac arrests in general ward patients	Cardiac arrest occurring in hospitalised ward patients who met the hospital's escalation threshold at least 30mins prior to and within 24 hr of the cardiac arrest.	IHCA associated with a mortality risk of 80% historic data show that there are preceding derangements in patient observations for up to 8 hours prior to the CA. This forms the basis for escalation criteria for the RRS.	From the RR/CA audit form we have a record of monthly Cardiac arrests that had a NEWS> 6 in the 24hrs prior to arrest. Cardiac arrest review meetings are conducted monthly to review all cardiac arrests within the secondary sites
Hospitals should measure timeliness of their response to ward patient deterioration	measure hospitalised patients who received evaluation by staff with critical care skills or advanced skills within the pre specified time	To assess whether the response of the RRS is timely	There is a box on the audit form that is Y/N for a timely response. Rather than having specific response times in there it may be a judgement call of the auditor whether there was a timely response or not
Hospitals should evaluate timeliness of critical care interventions	Proportion of hospitalised ward patients who receive critical care within 6 hrs of an escalation criteria breach	To measure the facilitation or provision of critical care within 6 hrs. Respiratory support invasive/non invasive Vasopressors/ inotropes Invasive monitoring	In the rapid response box, we record Critical Care intervention and a Time (which could mean transfer to ITU or intervention on the ward or t/f to theatre etc) There is also an updated data system MedICUs in use within PCH/PoWH that the CCOT teams use to enter data on reviews
Patients that exhibit warning signs should receive a timely documentation of goals of care	Proportion of hospitalised ward patients who had goals of care discussions either in place or newly documented by a clinical provider within 24hrs of	Delays of care at either end of palliation-invasive spectrum are associated with avoidable morbidity. The deteriorating patient's best	This is recorded in the DNACPR/Not for escalation box.

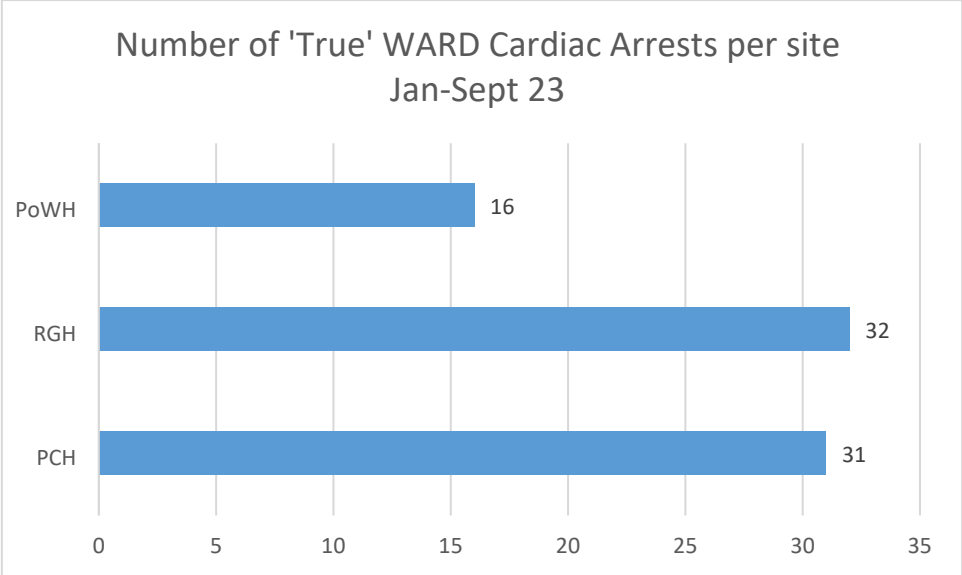
	first breaching the escalation criteria	interest can only be served if a treatment plan communicating the goals of care is developed and implemented at this time.	
Hospitals should provide means by which patients and family members can activate the rapid response team			This is under discussion.
Hospital should consider measuring the frequency of RRT activations by patients and family members			This would be easy to measure when we proceed with family member activation.
Hospitals should evaluate safety culture in relation to deteriorating patients and their care	The hospital uses a survey tool regularly to evaluate hospital staff perceptions of safety culture in relation to the Rapid response systems Adapt existing tool.	RRS organisation wide patient focused systems to be developed to prevent potentially avoidable deaths and serious adverse events as cardiac arrests. Culture and attitudes of an organisation affect patient outcomes	The regular Staff feedback form on Outreach records this.
Hospitals should measure the length of stay on general wards of all patients with breach of escalation criteria	Measure total length of stay for ward patients who breach escalation criteria differentiated form those patients with timely	RRS operates under the premise that early identification of patients experiencing clinical deterioration leads to early intervention and	A NEWS of 9 is a rapid response call. Further administrative support is needed to ascertain this data.

	documented goals of care. Should include ITU LOS	better clinical outcomes.	
Hospitals should measure ICU length of stay of patients transferred to ITU following breach of local escalation criteria.	Measure the length of stay for patients admitted to ITU from the ward within 24hrs of triggering deterioration. Patients admitted with delayed initiation of critical care should be differentiated from those with prompt escalation of care.	Value in healthcare is defined as the health outcomes achieved relative to their financial cost. The cost of emergency ITU admissions from general wards unknown	This is deliverable if and when as above, administrative support is forthcoming.

Graph illustrates the total number of monthly Cardiac Arrest calls and true Cardiac Arrest calls within PCH/RGH/POWH Jan-Sept 23

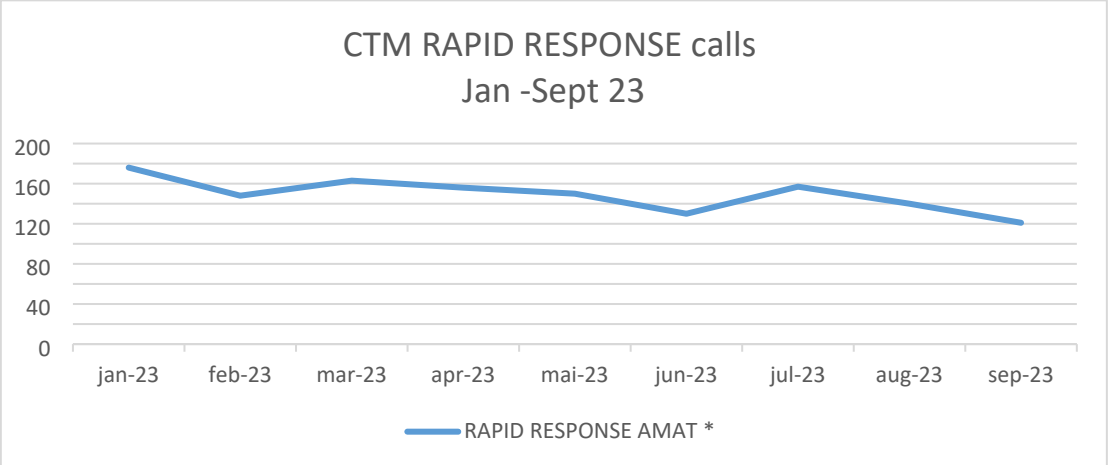


*Not all Cardiac arrests within ED's Recorded



Rapid Response calls for RGH/POW/PCH sites via AMaT *not all recorded dependent on CCOT service)

Jan 23-Sept 23



2.2.9 Treatment Escalation Plans (TEPs)

A TEP form is a way of the healthcare team recording a patient's individual care plan should they deteriorate in an emergency, focusing on which treatments may or may not be most helpful to them. The information recorded on the TEP form helps to guide healthcare professionals in an emergency, as to which treatments would or would not help an individual patient.

A TEP encourages a patient and their team to discuss certain aspects of treatment in advance, promoting careful planning. A TEP ensures that a patient does not receive treatments that they wouldn't want.

In CTMUHB we have adapted and adopted the All-Wales TEP template and are currently progressing with rollout on each secondary site
(Ref 6

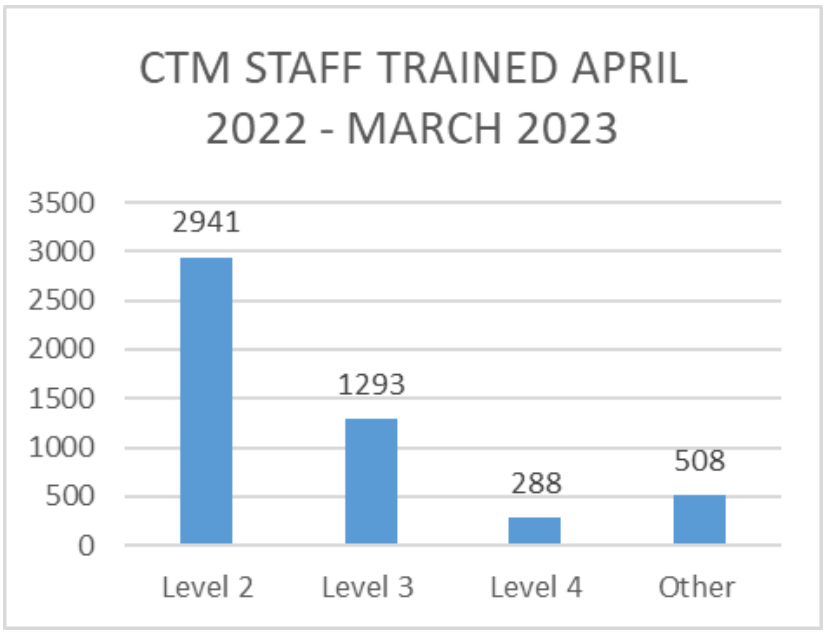
DNACPR *Sharing and Involving- A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales.*

This policy was updated in April 2022 and recommends a biennial audit into documentation of the DNACPR discussion using the DNACPR forms. Our most recent audit is available on request along with an action plan. The audit is being repeated in May 2023. (Ref 7)

2.3 Education and Training

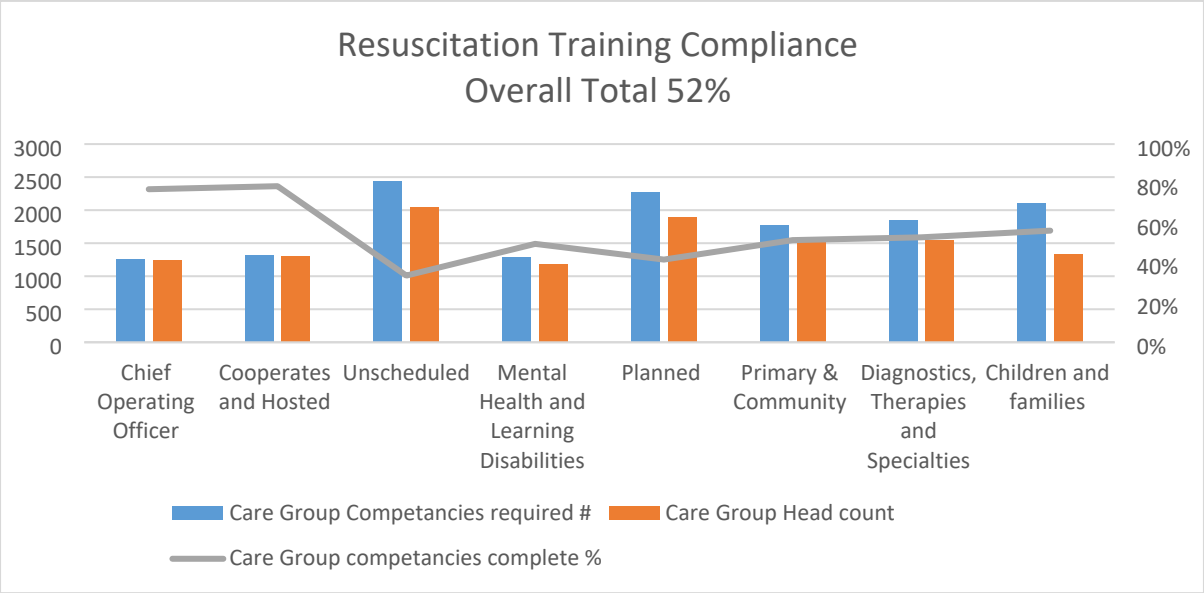
2.3.1 Resuscitation training

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 (graph 1 and 2), for CTMUHB, Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborns and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver. The number of staff trained is outlined below



Staff trained, April 2022 to March 2022

Resuscitation Training Compliance



Vaccination Teams across the UHB have been supported with training to enable them meet the urgent demand throughout the Covid-19 pandemic. Upskilling training was also delivered to 44 ITU staff and 52 Paediatric staff with level 3 Paediatric Immediate Life Support (PILs) in response to the Respiratory Syncytial Virus (RSV) risk.

Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) to deliver 'Train the Trainer' (TTT) 'in house' training programmes for Level 2 Basic Life Support, increasing flexibility and opportunity to offer further training places and therefore increasing compliance. This in turn releases time for the Resuscitation Practitioners and Training Officers to focus on the delivery of Level 3 training, organising and facilitating debriefing sessions following arrest calls, investigating and preparing evidence for Rapid Reviews and scrutiny panels, attending 2222 calls, cardiac arrest audits, and Datix queries. Through this activity areas for improvement are identified and training needs incorporated into future training programmes. E.g., redesign of the cardiac arrest audit form. The revised audit enables identification of areas needing improvement in training and provides a trail of decision making.

In order to meet service demand and provide the UHB with the most appropriate training, alternative training packages have been considered beneficial. Following investigation into the prevalence of sick patients and cardiac arrests in our Community Hospitals, it has been agreed to offer qualified nursing staff a bespoke package, which includes Basic Life Support, Sepsis and AKI, among other things. This package is being designed in conjunction with the UHB's Critical Care Outreach Teams. This will replace the previous training of ILS, which is more suitable for acute sites. This has enabled the service to increase the number of participants on each course and collaboration between Resus and CCOT has increased training delivery capacity.

Additionally, training for other allied health professionals has been reviewed, identifying appropriate level of training for the role being undertaken e.g., level 2 rather than level 3, as they are either looking after "well patients" in outpatient departments or in an area covered by CCOT/2222 calls and where the patient should be accompanied by a nurse i.e., Radiology. In response to changes to the Resuscitation Council UK Guidance regarding the suitability of Paediatric ILS up to the age of 18, we have changed training requirements for staff working within Ty Llidiard to reflect this.

The changes to CTMUHB training compliance standards to more appropriate requirements for each health care role and the promotion of Train the Trainer packages are intended to enable increases in compliance for Resuscitation training (for training matrix please see ref 11).

2.3.2 Critical Care Outreach Service

The Critical Care Outreach Teams (CCOT) deliver acute deterioration training within the secondary sites. NEWS training is also provided by the health care support worker programme and the resuscitation practitioners during Immediate Life Support and Advanced Life Support.

To complement the Immediate Life Support (ILS) course provided by the resuscitation team, the Acute Life-Threatening Events-Recognition and Treatment (ALERT) course has been introduced across CTMUHB for all registered nursing staff. This ensures a unified approach to education to manage an acutely unwell patient within a ward environment. The plan for 22-23 is to extend the provision of the course and develop a multi-professional faculty to facilitate, this would provide best learning environment for the candidates on the course.

Title	**Sites**	**Frequency**	**Staffing and hours**
Acutely unwell study day	All	Monthly	X6 staff total 36hrs
ALERT	All	Monthly	X6 staff total 36hrs
NEWS		Weekly	12 hrs. monthly
Sepsis		weekly	12 hrs. monthly
AKI		Weekly	12 hrs. monthly
Newly Registered Nursing Induction Programme (NRNIP)	All	Bi-annually	6 hrs. annually
Student Nursing Programme	All	Bi annually	18hrs annually
CTM Tracheostomy training	All	Monthly	6hrs monthly

2.4 National Work

The focus of RADAR since it commenced in 2021 has been on establishing fit for purpose ways of working across CTMUHB. It has noted activity ongoing at a National Level and has been working to identify what would be appropriate to engage with further. This is an area of focus and further development over 2023-24.

2.4.1.1 Work within UK

Resuscitation Council UK. (RCUK)
CTMUHB adheres to the RCUK's guidelines for protocols and training of staff. The RCUK are a collaboration of research councils working effectively to enhance the overall impact and effectiveness of resuscitation research, training and innovation activities in the delivery of the government's objectives for science and innovation.

The National Cardiac Arrest Audit (NCAA)
The NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrest in the UK to inform practice and policy. Many organisations in the UK are enrolled in the audit but no LHB in Wales is. A paper was submitted to the RADAR committee in 2021 which agreed that CTMUHB should participate in the NCAA. We are working with the Welsh Resuscitation Forum on taking this forward.

Academy of Medical Royal Colleges (AoMRC)
A recent paper from the AoMRC (Ref 9) led healthcare organisations across the UK to review their approach to Sepsis screening. In summary, the paper acknowledges there is a balance to be found between early antibiotic administration and the danger of over-use of antibiotics and that priority is given to sicker patients based on NEWS scoring. Decision to treat should come from early review by a senior clinical decision maker.
Both at an LHB and a Wales level we are engaged in addressing the paper.

2.4. 2 Work within Wales:

The predecessor to Improvement Cymru, 1000Lives+, had several national workstreams focussed on Acute Deterioration pulled together via the Rapid Response to Acute Illness learning set (RRRAILS).
CTMUHB worked closely with RRAILS and led the way in updating and standardising our approach to NEWS, sepsis and AKI.

After a 4-year hiatus, Improvement Cymru, at the behest of Welsh Government, is attempting to set up a National Acute Deterioration Faculty: an expert panel that will review the current evidence and make recommendations to LHBs in Wales.
The Clinical lead for RADAR and Lead for Acute Deterioration are key members of this expert panel and expect CTMUHB to be at the forefront of any changes.

Up until last year Welsh Government required all LHBs to submit monthly data on Sepsis incidence and compliance. It is expected that Welsh Government will resume a requirement for data when the Acute Deterioration Faculty advises it what data is meaningful to collect.

Our Lead for Acute Deterioration is the Chair of the Welsh Outreach Forum, a part of the UK National Outreach Forum. Regular meetings occur where peers share service innovations and discuss future collaboration.

The Sepsis in Wales group has recently been set up to bring all LHBs together to update and standardise our approach to Sepsis screening following the publication of the Academy of Medical Royal College's Sepsis paper. The group is chaired by our Clinical lead for RADAR.

Welsh Advanced and Future Care Planning Group:
In many clinical interactions, the response to Acute Deterioration is good. Often, where the response is less good, the problem lies in issues around appropriateness of escalation. Too often, patients in the last few hours of a natural and anticipated death are subjected to investigations and interventions that are futile and distressing for them and their families.
We receive regular reports from the Mortality Review process which illustrate these issues.
Thoughtful, early advanced care planning aims to reduce these issues.
In CTMUHB our work to roll out Treatment Escalation Plans is key to ensuring good, prudent and dignified care to all our patients.

Reference for papers All available on request

1 CTUHB Peer review report:	2 Resuscitation Services review
3 RADAR TOR	4 WG critical care report
5. CTM Sepsis Screening Tool	6. Burden of Acute Illness Audit
7. TEP policy/form/patient information leaflet	8. DNACPR audit and Policy
9. AoMRC Statement on Antibiotics In sepsis	10. International Society for rapid response systems Metrics
11. Cardiopulmonary policy and Resuscitation Training matrix	

Agenda Item
9.2.7

Quality & Safety Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2023-2024

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit & Quality Informatics, Lauren Dyton – Clinical Audit Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
CA&QI	Clinical Audit & Quality Informatics Department
NEIAA	National Early Inflammatory Arthritis Audit
NAIF	National Audit of Inpatient Falls
NELA	National Emergency Laparotomy Audit
SWTN	South Wales Trauma Network

PWH	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
AMaT	Audit Management and Tracking
iCTM	Innovate Connect Transform Motivate
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MINAP	Myocardial Ischaemia Audit Project
STEMI	ST Segment Elevation Myocardial Infarction
NSTEMI	Non-ST Segment Elevation Myocardial Infarction
PCI	Percutaneous Coronary Intervention
ACS	Acute Coronary Syndrome
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
COPD	Chronic Obstructive Pulmonary Disease

1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2023-2024 aligned to the NCA&ORP for 2023/24. The WG have yet to confirm the official released date for the 2023-24 plan.

1.2 **29** out of 33 national audits and 9 clinical outcome reviews (tier 1) are green fully compliant and **4** amber where the audits are delayed, a backlog exists but a plan is in place to comply with the national audit deadline.

1.3 The Consent (all-Wales) Tier 2 organisation priority audit has been completed; findings are being disseminated. The DNACPR audit specifically reviewing fractured neck of femur cases is complete and due for presentation, the overarching DNACPR audit is in progress.

1.4 A revised format for the Tier 2 organisation priority documentation audit is currently in development and will utilise AMaT functionality.

1.5 The AMaT system continues to develop with work in progress to establish if the Quality Improvement module is suitable for use by the iCTM team. The ward and area module is also is being extended to District Nursing, Therapies and a number of other specialities.

2. Specific Matters for Consideration

2.1 Clinical Audit Forward Plan 2023-2024 Current Position

NEIAA remains amber due to Rheumatology service limitations (PWH in particular). Recruitment is in progress.

NAIF requires clinical input for case note review activity on all three District General Hospital sites.

NELA current compliance lower than anticipated at RGH, enhanced engagement with NELA leads, anaesthetic and surgical staff to encourage active data submission.

TARN interim measures in place following the taking down of the system by the University of Manchester (refer to key risk point 3.1) which has impacted on national data capture.

Noting the above exceptions the clinical audit team are working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

2.2 Key clinical audit publications, findings and actions

NCEPOD Transition Study Report: The 'Inbetweeners'

The aim of the study was to assess the barriers and facilitators for young people receiving a good transition to adult healthcare services, data collected on children and young people with one of 12 complex conditions identified from a sample period between 1st October 2019 and 31st March 2021.

The study identified that there is no clear pathway for the transition from healthcare services for children and young people to adult healthcare services. Moreover, the process of transition and the subsequent transfer is often fragmented, both within and across specialties. Concluding that developmentally appropriate healthcare needs to be everyone's responsibility and adequate resources need to be made available to allow this to happen.

Key recommendations include:

1. Make developmentally appropriate healthcare core business for all involved
2. Involve young people and parent/carers in transition planning and transfer to adult services
3. Improve communication and co-ordination between all specialties
4. Organise healthcare services to enable young people to transfer to adult services effectively
5. Provide strong leadership at board and specialty level at all stages of transition and transfer

The NCEPOD report recommendations are aligned to the WG guidance on managing the transition of care from child to adult services. Work is currently ongoing with the Directorate of Strategy & Transformation, Child and Adolescent Mental Health, Adult Mental Health services and Children and Young People's services to develop transition protocols, establish a Transition strategy group and broaden the activity further.

MINAP: Management of Heart Attack (2023 report 2021/22 data)

This report summarises the care provided by hospitals in England, Northern Ireland and Wales to over 85,000 heart attack patients during the 2021/22 financial year. The report covers a time when clinicians and managers were attempting to restore services that had been significantly affected by the COVID-19 pandemic but largely precedes the extraordinary pressures on the National Health Service witnessed during the winter of 2022/23, which resulted in delayed pre-hospital responses, delayed admissions through Hospital Emergency Departments and delayed discharges to the community.

Key national observations:

- There were significantly more heart attack patients admitted to hospital 16% increase in the overall number of confirmed cases compared with the previous year, which was substantially affected by COVID-19.
- The time taken to treat higher-risk STEMI heart attacks with primary PCI continues to deteriorate.
- Angiography and PCI for NSTEMI – more cases and greater delays
- Longer hospital stays
- Increase in people self-presenting to hospital.
- Improvements in the provision of echocardiography and referrals to cardiac rehabilitation.

Local observations and areas for improvement:
The introduction of weekend cardiology cover and angiography service would improve timely access to treatment and support compliance with the 72-hour angiogram quality standard for NSTEMI patients.

Inconsistencies in local data due to PCI service provided by tertiary centres. It is anticipated that the ACS app developed by the South Wales Cardiac Network will improve access to cardiology performance data and support service improvements.

Tier 2 (Organisation Priority) Audit - CTMUHB Consent Audit
The purpose of the audit was to measure CTMUHB's consent process / practice against the national guidance, further adding, the seriousness of the subject due to the legal requirement on gaining consent for treatment. The key objectives to the audit were to measure the compliance against defined aspects of the All Wales Consent to Treatment programme guidance, to assess whether the consent was informed and the correct consent to treatment forms were used and to identify areas of risk to enable targeted improvement initiatives.

Results show only 51% of cases had a true 2 stage consenting, 45% had recorded discussions regarding the procedure, 44% of cases had a two-way conversation documented in their records. Only 44% of cases had alternative treatments discussed (this counts as invalid consent).

Completion of consent forms has improved with risks and benefits being discussed and recorded. However, material risks were documented in only 41% of cases meaning 59% were uninformed consent. 24% of cases had clear evidence of a patient information leaflet provided, which would impact on Welsh Risk Pool if these cases went to litigation.

The next round of the consent audit is anticipated to take place in quarter 4, 2023/24.

2.3 **Clinical Audit Training**

AMaT training has taken place in conjunction with Medical Education at POW hospital in September 2023. Dedicated training sessions have been organised for Pharmacy trainees and pharmacy technicians during October to December 2023. A session dedicated for Pathology leads planned for November.

In addition, Clinical Audit experience for student nurses remains a priority with links forged with the University of South Wales.

Active engagement with the Learning & Development team to encourage young people to consider a role in the field of clinical audit through the Jobs Growth Wales+ scheme.

A programme of AMaT ward and area module dashboard and action plan training has continued through quarter 2, 2023/24.

2.4 **AMaT Implementation**

The organisation continues to develop its use of the AMaT system. A review by the iCTM team is being undertaken to establish if the AMaT Quality Improvement module can replace the existing system that is due for renewal.

The AMaT ward and area module is being extended to District Nursing, Therapies and a number of other specialities.

2.5 **NICE Compliance Programme of work**

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups. However, in collaboration with the Medical Director's office a process to disseminate new NICE guidance and to receive feedback from care groups and annotate compliance statements on the AMaT system is under development.

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

Welsh Health Circular and NHS Wales National Clinical Audit and Outcome Review Plan for Wales has yet to be published. The CTMUHB Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

3. Key Risks / Matters for Escalation

3.1 On 9 June, the University of Manchester confirmed it had taken down the Trauma Audit Research Network's National Major Trauma Database, resulting in the inability to submit or access data.

SWTN liaised with Health Boards and Welsh Government to address the issue.

This is preventing the review of Major Trauma dashboard data for improvement and has resulted in a 5 month backlog of TARN cases that may need to be input into the new data collection system. This may impact on the clinical audit department's ability to maintain compliance for other national audits.

Interim data capture solutions provided by SWTN are in use and SWTN is working in collaboration with Digital Health Care Wales regarding the creation of a long-term data capture solution for use by Health Boards in Wales.

