Quality & Safety Committee

Thu 21 September 2023, 08:30 - 11:30

Virtually via Microsoft Teams

Agenda

08:30 - 08:35
5 min

1.
PRELIMINARY MATTERS

1.1.
Welcome & Introductions

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.2.
Apologies for Absence

Information *Carolyn Donoghue, Independent Member/Committee Chair*

1.3.
Declarations of Interest

Information *Carolyn Donoghue, Independent Member/Committee Chair*

08:35 - 09:05
30 min

2.
SHARED LISTENING & LEARNING

2.1.
Listening & Learning Story - Snowdrop Breast Centre

For Discussion and Shared Learning *Jo Lines, Lead Nurse*

Strategic Goal: Improving Care

Domains of Quality: Person Centred, Effective, Equitable

2.2.
Care Group Spotlight Presentation - Planned Care - Focus on Ophthalmology Backlog

Discussion *Sharon O'Brien, Care Group Nurse Director, Planned Care*

Strategic Goal: Improving Care

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

09:05 - 09:10
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.

09:10 - 09:15
5 min

4.
MAIN AGENDA

4.1.
Matters Arising not contained within the Action Log

Discussion *Carolyn Donoghue, Independent Member/Committee Chair*

09:15 - 09:45
30 min

5.
SETTING THE SCENE - SERVICE DELIVERY

5.1.
Report from the Chief Operating Officer

Discussion *Gethin Hughes, Chief Operating Officer*

Strategic Goal: Improving Care

Domains of Quality: Timely

5.1 COO's Overarching Report QSC 21 September 2023.pdf (9 pages)

5.2.
Care Group Highlight Reports

Discussion *Care Group Nurse Directors*

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

Strategic Goals: Improving Care, Creating Health, Inspiring People

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

5.2a DTPS Care Group Highlight Report QSC 12 September 2023.pdf (12 pages)
5.2b Unscheduled Care Highlight Report-Sept 2023 QSC 21 September 2023.pdf (7 pages)
5.2b Appendix 1 USC Care Group Highlight Report QSC 21 Septembern 2023.pdf (3 pages)
5.2c Children & Families Highlight Report QSC 21 September 2023.pdf (6 pages)
5.2d MHLD Highlight report for QSC 21 September 2023.pdf (6 pages)
5.2e PCC Highlight report for QSC 21 September 2023.pdf (5 pages)
5.2e Appendix 1 PCC Care Group Highlight Report QSC 21 September 2023.pdf (1 pages)
5.2f Planned Care Group Highlight Report QSC 21 September 2023.pdf (5 pages)

09:45 - 10:30
45 min

6.
GOVERNANCE, RISK AND ASSURANCE

6.1.
CTMUHB Staff Process for Raising Concerns

Discussion *Dom Hurford, Medical Director*

Strategic Goal: Inspiring People

Domains of Quality: Person Centred, Equitable

6.1 CTMUHB Staff Process for Raising Concerns QSC 21 September 2023.pdf (7 pages)

6.2.

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

Discussion *Gareth Watts, Director of Corporate Governance*

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

6.2a Org Risk Register - September 2023 - QSC 21923.pdf (6 pages)
6.2b Appendix 1 Master Organisational Risk Register -Final Draft September 2023 - QSC.pdf (7 pages)

6.3.
Healthcare Inspectorate Wales Improvement Plan Tracker Report

Discussion *Greg Dix, Executive Director of Nursing*

Strategic Goal: Improving Care

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

6.3 HIW Tracker Inspection Improvement Plans QSC 21 September 2023.pdf (6 pages)

6.4.
Learning From Events Reports

Discussion *Stephanie Muir, Assistant Director of Concerns & Claims*

Strategic Goal: Improving Care

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

6.4 Learning from Events QSC 21 September 2023.pdf (7 pages)

6.5.
CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unit Interim Learning Report

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

Strategic Goal: Improving Care, Creating Health

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

6.5 CTMUHB NOSOCOMIAL COVID 19 QSC 21 September 2023.pdf (13 pages)

6.6.
Quality & Safety Committee Annual Self Effectiveness Survey

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

Strategic Goal: Improving Care

Domains of Quality: Safe

6.6 Quality & Safety Committee Effectiveness Survey Themed Action Plan QSC 21 September 2023.pdf (7 pages)

6.7.
Summary of Irradiated Blood Alerts incorrectly added to Digital Patient Records

Discussion *Dom Hurford, Medical Director*

Strategic Goal: Creating Health

Domains of Quality: Safe

6.7 Irradiated Blood Alerts QSC 21 September 2023.pdf (5 pages)

10:30 - 10:45
15 min

7.
DELIVERING OUR PLAN

7.1.
Patient Safety & Quality Dashboard - to include an update on CIVICA

Discussion *Nigel Downes, Assistant Director Quality & Safety*

Strategic Goal: Improving Care

Domains of Quality: Safe

- 7.1a Quality Safety Dashboard Report QSC 21 September 2023.pdf (17 pages)
- 7.1b Compliance summary Alerts QSC 21 September 2023.pdf (2 pages)
- 7.1c Compliance summary Notices QSC 21 September 2023.pdf (4 pages)
- 7.1d CIVICA Update QSC 21 September 2023.pdf (6 pages)

10:45 - 11:15
30 min

8.
DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1.
Closure of the Maternity & Neonatal Improvement Programme

Decision *Suzanne Hardacre, Director of Midwifery*

Strategic Goals: Improving Care, Creating Health, Sustaining our Future

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

- 8.1a Closure of the Maternity Neonatal Programme QSC 21 September 2023.pdf (5 pages)
- 8.1b Mat Neo Metrics QSC 21 September 2023.pdf (16 pages)

8.2.
Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

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

Strategic Goal: Improving Care

Domains of Quality: Safe, Person Centred, Effective

- 8.2 Ty Llidiard QSC 21 September 2023.pdf (11 pages)

8.3.
Mental Health Adult Inpatient Improvement Programme

Discussion *Ana Llewellyn, Care Group Nurse Director, Mental Health & Learning Disabilities*

Strategic Goal: Improving Care

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

- 8.3 MH In-patient Improvement QSC 21 September 2023.pdf (6 pages)

8.4.
National Collaborative Commissioning Unit (NCCU) Quality Improvement and Assurance Service Annual Position Statement

Discussion *Adrian Clarke, Deputy Director & Head of Nursing, NCCU*

Strategic Goal: Improving Care

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

- 8.4a NCCU QAIS Annual Position Statement 2022-23 QSC 21 September 2023.pdf (6 pages)
- 8.4b QAIS Final APS 2023.pdf (3) QSC 21 September 2023.pdf (82 pages)

11:15 - 11:20 **9.**

5 min

CONSENT AGENDA

9.1.
For Approval

9.1.1.
Unconfirmed Minutes of the meeting held on 25 July 2023

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

9.1.1 Unconfirmed Minutes QSC 25 July 2023 Final QSC 21 September 2023.pdf (18 pages)

9.1.2.
Unconfirmed Minutes of the In Committee meeting held on 25 July 2023

Decision *Carolyn Donoghue, Independent Member/Committee Chair*

9.1.2 Unconfirmed In Committee Minutes QSC 25 July 2023 Final QSC 21 September 2023.pdf (2 pages)

9.1.3.
Medicines Policy

Decision *Dom Hurford, Medical Director*

Strategic Goal: Improving Care

9.1.3a Use of Medicines Policy - Policy Approval Cover Paper QSC 21 September 2023.pdf (3 pages)
9.1.3b Use of Medicines Policy QSC 21 September 2023.pdf (10 pages)

9.1.4.
Safeguarding Policy

Decision *Greg Dix, Executive Director of Nursing*

Strategic Goal: Improving Care

Domains of Quality: Efficient, Effective, Equitable

9.1.4a CTMUHB Safeguarding Policy CoverPaper-Final 18.9.23 QSC 21 September 2023.pdf (4 pages)
9.1.4b Safeguarding PP Policy - April 23-Final QSC 21 September 2023.pdf (29 pages)

9.1.5.
Clinical Policies Approval Process

Decision *Dom Hurford, Medical Director*

Strategic Goal: Improving Care

Domains of Quality: Effective

9.1.5 Clinical Policies Process QSC 21 September 2023.pdf (6 pages)

9.2.
FOR NOTING

9.2.1.
Action Log

Information *Carolyn Donoghue, Independent Member/Committee Chair*

9.2.1 Action Log QSC 21 September 2023.pdf (10 pages)

9.2.2.
Committee Annual Cycle of Business

Information *Gareth Watts, Director of Corporate Governance*

9.2.2a Committee Annual Cycle of Business QSC 21 September 2023.pdf (4 pages)

9.2.2b Quality Safety Committee Cycle of Business QSC 21 September 2023.pdf (4 pages)

9.2.3.
Committee Forward Work Programme

Information *Gareth Watts, Director of Corporate Governance*

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

9.2.4.
WHSSC Quality & Patient Safety Committee Chairs Report

Information *Dilys Jouvenat, Independent Member*

9.2.4a Quality Patient Safety Committee Chairs Report August 2023 QSC 21 September 2023.pdf (7 pages)
9.2.4b Appendix 1 - Summary of Services in Escalation QSC 21 September 2023.pdf (8 pages)
9.2.4c Appendix 2 - WHSSC Newsletter Spring-Summer 2023 QSC 21 September 2023.pdf (10 pages)
9.2.4d Appendix 3 - WHSSC Newsletter Spring-Summer 2023 Welsh QSC 21 September 2023.pdf (10 pages)

9.2.5.
Infection, Prevention & Control Report Annual Report 2022 - 2023

Information *Greg Dix, Executive Director of Nursing*

Strategic Goal: Improving Care

Domains of Quality: Safe

9.2.5a IPC Annual Report 2022 - 23 QSC 21 September 2023.pdf (3 pages)
9.2.5b Annual IPC Report 2021-22 Final QSC 21 September 2023.pdf (36 pages)

9.2.6.
Regulatory Review Recommendations Update Relating to Healthcare Inspectorate Wales

Information *Greg Dix, Executive Director of Nursing*

Strategic Goal: Improving Care

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

9.2.6 HIW Reg QSC Report QSC 21 September 2023.pdf (6 pages)

9.2.7.
Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2022/23

Information *Philip Daniels, Director of Public Health*

Strategic Goal: Improving Care

Domains of Quality: Safe, Effective, Efficient

9.2.7 IPFR Annual Report 2022-23 QSC 21 September 2023.pdf (11 pages)

9.2.8.
Public Services Ombudsman For Wales A Year of Change – A year of Challenge Annual Report and Accounts 2022/2023

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

Strategic Goal: Improving Care

Domains of Quality: Effective

9.2.8a Public Services Ombudsman For Wales QSC 21 September 2023.pdf (5 pages)
9.2.8b CTMUHB - ENG - 22-23 Annual Letter QSC 21 September 2023.pdf (8 pages)
9.2.8c CTMUHB - CYM - 22-23 Annual Letter QSC 21 September 2023.pdf (8 pages)

9.2.9.
Incident Management Internal Audit Report

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

Strategic Goal: Improving Care

Domains of Quality: Safe

- 9.2.9a Incident Management Report QSC 21 September 2023.pdf (5 pages)
- 9.2.9b CTMUHB 22.23 National Incident Framework Final Internal Audit Report QSC 21 September 2023.pdf (21 pages)
- 9.2.9c Internal Audit Incident Management Action Plan 2023-08-07 QSC 21 September 2023.pdf (6 pages)

9.2.10.
A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report

Information *Dom Hurford, Medical Director*

Strategic Goal: Improving Care

Domains of Quality: Safe

- 9.2.10 National Review of Consent to Examination & Treatment QSC 21 September 2023.pdf (5 pages)

9.2.11.
Public Services Ombudsman for Wales Groundhog Day 2: An opportunity for Cultural Change in Complaints Handling?

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

Strategic Goal: Improving Care

Domains of Quality: Effective

- 9.2.11 PSOW-Groundhog Day 2 QSC 21 September 2023.pdf (6 pages)

11:20 - 11:25
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*

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

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

- Stillbirth Thematic Review 2022
- MBRRACE-UK Perinatal Mortality Report - 2021 Births

11:25 - 11:30

11.

5 min **DATE AND TIME OF NEXT MEETING - TUESDAY 21 NOVEMBER 2023 AT 9:00AM**

11:30 - 11:30
0 min **12. CLOSE OF MEETING**

Agenda Item
5.1

Quality & Safety Committee

Chief Operating Officer's Overarching Report

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lucy Timlin, Head of Business Support, COO's Office
Cyflwynydd yr Adroddiad / Report Presenter	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**
Other QSR Meetings	Click or tap to enter a date.	Noted

Acronyms / Glossary of Terms	

1. Situation /Background

This brief paper provides an overarching update on a range of issues within the remit of the Chief Operating Officer.

The areas include:

- An update on the risk register issues touched on in the last report including:
    - Items from all Care Groups including updates from the last meeting
    - A brief update on the Phase 2 of the UHB's Reorganisation

Colleagues will understand that these issues continue to provide a key focus for colleagues across the UHB. The full details of the matters outlined in this COO Report are covered in more depth within individual reports or available via the appropriate Department.

2. Specific Matters for Consideration

2.1 Children & Families

Work continues on progressing the work programme in Children & Families – committee members will be interested to note the following:

- The Care Group is pleased to see the **waiting times at stage 4 for Gynaecology** continuing to reduce – this is as a result of increased operating and a focus on long waiters. The focus will now shift to validating stage 2 and 3 as well as a plan to clear stage 1 patients waiting more than 52 weeks by the end of the year;

- **Safe guarding** – following concerns raised around safeguarding in POW, a full review of the cases is underway led by the Community lead and safe guarding team. A Safeguarding Improvement Plan will be prepared and submitted in the coming month;

- The Care Group has undertaken detailed work around **medical staffing and solutions** for the complex use of long term medical locums caused by vacancies and gaps. This remains on going and it is anticipated that it will make a positive impact on patient care;

- The Care Group will be holding meetings with colleagues from WHCSS towards the end of September 2023 to discuss changes within **neonatal cot provision**. There will be further updates available on this issue which may have implications for other services.

2.2 DTPS

The work programme underway within DTPS is broad, but committee members will be interested to hear about the following:

- Work has started in **Radiology on a workload allocation tool** to prioritise consultant reporting time to MRI and CT and allow reporting radiographers to continue with plain film reporting. It is anticipated that this will assist with timings in this area;

- The UHB is now fully compliant with the **Medicines Act** following a significant amount of work undertaken by Pharmacy with colleagues in Care Groups;

- Following a **Consultant resignation in Histopathology**, the Care Group is exploring the opportunity for joint appointments with Cardiff and Vale UHB;

- Colleagues will be pleased to hear that the issue with **sonographer sickness** has been resolved – all colleagues are back in work (with one on a phased return) and there is now a rotational plan in place aimed at avoiding this problem in the future. Additionally, two members of staff have been appointed on a fixed term basis.

2.3 Mental Health

Issues within Mental Health that may be of interest to committee members are as follows:

- There has been significant **progress towards improved CAMHS performance**, with part 1A over trajectory and parts 1B and 2 looking very positive;

- **Adult services** performance remains broadly on target – with improvements within psychological therapies. Colleagues will be updated of actions within adult services if they are needed, at the next meeting;

- The **MH Adult Inpatient Improvement Programme** is continuing, chaired by the Executive Director for Therapies and Health Science. The Programme meets two monthly, has a number of workstreams to address the recommendations made by HIW;

- Colleagues will be pleased to hear that a notification letter received from WHSSC indicates that **Ty Llidiard has been de-escalated** to Level 0. This is a significant development and reflects much hard work from the staff in the area.

2.4 Primary & Community Care

Issues within Primary and Community Care include:

- The UHB is preparing to start its **vaccination programme** in the near future – some decisions are expected from Executive colleagues for this to happen smoothly;

- The Care Group is working with Planned Care to seek a resolution to the need for **additional paediatric GA dental and Special Care GA lists**;

- There are challenges around the **recruitment of orthodontics** across the UK and this is an issue for the Community Dental Service. Work is underway to mitigate and resolve the issue caused as a result of retirement;

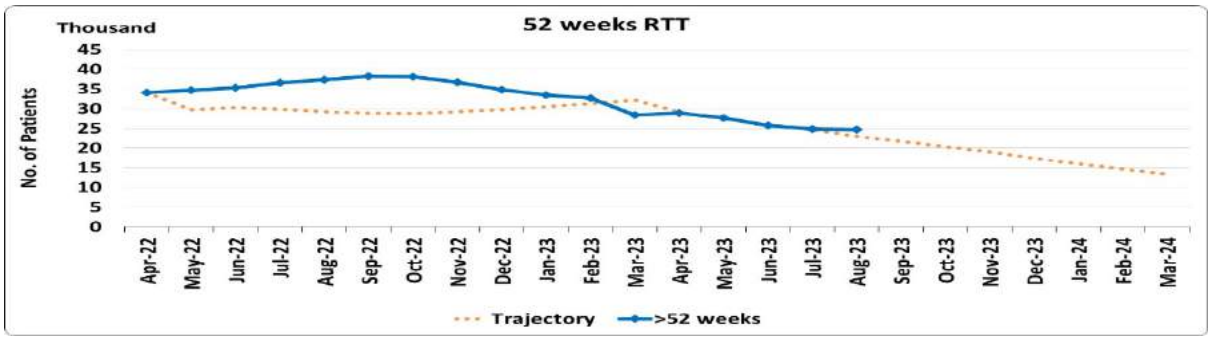
- **Registered Nurse vacancies** within Community Hospitals is still an issue for the Care Group – work is ongoing to recruit and also to mitigate the situation;

- The **management focus on the Navigation Hub** continues, especially as the pressures on the UHB increase as the autumn and winter approach. It is anticipated that this will make a real difference to flow across the services provided by the UHB.

2.5 Planned Care and Cancer Services Care Group

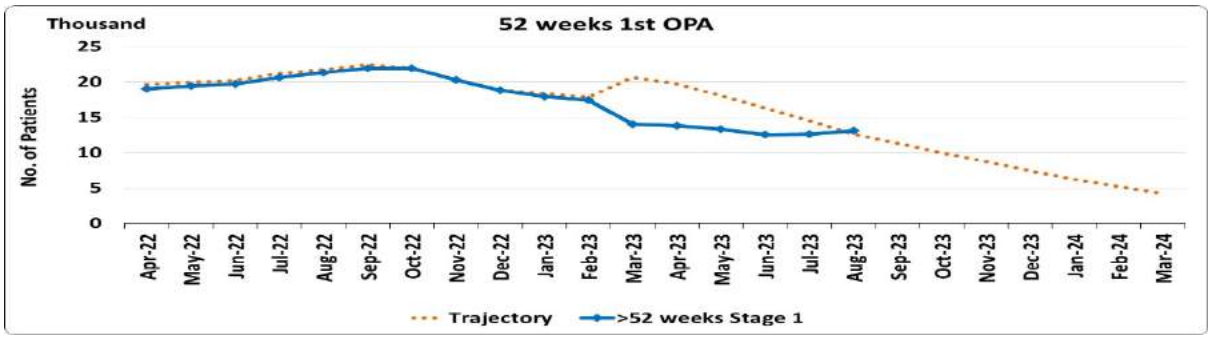
Focused work continues to address waiting times across the UHB – the position by area is outlined below.

>52 week position RTT



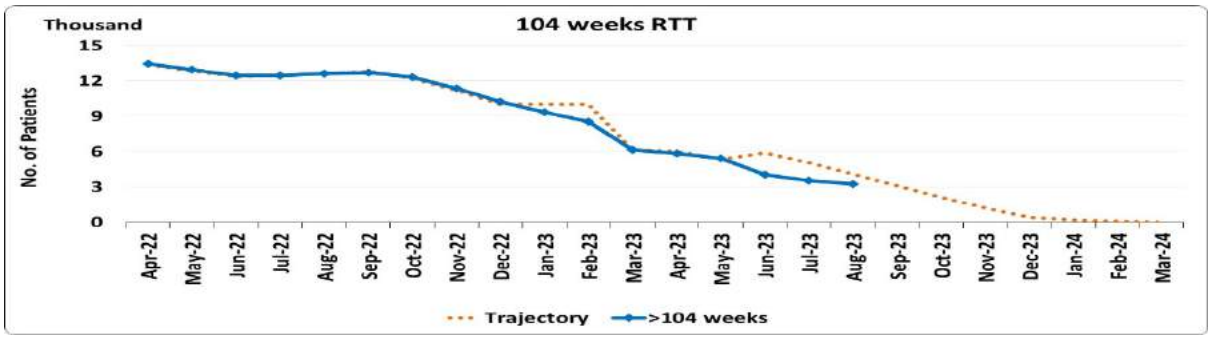
The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of August is 24,734, a small reduction of 0.5% (119) from the July reported position.

>52 Week position New Outpatient Appointment



The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of August is 13,084, an increase of 3.7% (465) from the July reported position.

>104 week position RTT



The provisional position across the HB for patients waiting over 104 weeks for referral to treatment at the end of August is 3,256, a reduction of 7.7% (271) from the reported July position

>156 Weeks position RTT

The position continues to improve with the weekly tracking meeting and the implementation of the Planned Care Recovery bids will support the improvement process.

156 Weeks Stage 1

156 week stage 1 has delivered a reduction across all specialities across the last six months.

Committee members will be interested to hear the following:

- **Single Cancer Pathway** – despite continued effort, the position is off trajectory and is heavily impacted by BSW reporting. Performance for July was >50% for the first time.

Services of concern have all had NHS Executive support and action plans for improvement have been developed for Endoscopy, Urology and Gynaecology, with task and finish groups established – the first two specialty areas meeting weekly.

- Colleagues at the **Welsh Cancer Network** have now removed LGI and Urology from the top 10 risks, with Gynaecology remaining at number 10. The work streams continue in each area to ensure continued improvements.

The current situation with administrative staffing and payments are having an impact on delivery, however it is anticipated that this will improve as processes are implemented. Matters of focus at present include:

- **PCR bids -** The fortnightly meetings continue, with current schemes being reviewed and will report to the Planned Care Board. 'Pipeline' schemes have been developed if there are opportunities during quarters three and four;

- **ID Medical – Theatre Insourcing** – this will continue until December 2023, whilst the theatre sustainability paper is approved. The Care Group then aims to phase out insourcing as recruitment starts;

- **Ophthalmology** – the GIRFT report has been received and a Group being established to review and implement change within the services;

- **INNU –** following on from work already undertaken, these interventions are being reviewed and updated to implement across the Board,

- **Service Transformation – the Care Group has now commenced transformation programmes in** ENT, Dermatology, Pre-assessment, Urology and Ophthalmology.

2.6 Unscheduled Care

Matters that will be of interest to committee members include:

- **Emergency Pressures Escalation Procedure** – the procedure was launched across the organisation on 14 August 2023, providing consistency for reporting and clinical colleagues;

- Work has been completed to refine the **Boarding and Pre-emptive Transfer Policy** which went live across the UHB on 14th August 2023. These are early days but it is anticipated that the Policy will improve patient safety across all sites;

- Following a significant amount of work to improve the situation, and compliance with targets, a **Zero Tolerance to Ambulance Handovers > 4 hours Policy** was launched at RGH in early May. This was followed up by a roll out at POW in July and PCH in early September 2023. The response has been encouraging and there has been a significant improvement in times – this has been a significant piece of work for colleagues and is a continuing challenge as activity remains high;

- A **Stroke Programme Board** has been established by the Care Group, with first meeting held in July 2023. The Board will align with the Regional Programme Board and the Stroke Strategy Meeting and an Operational Group is being established to look at the more day to day management issues within the service.

2.7 Organisational Change Phase 2

The consultation document for phase 2 of the UHB's organisational change proposals is now live and has been made available via Sharepoint.

The Consultation period will last until the end of September 2023 and the process of evaluating comments and making any changes needed will then start. There will be updates on progress on this important issue in future COO Reports and it is recognised that this is an unsettling time for staff who come under the scope of the proposals.

3. Key Risks / Matters for Escalation

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

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

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

4. 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))*	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))*	Timely 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 a report of existing schemes which will have been assessed wherever appropriate.

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 a report of existing schemes which will have been assessed wherever appropriate.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Failure to achieve waiting times and other targets may result in harm – with the consequent potential for legal action.	
Enw da / Reputational	Yes (Include further detail below)	
	Failure to achieve the aims of safe and high quality patient care are likely to have a detrimental impact upon the UHB as well as upon patients and staff.	
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

Members of the Committee are asked to note the content of this review.

6. Next Steps

Further updates will be provided at the next meeting. Additional information is available if required.

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Diagnostics, Therapies, Pharmacy and Specialties Quality, Safety, Risk and Experience (QSRE) Meeting

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lisa Love-Gould- Clinical Director of AHPs
Cyflwynydd yr Adroddiad / Report Presenter	Lisa Love-Gould- Clinical Director of AHPs
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	
AHP	Allied Health Professionals
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital

ITU	Intensive Treatment Unit
HTA	Human Tissue Authority
DTPS	Diagnostics, Therapies, Pharmacy & Specialties
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Specialties Quality, Safety, Risk & Experience Group up to August 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

Pathology

Outsourcing cellular Pathology:

- The outsourcing for Cellular Pathology is continuing at present but the Planned Care Recovery allocation for the year is forecast to be completely spent by end of November 2023 due to the increasing demand. This would result in a deterioration in the backlogs position and a change of the current risk rating. Discussion of options and a further proposal/bid has been submitted through Planned Care Recovery group to continue until March 2024.

- Current Clinical Haematology RTT data for end of July shows a notable decline in >26 and >36 weeks. Concern around increasing waits may potentially impact on patient outcomes. Additional support from within the admin team has been provided to the Clinical Haematology service to help focus on maximising efficiency, but this leaves other areas of pathology short of support and at risk. This will be closely monitored by the senior team and changes will be made to avoid risk escalating.

Radiology

Backlog of reporting – risk score reviewed and escalated as a high risk (15). Budget constraints have meant cessation of Waiting List Initiatives (WLIs), restriction on use of locums and inability to outsource routine work or work within core hours. Significant increase in Out of Hours (OOH) demand exacerbating issues and current vacancies. Current workforce does not reflect change in demand. Other departments continuing with additional activity also compounding the issue. There has been an increase in

	complaints from patients and other departments around the waiting times for routine reports. Current mitigations include: prioritization of USC/Acute Inpatient/Urgent reports; trial of new reporting allocation system; active recruitment campaign; Planned Care Recovery business case for additional funding.
Advise	**<u>Therapies</u>** • The freeze on recruiting to admin posts is having significant impact on therapy profession due to the timing coinciding with a higher than usual number of vacant posts and the volume of outpatient and community activity that is undertaken across these professions. The majority of activity sits outside of in-patients. • An internal Patient Safety Notice has been issued in relation to possible supply issues with procurement of Texture Modified Diets, (essential for dysphagia patients). The organisational process for sign off and communication took longer than expected but has resulted in learning to avoid similar delays in the future. • All therapy professions are noting an increase in verbal aggression from service users, alongside a worrying trend for aggressors to utilise social media to communicate their dissatisfaction, with staff names and roles being shared. Work has commenced with the HB V&A lead to explore solutions and to support colleagues. **<u>Pharmacy and Medicines Management</u>** • Parc Prison- significant absence in the team (combination of annual leave, sickness and bereavement). Support from acute sites has been utilised. • Governance issues around medication in Parc Prison have resulted in regular HB/Parc Governance meetings being established • Controlled Drug licenses - Home Office visit booked in Ysbyty Cwm Rhondda (YCR) on 14/11/2023 **<u>Radiology</u>** **Radiology Informatics System Procurement (RISP) implementation** Concerns highlighted previously in terms of the scale of programme and time slip with associated risks. Dedicated Programme Management support now in place and a number of initial milestones have been progressed. Agreed CTM stance on options for deployment provided to Digital Healthcare Wales (DHCW) which moves the timeframe into Q1 for 2026 (last of the Health Boards) for full go live. Local deployment work programme now being setup to deliver to those timeframes and mitigate what we will do

between the Swansea Bay (SBU) go live date and this Health Board in terms of data migration at the Bridgend side (currently still linked to SBU system). Care Group Service Director chairing the CTM implementation group.

Significant patient waits – for all modalities approx. 10,100 patients over 8 week target and reducing with current additional resource. The department receives approx. 32,000 referrals per month and offers approx. 30,000 appointments per month.

Ongoing concerns around the lack of Support Staff which can reduce clinical activity, particularly in ultrasound. With the new budget control around bank Healthcare Support Workers (HCSW) from October 2023, this will pose a further risk to the service delivery. What we can, and will do where chaperones are required, is to revert to supporting with substantive (qualified) staff but this will reduce scanning capacity.

Pathology

Outstanding Cancer Harm Review: In the last report there were 14 outstanding harm reviews for Clinical Haematology. A new Clinical Lead was appointed in August, who will be working through these in September as a priority. Progress will be reported in the next submission.

Clinical Haematology consultant cover:

Clinical Haematology cover risk (4053) has now been downgraded as cover was sourced and the situation has improved through August. The team is working through options for a more resilient workforce model with the Chief Operating Officer.

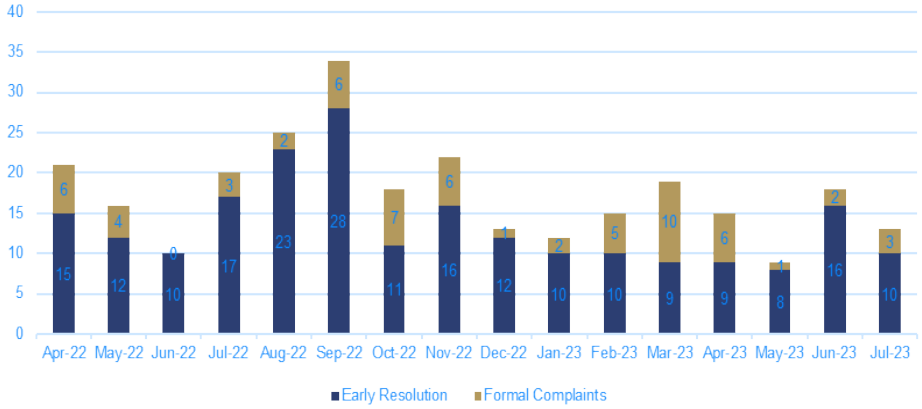
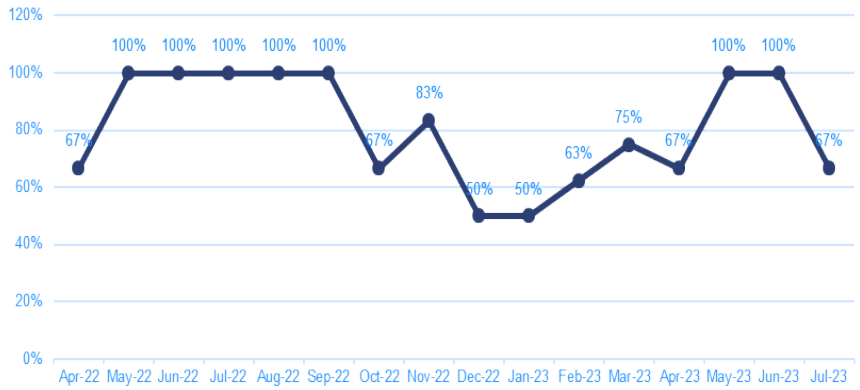
Microbiology cover issues in August:

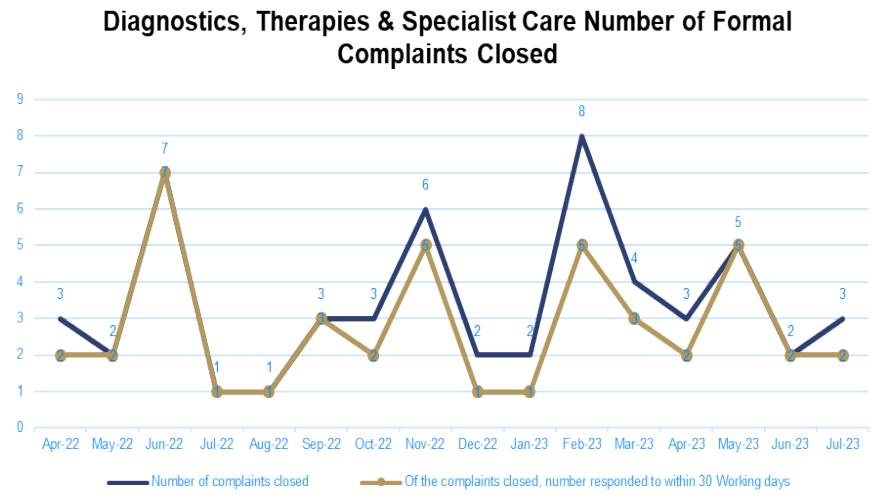
Through August we have had short notice sickness issues within biomedical scientist cover (for RGH and PCH), which is normally a full out of hours shift pattern. Consultant cover was not affected. The department set up an on call system overnight for emergency microbiology issues for the period, which addressed all urgent requests. Feedback is being gathered in order to evaluate this approach in case of any future shortfalls.

- **NHS Wales Red Cell Shortage Plan Consultation Document:** The document has been updated in line with revised requirements for managing a blood shortage nationally and is intended to support individual health board shortage plans. Internal business continuity and escalation procedures will be reviewed in line with this guidance.

- **Welsh government recommendations for community body stores:** Following the Fuller Inquiry and a submission of

	position by HBs, it was found that body stores which sit outside the mortuaries were not subject to the same level of governance as the mortuaries themselves. WG made a number of recommendations for community body stores. Additional resource will be required to comply with these recommendations and options are being explored within the Care Group.
Assure	**Therapies** • As a response to the continued trend in concerns being related to service user expectations, Therapy professions will develop written documentation that clearly describes the service offer, along with the supporting evidence base. This will also be useful in education tribunals. **Pharmacy and medicines management** • Regional QA audit of aseptic unit: temperature within the aseptic unit too high >30^{O}C. Cooling system for the hospital malfunctioned. Temporary cooling system now in place. Risk assessment underway regionally to determine extent of problem into the future, to present to Welsh Government • Use of Medicines policy going to Quality and Safety Committee • Recruitment for two admin posts for homecare team now restarting. Once recruited, cost savings to be realised **Pathology** • Ongoing issues with Blood Bank/Haematology out of hours rota at RGH. The result of not being able to cover would mean no service provision at RGH, resulting in significant delays to Haematology analysis and significant risk to patients requiring blood transfusion or Emergency Department/emergency theatre scenarios where blood is required at short notice. Various options are currently being considered and Staff Side are engaged in potential changes to rota. In the interim, gaps are being covered with experienced agency biomedical scientists but we are working on an exit strategy and training our substantive colleagues to be able to cover out of hours in the longer term. **Radiology** • Thematic review of IR(M)ER incidents provided to Executive Director of Therapies and Health Science, as there was a concern noted on the number of x-ray exposure incidents. Additional work is underway with the Quality and Safety Team in order to provide additional oversight and assurance. All IR(M)ER reported incidents have been investigated and closed down satisfactorily, with associated learning and

	actions put in place. Incident alerts sent to all areas following radiation incidents, and this has been expanded to include patient experience and health and safety information. This encourages learning, discussion and an open reporting culture. Staff feedback has been very positive. • Waiting List Performance: generally improved but backlog of MRI scans undertaken but awaiting reporting (routine) is rising. Department will be trialling a work allocation tool (currently used successfully in one site) in September and it is expected to help bring the backlog down. Progress will be reported through Operational Management Board (OMB).
Inform	**<u>Pathology</u>** 2023 UKAS assessment to commence 5th September, assessments are spread over 2 months, ending in mid-November **DTPS Complaints received and compliance** **Diagnostics, Therapies & Specialist Care New Complaints Received**  **Diagnostics, Therapies & Specialist Care Formal Complaints Response Rate** 



67% Care Group compliance with 30 working day (wd) response target – drop from 100%. 3 responses issued, 1 (Pathology) outside 30wd target. The small number of cases overall can result in a significant variation in percentages month on month.

Early Resolutions (ER) higher than formal concerns, reflecting a commitment to resolving at the earliest opportunity.

Consistently low number of formal complaints month on month

(only March has reached double figures)

Pathology –
Clinical Haematology:

- 1 x open ER concern from March – Pathology has responded and awaiting further update by the concerns team
- 1 x ER – awaiting holding letter
- 1 x Formal (Phlebotomy) – response in progress, within timeframe.

DTPS Patient Safety Incidents

Incidents	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-
Total Number Reported	95	85	109	158	86	116	118	145	112	129	130
Patient Safety	82	74	88	136	66	97	87	123	98	107	100
No Harm	35	33	34	73	32	49	51	53	20	33	34
Low	33	18	32	42	30	40	27	54	65	57	53
Moderate	7	19	13	11	4	8	9	14	6	16	11
Severe	0	0	0	0	0	0	0	2	1	1	2
Death	0	1	0	0	0	0	0	0	0	0	0

Future reports will include supporting narrative to outline any trends, learning and actions.

Incidents - July 2023	Therapies	Radiology	Pathology	Med Man
Total Number of Incidents Reported	33	22	28	
Patient Safety	24	21	23	
No Harm	3	6	6	
Low	20	13	15	
Moderate	1	2	2	
Severe	0	0	0	
Death	0	0	0	

4 open NRIs (3 closures overdue / 1 new NRI)

3 x Radiology

(8141):Everlight (Out of hours outsourced reporting) missed finding - blood clot/CT Head Scan – July 2022

(25842) - Missed finding - kidney obstruction/CT Thorax/Abdo – Feb 2023

(32863):USS finding (renal mass) not acted on–newly reported NRI Jul 2023

1 x Pathology

(14945) - reporting turnaround (8 mth marked as routine) USC gynaecology biopsy – Oct 2022

1 x open LRI (closure overdue)

1 x Pathology (2161) - reporting turnaround (4 mth) non urgent oesophageal biopsy-May 2022

1 x HTARI

(25126) - Medilink post mortem - incident closed with HTA; awaiting datix closure

2 x open IRMERs

(27485): Equipment failure/lost imaging PoW (closure bundle submitted; awaiting HIW confirmation of closure)
(32435/32438): Missing images PoW (closure due 4/10/23)

(3844): incorrect addressograph PoW (closure due 4/10/23)

1 x DoC

1 x Therapies (30758):Lack of critical care Speech & Language Therapy (SALT) funding Actions:
Written notification has been sent.
SBAR, Action Plan & Putting Things Right (PTR) response has been quality checked and advice has been sought from legal team re: breach of duty.
Progress against plan we be overseen via reporting to Therapies Governance Meetings
Outcome: Funding has now been agreed and recruitment to 3 SLT posts for Critical care has been successful

Pathology focus

Pathology:

- 1 x LRI (Delay in Cell Path reporting – moderate harm): RCA and action plan submitted, awaiting further feedback.
- 1 x NRI (delay in Cell path reporting – severe): RCA and action plan submitted, with O&G for review prior to planned care directors sign off.
- 14 x outstanding cancer harm review (Clinical Haematology): action plan to be developed with support of newly appointed clinical lead.
- 4 x outstanding cancer harm review (Cell Path): for O&G to complete prior to investigation by Cell Path.
- 2 x open SABRE incidents (Blood Transfusion): both no harm incidents.
- 1 x HTARI: CAPA to be submitted by 8th September

Additional UKAS assessment 22/08/23: Under the terms of the UKAS agreement, the HB has a duty to inform UKAS of any serious incidents reported for Pathology. UKAS have been informed of the current NRI involving the delay in Cell Path reporting. This

prompted an additional assessment to ensure the incident has been investigated and actioned appropriately. The assessment went well, the assessor was assured that actions have been implemented and that Cell Path are now in a significantly improved position in relation to reporting turnaround times. There were no findings but there were 3 recommendations, which will be taken forward as part of an ongoing UKAS action plan.