NHS England confirmed that TARN will be renamed the National Major Trauma Registry (NMTR) to be hosted by NHS England.

3.2 **Auto-coding** introduction has identified potential additional cases for national audits after the close of the data capture window, national audits affected include the National COPD Audit and the National Heart Failure Audit. Processes are being established to improve communication between departments and support the identification of potentially incorrectly auto-coded cases for manual coding checks to be undertaken.

3.3 Limited clinical input across the Health Board is affecting compliance against the **NAIF audit**. Work is ongoing to identify clinical support across all 3 sites.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Data to Knowledge

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient and Safe Care
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
		If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

Agenda Item
9.2.8

Quality & Safety Committee

CLINICAL EDUCATION ANNUAL REPORT 2022/23

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Janet Gilbertson – Head of Clinical Education
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Clinical Education Forum Executive Leadership Group	07/11/2023	Endorsed for Approval

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
HEIW	Health Education and Improvement Wales
NEWS	National Early Warning Score
RADAR	Recognition of Acute Deterioration and Resuscitation

1. Situation /Background

1.1 The purpose of this report is to highlight the activities and performance of Clinical Education for the academic year 2022/23 and to share the Strategic Direction for Clinical Education.

1.2 The Clinical Education Annual Report is presented in Appendix 1 for noting

2. Specific Matters for Consideration

2.1 That investment in education and training of our workforce underpins the required transformation to the way we work. Underpinning the CTM2030 strategy will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development. Education and support is key and as our workforce is forever changing, this is an ongoing need.

2.2 An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

2.3 To note the progress that has been made in 22/23 towards the delivery of the Strategic Direction for Clinical Education including;

2.3.1.1 Raising the profile and identity of our service through a branding and refresh of Clinical Education facilities across all sites.

2.3.1.2 Continuation, with Finance, of a three year plan to align and standardise Service Increment for Teaching (SIFT) funding, enabling the robust resource support structures of the undergraduate medical education activity, and increasing governance and clarity over the utilisation of SIFT funds.

2.3.1.3 Establishment of the Clinical Education Forum and reporting forums as a robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards.

2.3.1.4 Significant progress in the development of Interprofessional learning and practice.

2.3.1.5 Significant progress with our widening access programmes.

2.4 Recognition of the organisational contribution of this function through its many education and training activities to safe working practices and patient care.

3. Key Risks / Matters for Escalation

3.1 Permanent accessible training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services. It is recommended that the creation of a dedicated multi-professional Education and Learning facility is included as part of the strategic site development plan.

3.2 Continuing support will be needed from executives for the 3 year plan for the re-alignment and re-allocation of SIFT throughout the organisation.

3.3 The establishment of strong strategic workforce planning activity considering the workforce as a whole is needed to better inform education commissioning, in order to support multi-disciplinary service redesign to deliver our Clinical Strategy.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Inspiring People
	If more than one applies please list below: Improving Care Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No policies or services are new or have been withdrawn
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No policies or services are new or have been withdrawn.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 It is recommended that the Quality and Safety committee notes the Clinical Education Annual Report 2022/23 and the contribution quality education and training makes to our services and improving patient care.

6. Next Steps

Approval of the report.

Clinical Education

Cwm Taf Morgannwg

University Health Board

Annual Report Academic Year 2022/2023


MAE EIN GWERTHOEDD YN EIN HELPU NI I FOD AR EIN GORAU
#CTMareingorau
RYDYN NI'N GWRANDO, YN DYSGU AC YN GWELLA
WE LISTEN, LEARN AND IMPROVE
RYDYN NI'N TRIN PAWB Â PHARCH
WE TREAT EVERYONE WITH RESPECT
RYDYN NI I GYD YN CYDWEITHIO FEL UN TÎM
WE ALL WORK TOGETHER AS ONE TEAM
OUR VALUES HELP US BE AT OUR BEST
#CTMatourbest

What will this Annual Report tell you?

Our Annual Report provides you with information about the Clinical Education Service within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do, how we work in partnership with external organisations including Universities and Health Education & Improvement Wales (HEIW), and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements in 2022/2023 and how we have made continued progress towards delivery of our strategic ambition of the CTM Learning Academy, developing and embedding an organisational Learning Culture that enables staff to work flexibly and with agility to respond to the health needs of our population by;

- Encouraging life-long learning
- Generating openness to collaboration and effective co-design
- Developing a greater understanding of human intelligence.
- Promoting multi-professional learning.
- Developing staff to work at the "top of their licence" both registrants and support staff.

It is well recognised that there is a strong causal relationship between targeted and well-designed education and training, service improvement and patient outcomes and that quality healthcare for patients is supported by maintenance and enhancement of clinical, management and personal skills.(1)

Our Annual Report for 2022-23 includes:

- Current health education context in Wales
- Current Education context in CTMUHB
- University Health Board Status
- About us and what we do & activity in 22-23
- Progress with our strategic direction & where we plan to go next.

Contents:

Page

1. Introduction and Current Health Education context in Wales and CTMUHB..... 4

2. About the Clinical Education Service and what we do..... 7

3. Clinical Professional Education..... 9

3.1. Undergraduate/ preregistration education
3.2. Health Care Support Worker Education
3.3. Post Graduate/ post registration Education, Continuing Professional Development and Advanced Practice.
3.4. Acute Deterioration, Resuscitation and Clinical Skills
3.5. Libraries and Knowledge Management

4. Strategic Direction for Clinical Education for CTMUHB..... 32
Progress and future development focus.

5.1. Learning Environment and Culture
5.2. Education Governance
5.3. Multi-professional Approach and Inter-professional Learning.
5.4. Partnership, recognition and mastery.
5.5. Opportunity, Vision and Innovation.

Introduction

Health Education Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver '*A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment, resource and severe financial challenges as healthcare services continue to try to reset from the impacts of the Covid pandemic and meet the growing health care need.

Health Education and Improvement Wales (HEIW) is the strategic workforce organisation for Wales. Now in its fifth year it is committed to the development of a highly qualified, empowered and sustainable workforce for both now and the future. Its purpose is to address assessed workforce requirements and invest in quality education and training for health and care.

The benefits of their approach are:

- A modernised workforce with extended skills
- Access to care closer to home
- Quality learning and service environments to accommodate service transformation
- Sustained growth benefiting the foundation economy
- Increased access to education across the geography of Wales
- A multi-professional workforce that use their skills in line with the prudent in practice principles.

Reshaping and development of the healthcare workforce is fundamental to the successful implementation of the Welsh Government's vision for the NHS in Wales.

Context in CTMUHB

The year from April 2022 was the period in which we emerged from the Pandemic and began to understand its impacts and legacies.

The Cwm Taf Morgannwg workforce has continued to adapt to new working models and service challenges however we are now facing greater health need, driven by the impacts of lockdowns and lack of access to support mechanisms and services. This has created greater demand in areas such as mental health, cancer diagnosis and emergency illness, whilst at the start of the year the elective care backlog was the greatest it has ever been.

This year has also seen the further establishment of our new organisational structure moving from a locality based model to a Care Group structure.

The Board is developing an organisational strategy and a plan for our clinical services which delivers on our mission of "building healthier communities together". Work continued during 2022-2023 to develop and implement the organisational strategy, including the

future of our clinical services through CTM2030. CTM2030 has engaged with staff, our population and partners to identify our four strategic goals which are as follows:

Fig 1 – CTMUHB strategic goals

The work on the strategy will continue to develop in 2023-24 with a focus on developing services across our organisation which are safe, high quality and sustainable from both a workforce, estates and financial perspective.

The Health Board employs 11,148.04 whole-time equivalent (WTE) staff, with a headcount of 12,793. Some 77% of our workforce live within the CTMUHB's area, development of our staff has a direct impact within the communities we serve. Widening access activities to enable more of our communities to achieve successful careers in health care are a key focus of activity for Clinical Education.

Underpinning the CTM2030 strategic goals will be the development of staff including new clinical roles, career development programmes, staff wellbeing and leadership development.

An effective culture of learning at every level enables the workforce to re-frame their knowledge and includes developing a strong workplace learning infrastructure, cultivating a reputation for training and support and excellence in education.

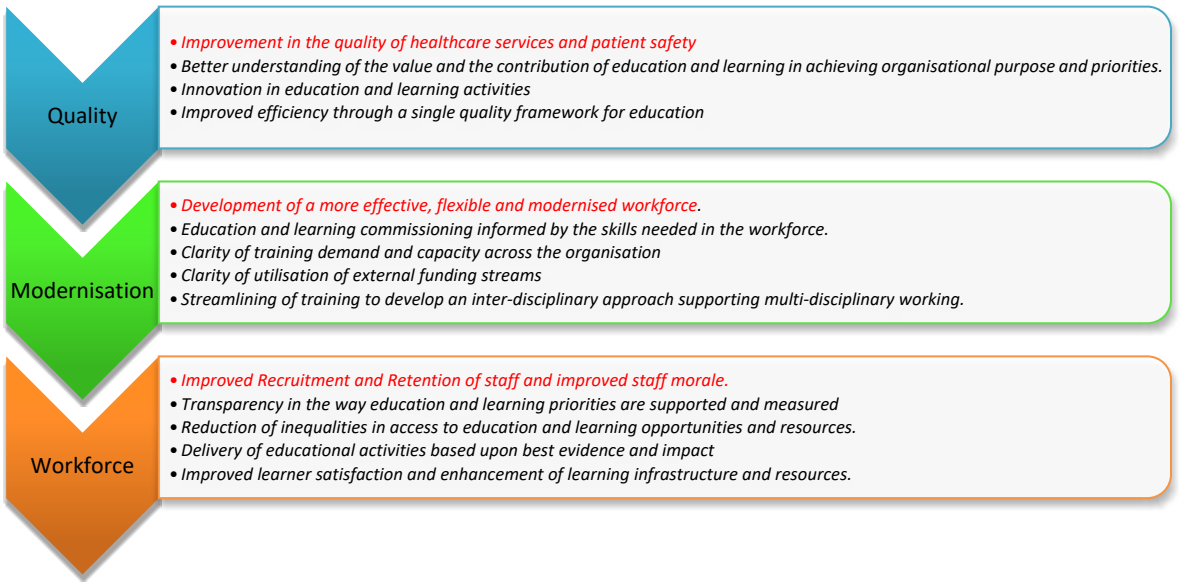


Fig (3) Organisational Benefits of Excellence in Education

University Health Board Status.

Cwm Taf Morgannwg continues to be recognised as a University Health Board, a status first awarded in 2013, due to activity in three pillars; Education & Training, Research & Development, and Innovation.

Welsh Government has incorporated the review of university health board status into the annual Intermediate Medium Term Planning process, requiring consideration and evidence of university health board activity at every level of strategy and delivery.

The potential of University Health Board status, is in the manifestation of the symbiotic and synergistic relationship between three priority activities:

Fig 4

A Learning Culture energises all three elements of university health board activity resulting in Innovation and Improvement

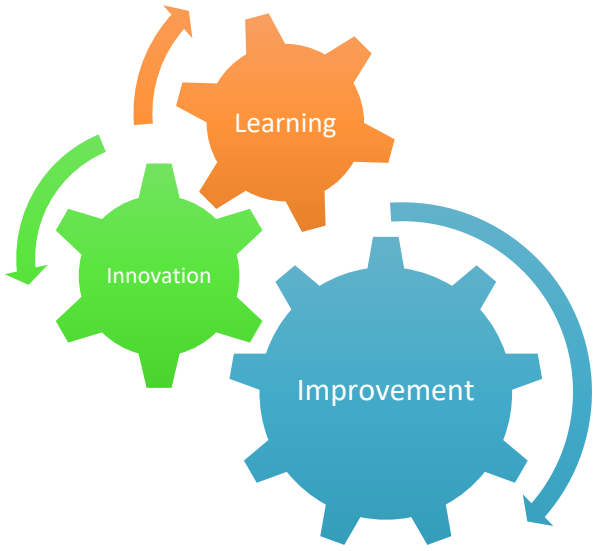


Fig 5

Working in partnership with our Higher Education Institutions (HEI) colleagues in the fields of research, teaching, innovation and evidence based practice, is vital to drive up standards and build momentum for co-creative roles and a collective drive for a better future for our communities.

This year CTMUHB hosted a multi-agency summit with our educational partners including university partners and colleges of further education offering a space for organisational ambitions to be shared and collaborative conversations to emerge. Following on from that a further collaboration event was held between University South Wales (USW) and CTMUHB, hosted by USW. This event utilised a world café format to explore collaboration opportunities in education and training, digital, research, innovation and leadership. A collaboration steering group has been formed to take forward the action plan developed from this event.

About the Clinical Education Service:

The Clinical Education function sits within the portfolio of the Executive Director of Nursing and Midwifery. There are also strong professional leadership accountability lines with the Medical Director and Director of Therapies & Health Care Sciences.

Over 22-23 we have continued our focussed development work, commenced in 2021 to bring together what was a group of separate departments to create a cross-functional multi-disciplinary Clinical Education Service. This work has supported and enabled progress with the delivery of the Strategic Direction for Clinical Education in CTMUHB.

Fig 6 Clinical Education Team.

The Clinical Education Service encompasses the following functionalities:

Fig 7 Clin ED Services

The Clinical Education service is a highly-skilled education workforce of both clinical and specialist administration staff. A central management structure ensures overarching CTMUHB wide consistency of service whilst dedicated education teams manage, deliver and support education activity across all 3 acute hospital sites; Prince Charles, Royal Glamorgan and Princess of Wales and at Keir Hardie Academic Centre. Over 22-23 we have also utilised temporary training accommodation in Ysbyty George Thomas.

Clinical Professional Education.

Undergraduate/ Pre-registration Education and Training

CTMUHB as an organisation contributes significantly to the education and training of healthcare professional students in Wales. Each year our organisation delivers undergraduate clinical placement training weeks including:

- > 6000 medical student training weeks
- > 10,000 student nurse weeks
- > 1600 AHP student weeks

Over 2022/23 we have worked in partnership with 5 universities (HEIs) to deliver clinical placements for healthcare professional students:

- University of South Wales including–
  - Nursing & Midwifery, Operating Department Practitioners and Part-time Occupational Therapy & Physiotherapy courses.
- Cardiff University including
  - Medical, Physiotherapy, Occupational Therapy, Health Care Sciences & Pharmacy – (new pilot programme for 22/23, ongoing from 23/24)
- Swansea University including
  - Nursing, Paramedics and Physicians Associates.
  - (Will include Pharmacy Students from 23/24)
- Cardiff Metropolitan University including
  - Speech and Language Therapy, Dietetics, Podiatry.
- Open University (Part time distance learning) & Bangor University (Full time Distance Learning) from 22-23) Nursing.

Focus on Nursing and Midwifery

The following preregistration routes to nursing are supported:

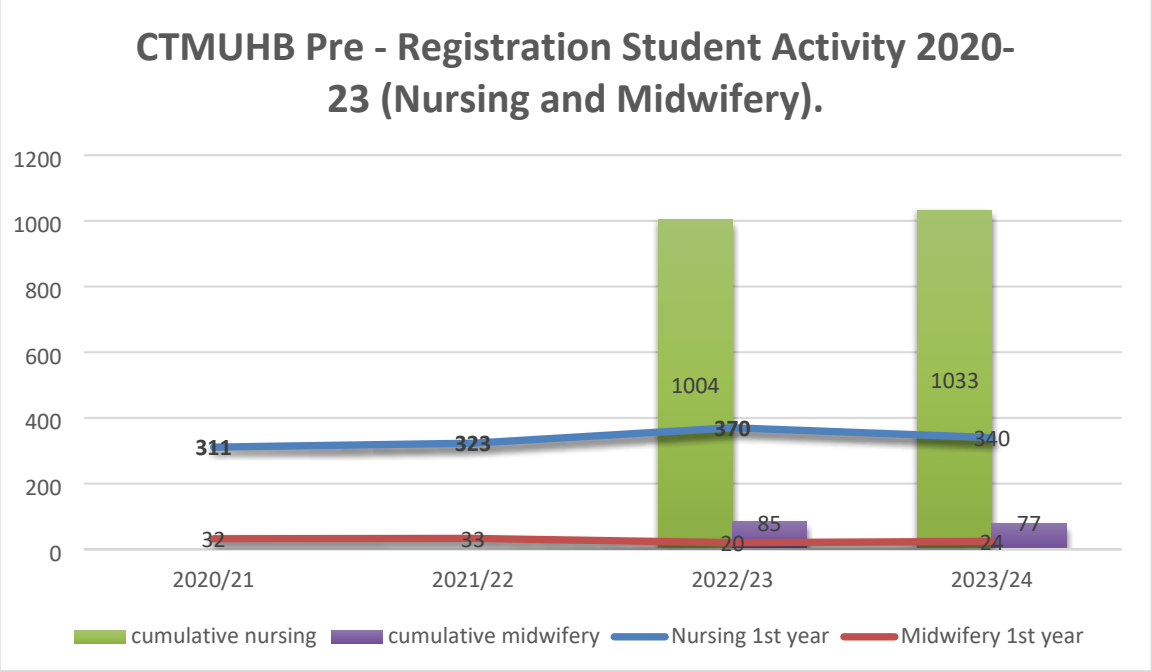
- Full-time 3 year programmes
- Flexible routes in either Adult, Child, Learning Disability or Mental Health.
- Full time Midwifery programme

The Practice Education Facilitators (PEFs) within the Nurse Education Team actively support the clinical placements within the health board and deliver clinical teaching within the university. The PEF team also support student issues both clinically and pastorally in collaboration with our clinical and HEI partners.

The table below shows the number of 1st year nursing & midwifery students allocated to CTMUHB over the last 4 years. As students are placed with us for the 3 years of their undergraduate course, cumulative figures are shown for 22/23 and 23/24. The Practice Education Facilitator Team work closely with the clinical areas and university partners to

ensure areas are supported to provide a positive learning environment as these students represent our future nursing workforce. Monthly meetings with our partner HEI's help identify areas for development including those out of compliance with educational audits & struggling with student numbers and also where excellence is shown by those who go over and above to support our students in practice.

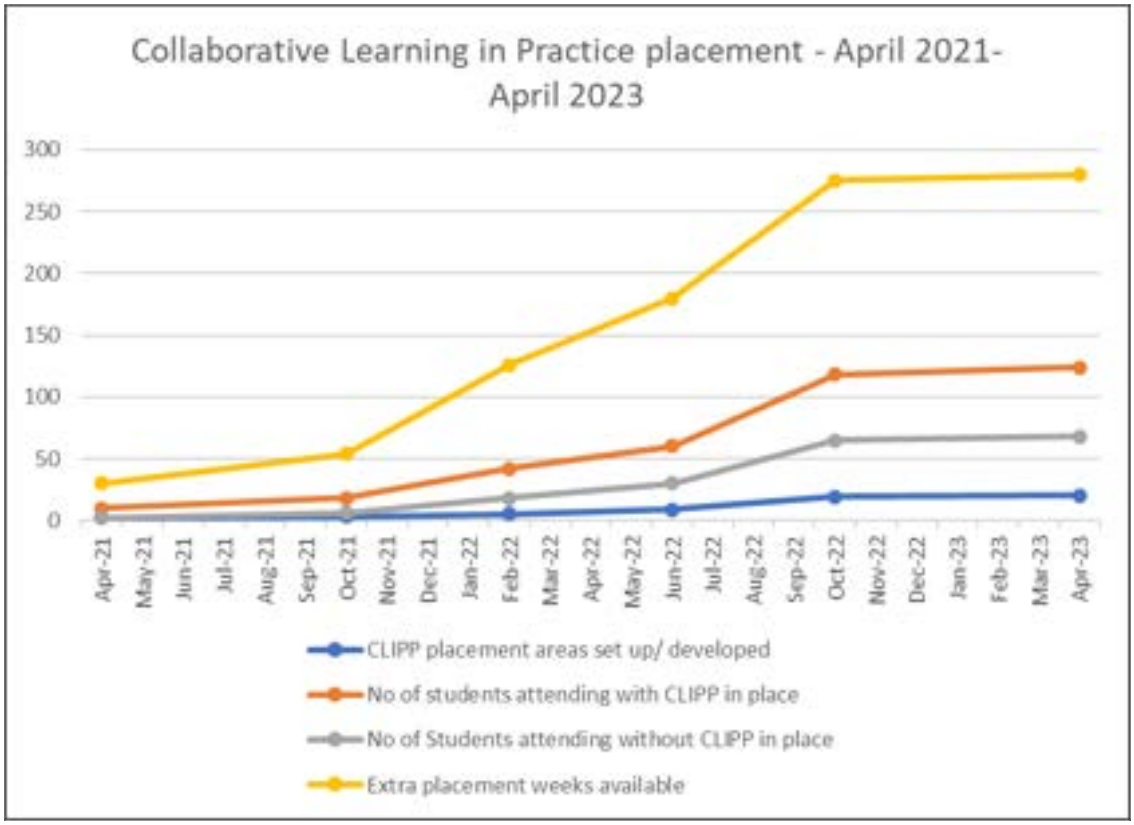
Student training Activity



Training capacity is a constant challenge and we are continually working to create innovative nursing placement developments. New placements for 2022/23 include;

- Cardiology rotational placements
- Research and Development
- Corporate placements.

Following successful pilot results the Collaborative Learning in Practice (CliPP) model is now embedded in a number of areas. Whilst feedback has overall been positive it is not without its challenges, CliPP aligns 1st years to 2nd and 3rd year student mentors and is currently limited by placement timings being aligned. CliPP is still developing in further clinical areas, so capacity and numbers for next year should increase again. Moving forward we will be trialling other alignment combinations to see if it is still as effective, which would maximise utilisation of CliPP in practice.



Fitness to Practice (FtP)/Cause for concerns

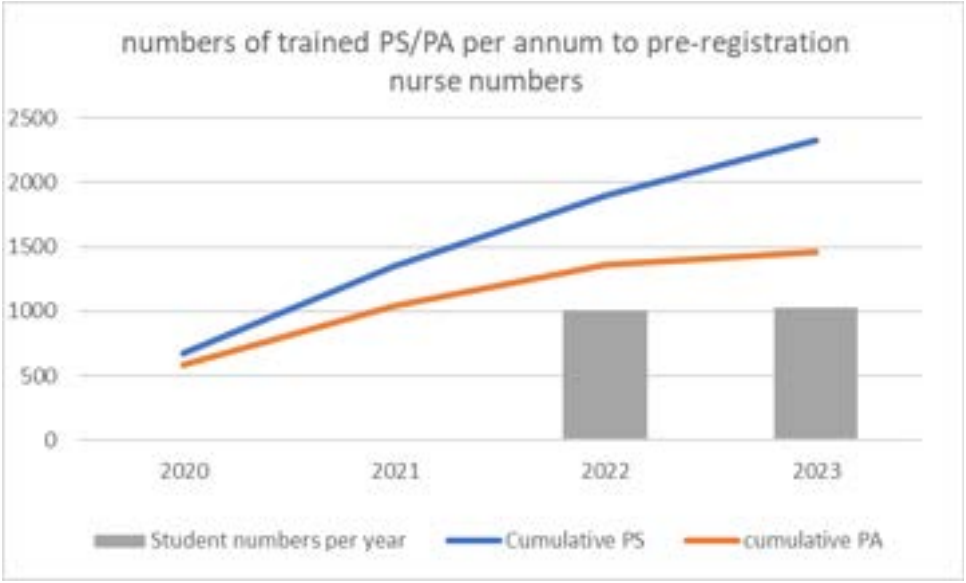
The increase in student numbers has also been accompanied by an increase in student issues. These can include pastoral and clinical concerns. The PEF team and Senior Nurse work across university and health board processes, including referral of clinical cause for concern issues to universities, attending FtP panels and participating in FtP hearings as 'expert witness'. They also ensure students are supported in practice through the development of bespoke action plans to achieve required proficiencies and ensure safe and knowledgeable practitioners upon registration.

Since Covid we have seen an overall rise in the number of Action Plans being required for students allocated in CTM UHB and this rise is mirrored across Wales. The are many reasons for this, including rise in student numbers, earlier identification of issues, changes in student's expectations and impact of Covid on student experience. Action plans may only be required for a short period of time to support the student to achieve or they move in and out of needing one as the course progresses. We are working closely with university partners to monitor this situation.

In 2022/23 there were 13 Official Cause for Concern referrals following clinical issues with two resulting in discontinuation from the programme. Due to the rise in student concerns and the potential movement across the sites the PEF team piloted a 'student pathway' to help document the placements students were attending and also to log any student concerns, so all the PEF team have the ability to access the student 'pathway' and easily link any prior issues. This was successful on the RGH and is now being implemented across all of the PEF teams.

Collaborative working between HEI's and the PEF teams are essential in managing the issues effectively and efficiently. As there is a demand to grow nursing numbers even further then there is a continuing need to widen access to the recruitment pool. This means that the increased need for student support is likely to continue and further investment in Practice Education Facilitator roles will be a key enabler in achieving successful registration for more people into the nursing profession.

All nursing students on clinical placements require Practice Assessors (PA) and Supervisors (PS). The PEF team continue to deliver an annual schedule of Practice Supervisor (PS) and Practice Assessor (PA) training to eligible registrants to ensure they have the appropriate skills and knowledge to support our students in clinical practice. There are currently 2233 trained PA/PS on the database (NMC requirement) for CTMUHB (see graph below). The ratio of supervisors & assessors to students within each care group will be monitored over the coming academic years to ensure we understand where training may need to be targeted.



To ensure all of our students have had the opportunity to achieve all of their Annex B skills, the teams have developed 'skills' days which can be attended by pre-registration students from all of our partner HEI's.

Our HEI partners continue to face challenges in filling the commissioned number of places for the re-registration courses, in particular for the adult nursing field. In order to fill these spaces from Autumn 2023 University of South Wales will be recruiting international students to fill places. Our learning from recent years of recruitment of internationally qualified nurses, is how important it is that these individuals feel supported and settled. We are working collaboratively with USW colleagues to share our learning. The health board induction itself will be more focused to meet their specific needs and will include meet and greet with our existing internationally educated nurses, joint induction and social events.

Internationally Educated Nurses (IEN's) 2022/23

Between June 2022 and March 2023, the International Nurse Education team have successfully trained an additional 97 Internationally Educated Nurses to work across the health board. This education included OSCE preparation training and a post OSCE programme, which was developed to address gaps identified in practice and for the IEN's to be familiarised with CTM's policies and procedures, to enable them to settle sooner into the health board. This programme ended March 23 as no further funding was confirmed by CTM at that time. Knowledge surrounding the specialist IEN educational needs was retained as the lead PDN is a permanent member of the PDN team, however two of the three WTE IEN Practice Development Nurses had to return to their substantive roles at the end of their secondment in March 2023. The project was then recommenced in force from July 2023 with a CTM plan to recruit a further 30 IEN's internationally. To support this funding has been re-established for 2wte IEN PDN's until end of March 2024. These posts will have to be recruited and trained to support this work.

Also, in conjunction with People & Culture and Corporate teams it was highlighted that a number of our HCSW employees were spouses of our existing IEN registered workforce. To support retention and also to capitalise on the fact that they were settled in CTM, up to date with mandatory training, familiar with CTM values and behaviours and embedded within our local communities, a scoping exercise was undertaken to establish how many would be interested in an International Nurse adaptation programme and how many would be 'OSCE ready'. It has been established that we have 5 individuals who are eligible for this and they will commence the OSCE preparation programme in August 2023. Due to the changes in the NMC English language requirements it is envisaged that these will become NMC registrants by March 2024.

Focus on Medical Education

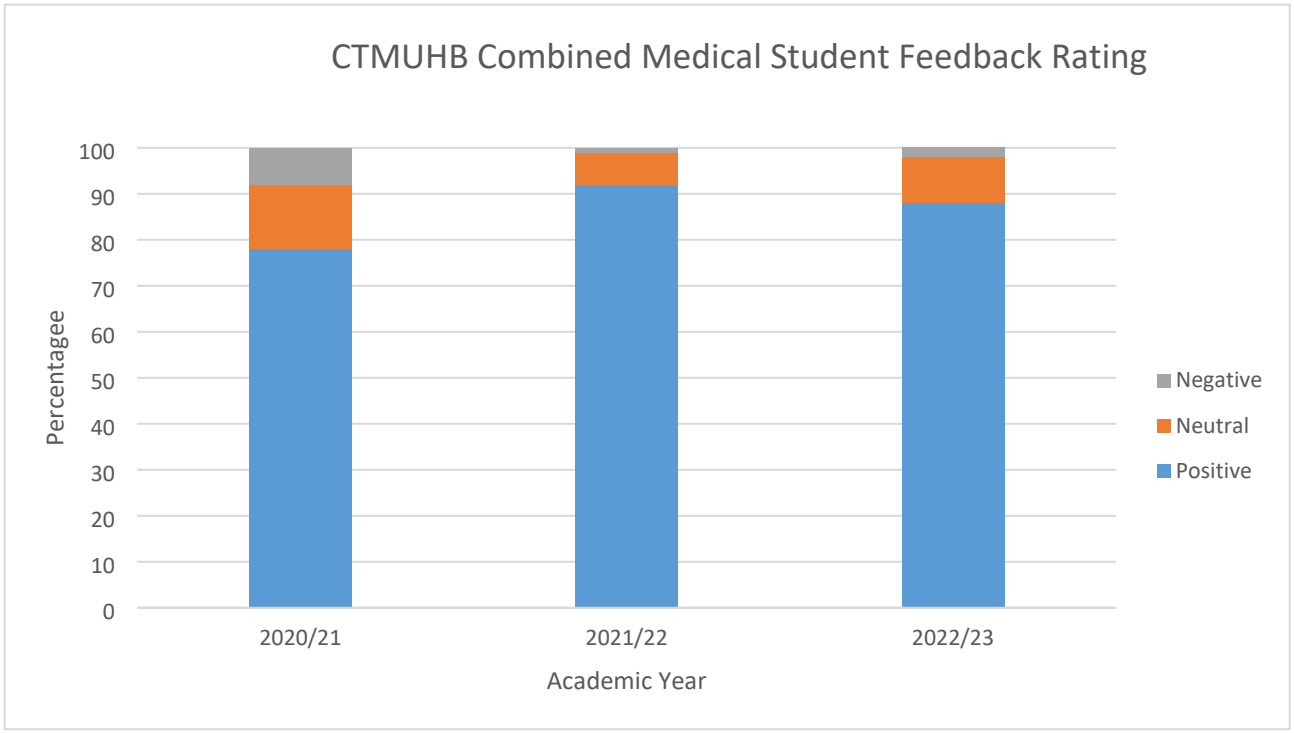
UNDERGRADUATE

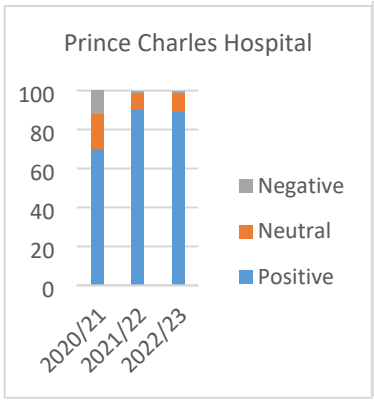
Teaching/placement delivery

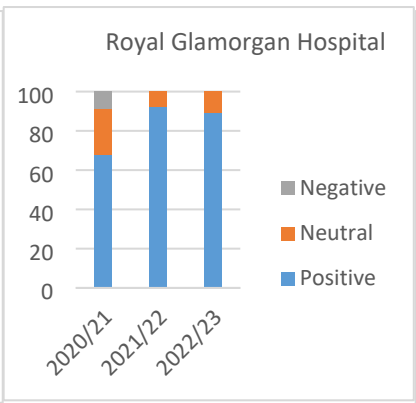
During the Academic Year 22/23 we delivered teaching/placements across the 5 year medical undergraduate (UG) programme –

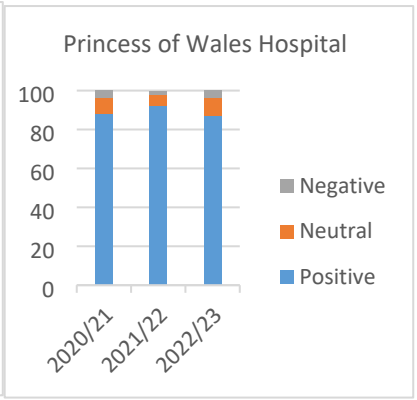
Medical Student Numbers				
Year of Study	No. of Students		No. Student Weeks	
	2021/22	2022/23	2021/22	2022/23
1	113	108	180	238
2	222	227	266	250
3	289	371	2312	2968
4	262	320	1952	2284
5	140	154	1120	1164

The have been significant success in the performance of the UG Faculty during the last academic year and at the Annual Teaching Review, Cardiff University presented the feedback from students, showing that CTMUHB had risen in the overall satisfaction of students by 14 percentage points to 92%, second only to Cardiff and Vale UHB. This is an outstanding achievement and recognition of the hard work and commitment of our medical education teams across the health board. Early indication from the 2022/23 results illustrate that we are maintaining a relatively stable position.









Clinical Fellows

Continuing the success of previous appointments, during the 2022/23 Academic year there were 6 new Clinical Fellows in Medication Education across CTMUHB, as one year tenures with an expectation to engage in a level 7 medical education qualification.

The Clinical Fellows continue to provide a solid and robust teaching resource, which again the feedback shows has been a significant success. In addition, the Clinical Fellows have produced significant quality improvement projects, including a tiered mentoring scheme, advanced bleep simulation and investigation into the use of real patients in teaching. Some of this has been nationally recognised and continues to be presented on national forums.

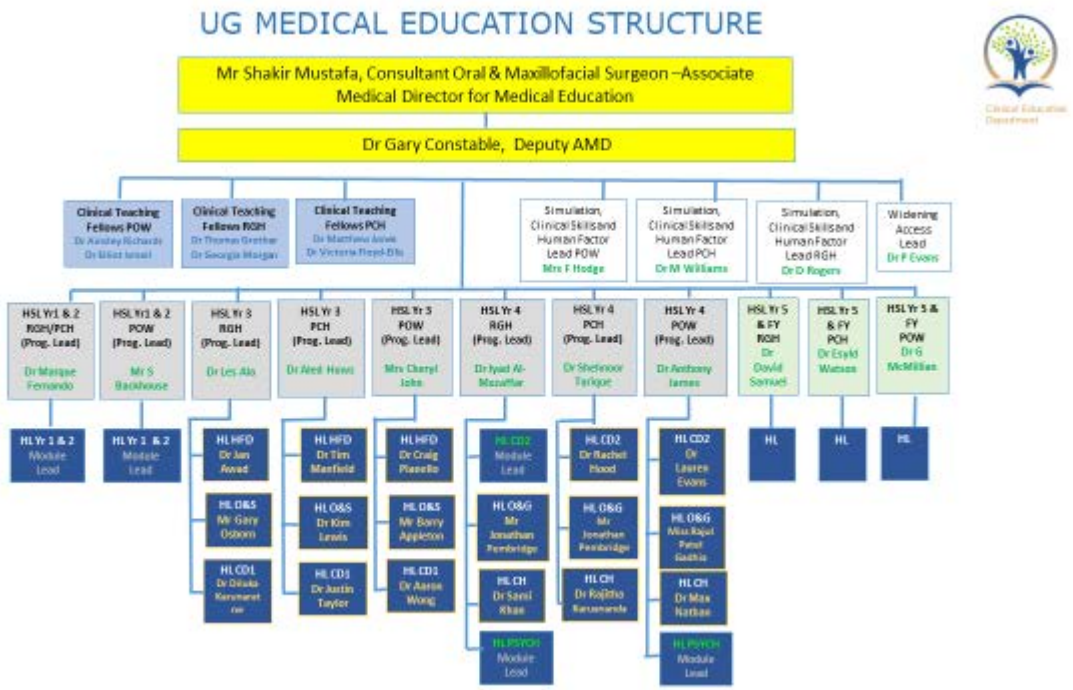
SIFT Reallocation

The reallocation of Service Increment For Teaching (SIFT) continues. Financial year 2022-23 was the first full year of transition of funds and additional SIFT monies were made available to complete appointment to the Faculty structure and support additional administration resource. We have also been able to support education within care groups with new simulation equipment and digital teaching aids.

As indicated in previous annual reports, the SIFT transition's purpose is to better identify the flow of SIFT funds to services, care group and directorate budgets, enabling the robust resource support of UG medical education activity, alongside enabling the organisation to have more clarity and assurance on utilisation of medical undergraduate SIFT funding (approx.£3.2m per annum).

The Clinical Education function continue to engage with Finance colleagues to further progress this work to establish an agreement to the allocation of funds on a more permanent basis, and will be a key player in the working group that Finance are to create.

The following diagram illustrates the current UG Faculty structure.



Health Care Support Worker (HCSW) Education

Clinical Education supports the skills and career development education pathways for health care support workers across CTMUHB as defined in the HCSW Framework, including clinical and non-clinical roles in primary and secondary care settings.
HEIW continues to allocate funding to CTMUHB for HCSW Education and Development, in financial years rather than academic years, in line with compliance with the All Wales HCSW Framework, with £276k being allocated 2022-2023. This was significantly increased for 23-24 to £410k. This was to support expansion of the educational offer to our social care colleagues and also to recognise the support required for the AHP's HCSW workforce. Unfortunately delays in confirmation of this funding coincided with the freeze on recruitment to admin and management staff in summer 23/24 and so we have been unable to recruit the staff needed to make significant progress with the offer to our social care colleagues. This remains an ambition for 24-25 and will be included in our annual bid.

Attendance to the All Wales Induction Framework was less in 2022-23 than in previous years whilst the places were booked attendance was poor. The team have worked hard to improve engagement and attendance and are working closely with Staff Bank to ensure HCSW's are booked onto the programme in a timely manner to enable them to support the clinical areas. Challenges remain with Manual handling training capacity.

The CPD days commenced in 22-23.The Pilot NEWS Study day has proved to be very successful and work is ongoing to ensure availability on a regular basis.

30 HCSW's have been accepted onto year one of the Level 4 Certificate Higher Education, which provides a route into the nursing degree, for September 2023 which is the biggest cohort the team have recruited. 25 HCSW will be progressing into year two. In addition to this a further 8 HCSW's commenced the Open University Part time route to nursing in 22/23 which continues to allow us to 'grow our own' staff and to invest and develop our workforce.

Part-time pathways into health care professional careers are increasingly being commissioned and now include physiotherapy and occupational therapy routes in addition to nursing. The health board needs to focus on further supporting these routes as a way to grow our workforce in the coming years.

A HCSW conference was held in May 2023. This was an excellent event that showcased the fantastic work undertaken by our HCSW workforce. We are hoping to hold another in 2024. The following feedback was shared by one of the HCSW's who presented at the event.

'I never thought I'd be applying to talk again but I must say even though I was nervous the feeling of adrenaline afterwards was great and learnt a lot by doing it and watching others, I even said yes to RCN when I was asked to talk in their HCSW conference at North Wales, so just want to say thank you for the education department for giving us opportunities like this, even when we don't take part just being there and able to see others and learn from them is great, so just want to say thank you all.'

Post Graduate/ Post registration Education and Training, Continuing Professional Development and Advanced Practice.

The Clinical Education Service manages the education, training and development of registered clinical healthcare professionals including:

- Design and delivery of bespoke in-house education programmes to meet training needs e.g. New Nurse Graduate development programme, education packages in response to Clinical Incidents e.g. Nasogastric training.
- Delivery, Management and co-ordination of Education pathways for Foundation Medical Trainees.
- Management of Health Education Improvement Wales Advanced Practice & Non-Medical Prescribing funding streams.
- Management of HEIW (HEIW) Nursing CPD allocation via University of South Wales.
- Recognition of Acute Deterioration & Resuscitation and Clinical Skills including advanced programmes accredited by the Resuscitation Council and Royal College of Surgeons.

Focus on Nursing post registration

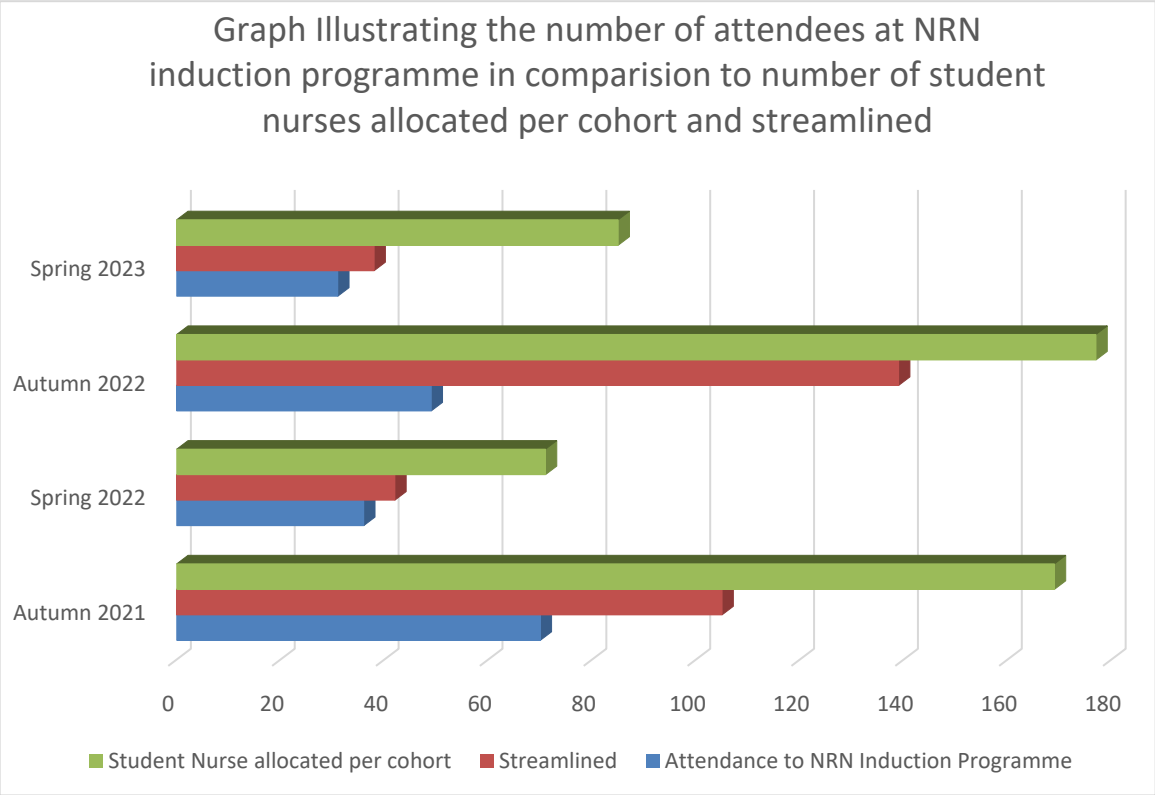
The new Nursing and Midwifery Council's (NMC) Standards of Proficiency and Education for Registered Nurses were launched in May 2018. The new standards made significant changes to proficiencies for registered nurses, standards for preregistration programmes, and student supervision and assessment. The first cohort of the students who undertook the new programme will be registering as new registrants in September 2023 and will be working here in CTM UHB.

We understand the link between experience on placement and early years post registration development and retention into our registered nursing workforce. We offer a robust New Registered Nurse Programme (NRNP) for all graduate nurses employed within the organisation across all fields of nursing, which aligns with the Preceptorship that each new registrant should have in place. The impact of this programme is continually evaluated and amended to ensure clinical need is met and key issues addressed.

The format of the programme has changed to maximise attendance and is now over a period 6 days and in 2022/23 eighty newly registered nurses attended the programme. The plan is to formalise the Preceptorship offer alongside this and education sessions have been developed for experienced staff to enable this.

The PEF team and the Practice Development Nurses facilitate Student Streamlining (recruitment) events in the HEI's and also hold in-house events. Staff from the clinical areas are invited to these events as it provides them with an opportunity to showcase their area, talk about their own induction programmes and share development opportunities that would be available, as well as the day to day information needed about ward life. Attendance at these is good however recent figures illustrated in the graph below would indicate that some students are not staying in the HB to work as registrants and those who do are not all joining the NRN programme. Reasons for this may include,

- Student attrition from the programme. This may have been impacted by the Covid 19 Pandemic
- Delays in students completing the programme and were delayed in taking up NRN post so either missed the programme or joined later.



Further work needs to be done across CTMUHB to understand reasons impacting on retention rates.

The Professional Development and Innovation Programme, targeted for nurses in band 6 roles, focusses on developing their experience of management, leadership and innovation roles to consolidate preparation for the next phase of their careers. The programme is a valuable resource in supporting our Band 6 Nursing workforce. Registrants have attended the programme with more dates planned for 2023-24.

To build on its success the team have planned a similar two day programme for Band 7 registrants which they plan to deliver in the autumn 2023

What is clear from the impact of this programme is the agency and self-authorisation shown by the participants to in offering their leadership through their roles and really making a difference, for colleagues, patients and their care. Attendees are also asked to complete a small improvement project as part of the course and these have been excellent. Here are two examples;

Health: Ward7 YCC*- Highlighted a Wellbeing initiative that she and one of the HCSW had started; "Wellbeing Wednesday". The Band 6 programme provided an opportunity to reflect on its success and to see how they can best develop the initiative. Also by promoting it, it could potentially inspire others to do something similar.*

Community Health Team*- The staff developed a new student information pack with supporting power point information. There had been changes within the team and services, therefore it was recognised that an information pack would help students feel more welcome and provide valuable information about the service and the roles of the individuals in the team.*

The Practice Development Team are developing a number of nurse education days. These include for 2023;

- Falls training- a one day course for registrants and HCSW, delivery will include a session delivered by the Patient Concerns team to enable attendees to fully understand the impact of falls on complaints.

- 'New to Health Board' day- a one day programme for experienced staff who are new to the health board to ensure they are upto date with Cwm Taf Morgannwg values and behaviours, key policies and issues.

- Clinical Supervison- sessions have been delivered to Interprofessional groups and also registrants. And feedback has been excellent. We are awaiting further guidance from the Chief Nursing Officer (CNO) for Wales before completing plan for roll out.

- Preceptorship -. Awaiting further guidance from the CNO for Wales before completing plan for roll out.

- Mental Health Day- a one day course for all registered staff to raise awareness of mental health in all areas and how to manage them.

A Prospectus is being finalised to showcase all the courses Nurse Education offer. Once finalised it will be updated annually.

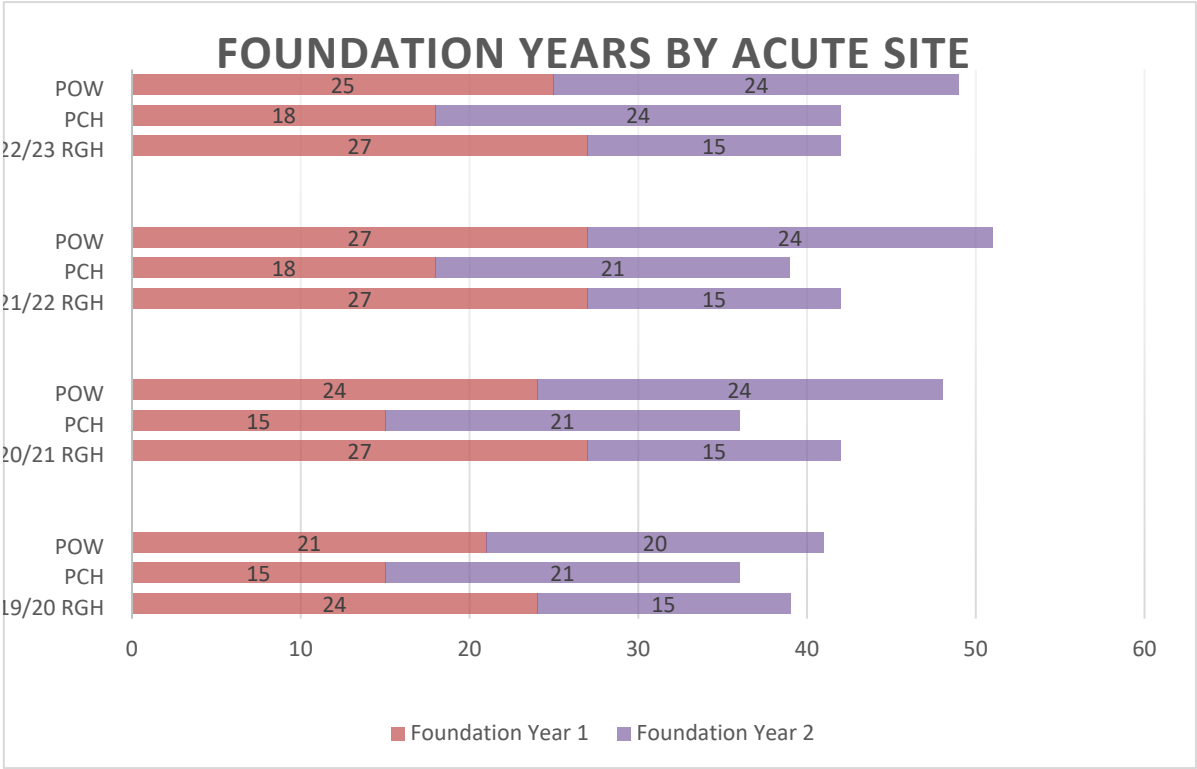
Focus on Medical Post Graduate

In Academic Year 2022/23 CTM UHB had a total of 70 Foundation Year 1 (FY1) doctors and 63 Foundation Year 2 (FY2) doctors starting their rotations across the three acute hospital sites. In addition, throughout the academic year, we held induction for 281 junior doctors as they started with the UHB. This induction covers corporate/legal requirements and site specific information.

Foundation training for FY1 and FY2 took place weekly on specific, regular times on each acute site. In addition we held frequent, speciality-related teaching and journal clubs through the year. We also trialled four simulation afternoons for the FYs which proved to be very beneficial for the new curriculum.

For junior doctors there is facilitated weekly teaching as well as ad hoc events and "Grand Rounds" for all trainees and consultants.

In Spring 2023, we held two Foundation Away Days, which were held in Bronylls Hospital Basil Webb Building in Powys. As well as Foundation Doctors we included some Year 5 students to help building the shadowing relationships. The mornings concentrated on Human Factor training and exercises and the afternoons were team building adventure sport experiences. The feedback was overwhelmingly positive and we intend this to become an annual event.

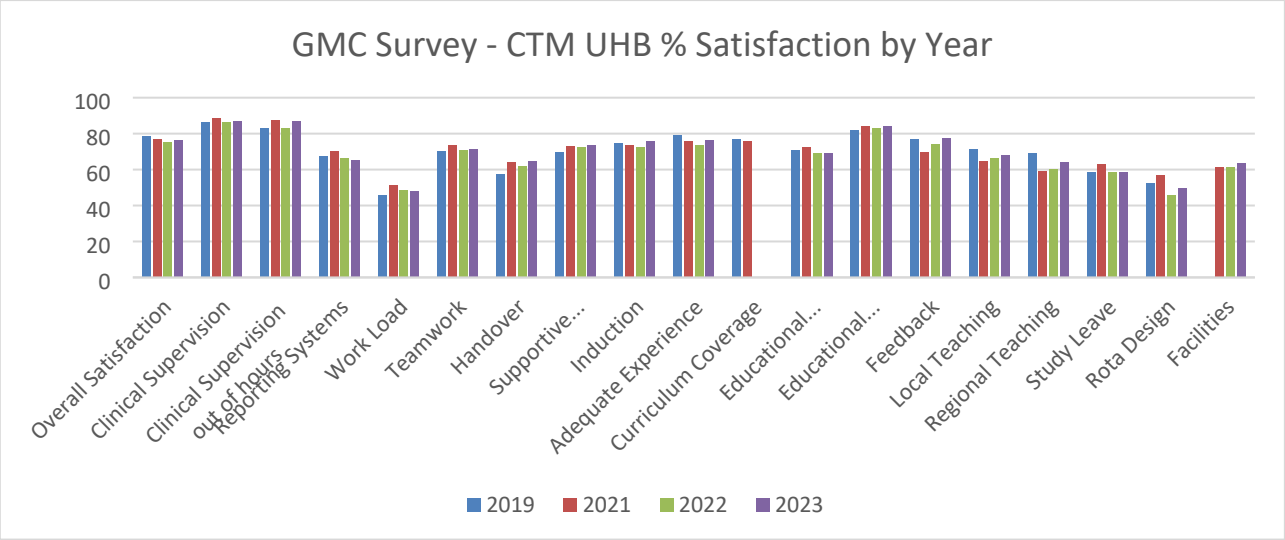


Performance

Performance is monitored via the HEIW Quality Unit. The HEIW CTM UHB "Risk register", maintained by the Quality Unit, records areas of concern through a number of different data sources, most notably the General Medical Council (GMC) National Trainee Survey.

The sources of concern can range from anecdotal evidence, to formally recorded results on GMC surveys, and the scope of the "risk" from a single point of contact, to covering the whole health board.

The following table provides the GMC Survey overall satisfaction rates by element over the last four years. It indicates relative stability over the period, with some small movement in each direction.