In addition

LRI Reporting - process will be stood down from 01.10.2023; Incident Management Framework to be updated to reflect this. DoC process to provide assurance re: management of incidents involving patient harm.

LFERs – co-ordination of deferred cases led by Head of Legal Services and Assistant Director of Concerns. Regular meetings with senior Radiology colleagues to support with progressing deferred Radiology LFERs – improved position.

1 Ombudsman case closed in Clinical Haematology – complaint not upheld. Recommendation made for the department to review communication with relative (wife in this case did not know how serious the condition was) as part of the learning. (Communication with patient was not raised as an issue).

Radiology

<u>Cancer Navigator</u>
Featured in CTMUHB and University of South Wales news articles in September 2022 and again in May 2023.

Presented/presenting to the:
- CTMUHB Innovation Leads and Executive Directors showcase in March 2023
- Imaging and Essential Services Group (4th July 2023)
- Bevan Commission 'The Tipping Point: Where next for healthcare?' Conference (5th-6th July 2023)
- Front page of Radiology news supplement, RAD Magazine PCIP National Showcase Event (20/09/23)

Therapies – sharing good practice

Food and Fun is a school-based education programme that provides food and nutrition education, physical activity, enrichment sessions and healthy meals to children during the school summer holidays.

2023 "Food and Fun" saw a 650% increase in eligible schools in Merthyr sign up. 34 schools signed up across the HB.

	Positive feedback from Director of Education, WLGA, school staff and families. What are Food and Fun's intended outcomes? 
Appendices	No Appendices

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care Creating Health
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well Growing well Ageing well Dying well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	A Healthier Wales

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
	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))*	Effective
	Person centred Timely Safe Equitable Efficient
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

4. Recommendation

4.1 The Committee is asked to **NOTE** the highlights outlined in section 2 of this report.

Agenda Item
5.2b

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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**

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

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 24th August 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	**Major Trauma** The South Wales Trauma Network model relies on an automatic acceptance policy for major trauma centre (UHW) admissions and local repatriation. The current repatriation procedure often leads to confusion as to where patients should be repatriated, and which medical team should be responsible for ongoing care. This results in a delay in patient transfer and potentially patients landing on a ward without the appropriate skill mix to care for their needs effectively. This is a particular problem with complex spinal injuries. Now that the major trauma service sits within the unscheduled care group portfolio, work has been initiated in collaboration with the planned care group, to redesign this repatriation policy with the aim of providing a set of key principles to reduce ambiguity in where patients should go and under which team. We are also exploring options for centralising care for spinal injuries with

	complex needs. This should reduce delays in local major trauma repatriation and ensure consistent skill mix. **Medical Outlier Patients** There is currently no agreed Standard operating procedure (SOP) for medical outlier patients in Prince Charles Hospital. There have been some occasions over recent months where patients have been transferred from the Emergency Department to the surgical wards under the medical team, but without clear consultant ownership. These have then not been seen for one or two days, leading to delays in treatment and discharge. No direct patient harm has been identified, and an SOP is in development to ensure flow to outliers directly from speciality wards to give clear 'ownership' of these patients. This has broad buy in, and needs finalising before escalation for approval.
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 target has increased from 32% in May to 58% in July 2023. Currently there are 34 open complaints and 14 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 and 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. 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. The Prince Charles Hospital will go live with this approach with effect from 09:00 am on Monday 4th September 2023.

	The ED Transformation Programme was developed and encompassed an action plan following the HIW inspection of the Emergency Department at Prince Charles Hospital in October 2021. Of the 74 actions that were recommended within the Programme, 72 have now been completed and the 2 remaining open actions are involving the capital redesign of the department and the Paediatric pathway which both require investment cases which are subsequently being refreshed to the new care group structure. As the Improvement Programme evolved a further 102 actions were generated from staff wellbeing, audit, policy development, medicines management and Workforce and Organisational Development. Of these actions 2 remain outstanding but in progress to complete soon and will now move over to the Six Goals Programme to progress. **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 is the compliance for all areas within the USC care group to highlight areas which require improvement.
Assure	**Wales Ambulance Services Trust (WAST) Immediate Release Review** Sustained improvement in the compliance against immediate releases for both red priority and all priority calls. No immediate release requests have been refused from within the organisation and these numbers reflect WAST inability to accommodate crews being released. There is a clear process in place within the organisation that if any immediate release requests are refused this will be investigated within the nationally reportable incident process. **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 mandatory training is being monitored, allowing a trend analysis. **IPC updates following the environment audit** Following the HIW inspection within the ED in POW on 17-19th October 2022, the previous DoN for USC commissioned a full Infection Prevention Control (IPC) environmental review on each ED site, with the lead infection control nurse, this included staff and public areas. IPC audits were carried out across the ED sites and an update was provided within the May Q&S committee report. An action following this was for the USC Nurse Director and IPC to develop an improvement plan. During the last audit PPE within ED at PCH reported 17% compliance, however following the reissue of the 5 moments of hand hygiene posters, June and July 2023 have now obtained a 90% compliance. There has been a successful pilot of 'treatment escalation plan' forms in CTM. These forms go beyond a 'DNACPR' form, and instead talk about what treatment should be offered, including intensive care, ward based intensive treatments, and less intensive treatments. These have been piloted on selected wards and only for while an inpatient as part of a national scheme. The forms have been positively received by medical and nursing teams, as well as patients. These are now being explored for wider roll out across the acute services in the Health Board. Updated improvement plan submitted to Health Inspectorate Wales (HIW) following the HIW inspection of Ward 5, Princess of Wales on 25th & 26th January 2023. HIW has evaluated the response and concluded that it provides them with sufficient assurance that the improvements identified have been addressed.
Inform	HIW completed an unannounced inspection on 31st July 2023 at the Emergency department at Prince Charles Hospital. Initial feedback received from HIW has been positive and the USC care group are awaiting official feedback. **Acute care of the elderly unit** Previously, in Princess of Wales the Care of the Elderly team provided an in-reach service to AMU with a dedicated team of predominately ANP's who were seeing patients Monday to Friday that had been identified as 'COTE' after their initial medical clerking. Implementation of the Acute Care of the Elderly Unit co-located on AMU utilising 15 beds since April 2023 as a proof of concept

	for wrap around frailty at the front door has had positive outcomes from both patients and staff with a reduction in length of stay and reduced requirements for additional staffing. Cohorting COTE patients within ACE has had a positive effect on the frail and elderly patients and their discharges. The environment alone is calm with the patients responding well resulting in no requests for 1:1's, minimal PRN medications and falls. Staff from ward 15 who are specialised in Dementia and delirium care are able to recognise the signs of agitation and manage accordingly, educating other staff to learn at the same time. The activities coordinator and volunteer have also assisted in managing patient's needs by spending time talking and engaging with them. Patients are getting up, sitting out and mobilising as soon as possible aiding their recovery and preventing de conditioning. Board rounds are conducted at 09:00am every morning following Safe 2 Start and patients are highlighted for discharge as well as clinically unwell ensuring that they are assessed and reviewed as a priority. The unit also has a new Consultant who conducts a ward round every Monday, Wednesday and Friday and staff that are allocated to those patients attend too providing continuity of care and effective communication.
Appendices	

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 *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr	Leadership

Ansawdd *(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: 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)	No - Not Applicable
	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.

AMaT Audit SUMMARY 2023-24

Last Update:

By Audit

IPC

Site

Bridgend CSG	MC CSG
RTE CSG	#N/A

Nursing Director

Ana Llewellyn	Emma James	Sharon O'Brien	Suzanne Hardacre	#N/A

Care Group

Community	Mental Health	Planned Care
Primary Care	Unscheduled Care	Women & Young Persons
#N/A		

Head of Nursing / Lead

Brahms Robinson	Catherine Theron	Clare Yates	Deborah Matthews
Fiona Wood	Gail Clack	Jennifer Proctor	Lucie Williams
Robert Richards	Sarah Fox	#N/A	

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

AREA	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Cefn Yr Afon Open Rehabilitation			-									
DSH Integrated Sexual Health Unit	94%		100%									
GLANRHYD Ward 1 Angleton	85%	88%	96%									
GLH Ward 2 Angelton	73%	79%	71%									
KHHP Ty Enfys			-									
KHP Integrated Sexual Health Unit	100%		97%									
MCH Ward Llynfi (temp Wd 21 PoW)	84%	89%	92%									
PCH Children's Ward	97%	100%	100%									
PCH Clinical Decision Unit	100%	92%	95%									
PCH Colposcopy / Hysteroscopy Unit	100%		97%									
PCH Day Surgical Unit	100%	100%	100%									
PCH Emergency Department	92%	-	92%									
PCH Endoscopy Unit		95%	-									
PCH Gynaecology Assessment Unit	-		93%									
PCH ITU	87%	90%	90%									
PCH Medical Day Unit	100%	100%	-									
PCH Neonatal Unit	86%		100%									
PCH Outpatients Department - Children's			100%									
PCH Outpatients Department - Main		100%	100%									
PCH Paediatric Emergency Department			97%									
PCH Theatre Department			95%									
PCH Ward 01 CCU	92%	97%	95%									
PCH Ward 02	95%	97%	97%									
PCH Ward 03 (formerly ward 7)	92%	92%	99%									
PCH Ward 05	74%	89%	97%									
PCH Ward 06	90%	95%	92%									
PCH Ward 07 (formerly ward 3)	87%	90%	84%									
PCH Ward 08	97%	97%	95%									
PCH Ward 09	92%	95%	95%									
PCH Ward 10	97%	97%	92%									
PCH Ward 11	100%	97%	100%									

PCH Ward 12		92%	97%	95%									
Pinewood House				-									
PWH Acute Medical Unit		78%	95%	95%									
PWH Day Surgical Ward				86%									
PWH Emergency Department				84%									
PWH Endoscopy Unit		86%	91%	89%									
PWH ITU		97%	97%	100%									
PWH Neonatal Unit		81%		-									
PWH Outpatient Department		94%	97%	94%									
PWH Outpatients - Ophthalmology				72%									
PWH Outpatients Department - Children's				-									
PWH Outpatients ENT				93%									
PWH Psychiatric ICU			-	-									
PWH Theatre Department				-									
PWH Ward 04		95%	95%	92%									
PWH Ward 05		87%	-	84%									
PWH Ward 06		95%	100%	-									
PWH Ward 07			-	92%									
PWH Ward 08		100%	97%	100%									
PWH Ward 09		100%	84%	95%									
PWH Ward 10		85%	92%	92%									
PWH Ward 14			-	-									
PWH Ward 15		90%	87%	81%									
PWH Ward 18		87%	87%	82%									
PWH Ward 19		100%	92%	92%									
PWH Ward 20		82%	92%	92%									
PWH Y Bwythyn		97%	95%	100%									
RGH Children's Ward		91%	97%	100%									
RGH Day Surgical Unit			-	-									
RGH Emergency Department			-	-									
RGH Endoscopy Unit			100%	100%									
RGH Gynaecology Assessment Unit			-	100%									
RGH ITU/HDU		100%	100%	100%									
RGH Maternity Birth Centre (Tirion)			100%	97%									
RGH Maternity WHU			-	94%									
RGH MH Admissions Ward		94%	-	97%									
RGH MH PICU			97%	100%									
RGH MH Seren Ward		88%	97%	97%									
RGH MH St David's Ward		97%	97%	100%									
RGH MH Ward 21			91%	94%									
RGH MH Ward 22			-	-									
RGH Outpatients - Ophthalmology			-	-									
RGH Theatre Department				100%									
RGH Ward 01 AMU / SAU		92%	-	92%									
RGH Ward 02		92%	89%	89%									
RGH Ward 03		95%	90%	90%									
RGH Ward 04 AMU		92%	95%	95%									
RGH Ward 05		97%	100%	95%									
RGH Ward 06		84%	90%	95%									
RGH Ward 08		89%	95%	95%									

RGH Ward 09		89%	95%	95%									
RGH Ward 10		95%	97%	95%									
RGH Ward 12		92%	100%	97%									
RGH Ward 14		97%	84%	84%									
RGH Ward 15		97%	97%	97%									
RGH Ward 19		95%	97%	97%									
RGH Ward 20		97%	97%	84%									
RGH Y Bwythyn		97%	92%	100%									
YBP Ton Teg Day Unit				-									
YCC Integrated Sexual Health Unit		100%		100%									
YCC Ward 01		97%	97%	100%									
YCC Ward 02		89%	97%	97%									
YCC Ward 03		95%	97%	97%									
YCC Ward 04		97%	97%	100%									
YCC Ward 06		92%	-	94%									
YCC Ward 07		97%	89%	95%									
YCR Ward A1		95%	95%	92%									
YCR Ward B2		97%	95%	95%									
YCR Ward C3		97%	97%	95%									
YCR Ward D4		87%	95%	95%									
YGT LMDU				-									
YGT Support Recovery Unit				-									

Agenda Item
5.2c

Quality & Safety Committee

Highlight Report from the Children & Families Care Group Quality & Safety Meeting held on 10th August 2023

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre Director of Midwifery & Nursing, Mohamed Elnasharty, Medical Director C&F Care Group
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre Director of Midwifery & Nursing,
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	
CTMUHB	Cwm Taf Morgannwg University Health Board
HIV	Human Immunodeficiency Virus

IFS	Intrapartum Fetal Surveillance
IP&C	Infection Prevention & Control
MatNeoSSP	Maternity & Neonatal Safety Support Programme
MDT	Multi-disciplinary team
NHS	National Health Service
NNU	Neonatal Unit
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
Q&S	Quality & Safety
RN	Registered Nurse
SCBU	Special Care Baby Unit
SCPHN	Specialist Community Public Health Nurse (School Nursing)
SWAG	Service Wide Assurance Group
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WRP	Welsh Risk Pool

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children & Families Care Group Quality & Safety at its meeting on 10th August 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	• In accordance with patient safety and quality governance arrangements, a review of neonatal morbidity and mortality is underway within maternity and neonatal services. • MatNeoSSP Discovery Report received. Welsh Government (WG) also shared a national and local priority template for review and consideration. Gap analysis completed 11.8.23, comments returned to WG by 21.8.23. 'Bright spots' being progressed. Expectation that resource neutral local priorities

	will be progressed prior to national phase 2 which begins in April 2024. • Closure of Neonatal Unit POW completed 19th-23rd June following IP&C recommendations. Re-opened to schedule. There were two significant occurrences during the week: Maternity service in PCH at capacity on one occasion. Excellent team work and consultant ward rounds enabled discharges to be managed as safely as possible. Three NNU admissions were required over a period of an hour. Extra staff and equipment were required, the escalation policy was implemented and maternity activity diverted for five hours. Debrief MDT meeting held on 26.7.23. Paper being developed for next Care Group Quality & Safety (Q&S) Meeting by Clinical Service Group Manager to reflect learning. • Angharad Oyler has been appointed as Head of Midwifery, Gynaecology & Integrated Sexual Health on 15th August 2023.
Advise	• SCBU refurbishment completed in POW, however still working through some snagging and IP&C issues. Long term storage solution being sought. • Welsh Risk Pool Safety & Learning Team have introduced a new programme entitled 'IFS Wales' (Intrapartum Fetal Surveillance), which will see the development and implementation of a new standardized programme of education and training for NHS Wales maternity services. A national review of all Health Board training in Wales has been completed and a report received into CTMUHB. The report highlights variation across Wales, however it is important to note that CTMUHB meets the All Wales Intrapartum Fetal Surveillance Standards. The Fetal Surveillance lead midwife and a consultant obstetrician from CTMUHB are part of the national review and working group within WRP. • Women's Health Unit in POW reviewed by infection control. Improvement plans and monitoring in place. The Care Group are reassessing use of the area to ensure timely, dignified care. • Remaining longer term neonatal deep dive recommendations transferred to a 'wash up plan'. Formal programme closure paper being prepared. Monitoring and oversight arrangements in place in accordance with the MatNeo Assurance Framework. • School Hearing Screening – update awaited on plans.

	• Neonatal Services (Intensive Care, High Dependency and Special Care) Service Specification consultation response prepared and submitted to WHSSC. • A review of HIV presentations will be carried out to understand why we have the number of late presentations. The outcomes will be reported to Quality & Safety (Q&S) and the all Wales HIV Group. • Transitional care area three month test of change was completed 17.07.23 (and will continue). Summary report to be written by Lead Neonatal Nurse for Quality Improvement for discussion at SWAG 27.08.23. • Maternity Statistics Wales reported July 2023. Gap analysis underway, a paper and metrics will be prepared for Q&S Committee in November 2023 Maternity and birth statistics: 2022 | GOV.WALES
Assure	• Not all RN vacancies will be filled across SCPHN (School Nursing) services, Neonates POW, Paediatrics PCH following student streamlining but plans in place for further recruitment. • There are 21.4 wte midwifery vacancies across CTMUHB. Twenty newly qualified midwives start in September. Once recruited the service will re-advertise & recruit according to skill mix. • The Care Group is implementing 'Leadership Visits with a Purpose' for leaders to meet with service groups and teams, 15 Steps methodology will be used to support visits to the clinical areas. • Community PROMPT Wales quality assurance review was completed on 28th April 2023 and a final report received into the Health Board at the end of July. The PROMPT faculty are working through the actions (most are completed) with recommendations monitored through the Maternity and Neonatal Safety Board
Inform	• Successful Health, Local Authority & Families 'Baby Shower' event held in Merthyr (June) further dates organised for next year across CTMUHB. • Butterfly Garden of Remembrance opened by television presenter Andrea Byrne at PCH on 1st August 2023. • Band 7 team leader away day planned for 18th September

	• 20 members of the maternity team attending Baby Lifeline Labour Ward Coordinatory Training in partnership with Cardiff and Vale Maternity Services on 27th September 2023. • NMC Council visiting Maternity Services at Prince Charles Hospital on 26th September 2023. • Care Group wide information programme held during World Breastfeeding Week 1-7th August 2023. • **Risks** Risks > 15 reviewed in Care Group Operational Management Board. • We have 4 risks >15 ➢ Waiting times/performance ND service ➢ Ensuring correct establishment for SCBU ➢ Risk of injury due to poor compliance with Manual handling training. ➢ Obstetric theatre bed not able to be easily maintained due to age (around 15 years old) We also recognize that the Care Group activities are included in the Health Board wide risks e.g. RTT and Cancer. We have closed one risk and 3 risks have been re graded to below 9.
Appendices	

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care Creating Health
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well If more than one applies please list below: Growing Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	A Healthier Wales

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: Leadership Culture and Valuing People 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 Effective Equitable Efficient Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. Recommendation

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

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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
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 2nd August 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

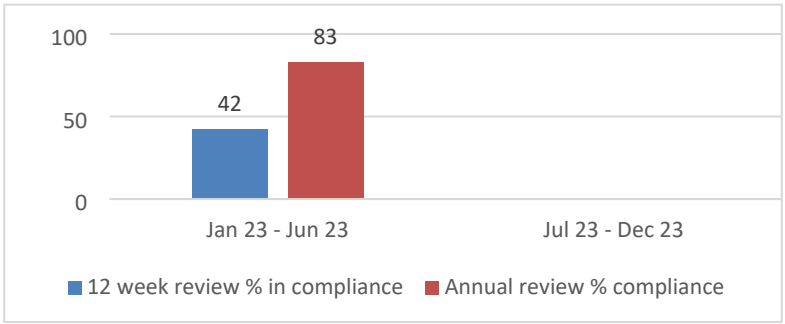
ALERT / ESCALATE	• Committee is advised of progress towards a **Single Clinical Record System** (Datix Risk Register ID 3337). The Executive Team and Board have supported the progression toward implementation of WCCIS and an Implementation Board jointly chaired by the Director of Digital and the Deputy 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. • The RGH Mental Health Unit has 6 wards and there are currently 25 wte Band 5 **Registered Nurse Vacancies** and this is a vacancy rate of 47% of all Band 5s in the establishment. This

compares to a Care Group Band 5 vacancy rate of 37%. Workforce colleagues are currently engaged in a programme of work to review reasons for leaving at RGH. In addition there is a care group programme of work to review nursing establishments as part of Phase 1 of the Nursing Workforce Plan. This phase is due to be completed by the end of September.

- An **anonymous concern** about the Mental Health Unit has been received from a member of staff. A series of confidential conversations for staff at the unit is underway and the outcome of this will be reported to the Executive Team on 11th September.

ADVISE

- The August QSRE received a deep dive into **Commissioned Services.** The Commissioning team aim to undertake a 12-week review and an annual review of all health funded packages. At the time of reporting there were currently 397 live packages, and 33 pending packages. (73 standard EMI packages not included as reviewed by Adult CHC Team). The 12-week review compliance for the reporting period was 42%. Issues in reporting 12-week review are being addressed to improve accuracy of this data.



- There are 2 **Commissioned Services,** The Mountains and Cwm Gelli Lodge EMI Nursing subject to an ongoing interagency improvement plan and embargoed to new admissions. The Willows Nursing Home has served notice of its pending closure. This nursing home is a specialist nursing home for people with dementia and plans are underway to ensure the safe transition of its residents. The closure of this nursing home is likely to impact on Delayed Pathways of Care for people living with dementia.

- The care group has noted an increased number of challenges in the **Mental Health / Police** interface. This appears to be associated with South Wales Police interest in the introduction of Right Care Right Person in England. A review of cases and the principles of liaison is underway so that colleagues are clear about roles and responsibilities.

- **Homicide in Rhondda 2020**

RTE CSG has reviewed the externally commissioned safeguarding review into the circumstances around the tragic events in Pen y Graig in 2020. The Lead Nurse is developing an action plan with the Local Authority which will be overseen by the CTM Safeguarding Board for the shared learning of the Care Group. The Coroner has re-opened the inquest for the victim and the Health Board is in the process of providing the requested information.

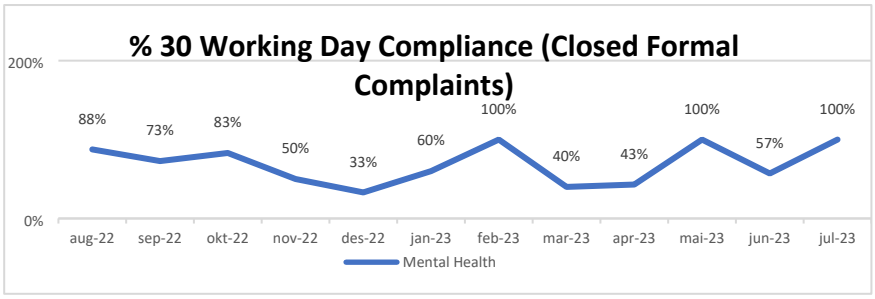
- **111#2**
  Has moved from project to operational status. Following National roll out in June and media campaign there has been an increase in activity. There is a pending peer review process with C&V UHB support (pending late September). The 111 team continues to develop governance and is building feedback and assurance processes with the wider MH service.

- **Smoke Free Environment**
  Care Group smoking cessation group is continuing to monitor and review reports from adult in-patient wards highlighting challenges with smoking legislation. The smoking cessation work reports via Health and Safety but is included here for advisement as there are associated quality and safety risks. Staff have reported an increase in violence and aggression incidents – a review of incidents is underway to determine if there is any association.

ASSURE

- **Ty Llidiard** has been de-escalated to routine monitoring by its commissioner WHSSC

- **Complaint Closure Compliance** is a key priority for the Health Board. Compliance in the MHLD Care Group is currently at 100%. The low volume of formal complaints can artificially skew the reporting and contributes to a perception of variation in closure compliance performance in the Care Group.



- There are 8 open **Nationally Reportable Incidents** with 7 of those overdue for completion. These cases are complex, some are being externally reviewed and all are being actively managed.

INFORM	• The **Older Adult Falls Safe Care Collaborative** is progressing its work. The improvement project commenced at Angelton and is now being progressed across the care group with an official launch for the wider care group project being planned for 13th September. • A professional referral scheme is under development for the **Silver Cloud Virtual Therapeutic** Service (previously self-referral only) – awaiting go live date
APPENDICES	Choose an item.

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	Effective
	If more than one applies please list below:

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	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
5.2e

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Head of Nursing Primary Care and Communities
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	
CAPU	Community Acquired Pressure Ulcer
FVMC	Forest View Medical Centre
GA	General Anaesthetics
GDP	General Dental Practitioner
HIW	Health Inspectorate Wales

HMP	His Majesty's prison
VBHC	Value Based Health Care

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 11th August.

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	• **Registered Nurse (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 is 36% at both sites. • **Primary Care** paediatric GA referrals are increasing, in January 2021 there were 390 on the list. Numbers on waiting lists currently stands at 800. Current mitigation is that the children go back to their GDP for urgent care treatment until they come in for assessment. Service evaluation currently underway with paper to go to board in September. • A dedicated governance resource is required for **HMP Parc** due to the volume of concerns recorded each month.

Advise	• Medication risks at **HMP Parc** being reviewed and pathways to be developed to prevent further medication incidents. Task and finish group meeting arranged. • Long waiting lists for Mental Health assessments at **HMP Parc** which has increased due to staffing deficit – waiting lists can be 10-16 weeks and is not compliant with Mental Health targets of 28 days. • **Taff Ely Cluster** have planned to end funding for the 2 x Frailty Nurses March 2024. This is following a one-year extension, whilst they work with the Health Board to determine how these roles fit into the CTM2030 Frailty model. • There is an access issue for **Dental** treatment, 11,900 patients are waiting to access a GDP. The CTMUHB Dental Waiting List is a massive pressure within the team and consuming the Band 4 Admin time. There are dental practices under Contract Reform that are currently providing urgent access treatment in areas across CTM. To mitigate this the team are working hard to ensure the urgent access appointments are being utilised, if not then discussions with practices will be taking place to see patients from the CTMUHB waiting list. • **Ysbyty Cwm Cynon (YCC)** hospital x1 avoidable fall. Actions noted within appendix attachment. • **Palliative Care Clinical Nurse Specialist (CNS)** weekend service reduced in Bridgend due to staff deficits. Vacancies filled, new staff in post to be inducted.
Assure	• **HMP Parc Prison** governance processes being embedded and improvements shown with concerns management. • **HMP Parc Prison** training needs analysis being undertaken for nursing team, to ensure safe and effective care is delivered. • **Spirometry** approx. 8,000 patients require testing by March 2024. Proposed model has been developed with a 2 phased approach. Phase 1 for COPD diagnosis to commence Autumn 2023. Phase 2 to include asthma diagnosis April 2024. • **District nursing medication charts** Task and finish group arranged to facilitate the safe prescribing and transcribing of medication for District Nursing (DN) administration. • **HIW inspection** on FVMC-one immediate assurance issued. The practice has taken appropriate action to ensure processes are correct and this has been fed back to HIW. • Plans to create 5 designated palliative care bed areas within **HMP Parc.**

Inform	• **Community Nursing specification and action plan** work ongoing. • **Demand and Capacity** work continuing with support from planning. • **DN Principles** return submitted end of March 2023. One area of non-compliance being 1 Community Navigator supporting 4 teams (M/C). • **HIW** have served notice on an inspection of Ferndale and Maerdy medical practice (LHB managed) on September 13th, 2023. The team now have a practice manager and working towards this. • **Taff Vale GP practice** have requested to close the Cilfynydd branch. CTMUHB have agreed to support closure. Primary care management team are starting due process to inform all key stakeholders including patients. • Quality Improvement work continues in **CAPU project** • **Lymphoedema Service** PREMS/PROMS data set agreed and implemented to inform the VBHC "On The Ground Education Project" (OGEP) evaluation report. • AMAT pilot for **District Nursing services** has commenced which includes the development of the District Nursing Documentation and Pressure Ulcer Prevention Audit. • Good feedback from coroner investigation for **HMP Parc** where a process re illicit drug use was deemed as very effective and stated that he would be making a recommendation that the process is adopted by other prisons.
Appendices	• Appendix 1

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.

Shared Listening & Learning Forum

7 Minute Briefing – incident 26008

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

1) Incident/concern raised

An incident was submitted following a patient who sustained an unwitnessed fall on a rehabilitation ward, YCC. Subsequently a formal concern was submitted around the level of supervision the patient received leading up to the fall.

At falls scrutiny panel it was found that the fall was avoidable for two reasons:

1. Patient did not receive the required level of supervision due to discrepancies in the handover from PCH to YCC and poor risk assessment in YCC;
2. Lack of evidence to substantiate the level of supervision that was being given.

2) Action

1. Action plan in place to provide targeted improvement;
2. Ward staff to reflect on incident and identify areas of improvement to prevent this from reoccurring;
3. Review supervision requirements section on ETOC form & verbal transfer documentation with a view to making this clearer prior to transfer;
4. Learning to be shared across all wards to minimise risk of reoccurrence.

3) Learning theme 1 Documentation

There was little evidence of care roundings being undertaken, despite it being stated that the patient was to receive hourly roundings. This lack of evidence did not demonstrate the patient received the level of supervision that he was assessed to require.

4) Learning theme 2 Robust risk assessments

The verbal handover from PCH stated that the patient required hourly roundings. This was replicated at YCC.

However, on observing the latest risk assessment prior to transfer from PCH, this showed the patient was receiving 15 minute roundings when in the chair. This was not identified when YCC undertook their initial risk assessment post transfer. Previous risk assessments should be taken into account when undertaking a current risk assessment.

5) Learning theme 3 Clarity of information on transfer

The clarity of information on patient transfer is important to ensure the resources required to meet the patients' needs are identified and in place.

The verbal handover documentation and ETOC will be reviewed to potentially make this information clearer for all.

6) Learning theme 4 Need for early transfers

This patient was transferred to YCC late in the evening, which likely impacted the nursing teams' ability to undertake a robust risk assessment.

Transfers are encouraged to take place as early as possible.

7) Further actions

Redress to be discussed with family via the Legal team.

Learning to be disseminated to all wards and other sites.

Outstanding actions to be completed within deadlines set in the action plan.

Adapted from 7 minute briefing created by Hywel Dda University Health Board

Agenda Item
5.2f

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Director of Nursing, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Director of Nursing, 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	
CNS	Clinical Nurse Specialist
GIRFT	Getting It Right First Time

1. Introduction

1.1 This report had been prepared to provide the Quality and Safety Committee with details of the key issues considered by the planned care quality, safety, risk and experience (QSRE) Committee at its meeting on 30th August 2023

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

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 30th August 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	**Ophthalmology** • Committee Spotlight report, provides detailed Ophthalmology update. **Urology** • Transformation and T&F group required regarding review of medical, nursing and CNS workforce to support the ability to enable routine cancer care delivery and reduce waiting lists. **Critical Care** • Medical workforce to ensure safe, consistent staffing of the 3 Critical Care Units.
Advise	**<u>Corporate Risk Register</u>** • 4 Planned Care risks on the corporate risk register scoring 20: ○ 5214 Critical Care Medical Cover in Princess of Wales (POW) – Intensive Treatment Unit (ITU) resilience model for Health Board in development and being managed by Unscheduled Care (where ITU is moving to) ○ 4491 Demand for Planned Care services exceeds capacity – theatre insourcing has increased in PoW to increase capacity ○ 4071 Failure to meet Cancer targets – some improvements noted but some service improvements linked to diagnostic capacity ○ 4103 Sustainability of a Safe and effective Ophthalmology service - Ophthalmology Harm review funding agreed up until March 2024.

Overview Incidents (July 23)

	Bridgend	Merthyr & Cynon	Rhondda & Taf
Total Number of Incidents Reported	89	41	103
Total Patient Safety	71	39	92
No Harm	12	12	23
Low	46	26	51
Moderate	9	1	17
Severe	3	0	1
Death	0	0	0

Overview Concerns

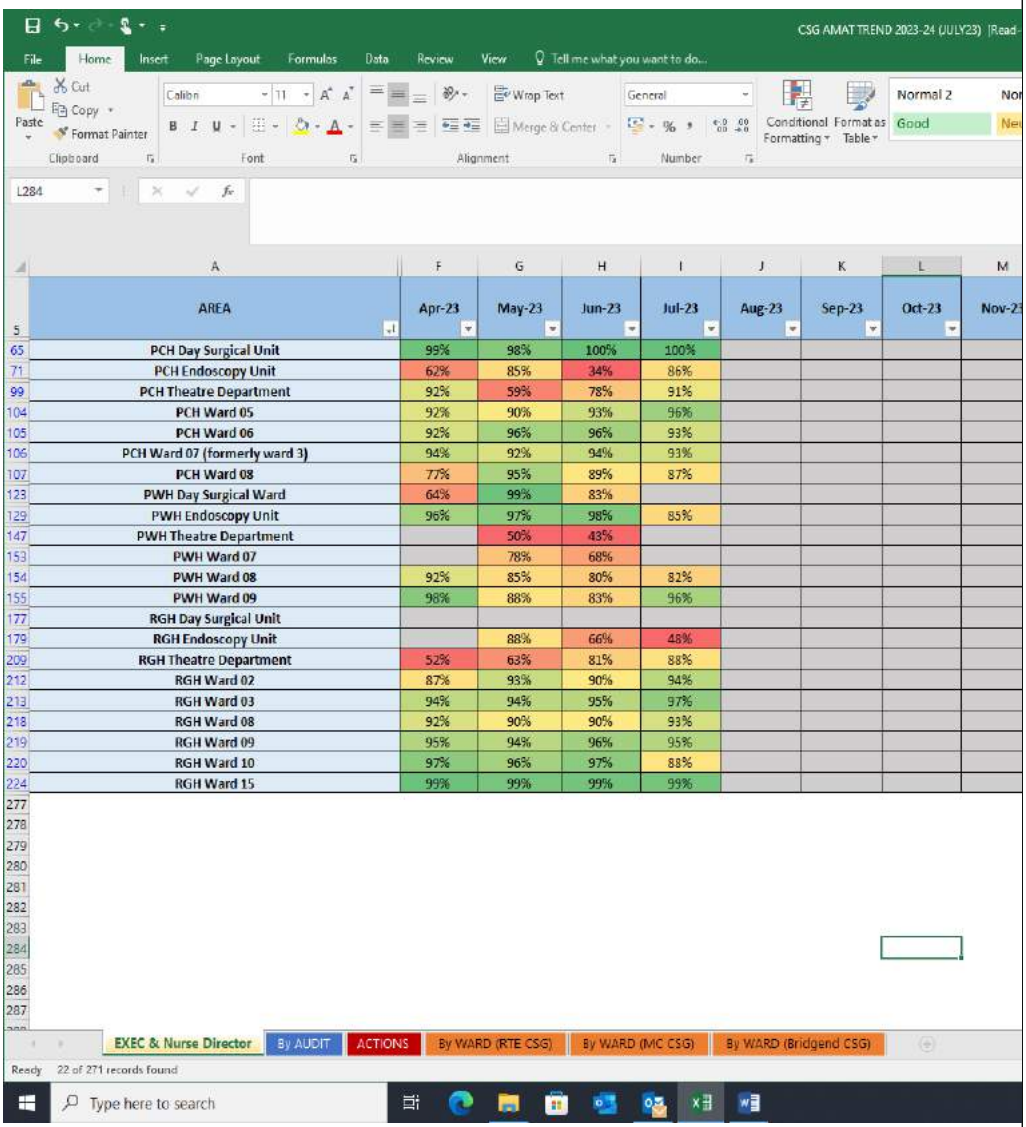
- **Complaints received - Jun : 85** (21 formal) **/ Jul : 69** (17 formal)
- **Early resolutions** – higher than formal concerns Jun : 64 of the 85 (75%)
  Jul : 52 of the 69 (75%)
- **Compliance with 30 wday response timescale**

	Planned Care	Bridgend	Merthyr	Rhondda	CTM
Jun	58%	55%	20%	**88%**	85%
Jul	92%	**100%**	**100%**	67%	90%

Timely Incident Rapid Review Process has improved in PoW

Assure

- As part of the WG, GIRFT, Theatre Utilisation Project has commenced. The GIRFT team are visiting and undertaking a focused review of theatres in PoW over 2 days end of September 2023. This will coincide with HB's 'Theatres Perfect Month'
- Full implementation of the Enhanced Supervision documentation and process across wards in PoW has resulted in a reduction in falls.
- Teaching sessions for all staff in PCH arranged for Sept/Oct to address themes from concerns and incidents:
  - NEWS
  - Fluid balance
  - Sepsis management
  - Escalation of patient clinical concern protocols

Inform	• Infection, Prevention & Controls (IP&C) priorities-declutter environments and identify estates works on wards. • Planned Care Ward reconfiguration being undertaken across PoW and RGH. • **Monthly Ward Assurance** Amended 'fit for purpose' audits created for Theatres and Endoscopy will be implemented across Theatres and Endoscopy from September. 
Appendices	•

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

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
6.1

Quality & Safety Committee

CTMUHB Staff Process for Raising Concerns

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Luke Garthwaite, Medical Directorate 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**
N/A	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
CTM	Cwm Taf Morgannwg
SUS	Speaking Up Safely
FTSUG	Freedom to Speak Up Guardian – *Noting this is a protected term which is only used in NHS England*

SUSWG	Speaking Up Safely Working Group
JNLC	Joint Negotiating Local Committee
LPF	Local Partnership Forum
ELG	Executive Leadership Group

1. Situation /Background

1.1 In light of the Lucy Letby Court Case[1] and the concerns highlighted by staff at that hospital regarding the process for raising and responding to concerns, on 21st August a briefing was produced by the Executive Leadership Group (ELG) to provide health board staff with information of how CTM staff are able to raise concerns.

1.2 CTMUHB will be undertaking a proactive self-reflection on its process and mechanisms to enable staff to raise any concerns and complaints in a clear, safe and simple way.

1.3 This paper outlines the current work being undertaken within the health board in line with Welsh Government guidance and aims to provide the Quality & Safety Committee with the appropriate assurance.

2. Specific Matters for Consideration

2.1 CTMUHB is working towards the launch of its Speaking Up Safely (SUS) framework that will provide staff with a simpler, more effective way of raising concerns.