HEIW formally review risk position with the health board 3 times a year, operating on a traditional traffic light system. The current version of the risk register (July 23) has 20 risks (24 in August 2022) with 5 being removed since August 22 and 1 being added. The Associate Medical Director (Education) and the Clinical Education Manager continue to tackle each individual risk, liaising with trainees and trainers as required, collecting and collating feedback and assisting with the development of action plans. The matrices below show the risks from August 2022 to July 23.

Hospital Matrix

		Aug 22	July 23
RED RISK High Risk	RGH	0	0
	PCH	3	3
	POWH	0	0
	ALL	0	0
ORANGE RISK Medium Risk	RGH	6	3
	PCH	5	1
	POWH	4	5
	ALL	2	2
YELLOW RISK Low Risk	RGH	2	4
	PCH	1	2
	POWH	1	0
	ALL	0	0
	TOTAL	24	20

Specialty Matrix – Movement since August 2022

	August 2022	July 2023	Score rating movement
HIGH RISK	TP256 Emergency Medicine- PCH	TP256 Emergency Medicine- PCH	↔
	TP487 Surgery – PCH	TP487 Surgery – PCH	↔
	TP544 General Internal Medicine - PCH	TP544 General Internal Medicine - PCH	↔

MEDIUM RISK	TP361 Psychiatry – All	TP361 Psychiatry – All	↔
	TP431 Medicine – POWH	TP431 Medicine – POWH	↔
	TP483 Paediatrics - POWH	TP483 Paediatrics - POWH	↔
	TP531 Diabetes and Endo - POWH	TP531 Diabetes and Endo - POWH	↔
	TP078 Ophthalmology –RGH	TP078 Ophthalmology –RGH	↔
	TP488 Anaesthetics -PCH		**REMOVED**
	TP160 General Surgery – RGH	TP160 General Surgery – RGH	↔
	TP484 General Internal Medicine - POW	TP484 General Internal Medicine – POWH	↔
	TP319 Multiple Specialties – All	TP319 Multiple Specialties - All	↔
	TP523 Otolaryngology – RGH		↓
	TP543 Acute Internal Medicine - RGH		**REMOVED**
	TP545 GP – PCH		↓
	TP546 Geriatric Medicine – RGH		↓
	TP547 Paediatrics - PCH		**REMOVED**
	TP548 Acute Medicine – PCH	TP548 Acute Medicine – PCH	↔
	TP549 Cardiology – RGH	TP549 Cardiology – RGH	↔
	TP552 General Surgery – PCH		**REMOVED**
		TP575 Intensive Care Medicine - POWH	**NEW**
LOW RISK			
		TP523 Otolaryngolog – RGH	↓
	TP245 Obs & Gynae – RGH	TP245 Obs & Gynae – RGH	↔
	TP316 T & O - PCH	TP316 T & O - PCH	↔
	TP318 T & O – RGH	TP318 T & O – RGH	↔
	TP428 Geriatric Medicine – POWH		**REMOVED**
		TP545 GP – PCH	↓
		TP546 – Geriatric Medicine - RGH	↓

Annual Report – Dental Education

In April 2023, Clinical Education, with HEIW's agreement, took on the responsibility for Dental PG within the Health Board. This involved assuming responsibility for managing Unit 3 Dental PG in PCH and the associated staff.

We are integrating the staff into the wider department to ensure that they have formal frameworks and policies within which to operate, and to secure adequate support for the activity.

<u>Bespoke Education and Training activities</u>

The Teaching skills for Doctors Course is an in-house development which has been so successful that an additional course was commissioned by HEIW. We expect this course to run at least twice a year.

The annual Teaching and Educators Development Conference (TED) was held in POW on the 7th of July and was themed "Interprofessional Education." In line with the theme, the conference was opened out to all health-care professions and enjoyed a multi-professional audience providing rich and diverse learning opportunities. Over 70 delegates attended and

talks and workshops were given with members of CTM UHB clinical staff, as well as guest speakers including Dr Neil Spenceley from the Royal Children's Hospital in Glasgow and Dr Athanasios Hassoulas the Director of the HIVE (Hybrid & Interactive Virtual Environments) Innovation Hub in the School of Medicine at Cardiff University.

Continuing Professional Development Education

It is absolutely essential that continuing education for all staff is aligned to and centred on patient care and service developments.

Focus on Nursing

CTMUHB and the University of South Wales (USW) continue to have an excellent partnership and team approach ensuring that the educational requirements of practice are met with the academic infrastructure of the University.

Clinical Education manages utilisation of the contract with USW for continuing post-registration education for nursing and midwifery. The equivalent of approx. 352 module places per annum have been available via an internal application and allocation process. Clinical Education continue to work with the USW to develop modules and educational courses which are tailored to support specific service change across the organisation.

We reviewed our application process in early 2023 for MSc Advanced Clinical Practice to ensure the right individuals were undertaking the appropriate course for their development and clinical need. This has also ensured that the individual receives the support to complete the programme and fulfil the course requirements as a trainee Advanced Nurse Practitioner and as a qualified Advanced Nurse Practitioner by having the correct Job Description in place.

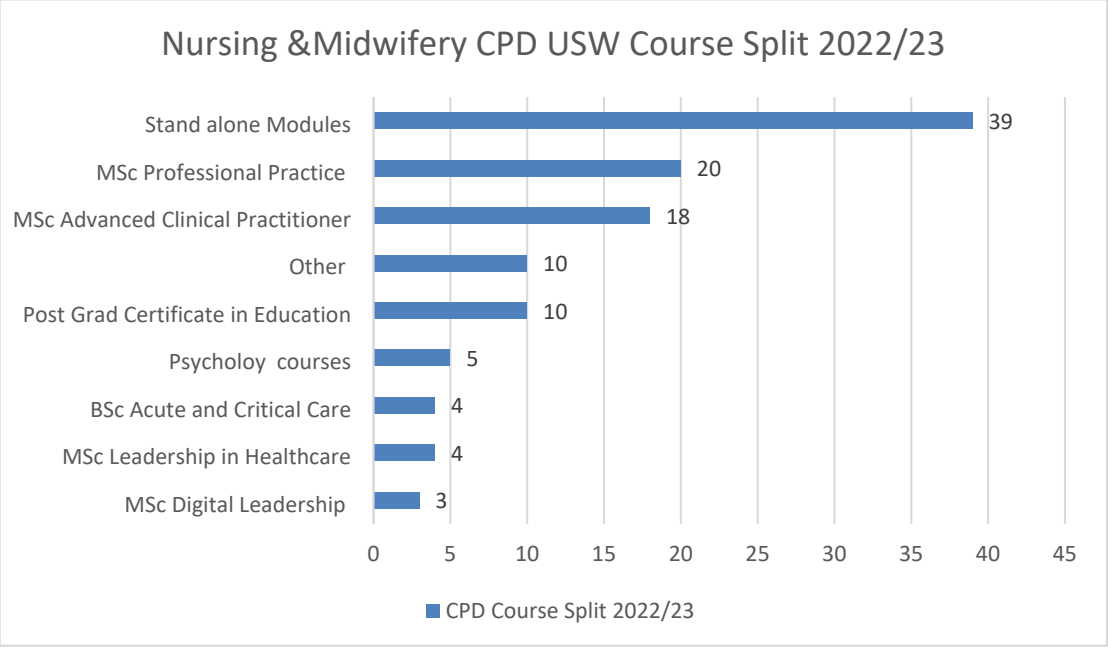


Fig 11 CPD USW Course Split 22/23

Focus on Multi-Professional Advanced Practice

Welsh Government via HEIW continue to invest in health professional education by providing annual funding for *Advanced Practice & Extended Clinical Skills.*

The funding provided by HEIW is to supplement our local investment to ensure that the appropriate staff can access the educational requirements as identified in our Integrated Medium Term Plan (IMTP), in terms of advanced practice/extended skills education requirements and Non-Medical Prescribing programmes. This funding is utilised across our organisation and is inclusive of nursing, therapies & healthcare sciences. There is a separate funding stream for Pharmacy advanced practice and prescribing.

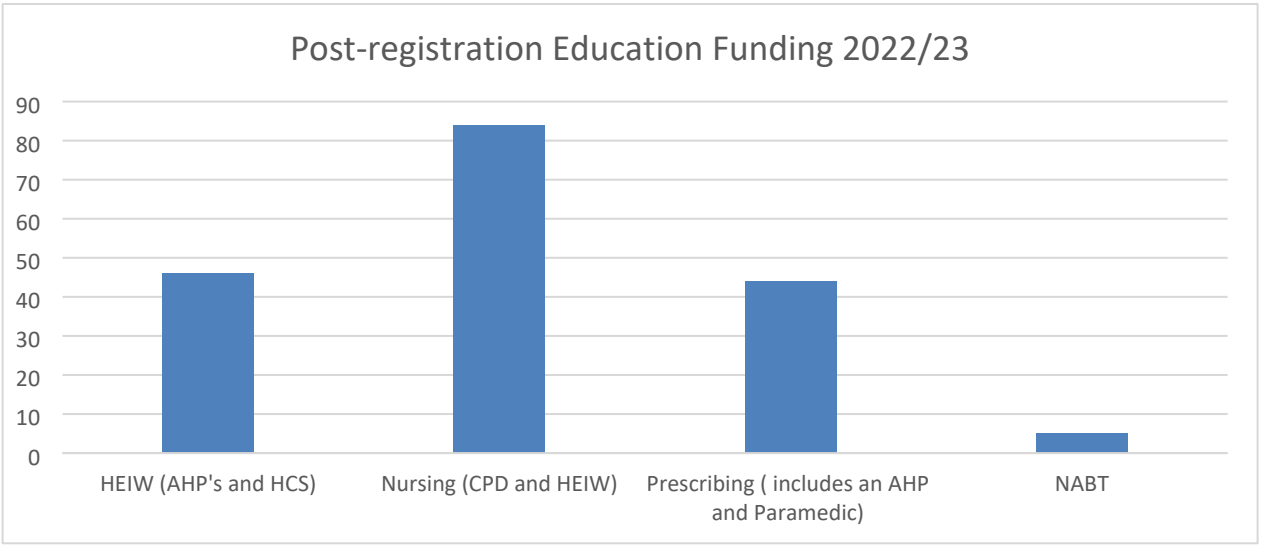
The allocation is informed by an annual CTMUHB Education Commissioning return including undergraduate and advanced practice education requests. HEIW notifies the UHB of its Advanced Practice and Non-Medical Prescribing allocation between April and May each year the allocation is split across primary and priority areas in acute care settings.

Advanced Practice allocation is agreed via a multi-professional Allocation Group and managed via Clinical Education. All applications must describe the intended service impact to be achieved as a result of the educational request. We meet requests flexibly across both Advanced Practice and Nursing CPD funding streams where appropriate to maximise access to funding for all health care professions and to enable optimal use of resources. In 2022/23 the HB was allocated £192k split equally between primary and acute care.

HEIW also funded 48 places for Independent Prescribing Programmes in 22-23 (42UoSW and 6 Swansea) and also new for 22-23 were 6 NABT places in Swansea which were utilised. All funded places are available to nurses, midwives and AHP's.

Pharmacy Independent prescribing places are allocated directly to the pharmacy department

New for 2022-23 are Practice Specific Funded training places, these include Child and Adolescent Mental Health, Critical Care, Medical Ultrasound and Reporting Radiology. These weren't fully utilised but interest for 2023/24 has grown and uptake has improved.



To reflect the organisational restructure work is being undertaken to record advanced education uptake by Care Group for future reports.

Acute Deterioration, Resuscitation and Clinical Skills

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Resuscitation related issues within the Organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 (currently based within Clinical Education) which has enabled a structured and unified approach across Cwm Taf Morgannwg University Health Board (CTMUHB) in the identification, escalation and response to the acutely unwell patient.

This group reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

The work of this governance structure is directly supported by the Head of Clinical Education, the Lead Nurse for Education and the Resuscitation & Clinical Skills team.

Further information and activity and impact data can be found in RADAR annual report

Resuscitation and Clinical Skills

Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) and the Senior Nurse, Nurse Staffing Act Professional Lead to deliver 'Train The Trainer' (TTT) programmes e.g. cannulation, which has increased flexibility and opportunity to offer further training places by competent trainers such as PDNs and PDMs, with the aim of increasing compliance. As a consequence, this will release time for the Resuscitation Practitioners and Training Officers to focus on the delivery of other resuscitation training across CTM.

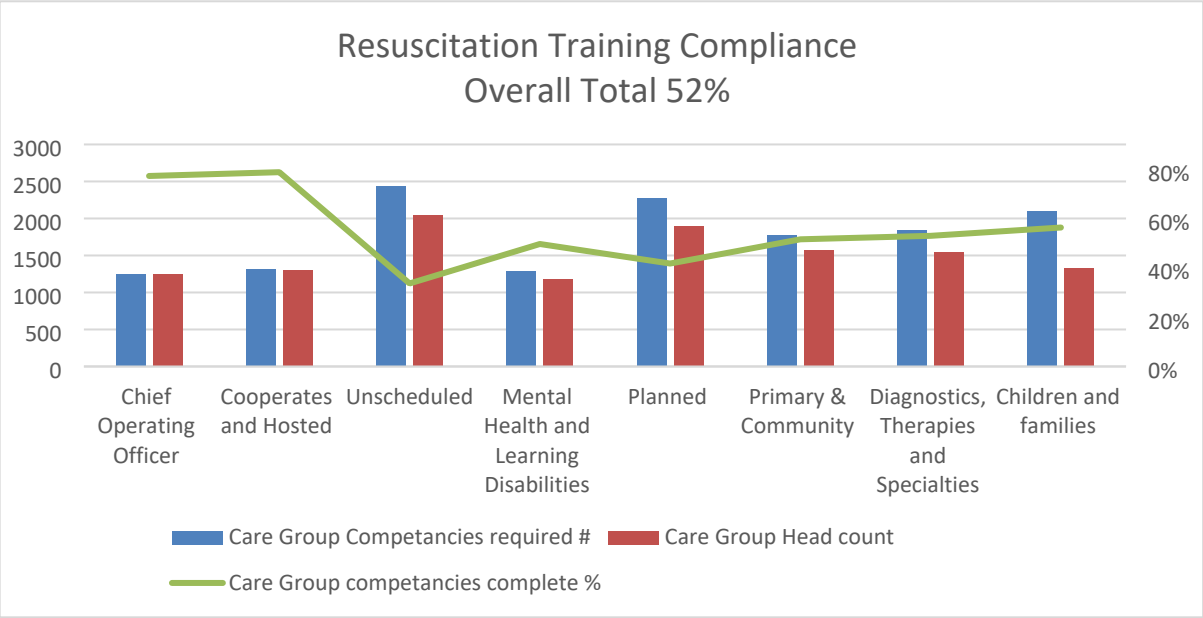
Another focus has been the continued effective partnership working with the medical teams across the organisation, in organising and facilitating cardiac arrest 'Team Huddles' along with debriefing sessions following arrest calls. The Resuscitation department and the Outreach and Acute Deterioration Lead have set up Cardiac Arrest Review Meetings (CARM) which allows the teams to analyse cardiac arrest forms along with patient's notes for any areas of missed opportunities which require further escalation. In turn, investigating and preparing any evidence required for Rapid Reviews and scrutiny panels.

The team have continued to provide cover to cardiac arrest calls, to support and encourage best practice when responding to cardiac arrests. Attending calls, auditing cardiac arrests and investigating Datix queries allows the team to proactively identify areas for improvement and any training needs that need to be incorporated into future training programmes e.g. revision of the cardiac arrest audit form. The revised audit form enables identification of areas needing improvement in training and provides a trail of decision making.

During 2022-23, the Resuscitation Team have worked in partnership with the Pharmacy Department to standardise and remove or update green drug boxes from our community-based hospitals and clinics to ensure safe and effect administration is provided to patients, this is expected to be completed end of 2023. Also identified there will need to have further changes to defibrillator replenishments before 2024 as the current community defibrillators are out of commission and no longer supported by manufactural guidance.

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 for CTMUHB (Graph 1: UHB Compliance in Care Groups), Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborn's and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver.

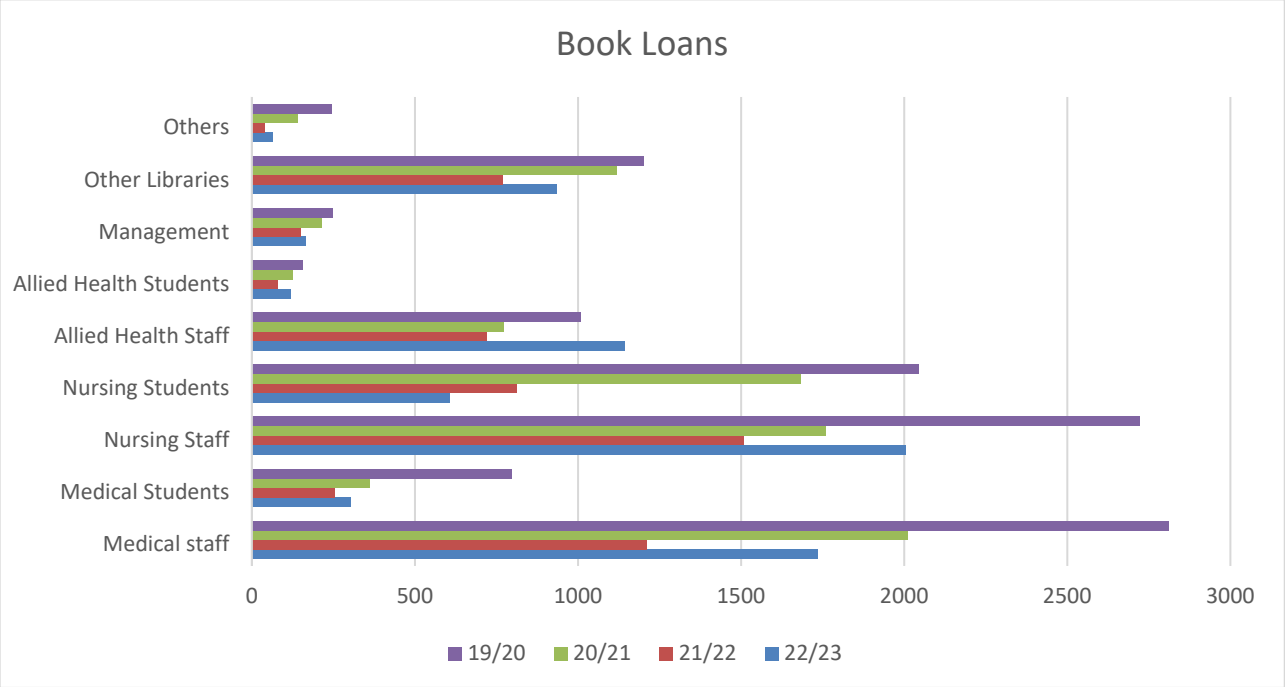
Graph 1 Resuscitation Training Compliance

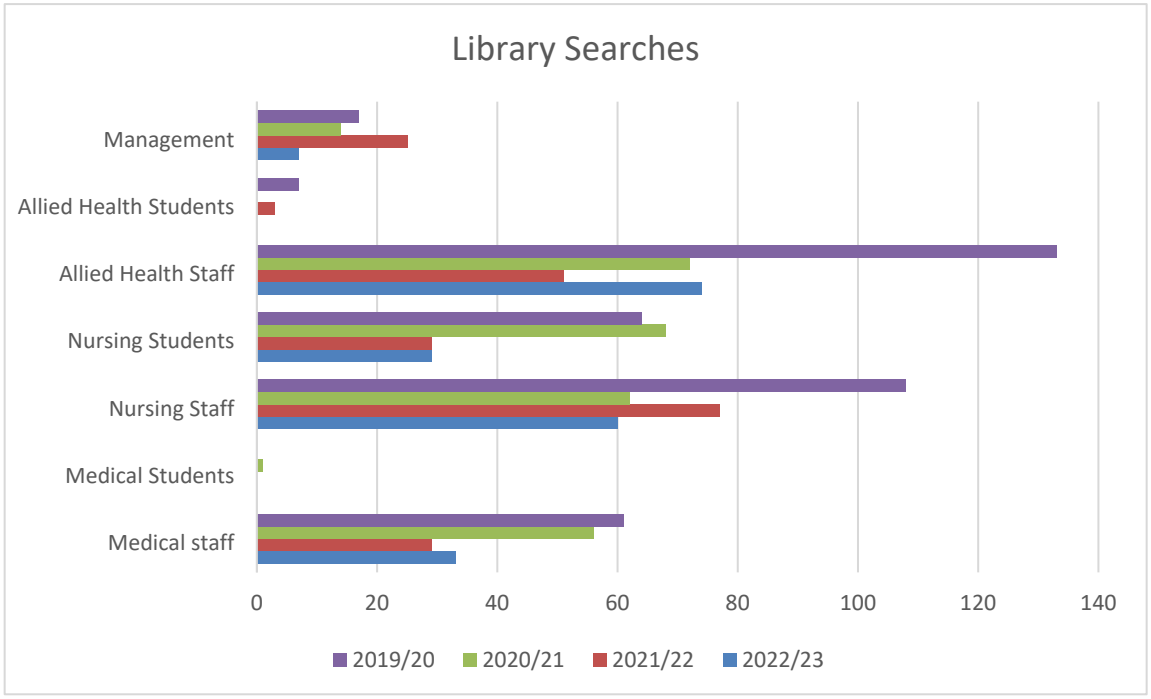


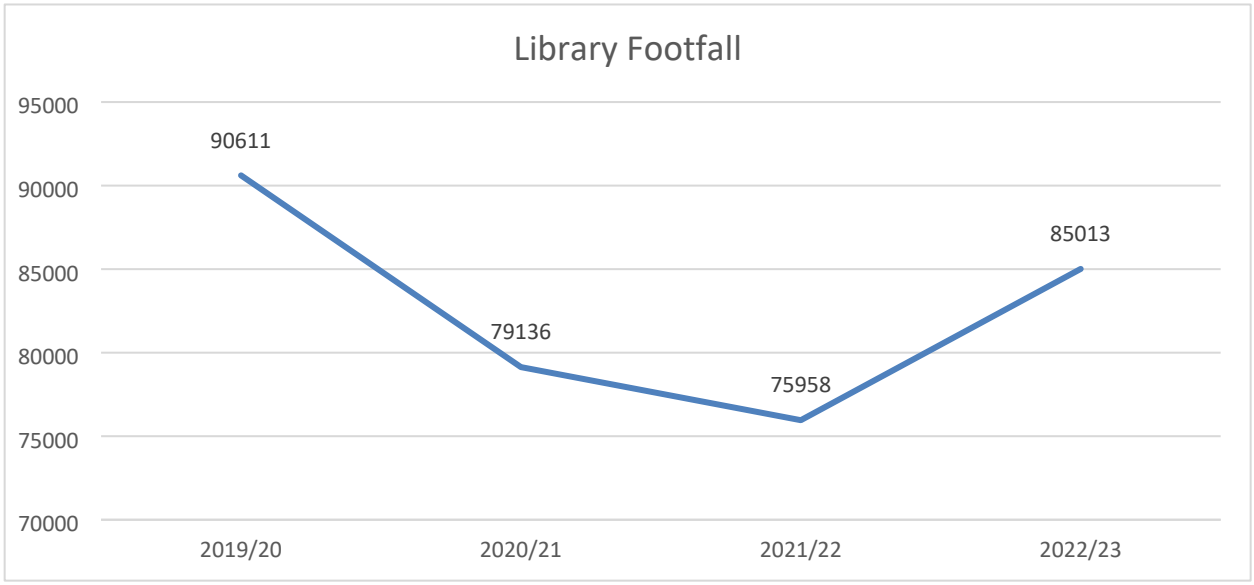
Libraries and Knowledge Management.

Library Usage

There are dedicated Libraries on each of the acute sites operating 24/7 access for our staff and students, to our literature collections; journals and books both electronic and physical and quiet study space with IT access & printing. Our specialist librarians are also available for help and support including literature searching, reference sourcing and critical analysis skills. Our libraries are an important part of our health board activity. The following data visualisations provide the detail of the usage of the library resources over the last 4 academic years and indicate that although there an increased use of online support, footfall within the library spaces is on the upward trajectory, and is increasing towards the levels experienced prior the pandemic.







CTM Libraries & Knowledge Services (LKS) – Annual Report 2022-23

CLA Submissions

The Library teams across CTM have been busy collecting data for the Copyright Licensing Agency via the Library Management System ALMA. This is part of a Wales-wide data collection project to ensure that authors and publishers are properly compensated for the use of their work.

Staff Development

A number of online training courses have been made available to Library staff by the NHS Wales Library network. These have ensured that as a service we remain up-to-date with changes and new technologies. Some of the topics covered include:

Artificial Intelligence

Critical appraisal

e-Books platforms

Embase

iRefer

Literature searching skills and networking

Research process and publishing

Unravelling Copyright

User Training

More online webinars have been provided nationally on how to search databases etc. effectively with support from CTM LKS staff. These are being promoted across CTM Libraries and have proved very popular. In person inductions, teaching and training have continued to increase.

Wellbeing

The LKS continues to support the HB wellbeing agenda with an ever-expanding range of books including the Reading Well for Teens collections. Each Library has also purchased a range of books to assist with making money go further with financial planning and cooking advice. To mark LGBTQ+ History Month in Cwm Taf Morgannwg each of the libraries had a display of resources. Recommendations for items to add to our collections were requested and a number of titles were purchased. The pictures were also published on the CTM Staff Facebook page. This is a great example of working together to promote allyship across the Health Board and to present the libraries as welcoming, supportive spaces for all staff.



Induction films

Following a request from Clinical Education to provide weekly library inductions for Pharmacy students, it was decided that an induction video would be the most suitable solution. Working closely with Dafydd Snelling, the Digital Lead, scripts were written and the videos recorded. Video introductions for staff were also created and hosted on our intranet site to provide a quick overview of the services and facilities on offer.

Literature/Evidence Searching Service

This is one of the most important services the Library & Knowledge Service provides. Feedback is collected at regular intervals following a request and consistently scores 5/5 for quality of service. Time saving is the comment most often received plus improvements to quality of patient care. Selected comments include:

"*The literature search service in our library is invaluable to myself. I have limited non clinical time and this means that I can use the service and the results to undertake more work that I need to do for undergraduate medical education instead of this time being on literature searches. This enables me to develop evidence based materials for training to ensure up to date practice" (Allied Health Care Manager).*

"Enabled completion of a project on the evidence behind use of structure and routine which impacted on service delivery. This helped us make a decision on how to proceed with service development in the unit."(Occupational Therapy Manager).

"Enabled patient treatment, improved my confidence with prescribing this rarely used antiarrhythmic medication." (Cardiology Consultant).

"Absolutely saving me so much time, which meant that I was able to continue seeing patients instead. I can't stress that point enough" (Allied Health Practitioner).

Strategic Direction Progress

This report reflects the significant progress made over academic year 22/23 by the Clinical Education Service to deliver the strategic ambition for a Multi-professional Learning Academy, meeting the individual education needs of each profession whilst also taking a multi-disciplinary education and inter-professional learning approach, encompassing and enabling benefits from diversity of thought and skill set, contributing to improving patient care and population health and wellbeing.

Creating, sustaining and growing a Learning Culture in Clinical Education

Our Clinical Education Strategy follows a hierarchy of needs model to build and ensure motivation of the individual and therefore supporting and nurturing the development of a Learning Culture in CTMUHB.

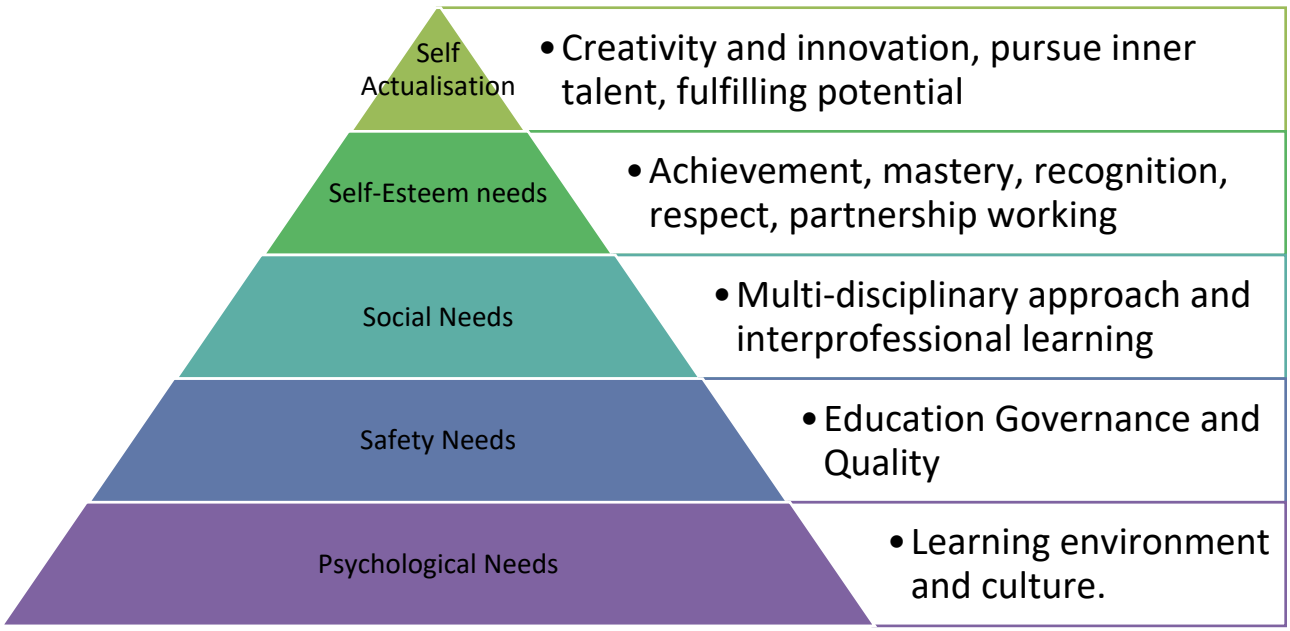


Fig 21 Heirarchy of Needs

Learning Environment and Culture: Resource investment and utilisation

Direction:

- *Quality and excellence in Education and Training is an established and valued part of organisational culture.*
- *CTMUHB is a Centre of Excellence for multi-professional learning.*
- *There are clearly defined, recognisable, flexible, accessible, up-to-date Clinical Education facilities that meet the learning needs of learners from all professional groups.*

Progress over 22/23

Updated Facilities

PCH

The past year has seen the library in PCH bedding in to the new space and adding some welcome new features. In addition to some more stylish and comfortable furniture, inspired by the new look in RGH, an acoustic pod was purchased. The pod is perfect for users who need space to hold Teams meetings or just study in a quiet space and can be booked in advance. One member of staff even used it for an exam. It's a welcome addition to the library and has proved very popular with users.

POW

At POW the print journals were streamlined and shelving removed last year creating more space. This allowed a re-design of the main central seating area. The update includes 24 new study chairs, 4 new study/relaxation chairs with laptop tables, a new coffee table and a new 4 seat study table with extra laptop/mobile charge points. The Library paintwork has also been updated.

RGH

The new group seating area of the library in RGH were further enhanced by the development of a wellbeing corner. This has provided an opportunity to highlight the wellbeing resources the Library holds and the support that is available to staff and students. During the #NHS75 celebrations members of the Wellbeing team came to the corner to demonstrate the VR headsets that are available for loan assist with stress and anxiety management.

Fig 22 RGH Refresh

Permanent training accommodation continues to be a challenge as the demand for increased clinical space becomes an issue across all sites and services.

It is recommended that the creation of a dedicated multi-professional Education and Learning facility should be included as part of the strategic site development plan.

Strong workplace infrastructure - Education Governance and quality infrastructure.

Direction:

CTMUHB has established effective systems of educational governance and leadership

1. *A robust and established Clinical Education Governance infrastructure providing confidence and assurance for individuals and the organisation of excellence in Clinical Education and Learning activity.*
2. *A clear and well developed understanding of Clinical Education, Training and Learning activity and risk management across the organisation.*
3. *Maturing organisational processes around clinical education commissioning, informed and aligned with service delivery priorities and training needs analysis, supporting the development of new models of care, innovative service redesign and workforce modernisation.*

Progress in 22/23

Progress has continued in 22/23 to develop and establish robust organisational wide education governance infrastructure to assure high quality education and training meeting the requirements and standards determined for the NHS in Wales, with oversight of undergraduate and postgraduate education and continuing professional development for all registered health care professions and clinical healthcare support workers.

The purpose of the Clinical Education Forum is to provide effective systems of educational governance and leadership that ensure optimal investment and resource utilisation in education activity to support and underpin the capability, capacity and confidence of our clinical workforce. This forum has been streamlined in response to the organisational restructure

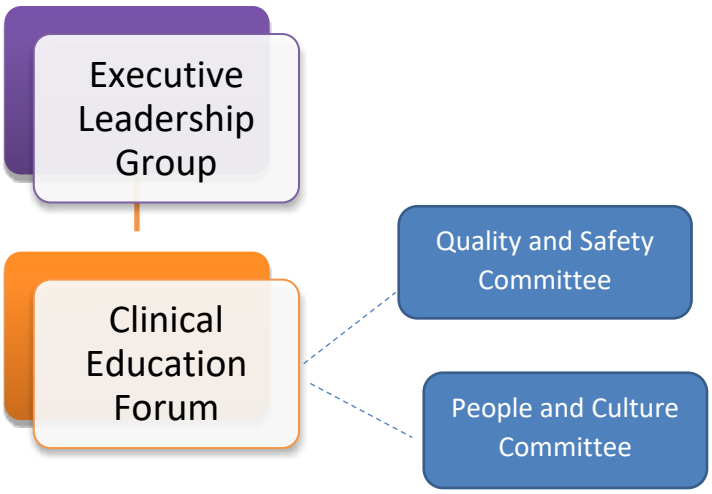


Fig 25 Clinical Education Governance Structure

Multi-disciplinary Learning and Inter-professional Development.

Direction:
*There is a high quality multi-professional education model that delivers equitably for **ALL** healthcare professionals and their support staff. Meaningful inter-professional learning and development is evident throughout the education model.*

Inter-professional learning has been an area of focus and significant progress over 22/23.

The Multi-professional practice education facilitator (MPEF) role continues to lead the way in Wales and has been positively received from universities, students, and CTMUHB health board, along with other health boards, who have linked in to see what growth there is in the role and how IPE opportunities have developed within CTMUHB. Work has included a scoping exercise to gauge what interprofessional education (IPE) opportunities are available in practice for students across different professions. Many key stake holders have been engaged with; clinicians, professional leads within the health board, and affiliated universities, students, clinical education team, educators across professions, HEIW programme leads, and practice education facilitator teams. A student placement planner has been developed, which holds all HCP student's placements in one place, allowing more efficient planning, and giving people the opportunity to see which students are out on placement across the professions.

Further progress has been made establishing an Inter-professional Learning (IPL) Faculty. The MPEF role has been pivotal in collaborative working across professional groups, and has been an anchor for advice, guidance, resource, and IPE development within the health board and for affiliated higher education institutions.

Further detail on progress made through these working relationships is shown in Appendix 1.

Pharmacy Student Undergraduate Clinical Placements.

As a result of regulatory changes by the General Pharmaceutical Council for the initial education and training standards for pharmacists, clinical placements for pharmacy students have been introduced. Numbers will increase over the next few years reaching steady state by 2026. This has produced a significant challenge to traditional pharmacy training within managed sector.

Clinical education have worked in partnership with CTM Pharmacy department to pilot a new model to support delivery at scale. This pilot was successful and the new model has been introduced for 23/24, with central support for placement administration coming from a post based within Clinical Education, building on and sharing the existing knowledge and

skills developed by clinical education colleagues. Further multi-professional relationships have been developed as a result of this collaborative working. CTMUHB is the first health board in Wales to offer pharmacy clinical undergraduate placements at scale with both Cardiff and Swansea universities.

Partnership, Achievement, Recognition and Mastery

Direction:

Our workforce are our most significant asset. There will be clear educational frameworks to support career development pathways in CTMUHB.

Learning and development frameworks establishing levels of practice from foundation through to consultant are being taken forward nationally with profession / speciality and multi-professional scope. Career development pathways continue to be supported through multi-professional development frameworks to define our CTM educational offer for:

- Early / foundation years
- Extended/ Specialist/Advanced Practice – including Clinical fellowships; practice, education, research, leadership, clinical informatics
- Consultant.

Clinical Education staff have supported the development of the Advanced Clinical Practice Board, which is developing organisational assurance practices for governance of advanced clinical practice.

In Summer of 2023 HEIW published its Professional Framework for Enhanced, Advanced and Consultant level practice, further work will be required across CTM to establish the required supportive activities including; job-planning and clinical supervision and will be a priority for the coming academic year.(heiw.nhs.wales/files/enhanced-advanced-and-consultant-framework/).

Opportunity, Vision and Innovation.

Direction:
Cwm Taf Morgannwg Learning Academy.

A space where people could feel inspired to think, create and dream, build relationships and collaborate and learn together to improve practice and health.

A living manifestation of University Health Board Status, networked with multiple HEI partners, and HEIW creating a virtuous cycle of learning, innovation and improvement.

- *Widening Access*
- *Innovation ideas supported e.g. Bevan fellowship/ exemplars, Environmental Impact.*
- *Challenge exchange*
- *Systems Design Thinking*
- *Collaborative work e.g. Product Designers 3D personalised healthcare innovation*

Progress and plans.

We have continued to deepen relationships with our partner universities and research and innovation colleagues.

With a focus on advances in simulation Clinical Education was successful in obtaining Levelling Up Funding from WIDI (Wales Institute for Digital Informatics) and enabled the release of staff time to develop a Digital Simulation Education Strategy (Multi-professional) and a pilot education package. This work commenced in April 2022 and completed in December 2022. Supported by colleagues in Cardiff Metropolitan University a prototype digital learning package was developed around acute deterioration which will be further developed through continuing collaboration.

In partnership with University of South Wales we will be progressing the development of educational packages utilising their Hydra facility.

Widening access

Medical Work Based Observation Scheme

Building on progress from previous years, we ran a Medical Work Observation Scheme for pupils of Year 12+ from 3 July to 21 July 2023. The content included a mix of virtual and on-site opportunities, to use work experience as a crucial tool in helping pupils decide whether to pursue a career in Medicine or Dentistry.

Eighty nine school pupils were enrolled on this scheme in 2023 and the feedback was overwhelmingly positive.

Widening Access Developments

Since May 2022 we have had a Widening Access lead in place as part of Medical Education's Undergraduate Faculty, as we understand that doctors who are representative of their local population are often well placed to address the local needs. As a health board, we represent communities with significant areas of deprivation and are committed to provide support for students from these under-represented areas.

With this in mind, the new 'Widening Access Programme' was launched by Dr Philip Evans and the Widening Access Team in September 2022. The programme aims to:

- raise awareness of opportunities within the local and wider healthcare service

- encourage talented students to believe in their ability
- remove barriers, perceived or real, to enable students, to gain fairer access to higher education, particularly from backgrounds where pupils do not generally go to university
- prioritise pupils from state schools in deprived areas or from a 'widening access targeted background' within CTMUHB

Where the CTMUHB Widening Access Programme is oversubscribed, eligibility to participate will be based on the following criteria:

Pupil attends school in a widening access area:

- defined by social and economic data

Comes from a widening access targeted background:

- in receipt free school meals
- first in family to attend university
- comes from a community that has a low number of pupils that go on to university
- are care experienced

The CTMUHB Medical Education Faculty now hold widening participation events for young people, their parents, and teachers throughout the year. Once fully established, the programme will begin in Year 5 in primary schools and extend through to the application and admission process in Year 13.

We have discussed the project with senior Education officers from Bridgend, Merthyr Tydfil and Rhondda Cynon Taf County Borough Councils, and it was well received. They, in turn, have given us their support to approach the schools in their area.

Widening Access Timetable example can be found in Appendix 2

Collaborative Working

Recognising that our partner HEI's are challenged to recruit into the Pre-registration programme and an eagerness from our local colleges for their Level 3 Health and Social Care Students to have clinical placements, we have been working in partnership to promote nursing and midwifery as potential career choices by providing 60 hours of clinical placements to Merthyr College students. This was a pilot held in early 2023 and we will be repeating in the autumn

We also held a 2 day 'Nursing Academy' for Bridgend College students which was successful. The 2 days included presentations and interactive sessions by clinical colleagues and also a session from University of South Wales on Personal Statement Writing.

Following evaluation of the above we plan to hold the Nursing Academy in Year one of the course and clinical placements in Year 2 of the course, this will ensure the students are better prepared for the placements.

Evaluations were excellent, from a cohort of 13, all doing level 3 health and social care (17/18yrs);

- One learner wanted Midwifery but was unsuccessful on initial application so is doing a foundation degree with the intention of re-applying next year
- 2 learners are starting their Adult Nursing degrees shortly
- 2 learners are doing a foundation degree with the intention of one doing adult nursing and one doing child nursing next year.
- One learner has been offered a job as a HCSW in POW
- One learner is starting his ODP course in Swansea.

Below are some photographs of the Nursing Academy held in Princess of Wales Hospital in June.

Nurse Education have also been working with Careers Wales and attended a number of Careers fayres in our local schools to promote nursing and midwifery as career choices and also showcase Cwm Taf Morgannwg as a potential employer. Our involvement has been well received by pupils and staff. The team enjoy attending these events and it aligns with the Health board values to inspire others and to sustain our future.

'Just to say a massive THANK YOU for your offering time at Cynffig Comprehensive's carousel event on Monday. I think you will agree that the pupils thoroughly enjoyed the experience and feedback from school has been very positive.

Your support is very much appreciated and I look forward to meeting with you again in the near future. '

We also recommenced our involvement with the Royal College of Nursing Cadet scheme this year which has been on hold since the Covid 19 Pandemic and we look forward to it growing in the next year.

Refs:

1. *A Healthier Wales: https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf. Accessed 10.10.2019*
2. *Workforce Strategy for Health and Social Care.* https://heiw.nhs.wales/files/workforce-strategy-for-health-and-social-care1/

Appendix 1: Interprofessional Faculty Progress.

Objectives		Outcome Measures	Progress
1	Develop a shared understanding of the standards for education / learning outcomes and clinical proficiencies / competencies that students must achieve across professions. Identify appropriate clinical environments within CTMUHB that offer learning opportunities for students to meet these, and develop processes to review.	Agreed outcomes regarding opportunities in placement, based on IPE principles in practice. Full IPE structured placement layout agreed between each HEI and CTMUHB. Joint review process between HEI and CTMUHB for IPE in practice agreed. Evaluations, feedback, meetings, audits.	CTM IPE AHP group formed and outcome discussed and agreed. • IPE student learning sessions. • IPE structured placements. Structured placements planned and implemented for specific professions. Evaluations are positive. Work ongoing to expand further.
2	Interprofessional placements/ experiences: • Developing structured IPE opportunities/ placement models/ simulation / student learning sessions in practice for students. • Scoping out opportunities across the HB. Consulting with professional leads from HB and AEI's regarding common themes, learning outcomes, and barriers to IPE placements and possible solutions.	Student pathway database. Gap analysis to drive initiative forward. Audits and evaluations of placements. Placement handbooks. Updated database populated with placement opportunities. Review of performance to create continuous improvement with the strategy.	Student placement planner developed for all professions attending CTM. Evaluations reviewed regularly, and support in practice available. Communication to all professions and clinicians in place to drive initiative forward. MPPEF structured IPE placement list in situ for academic year.
3	Student placements: • Bringing placements in house through one central allocations team to maximise audited placement capacity. • Develop database, containing all available placements across the HB for all professions. • Develop new student centred HB wide placements with appropriate induction, supervision; sign off against learning outcomes, and appropriate orientation of supervisor/ educators to students clinical practice documentation.	Placement database and allocation system. Compare historic placement capacity against new models / placement opportunities. Functioning database, and student placement information. Management of KPI's. Database of supervisors / educators. Induction attendance / content review. Audits and evaluations of placements. Placement handbooks detailing the format and structure of placements.	Unable to bring placements in through central system at present, and each HEI/ profession works differently. Student centred IPE placements developed and in place. Training developed for practice educators in certain professions, IPE promoted as part of this.
4	Assess stakeholder satisfaction with new ip faculty model	Survey stakeholder satisfaction	MPPEF role has been positively received. Great feedback, and HEI's wish for parity across the health boards.
5	Monitor placement capacity	Compare historic placement capacity against new model (no of students per HB)	0 HEIW IPE hours were in place prior to MPPEF role being implemented. 136 student weeks planned so far for HEIW commissioned courses 2023-2024. Work ongoing across various professions to expand this. Onoing work with non HEIW commissioned course – approx. 270 student weeks planned this academic year.
6	Identify placement model and resource requirements	See measures for objectives 1 & 2 and establish delivery model	MPPEF role at maximum capacity now. To develop further would need further MPPEF role in place / profession specific PEF's.

Appendix 2

Widening Access Timetable

Month	School year	WAM topic *(Facilitators)*	School year	Medical school Application Timetable
September		Contact Head teachers / schools *(Widening access team)*	13	Sit UCAT Exam
October	13 13	The medical Interview & Mock interviews including MMI *(Clinical fellows / medical staff)*	13 13	Sit UCAT Exam UCAS application closes
November	12 12	Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible)* Application for Medical Work Observation sent to Schools in CTM Catchment *(Widening access team)*	13 13	Sit BMAT Exam Attend Interviews
December	12 12	Studying at a University Finance – course costs / SFW Routes to medicine and entry requirements *(Ideally F2F; TEAMS vis schools also possible)*	13	Attend Interviews
January	12	**Parents evening:** Why go to University; Medical school information; Careers advice; Selecting a medical school; Application process; Admissions process; Key dates; Preparing for University *(Face to Face; Widening access team)*	13	Attend Interviews
February	11	A career in medicine: Career options Include info on subject choices and grades UG v PG courses *(Ideally F2F; TEAMS vis schools also possible)*	13	Attend Interviews
March	5&6	Primary school sessions *(Year 3 SSC)*	13	Attend Interviews
April	5&6 12	Primary school sessions *(Year 3 SSC)* Application for Medical Work Observation closes and shortlisting done. *(Widening access team)*	13	Attend Interviews
May	5&6 12	Primary school sessions *(Year 4 SSC)* UCAT training & UCAT mock (Bank questions / online material) *(Clinical fellows)*	13	Confirm University choices
June	5&6 12	Primary school sessions *(Year 4 SSC)* MWOBS induction *(Widening access team)*		
July	12 12	MWOBS virtual sessions *(Widening access team)* MWOBS in hospital week *(Widening access team)*	12	Sit UCAT exam
August			12 12	Sit UCAT exam Start writing statement

Agenda Item
9.2.10

Quality & Safety Committee

CTMUHB COVID 19 PUBLIC INQUIRY PREPAREDNESS

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CP	Core Participant
CTMUHB	Cwm Taf Morgannwg University Health Board

1. Situation /Background

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

1.2 The Covid-19 pandemic, which took hold in March 2020, has been one of the greatest challenges faced by the country and in the history of the NHS; challenges which have been predicated on unprecedented levels of demand across the whole system that have called for an equally unparalleled response.

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

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

1.5 In order to allow a full and focused examination of all of the different aspects of the pandemic that are covered in the Terms of Reference, Baroness Hallett has decided to divide the Inquiry's investigation into Modules.

1.6 There are currently four active Modules:

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

Future modules:

- Government procurement
- Care sector

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

1.8 The Health Board is a CP for Module 3. CP status is considered for all modules once released, however, currently the Health Board has only applied for CP status for Module 3.

2. Specific Matters for Consideration

2.1 *Rule 9 Requests Module 2b* – the Health Board has received requests for witness statements under this module and are managing the requests in accordance with the Inquiry process. Health Board current or former employees who have been approached are receiving the full support of the organisation and the appointed legal team.

2.2 *Module 3 Update as at 29.7.2023* – the hearing will be 10 weeks in duration with two short breaks, next autumn, with a further preliminary hearing in spring 2024. Legal & Risk Services have been informed only two Rule 9 requests in Module 3 will be sent to two Health Boards/Trusts in Wales before the end of the year (2023). The Inquiry solicitor has not yet identified which organisations will receive the requests.

2.3 Rule 9 requests will be sent out for *Module 4* and enquiries are being made to seek further information as to which organisation these will be directed.

2.5 *Legal Guidance and Support*

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

2.6 *Programme Management Approach*

- There is a Covid-19 Pandemic Inquiry Working Group which has two clear functions, this is to:
    - **Prepare:** the CTMUHB for the Covid-19 Public Inquiry
    - **Respond:** Provide the UK government, when requested, with accurate and complete information pertaining to the Covid-19 public inquiry
- A preparedness plan has been developed which is received and updated via the working group.
- The Health Board is represented on the Group: 'All Wales Covid-19 Public Inquiry Channel", established by Legal & Risk Services, the purpose of this channel is twofold. Firstly, to provide a place for members to communicate with each other and share useful information and, secondly, to allow Legal & Risk Services to communicate updates quickly to organisations.
- *CTMUHB Senior Responsible Officer* for the Inquiry response will shortly be changing from the Deputy Chief Executive / Executive Director of Nursing back to the Director of Corporate Governance / Board Secretary.

2.7 *Information Management* - The Health Board successfully filled its Covid-19 Information Manager role at the end of May 2023, fixed term into the 31st March 2024. The main purpose of the role is to undertake robust, comprehensive, efficient, organised and confidential record and information management practices in relation to CTMUHBs pandemic response, and apply a programme / project management approach to the Health Boards preparedness. As a result of difficulties in recruiting to the role the pace in the preparedness of the Health Board has been impacted and this has been escalated to the Organisational Risk Register (Datix Risk ID 4922 - Covid-19 Inquiry Preparedness - Information Management – Risk Score of 20). Since successful recruitment at the end of May 2023, systems have been established to support the information management approach and archiving has now commenced.

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

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

3. Key Risks / Matters for Escalation

3.1 The following areas of development have now commenced, however, the pace of implementation has been significantly impacted by the difficulties in recruiting to the Covid-19 Information Manager position.

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

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

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

3.2 The Inquiry have expressed concern as to the impact of the *NHS Wales Data Loss incident* identified by Digital Healthcare Wales relating to the deletion of inactive Microsoft Office 365 mailbox accounts that may affect

organisations ability to respond. The Health Board were able to assure the Inquiry that it had processes in place which mitigated this risk. In summary the current process for migrated users (Microsoft 365 mailboxes) who are inactive or have left the Health Board, allows for the mailbox to remain active in Microsoft 365. Whilst the mailbox is not licensed, the mailbox remains within CTMUHB's permissions' and the Health Board is able to access the data when required within the National retention policy of 7 years.

3.3 Additionally, consideration should also be given to the *retention and storage of emails* outside of the seven year automatic retention period and whether emails of key decision makers are retained and backed up separately. The issue presented is that pandemic related emails cannot be extracted from the day to day business and so every email will need to be retained and could create a challenge in relation to the Data Protection Act 2018. As indicated in section 3.2, under the current arrangements there is capability to recover emails and one drive documents even after deletion; however, this is only for a period of 7 years which may not cover the period of an inquiry.

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

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

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

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Sustaining Our Future
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /	Not Applicable
	If more than one applies please list below:

Link to CTMUHB Strategic Areas	
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: All Domains of quality could apply.
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this summary update report.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for this summary update report.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Legal representatives are instructed and are advising the Health Board.	
Enw da / Reputational	Yes (Include further detail below)	
	Trust and confidence in the Health Board in its response to the pandemic and its learning for the future.	
Effaith Adnoddau	Yes (Include further detail below)	

(Pobl /Ariannol) / **Resource Impact** *(People / Financial)*	The level of activity and legal support required is uncertain at this stage. Rule 9 requests do require a significant amount of time to ensure that a robust response is returned to support the Inquiry's investigations.

5. Recommendation

5.1 The Quality & Safety Committee are asked to:

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

6. Next Steps

6.1 None identified at this stage. Further updates and/or escalations will be managed on an Adhoc basis.

Agenda Item
9.2.11

Quality & Safety Committee

Human Tissue Act (2004)
Compliance and Progress Report

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Dr Paul D Davies Designated Individual for the Human Tissue Act
Cyflwynydd yr Adroddiad / Report Presenter	Mr Gethin Hughes, Chief Operating Officer
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gethin Hughes, Chief Operating Officer

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
- Chief Operating Officer - Executive Medical Director - Director of Operations	16/10/2023	Approved

Acronyms / Glossary of Terms	
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
HTARI	Human Tissue Act Reportable Incident
PLR	Pregnancy Loss Remains

1. Situation /Background

1.1 The Health Board manages a range of clinical and support services which are involved in the removal, storage, use and disposal of human tissue in the Post Mortem sector across the three main hospital sites and thus is subject to the legal requirements of the HTA (2004) and regulated by the HTAuth.

1.2 The purpose of this progress report is to present the work undertaken to maintain HTA compliance and provide assurance to the Health Board that services within its licenced sites are legally compliant.

1.3 The Health Board is licensed by the HTAuth through compliance inspections which are undertaken every four years or as required.

1.4 This report presents the follow-up of the findings of the most recent HTA Inspection in February 2023 and also provides a status update on the Welsh Recommendations (November 2021) with regard to community body stores at YCC and YCR.