2.2 On 9th August 2023 a detailed paper was taken to People and Culture Committee outlining the rationale for a Welsh Government Framework named 'Speaking up Safely'. The SUS framework was initiated as Do No Harm Wales. An independent group of healthcare professionals with extensive personal experience as whistle-blowers within NHS Wales, submitted a paper to the Health Social Care and Sport Committee Health and Social Care (Quality and Engagement) (Wales) Bill[2]. In this paper they urged the Welsh Government to distance itself from the current FTSUG Scheme in England by renaming the guardian role to avoid any doubt that the Welsh FTSU Scheme is different.

This is the framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of raising concerns and where organisations learn and improve as a result of listening and responding to the workforce.

2.3 The SUS framework does not replace existing mechanisms and there is an expectation that all efforts will be made to exhaust existing problem-solving approaches (line management, Trade Union representation, multi-disciplinary team processes and procedures) and internal policies and procedures to resolve the concern before raising through SUS. Equally, the role of the SUS is not to investigate but to work collaboratively with those who raise concerns, to problem solve and identify a way forward.

2.4 The All Wales SUS Framework is due to be finalised in Autumn 2023. Whilst awaiting final confirmation of the framework, a Speaking Up Safely Working Group (SUSWG) has been established to provide the environment and conditions that supports and values speaking up. The SUSWG will also oversee the implementation of Speaking up Safely framework across the Health Board. The original health board process for staff to raise a concern is still applicable and the link can be found on the CTM intranet page.

2.5 The work undertaken relating to the SUS Framework has been tabled on the agendas at the next Joint Negotiating Local Committee (JNLC) and Local Partnership Forum (LPF). Both groups will be asked to disseminate the information to colleagues for information.

3. Key Risks / Matters for Escalation

3.1 There is a need for a culture where staff concerns are taken seriously, investigated, and resolved with the proper corrective actions. Speaking up difficulties will continue to exist and even grow if there isn't a widespread culture of openness and honesty where speaking up is encouraged and staff who do so are recognised.

3.2 The failure to listen to and protect staff speaking up has been described by the House of Commons Health Select Committee as a "stain on the reputation of the NHS"[3]. CTMUHB is under an obligation to both its staff and patients, to provide a robust mechanism for staff to raise their concerns.

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:
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 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))*	Culture and Valuing People 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 Equitable
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: Allowing staff to raise concerns in an easily understood and safe manner will have a positive impact on the quality and safety of CTM's services, and	If no, please include rationale below:

	consequently improve experience.	
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	Yes (Include further detail below)	
	Assurance that there are mechanisms for staff to speak up and raise concerns – important for CTMUHB to have this in place	
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 Quality & Safety Committee are asked to note the content of this paper and the steps already undertaken to allow staff to raise concerns.

6. Next Steps

6.1 The Quality & Safety Committee will be updated in the Autumn when the All Wales Framework is published. This update will highlight how the Framework with impact CTM and will also include a flow chart from the initial staff concern through to Executive Director acknowledgement.

Appendices

Speak up Safely Paper

Speak up Safely PC paper final.docx

References

[1]https://www.bbc.co.uk/news/live/uk-66551231

[2]Do No Harm Wales: Submission to the Health Social Care and Sport Committee Health and Social Care (Quality and Engagement) (Wales) Bill

[3]House of Commons Health Committee. Complaints and Raising Concerns. London: The Stationery Office; 2015 URL: https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/350/350.pdf

Agenda Item
6.2

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	18/09/2023
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 Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	August / September 2023	RISKS REVIEWED
Operational Management Board	Via Email 12.9.2023	ENDORSED FOR ELG
Executive Leadership Group	18th September 2023	REVIEWED AND MANAGEMENT SIGN OFF RECEIVED
Quality & Safety Committee (Public Session)	21st September 2023	*PENDING*

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 Monthly Risk Management Awareness Sessions (Virtually via Teams) continue. **476** members of staff trained to date. Focussed sessions to discuss risk has also been undertaken with Care Group Leads during June 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 2713 - Backlog of Reporting Radiology Examinations. Risk scored at a 20.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Nil in terms of risks currently escalated to the organisational risk register. There have been new risks escalated to the organisational risk register following an increase in scoring at the latest risk review.

b) Risks where the risk rating DECREASED during the period

Care Group – Diagnostics, Therapies, Pharmacy and Specialties

- Datix Risk ID 5036 – Pathology Services unable to meet current workload demands. Risk score reduced from a 16 to a 15.

Care Group – Unscheduled Care

- Datix Risk ID 1133 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Risk score reduced from a 16 to a 12.

Care Group – Children and Families

- Datix Risk ID 4928 - Special care baby unit infrastructure does not comply with recommendations. Risk score reduced from a 15 to a 9.
- Datix Risk ID 4650 - Ensuring correct establishment for Special Care Baby Unit. Risk score reduced from a 15 to an 8.

Central Function – Infection, Prevention & Control

- Datix Risk ID 4217 – No IPC resource for primary care. Risk score reduced from a 15 to a 12.
- Datix Risk ID 4479 - No Centralised decontamination facility in Princess of Wales Hospital (POWH). Risk score reduced from a 16 to a 12.

Central Function – Patient, Care & Safety

- Datix Risk ID 4148 - Non-compliance with Deprivation of Liberty Safeguards (DoLS) legislation and resulting authorisation breaches. Risk score reduced from a 16 to a 12.
- Datix Risk ID 4907 - Failure to manage Redress cases efficiently and effectively. Risk score reduced from a 20 to a 16.
- Datix Risk ID 5267 - There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses on acute hospital sites. Risk score reduced from a 20 to a 12. There is a residual risk remaining in relation to retaining and recruiting nursing staff in the community and mental health services, and a new risk is being developed by the Deputy Nurse Director and relevant Care Group Nurse Directors which will come forward in the next iteration of the Organisational Risk Register.

Rationale for changes captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

No risks have been closed this period.

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

Consequence						
	5			3337 3993 4080	5276	
	4				4906 3131 5364 4908 5462 5404 4152 3133 4922 5254 4798 3826 5304 4907	4491 4632 4071 4103 2713
	3					4691 4732 2808 5036
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. MATTERS TO NOTE

4.1 Diagnostics, Therapies, Pharmacy and Specialties: There is an emerging risk to the regional (South East Wales) ability to produce systemic anticancer therapy. The Chief Pharmacists in each of the Health Boards have developed a paper to articulate the risks if the Transforming Access to Medicines (TrAMs) project does not go ahead on schedule. This paper was presented to the Operational Management Board in September 2023 and the associated risk will be added to the organisational risk register as a collective and consistent report once fully developed.

5. 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:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing	A Resilient Wales
	If more than one applies please list below:

Goals *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))*	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	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.	

6. Recommendation

6.1 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

7. Next Steps

7.1 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	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.	Quality & Safety Committee Planning Performance & Finance Committee	20	C4xL5	4 C4xL1	New risk escalated to the Organisational Risk Register September 2023	08.02.2017	21.08.2023	30.09.2023
4	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.	Updated September 2023 - On the 13th June 2023, NHS Wales and the software company jointly agreed to end the contract for the implementation of a Laboratory Information Management System. This decision was made on the basis of the current and future requirements of the pathology service in Wales. Both parties remain committed to managing the transition out of this project in the best interests of patient outcomes in Wales. CTM Local Deployment Project Group have reassumed meeting once a month to ensure any Programme actions can be progressed. Review end of October.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	8.9.2023	31.10.2023
7	4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	~~Patient / Staff /Public Safety~~ ~~Impact on the safety – Physical and/or Psychological harm~~ 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 August 2023 - Timeline including World Health Organisation (WHO), Welsh Government (WG) and Public Health Wales (PHW) Guidance is in place. The Covid-19 Information Manager is prioritising mapping CTMUHB response and catalogue of information against that timeline . Approach from other Health Boards has been shared. Next review October 2023.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	17.8.2023	31.10.2023
10	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. Reviewed 12th September no change to mitigation as reported in July (above) - no change to risk score. Review 31.10.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	12.9.2023	31.10.2023
11	4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update June 2023 - Action plan in response to Welsh cancer patient experience survey finalised. Roll out of Canisc replacement piloting with the Breast MDT. Implementation of weekly performance meetings with highlight report to COO weekly. Action plans developed for high risk challenged areas - Gynaecology, Lower GI, & endoscopy with support from the DU to implement required changes. Update September 2023 - risk score reviewed and no changes made to scoring or mitigation as detailed in the July update. Next review October 2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01.04.2014	11.09.2023	31.10.2023
12	4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HIW action plan being reviewed to ensure timely actions and reviews Next review 31.8.2023 Update September 2023 - risk score reviewed and no changes made to scoring or mitigation as detailed in the July update. Next review October 2023.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01.04.2014	11.09.2023	31.10.2023

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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
13	4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation)	**IF:** changes are not made to improve and align stroke prevention initiatives, early intervention campaigns, and acute and rehabilitation stroke care pathways across CTM **THEN:** avoidable strokes may not be prevented, patients who suffer a stroke may miss the time-window for specialist treatments (thrombolysis, thrombectomy), and patients may not receive timely, high-quality, evidence-based stroke care **RESULTING In:** higher than necessary demand for stroke services, poorer patient outcomes/increased disability, increased length of stay, and poor patient/carer experience. Impact will extend to the need for increased packages of care, increased demand for community health services, and increased carer burden when discharged to the community.	• Executive-led Stroke Strategy Group in place, with targeted task and finish under development. Membership updated to reflect senior Ops changes. • ToR and membership of Strategy Group updated. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Board briefing to ensure all sighted to challenges • Quarterly briefings to Quality and Safety Committee • Performance data regularly presented to Performance, Planning and Finance Committee • Strong CTM input to regional and national Stroke Programme Boards • Unified, evidence-based pathway developed for thrombolysis • Preparations progressing to prepare for 24/7 thrombectomy service at Bristol and updated RCP guidance on thrombolysis and thrombectomy • Designated senior operational lead for performance and improvement leadership for stroke pathway	Update 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	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	4.9.2023	31.10.2023
14	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.	AWMS Monitor Capacity and Demand: Update 30.8.23 - Monitoring and reporting within current structures. Current WL for L3 as of 31/7/23 was 998. with expected capacity of 150/year waiting list currently standards at 6.6 years. Team reviewing interventions and working towards group interventions due to be piloted in September 2023. Should see capacity increase to at least 250/year. Timeframe 29.9.2023. AWMS - Pathway Design - Update 30.8.23 - first group trial likely September. Working with research department to support evaluation. Timeframe 31.10.2023.	Quality & Safety Committee People & Culture Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	30.08.2023	31.10.2023
16	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	~~Patient / Staff /Public Safety~~ ~~Impact on the safety – Physical and/or Psychological harm~~ 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 September 2023 - This risk has been reviewed and re-assessed against the domain matrix Statutory Duty, Regulation, Mandatory Requirements and the risk score re-evaluated to a 16. Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. Moving forward consideration will also need to be afforded to the compliance with the Duty of Candour statutory requirements, with an expected increase in cases and current workforce challenges. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	20 4 16	C4xL4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
17	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.	Update 31.8.2023 - Senior Management Team improvement plans in place as part of the 6 goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for the Unscheduled Care Group relating to 4 hour ambulance delays and patients waiting over 12 hours within the department which will improve overcrowding. This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. SMT reviewed and mitigating actions remains and new review date of 31/10/23	Quality & Safety Committee Planning & Performance Committee	16	C4xL4	12 (C4xL3)	↔	24.09.2019	31.8.2023	31.10.2023
18	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	~~Patient / Staff /Public Safety~~ ~~Impact on the safety – Physical and/or Psychological harm~~ 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 September 2023 : Post Covid the number and complexity of inquests has become more challenging owing to an increasing number, with backlogs being experienced both within the Coroners Office as well as the Health Board. Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
19	5304	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Environmental / Estate / Infrastructure	The Air Handling Unit (AHU) for the pharmacy aseptic production suite	The AHU is over 20 years old and is at risk of malfunction. If: the air handling unit malfunctions Then: the aseptic unit will not be able to function Resulting in: patients not being able to receive certain drug therapies.	The room pressures are being monitored on a daily basis. The estates department maintain the AHU regularly. Monthly in-house QC testing of air quality provided by AHU. 6 monthly external testing of air quality provided by AHU. Contingency plan in place if the AHU does malfunction.	Update September 2023: NWSSP Audit has been carried out with a number of recommendations identified that are being considered by the DTPS Care Group and specifically the Chief Pharmacist. The recommendations will now be considered in terms of a management response and timeframes for completion that will be monitored via the Audit & Risk Committee.	Quality & Safety Committee	16	C4xL4	4 (C4xL1)	↔	29.11.2022	11.09.2023	31.10.2023
20	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 30.08.2023 - Awaiting feedback form paper submitted outlining challenges in Post Mortem service/after death service flows. Conversations for winter planning arranged with MES. Additional concern around impact of proposed introduction of MES into the community, leading to increase in referrals of deceased to Hospital Mortuaries.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	30.08.2023	30.09.2023
21	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.	Update September 2023: Successfully recruited to 3 x part time Speech and Language Therapy roles to provide specialist services to all 3 ITUs in CTM. This is great news and will have a significant impact on MDT morale, patient safety and patient care. POW role has commenced the other 2 are awaiting pre-employment checks and subsequent start dates. Gaps in other AHP provision remain. Next review date 1.11.2023.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	20.08.2021	1.9.2023	1.11.2023

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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
22	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update June 2023: - Submit paper to HTA board regarding releasing deceased on MES certificate. By releasing deceased following MES certificate this will improve flow of deceased. Reviewed following further scrutinisation of relevant guidance, which suggests this might be appropriate for urgent releases recognizing risk. Timeframe 31.7.2023. - Review processes to encourage collection by Funeral Directors. Explore options to reduce length of stay of the deceased and engagement with stakeholders. Timeframe 31.7.2023. Update 30.8.2023 Awaiting feedback form Paper submitted outlining challenges in Post Mortem service/after death service flows. Conversations for winter planning arranged with MES. Additional concern around impact of proposed introduction of MES into the community, leading to increase in referrals of deceased to Hospital Mortuaries.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	30.08.2023	30.09.2023
23	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 September 2023 - Mitigations previously documented have not all come to fruition. In response, the Legal Services Team are currently developing a new invest to save bid to support this area of risk focussing upon the backlog. Moving forward consideration will also need to be afforded to the compliance with the Duty of Candour statutory requirements, with an expected increase in cases and current workforce challenges. The next review of this risk will include a robust review of the detailed narrative and what this risk is measuring.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	04.09.2023	31.10.2023
26	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.	August 2023 - update: the Health Board compliance percentage has increased to 29% based on a 3 year compliance (change to previous reporting). Whilst this is a slight improvement in overall compliance, this increase is not considered sufficient to reduce the severity of this risk. In addition, there has been no progress with developing an E Learning package. Next review 3 months.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01.05.2018	22.8.2023	31.10.2023
27	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	WLIs are being undertaken by consultants to reduce reporting backlogs, this is part of the work agreed via Planned Care Recovery (PCR) funding. Use of fixed term locum staff to help relieve pressure from vacancies. Overtime payments have been made in line with agreed PCR schemes for sessions to help reduce backlogs. Weekend scanning sessions being provided and added lunchtime lists as overtime being run. Re-vetting of referrals against BMUS guidance, review of pathways/criteria, increased productivity per scanner. Close monitoring of USC waiting times and working collaboratively with Cancer Business Unit and other colleagues. There is an ongoing review of capacity plans for the whole service but without additional investment the WG target will not be met. PCR funding bid for 2 biochemists - FITT testing - new vetting criteria Update July 2023 - The referral pathway for lower gastrointestinal (GI) investigations has been modified following national guidance and FIT testing. This is ensuring the patients are receiving the correct investigation at the start of the pathway. Referral criteria for non-obstetric ultrasound scans have been updated to include national guidance. This ensures scanning only when clinically indicated. Next review due 31.8.2023.	Quality & Safety Committee	16	C4 x L4	4	↔	01.06.2020	21.08.2023	18.09.2023
30	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 August 2023 - The new operational model review in respect of quality, safety & governance has ensured that the facilitation of LFERs sits within the Care Group Governance Teams, with Patient Safety Improvement Managers taking a lead of facilitation. LFER status is regularly reviewed in the weekly Patient Safety, Complaints and Legal Services data meeting, weekly Executive Patient Safety Meeting and Quality & Safety Committee. The business intelligence team have developed reports and dashboards. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Penalties have recently been realised. Letter from Medical Director outlining the importance of engagement in the quality and safety agenda has been distributed. However, LFERs still remain a difficult area to manage. Weekly meeting with AD Claims & Complaints, Head of Legal Services and Heads of Quality & Safety to review all deferred LFERs. Actions are taken to assist service areas to produce learning. Penalties have been received over the past few months and are set to continue for anything deferred for more than 6 months. New procedures come into place from 1st September 2023 and all LFERs triggered before this date will have to be submitted and approved before 31st January 2024	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	04.09.2023	31.10.2023
32	5364	Chief Operating Officer	Children and Families Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Merthyr Cynon Band 6 - Special Community Public Health Nurses (SCPHN's) shortage	IF we are unable to recruit SCPHN School Nurses into vacant caseloads. THEN there will not be enough SCPHN's to deliver the School Nursing Framework and Welsh Government priorities. In addition increased pressure on existing staff. RESULTING IN – the school nursing service being unable to fulfil all of its statutory obligations to safeguarding, optimise immunisation uptake rates, support CYP with their emotional health and compliance with the CMP. It is also predicted that there will be increased levels of staff sickness and impact on recruitment and retention of staff.	Vacancies to be advertised as required. Development of a SCPHN SN bank Team Leader and CNS safeguarding to support staff to ensure safeguarding statutory duties are met. Plan in place to prioritise, Immunisations, CMP, SEHS. Where possible, Team Leader to protect SCPHN time to hold drop in sessions within schools. Vacant caseload policy has been activated. Letter send to Directors of Education and Head Teachers regards reduced SN service capacity. Development plan in place for junior staff to complete SCPHN training and ensure succession planning of future SCPHN workforce. Cross cover support from School Nursing staff across the HB. Extra hours have been offered throughout the team. Team leader review workforce capacity as required and escalate to Senior Nurse when required. Skill mix approach by MC team to deliver school nursing service Senior Nurse to escalate to senior management as required	Due to a national shortage of SCPHN students qualifying across Wales, all vacant SCPHN posts will be recruited into at every opportunity. Band 5 development plan, to support succession planning and future of SCPHN workforce Timeframe: 21.7.2023 Reviewed by Children and Families Care Group on the 30.08.2023 - proposed for closure. Rationale for closure being sought prior to de-escalation / closure from the Organisational Risk Register.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	03.02.2023	30.08.2023	30.09.2023

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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
34	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.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	21.08.2023	31.10.2023
35	5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Service Director - Diagnostics, Therapies, Pharmacy and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan Due date 30.9.2023 Demand & capacity review Due Date 30.9.2023 Workforce redesign Due date 30.09.2023 Dedicated Pathology IT resource Due Date 30.09.2023 Accommodation review Due Date 30.09.2023 Novation of Equipment to the Managed Service Contract Due date 30.09.2023 Update August 2023 - The current control measures are ongoing. Care Group have reduced the current score slightly to 15 to more accurately the current consequence and likelihood. Risk score likelihood remains as a 5 in light of current staffing capacity and Administrative and Clerical / Managerial vacancy restrictions within the Health Board. There will be particular challenges within the Cell Path Consultant teams as a result of a staff member leaving later in the year which could result in a potential need to increase outsourcing. Current Planned Care Recovery funding is forecast to be exhausted by November 2023 based on current activity levels and this risk has been escalated via the Planned Care Recovery Board and through Operational Management Board.	Quality & Safety Committee	15 ↓ 16	C3 x L5 Risk scoring reviewed August 2023.	6 (C3xL2)	↓ Decreased from a 16 in September 2023	02.03.2022	09.08.2023	31.10.2023
36	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Waiting Times/Performance: ND Team	IF: The Neurodevelopment service does not have capacity to achieve the WG assessment target (80% of assessments to commence within 26 weeks of referral) and to follow up patients in a timely way, due to demand exceeding capacity Then: Patients will wait excessive periods to reach a diagnosis and children on medication that require titration and monitoring may not be able to be seen within the appropriate timeframes Resulting in: Delays in appropriate treatments being commenced, delays in accessing support e.g. in school following a diagnosis, delay in being effectively titrated, risks associated with delays in medication monitoring	The service is operating as efficiently as possible e.g. enhanced roles for SLT/CNS/Pharmacist. Pathways have been reviewed e.g. ADOS's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recurrent funding agreed at Planned Care Board 25/08/2022 and successfully appointed 1.0 wte Psychiatrist (clinical lead role, Uplift from 8a to 8b 0.6 wte Pharmacist, 1.0 wte Band 3 admin & 0.6 wte Band 3 HCSW - appointed Nov 22 Meetings with National Lead for Values Based and Prudent Health Care taken place to look at modelling of the service. Bids have been submitted through successive IMTPs and previously against new WG funding sources for the ND service. Internal working group in place to repatriate SLA from Swansea Bay so that a local service can be developed WG funding (£12m) announced for ND services - health, education and third sector. SBARS being developed to bid for funding to enhance provision moving forwards. WLI agreement following Neurodivergence Improvement Programme funding via RPB until end of March 2023 to address longest waiters achieved no patients to be waiting over 104 weeks at end of March 2023. WLI agreed to continue April 2023 onwards to maintain current wait times whilst additional funding is being agreed through regional partnership board to develop a pan CTM model.	Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred. Meetings scheduled to bid for funding via Regional Partnership Board. Timeframe 29.9.2023	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	05.07.2023	31.07.2023
37	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Update June 2023 -options for decant remains under strategic review and is proposed for discussion at Improving Care Board on 27th June. If this is the agreed way forward this will be discussed at a formal review with Welsh Government, likely to be late July. If approved then the contractor can be re-engaged and works commence on procuring the decant solution and developing the design for the theatre department works for inclusion in a business case. Further funding will need to be applied for to develop the business case. Once approved then the decant will need to be installed. Likely to require a further extension on the Fire enforcement notice which is due to expire on 31st December 2023. 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.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	20.06.2023	31.08.2023
39	4732	Chief Operating Officer	Unscheduled Care Group Proposed change to Planned Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Update August 2023 - Orthogeriatrician service model is being reviewed and CTM as part of the trauma and orthopaedic reconfiguration of service. New review date 31.10.2023. Senior Management Team reviewed and has requested that this risk is transferred to planned care Directors for management.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	31.10.2023	30.09.2023
41	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 September 2023: See control measures which also include mitigating action being taken. New WCCIS Programme Board and Operational Group established for CTM.	Quality & Safety Committee	15	C5xL3	6	↔	07.11.2018	6.9.2023	31.10.2023
42	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.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	5.9.2023	31.10.2023

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
4217	Executive Director of Nursing & Midwifery Infection Control	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	A strategic review is planned to determine what is required to provide an integrated whole system approach for IPC. Update August 2023 - Reduced to 12 following discussion and risk appraisal with Deputy Executive Director of Nursing and Lead IPC Nurse. The risk consequence remains major with current partial mitigations, however, based on evidence (number of recorded preventable cases), the likelihood has been adjusted to monthly.	Quality & Safety Committee	12 ↓ 15	9	Update August 2023 - Reduced to 12 following discussion and risk appraisal with Deputy Executive Director of Nursing and Lead IPC Nurse. The risk consequence remains major with current partial mitigations, however, based on evidence (number of recorded preventable cases), the likelihood has been adjusted to monthly.
4479	Executive Nurse Director / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No Centralised decontaminatio n facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly ILG decontamination meetings take place where all concerns are escalated to the HB Decontamination Committee meeting. SOPs is place Water testing carried out as per WHTM guidance Maintenance programme in place for decontamination equipment 07/10/2021 - In view of aging Urology washer disinfectors, urology service managers to liaise with APDs to initiate/ agree a service contract for maintenance and servicing of equipment with an external.	The planning application for the centralised decontamination unit has been approved by Bridgend County Borough Council and the tender has been shared with 5 companies. Update 30/6/23 - Capital planning are in a position to develop the business case for WG however, awaiting Executive steer on future plans for decontamination. Ongoing concerns with Urology decontamination equipment in POW, care delivery group informed and awaiting a response. Review 31.8.2023. Update August 2023 -risk reviewed and score reduced to 12 (4x3). Incidents due to aging equipment are reported monthly rather than weekly.	Quality & Safety Committee	16 ↓ 12	8	Likelihood of the risk reduced. IPC have received confirmation that the failures associated with aging decontamination equipment in POW are reported monthly rather than weekly. In view of this information, the risk score has been reduced to 12 (4x3).
1133	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	Update September 2023: Senior Management Team reviewed and there was an agreement for funding to be approved for two substantive posts for Royal Glamorgan Hospital. Currently within the recruitment phase, 1 has commenced role as Locum. Nursing workforce vacancies are currently being filled with use of bank an agency with an invest to save in progress. With these mitigating actions this will reduce the risk score to 12, with C4 & L3. Target date 8. Next review date 31/10/23	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16 ↓ 12	8	Update September 2023: Senior Management Team reviewed and there was an agreement for funding to be approved for two substantive posts for Royal Glamorgan Hospital. Currently within the recruitment phase, 1 has commenced role as Locum. Nursing workforce vacancies are currently being filled with use of bank an agency with an invest to save in progress. With these mitigating actions this will reduce the risk score to 12, with C4 & L3. Target date 8. Next review date 31/10/23

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
4148	Executive Nurse Director / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**IF:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	Recurrent Welsh Government funding has been approved to continue to reduce the DoLS backlog and further strengthen Mental Capacity Act awareness. Procurement are sourcing an agency to complete authorisations through tender. Once an agency is agreed and contracts confirmed they will be utilised to address the backlog. The backlog has already been reduced through the appointment of two further BIA and performance management. Review 31.8.2023.	Quality & Safety Committee	16 ↓ 12	9	Update August 2023 - Risk reviewed with Head of Safeguarding and Deputy Nurse Director, owing to the consequence being affected (reduced) with the backlog being attended to, the risk has been reduced to 12. It is anticipated that with the clearance of the backlog, the likelihood will also reduce, bringing the risk down to the target range of 9 and therefore tolerated and suitable for closure. This will be reviewed again in mid-October.
4928	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Special care baby unit infrastructure does not comply with recommendations.	The current neonatal unit infrastructure is based on a dated footprint that does not comply with current recommendations. (Health Building Note 09-03:Neonatal Units, DoH, 2013) IF the unit remains the same as it is now the ability to provide safe patient care will be compromised. THEN as well as patient care being effected we will continue to fail IPC audits and medicines management audits. We will not be able to provide the best possible care for the families on the unit and staff morale will continue to suffer. RESULTING IN: Unsatisfactory environment for patient	In order to mitigate the ongoing situation all available areas of the ward have been utilised to support patient safety. An extra cubicle has been created by moving the ward managers office to a family room. Storage for equipment has been temporarily sought in the parent accommodation. The patient areas have been moved around to try to ensure space between cots is optimised.	Update June 2023:Meetings to be convened with capital colleagues. Latest IPC audits to be highlighted. Risk score reduced as there has been refurbishment following Infection Prevention Control recommendations and Public Health Wales audit. Footprint remains the same regarding spacing in some areas.	Quality & Safety Committee	15 ↓ 9	6	Risk score reduced as there has been refurbishment following Infection Prevention Control recommendations and Public Health Wales audit. Footprint remains the same regarding spacing in some areas.
4650	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ensuring correct establishment for Special Care Baby Unit	IF: the current staffing levels are maintained as minimum BAPM level of staffing requirement THEN: safe staffing of the unit will not comply with WTE directive. Also there will be an increase in the use of overtime/ bank/ agency to cover shift patterns. RESULTING IN: a core staffing deficit of 2.45 wte NNEB, as per BAPM requirements.	Care Group are currently running a roster that aims to maintain 4 staff (3 registered and 1 nursery nurse)on each shift by utilising bank and overtime when available. Ward manager/Practice development Nurse also steps in to cover short fall when needed. Shifts are managed depending on patient acuity and skill mix.	Continue to utilise bank and overtime shifts when needed. Continue to work collaboratively with paediatric staff if support is needed. Acknowledging the shortfall and filling the vacancy will ensure the use of overtime and bank is reduced and give staff confidence in the staffing levels.	Quality & Safety Committee	15 ↓ 8	6	Risk score reduced as update as at 05/09/23 Band 4 and Band 5 posts now filled and awaiting start date. One band 5 vacancy currently due to investigation in process. Sickness remains a challenge however, lower levels noted.
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Nurse Director / Deputy Chief Executive	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses on acute hospital sites.	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	LOCAL MITIGATION: 1. Safe to start is in operation daily across all three acute hospital sites, giving an overview of staffing numbers, acuity and dependency to enable team decision-making. 2. Utilisation of the monthly dashboard on areas such as sickness, vacancies, safe-to-start information and other quality/safety measures. 3. Improving level in the utilisation of data to support analysis and associated actions across the clinical areas. 4. All acute hospital sites now using safe care to report staffing levels, acuity and dependency to support decision-making and data transparency. 5. Wards and clinical areas now working to the agreed rostering policy which is in turn monitored through the care group leadership teams and corporate nursing.	Update August 2023. CTM WIDE APPROACHES: 1. Corporate nursing and local nursing representatives are working with HEIW on the implementation and translation of the 'Retention Toolkit'. 2. International nursing recruitment continues for 2023/24 and is being managed as a workstream through the Nursing Productivity Group which in turn reports to the Value and Effectiveness Group monthly. 3. The Advanced Practice Board is now substantiated and is reforming the governance to support the progression of nursing and allied clinical staff whilst ensuring a consistent and measured approach to ensure stability in general and specialist ward nursing levels where advancement is occurring. 4. Advancement of the bank utilisation programme, establishing set KPIs for the recruitment and sourcing of bank nurses and HCSWs is being coordinated and overseen via the Nursing Productivity Group.	Quality & Safety Committee	12 ↓ 20	9	Based on the local mitigation being undertaken as outlined under controls in place the likelihood of this risk being realised has been reduced. There is a residual risk remaining in relation to retaining and recruiting nursing staff in the community and mental health services and a new risk is being developed by the Deputy Nurse Director and relevant Care Group Nurse Directors which will come forward in the next iteration of the Organisational Risk Register.

	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	Nil this period										
3											
4											

Agenda Item
6.3

Quality & Safety Committee

HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT

Dyddiad y Cyfarfod / Date of Meeting	25/09/2023
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	Greg 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 tool
PCH	Prince Charles Hospital
CDU	Clinical Decision Unit
CTMUHB	Cwm Taf Morgannwg University Health Board

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.

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 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 and everyday practice where practicably possible.

17 improvement plans are on the HIW Tracker to date with the date range of December 2020 to August 2023.

From these 17 action plans there are a total of 568 actions to be completed.

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

- 273 reported as Green - Completed actions
- 50 reported as Amber – actions partially complete/ongoing to meet deadline date
- 17 reported as Red with the actions being those which are incomplete and have passed the agreed due date
- 228 reported as no update received for this report and no status update provided. For noting: the majority of these actions are related

to Mental Health improvement action plans; for which there is a significant amount of work ongoing by the Care Group. The improvement plan(s) are being overseen by the Improvement Board, next meeting on 18th September 2023, and an update will be available following that meeting.

2.3 Current Position

The tables below provide a summary of the position as at end of August in relation to the open and agreed actions following a HIW inspection.

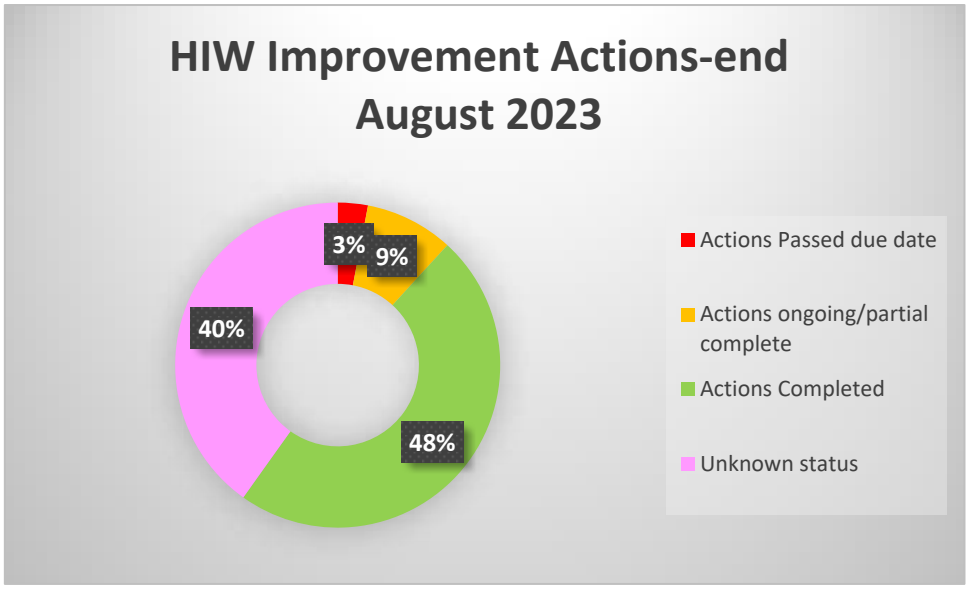
Improvement Plans added to the tracker during this reporting period

- PCH Emergency Department & CDU (July and August inspection date 2023)
- Review of Discharge Arrangements for Adults from Inpatient Mental Health Services within CTMUHB

Improvement Plans fully completed/closed during this reporting period

- PCH Emergency Department & CDU (January 2022)
- POW Ward 5 (updates accepted by HIW)
- Seren Ward

Actions by Status-end August 2023			
Total Actions	Actions passed due date	Actions ongoing/partial complete	Actions Completed
568 ↑ (196)	17 ↓ (41)	50 ↓ (27)	273 ↑ (36)



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 received.

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 complete all the improvement plans in an agreed and timely manner.

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 improvement plans across the Health Board following HIW Inspections.

6. Next Steps

6.1 Work continues to ensure a smooth and robust transition from the Patient Care and Safety team to the Assurance and Compliance team with agreement to ensure regular reports are presented to this Quality and Safety Committee.

Agenda Item
6.4

Quality & Safety Committee

LEARNING FROM EVENTS REPORTS

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Stephanie Muir, Assistant Director of Concerns & Claims
Cyflwynydd yr Adroddiad / Report Presenter	Stephanie Muir, Assistant Director of Concerns & Claims
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**

Acronyms / Glossary of Terms	
LFERs	Learning from Events Reports
QL	Qualifying Liability
WRP	Welsh Risk Pool

1. SITUATION/BACKGROUND

1.1 The Health Board are required to submit Learning from Events Reports (LFERs) to Welsh Risk Pool (WRP) in respect of learning information relating to claims and redress cases in order that costs can be reimbursed.

1.2 LFERs should be submitted to WRP along with evidence of learning as follows:

- Claims – 60 working days from decision to settle.
- Redress – 60 working days from admission of qualifying liability.

1.3 The Health Board received written confirmation from WRP in July 2023 outlining that following the WRP Committee meeting held in July 2023, that no penalties were applied to the Health Board for overdue LFERs.

1.4 However, it was highlighted that there was an expectation that all outstanding deferred cases were resolved by 1st September 2023. Failure to address this would result in penalties likely to be applied to any cases which have been deferred for longer than six months when the committee meets in September.

1.5 The Health Board has had a historic backlog of LFERs. Various actions were taken to address the backlog, however the completion and submission of LFERs and supporting evidence continues to be a challenge for the Health Board.

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

2.1 The health board received a tracker of cases from WRP, which highlighted the number of cases that were over 6 months deferred or would be over 6 months deferred by 1st September 2023.

2.2 There were 53 cases which fell into this category.

2.3 The gathering of evidence and submission of these LFERs was prioritised and a weekly meeting was held with the Assistant Director of Concerns and Claims, the Head of Claims & Inquests and the Heads of Quality & Safety.

2.4 Evidence was submitted on all 53 cases, with confirmation received on 48 cases that evidence was sufficient for the LFER to be returned to panel for scrutiny.

2.5 Five cases required further information, which was still being sought. The majority of these were linked with training compliance.

2.6 The tracker also indicated 37 cases which would shortly be deferred for more than 6 months.

2.7 These cases are now being prioritised.

2.8 Weekly meetings will continue well into the New Year to ensure that the backlog of LFERs is reduced and remains at a manageable number.

2.9 Currently we have the following information on the Health Board's Datix Cymru system.

Please note that although many of the deferred LFERs mentioned above have been submitted to WRP, not all have been reviewed within the WRP scrutiny panel, and therefore will still be showing as deferred.

	Position @11.09.23
Total Number deferred	79
Deferred information Outstanding	29
Deferred for longer than 12 months	21
Deferred between 8 - 10 months	11
Deferred between 6-8 months	27
Deferred less than 5 months	20

2.10 The recent revision of the Quality Governance Delivery model, with proposed new arrangements for quality, safety and governance provided an opportunity to revisit how LFERs are managed within the Health Board, realigning the process to within the Heads of Quality & Safety teams. These changes in the management of LFERs were established on 1st April 2023.

2.11 From 1st April 2023, 55 LFERs have been newly triggered. To date 35 LFERs with supporting evidence have been submitted to WRP, with 20 currently overdue.

2.12 The 35 LFER submissions (noted in 2.11) have not yet been reviewed by WRP panel. The Health Board is therefore awaiting the outcome of whether any of these submissions will be approved or deferred.

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

3.1 The Health Board still carries a risk that the non-submission of LFERs can result in the WRP imposing financial penalties.

3.2 As from 1st September 2023 new WRP Reimbursement procedures have been introduced, which has amended the timescales for submission of LFERs.

3.3 The timescale for a completed and signed LFER, summarising a matter is **four calendar months**. The previous timescale of sixty working days, which was aligned to reporting standards for serious incidents, has been removed because this standard no longer applies in relation to reportable incidents.

3.4 The trigger for the start of the four calendar months' timescale is linked to the decision to settle a negligence claim or redress case. For redress cases, the trigger is the determination that a Qualifying Liability (QL) exists. The exact date for the commencement of the four calendar months is the date that the letter confirming QL is sent to the claimant. For negligence claims, the trigger is identified as the point when instructions were given to settle a case.

3.5 This may not actually have led to settlement but could include making or accepting an offer and making admissions of liability. The rationale for establishing these trigger points is that issues and failings in a case can reasonably be identified at the point QL is determined or a decision to settle a case is made. The use of the trigger also enables progress and compliance with the submission of a LFER to be monitored and audited. The deadline for submission of an LFER is four calendar months from the decision to settle a case. If the four calendar months falls on a non-working day (such as a weekend or bank holiday), the deadline will be the working day immediately prior to the four-month deadline date.