2. Specific Matters for Consideration

Quality Control

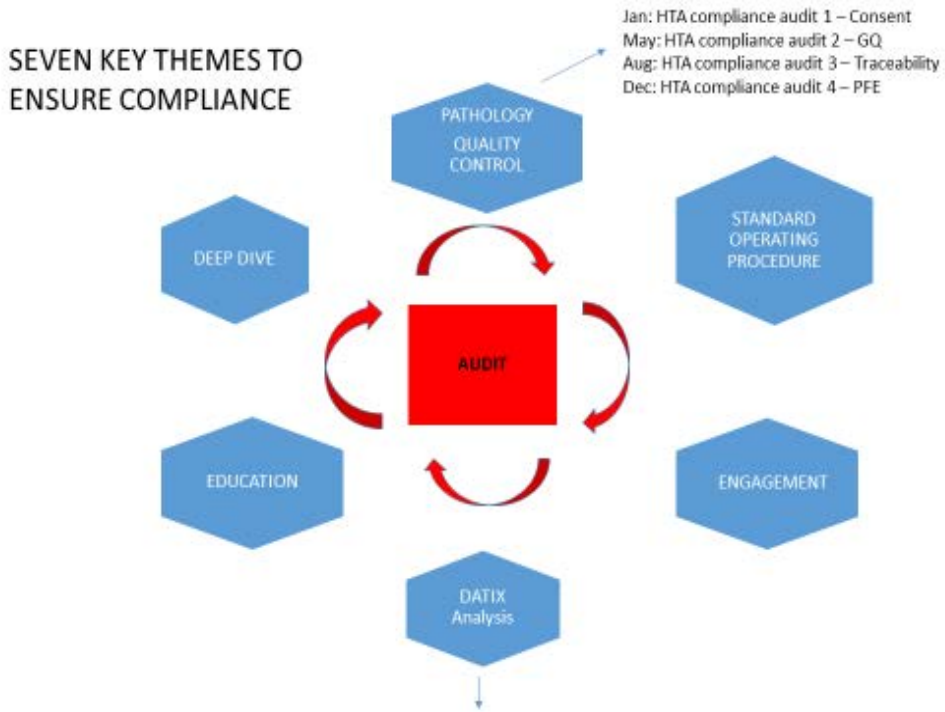
2.1 The Designated Individual was appointed by the Health Board and HTAuth in November 2020 and has worked toward strengthening the governance of compliance with the standards set out within the HTA. The focus of the Designated Individual has predominantly focused upon seven key themes (Figure 1) within a clinical governance framework.

2.2 The Quality Control Department within Pathology also has a specific role in terms of ensuring there is an annual and cyclic programme of audit around the specific standards with the HTAuth Codes, predominantly Code A (Consent) and Code B (Post Mortem).

2.3 This quality system is augmented through regular inspections of a range of services by the Designated Individual including Mortuary Departments, Maternity Services, Emergency Departments, Theatres, Early Pregnancy Units and Gynaecology Wards.

2.4 For those departments outside Pathology, the focus is mainly upon compliance with guidance regarding the sensitive disposal of PLR under 24 weeks and dignity of the deceased.

Figure 1 HTA clinical governance; the 7 key themes to ensuring compliance



2.5 During 2022 the Designated Individual conducted 39 inspections and to date in 2023 has conducted 24.

2.6 The outcomes of each local inspection is reported to the Persons Designated for the clinical area and corrective actions put in place.

2.7 Shared learning arising from all inspections is reported widely to clinical teams and the HTA Board.

2.8 The inspection process and the clinical governance framework (Figure 1) ensures the Health Board is HTA compliant.

Engagement

2.9 Engagement is key to ensuring there is compliance with the HTA and making sure there is effective communication on a number of issues such as audit findings, incident outcomes, standard operating procedure reviews, improvements in standards and seeking ideas on the development of services.

2.10 To assist this goal the Designated Individual has introduced a network of 14 Persons Designated across a wide range of services and specialities within the Health Board, focused mainly at the three HTA licenced sites which are Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.

2.11 Persons Designated appointed by the Designated Individual are able to directly influence services in relation to licensable activities.

2.12 The HTA recommends that the role is supplementary within the governance framework, although the Designated Individual remains responsible for supervising the activities to be authorised by the licence.
2.13 The Designated Individual meets up with the Persons Designated group every six weeks to share learning and provide support where needed.
2.14 Establishing such a wide ranging network ensures that there is support across departments. To date this has been received well.
2.15 One key area of development for engagement has been the introduction of an *Office 365* Sharepoint page specifically to support Persons Designated and relevant clinicians / managers in relation to the HTA.
2.16 With the support of the Assistant Director of ICT this intranet portal is now operational and has been helpful as a *one stop* site for all matters related to the HTA to support departments throughout the Health Board.
2.17 For example, the following information can be found at this site for shared learning by Persons Designated and for prospective inspection by the HTA;

- Outcomes of local inspections and audit
- HTA newsletters
- Incident Trend Analysis
- Shared Learning log
- Educational Powerpoint presentations
- Estate reports on service records for the ventilation systems within the Mortuary Department

2.18 This new sharepoint page continues to be improved and developed.

Legal Compliance

2.19 The Health Board was inspected by the HTAuth and the published report is now available on the HTAuth website at;
https://content.hta.gov.uk/sites/default/files/2023-04/2023-02-16%2021%2022%2012338%20Royal%20Glamorgan%20Hospital%20Post%20Mortem%20inspection%20report%20-%20FINAL_0.pdf

2.20 The outcome of the inspection concluded that the Designated Individual and the Licence Holder are suitable in accordance with the requirements of the legislation.
2.21 The HTAuth found that the Health Board had met the majority of the HTA's standards and only two minor shortfalls were found against standards for Consent and Governance and quality systems.
2.22 These related to the consent policy, recording of competency assessment for consent seekers and mortuary standard operating procedures regarding condition monitoring.
2.23 The Designated Individual and operational team resolved these matters in short order and thus the Corrective and Preventative Action Plan accompanying the final inspection report had both these minor shortfalls 'closed' at publication.
2.24 The HTA also fed back 15 advisory items for the Health Board to consider within the final report.

2.25 Whilst advisory items are not classed as shortfalls against the current standards, they are important suggestions for quality improvements to service delivery. Many of these advisory items have now been addressed including a new door swipe access system for the viewing room at PCH Mortuary.

2.26 One item related to security caging for the external condensers at POW and a Capital Statement of Need has been submitted for circa 11k.

2.27 It was indicated by HTAuth that in time some of these advisories are likely to inform future changes to statutory standards, thus it is important to consider their value in practice.

Good Practice

2.28 The HTA do not publish areas of good practice within the formal inspection reports, however they did highlight a number of areas within their verbal feedback, which included;

- The dignified care provided by the Mortuary staff
- The overall governance arrangements
- The Tissue Traceability set up and work of the HTA Compliance department
- Clear and well documented follow-up of actions between HTA Board meetings
- The overall cleanliness and maintenance of the estate
- The Maternity service compliance with the HTA standards at the Princess of Wales Hospital
- The quality of the Portering staff and the overarching training manual which drives their practice
- The HTA Sharepoint Portal to support Persons Designated and their role
- The proactive and transparent engagement with the regarding service changes as well as incidents, potential incidents and corrective actions taken.

2.29 The Licence Holder and Executive Director of Therapies & Health Sciences have written to staff to thank and congratulate the team on such a successful outcome.

2.30 The HTAuth have requested to conduct a video for social media regarding the good practice found at the Health Board and in liaison with local management and the Health Board communications team there is plan to commence this work in late November 2023.

Annual Incident Analysis

2.31 All Datix reports which have indicated that an incident involved a deceased person and / or have key words such as "Pregnancy Loss Remains", "Death" or "Mortuary" are automatically copied to the DI. This provides an 'early warning' system so that the Designated Individual can quickly follow-up such incidents, alert Persons Designated and support corrective actions.

2.32 All HTA related incidents are collated by the Designated Individual and presented on a quarterly basis to the HTA Board and Persons Designated and Table 1 presents data collated over the last three years.

2.33 The importance of collating such data is primarily to analyse trends and seek improvements in clinical / service areas which may be experiencing issues with training compliance and high staff turnover.

Table 1: HTAct Related Datix incidents reported from April 2021 by Incident Type and Hospital site

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2021/22	Q1	3	9	0	0	0	2	10	0	12	1	0
	Q2	7	14	1	0	8	7	6	1	22	1	0
	Q3	11	15	2	0	10	10	8	0	28	0	1
	Q4	4	5	0	0	4	1	3	0	9	0	0
2022/23	Q1	4	4	0	3	6	0	4	1	11	0	1
	Q2	3	5	0	0	3	3	2	0	8	1	0
	Q3	6	6	0	1	5	2	6	0	13	0	1
	Q4	7	3	0	0	8	1	1	0	10	1	0
2023/24	Q1	2	2	0	0	0	0	4	0	4	0	0
	Q2	1	8	1	1	5	1	5	0	11	0	0
	Q3											
	Q4											

2.34 For 2021/22 there were **71** HTA related incidents including two HTARIs and one near-miss HTARI.

2.35 In 2022/23 there were **42** HTA related incidents including two HTARIs and two near-miss HTARI.

2.36 For the first six months of 2023/24 there were **15** HTA related incidents and no HTARIs.

2.37 The overall reduction can be attributed to diligent follow-up and learning post incidents, general awareness raising and regular inspection and audit.

2.38 As with the audit programme, any shared learning from the outcomes of the incidents is communicated and discussed within the Persons Designated group and HTA Board.

Welsh Government Guidelines for Community Body Stores

2.39 Welsh Government has published interim recommendations to Health Boards in Wales following the Fuller Inquiry in 2021. These recommendations are as follows:

- Identify and appoint a single accountable officer for body storage facilities who can oversee implementation of the recommendations and provide updates to your Board / Welsh Government.
- Review and consolidate where possible their body storage arrangements, especially in community hospital settings
- Consolidate the management of body stores and where possible align them to mortuary and post-mortem services
- Apply relevant HTAct post-mortem sector licensing standards and guidance to body storage areas

2.4 At the time of the report both YCC and YCR were determined to be secure however a plan to consolidate the management of the body stores and align these to mortuary services in Pathology was determined to have an annual cost implication of circa 52k.

2.5 This plan would ensure that the relevant HTAct post-mortem sector licensing standards and guidance would be applied to body storage areas and the Welsh Government recommendations would be met.

2.6 If agreed, the Pathology Directorate will have overall responsibility of standards with the support of the Designated Individual; a similar set up to HTA licenced sites.

2.7 The Designated Individual inspected the body stores at both YCC and YCR on the September 18th 2023 and it is clear they do not meet the higher standard within HTA licenced sites.

2.8 The Designated Individual has reported his findings to Facilities and local management with a suggested action plan for their consideration until a longer-term agreement for consolidation is achieved.

3 Key Risks / Matters for Escalation

3.1 The mortuary team and relevant clinical services have demonstrated excellent leadership and great aplomb to achieve the successful HTA inspection report for 2023.

3.2 The overall mortuary space capacity has improved since the commissioning of a new 85 space Unit at Prince Charles Hospital in January however the waiting list for Post Mortems continues to be challenging due to the increased volume of referrals to the Coroner.

3.3 This is currently being managed through extra Pathology sessions procured by the Coroner's Office and development of a winter capacity plan.

3.4 There is a need to address the recommendations from Welsh Government for the consolidation of community body stores to the overall management of mortuary services within the Pathology Directorate.

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Dying Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) /	No - Not Applicable
	If more than one applies please list below:

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This paper is for noting.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This paper is for noting
Cyfreithiol / Legal	Yes (Include further detail below)	
	HTA Compliance at POW/RGH/PCH is a legal requirement and the Designated Individual has primary legal responsibility under Section 18 of the Act.	
Enw da / Reputational	Yes (Include further detail below)	
	Non-compliance with the HTA is a reputational risk for the Health Board.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	To achieve the Welsh Government recommendations for Community Body stores is an annual cost of 52k. A Capital Statement of Need for an HTA advisory item at POW Mortuary is 11k.	

5 Recommendation

5.1 This paper is for discussion and **NOTING**

6 Next Steps

6.1 Continue to implement the governance framework of the 7 key themes within Figure 1 (page 2) to ensure and maintain compliance with the Human Tissue Act.

6.2 Work with Facilities and local management at both YCC and YCR with regard to an intermediate plan for improving standards within the body stores whilst there is consideration of the funding request for consolidation with mortuary services within the Pathology Directorate.

Agenda Item
9.2.12

Quality & Safety Committee

Organ Donation

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr David Jones. Regional Clinical Lead for Organ Donation, South Wales
Cyflwynydd yr Adroddiad / Report Presenter	Dr Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CLOD	Clinical Lead for Organ Donation (0.5PA)
R-CLOD	Regional Clinical Lead for Organ Donation (1PA)
SNOD	Specialist Nurse for Organ Donation

1. Situation /Background

1.1 Cwm Taf Morgannwg UHB is recognised by NHS Blood and Transplant (NHSBT) a Level 2 Health Board. In 2022/23, from 14 consented donors, CTMUHB facilitated 12 solid organ donations that resulted in 29 patients receiving life-saving, or life changing, transplants.

1.2 CTM UHB has two embedded Specialist Nurses for Organ Donation (SNODs), three Clinical Leads for Organ Donation (CLODs), and the current Regional CLOD for South Wales is a CTM Consultant. These are NHSBT funded activities and are subject to annual performance management.

1.3 CTM UHB has a well-attended Organ Donation Committee (ODC), which has representation from all relevant internal and external stakeholders, including patient and family representatives. The ODC is the forum in which Health Board performance is reported, missed opportunities discussed, a communication strategy developed, and education sessions are planned.

1.4 Financial support for Organ Donation activities are funded by NHSBT. These monies are held in a regional fund, which can be easily accessed by the local Organ Donation Committee. These funds can support educational events, memorial activities, facilities for visitors to Intensive Care, and artwork installations on hospital sites.

1.5 Clinical performance and engagement within CTM is excellent. In the year 2022/23, there were only 2 (out of 39) occasions when organ donation was not referred for organ donation – good clinical reasons to justify this. There was only 1 occasion (out of 20) when a SNOD was not present during family discussions – in this case, it was a known decision to Opt-Out of the Organ Donation Register. 100% of patients who meet criteria for neurological death testing were tested, reflecting a confidence within the clinical team with the process. A performance dashboard is available to the public.

1.6 We have excellent support from HM Coroner for South Central Wales – should a potential donor require coronial investigation – we are able to discuss the matter with the Coroner out-of-hours, and there was 1 case when the Coroner placed restrictions on donation of specific organs.

1.7 In March 2022, the Welsh Organ Donation and Transplantation Plan 2030 was launched. This was developed by the Welsh Transplant Advisory Group (WTAG) which identified 5 key targets

i) Increasing deceased donation opportunities
ii) Increasing tissue and eye donation
iii) Increasing living donation and transplantation
iv) Increasing access to transplantation
v) Improving transplant outcomes
vi) Supporting a sustainable and diverse workforce

1.8 The National Organ Retrieval Service (NORS) receive excellent support from our theatre teams when retrieving organs from our donors. There are no obstacles in accessing theatre space, and it is widely accepted that an Organ Retrieval is a "life saving" procedure – in a much wider sense than usual.

1.9 The theatre team are now comfortable and familiar with the process of the Withdrawal of Life Sustaining Therapies in the anaesthetic room, and our practices and experiences have been shared at national level as examples of good practice.

1.10 There is excellent follow-up support for the families of deceased donors. The Critical Care psychology service are sector leading in the bereavement service that they provide, and this is supplemented by the SNOD feeding back to families the outcomes of their gift of life.

1.11 All donor families are invited to an annual memorial event where the Gift of Life is recognised and they are presented with an Order of St. John Award.

2. Specific Matters for Consideration by the Group going forwards

2.1 How the Health Board, with the ODC, will continue the excellent practice

2.2 How the Health Board will support the SNOD and CLOD in meeting the key priorities of the 2030 plan

2.3 How the Health Board work with NHSBT to increase the number of CTM residents on the Organ Donation Register

2.4 Supporting NHSBT to ensure the CLOD and SNOD workforce matches the reconfiguration of Critical Care Services in CTM.

3. Key Risks / Matters for Escalation

3.1 Appointment of a Chair of the CTM Organ Donation Committee, was previously held by an Independent Member whose term in office has ended. Interim arrangements are in place until the new Independent Member arrangements are in place from January 2024.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	Not Applicable
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below: • Timely • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Activity overseen by NHSBT	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality**	Yes: ☒	No: ☐
	Outcome: Activity overseen by NHSBT	If no, please include rationale below:

Have you undertaken an Equality Impact Assessment Screening?		
Cyfreithiol / Legal	Yes (Include further detail below)	
	All practices are performed in-line with the Human Tissue Act and Welsh "Deemed Consent" law.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

51 The Committee are sked to **NOTE** the report.

Agenda Item
9.2.13

Quality & Safety Committee

Cwm Taf Morgannwg Maternity Metrics
An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022

Dyddiad y Cyfarfod / Date of Meeting	21/11/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Elinore Magillivray, Quality Improvement Lead Midwife Suzanne Hardacre, Director of Midwifery
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
None within the report	

1. Situation /Background

1.1 The Maternity and Birth Statistics 2022 were published by Welsh Government on 9th August 2023 Maternity and birth statistics: 2022 | GOV.WALES.

2. Specific Matters for Consideration

2.1 The Maternity Service has taken opportunity to review the Cwm Taf Morgannwg University Health Board position against each of the indicators.

3. Key Risks / Matters for Escalation

3.1 **Booking by ten completed weeks**: Target 85%, Cwm Taf Morgannwg 77% compliance is being monitored. Improvements being made through dedicated Quality Improvement projects with early signs of improvement.

3.2 **Age profile of mothers:** Cwm Taf Morgannwg is in line with all Wales data

3.3 **Body Mass Index:** National statistics show 31% of mothers had a body mass index of 30 or greater. In Cwm Taf Morgannwg, this was 36.7% in 2022 at initial booking appointment

3.4 **Smoking at booking:** 14.1% of women smoked in Wales compared to 15.6% within Cwm Taf Morgannwg

3.5 **Induction of Labour:** The nationally reported induction of labour rate was 35% compared to 37% at Cwm Taf Morgannwg. This is the first increase seen by the Health Board in three years.

3.6 **Home Births:** Home births in Cwm Taf Morgannwg were 2.2% compared to Wales national rate of 2.1%

3.7 **Spontaneous Vaginal Births:** 56% of births in Wales compared to 61% in Cwm Taf Morgannwg.

3.8 **Caesarean Section:** 35% of babies in Wales were born by caesarean section, the median rate at Cwm Taf Morgannwg was 33%.

3.9 **Epidural in labour:** 24% had an epidural in labour across Cwm Taf Morgannwg and in Wales

3.10 **Apgars >7 at 5 minutes:** 98.2% of babies in Cwm Taf Morgannwg had a score of >7 at five minutes compared to 98% in Wales

3.11 **In response, a Quality Improvement Programme of work is underway which also considers staff and service user feedback:**-

3.11.1 Developing a postnatal contraception service. Aim to launch in January 2024.

3.11.2 Drymester: supporting women and pregnant people to remain alcohol free in pregnancy (launch Autumn 23)

3.11.3 Self-referral digital booking system. Full launch 24th July 2023. Quality Improvement work ongoing.

3.11.4 Induction of labour ongoing Quality Improvement collaborative, including improving the booking process and developing an out of hospital Induction of Labour service.

3.11.5 Developing a communication passport for neuro-diverse maternity service users.

3.11.6 PERIPrem Cymru (Perinatal Optimisation) to improve outcomes for babies born below 32 weeks gestation

3.11.7 Improving the Help Me Quit for Baby service, including a digital self-referral pathway

3.11.8 Community midwifery transformation programme

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: • Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Living Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Timely • Equitable • Efficient • Effective • Equitable • Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a policy or a guideline

Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not a policy or a guideline.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 Committee receives and notes the Cwm Taf Morgannwg position against the Welsh Government national maternity statistics 2022

6. Next Steps

6.1 Committee notes the ongoing Quality Improvement work to improve care for women, birthing people and their families.

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

CTM Maternity Metrics:

An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022

(Maternity and birth statistics: 2022 | GOV.WALES

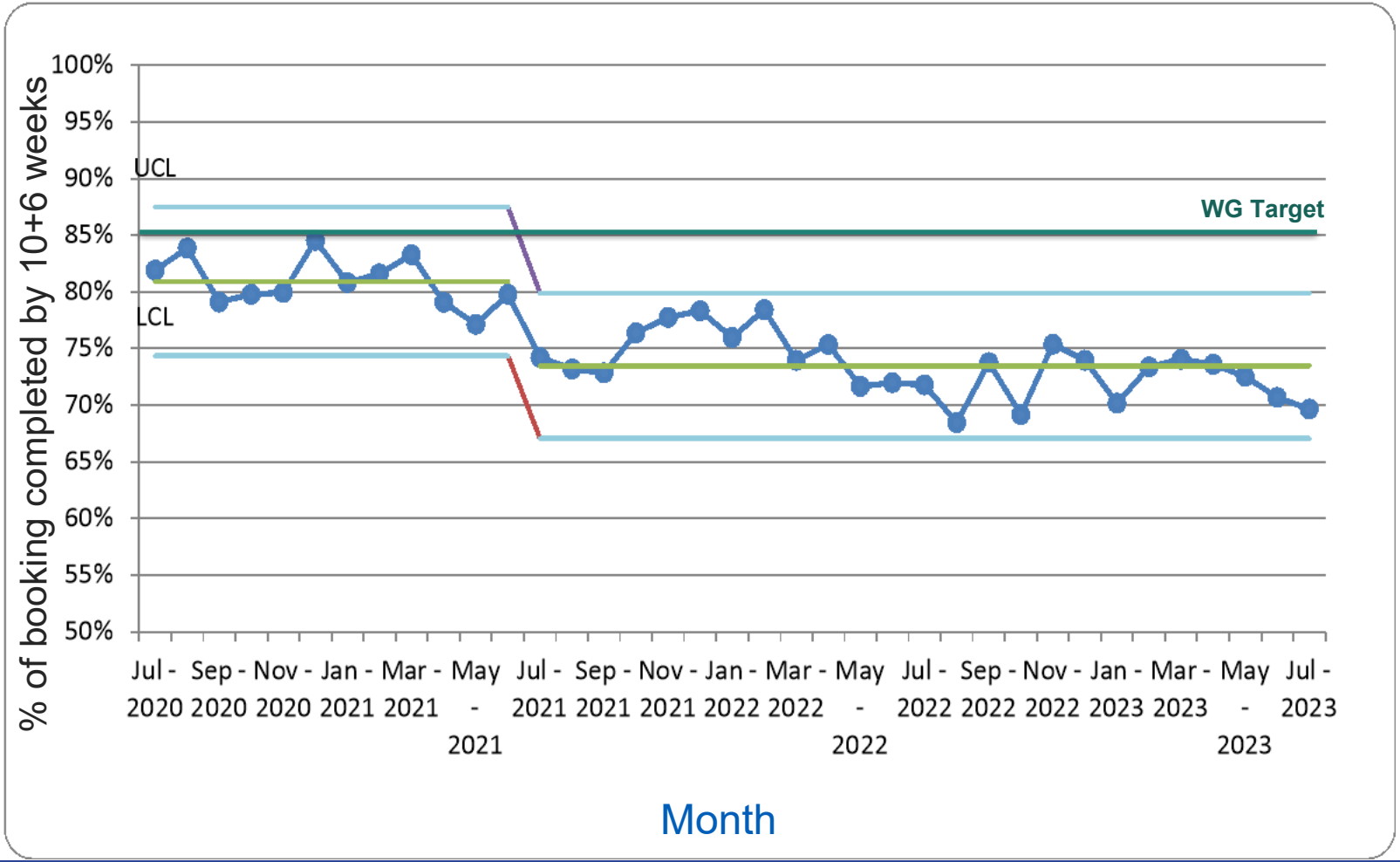
August 2023

(Data for July 2020- July 2023)

Elinore Macgillivray, Quality Improvement Lead Midwife

NB. Unless otherwise stated, time series charts show data from July 2020- July 2023

Booking by 10 Completed weeks gestation



The rate of compliance was higher in 2020 as appointments were carried out by telephone during the COVID 19 pandemic.

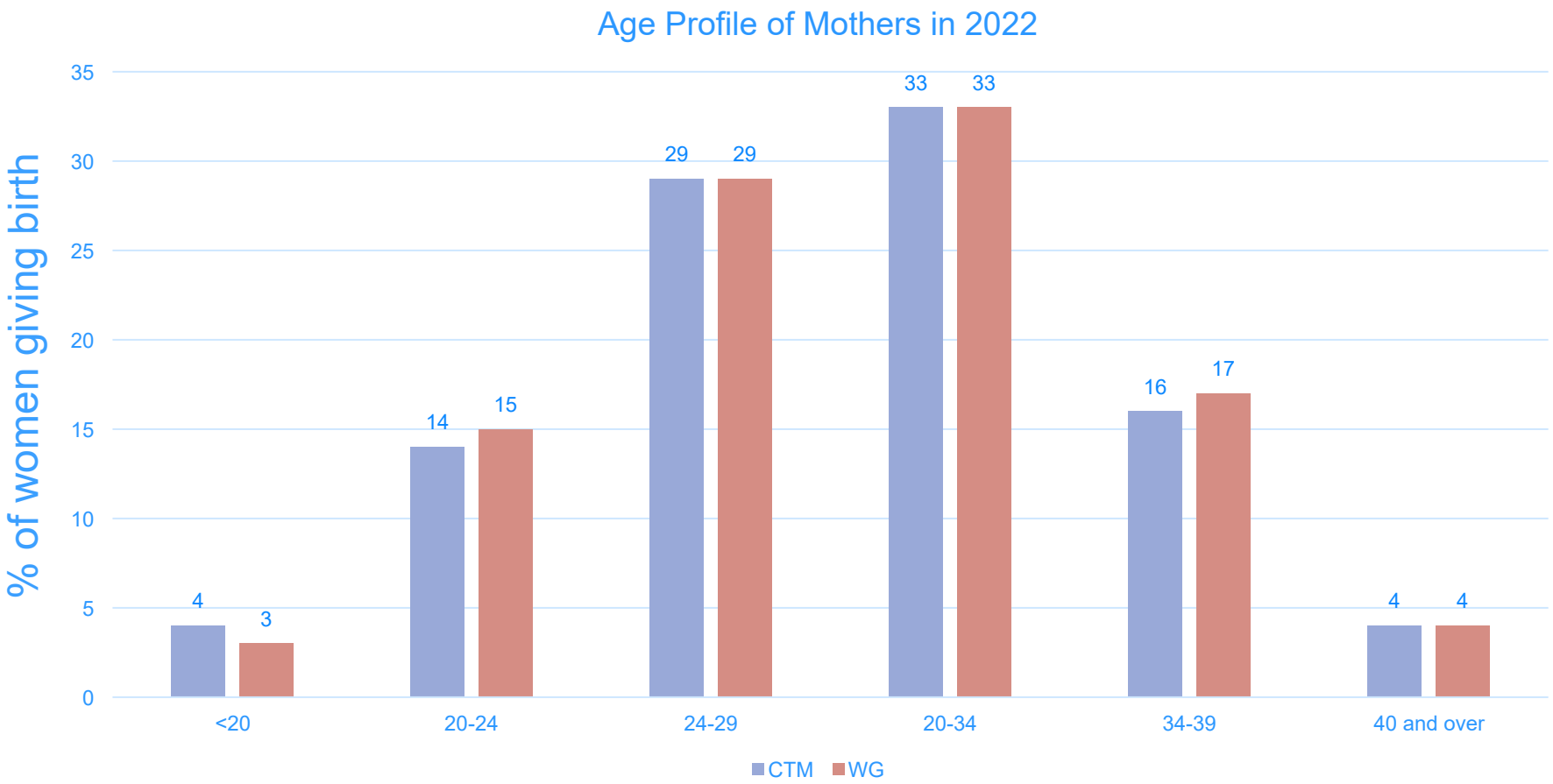
Welsh Government (WG) set a target rate of 85%. This allows for a proportion of women who may present later than 11 weeks gestation. **The median rate in 2022 was 74%**

The digital self-referral system was launched at the end of July 2023, with training to support implementation. Data are being collected for the purposes of QI and is helping to understand the barriers to early booking. QI work is ongoing.