3.6 Where a LFER is not approved by the WRP Committee, the health body will be notified in writing of this decision. This is known as a deferred case and no reimbursement will be permitted in the matter until approval of the learning has been achieved. Where a case is deferred, it is expected that the health body works to provide the outstanding information promptly to be re-considered as appropriate by the National Learning Advisory Panel and the WRPC. It is anticipated that any outstanding information is supplied promptly from it being requested.

3.7 The deferred case must be recommended for approval by the National Learning Advisory Panel within **twelve calendar months** of the trigger to settle a case. Health bodies should liaise with the WRP Operations Team to ensure any outstanding information is submitted within a timescale to enable it to be considered by the panel within the twelve-month period.

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**	Effective
	If more than one applies please list below: Efficient, Equitable, Person Centred, Timely, Safe

(Duty of Quality Statutory Guidance (gov.wales))	
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 and completion of a Quality Impact Assessment is 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: This is an overarching report and completion of an Equality Impact Assessment is not required.
Cyfreithiol / Legal	Yes (Include further detail below)	
	LFERs are integrally linked to the Legal Claims process and the recovery of monies.	
Enw da / Reputational	Yes (Include further detail below)	
	Poor compliance with LFERs may have a negative effect on the reputation of the Health Board across NHS Wales and Welsh Government.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	If each individual LFER is not submitted within the timescale or with the required evidence of learning, there may be a penalty, which may be up to the value of the claim.	

5. Recommendation

5.1 The Quality & Safety Committee is asked to **NOTE** this report.

6. Next Steps

- LFER facilitation moved to Heads of Quality & Safety teams from 1st April 2023.
- Weekly 3 hour LFER huddles have been taking place and are to continue until October 2023. Following this, these will revert to fortnightly and then monthly.
- Regular LFER reconciliation meetings with WRP Safety Learning Advisor.
- Reports/dashboards available for the newly formed care groups.
- Escalation process for missed deadlines formulated.
- Training and buddy system available.
- "LFER how to guide" developed and shared.
- Learning Framework developed.
- Learning Repository to capture learning.
- Training undertaken on Datix, highlighting the need to complete actions and upload evidence of actions.
- Early notification being developed that would give Care Groups early notification that learning is required i.e. at breach of duty.
- Ensure accountability for learning is clear in the new Care Group set up.

Agenda Item
6.5

Quality & Safety Committee

CTMUHB NOSOCOMIAL COVID-19 INCIDENT MANGEMENT PROGRAMME DELIVERY UNIT (DU) INTERIM LEARING REPORT

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Debbie Bennion, Head of Covid19 Nosocomial Investigation Team
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality and 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**
Improving Care Board	26th July 2023	NOTED
Executive Leadership Group	11th September 2023	NOTED

Acronyms / Glossary of Terms	
COVID-19	COVID-19 is an illness caused by a strain of coronavirus called SARS-CoV-2. This virus is responsible for the global pandemic since 2020.
CTMUHB	Cwm Taf Morgannwg University Health Board
DU	NHS Wales Delivery Unit

HCAIs	Health Care Associated Infections
IPC	Infection, Prevention and Control
NNCP	National Nosocomial COVID-19 Programme
PTR	Putting Things Right
SRO	Senior Responsible Officer

1. Situation /Background

1.0 In March 2023 the Delivery Unit published the "National Nosocomial COVID-19 Programme Interim Learning Report." The purpose of the Interim Learning Report is to outline the early learning that has emerged as a result of the nosocomial investigations and the wider programme of work. A copy of this report is attached to this SBAR.

1.1 It is important to recognize that the programme is not a nationally led investigation into nosocomial (hospital-acquired) COVID-19 in Wales, nor does it seek to detract from the role of the UK COVID-19 Inquiry. The National Nosocomial Covid-19 Programme (NNCP) was established to support NHS Wales organizations undertake their duty to investigate patient safety incidents in a proportionate way, whilst reflecting the complexities of COVID-19 which caused unusually high number of incidents.

1.2 In response to the pandemic, NHS Wales rapidly adapted and altered its operational focus to minimise the harmful impact of COVID-19 as far as possible, at a time of high levels of uncertainty and anxiety.

1.3 Whilst infection prevention and control (IP&C) measures are routine practice for the NHS, the spread of COVID-19 in healthcare settings proved challenging, particularly at times when community prevalence was high, and hospitals had significantly high levels of patient complexity, demand and occupancy.

1.4 The scale of the pandemic meant that, despite being in a healthcare environment, patients in hospitals and other in-patient settings inevitably faced an increased risk of contracting nosocomial COVID-19.

1.5 Whilst Health Care Acquired Infections (HCAIs), now including COVID-19 are a recognised risk in healthcare settings, learning and developing understanding of how to investigate such matters of patient safety is important to help inform IP&C design and implementation.

1.6 The NNCP was established in April 2022 to support NHS Wales organisations to conduct proportionate investigations into patient safety incidents of nosocomial COVID-19, which occurred between March 2020 and April 2022.

1.7 It is a collective membership of all NHS organisations across Wales who worked together to implement as consistent an approach as feasible, to investigate nosocomial COVID-19 patient safety incidents. To assist NHS organisations investigating patient safety incidents of nosocomial COVID-19, a "National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19" was developed, to ensure as consistent

an approach as feasible was followed and investigations were done once and done well.

1.8 By March 2023 the framework has supported NHS Wales organisations to assess and investigate over 5,000 cases of nosocomial COVID-19 where they met the definition of a patient safety incident. Acknowledging the impact of COVID-19 on service users, families, carers and NHS Wales staff, the programme has adopted a learning approach that seeks not to place blame but maximise the opportunity for learning and improvement.

2. Specific Matters for Consideration

2.1 Good Practice and Learning Identified

The Interim Learning Report has combined learning from across organisations and collated this into national themes to further support the identification of areas for improvement in the quality and safety of services.

The learning themes which emerged through the **first year** of the programme were categorised into the following themes, the elements of good practice and key learning are summarised under each heading: -

People's experiences

2.2 Bereavement support and care-after-death services

Access to high-quality bereavement and care-after-death support services can be extremely helpful in managing grief. When the NNCP programme was established, consideration was made about how service users - particularly the bereaved - would be supported.

Good Practice

The Development of the National Framework for the Delivery of Bereavement Care launched in 2021 which has assisted in setting a standard of expectation to be implemented within all organisations for the provision of a bereavement support service. It is noted that organisations have worked hard to implement this requirement.

Key learning

It is noted that Bereavement support services should be proactively made available to all families, particularly for those where there may be a link with an associated patient safety incident.

2.3 Supporting service users during an investigation process

There is a need to support the service user during the investigation process and it is recognised that navigating and understanding the concerns process and knowing who to contact when people have a question is sometimes the difference between understanding and trusting the process, or dissatisfaction and lack of trust.

Good practice

To improve this experience, organisations established a dedicated five-day single point of access for service users, families and carers, when managing a concern.
To ensure this principle was facilitated for service users, families and carers, a set of minimum standards were established by the NNCP for how services should engage the public. The provision supports a coordinated approach to handling queries about nosocomial COVID-19, with ease of access to address additional queries or broader concerns regarding nosocomial COVID-19.

Key Learning

It was noted that every service user, family and carer should have timely access to a dedicated and easy-to-access single point of contact to provide feedback, and raise questions, concerns or queries. This is particularly key for patients and families involved in the concerns process. Supporting information should be available and easily accessible to assist families in understanding the sometimes-complicated language linked to the concerns process.

2.4 Visiting restrictions

The programme identified that visiting restrictions had many adverse effects on the physical and mental health of patients - especially those in the vulnerable groups that the restrictions were intended to

safeguard, many of whom were not able to fully understand the decisions made. The limited alternative opportunities for making contact and communicating with loved ones, also negatively impacted the experience for many other service users, families and carers.
Investigations highlighted that families often relied on clinical teams and ward staff to connect with their loved ones. Whilst this communication in the main has been highlighted as positive, there are instances where communication was below the expected standards, especially the inability to make contact during busy periods.

Good practice

Organisations developed many innovative ways to minimise the impact of the visiting restrictions. These included examples such as virtual visiting via tablet devices, outdoor visiting and utilising ward-based patient support teams to bridge the gap. Volunteers also played a key role in bridging the gap, particularly later in the pandemic. Many organisations have continued to strengthen these services.

Key Learning

The report recommended all services and wards should have named dedicated patient support teams and volunteers to support service users, families and carers who may be finding it difficult to visit a loved one in hospital. Future visiting guidance should pay particular reference to the role carers have as an important part of a patient's care team.

2.5 Patient Safety incidents and concerns
Patient safety incidents outside of NHS Wales hospitals

Patients often receive NHS-funded care in other settings, for example, their own homes, care homes, and facilities outside of Wales. Whilst NHS Wales organisations, under the duty of candour, have a responsibility to ensure any patient safety incidents that occur to their local population are reported to them, the requirement to undertake investigations can alter.
In applying the National Framework for the Management of Patient Safety Incidents Following Nosocomial Transmission of COVID-19, it has been identified that how the Regulations are applied in different parts of the health and social care system, as well as other sectors such as independent providers (private and public service), is variable and confusing.

The programme identified that the Regulations create variability and inequity for service users, families and carers who receive NHS-funded healthcare via another provider when a concern is raised. Evidence from the experience of service users, families and carers connected to the programme to date, suggests they are not routinely informed of these differences.
On this basis of the Regulations, the current programme does not extend to investigating all instances of nosocomial COVID-19 which occurred through an independent provider setting under NHS-funded care, including care homes.

Good practice
The learning from applying the National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 has been shared with social care colleagues.
A good practice guide is being developed for non-NHS support services in other sectors to apply a more consistent and standardised approach to concerns in social care and care home settings.

Key learning

All policies and procedures relating to the management of patient safety incidents which occur **during NHS-funded care** should set expectations of the standards required across all care settings to minimise confusion for service users, families and carers who may be receiving care across multiple complex care pathways.

2.6 Identification, reporting and investigation of Health Care Acquired Infections (HCAIs) as a patient safety incident

Beyond the management of nosocomial COVID-19 as a patient safety incident, learning has identified that current arrangements within NHS Wales for the identification, reporting and investigation of all HCAIs that meet the definition of a patient safety incident are variable. The programme also identified inconsistent approaches to the management and reporting of HCAIs across Wales and variations in the methodology used to investigate such incidents.

Good practice

As a result of this learning, the National Policy on patient safety incident reporting has been updated to reflect new national reporting

requirements for HCAIs, including the reporting of nosocomial COVID-19.

Key learning

All health-acquired infections need to be assessed against the requirement to report as a patient safety incident, in line with national incident policy, and a proportionate patient safety investigation needs to be initiated.

2.7 Application of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions

A common theme in the concerns raised by families and carers during the early part of the programme was the application of DNACPR decisions for patients who acquired COVID-19. Some of the themes in the concerns related to a view that there was a 'blanket approach' to applying the decision when somebody was diagnosed with COVID-19, and a lack of knowledge or consultation in the process of applying the decision.

Whilst a DNACPR decision does not strictly require consent from a next of kin or carer before application, unless the patient lacks capacity, learning from the investigations has recognised the importance of such communication, and the impact the management of this sensitive subject can have when managed well, and in these instances, not so well. The analysis did not identify evidence or trends that DNACPR decisions had been placed inappropriately, or not in keeping with the current All Wales DNACPR Policy.

Findings from investigations and other sources such as the Medical Examiners Service and mortality reviews have identified that there was a:

- Need to improve the description of patient's co-morbidities and their impact on the reason for a DNACPR being enacted
- Need to improve communication, especially around the rationale for DNACPR implementation and discussions with patients, families and carers and the need to improve documentation related to discussions with patients, families and carers
- Need to improve the DNACPR document, particularly whether a decision should be reviewed if a patient's condition improves.

Good practice

The NHS Wales Strategic Advance & Future Care Planning group has agreed to strengthen the section in the policy relating to appropriate and timely communication with patients and families. This is seen as an important step to support clinicians to move beyond the formal process of DNACPR, providing helpful guidance and support in how, when and with whom to communicate to ensure understanding, and minimise upset.

Key learning

Service users, families and carers place great value on good communication around the DNACPR process and need to be involved as much as possible in the decision-making process.

2.8 National infection prevention and control guidance Roll out of guidance

Due to the need to respond rapidly to the significant population health risk that COVID-19 posed, guidance updates were published frequently, at short notice and often out of normal business hours. NHS Wales staff experience has shown that the frequency in which the guidance was updated and created caused challenges for all staff including the IP&C teams, who are responsible for leading the necessary changes for all HCAIs across often large and complex organisations.
The expectation that guidance should be implemented immediately, once published, was a significant challenge during the pandemic, particularly given the level of resources required to ensure training, communication and application across large workforce numbers and settings.
It was noted that it can take time to assess and disseminate guidance which requires organisations to make significant adjustments to care delivery.

Good practice

Organisations developed extraordinary systems to respond to the rapid increase in the prevalence of COVID-19 and the high demand on health and social care. In addition, due to the emergence of new evidence, they also had systems in place to respond at pace to updating the necessary guidance on an almost weekly basis.

2.9 Outbreak management

The increased demand for COVID-19 testing during the pandemic posed a significant challenge to the existing testing infrastructure. Demand exceeding capacity and the inability to test rapidly for COVID-19 during periods of 2020, meant that testing was somewhat ineffective as a mechanism for reducing infections, until the supply of consumables met demand and testing capacity increased. Due to the testing capacity challenges early in the pandemic, service users were discharged into other care settings or their own homes without the ability to rapidly test for COVID-19. This was in line with national guidance at the time.

Further UK guidance, especially early in the pandemic, actively encouraged the discharge of patients from hospitals into care home settings, to free up hospital capacity in order to manage the anticipated demand for services. Whilst a testing strategy produced by Welsh Government was launched on 15th July 2020, significant challenges in applying the policy existed due to limited access to the volume of consumable items required to undertake tests, and laboratory capacity to manage the extreme demand.

Additional capacity beyond the existing infrastructure was achieved with the launch of the lighthouse laboratory (IP5), towards the end of August 2020, this meant it became easier and quicker to test patients and staff for COVID-19.

An aged estate and limited isolation facilities (such as access to single rooms) meant that patients were often unable to be isolated in single rooms, and co-horting was established to maintain operational flow through hospitals during extreme demand.

The inability to isolate patients often meant that, in an attempt to reduce spread of infections, service users were subjected to multiple ward movements. In line with UK guidance, the introduction of designated care pathways, which tried to prevent onward transmission (as far as reasonably practicable), played a significant part in multiple ward movements especially in older estates.

Good practice

Organisations rapidly implemented increased point-of-care testing (POCT) to support clinical care delivery and assist in more timely diagnosis and clinical decision-making. This supported improved daily epidemic control by reducing patient movements and achieving early detection for treatment plans to be put in place which assisted in the

safe timely transfer and discharge of patients into alternative care settings where necessary.

Key learning

Policies and procedures should reflect mechanisms that result in limiting the number of patient moves, ensuring patients are in the right place at the right time.

3. Key Risks / Matters for Escalation

3.1 Members should recognise that some of the content of the report may be upsetting for many and teams should be conscious of Cwm Taf Morgannwg Health Board (CTMUHB) staff, service users families and carers who are involved when discussion these findings

3.2 To be advised that this SBAR was presented to the Improving Care Board in July 2023

3.3 To be advised that this SBAR was presented to the Executive Leadership Group in September 2023.

3.4 The Delivery Unit Interim Learning Report can be accessed via this link Interim Learning Report - National Nosocomial COVID-19 Programme (English) (nhs.wales)

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care Creating Health
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	Learning, Improvement & Research

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole Systems Perspective 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, Equitable, 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:	The Interim Learning Report has been produced and published by the Delivery Unit (NHS Executive) thus QIA screening not required for this paper.
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:	The Interim Learning Report has been produced and published by the Delivery Unit (NHS Executive) thus EIA screening not required for this paper.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Any incidents where a breach of duty or qualifying liability is believed to exist will follow appropriate legal process. The Health Board will work closely with NWSSP Legal and Risk services.	
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) Dedicated fixed term workforce has been recruited. The funding stream is confirmed and provided by Welsh Government. No additional financial impact is anticipated other than through existing legal Redress and Claims provision.

5. Recommendation

5.1 The Quality & Safety Committee is asked to **NOTE** this report.

6. Next Steps

6.1 To be advised that in the second year of the programme the NNCP will be working with NHS Wales organisations to further share and embed learning of the second year of the programme. In addition to progressing the learning on the subjects listed in this report, the programme will continue to identify and explore new and emerging topics which will be included in the final learning report.

6.2 The following topics are currently emerging and will be reported on in the final report:

6.3 Staff experience to help further inform learning themes

6.4 Service user experience of the NNCP to date

6.5 Healthcare environments (estate and ventilation in relation to IP&C)

6.6 Consideration of Safeguarding in the emergency response to COVID-19

6.7 Discharge planning

Agenda Item
6.6

Quality & Safety Committee

OUTCOME REPORT: QUALITY & SAFETY COMMITTEE EFFECTIVENESS SURVEY

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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	Carolyn Donoghue, Committee Chair/Independent Member
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. PURPOSE

1.1 The Chair of the Quality & Safety Committee is required to present an annual report outlining Quality & Safety business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to Quality & Safety. As part of this process the Committee are required to undertake an annual self-assessment questionnaire.

1.2 Members of the Quality & Safety Committee are asked to discuss and review the Committee self-assessment questionnaire relating to the activities and performance of the Quality & Safety Committee during 2022/2023.

1.3 Members should note 16 responses had been received.

2. SUMMARY REPORT

Positive Assurance	**1. Committee Effectiveness:** The majority of Members/Attendees were aware that: • There were approved Terms of Reference in place defining the role of the Committee which were reviewed annually. One comment was received that whilst the responder was aware that the Terms of Reference were added to the agenda annually, they could not recall a detailed discussion being held regarding them. **2. Committee Business** There was a clear consensus that Members/Attendees considered that: • The Committee had been provided with sufficient authority and resources to perform its role effectively; • The Committee prepares an annual report on its work and performance in the preceding year for consideration by the Health Board; • The Committee had established a Cycle of Business which was dealt with across the year. One responder commented that they had not recalled seeing a cycle of business; • The atmosphere at Committee meetings were conducive to open and productive debate; • The behaviour of all Members/attendees was courteous and professional; • The Committee meetings were being scheduled prior to important decisions being made; • In Committee meetings were convened throughout the year to assist with timeliness of information flows and it was felt that these were used appropriately for items that should not be discussed in the public domain;

	• Each agenda item was **closed off** appropriately so it was clear what the conclusion was on items following discussion; • They were satisfied that boundaries between this Committee and other Committees were clearly defined with appropriate cross-referral if required; • It was felt that the Committee meetings had been chaired effectively and with clarity of purpose and outcome. It was felt that the Committee had grown in confidence under the leadership of an outstanding Chair and a supportive Executive and Corporate Team; • It was felt that through the Committee Highlight Report to Board, the Committee Chair provided clear and concise updates on the activities of the Committee and escalated areas of concern as appropriate.
Areas Requiring Further Assurance	**1. Committee Business** • Whilst the majority of Members felt that the Committee met sufficiently frequently to deal with planned matters and that sufficient time was allowed for questions and discussions, some members felt that there had been occasions when there had been insufficient time to hold meaningful discussions against some agenda items due to the amount of business to manage within the meeting. There had been occasions where the discussions became operational and there were occasions when some agenda items had been rushed. The Committee will need to reflect on the balance between strategic and operational discussions; • It was felt that the introduction of a longer break in the middle of the meeting would be welcomed; • **Welsh Language** at meetings. There was a mixed response but overall Members would welcome greater use of the Welsh Language at meetings; • Virtual Meetings had overall been a positive experience in that it had allowed meetings to continue and also continued scrutiny. It is acknowledged that some Members/Attendees considered that hybrid meetings can prove to be difficult and that the re-introduction of face to face meetings would be welcomed; • The majority of Members felt that the Committee had been appropriately supported by Executive Director leads in terms of attendance, quality of papers and in their response to challenge and scrutiny; • It was felt that greater assurance was required from Non-Clinical Services as the agenda was heavily weighted to Clinical functions; • It was felt that further work needed to be undertaken on less use of abbreviations or improved explanation of abbreviations. **2. Training & Development**

	• Whilst there was a clear consensus that Members/Attendees considered that they had sufficient training to fulfil their role, some Members advised that they would benefit from receiving additional training.
Areas Requiring Further Action	• **Committee Business** • **Terms of Reference –** Explore the possibility of including the Terms of Reference on the main agenda for discussion as opposed to the consent agenda to improve visibility; • **The Annual Review of the Committee Cycle of Business** will be placed on the main agenda to improve visibility; • **Agenda Size –** Consideration to be given as to whether the size of the agenda needs to be curtailed further to allow adequate time for discussion. Consider introducing regular comfort breaks into the agenda. Debriefs are already being held during agenda planning sessions to discuss feedback on how the previous meeting went; • **Face to Face meetings –** Explore the possibility of re-introducing some face-to-face meetings throughout the year. It has been suggested by the Committee Chair that we hold one meeting per year as an in person meeting with an option to join the meeting virtually for members/attendees who are unable to attend in person; • **Quality of Papers –** improvement recognised, however, further work is needed on focussing of the needs of the Committee so focus could remain on governance and strategic oversight as opposed to operational issues. Further work required to ensure less use of abbreviations or improved explanation of abbreviations within reports. It has been noted by the Committee Chair that the launch of the new cover report template may help with further improving the quality of reports; • Consider how greater assurance could be provided in relation to Non Clinical Service areas. Committee to discuss if it would wish to receive updates from non-clinical areas in relation to Quality & Safety matters. It has been suggested by the Committee Chair that consideration could be given to the Committee receiving a Spotlight Presentation from non-clinical areas periodically within the Committee's cycle of business; • **Behaviour, Culture and Values –** Committee to be mindful of the focus of scrutiny and ensure it remains strategically focused, directed at the collective officers attending the meeting;

	• **Training & Development –** Members to be offered additional training to enable them to fulfil their role. Members to identify what additional training they require.
Action Plan	• Annual Review of Terms of Reference and Committee Cycle of Business to be placed on main agenda for discussion; • Agenda planning meetings to continue to ensure focused agendas on key issues. Continue with undertaking a debrief of the previous meeting during the agenda planning sessions. Committee Chair to consider time allocated to presentation of topics, aiming to allow more time for discussion. Consideration to be given to building comfort breaks into the agenda; • Explore the possibility of holding one meeting per year as in person meetings with Teams option available for those unable to attend face-to-face; • Further work needed on focussing of the needs of the Committee so focus could remain on governance and strategic oversight as opposed to operational issues. Executive Sponsors to reflect on use of abbreviations and acronyms used in their reports; • Committee to discuss if it would wish to receive updates from non-clinical areas in relation to Quality & Safety matters. Spotlight presentations from non-clinical areas to be built into the forward work programme; • Continue report writing training & feedback to individual report authors on quality of papers (ON-GOING); • Chair to seek views from Committee members on issues IMs may wish to receive training on.
Appendices	Nil

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 / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol –	A Healthier Wales

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))*	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: Not applicable
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 applicable
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)*	

1. Recommendation

1.1 The Committee are requested to **DISCUSS** and **NOTE** this report.

2. Next Steps

2.1 The actions outlined within the report will be taken forward by the Corporate Governance Team.

Agenda Item
6.7

Quality & Safety Committee

Summary of Irradiated Blood Alerts incorrectly added to Digital Patient Records

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Bethan Marsh – Clinical Records Modernisation Manager
Cyflwynydd yr Adroddiad / Report Presenter	Matthew Swarfield – Head of Clinical Admin Transformation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stuart Morris, Director of Digital

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Stuart Morris Dom Hurford	01/09/2023	Monitoring/ Noting Updates

Acronyms / Glossary of Terms	
DPN	Digital Patient Notes
DNACPR	Do Not Attempt Cardio Pulmonary Resuscitation

1. Situation /Background

1.1 Patients requiring irradiated blood transfusions should have a distinctive sticker attached to their casenotes, to advise clinicians, in the event of future transfusions. The clinically agreed and documented process when digitising notes with these stickers or other alert factors (e.g. DNACPR) is to complete an alert sheet and scan this into the Alerts category in Cito. Clinicians can then view the alert document and see what category has been ticked; a special requirement for irradiated blood. DNACPR, Allergy, etc.

2. Specific Matters for Consideration

2.1 This agreed process was done correctly by the commercial scanning team and the CTM in-house scanning team from April 2021 until the pause in scanning in December 2022. When scanning re-started in February 2023, the commercial scanning partner was given an incorrect instruction by one of the Medical Records team regarding processing of the All-Wales Blood Transfusion form; namely that the simple presence of this form requires a special blood requirement alert. Every patient having a blood transfusion has this form completed. This change was brought to the attention of the Clinical Records Modernisation Manager on 18th July 2023.

2.2 On discovery of the above-mentioned incorrect change of process, immediate action was taken to reverse this change; the commercial partner was informed not to accept any future change of instruction without the authorisation of the Clinical Records Modernisation Manager's written authorisation. Reports were provided of all patients with an alert added to their Cito record since the scanning re-start in February 2023.

2.3 A Datix incident was raised with initial findings and an Early Warning Notice issued to Welsh Government.

2.4 Clinical advice was received from the Medical Director on 18 August 2023 that the clinical risk would be low for most patients, if they received irradiated blood products without need.

2.5 Work has subsequently been undertaken by the Medical Records Hub team to check alerts for 4,839 patients. The risk associated with an irradiated blood transfusion is low for most patients. From the investigation to date, no patients appear to have received such a transfusion or come to harm as result. Findings of the check are as follows:

No error	No error made; the alert form added for the patient was for a different reason (allergy, DNACPR, etc.) and is correct.	**4461**
Clinically certified	The special blood requirement alert was clinically documented and is correct.	**82**

Wrong alert – deleted completely	An incorrect special blood requirement alert form was added due to the wrong instruction given regarding processing of the transfusion form. No alert was actually required. The incorrect alert form has not been viewed by any clinical users and has been deleted from the record.	**172**
Wrong alert – corrected and replaced	An incorrect special blood requirement was added to the alert sheet, along with other (correct) alert factors, e.g. allergy, DNACPR, etc. The original incorrect alert has not been viewed by any clinical users and has now been deleted. It has been replaced with a corrected version stating only the correct alert factor.	**112**
Incorrect alert was applied to the patient digital record which could then have been viewed by a clinical user, and acted upon incorrectly	An incorrect special blood requirement alert has been added to the record. A non-clinical review of the information was conducted by the Medical Records team. There is no clear evidence that any patient received a treatment or that an action was followed, resulting from this incorrect alert. Since then the Medical Records team have addressed the matter and records now have the correct alerts, as required. Specific patient details are being provided separately to the Medical Director for clinical verification of my conclusions regarding these patients. The incorrect alerts have been deleted or corrected, as appropriate.	**5**
Duplicate entries, test patient entries	Patients / case numbers appeared on the report for checking, but were duplicate entries for patients already checked, or for test patients and not genuine cases. No corrective action was required.	**7**

2.6 The Medical Director and Director of Digital have been kept updated throughout the period and the above conclusions of the checking process have been shared with them on 4 September 2023.

2.7 The Medical Director is liaising with Welsh Government. Advice is awaited on next steps. A review of the alert process has been requested, with clinical advice, as there seems to be little clinical reference to this data.

3. Key Risks / Matters for Escalation

3.1 Following the investigation outlined above, it is determined that there has been no harm to any patients

3.2 There was an immediate escalation, and subsequently regular updates have been submitted to Welsh Government.

3.3 Welsh Government have acknowledged completion of the review and final status update.

3.4 No further work will be performed on this directly and the incident is considered closed.

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:
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))*	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))*	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: An impact assessment has been undertaken as can be seen in above section 2.5.	If no, please include rationale below:
Cydraddoldeb	Yes: ☐	No: ☒

Impact Assessment		
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: Not applicable
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 committee is requested **NOTE** the incident and subsequent investigation to the error in recording irradiated blood transfusions

5.2 The committee is requested to **NOTE** the associated remedial actions.

6. Next Steps

6.1 No further action identified

Agenda Item
7.1

Quality & Safety Committee

PATIENT SAFETY & QUALITY DASHBOARD

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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
PALS	Patient Advisory Liaison Support

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.07.23 to 31.08.23.23 taken from systems on 04.09.23, unless otherwise specified.

The Health Board is in the process of transitioning to a new operating model, which requires significant change to data alignment, in addition to changes to the quality governance model and arrangements are being embedded.

This transition provides an opportunity to review and build upon the structure, format and information contained within the Quality & Safety Dashboard. As a result, this revised iteration will continue to be refined over the forthcoming months to improve data accuracy, enable robust monitoring and provide assurance.

Key areas to note in this reporting period are:

- Decrease in the number of complaints received. Attributable to the re-alignment of the recording of primary care complaints to the All Wales process and embedding of the PALS service.
- Compliance with the 30 working day target for responding to complaints increased to 71% in August 2023. A plan is in place to address the number of complaints open over 30 working days while maintaining the focus on the complaints due.
- The number of Public Service Ombudsman for Wales referrals received remains relatively consistent with previous months.
- Options for engaging with staff to ensure robust recording of compliments received continue to be explored.
- Increase in Nationally Reportable Incidents linked to change in reporting process for incidents relating to Infection, Prevention & Control.
- Decrease in the number of medication incidents reported.
- Increase in Patient falls incidents reported
- Decrease in Pressure Damage Incidents reported
- Continued decrease in restrictive practice incidents reported

2. Specific Matters for Consideration

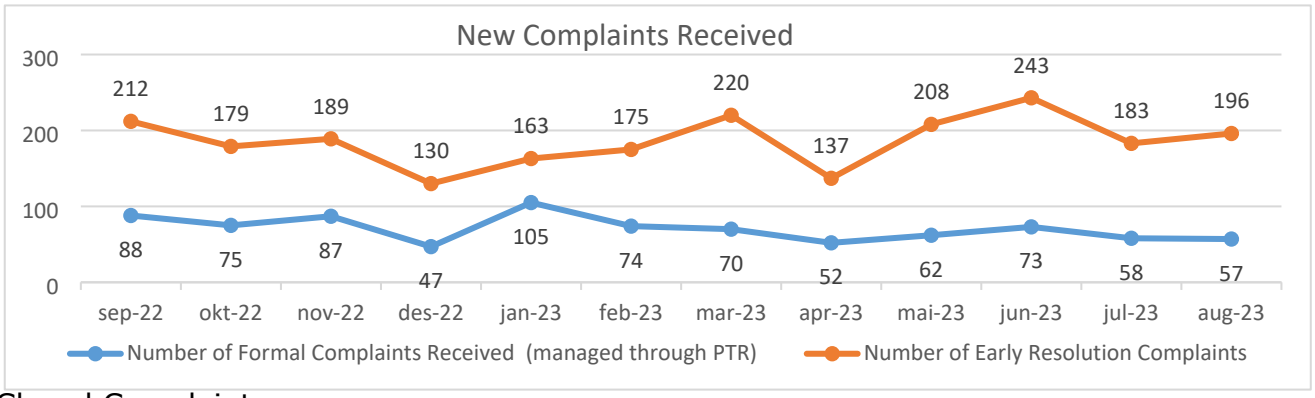
2.1 Patient / Service User Feedback

Complaints

<u>New Complaints Received</u>

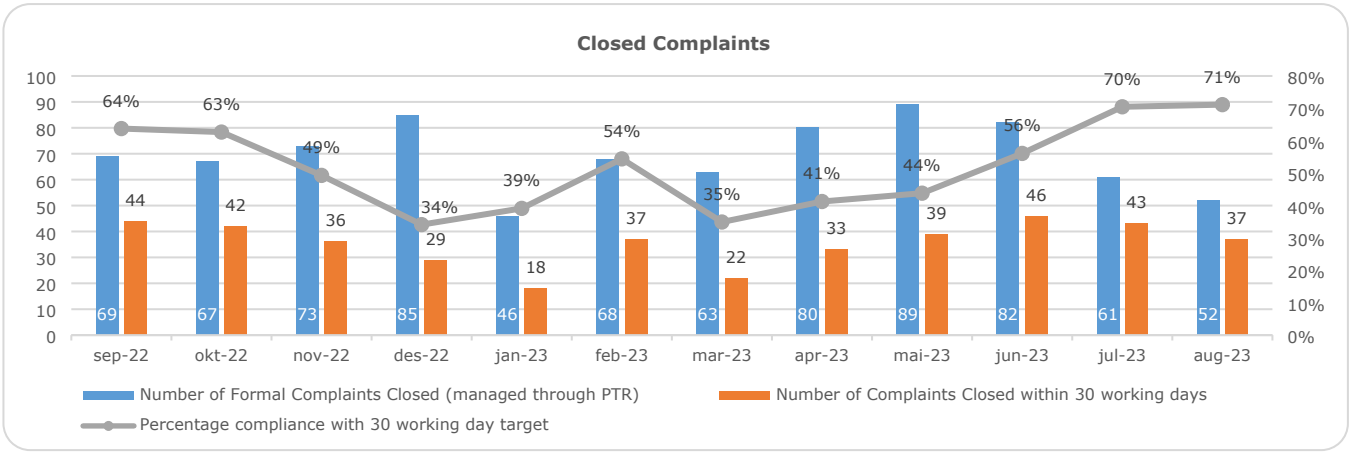
Between the 01.07.23 and 31.08.23 the Health Board received a total of 494 complaints. Of these, 115 were categorised as formal and managed under the Putting Things Right Regulations (PTR). The decrease in the number of complaints received in July and August 2023 can be partly attributed to realigning the recording of complaints relating to Primary Care in line with the All Wales process and continued embedding of the PALS service.

For all complaints received in July and August 2023, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (161), Appointments (102) and Medication (51).



Closed Complaints

Within the period of 01.05.23 to 30.06.23, the Health Board closed a total of 113 formal complaints (managed through PTR). Following an increase in compliance with the 30 working day target during June 2023, compliance for August 2023 has further increased to 71%.



As at 01.09.23 the Health Board had 177 open formal complaints. Of these 59 complaints were open over 30 working days. This represents a 63% reduction from the 160 open over 30 working days on the 01.04.23. A trajectory plan is in place to continue to improve compliance and address open complaints over 30 working days. These actions include daily Complaint Team Huddles to review cases and support the embedding of the early escalation process.

Patient Advisory Liaison Support (PALS)

The PALS Service continues to be embedded across Princess of Wales and the team is working proactively to support patients, families, and unpaid carers with any issues raised in relation to care provided and signposting to support within the community when needed.

'Care to Share' clinics are in place which allows the PALS team to visit every ward on a weekly basis to speak to patients, unless called to support family meetings etc. The team is averaging on a weekly basis twenty/twenty-five contacts with patients/families allowing the

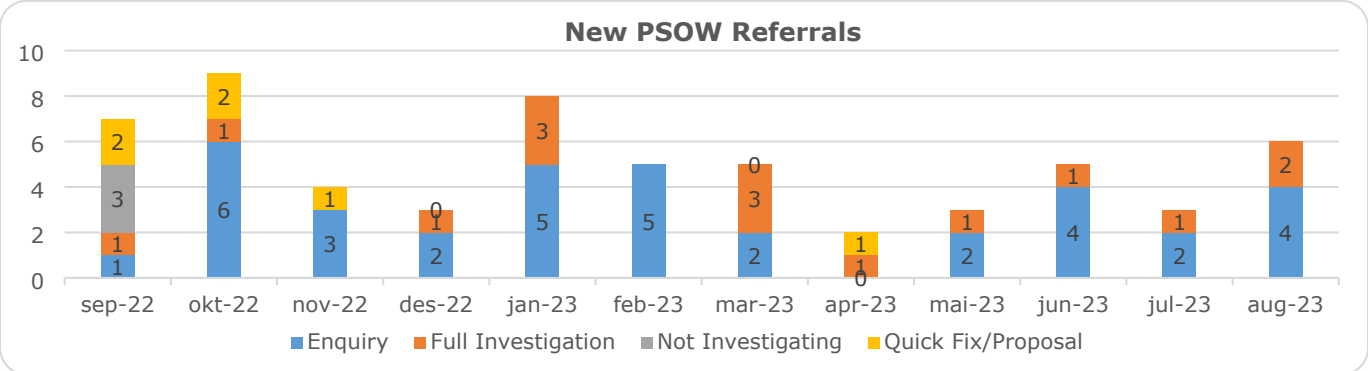
HB to demonstrate they are proactively working to resolve concerns before these are escalated through the complaints process, but will support if there is a need to implement Putting Things Right (PTR) guidelines. The team is also receiving increasing calls for support from staff on the wards to speak to patients/families due to an awareness of the impact the service has in supporting the resolution of issues.

Meetings continue to be arranged with third-party stakeholders to raise awareness of the team in Princess of Wales (POW), to understand what support is available within the community, and to highlight the Health Board's commitment to ensure these supportive roles are reflected across the whole of the Health Board. The Head of People's Experience was also contacted by a member of staff from the psychology service following a review of their web page and consultation with the public to ensure there is a reference to the PALS service, as there was a recognition of the amount of support provided by the team, particularly during covid. This engagement will be replicated within Prince Charles Hospital when the PALS team commences in September.

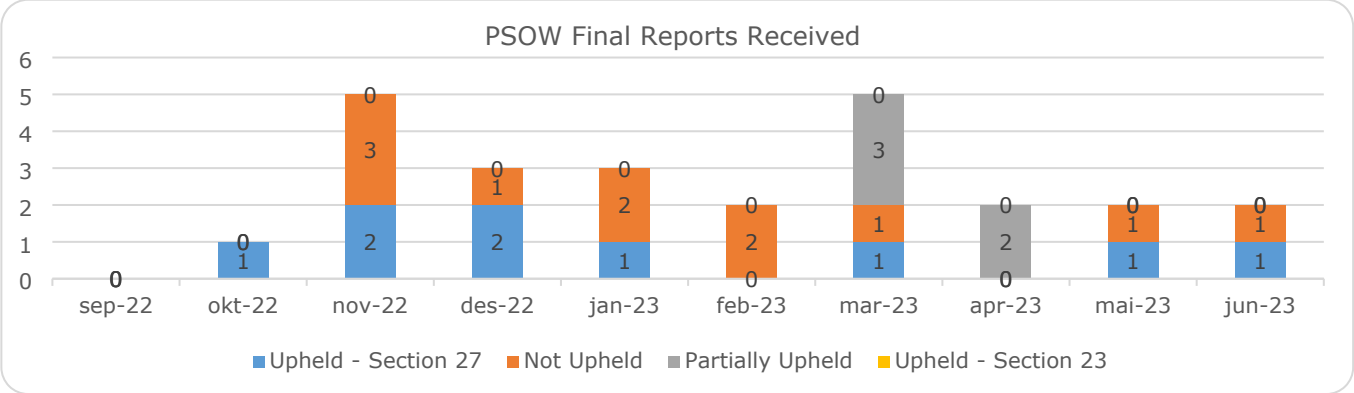
Weekly reports are provided to the senior nursing team in Princess of Wales to provide them with an insight as to the issues being discussed within this setting and to action/share as they feel appropriate. This will be replicated in Prince Charles Hospital when the team starts here.

Public Services Ombudsman for Wales

The Health Board received notification of 9 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.07.23 and 31.07.23. This remains relatively consistent with previous months. Of the 8 referrals, 3 were received as full investigations and 6 as enquires.



During the same period, the PSOW issued 4 final reports to the Health Board, 1 was partially upheld and 2 were not upheld. The partially upheld reports relates to services provided by Unscheduled Care, Princess of Wales Hospital (1) and Planned Care, Prince Charles Hospital (1).



As at 04.09.23, the Health Board currently has 56 Open PSOW cases, of these 39 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 39 cases. 6 are at final report stage with actions being implemented by the Care Groups.

Engagement

Engagement with the communities we support as a Health Board is key to understanding how the services we provide impact the general population's health and well-being. Feedback allows us an insight into people's experience of the services we provide and enables the Health Board to promote high-quality patient-centred care as well as encourage service users to influence the services and care provided to them.

There are several avenues this is collated via across the Health Board such as social media, feedback groups, and the use of local feedback forms. The main source is Civica, which is a patient feedback system embedded through the Values Based Healthcare project. The move to embed All Wales Surveys within the system is being explored on an All Wales basis which the Health Board is engaging with and will have representation within the newly formed All Wales Editorial Board.

The People's Experience team continues to work with staff across the Health Board to explore how we can encourage and increase feedback from patients and relatives and have created new bilingual posters/have your say cards to build a brand that is synonymous with patient feedback across the Health Board. An All Wales Emergency Department (ED) survey has been uploaded onto Civica and the Head of People's Experience and Civica team are exploring how this can be implemented. An All Wales Nosocomial Survey is also being utilized on the system and the Nosocomial Team is driving engagement. The Civica Team is also working with the Palliative Care team to introduce an All Wales Survey into this service. The extension of the Patient Advisory Liaison Support (PALS) team, into Prince Charles Hospital (PCH) will

allow the Health Board to extend the service driving engagement with the public to gain further feedback.

Throughout June and July 2023 the Health Board received 767 responses via Civica across a number of specialties. A push report mechanism allows the sharing of this data directly with service leads to review and action accordingly.

Compliments

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

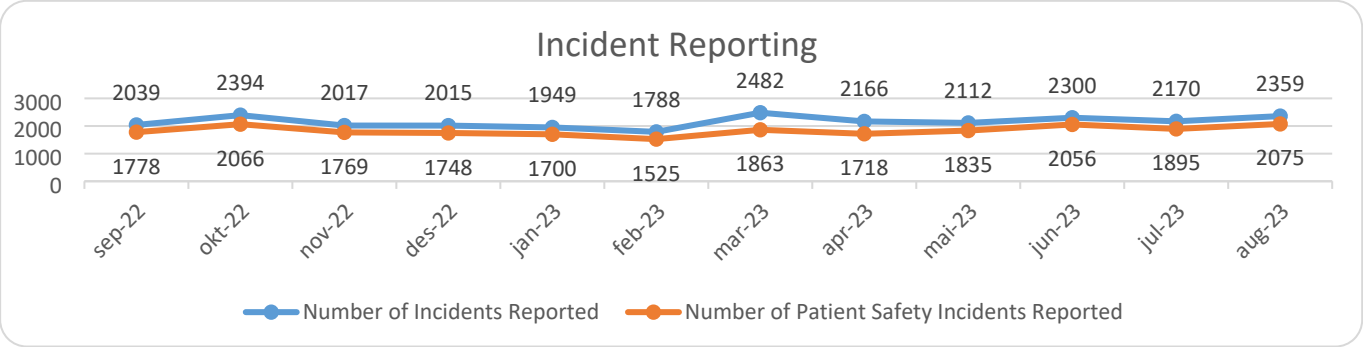
Actions to improve the recording of compliments has been established which includes:

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

2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4,529 incidents were reported between 01.07.23 and 31.08.23, this represents an increase of 117 when compared with the previous 2 months.

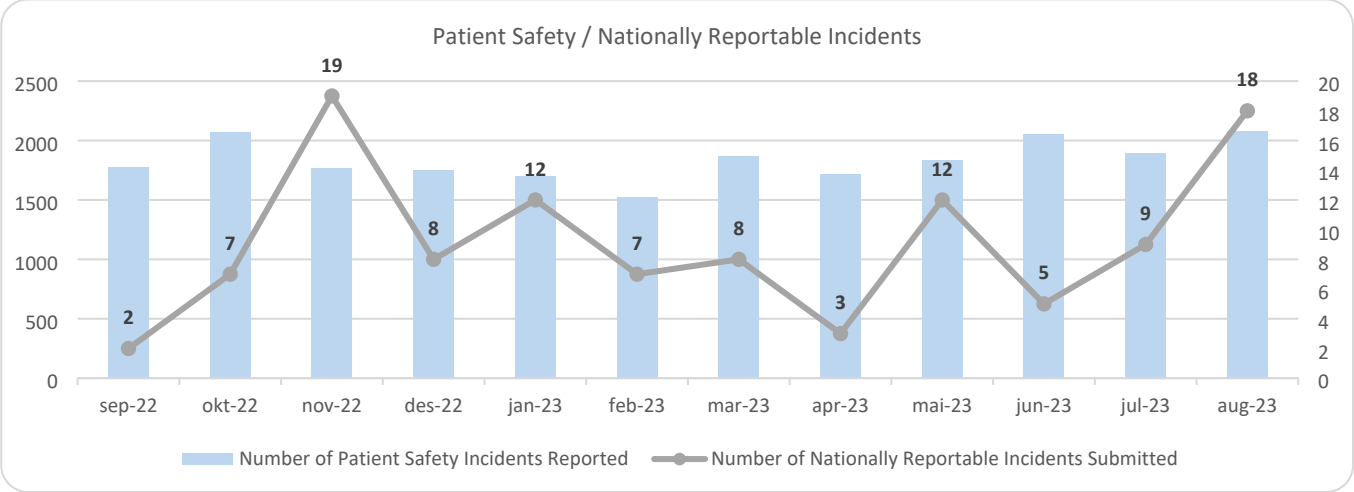


Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has continued to increase. Of the 4,529 incidents reported, 88% (3970) were reported as the patient affected.

The top 3 types of incidents reported for July and August 2023, linked to a patient affected are Pressure Damage /Moisture Lesion (1234), Infection, Prevention & Control (650) and Accident, Injury (597).

Nationally Reportable Incidents

Between 01.07.23 and 31.07.23, 27 Nationally Reportable Incidents were submitted to the NHS delivery unit. One never event was identified during this period relating to the administration of medication via the wrong route. The ratio of Nationally Reportable Incidents to the overall number of patient incidents is demonstrated in the chart below.



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

The Health Board currently has 94 open Nationally Reportable Incidents, of which 66 are overdue the timescale for completion. Of the outstanding Nationally Reportable Incidents, 29 remain open due to additional processes including Appendix Bs/ambulance delays (14) and Ophthalmology (15).

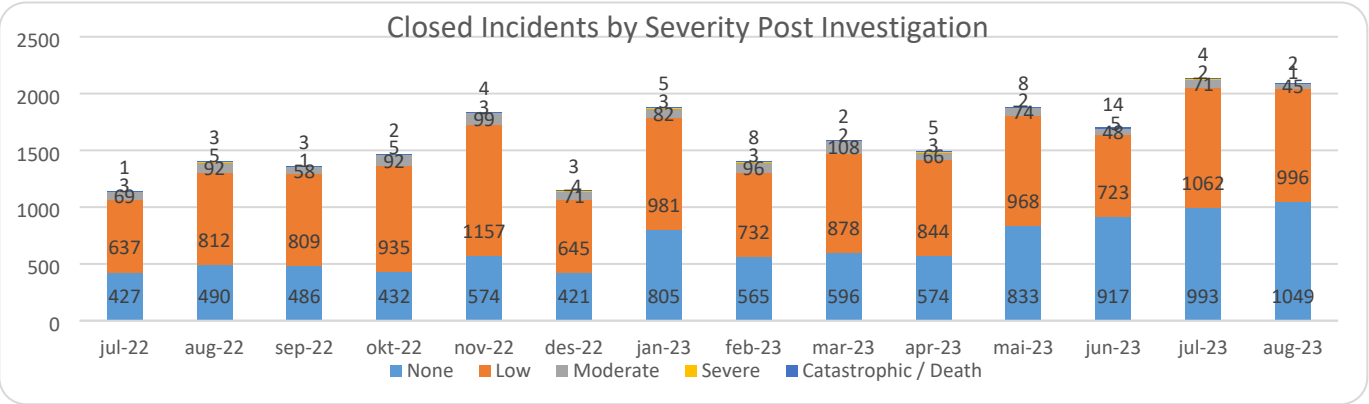
The type of Nationally Reportable Incident notifications submitted in May and June 2023 is highlighted in the table below:

	Jul 2023	Aug 2023	Total
Access, Admission	1	0	1
Assessment, Investigation, Diagnosis	2	1	5

Equipment, Devices	0	0	1
Infection Prevention and Control	0	6	6
Maternity adverse occurrence	1	4	7
Medication, IV Fluids	1	0	2
Patient/service user death	0	1	5
Pressure Damage, Moisture Damage	2	6	17
Treatment, Procedure	2	0	3
Total	9	18	47

Closed Patient Safety Incidents

Between the 01.07.23 and 31.08.23 a total of 4,225 patient safety incidents were closed. Of the 4,225 patient safety incidents closed, 29 were closed with severity post investigation of severe harm (3) or catastrophic/ death (6). 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 were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. As the implementation of the Duty of Candour progresses, further analysis of the data can be undertaken and included within this report. A review of the 65 incidents where the Duty of Candour field within Datix Cymru has been completed is currently being undertaken to ensure the duty has been triggered appropriately and all requirements fulfilled.

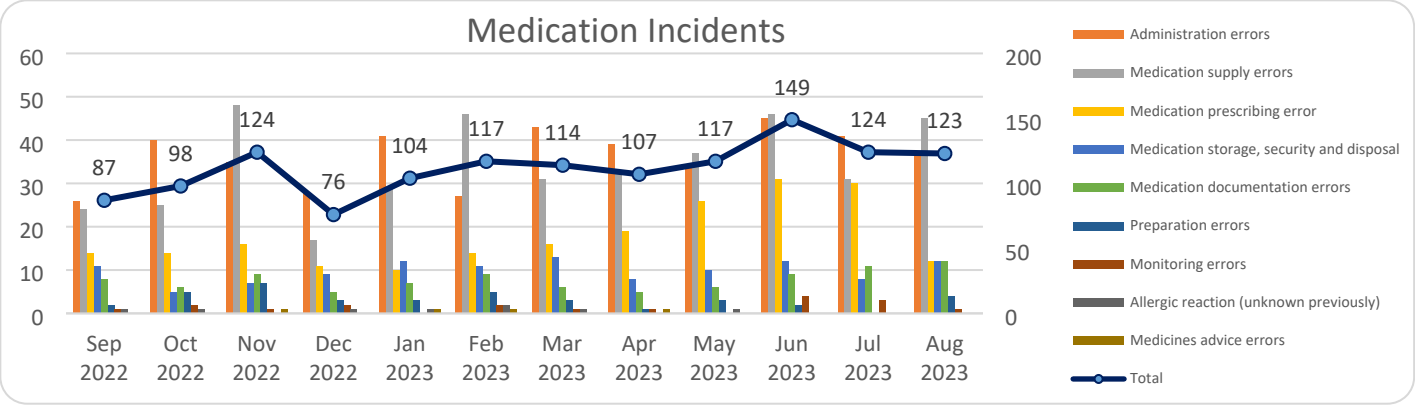
Number of Incidents	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Occurring during the month	1718	1835	2056	1895	2075
Initial Management Review Completed	1546	1445	1532	1468	1285
Identified as Moderate/Severe/Death following Management Review	44	45	64	52	72

Number of Incidents	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Where Duty of Candour Triggered	27	11	8	5	5
Where In-person notification completed	7	7	4	0	5
Where letter of notification sent	0	2	2	0	2

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

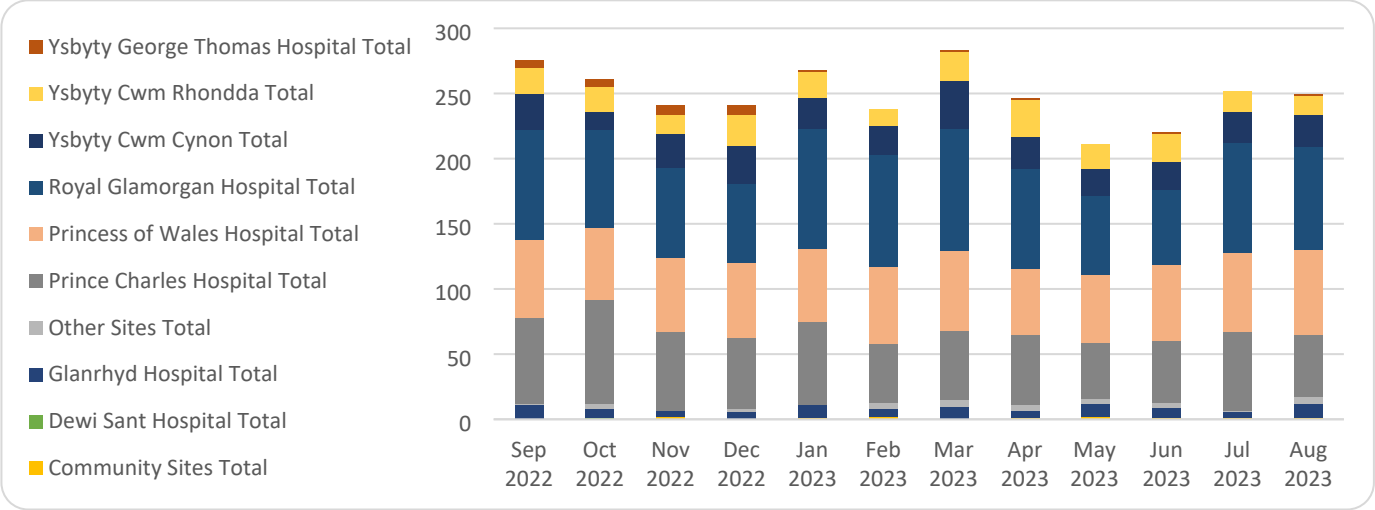
A total of 247 medication incidents were reported as occurring between 01.07.23 and 31.08.23. This is an increase of 7 when compared with the previous 2 month period and a continuation of the increase from January 2023. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (78), supply errors (76), and prescribing (42).



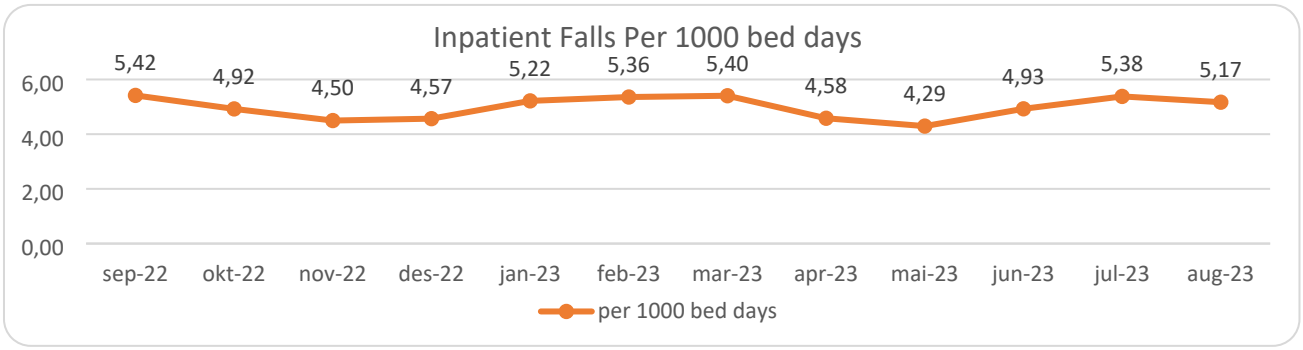
91% of the medication incidents were reported as resulting in no (117) or low (108) harm, with the remaining reported as resulting in moderate harm (20) and severe (2) harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 501 falls, where the person affected was a patient, were reported during July and August 2023. This represents an increase of 70 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 (131) or low (327) harm. The remaining incidents were reported as moderate (40) and severe (2) 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.



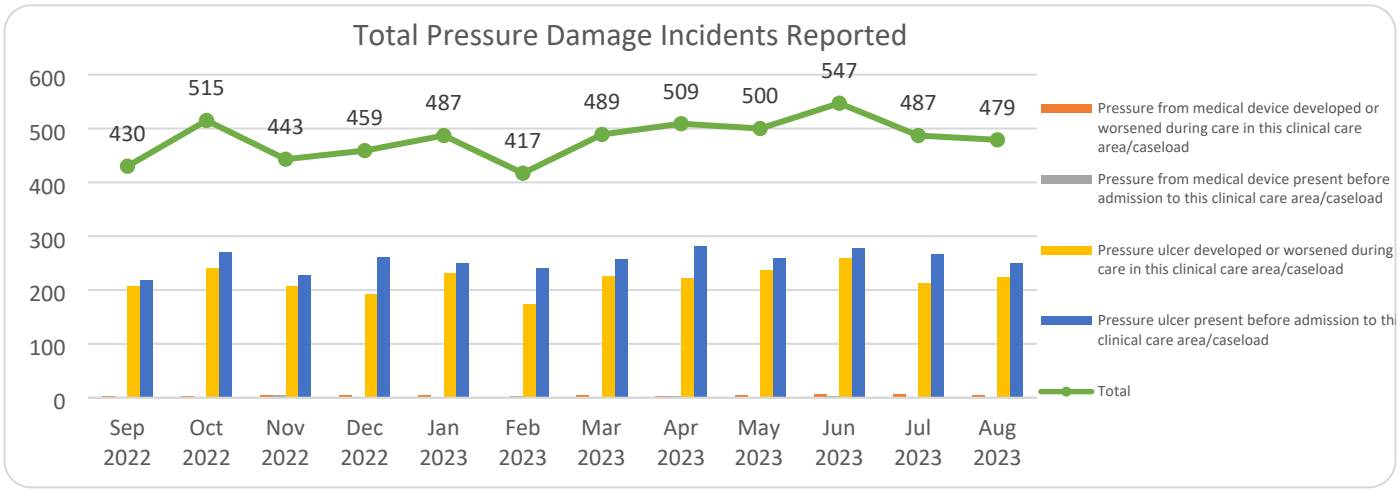
During the time period, the highest number of inpatient falls occurred on Ward 15 at Princess of Wales Hospital (20), Acute Medical Admissions Unit at Princess of Wales (18) and the Ward 7 at Ysbyty Cwm Cynon (16).



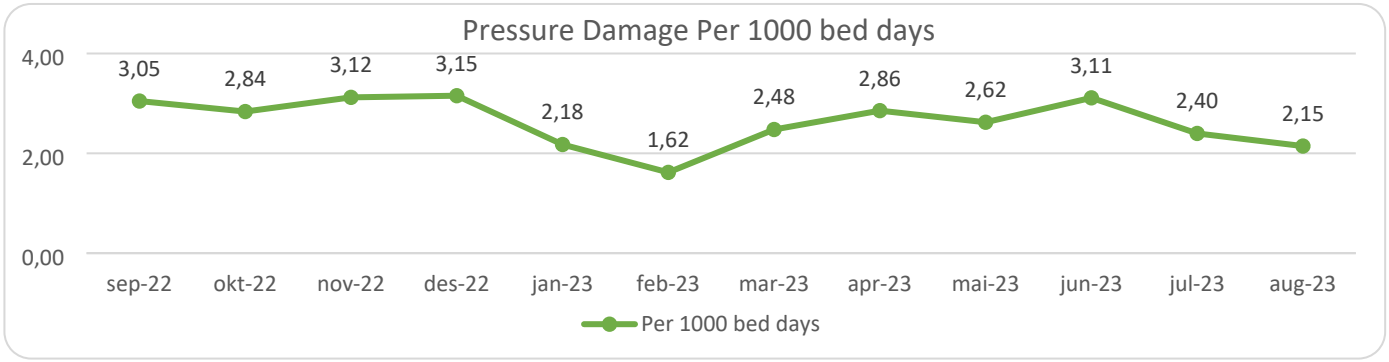
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.3.3 Pressure Damage

Between the 01.07.23 and 31.08.23, a total of 966 pressure damage incidents were reported, of which 447 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (519) were reported as being present before admission to this clinical care area/caseload.



Of the 447, identified as developing or worsening during current caseload, 180 were identified as occurring within the community. This represents a decrease of 103 when compared with the previous two months.



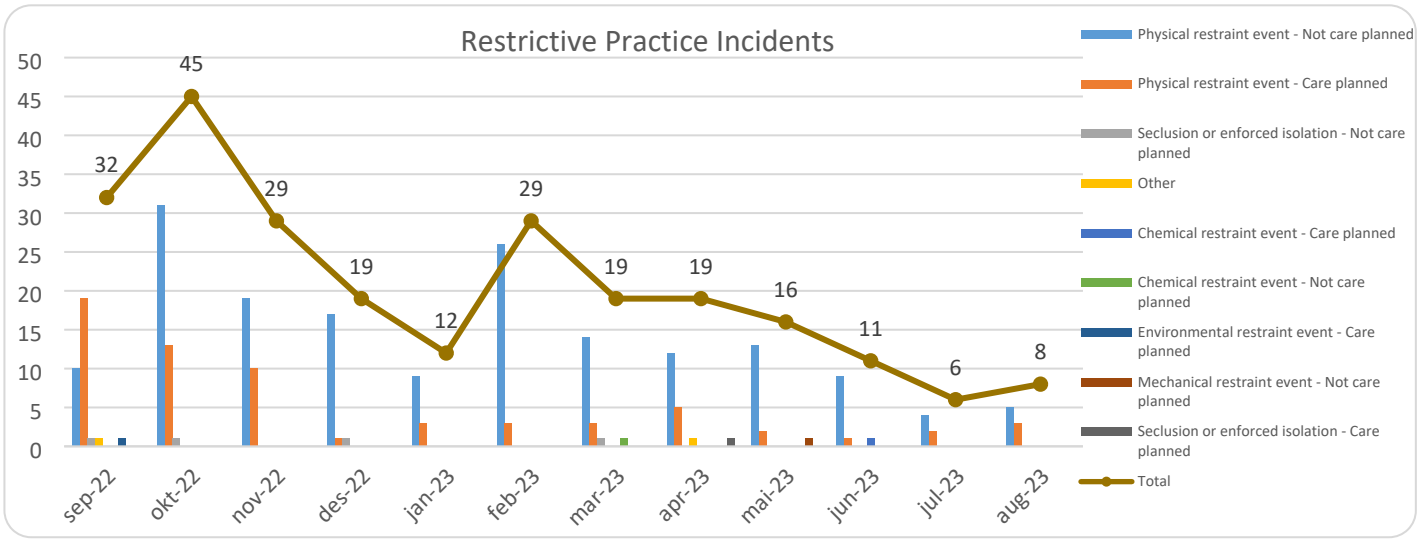
The pressure damage improvement continue to progress with a particular focus on grading of pressure damage and completion of required documentation.

2.3.4 Mental Health Metrics

Number of Section 136 (Mental Health Act 1983) Assessments in police cells

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

Restrictive Practices

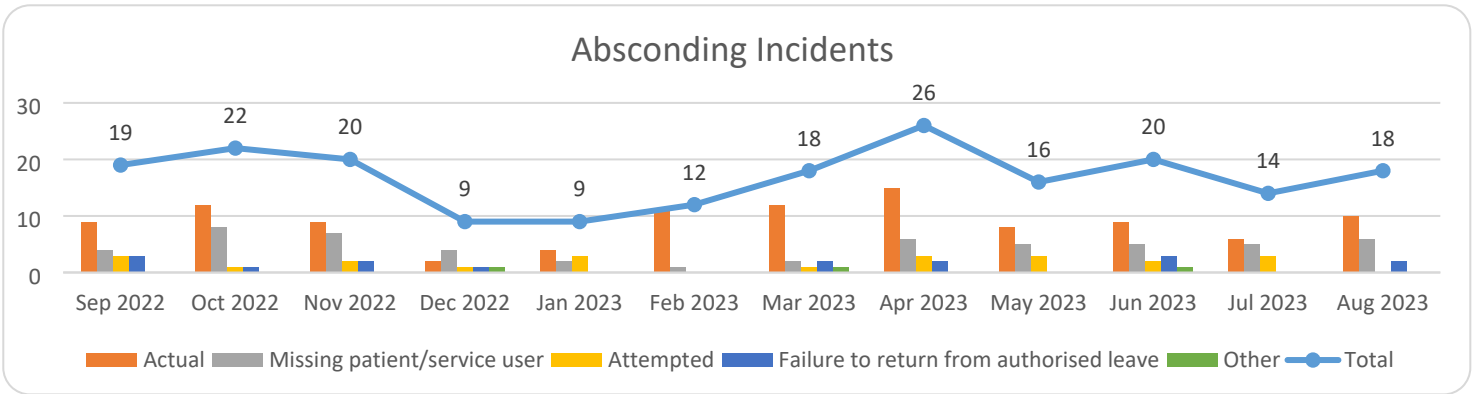


Between 01.07.23 and 31.08.23, a total of 14 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 13 incidents when compared to the previous two months. A reduction in restrictive practice incidents being reported is associated with a training programme and improved awareness in relation to restraint practices that places an emphasis on minimal physical intervention.

Of the 14 incidents, 9 were reported as not care planned and 5 were reported as care planned. The highest number of incidents were reported as occurring at the Psychiatric Intensive Care Unit at Princess of Wales Hospital (5).

<u>Absconding incidents</u>

During July and August 2023, a total of 32 Absconding incidents were reported, a decrease of 4 when compared with the previous 2 month period. 16 were recorded as actual absconding, with the remaining recorded as missing patient / service user (11) attempted (3), failure to return from authorised leave (2). The highest number of incidents were reported as occurring in the Emergency Care Department at Prince Charles Hospital (6).



2.3.5 Community Metrics

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

Palliative Medicine in Pontypridd / Royal Glamorgan Hospital whilst remaining relatively consistent with previous months on other Health Board sites.

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul – 23	Aug - 23
Referral to At Home Services (All Referrals)	128	119	125	138	121	145	182	127	179	180	134	158
Princess of Wales Hospital, Ward 21 (ALOS)	22	39	48	33	23	21	20	55	45	44	53	37
Ysbyty Cwm Cynon (ALOS)	64	57	56	72	80	74	50	64	56	51	47	52
Ysbyty Cwm Rhondda (ALOS)	62	80	68	73	72	79	62	76	69	74	53	93
Palliative Medicine, Bridgend (ALOS)	24	19	23	18	16	18	11	30	17	13	15	14
Palliative Medicine, Pontypridd/RGH (ALOS)	8	11	7	6	10	7	9	5	10	10	7	16
Palliative Medicine, YCC (ALOS)	4	25	28	24	25	18	23	38	37	10	26	21

2.5 Patient Experience Initiatives

2.5.1 Carers

The carer's coordinator role is funded by the Welsh Government on a yearly basis. There is a review underway of the carer's co-ordinator role, which is currently vacant, to ensure the role meets the parameters set by Welsh Government as well as the needs of the Health Board. Whilst overall progress is slow due to the vacancy, work is being undertaken i.e. meeting with Heads of Nursing across the three Emergency Departments (ED) to understand how the Health Board carers information leaflets are embedded and provided to unpaid carers who attend the ED with the person they care for.

Attendance at strategic meetings continues with stakeholders across the community and the Health Board through the Health Board Carers Steering Group. Locally focused work streams are in place: PALS teams coordinate and facilitate 'care to share clinics' with patients, families and carers and signpost to available support.

The Carers Champions network has been reinstated due to the above support with the initial meeting held in July 2023 and will continue to be taken forward by the People's Experience Team.

Work also continues to develop the short break funding that the Welsh Government has allocated via the RIF, which will also be discussed in the next Carers Steering Group.

2.5.2 Chaplaincy Support

Delivery of training sessions to student nurses, midwives, and newly qualified nurses is embedded as part of their induction program. The team has also developed competencies for

paediatric spiritual care champions in line with the Welsh Universities Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care (EPICC) program.

The chaplains were called upon to support clinical staff and families following two 'traumatic' deaths. This entailed providing them with emotional and spiritual support due to differing cultural and religious practices. The demographics of the catchment area are changing rapidly, to ensure we are able to provide multi-faith support, the team is exploring recruitment of differing faith leaders through the staff bank.

2.5.3 Bereavement

Following a review of a gap analysis undertaken of the Welsh Government Bereavement Framework, the Clinical Bereavement Lead continues to work with departments to give assurance on compliance, developing processes, and pathways thus enhancing people's experience within the services provided by the Health Board.
A number of documents have been created to support patients/families and staff such as:

- Adult Bereavement Booklet - reviewed and updated to reflect clear/concise wording, encompassing signposting to bereavement support in the community setting. Currently being reviewed before the booklet is sent for printing.
- Bereavement checklist - created for staff to aid appropriate care after death procedures. Currently being reviewed before sending to policy board.
- Paediatric bereavement booklet currently being created with input from service.

The Health Board website has been updated to reflect the bereavement support available in the community.
The Clinical Bereavement Lead has provided support for families who have suffered difficult and traumatic losses to ensure they are supported and signposted to appropriate bereavement support and enable memory making such as fingerprints, aching arms bears, To Wish support etc.

2.5.4 Patient Feedback Volunteers

The volunteer team continues to engage with the public to explore opportunities to increase the number of volunteers within the Health Board with face-to-face information sessions taking place. Further meetings were also held in June 2023 with the Occupational Therapist on the rehabilitation ward at Ysbyty Cwm Rhondda (YCR), to look at replicating the gardening therapy project with inpatients.

Following the success of the volunteers in the Emergency Department, Princess of Wales Hospital, this service is being extended across the other Emergency departments. Access to a specific volunteer handbook is available to support this role on-site and regular face-to-face support sessions to review the service have taken place.

Volunteers Week took place 1st – 7th June 2023 and articles, volunteer stories thanking our volunteers for their continued support and dedication were promoted via social media and Community Volunteer Centres.

In June 2023, interviews, Disclosure Barring Service (DBS) checks and inductions took place for Bliss Volunteers who will be providing support within the Neo-natal Special Care Baby Unit (SCBU) departments at Princess of Wales Hospital and Prince Charles Hospital. A further local orientation was undertaken with the volunteers and the Senior Nurse Manager for neo-natal care, and shifts will be coordinated once DBS clearance has been confirmed.

A further ward/activities volunteer was also identified during the information session and interviewed in June 2023. A local orientation is planned in August 2023 with the Activities Coordinator.

Interviews and inductions were held in July 2023 with a further two Cariad Pet Therapy Volunteers who will be visiting the Angleton Dementia Unit at Glanrhyd Hospital and Child Adolescent Mental Health Services (CAMHS) Unit at Ty Llidiard, Princess of Wales. A local orientation will be arranged at the units in August 2023.

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 is underway to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Work is required to ensure data from the range of Health Board systems included in this report are consistently captured and appropriately validated.
- Improving and maintaining compliance with the 30 working days complaints response rate.

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 *(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: 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) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

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

14/08/2023

	Alerts as at: 14/08/2023	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

14/08/2023

Notices as at: 14/08/2023												
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	Non-Compliant	Compliant	Compliant	Compliant	Compliant	N/A

Agenda Item
7.1d

Quality & Safety Committee

CIVICA Update

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Commercially Sensitive
Awdur yr Adroddiad / Report Author	Becky Gammon/Sam Connell
Cyflwynydd yr Adroddiad / Report Presenter	Sam Connell, Senior Project Manager
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	
PROMS	Patient Reported Outcome Measures
PREMS	Patient-Reported Experience Measures
VBHC	Values Based Healthcare
FREMs	Family Reported Experience Measures

WREMs	Workforce Reported Experience Measures
HB	Health Board

1. Situation /Background

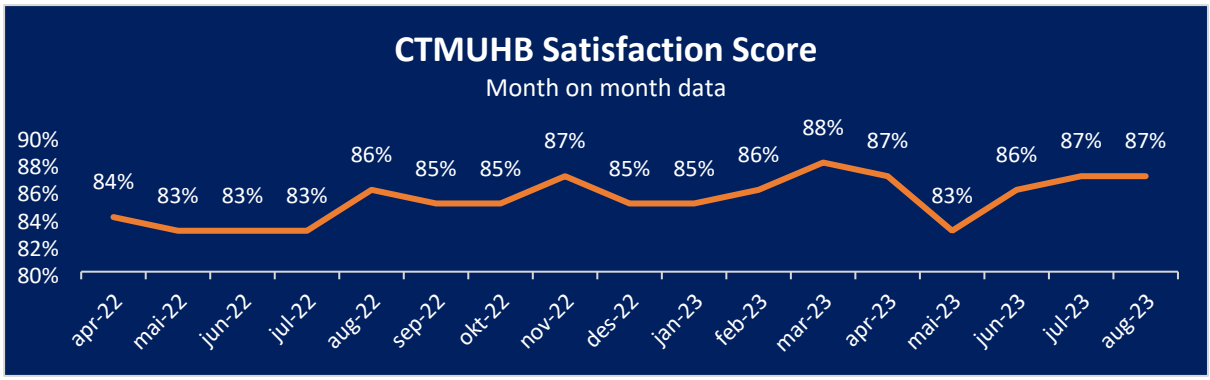
1.1 CIVICA was procured and rolled out across Wales in 2020 with a primary function to support Health Boards to introduce a patient feedback mechanism and to enable the communities to have a voice and influence service improvement through analysis of qualitative and quantitative data.

2. Specific Matters for Consideration

2.1 To date, 206 members of staff have access to the surveys on Civica. A total of 376 members of staff have received training, with further training identified as CIVICA is rolled out across the Health Board (HB). Currently, there are 102 surveys available on CIVICA with 32 added this month alone, covering a number of clinical areas capturing Patient-reported outcomes measures (PROMS) and Patient-reported experience measures (PREMS).

The below graph illustrates the overall satisfaction scores from all surveys combined. It is noted there is a slight fall to 85% between the months of April 2022 and July 2022, then dipped again in May 2023. This has now increased to 87% which has been maintained for the past 2 months.

To identify the themes, the system can undertake keyword replication analysis. 'Helpful' was the most commonly used word by patients (263 times) and 'helped' was another word used frequently (182 times). Words commonly used in negative comments about non-clinical service quality include food & and beverages, facilities, and comfort. A cross-section of some commonly cited words and phrases can be seen below.



To encourage and support service users to leave feedback, as well as the Civica system, Friends and Family Test toolkit and distributing hard copies of Have your say posters and feedback cards, in January 2022, the Health Board introduced an electronic version of the 'have your say' onto the CIVICA system using a digital QR code that can be scanned and allows immediate digital access to the surveys. A standard set of questions are used to support this which allows individuals to identify which specialty they have interacted with and to leave feedback via a standardised set of

questions. The advantage of using 'All Wales questionnaire', is that it enables the HB to draw on comparators across all specialties across the whole of Wales.

The patient Advisory Liaison Service (PALS) teams are developing a process to support "live" patient feedback on a rolling program across the various sites using MSM form which will complement "Have your say" and the wider National Civica feedback initiatives. This will support face-to-face discussions and feedback opportunities that will allow issues raised to be actioned at the time they are raised and support patient feedback driving service improvement.

3. Key Risks / Matters for Escalation

3.1 In order to gain an accurate insight from the data provided, the Health Board needs an automated structure that will allow the sending of SMS messages that provide a link to the specific patient survey as soon as a patient has interacted with our services. This, in turn, will increase accessibility and uptake of patient feedback.

3.2 Currently, there has only been the capacity to automate 9 surveys due to IT and staffing capacity to manage this. This is impacting the amount of data the Health Board is able to receive and utilise.

4. Assessment

The CIVICA system has enabled the opportunity for the Health Board to engage and develop the trust of our communities by ensuring they have a voice and remain at the heart of what we do, and will benefit from strategic support for governance, assurance and reporting. This area of work will be supported by the CTMUHB VBHC Team to raise awareness of patients, citizens and staff, and increase uptake and completion rates across our hospital sites and specialties.

The ability to learn from and benchmark our services not only within the Health Board but across Wales is an even greater step that can be utilised to improve our services, learn, and grow and ensure we are delivering against the new Duty of Quality.

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 *(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 updated paper from work undertaken.
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:	If no, please include rationale below: This is an updated paper from work undertaken.
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

To note the paper and recognise the systems that are in place to collect, analyse, and present service user feedback.

6. Next Steps

To continue with the roll out of Civica and support the generation of new surveys. Review and analyse the data and uses of the digital Have Your Say and support the PALS teams with face-to-face patient engagement.

Agenda Item
8.1

Quality & Safety Committee

MATERNITY & NEONATAL IMPROVEMENT PROGRAMME
TRANSITION PLAN PHASE 3

CLOSURE OF MATERNITY & NEONATAL IMPROVEMENT PROGRAMME

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre, Director of Midwifery & Nursing, Children & Families Care Group Leanne Richards, Clinical Improvement Lead Nurse – Neonates
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery & Nursing, Children & Families Care Group
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**
Maternity and Neonatal Safety Board	20/07/2023	Approved

Acronyms / Glossary of Terms	
IMSOP	Independent Maternity (& Neonatal) Scrutiny & Oversight Panel
IPAAF	Integrated Performance, Assurance & Assessment Framework
MNIB	Maternity & Neonatal Improvement Board
SEC	Safe & Effective Care
QLM	Quality of Leadership & Management
QSPE	Quality, Safety & Patient Experience
QWE	Quality of Women's Experience

1. Situation /Background

1.1 This transition plan outlines the elements of the Maternity and Neonatal Improvement Plan that have been progressed and completed sufficiently to transition from Programme to Operational 'Business as Usual' arrangements.

1.2 Phase 1 of this work involved the closure of the Quality of Women's Experience (QWE) work stream by the Maternity and Neonatal Improvement Board (MNIB) in May 2022. Quality of Women's Experience was also recently assessed according to the Integrated Performance, Assurance and Assessment Framework (IPAAF) by both the Independent Maternity (& Neonatal) Scrutiny & Oversight Panel (IMSOP) and Health Board as exemplary in August 2022.

1.3 Phase 2 approved the closure of the Maternity and Neonatal collaborative work stream due to work progressing as 'one team'.