WG Maternity Statistics 2022

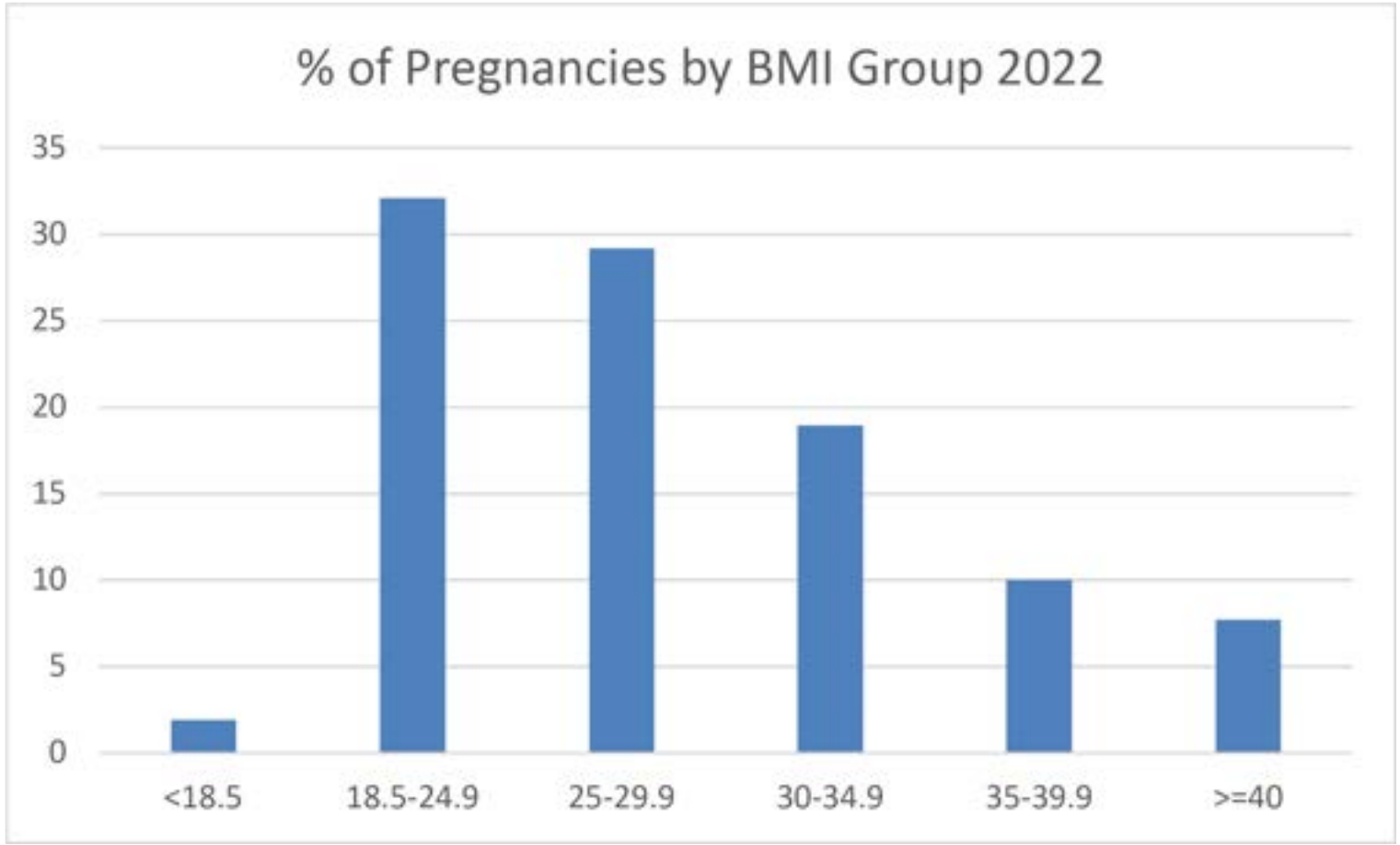
77% of women had their booking appointment by 10 completed weeks.

Age Profile of Mothers 2022



The proportion of pregnant women in each age group in CTM in 2022 was broadly in line with All Wales data.

BMI at Initial Booking Appointment 2022



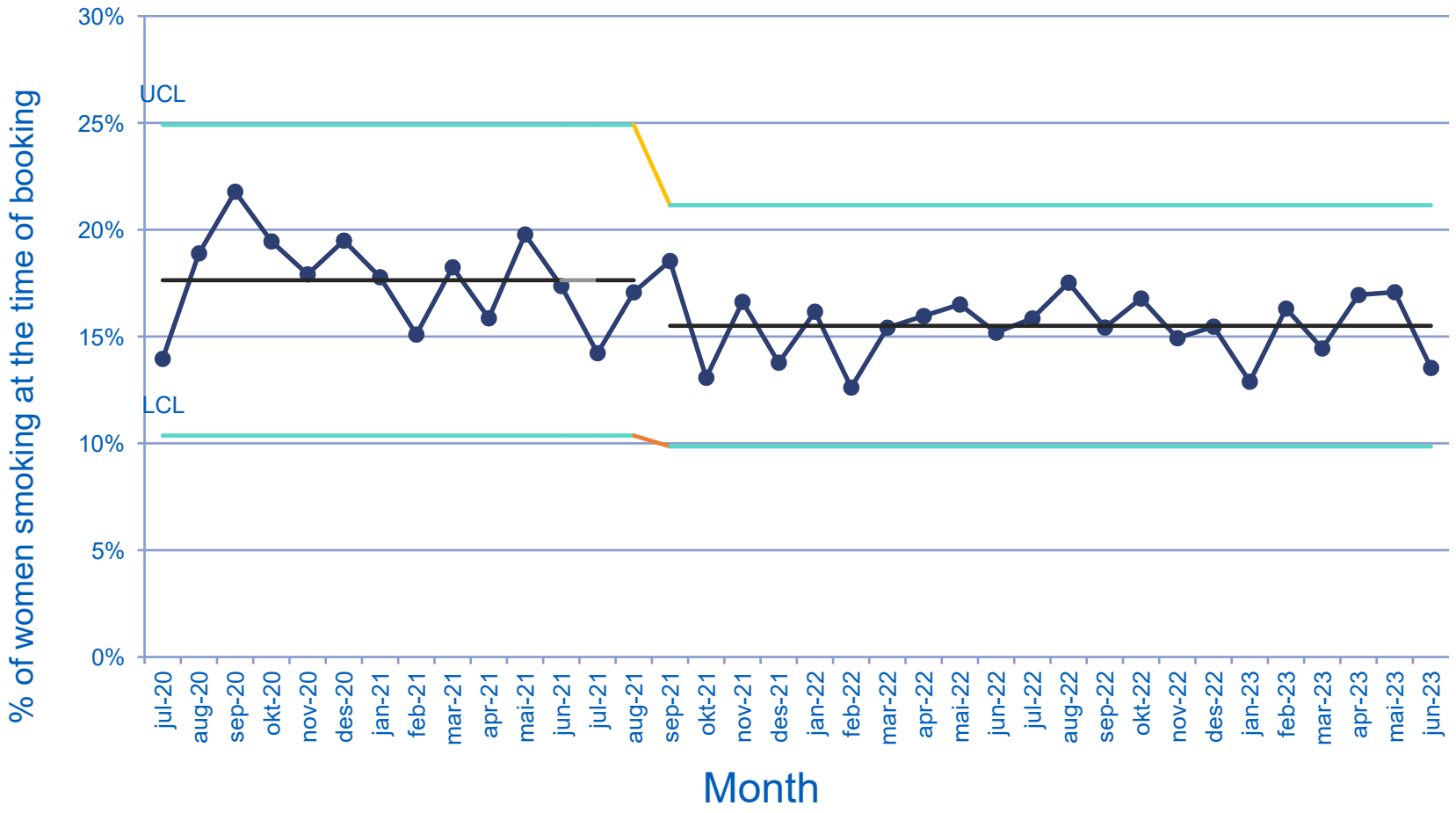
In 2022, **36.7%** of women booking for maternity care at CTM had a BMI of 30 or over at their initial booking appointment.

WG Maternity Statistics 2022

31% of pregnant women in Wales had a BMI of 30 or greater at their initial assessment, an increase of one percentage point from the previous year.

The percentage has increased every year since data collection started in 2016 and was five percentage points higher in 2022 than in 2016.

Smoking at the Time of Booking



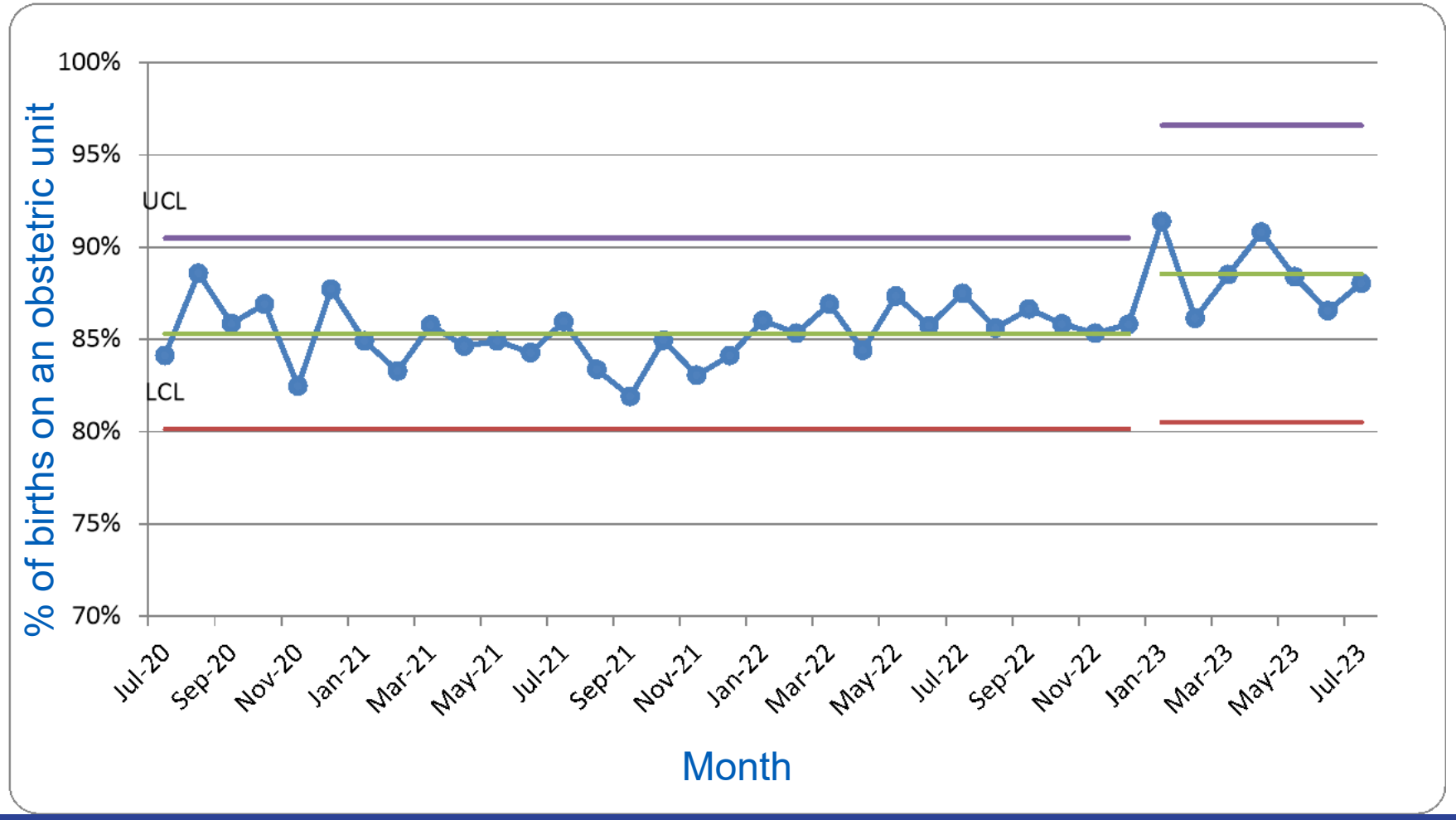
The rate women smoking at the time of booking has decreased from a median of 17.6% to 15% (as of September 2021).

NB.Vaping/ E cigarette usage is not currently captured.

In 2022, **15.6%** of women in CTM were smoking at the time of booking.

WG Maternity Statistics 2022
14.1% of women were smoking at the time of booking

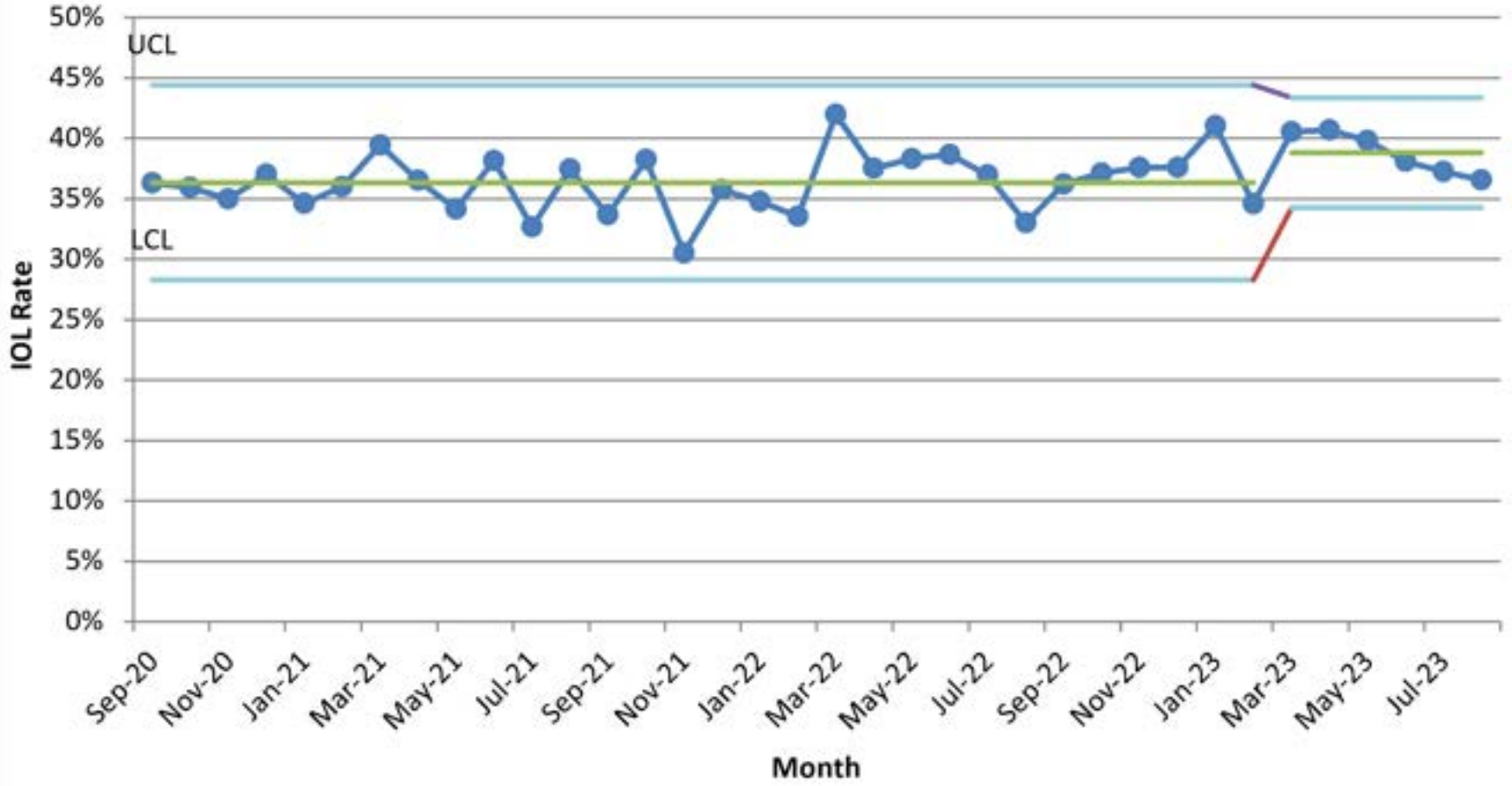
Rate of Births on an Obstetric Unit



The median rate of births on an obstetric unit has risen from 85% to 88%, as of January 2023.

This aligns with the overall picture of rising rates of intervention that are being seen across maternity services in Wales.

Rate of Induction of Labour

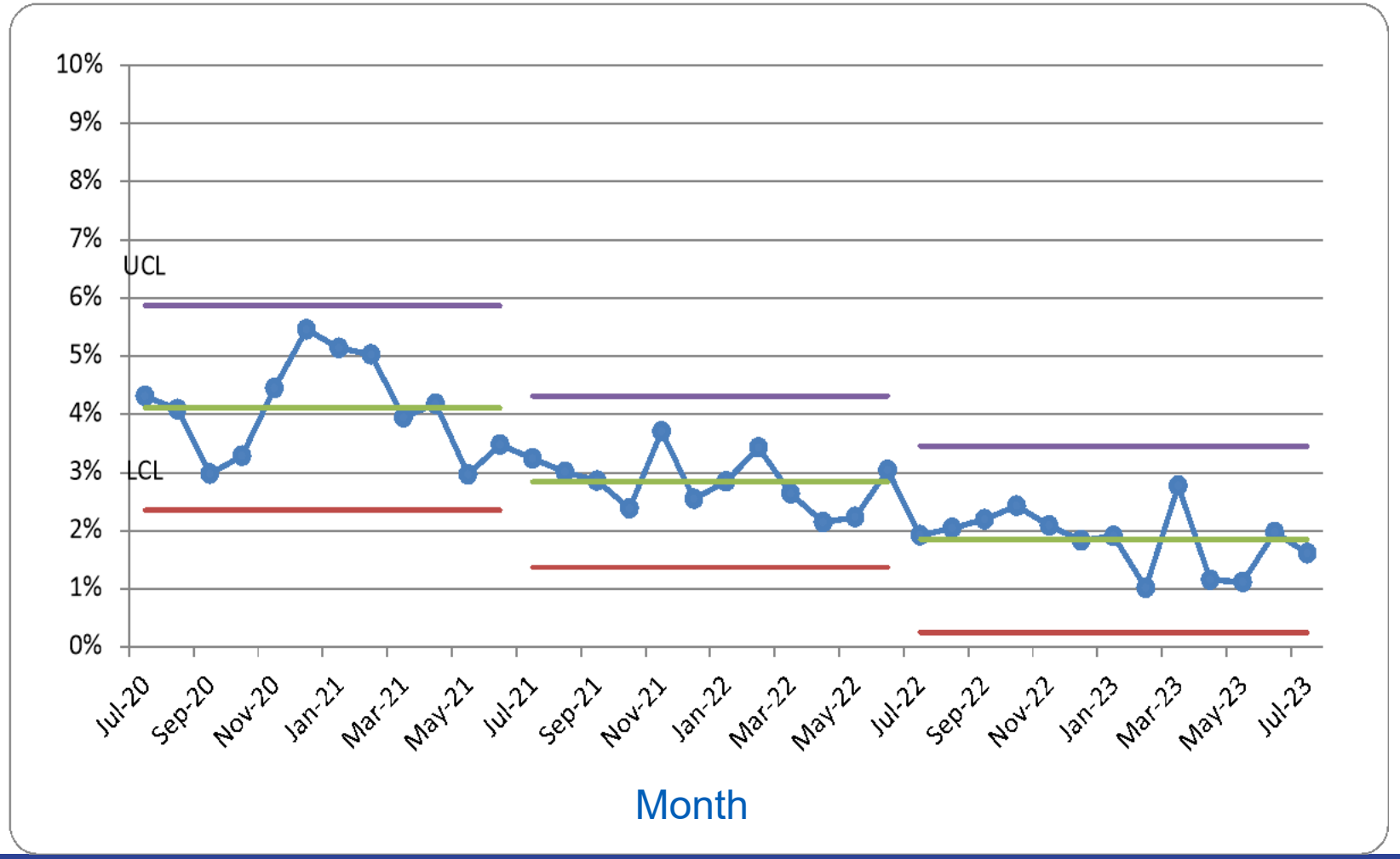


The induction of labour median rate has risen from 36% to 38%, as of March 2023. This is the first increase in median IOL rate seen in several years.

The median IOL rate in 2022 was 37%.

WG Maternity Statistics 2022
The Welsh median IOL rate was **35%**

Home Births

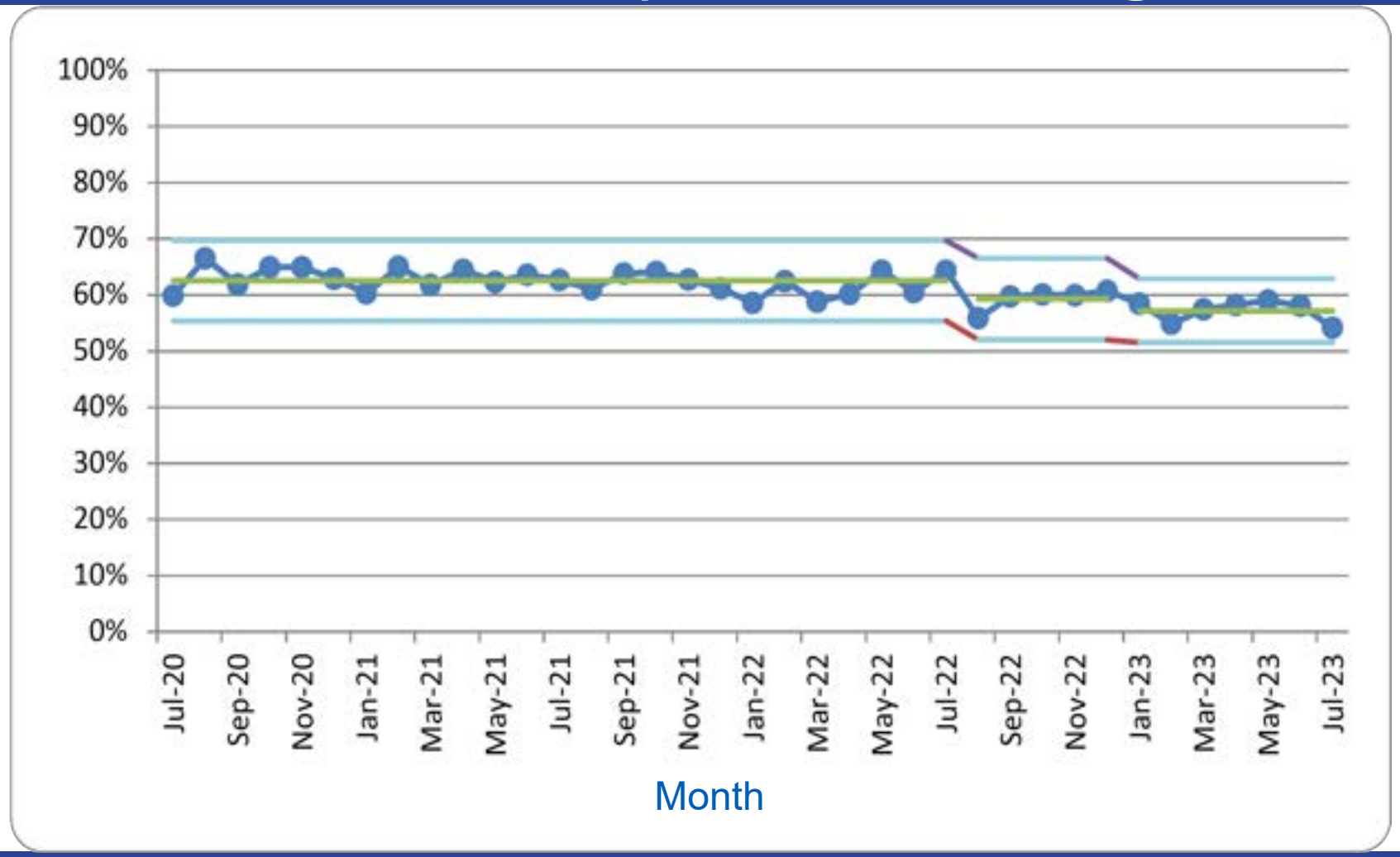


The median rate of home births has decreased from 4.1% to 2.8%, and again to 1.8% as of July 2022.