1.4 Phase 3 requests the Board approve the closure of the Maternity and Neonatal Programme to 'Business as Usual' arrangements

2. Specific Matters for Consideration

2.1 The Wash Up plan provides assurance for outstanding longer term actions of the Maternity and Neonatal Improvement Programme and continuous improvement monitoring for those actions already completed.

2.2 A Maternity and Neonatal Escalation Framework (v7.0) details the arrangements in place to ensure robust Quality, Safety and Patient Experience monitoring, scrutiny and oversight.

2.3 There is sufficient sustainable resource within the Maternity and Neonatal Workforce to maintain effective reporting, investigation, scrutiny and oversight.

2.4 The Director of Midwifery will remain as the lead for QPSE within the Children and Families Care Group. Together with the Care Group Medical Director and Service Director, the Maternity and Neonatal Programme Board will maintain oversight and monitoring of any programmes of work as identified within the Maternity and Neonatal Assurance Framework.

3. Key Risks / Matters for Escalation

3.1 No further risks identified.

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: Creating Health Sustaining our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Starting Well
	If more than one applies please list below: Growing 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: Learning, Improvement & Research Culture & Valuing People Leadership
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 Effective Efficient 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: This paper is not a guideline or policy.
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:	If no, please include rationale below: This paper is not a guideline or policy.
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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 Endorse for Board Approval the Closure of the Maternity & Neonatal Improvement Programme Board.

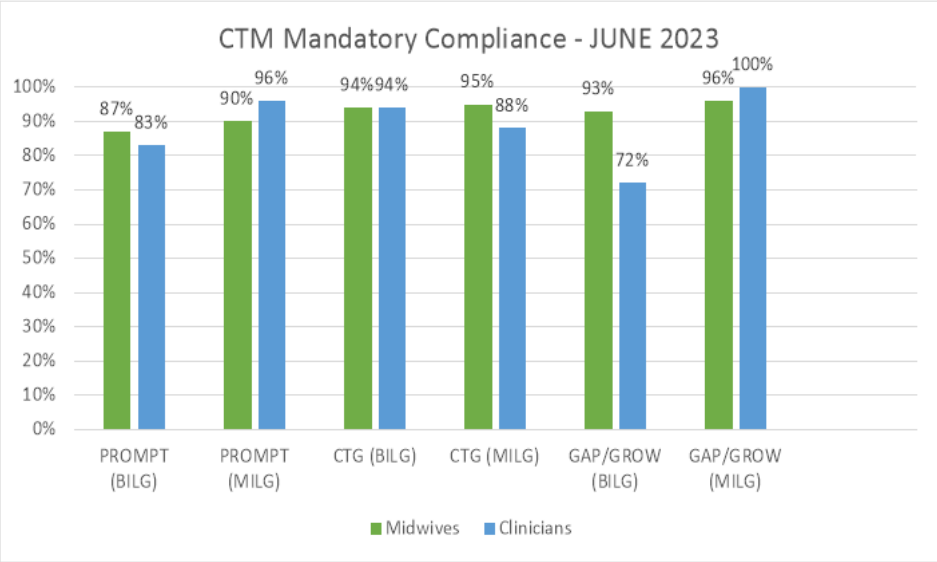
6. Next Steps

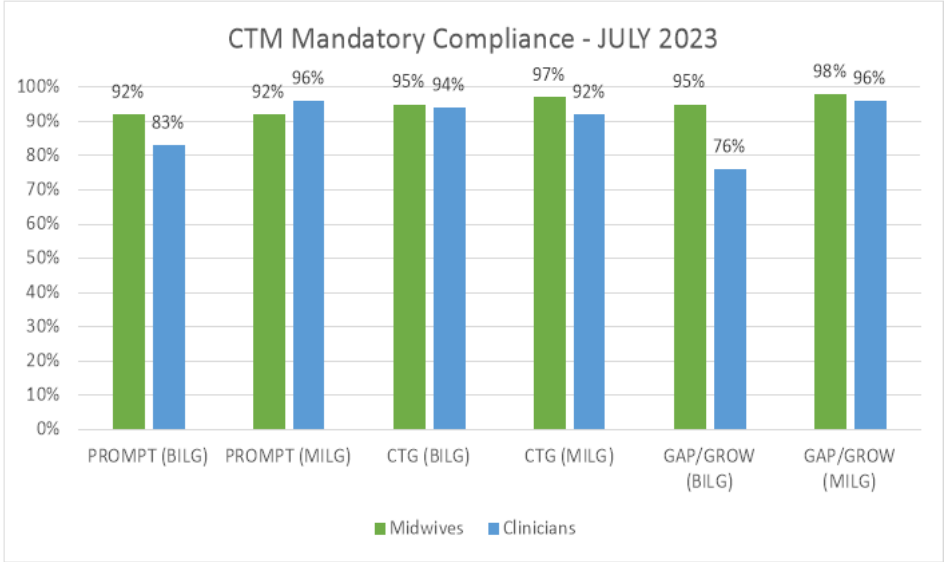
6.1 The remaining work will transition into the 'Wash Up' plan with oversight and scrutiny provided by the responsibilities set out in the Maternity and Neonatal Assurance Framework.

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

Cwm Taf Morgannwg Maternity & Neonatal Metrics Quality & Safety Committee September 2023

Maternity Training & Workforce

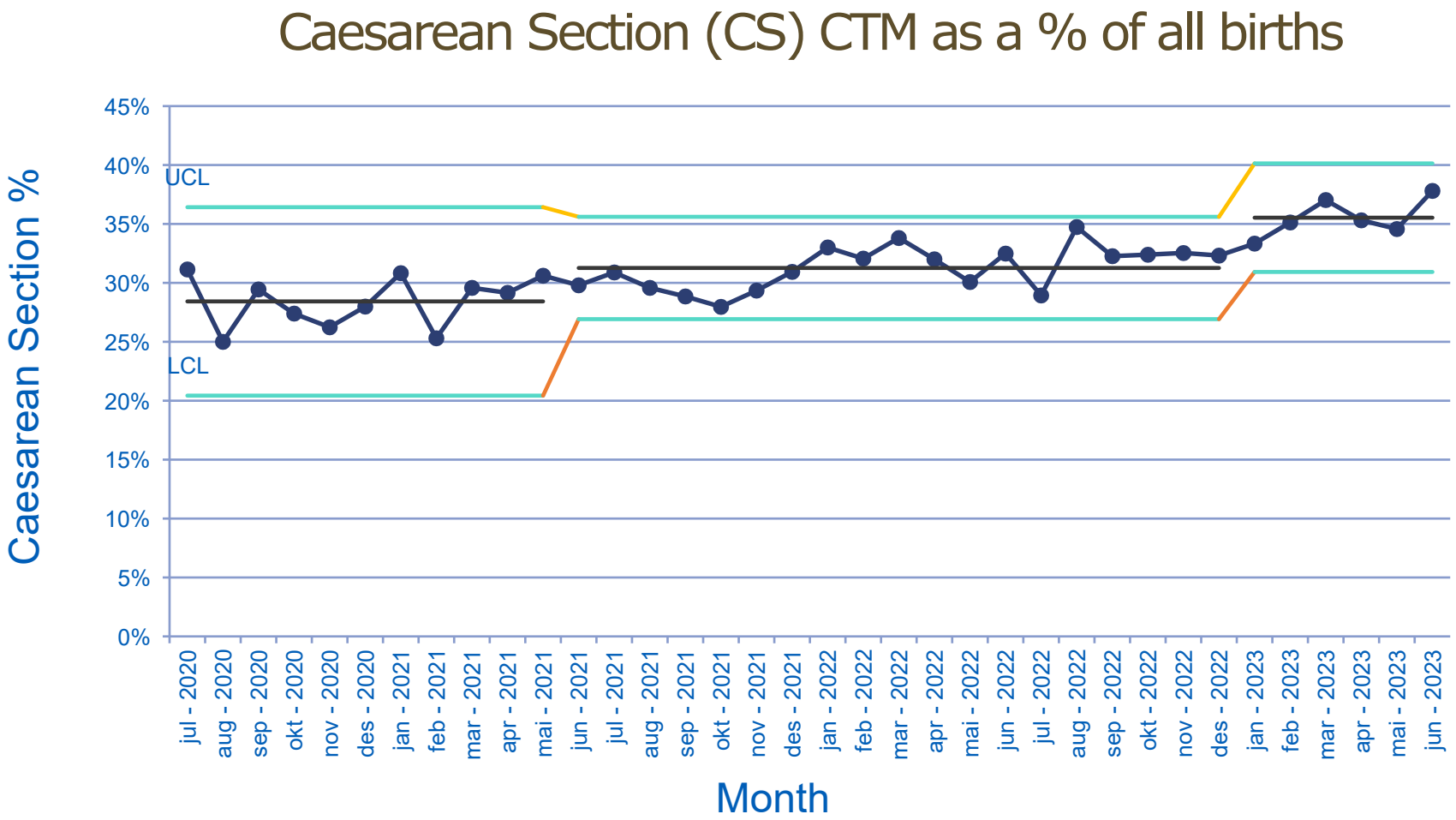




Midwifery Workforce

- 21.4 wte RM vacancies
- 20 Newly Qualified Midwives starting September 2023 (@16 whole time equivalent).
- BR+ 2023 workforce modelling underway to explore alternative ways of working to meet population health needs / obs theatre cover

Rate of Caesarean Section (all categories)



The median CS rate has shifted from 31% in July 2020, to 35% (as of January 2023).

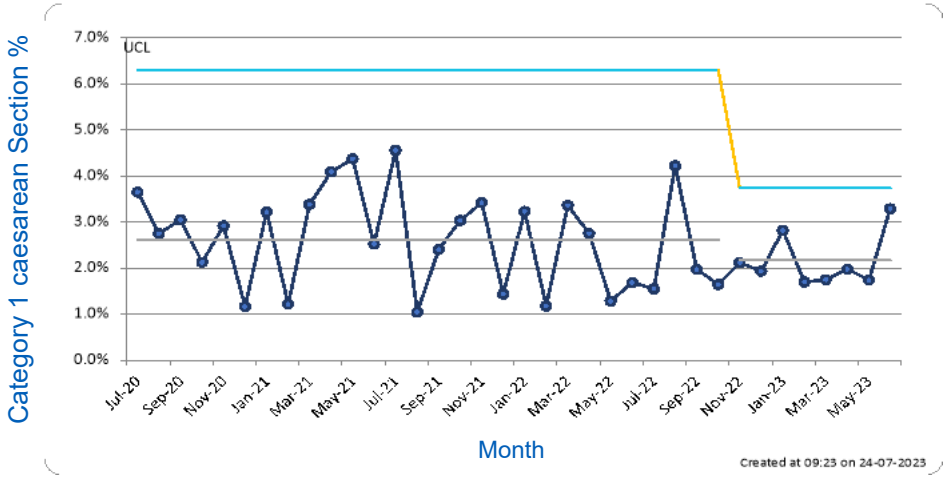
In June 2023, the rate was 38% - the highest it's been.

This is a picture that is emerging nationally in Wales.

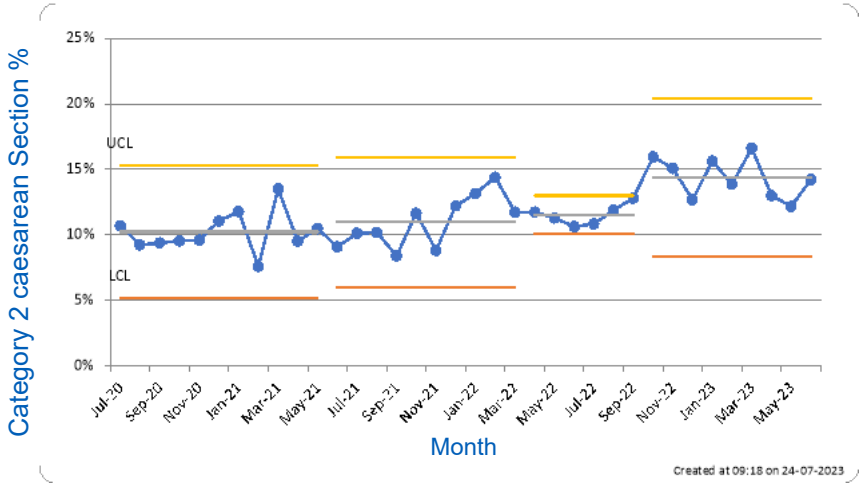
We have linked with colleagues in CaV, ABUHB and HD to work together on understanding the reasons for the rising rates.

The following slide will break this down by category of caesarean section.

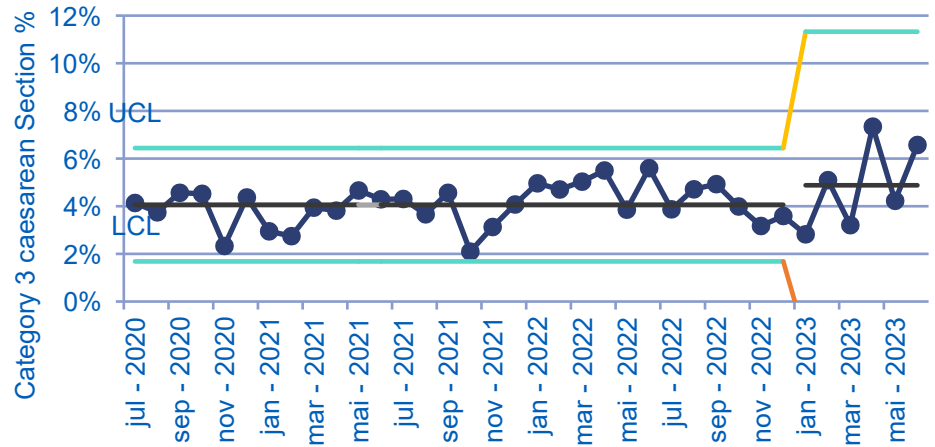
Rate of Caesarean Sections by Category



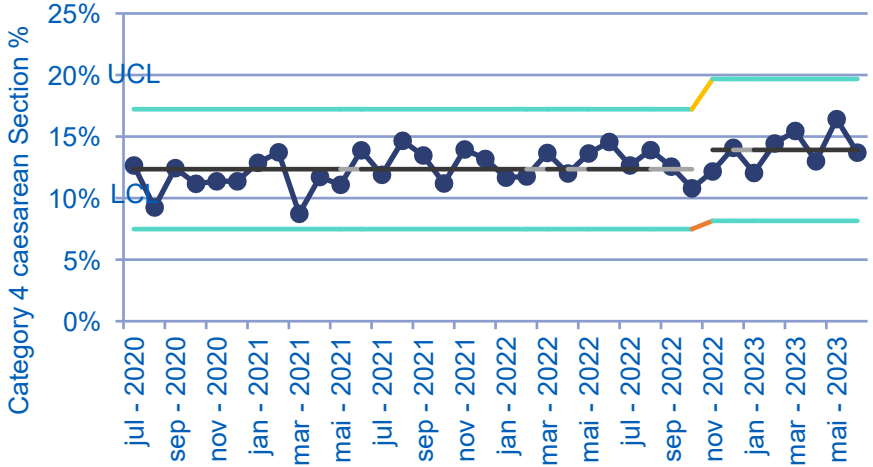
Category 1 CS rates have fallen slightly from a median of 2.6% to 2.1%.



Category 2 CS rates have risen from a median of 10% in July 2020 to 14.8% in June 2023.

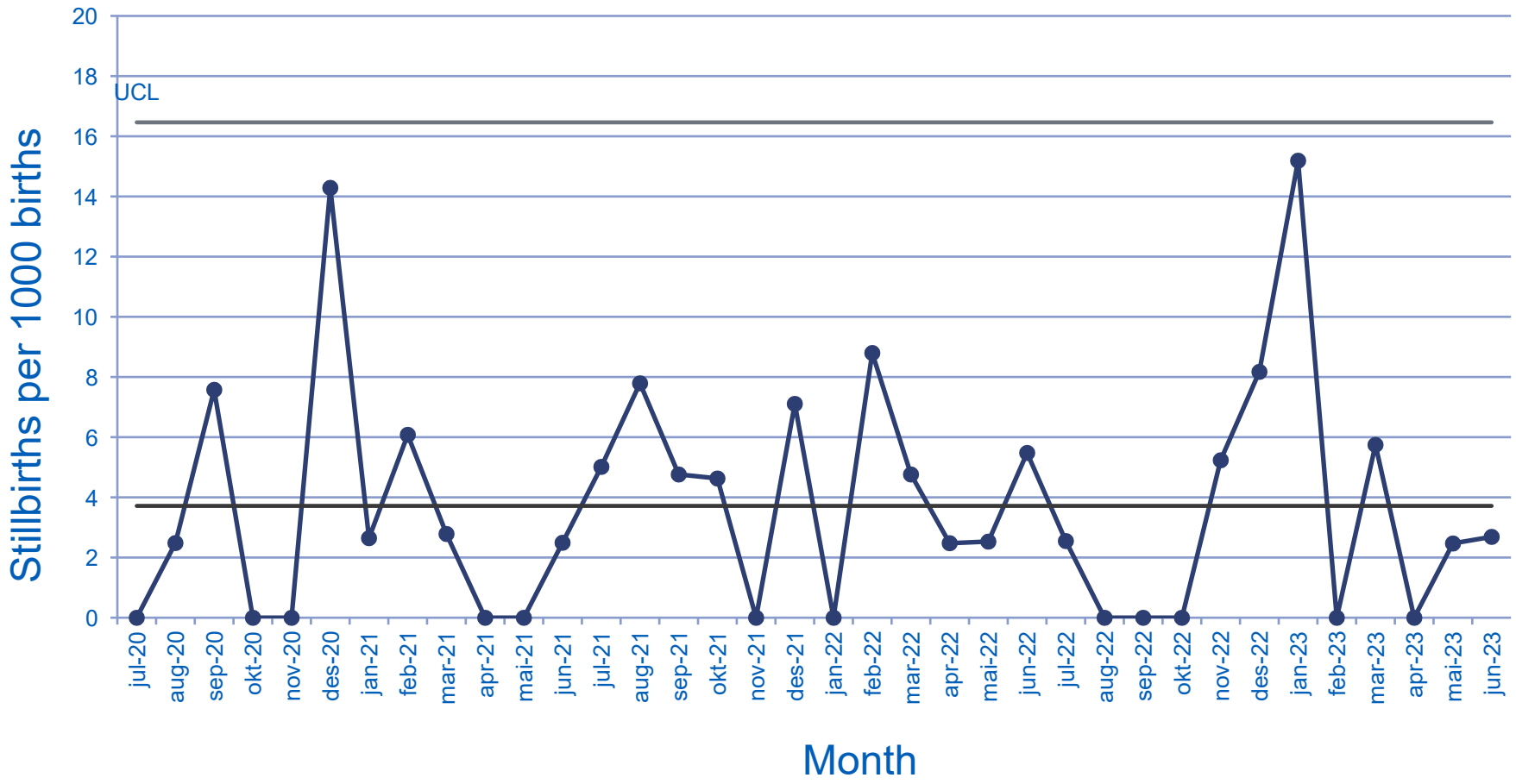


The median rate of category 3 CS has risen from 4% to 5% (since December 2022). The variation in the data is also increasing, suggesting more variation in practice.



The median rate of category 4 CS has risen from 12% to 14% (increase since November 2022).

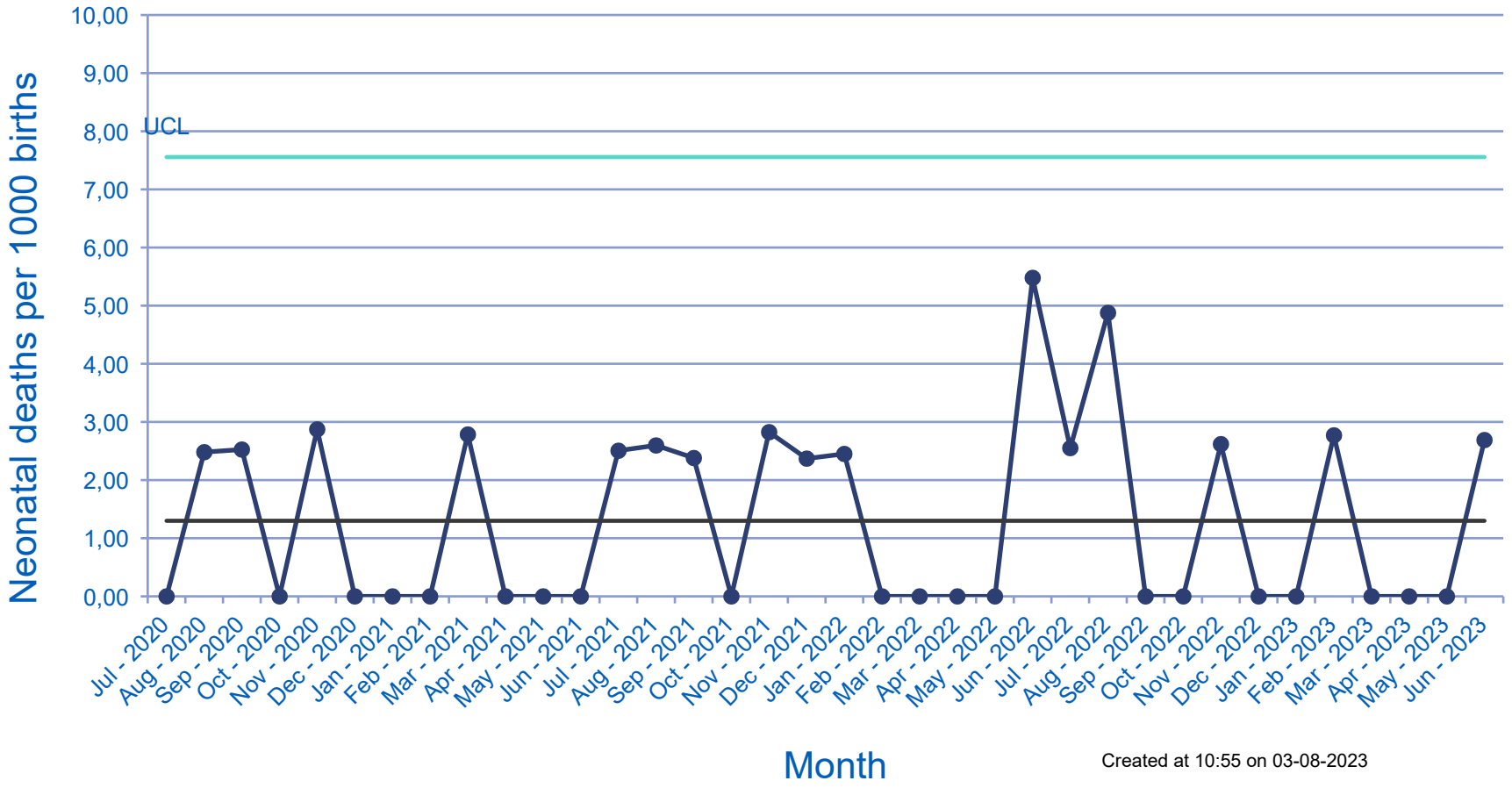
Crude stillbirth rates per 1000 births



The median stillbirths for the last 3 years is 3.7 per 1000 total births.

Per year:
July 20- June 21: 3.19
July 21- June 22: 4.35
July 22- June 23: 3.73

Crude Early Neonatal Death rate per 1000 Births



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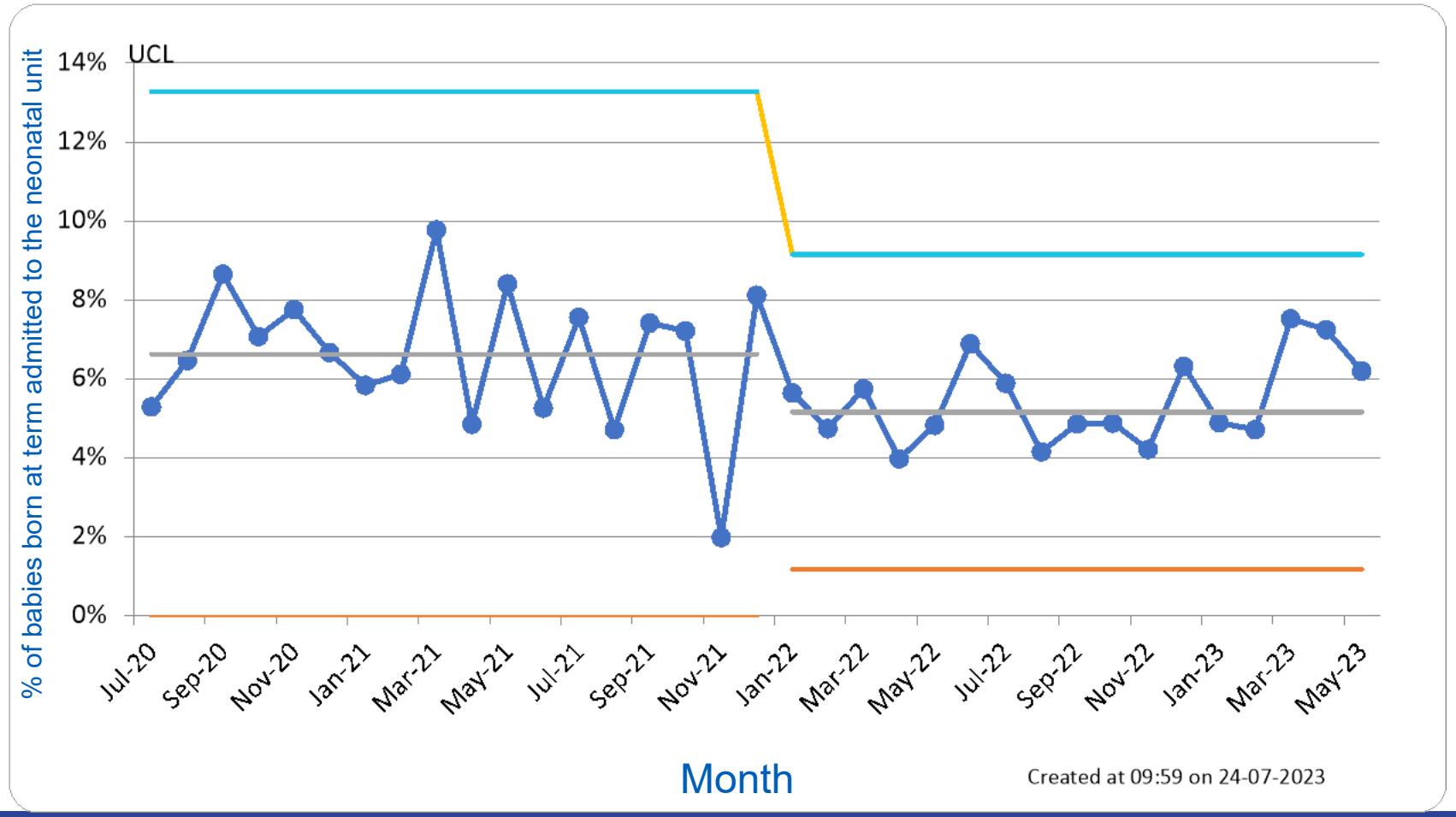
The median crude early neonatal death rate is 1.29 per 1000 births.

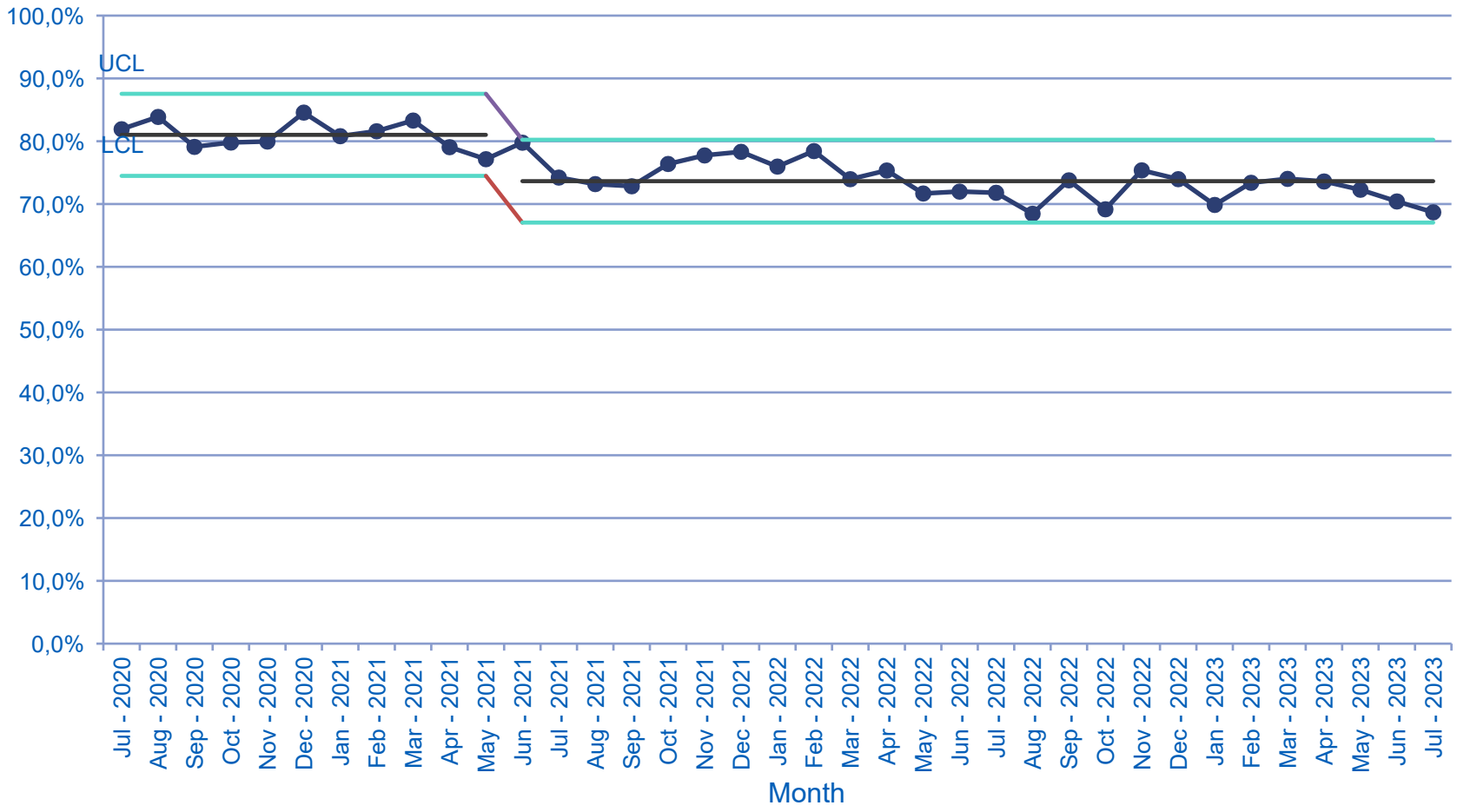
ATAIN: Term Admissions to the Neonatal Unit



The median rate of term admissions to the neonatal unit decreased in January 2022 form 6.8% to 5.3%, which is below the WG target of 6%.

Some months, the admission rate is above 6%. To have an admission rate of below 6% consistently every month is the ongoing aim of the continuous improvement programme.

Bookings by 10 completed weeks gestation July 2020- June 2023



The median rate of bookings by 10 weeks gestation decreased in May 2021 from 81% to 73%

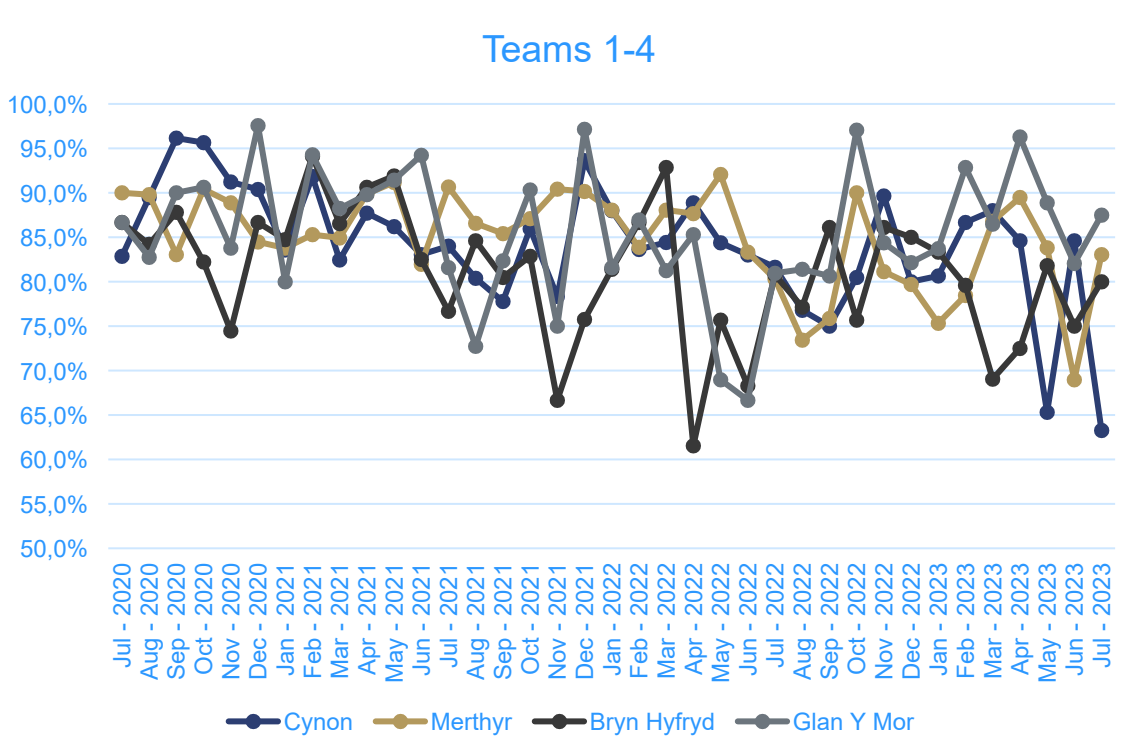
The digital self-referral booking system was tested in late June and fully launched in July 2023, with the expectation that it will result in improvement in rate of bookings by 10 weeks.

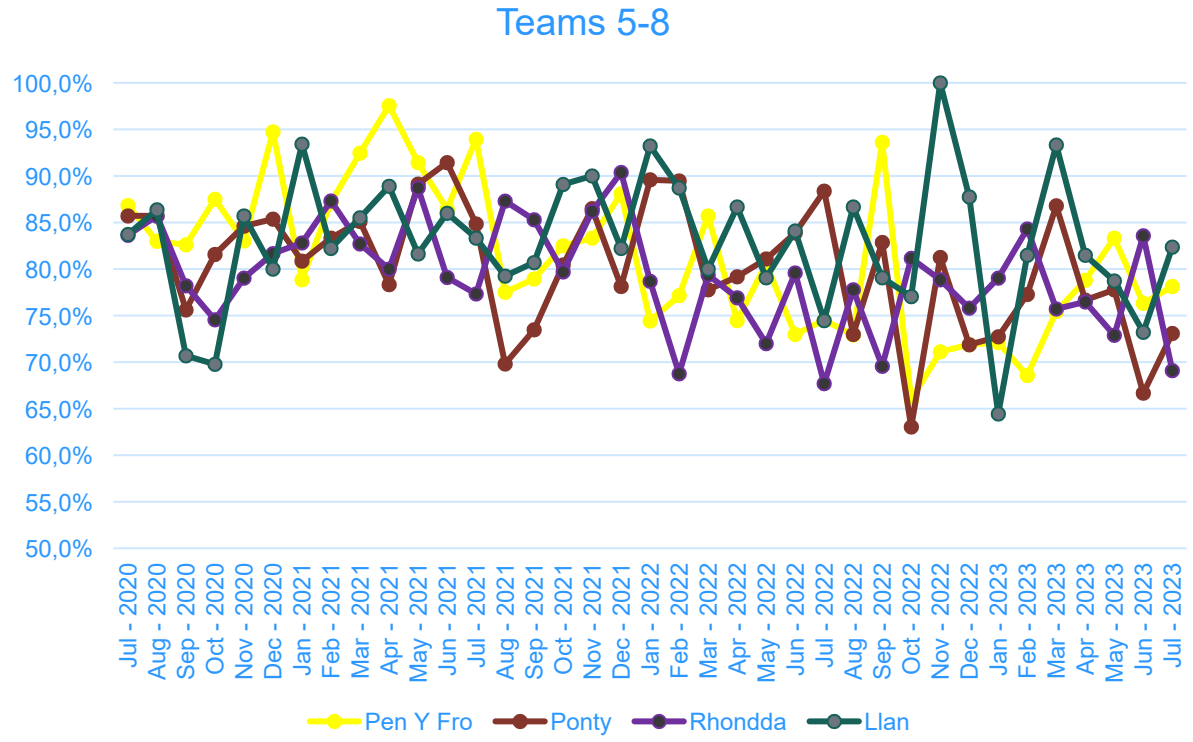
The digital self-referral system also allows for much closer monitoring of booking practices, with targeted QI.

The system is monitored weekly by community team leaders. Any booking which has not been accessed by a community midwife within 1 week of receipt or any booking where the receipt to booking appointment interval is greater than 14 days
will be addressed with the responsible midwife.

A communication campaign has also been launched to advise women of the importance of early booking.

Bookings by 10 completed weeks gestation by community midwifery team July 2020- June 2023

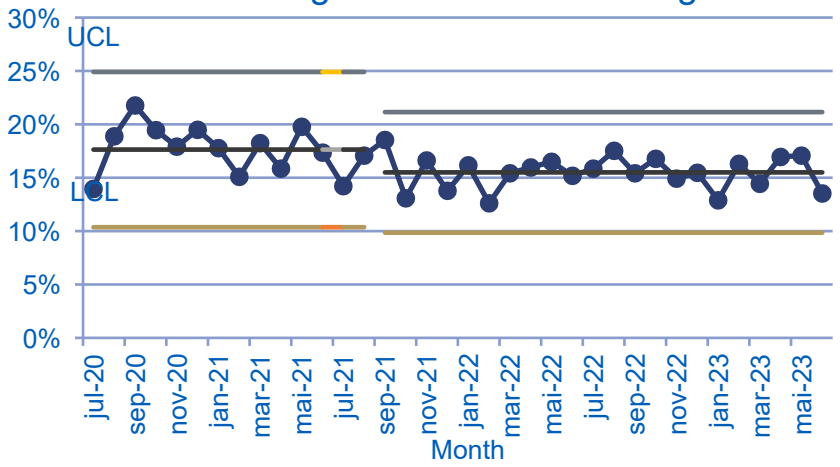




The eight community midwifery teams performance against booking by 10 weeks gestation has been split into 2 charts, as 1 chart was too busy. Analysing the data by team allows for a better understanding of where compliance is poor and for more targeted Quality Improvement work. All teams show a high month-to-month variation. Some teams vary between 60% and 95% monthly compliance. Bookings by 10 completed weeks is a part of a wider programme of community QI work.