The median rate in 2022 was 2.2%

WG Maternity Statistics 2022
The home birth rate was **2.1%**

Rate of Spontaneous Vaginal Births

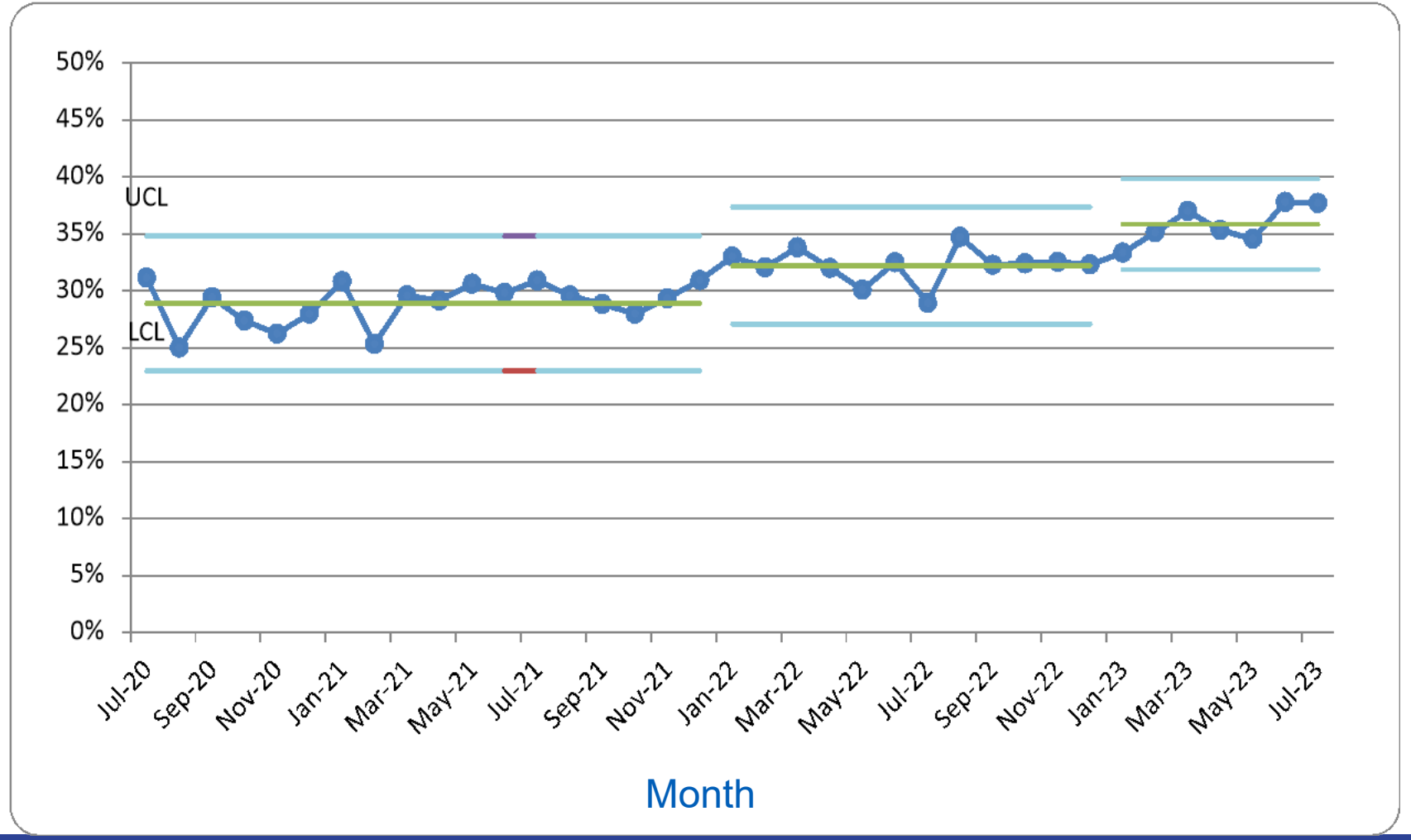


The median rate of spontaneous vaginal births has decreased from 62% to 59% in August 2022 and has fallen again to **57%** as of January 2023.

In 2022, the median SVD rate was 61%

WG Maternity Statistics 2022
56% of births were spontaneous vaginal births, 3.0 percentage points lower than in the previous year and 7.2 percentage points lower than in 2016.

Rate of Caesarean Section (all categories)

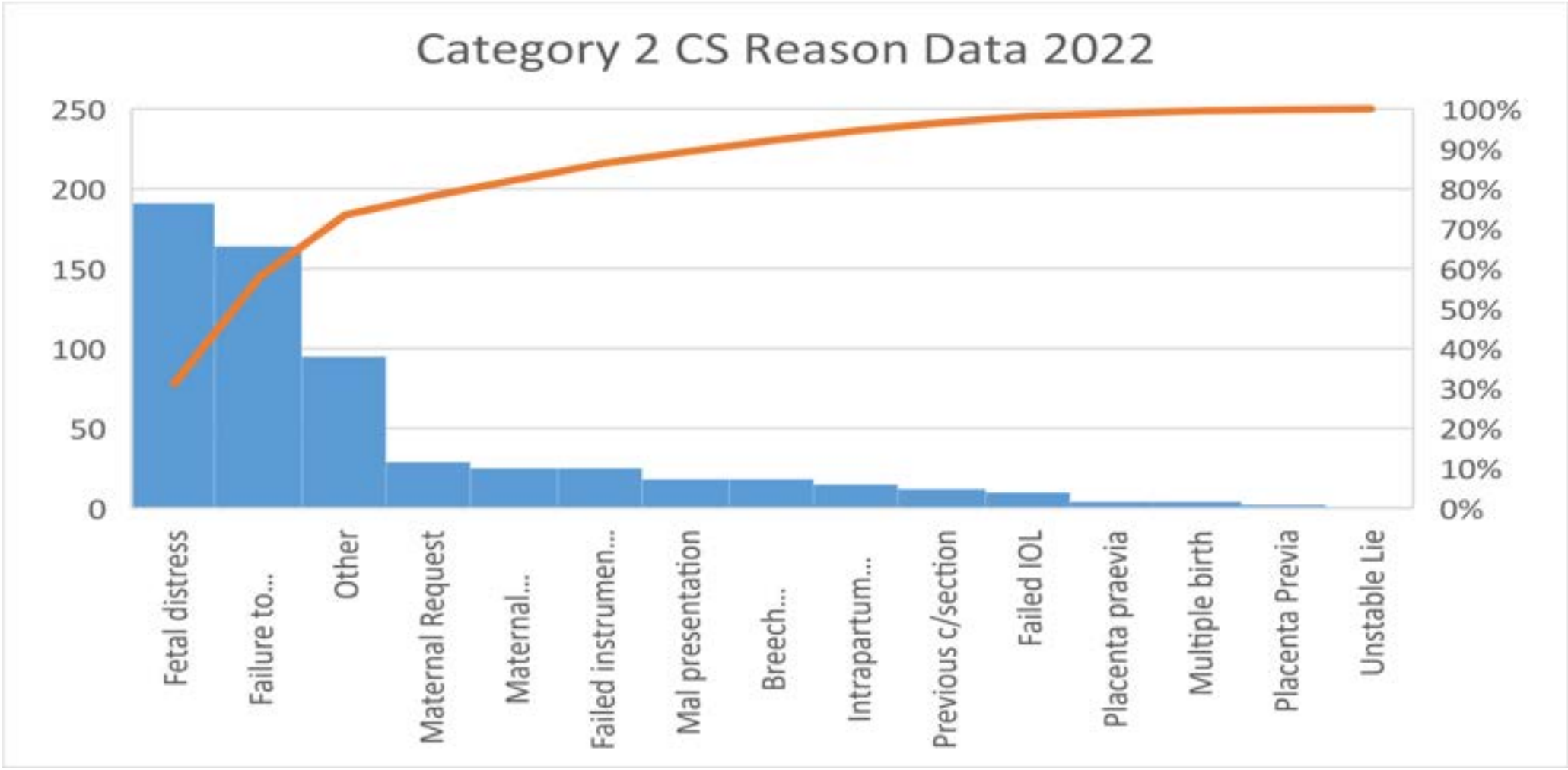


The median CS rate has increased twice in the last 3 years and is now **36%.** In June and July 2023, the rate of CS as a % of all births in CTM was the highest it's been. The most significant increase is in category 2 CS. Category 3 CS are also beginning to increase.

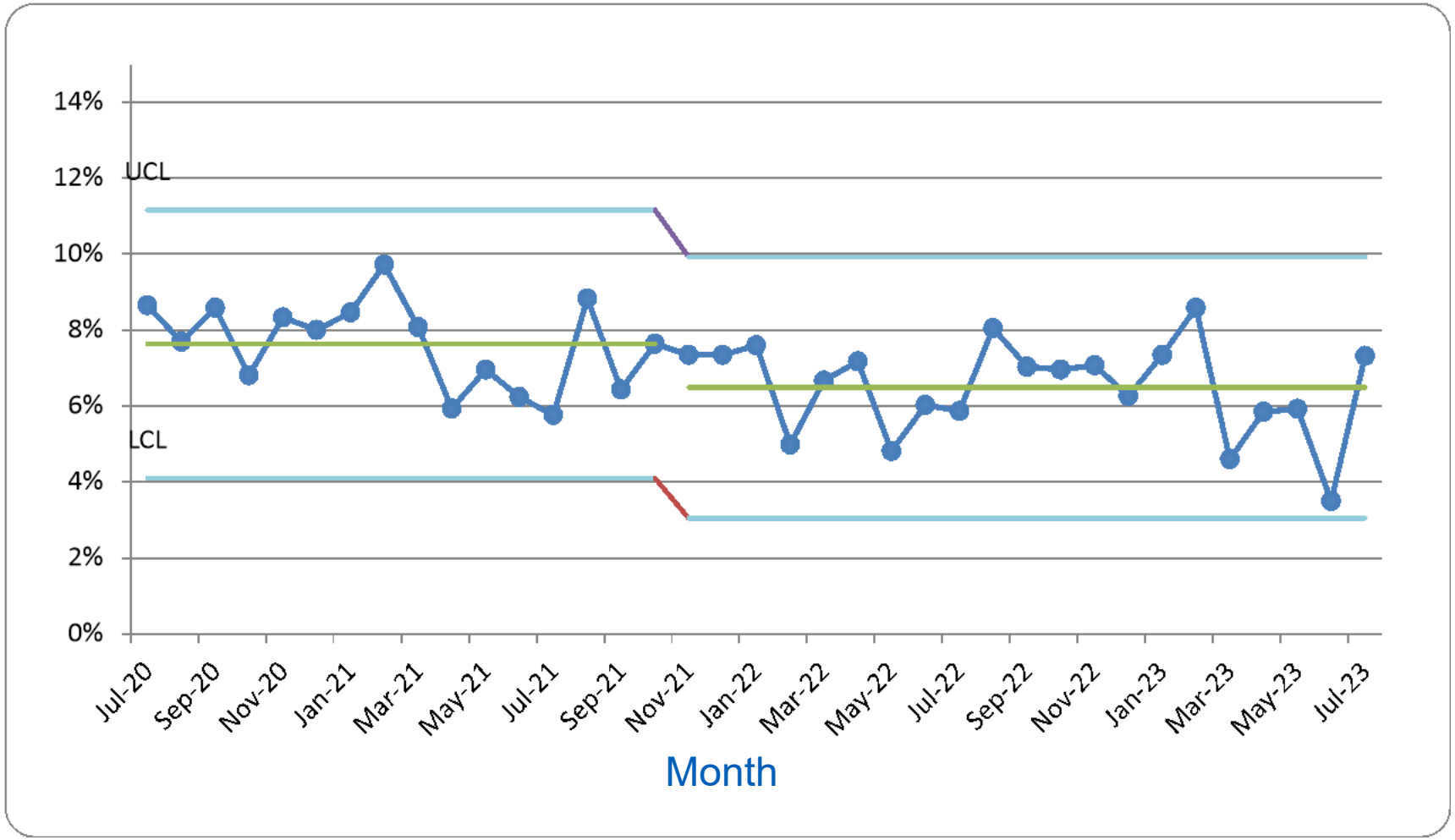
In 2022, the median CS rate was 33%

WG Maternity Statistics 2022
35% of babies in Wales were born by caesarean section, 3.4 percentage points higher than in the previous year and 8.3 percentage points higher than in 2016.

Reason for CS Data 2022



Instrumental Birth Rate

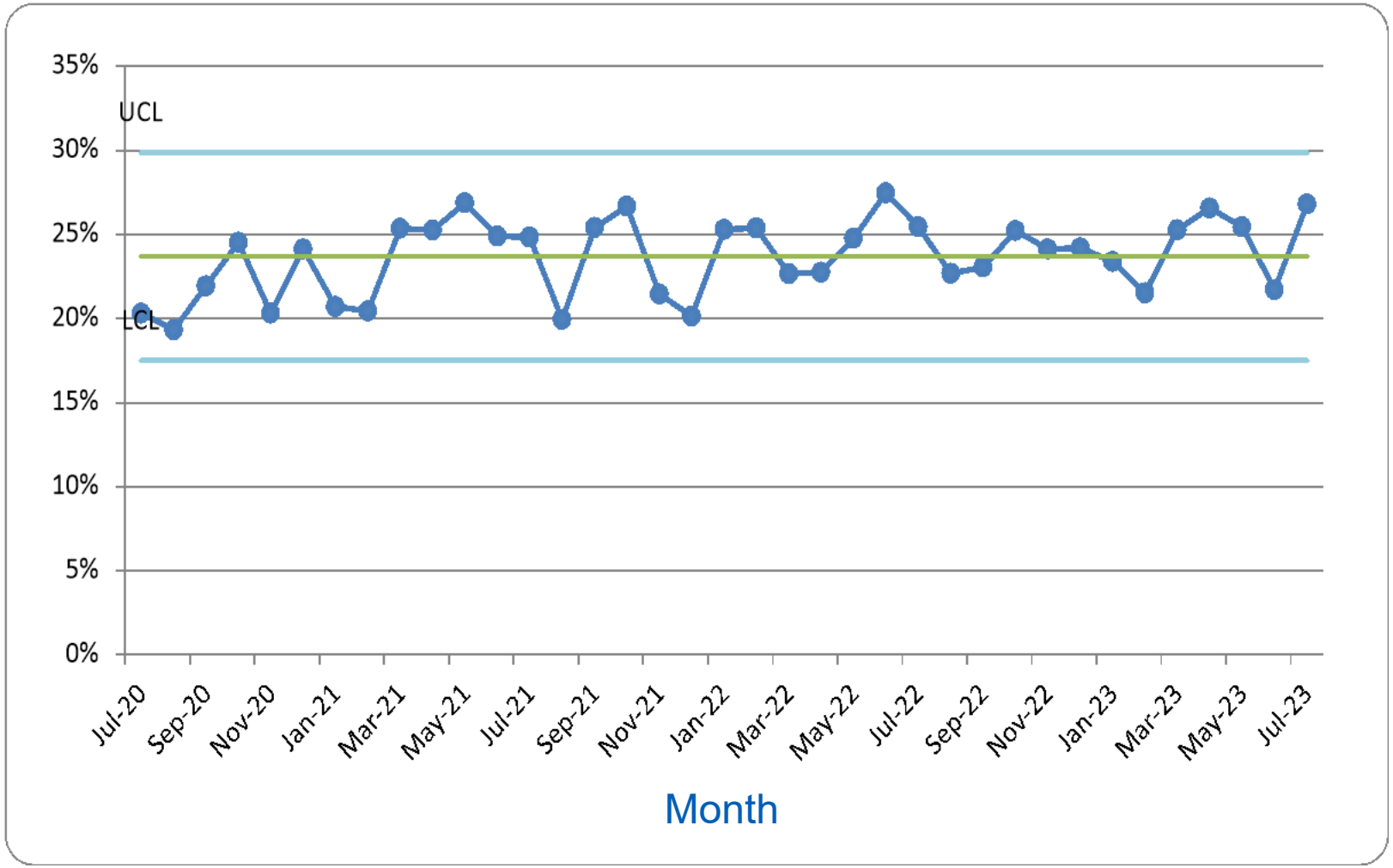


The median rate of instrumental births has decreased from 7.6% to 6.4%.

In 2022, the median instrumental birth rate was 6.5%

WG Maternity Statistics 2022
9% of babies in 2022 were born via the assistance of Ventouse or forceps.

Epidural in Labour Rate

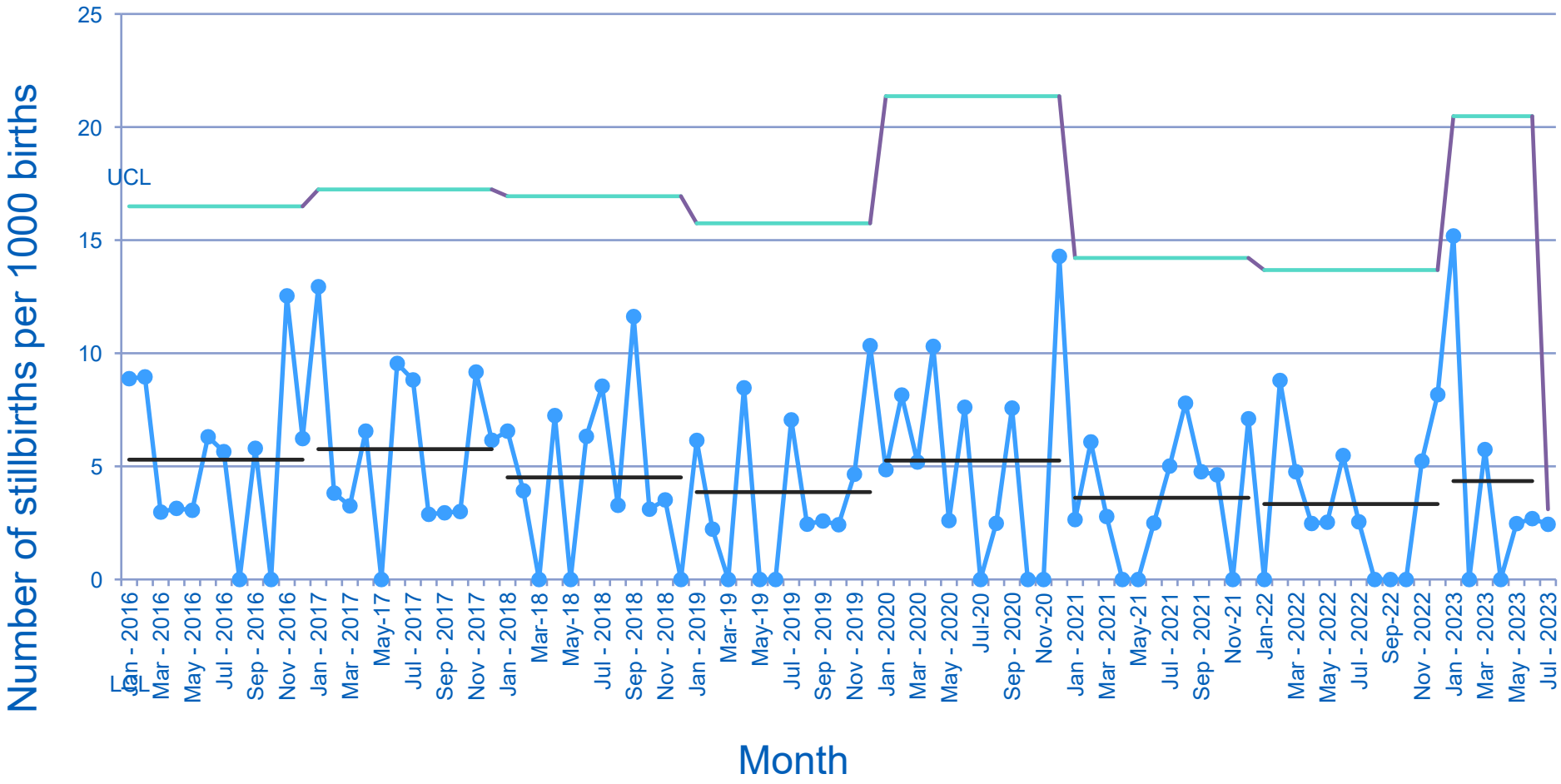


The median rate of epidural usage rate has remained stable for the past 3 years at **23%.**

The median in 2022 was **24%**

WG Maternity Statistics 2022
Welsh epidural in labour usage was 24%

Stillbirths per 1000 Births 2016-2023

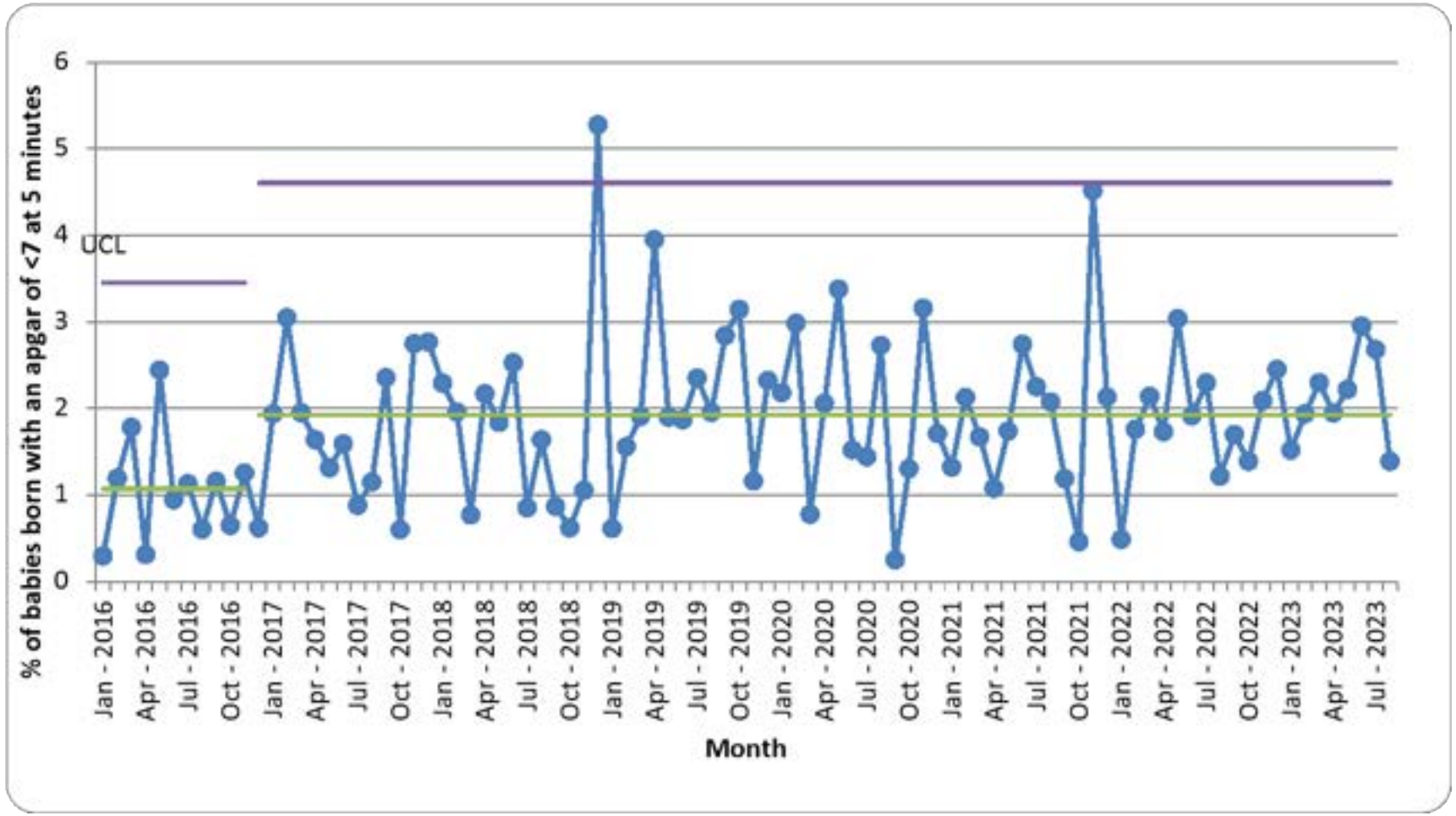


This chart shows the rate of stillbirths per 1000 births since 2016.

It should be noted that the earlier data is for CT before it became CTM in 2019.

Stillbirth rate was not included in Wales Maternity and Birth Statistics for 2022.

Apgar of > 7 at 5 Minutes (data for Jan 2016- August 2023)



The median rate of babies with an Apgar of less than 7 at 5 minutes has not changed since January 2017. NB. There has been no improvement since the implementation of PROMPT Wales training.

Note: in November 2019 and December 2021, the rate was outside normal variation (above the upper control limit).

In 2022, **98.2%** of babies born in CTM had an Apgar of 7 or over at 5 minutes of age.

WG Maternity Statistics 2022
98% of babies had an Apgar of 7 or more at 5 minutes of age.

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

Summary of CTM Data in Comparison with WG Stats (2022)

Measure	WG CTM Stats	CTM (local data)	WG Stats
Rate of bookings undertaken by 10 completed weeks	77%	74%	77%
Overall CS Rate (all categories)	33%	33%	36%
IOL Rate	39.2%	37%	35%
Instrumental birth rate	6.5%	6.5%	9%
SVD Rate	60.4%	61%	56%
Home births	2.8%	2.2%	2.1%
Median rate of women CO monitored at the start of pregnancy (recommenced May 2022)	Not reported	27%	1.8%
Smoking at start of pregnancy	13.9%	15.6%	14.1%
Smoking at end of pregnancy	7.3%	7.7%	12%
Percentage of term singleton babies born with a birthweight <2500g	Not reported	6.3%	6.1%
BMI ≥ 30 at booking	38%	36.7%	31%
Rate of babies with an APGAR score of 7 or over at 5 minutes	Not reported	98.2%	98%
Women reporting a mental health condition at booking	Not reported	34%	30%
Epidural for pain relief	19.5%	24%	24%

Equality, Diversity and Inclusion

- The MatNeoSSP report highlighted some work still to be done in terms of equality, diversity and inclusion. In particular, poor data collection about the ethnicity of our service users. There is an ongoing piece of work to improve data collection in order to better understand our population needs.
- The new digital booking system asks specifically about language needs. This allows for support, such as interpretation services, to be put in place prior to making the first contact.
- A QI project is underway to develop a neurodiversity passport for service users with different needs. The passport will be completed at the first booking appointment and will be used at every contact to ensure individual needs can be considered and met.
- We will be engaging with MatNeoSSP to implement any changes recommended.

QI Work in Progress– August 2023

Developing a maternity based postnatal contraception service. Aim to launch in January 2024.

Drymester: supporting women and pregnant people to remain alcohol free in pregnancy (launch November 23)

Self-referral digital booking system. Full launch 24th July 2023. QI work ongoing.

Induction of labour ongoing QI collaborative, including improving the booking process and scoping an out of hospital IOL service.

Developing a communication passport for neuro-diverse maternity service users.

PERIPrem Cymru to improve outcomes for babies born below 32 weeks gestation

Developing a suite of women's health physiotherapy classes.

Community transformation programme

Community Transformation

A programme of community transformation is underway across the Health Board. A set of community standards have been developed and agreed. Quality improvement work includes:

Improving initial booking processes. The digital system is fully implemented and highlighted further areas for improvement.

Birth Planning. A monthly data collection process is in place to monitor compliance. Work also includes improving quality of the birth plan process.

Antenatal care. Ensuring compliance with NICE recommended schedule of antenatal visits.

Working patterns. Responding to community midwives request for different ways of working, shift patterns have been reviewed.

Understanding data to understand population health and health needs.

A series of community midwifery workshops are taking place throughout September and October to engage all community midwives in the improvement programme.