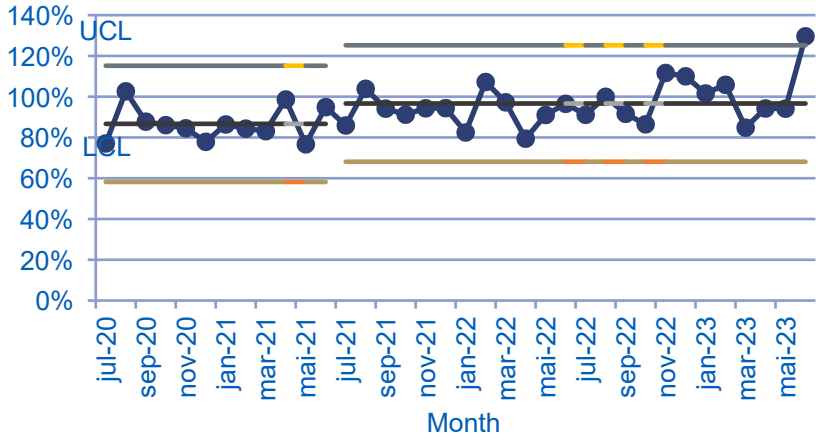
Smoking Cessation Data

Smoking at the time of booking



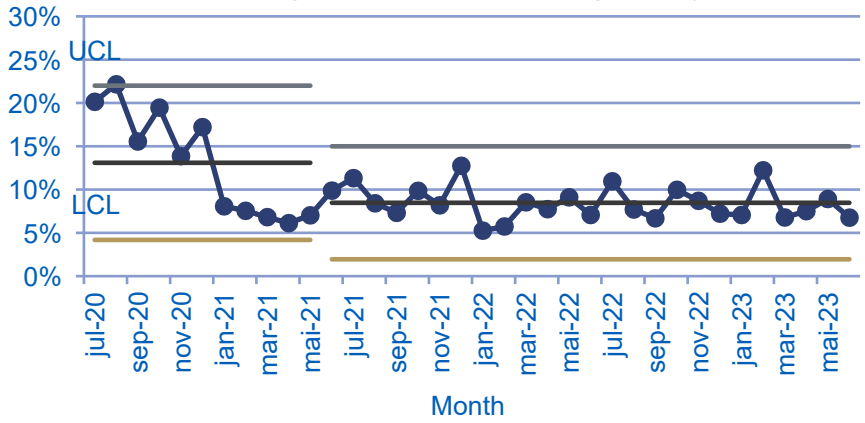
The rate women smoking at the time of booking has decreased from a median of 17.6% to 15% (as of September 2021). Vaping/ E cigarette usage is not currently captured.

Referrals to Help Me Quit for Baby



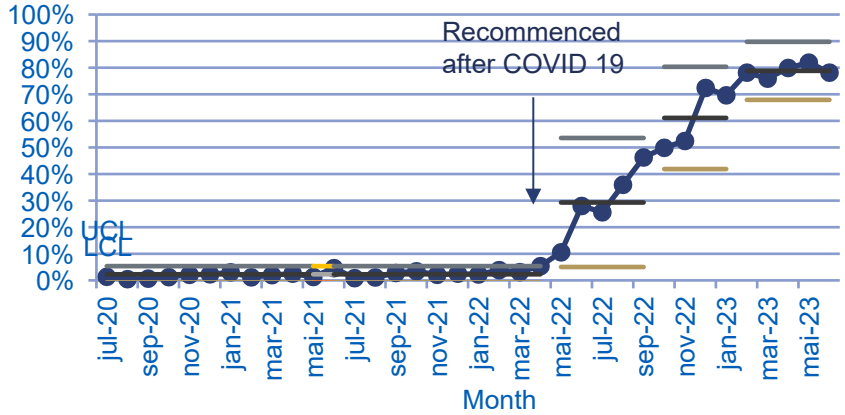
Referrals to Help Me Quit for Baby are increasing. There are many points above 100% due to re-referrals.

Smoking at the end of pregnancy



The rate women smoking at the end of pregnancy has decreased from a median of 13% to 8.4% (as of June 2021). Vaping/ E cigarette usage is not currently captured.

CO Monitoring at Booking



There has been good recovery of CO monitoring at booking since re-commencement following COVID 19 restrictions. The rate now surpasses pre-covid levels. The aim is 100% and is subject to ongoing QI.

Neonatal Data

Prince Charles Hospital

What Went Well..

- No exception reportable births.
- No term admissions for suspected infection.
- No hypothermic babies admitted to the neonatal unit.
- No unplanned extubations reported

What needs to improve..

- Term admissions at 8% for the months of May and June
- Respiratory distress remains the most common reason for admission of term babies
- % of parents receiving a consultation with a senior doctor within 24 hours of their baby being admitted to the neonatal unit

Ongoing projects..

- Breastfeeding & Golden Drops
- Themoregulation
- Peri-Prem (perinatal optimisation) – Quad team established, work well underway.

Princess of Wales Hospital

What Went Well..

- No term babies admitted with hypoglycemia or suspected infection.
- Number of term admissions returned to 'average' after two months of exceptionally high term admissions. NB- the neonatal unit was closed for 1 week in June
- No exception reportable admissions.

What needs to improve..

- % of term admission
- Respiratory distress remains the most common reason for admission of term babies (87.5%)
- % of babies discharged receiving breast milk at discharge (breast/bottle/nasogastric) continues to be low (33%)

Ongoing projects..

- Breastfeeding & Golden Drops
- Themoregulation
- Peri-Prem – Quad team established, work well underway
- Transitional Care QI project

Neonatal Data – Admissions outside criteria (June)

Total CTM births: 341

Total (in born) admissios =36 (10.5% of all births)

- Term (in born) admissions = 22 (61% of admissions or 6.5% of all births)
- Preterm births = 14 (4.1% of all births)

Exceptions outside admission criteria:

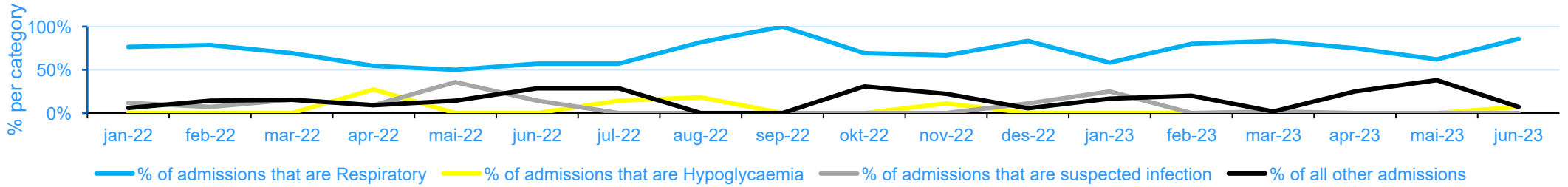
Total admissions outside guidance = 0

- Admissions <32 weeks = 0
- Admissions of multiple births <34 weeks = 0
- Admissions >32 weeks <1.5kg = 0

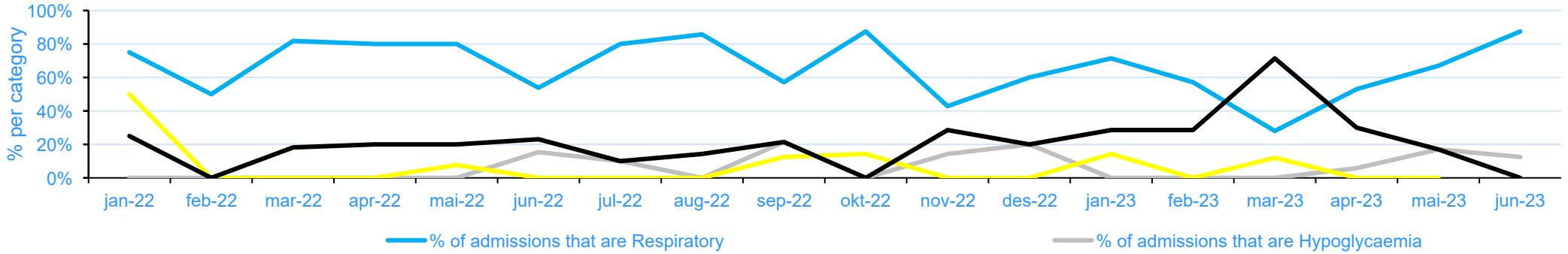
Neonatal Data – Main reasons for admissions >37 weeks (inborn)

Respiratory distress remains the primary reason for admission on both units. All term admissions reviewed as part of Avoiding Term Admissions into Neonatal Units (ATAIN)

PCH =>37 weeks Main Reasons for Admissions

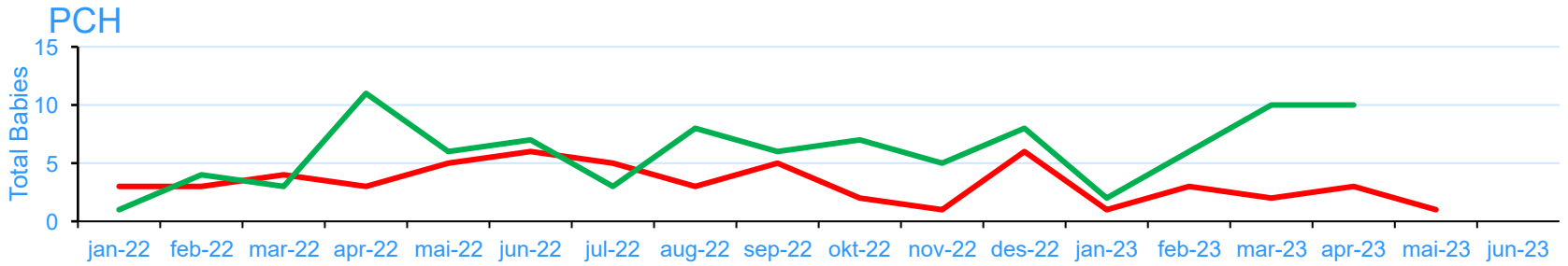


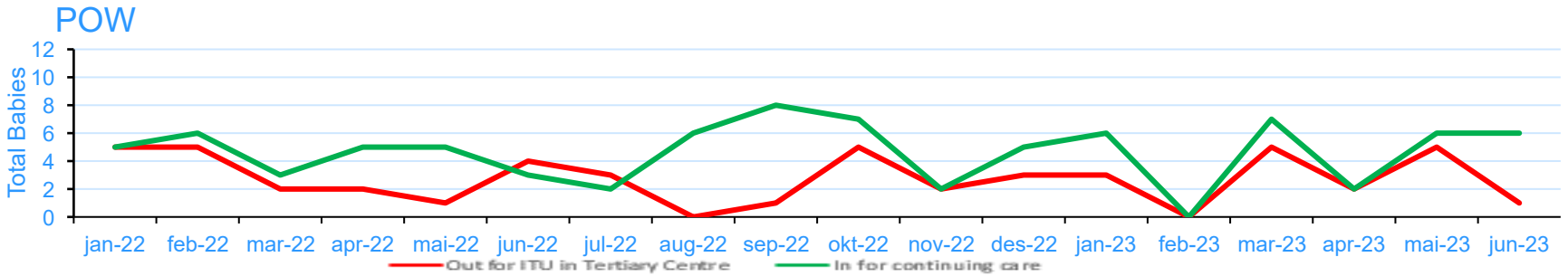
POW =>37 weeks Main Reasons for Admissions



Neonatal Data - Transfers

Transfers out – All babies requiring an increased level of care. Transferred to tertiary centres for intensive care.
Transfers in – Repatriation at the booking unit having delivered or received care at another hospital. Supporting local tertiary centres, babies who no longer require higher level of care are transferred to local neonatal units helping to relieve occupancy pressure



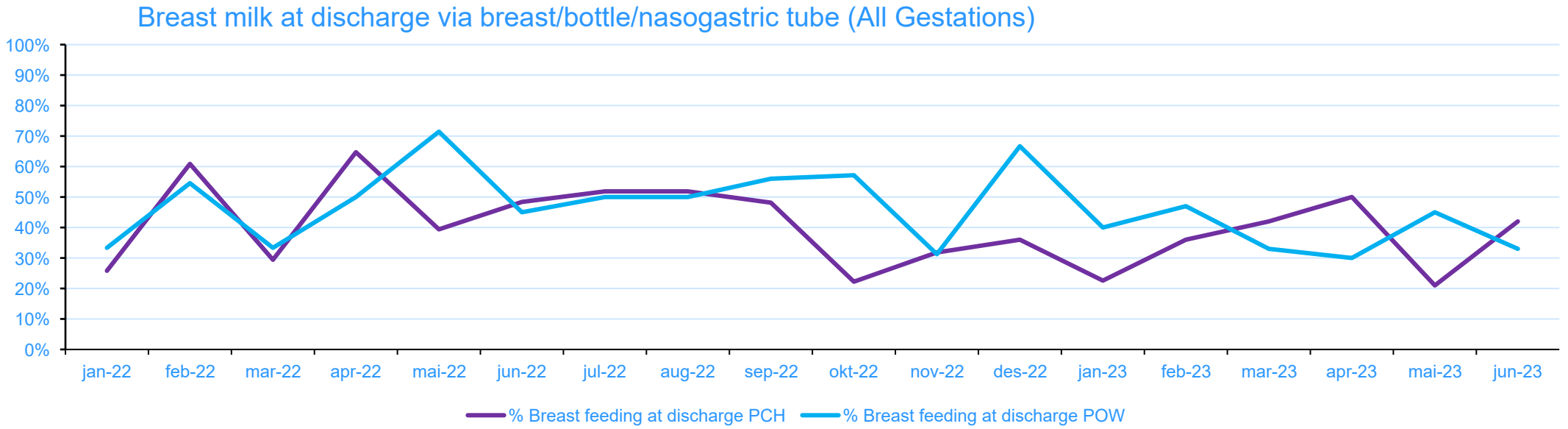


Princess of Wales Neonatal Unit closed for one week in June. Prince Charles Hospital Neonatal Unit primary accepting unit for babies requiring Level 2 care
Both units have supported the tertiary centres with repatriations and accepting babies to relieve occupancy pressure.

Neonatal Data – Receiving Breastmilk on Discharge

Percentage of all babies discharged to either Post natal ward or Home who were breast feeding or receiving EBM.

(Wales range 54.2% - 80% of new mums breastfeed at birth and between 29.4% - 54.1% of new mums who still breastfeed at 10 days)



Breast Feeding at Discharge (All Gestations) to either Postnatal ward or home. This is a percentage of all babies discharged during the month. This is as per feeding data inputted on BadgerNet on discharge summary (Discharge details – Milk at Discharge). All Data sourced through BadgerNet.

Training for staff is facilitated by the Neonatal Infant Feeding Leads. Breast feeding advice and support is part of the training to encourage breast feeding within our neonatal units. The leads also work directly with families to support their feeding needs.

Explanatory Notes

Live Births
Data manually inputted from Qlik app which contains health board Maternity data. Qlik links with other systems to collate data.

Admissions

% =>37 weeks - Wales national target term admissions to NNU 6% (Welsh Government Target)

% All gestations - Annual CTM Average (based on 2020 & 2021 figures) all gestations admitted to NNU = 12%
Annual UK average all gestations admitted NNU = 14% Bliss.co.uk (BadgerNet)

Reasons for Term Admissions

The 3 main reasons for term admissions as documented on BadgerNet by the neonatal team. This is the primary reason for admission.

Exceptions

<32/40 (singletons) - CTM works to a 32 week model for singleton deliveries. All babies delivered in CTM outside of this criteria are documented as an exception.

<34/40 (multiples) - CTM works to a 34 week model for multip deliveries. All babies delivered in CTM outside of this criteria are documented as an exception.

>32/40 and <1500gms - All babies born above >32/40 but are <1500gms are classed as exceptions for reporting

Deaths - split into 2 criteria for data collection - Term =>37 weeks and Preterm =<36.6 weeks
Inclusive of all babies who die in PCH/POW and if they die post transfer to another unit (BadgerNet)

Admission Temperature (All Gestations)

Based on NNAP criteria. All babies should be admitted with a temperature of between 36.5 - 37.5'c. The composite measure of timeliness and normal temperature should be met for at least 90%of babies. (BadgerNet)

Admission Temperature (All gestations) - Based on NNAP criteria. All babies should be admitted with a temperature of between 36.5 - 37.5'c. (BadgerNet)
Hypothermia - All Admissions with temperature below 36.5'c
Hyperthermia - All admissions with temperature above 37.5'c

Parent consultation <24 hours - NNAP criteria is that every parent should have been seen by a consultant/ST3 and above in the first 24 hours post admission. All babies included as per NNAP requirement of >12 hours stay on the NNU. Ratings adapted as achievable targets for CTM. (BadgerNet)

ROP screening - Number of babies discharged in that month, who were <32 weeks gestation or <1501g birthweight and were eligible to be screened in that unit based on NNAP analysis criteria. All (100%) of eligible babies should receive ROP screening within the time windows for first screening. (BadgerNet)

Breast Feeding at Discharge (All Gestations) - NNAP criteria for babies =<34 weeks to achieve 80% being discharged receiving breastmilk. Have applied this criteria to all gestations for our LNU data collection as the optimum target.
All Data sourced through BadgerNet.

Transfers (In/Out) - All babies transferred out for increased level of care e.g. ITU in tertiary centre and all babies transferred into unit from other units for continuing care. (BadgerNet)

Care Days - Care days as recorded on BadgerNet based on criteria set by BAPM for IC, HD, SC and NC (BadgerNet)

Staff Sickness - Nursing, midwifery & health visiting sickness rate average in Wales in 2021 (StatsWales). %
Sickness - Rating based on All Wales statistics. http://www.gov.wales/sickness-absence-nhs

2

Nursing staffing - % shifts with supernumerary shift co-ordinator
Numerator: The number of shifts where there is an allocated supernumerary shift coordinator
Denominator: The number of shifts per month (2 per day)
Displayed as: % of shifts where shift coordinator available
Inclusion Criteria: Shift coordinator in addition to direct care staff to BAPM

% Shifts staffed to BAPM Standards
Numerator: The number of shifts where nurse staffing met or exceeded BAPM recommended staffing levels for activity
Denominator: The number of shifts per month (2 per day)
Displayed as: % of shifts where nurse staffing met or exceeded BAPM recommended staffing levels
Inclusion Criteria: Count of shifts (based on a two-shift model of each calendar day), Staffing rules: 1:1 intensive care; 1:2 high dependency care; 1:4 special care

Agenda Item
8.2

Quality & Safety Committee

Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lloyd Griffiths, Head of Nursing for CAMHS
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards, Director of Therapies and Health Science
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	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advice and Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person
HoN	Head of Nursing for CAMHS
iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
MIHC	Music in Hospitals and Care

NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression
PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
QI	Quality Improvement
SI NRI LRI	Serious Incident Nationally Reportable Incident Locally Reportable Incident
QSRE	Quality, Safety, Risk and Experience

1. Situation /Background

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

2. Specific Matters for Consideration

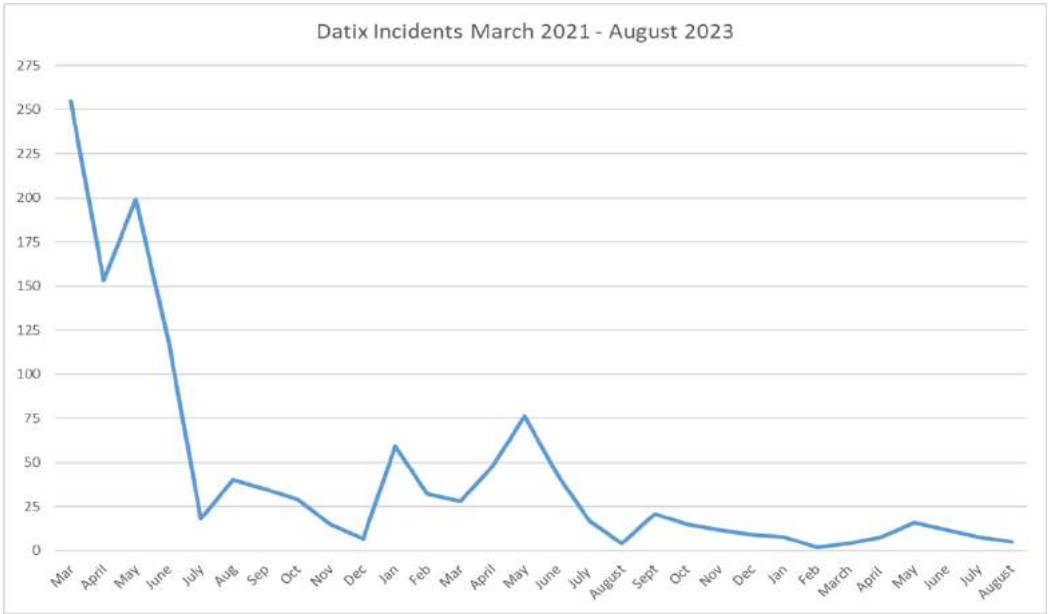
2.1 On 16th August 2023, TL was completely de-escalated by WHSSC to Level 0 - routine monitoring.

Routine performance monitoring meetings will be set up with WHSSC from September 2023 in line with the WHSSC Performance Framework.

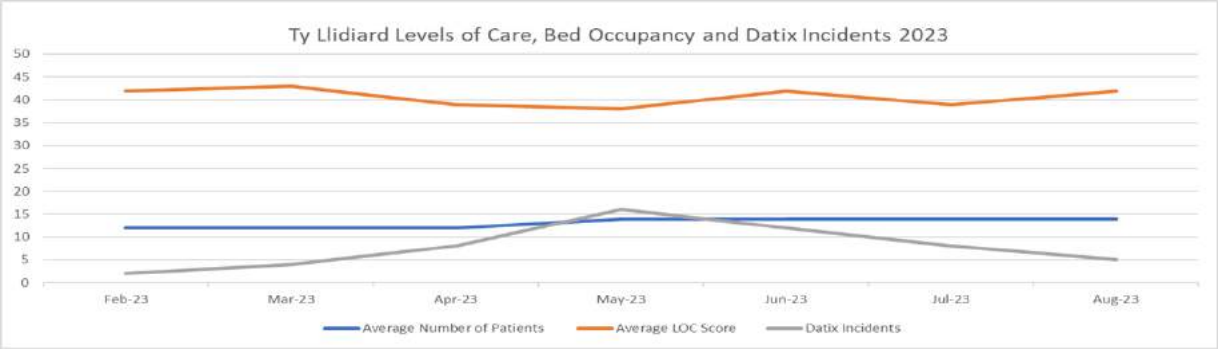
3. Quality Assurance

3.1 Patient Safety Incidents (July and August 2023)

There were 13 incidents reported during this period, compared to 21 in the same period in 2022. All incidents, other than 1 involving a staff accident, were categorised as no/low harm.



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



3.2 Reducing Restrictive Practices

3.2.1 The reduction in restrictive practices continues, with just 1 incident in this reporting period.

3.2.2 The team are delighted to report that Christian Harries and Kirsten Jenkins, two of the TL 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*. Christian and Kirsten will be attending the awards ceremony in Liverpool in November.

3.3 Complaints

3.3.1 There was 1 formal complaint received during this reporting period related to medical treatment, which is in the process of being addressed and will be completed within the target timescale.

3.4 Compliments

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

Ty Llidiard Written Compliments

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

3.4.2 All compliments are shared with the team at Ty Llidiard. There is a board in the staff room where compliments are shared. The team are in the

process of developing a monthly newsletter for colleagues, which will include a compliments section.

3.5 Current open SIs (NRI or LRI)

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

3.6 Ombudsman complaints

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

3.7 Claims/redress cases

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

4. People's Experience/co-production

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

4.2 The TL therapies team continue to work with Music in Hospitals and Care (MIHC) to provide combined music and art therapy groups at TL.

Following on from the success of the creative evaluation session at the end of the last project, where the team combined art activity with live music, MIHC would like to build on this approach by bringing together artists and musicians to deliver each session. It is hoped that this will allow the young people to engage with hands-on creativity while listening to the music.

The TL team have been successful in a partnership bid to Arts Council Wales for a new project. This will allow MIHC to deliver 24 sessions, running on a weekly basis between November and the end of April 2024.

MIHC now have a new Impact and Insight Manager who will be able to support the TL team with evaluation, with the aim of finding creative ways to collect feedback from the young people who attend the sessions.

https://mihc.org.uk/about-us/

4.3 TL continues to engage with people with lived experience to inform the continuous improvement journey.

4.4 The TL team were recently approached by someone with lived experience of TL after they saw a post on Twitter about the improvements. This person has become a healthcare professional and the last report to the committee reported their offer to assist with the improvement work as an Expert by Experience.

The team are now working with this person to co-produce a training manual for TL staff called;

"How to best support patients with eating disorders – from the perspective of former patients"

4.5 One of the first suggestions made by the YP in the community meetings was using animals to improve the programme of activities and in response to this the TL have arranged visits from dogs, rabbits and alpacas.

The latest suggestion from the YP was to bring reptiles into TL. This was arranged in July when a local company brought a collection of reptiles, including snakes, geckos and lizards to TL for the YP and staff to learn about and handle. This was one of the most popular activities the team has arranged.




5. Capital Works /Visual Identity

5.1 Phase 1 of the capital improvement scheme is now complete. This phase has included the creation of a new ward office in the heart of the ward. New furniture has been added to the space adjacent to the new ward office to create a new central square environment to give a safe and comfortable space for YP to sit and to improve communication and

interaction between staff and YP. The YP chose the type of furniture and the colour scheme.

5.2 The internal visual identity work is now complete, with all bedrooms having a door sign that the YP can customise with dry wipe markers.

6. Quality Improvement

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

6.2 The iCTM team have recently delivered the second day of a two day Quality Improvement (QI) training course to new staff at TL.

7. Improvement Board

7.1 An Improvement Board chaired by the Executive Director of Therapies and Health Science (DoTHS) continues to oversee the implementation of changes required to enable colleagues to consistently deliver high quality care and the best outcomes and experiences for the YP and families we care for.

8. Next Steps

8.1 Following full de-escalation, the TL team are keen to continue on their improvement journey. The team have set themselves a goal of becoming accredited members of the Royal College of Psychiatrists Quality network for inpatient CAMHS (QNIC) programme.

TL are long standing members of QNIC and several staff have completed peer reviews of other units. There are very few accredited units nationally but the team have started to benchmark themselves against the required standards and are confident that they can become accredited.

9. Key Risks / Matters for Escalation

9.1 Going forward, TL will report on matters relating to QSRE to the CAMHS and MHLD QSRE meetings, any pertinent issues will be included in the MHLD paper to this committee. It is proposed that assurance to the Quality and Safety Committee is provided via this route rather than a separate paper.

10. 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	Growing 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
	If more than one applies please list below: Person-centred Effective
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: QIA not required	If no, please include rationale below: Not required as not changes to service provision
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:	If no, please include rationale below: Not required as no changes to service provision articulated
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)	
	Estates work to support Phase 2 of submitted SON to create an ECA suggested by WHSSC/QAIS will be associated with significant capital requirements	

11. Recommendation

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

11.2 It is recommended that going forward, any matters related to TL are included in the MHLD report to committee rather than a separate TL report to this Committee.

Agenda Item
8.3

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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 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.

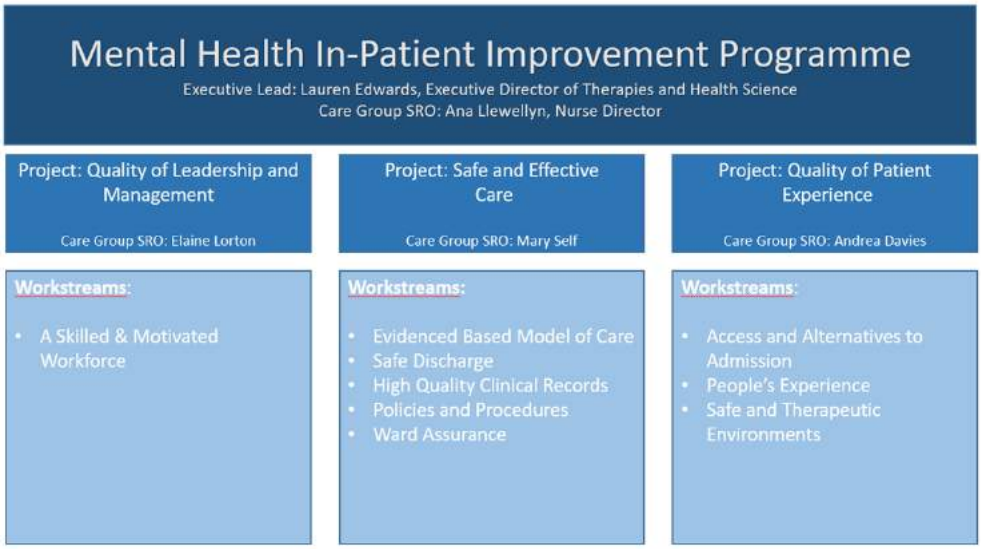
2.2 The Executive Director of Therapies and Health Science is the executive lead for the Inpatient Improvement Programme and chaired the first Improvement Board on 11th July. The Improvement Board agreed its Terms of Reference and agreed a meeting frequency of two monthly in order to provide work streams with the time to deliver on recommendations.

2.3 At the last committee, members were advised that a maturity matrix and Integrated Performance Assessment and Assurance Framework (IPAAF) had been developed to mirror the Maternity Improvement Programme and for ratification and endorsement by Welsh Government and the Performance and Assurance Division of NHS Wales Executive as part of Targeted Intervention.

2.4 Since the last Quality and Safety Committee, a number of conversations have taken place with HIW and Welsh Government about monitoring arrangements for the Health Board's discharge review improvement. Committee members are advised that the discharge review does not form part of Targeted Intervention with Welsh Government and that monitoring will be conducted by HIW, in keeping with the arrangements for HIW Local Reviews.

2.5 The Health Board has been advised that the Health Board's improvement plan has been accepted by HIW. It is currently pending publication on the HIW website. 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.

2.6 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. Of the 9 work streams, the 8 work streams with HIW recommendations are currently active.



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

2.8 The programme is currently on track to complete 36 recommendations by the next submission of the improvement plan to HIW in three months. There are 4 recommendations with longer timescales:

Recommendation 19 – Implementation of single record system (WCCIS)
Recommendation 27 – Final crisis space at PCH
Recommendation 31 – Full review of therapy workforce
Recommendation 36 – Review of all policies

Recommendations	Completed and Approved	Number completed since last QSRE (not yet approved)	Number due for completion by next QSRE (October 2023)	Number with later timescales	Number with slipped timescales
40	2	12	22	4	0

2.9 At the August MHLD QSRE, 12 recommendations were reported as complete. The evidence for these recommendations is currently being reviewed by work stream leads and SROs and will be reported to the Improvement Board in September.

3. Key Risks / Matters for Escalation

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

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)) /*	Learning, Improvement & Research If more than one applies please list below: Leadership Data to Knowledge

Link to Enablers of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	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** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: 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 also ask to note the ongoing progress of the Inpatient Improvement Programme.

6. Next Steps

6.1 The Adult Mental Health Inpatient Improvement Board, chaired by the Executive Director of Therapies and Health Science, meets on 19th September 2023 and will review progress and evidence against the HIW recommendations.

Agenda Item
8.4

Quality & Safety Committee

NATIONAL COLLABORATIVE COMMISSIONING UNIT QUALITY ASSURANCE AND IMPROVEMENT SERVICE ANNUAL POSITION STATEMENT 2022-2023

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	S Mahapatra, Head of Operations
Cyflwynydd yr Adroddiad / Report Presenter	Adrian Clarke, Head of Nursing & Deputy Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Choose an item. Managing Director of the National Collaborative Commissioning Unit / Chief Ambulance Services Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
NCCU MANAGEMENT BOARD	01/08/2023	Endorsed

Acronyms / Glossary of Terms	
NCCU	National Collaborative Commissioning Unit
QAIS	Quality Assurance and Improvement Service
UHB	University Health Board

1. Situation /Background

1.1 The purpose of the report is to provide an update to the CTMUHB Quality and Safety Committee (as host body) for assurance purposes.

1.2 The attached report at **Appendix 1**: 'NHS Wales Quality Assurance Improvement Service – National Collaborative Frameworks Mental Health and Learning Disabilities Annual Position Statement 2022-2023' provides the Committee with an overview of the two National Collaborative Frameworks which are overseen by the National Collaborative Commissioning Unit. The NCCU is hosted by Cwm Taf Morgannwg UHB and based in Charnwood Court in Nantgarw.

The National Collaborative Frameworks are as follows:

1. Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.
2. National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework')

Prior to 2012, externally provided mental health and learning disabilities hospital and care services were commissioned separately by each Health Board or through the Welsh Health Specialised Services Committee.

These commissioning arrangements led to disparity in costs, contractual obligations, standards and performance management across NHS Wales. Oversight of these commissioned services was the remit of individuals or small teams within organisations with little or no collaboration. An independent review in 2012 stated that the use of the independent sector and NHS England services by NHS Wales prior to the development of the National Framework was "inefficient, ineffective and inconsistent." (Tayside Centre for Organisational Effectiveness (2013). Review of the NHS Wales Mental Health & Learning Disability Secure Services Procurement Project, a retrospective view. Cardiff: NHS Wales)

In March 2012, a National Collaborative Framework for Medium and Low Secure Care was launched, and was successful in improving quality, enhancing assurance and reducing costs. Subsequently, the Chief Executives of the NHS Wales Health Boards considered that a broader suite of services such as locked and open rehabilitation required this level of assurance and the NHS Wales National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals was launched in April 2014. In October 2015, a National Collaborative Framework for Children and Adolescent Mental Health Services Low Secure & Acute Non-NHS Wales

Hospital Services was launched at the request of the Together for Children and Young People Programme.

In October 2016, the National Framework for Adults in Mental Health and Learning Disabilities Care Homes and Care Homes with Nursing launched and provides consistent quality, standards, placement process and contractual terms for all Health Boards and Local Authorities to commission placements.

In April 2022 both Adult and Children's Hospital frameworks were replaced with the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.

Legal Status

The NHS Wales National Collaborative Frameworks are a formal agreement and mechanism developed by the NHS Wales Collaborative Commissioning Unit and NHS Wales: Shared Services Partnership Procurement. This enables all signatory NHS Wales and Local Authorities to procure and performance-manage services under pre-agreed standards, costs, terms and conditions of a contract in a compliant manner in accordance with EU and UK Procurement Regulations and Health Board or Local Authority Standing Orders and Financial Instructions.

Commissioning Responsibilities

The National Collaborative Frameworks provide the enacting mechanism for the commissioning of services. These services are provided once a patient or resident is placed through the National Collaborative Framework processes and an individual placement agreement is generated, and therefore a contract enacted, between the commissioner (Health Board, Local Authority or Welsh Health Specialised Services Committee) and provider.

Benefits

The National Collaborative Frameworks have been developed to enable:

- Consistent and sustainable high-quality service provision and improved outcomes for individuals.
- An approved directory of suitably qualified, financially viable providers to meet specified quality, service and cost criteria.
- The establishment of bespoke care standards, standard contract terms/conditions, and a transparent pricing framework.

Scope
The scope of services covered by the National Collaborative Frameworks are Independent and NHS England hospitals and independent care homes providing the following services:

- Medium secure mental health
- Medium secure learning disability
- Low secure mental health
- Low secure learning disability
- Controlled egress (formally locked rehabilitation) mental health
- Controlled egress (formally locked rehabilitation) learning disability
- Uncontrolled egress (formally open rehabilitation) mental health
- Uncontrolled egress (formally open rehabilitation) learning disability
- Care homes without continuous staffing mental health
- Care homes without continuous staffing learning disability
- Care homes with continuous staffing mental health
- Care homes with continuous staffing learning disability
- Care homes with nursing mental health
- Care homes with nursing learning disability
- Low secure child and adolescent mental health
- Acute child and adolescent mental health
- Acute adult MH
- Adult Psychiatric Intensive Care Unit (PICU)
- CAMHS PICU

2. Specific Matters for Consideration

2.1 To note the activity for the two National Collaborative Frameworks throughout 2022/23.

2.2 On 31 March 2023 there were 29 Providers with 281 Units offering various services for Adults and 6 companies, 8 sites and 17 units providing 32 CAMHS Lots as part of the National Collaborative Framework for Adult Mental Health Learning Disability / Child and Adolescent Mental Health.

2.3 The use of the Care Home Framework Agreement has seen an exponential rise over the past six years. There were 438 residents receiving assurance under the National Care Homes Framework Agreement as of 31st March 2023. That is an increase from 370 (18%) the previous year.

2.4 The Hospitals Frameworks (Adult and CAMHS) ceased on 31st March 2022 and the new Adult and CAMHS Hospitals Framework agreement commenced on 1st April 2022.

3. Key Risks / Matters for Escalation

3.1 This is an annual position statement to describe arrangements across Wales.

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 Resilient Wales If more than one applies please list below: A healthier Wales A more equal Wales
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Culture and Valuing People If more than one applies please list below: Data to Knowledge Learning, Improvement & 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
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? /*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:

Quality *Have you undertaken a Quality Impact Assessment Screening?*		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.	
	However, the frameworks ensure value for money in line with the right quality of care for patients	

5. Recommendation

5.1 The Quality and Safety Committee is asked to:
NOTE the National Collaborative Frameworks Mental Health and Learning Disabilities Annual Position Statement 2022/23.

6. Next Steps

No next steps required. Report for noting only.

GIG CYMRU NHS WALES
Uned Gomisiynu Cydweithredol Cenedlaethol
National Collaborative Commissioning Unit

NHS Wales Quality Assurance Improvement Service

11th Annual Position Statement 2022-2023

Including update for the two National Frameworks

for Mental Health and Learning Disabilities

2023

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ABOUT THIS STATEMENT

Terms: 'Learning disability' is used as a term within this to describe individuals with a clinical diagnosis of intellectual disability. When discussing 'mental health hospitals' or 'learning disability hospitals' this denotes the classification of hospital not diagnosis of patients

Data: Some figures have been excluded in order to minimise disclosure risks associated with small numbers. Some percentages have been rounded, this means that for some figures the sum may not aggregate to 100%.

People Not Numbers: Whilst this report has many graphs and statistics, we note that behind every number is a vulnerable individual who deserves high quality and safe care.

Governance: This report will be received and approved by the Cwm Taf Morgannwg University Health Board's Quality and Safety Committee (In line with the National Collaborating Commissioning Unit's host body arrangements) and will be distributed to all health boards in NHS Wales.

WHO WE ARE

The NHS Wales National Collaborative Commissioning Unit, hosted by Cwm Taf Morgannwg UHB, is the collaborative commissioning service of NHS Wales.

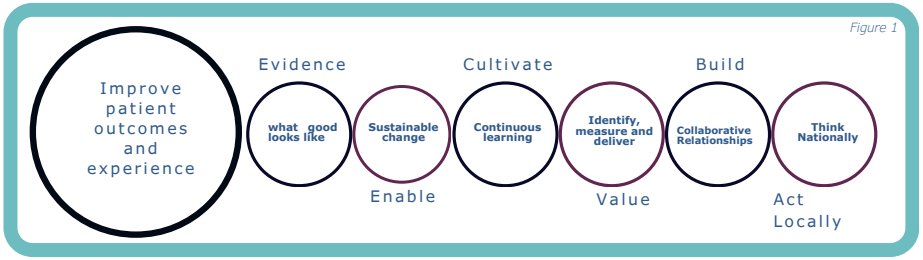
The vision of the National Collaborative Commissioning Unit is:

"Leading quality assurance and improvement for NHS Wales through collaborative commissioning"

The purpose of the National Collaborative Commissioning Unit is to improve patient outcomes and experience through the services it delivers. The Unit adheres to a set of guiding principles as shown in figure 1 below.

The objectives of the National Collaborative Commissioning Unit are:

- Improve patient outcomes and experience.
- From a patient's perspective - understand and articulate what good
- looks like.
- Embed national policy into local practice.
- Benefit from collaborative relationships.
- Deliver value.
- Change behaviour in order to embed innovation



THE QAIS

The Quality Assurance Improvement Service (QAIS) is a Division of the National Collaborative Commissioning Unit that focuses on improving care, quality and value.

The objectives of the Division are to:

- Ensure safe, effective and high quality care is delivered that improves patient experience.
- Robustly challenge substandard provider performance.
- Provide oversight, advice and support to improve the quality of care.
- Facilitate collaborative working between providers and commissioners with the patient as the focus of care delivery.
- Ensure all procured services deliver value for money for the public purse.

FOREWORD

I write this foreword in July 2023 and the QAIS has fully returned to its normal quality monitoring process. However, disruption and pressures continue to affect all health and care services caused by the Covid-19 pandemic.

2022 saw the launch of our new Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.
The introduction of the new framework has not been without its challenges and reporting processes have been developed and adapted during the course of the year as the new system has been embedded. However, through much welcomed support from providers and commissioners, and the diligence and effort of the QAIS team we are now seeing the benefits through a more outcome-focused and intelligence-led, citizen-centred service that ensures greater safety, quality and supports improvements in standards of care.

QAIS has visited just over 300 different care settings across both hospital and care home frameworks between 1 April 2022 and 31 March 2023.
We are pleased to see a further 2% decrease in the number of incidents in our Framework hospitals since last year, a reduction in number of complaints reported and the number of safeguarding referrals and we will continue working with providers to maintain this trend. However, we note that costs continue to increase significantly again this year and we are working with commissioners and providers to try and mitigate future cost increases whilst maintaining standards and capacity.

It is encouraging to report that placements with higher performing unit remains high with 96% of Adult hospital placements at 3Q providers.
There has been a significant increase in the number of patients receiving care under the Care Homes Framework. It is pleasing to note that 99% of patients receiving assurance under the National Collaborative Care Home Framework were placed in Wales, representing a 19% increase on the previous year.

Adrian Clarke
Dirprwy Gyfarwyddwr a Phennaeth Nyrsio
Deputy Director and Head of Nursing
NHS Wales

BACKGROUND

Introduction

Prior to 2012, externally provided mental health and learning disabilities hospital and care services were commissioned separately by each Health Board or through the Welsh Health Specialised Services Committee.

These commissioning arrangements led to disparity in costs, contractual obligations, standards and performance management across NHS Wales. Oversight of these commissioned services was the remit of individuals or small teams within organisations with little or no collaboration. An independent review in 2012 stated that the use of the independent sector and NHS England services by NHS Wales prior to the development of the National Framework was “inefficient, ineffective and inconsistent.”*

In March 2012, a National Collaborative Framework for Medium and Low Secure Care was launched, and was successful in improving quality, enhancing assurance and reducing costs. Subsequently, the Chief Executives of the NHS Wales Health Boards considered that a broader suite of services such as locked and open rehabilitation required this level of assurance and the NHS Wales National Collaborative Framework for Adult Mental Health & Learning Disability Hospitals was launched in April 2014. In October 2015, a National Collaborative Framework for Children and Adolescent Mental Health Services Low Secure & Acute Non-NHS Wales Hospital Services was launched at the request of the Together for Children and Young People Programme.

In October 2016, the National Framework for Adults in Mental Health and Learning Disabilities Care Homes and Care Homes with Nursing launched and provides consistent quality, standards, placement process and contractual terms for all Health Boards and Local Authorities to commission placements.

In April 2022 both Adult and Children’s Hospital frameworks were replaced with the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.

* Tayside Centre for Organisational Effectiveness (2013). Review of the NHS Wales Mental Health & Learning Disability Secure Services Procurement Project, a retrospective view. Cardiff: NHS Wales.

Legal Status

The NHS Wales National Collaborative Frameworks are a formal agreement and mechanism developed by the NHS Wales Collaborative Commissioning Unit and NHS Wales: Shared Services Partnership Procurement.

This enables all signatory NHS Wales and Local Authorities to procure and performance-manage services under pre-agreed standards, costs, terms and conditions of a contract in a compliant manner in accordance with EU and UK Procurement Regulations and Health Board or Local Authority Standing Orders and Financial Instructions.

Working in partnerhip with NHS Wales Shared Services Partnership

BACKGROUND

Commissioning

The National Collaborative Frameworks provide the enacting mechanism for the commissioning of services. These services are provided once a patient or resident is placed through the National Collaborative Framework processes and an individual placement agreement is generated, and therefore a contract enacted, between the commissioner (Health Board, Local Authority or Welsh Health Specialised Services Committee) and provider.

Benefits

The National Collaborative Frameworks have been developed to enable:

- Consistent and sustainable high-quality service provision and improved outcomes for individuals.
- An approved directory of suitably qualified, financially viable providers to meet specified quality, service and cost criteria.
- The establishment of bespoke care standards, standard contract terms/conditions, and a transparent pricing framework.

Scope

The scope of services covered by the National Collaborative Frameworks are Independent and NHS England hospitals and independent care homes providing the following services:

- Medium secure mental health
- Medium secure learning disability
- Low secure mental health
- Low secure learning disability
- Controlled egress (formally locked rehabilitation) mental health
- Controlled egress (formally locked rehabilitation) learning disability
- Uncontrolled egress (formally open rehabilitation) mental health
- Uncontrolled egress (formally open rehabilitation) learning disability
- Care homes without continuous staffing mental health
- Care homes without continuous staffing learning disability
- Care homes with continuous staffing mental health
- Care homes with continuous staffing learning disability
- Care homes with nursing mental health
- Care homes with nursing learning disability
- Low secure child and adolescent mental health
- Acute child and adolescent mental health

SECTION 1

Overview of National Collaborative Frameworks

CURRENT ACTIVITY ACROSS THE FRAMEWORKS

Figure 2 shows the overall activity (admissions and discharges) across both National Collaborative Frameworks from 1 April 2022 to 31 March 2023.

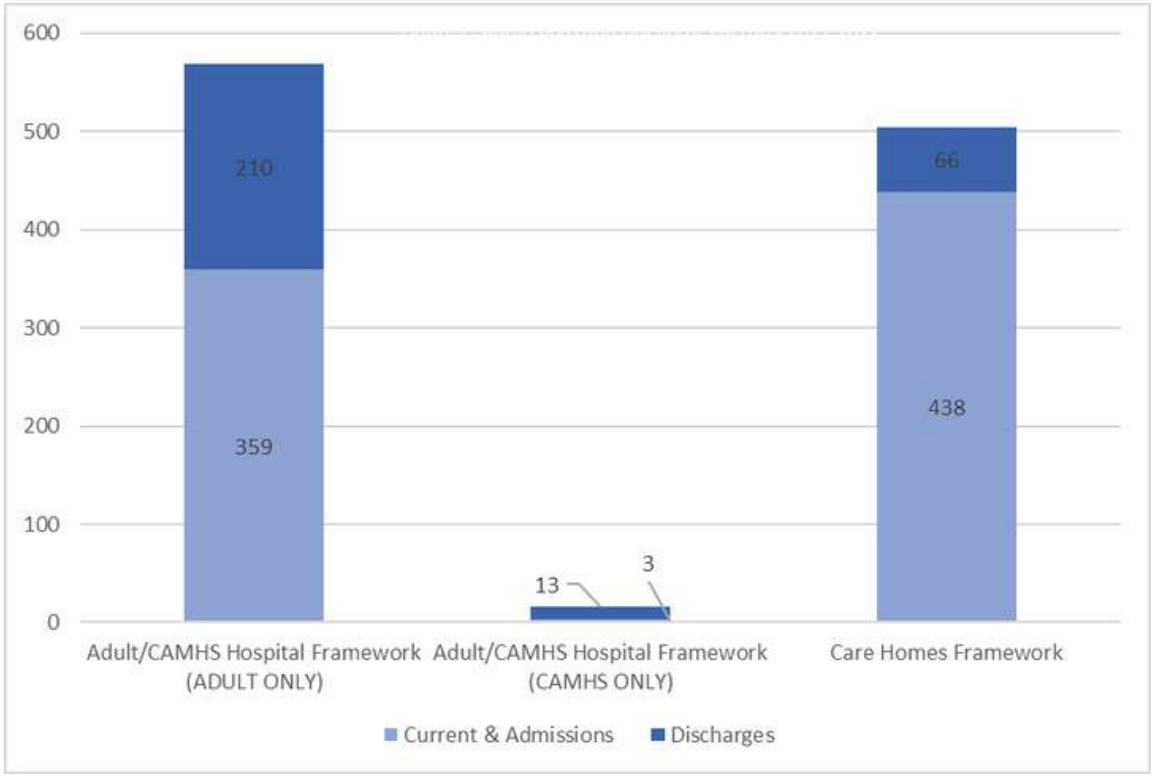


Figure 2: Admissions and Discharges Activity 20212-2023

For each National Collaborative Framework the following admissions and discharges were recorded between 1 April 2022 to 31 March 2023.

Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.

Adults

- 359 (current patients and admissions 31 March 2023)
- 210 (discharges 1 April 2022 to 31 March 2023)

Child and Adolescent (CAMHS)

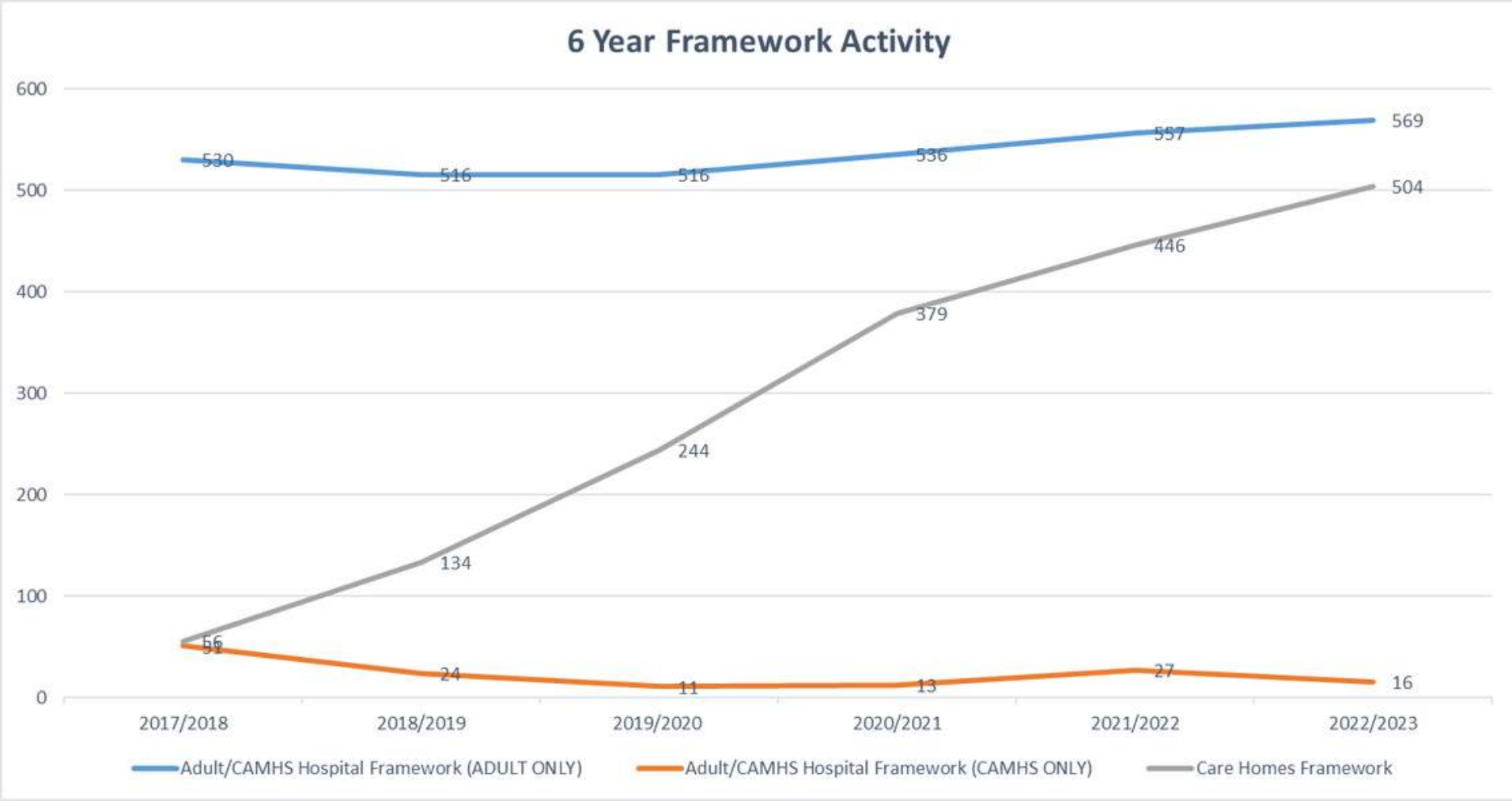
- 3 (current patients and admissions at 31 March 2023)
- 13 (discharges 1 April 2022 to 31 March 2023)

National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities Care Homes & Care Homes with Nursing for NHS and Local Authorities in Wales.

- 438 (current residents and admissions 31 March 2023)
- 66 (discharges 1 April 2022 to 31 March 2023)

6 YEAR FRAMEWORK ACTIVITY

Figure 3 illustrates the activity (all admissions and discharges) on both National Collaborative Frameworks over the past four years. During 2017-18 there were 637 patients / residents who received assurance under the National Frameworks, during 2018- 2019 there were 674, during 2019/20 there were 711, during 2020/21 there were 928 and during 2021/22 there were 1030, An increase of 62% since 2017-18 and an increase of 11% since 2020-21.



SECTION 2

National Collaborative Framework for Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals.
(ADULTS ONLY)

OVERVIEW OF ADULT/CAMHS HOSPITAL FRAMEWORK

Providers

On 31 March 2023 there were 29 Providers with 281 Units offering various services as part of the National Collaborative Framework for Adult Mental Health Learning Disability / Child and Adolescent Mental Health. (ADULTS ONLY)

The map on the left shows the geographical position of each site (please note multiple units from one provider may be denoted under an individual marker).

CURRENT STATE

On the 31 March 2023 there were 359 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework.

This compares to 345 from the previous year, equating to a 4% increase in the number of patients receiving assurance in 2021/22. Of the 359 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March 2023:

- 82 (23%) patients were the responsibility of Aneurin Bevan University Health Board
- 62 (17%) patients were the responsibility of Betsi Cadwaladr University Health Board
- 56 (15%) patients were the responsibility of Cardiff and Vale University Health Board
- 60 (17%) patients were the responsibility of Cwm Taf Morgannwg University Health Board
- 24 (7%) patients were the responsibility of Hywel Dda University Health Board
- 29 (8%) patients were the responsibility of Powys Teaching Health Board
- 42 (12%) patients were the responsibility of Swansea Bay University Health Board (+2%)
- *(4 (1%) patients were the responsibility of Manx Care - Isle of Man have now joined the framework agreement)*

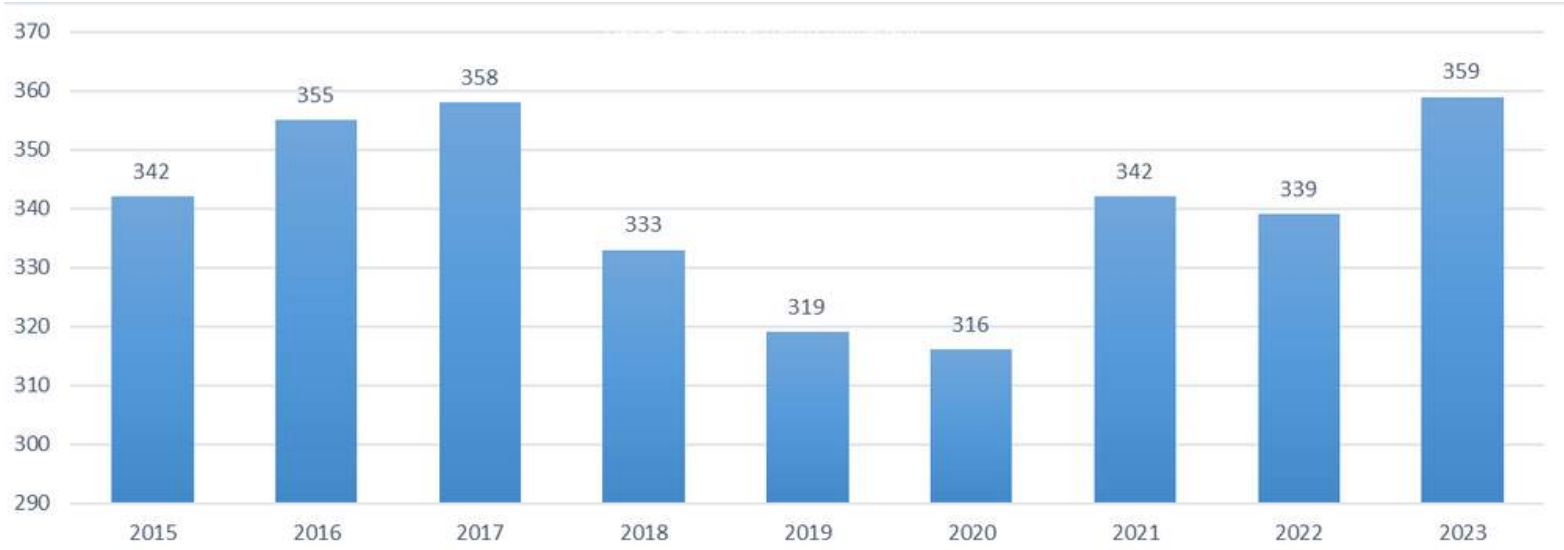


Figure 4 shows the number of patients receiving assurance at year end across 9 years.

NATIONAL TREND

9 YEAR NATIONAL TREND

There are five ‘tiers’ of Adult service on the new framework, which are medium secure hospitals, low secure hospitals, controlled egress hospitals and uncontrolled egress hospitals.

Medium Secure Hospitals: Medium secure services are specifically designed to meet the needs of patients who present a serious risk to themselves or others, combined with the potential to abscond. In many cases, patients in medium secure care will have been referred to hospital by court services.

Low Secure Hospitals: Low secure services are provided for those patients who have complex needs and cannot be safely cared for in non-secure units. These patients are usually detained under the Mental Health Act and present a level of risk to themselves and others that require specialist environmental security measures.

Controlled Egress Hospital: Controlled egress services, previously termed ‘locked rehabilitation’, provide reablement services to patients with complex needs and challenging behaviours. These units have locked or lockable doors to prevent unplanned egress.

Uncontrolled Egress Hospital: Uncontrolled egress services, previously termed ‘open rehabilitation’, provide reablement services to patients with longer-term needs. In general, these units only lock the entrances/exits at night for security purposes.

9 YEAR NATIONAL TREND CONTINUED

Figure 5 displays the number of patients in each tier of service each year on a specific date (31 March) between 2014 and 2022. Over the past nine years, there has been specific changes between service types such as:

- 17% decrease in number of patients in medium secure since 2015. (69 to 57)
- 6% increase in number of patients in low secure since 2015. (151 to 160)
- 9.5% increase in number of patients in controlled egress since 2015. (95 to 104)
- 15% increase in number of patients in uncontrolled egress since 2015. (27 to 31)

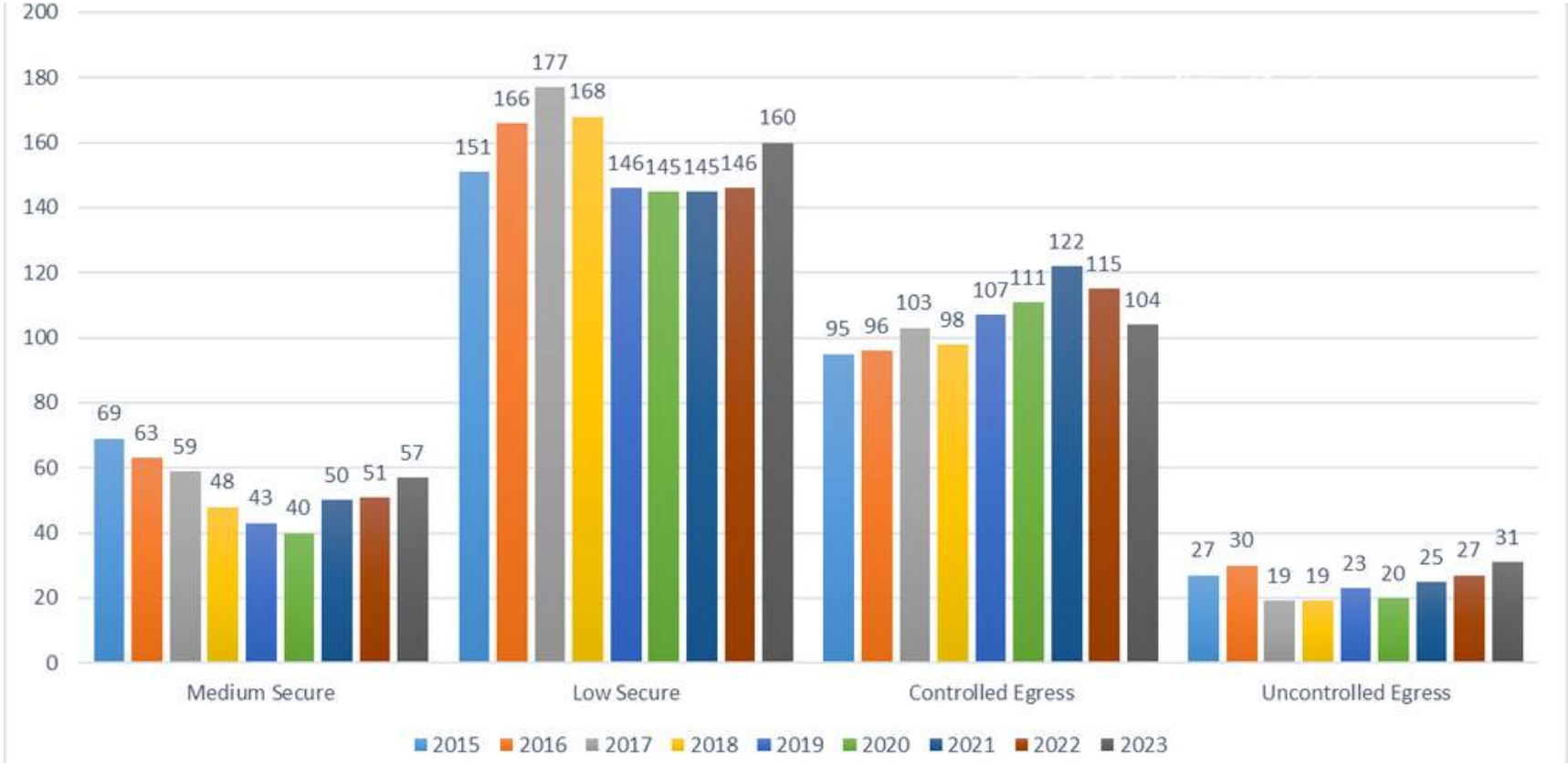


Figure 5. 9 Year National Tread

9 YEAR NATIONAL HEATH BOARD TREND

The trend in the number of patients from each Health Board receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March each year between 2015 to 2023 is displayed in Figure 6 below.

Comparing the eight-year trend since 2015, one Health Board saw a decrease, one Health Board remained the same and five Health Boards saw an increase in the number of patients who received care under the Framework between these years.

A comparison with 2021-22 of the health boards:

- Aneurin Bevan University Health Board has had an increase of 28% since 2015 and a 4% increase since last year.
- Betsi Cadwaladr University Health Board had a decrease of 2% since 2015 and a 19% decrease since last year.
- Cardiff and Vale University Health Board had an increase of 2% since 2015 and 24% increase since last year.
- Cwm Taf Morgannwg University Health Board had an increase of 40% since 2015 and the percentage stayed the same since last year.
- Hywel Dda University Health Board had a decrease of 27% since 2015 and 41% increase since last year.
- Powys Teaching Health Board had an increase of 53% since 2015 and a 32% increase since last year.
- Swansea Bay University Health Board had a decrease of 35% since 2015 and an 8% increase since last year.

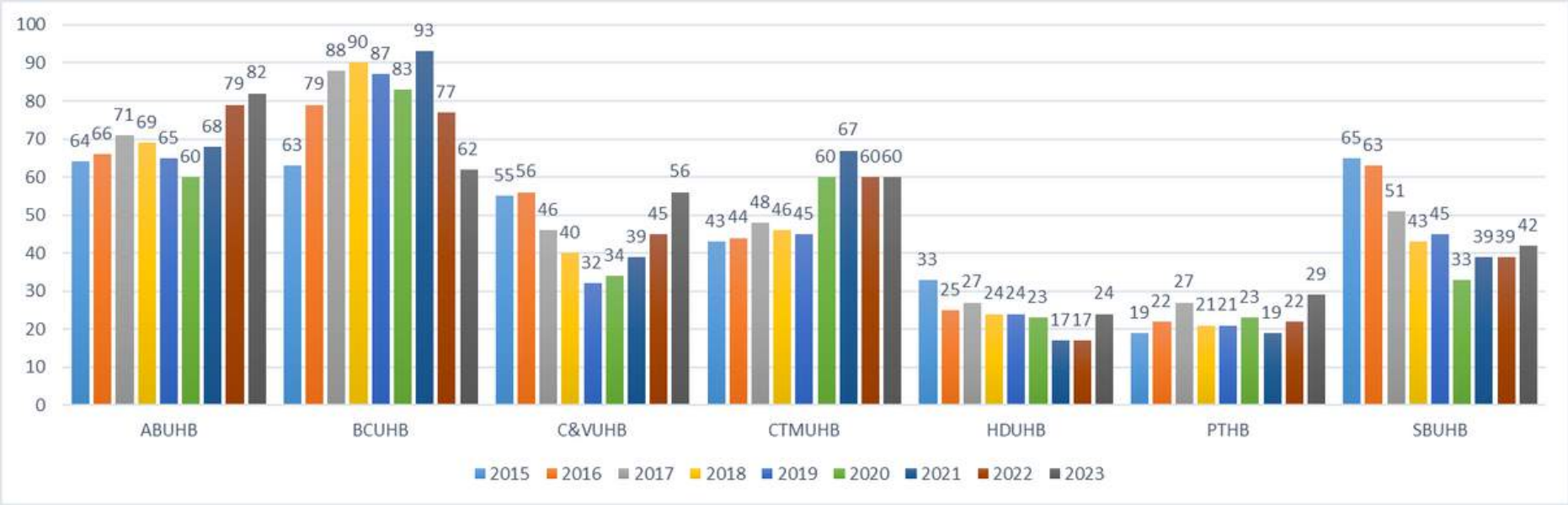


Figure 6: National Nine Year Tread of Placements by Health Boards

LEARNING DISABILITIES AND MENTAL HEALTH DISTRIBUTION

Of the 359 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March 2023, those cared for in Mental Health Hospitals consist of 87% of the total. Those cared for in Learning Disabilities Hospitals consist of 13% a decrease of 1% from 14% in 2022. Figure 7 shows a comparison of patients who have received assurance under the Framework over the past 9 years by speciality and figure 8 illustrates the distribution of patients placed in mental health and learning hospitals on 31 March 2023 by tier of service.

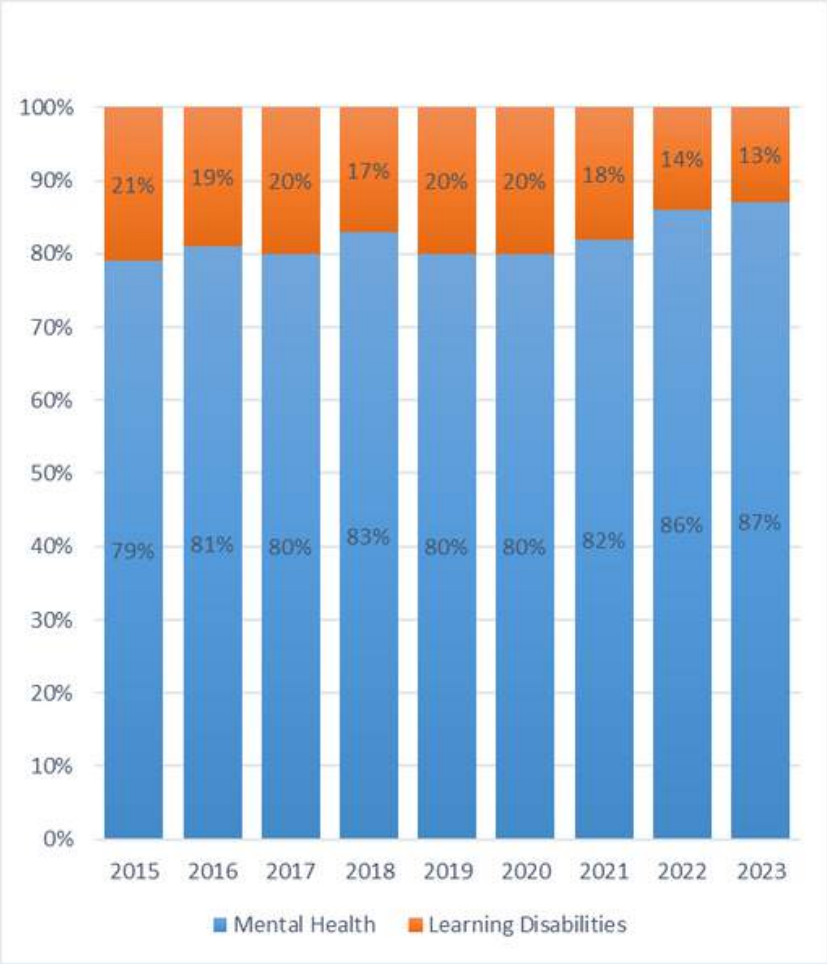


Figure 7: Nine Year Trend Mental Health and Learning Disabilities Distribution

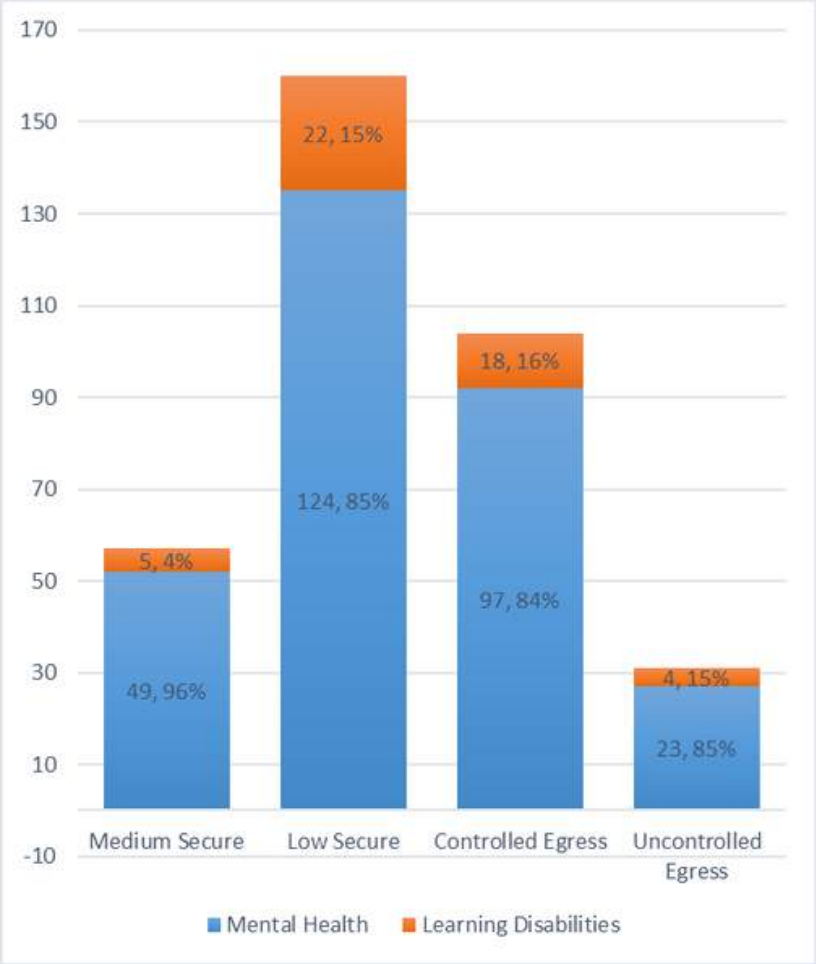


Figure 8: Mental Health/Learning Disability Distribution by Tier of Service

MALE AND FEMALE PATIENT DISTRIBUTION

Of the 359 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March 2023, 69% (249) of patients were male, an increase of 6% on 2021-22, and 31% (110) were female, an increase of 7% on 2021-22. The proportion of male patients decreased by 1% and the proportion of female patients increased by 1% in 2022-2023.

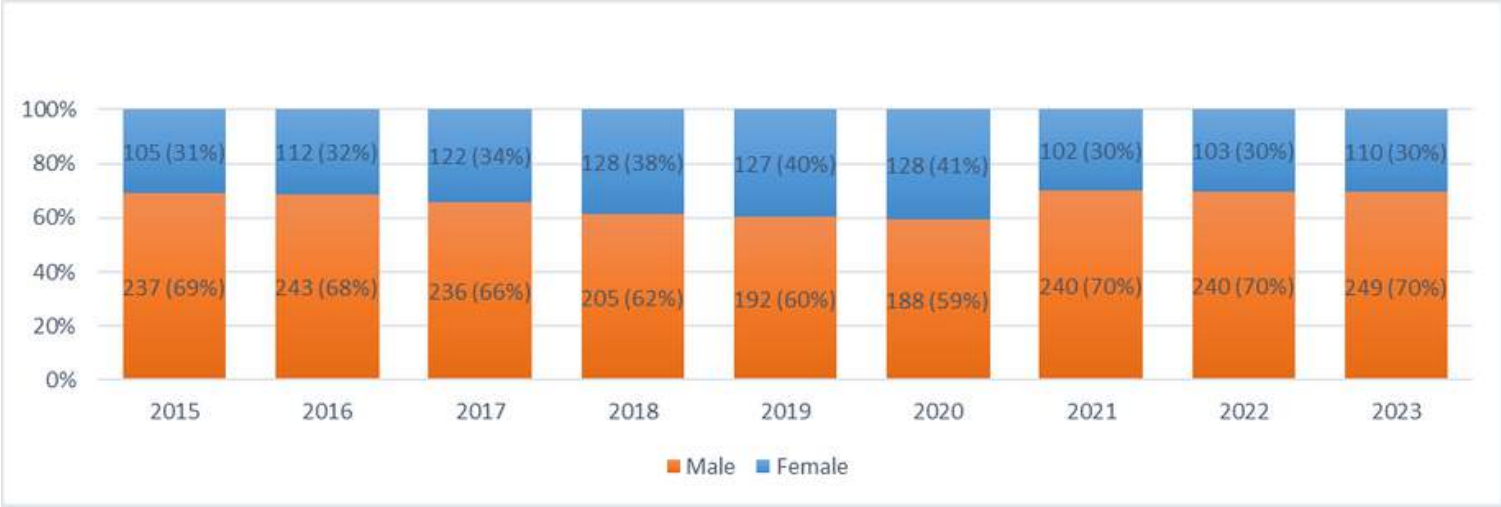


Figure 9 shows the proportion of male and female patients receiving assurance over the last 9 years.

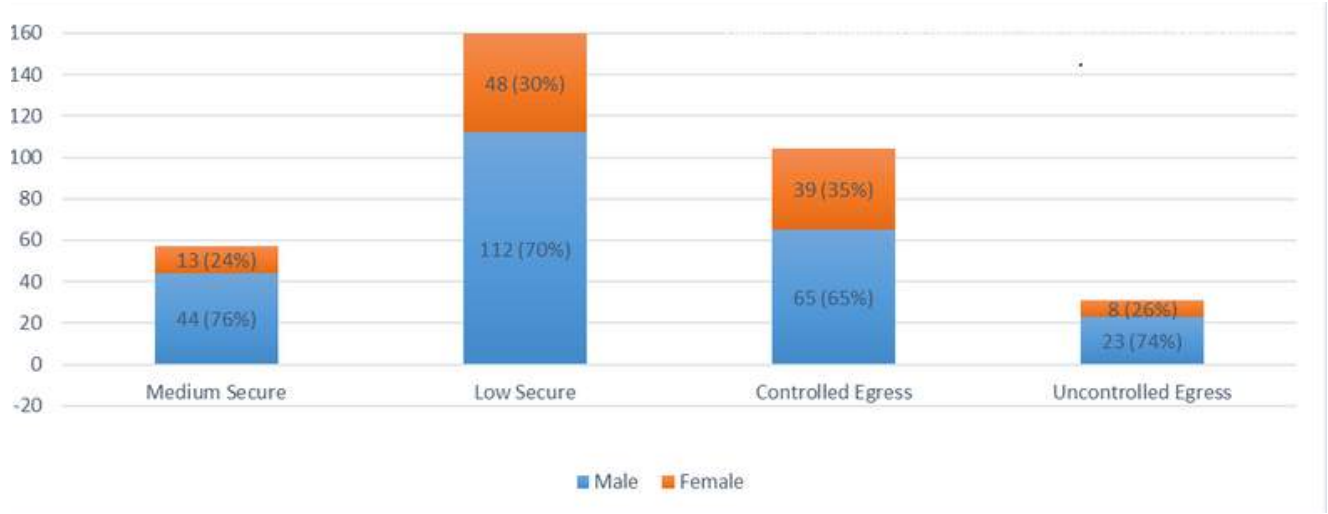
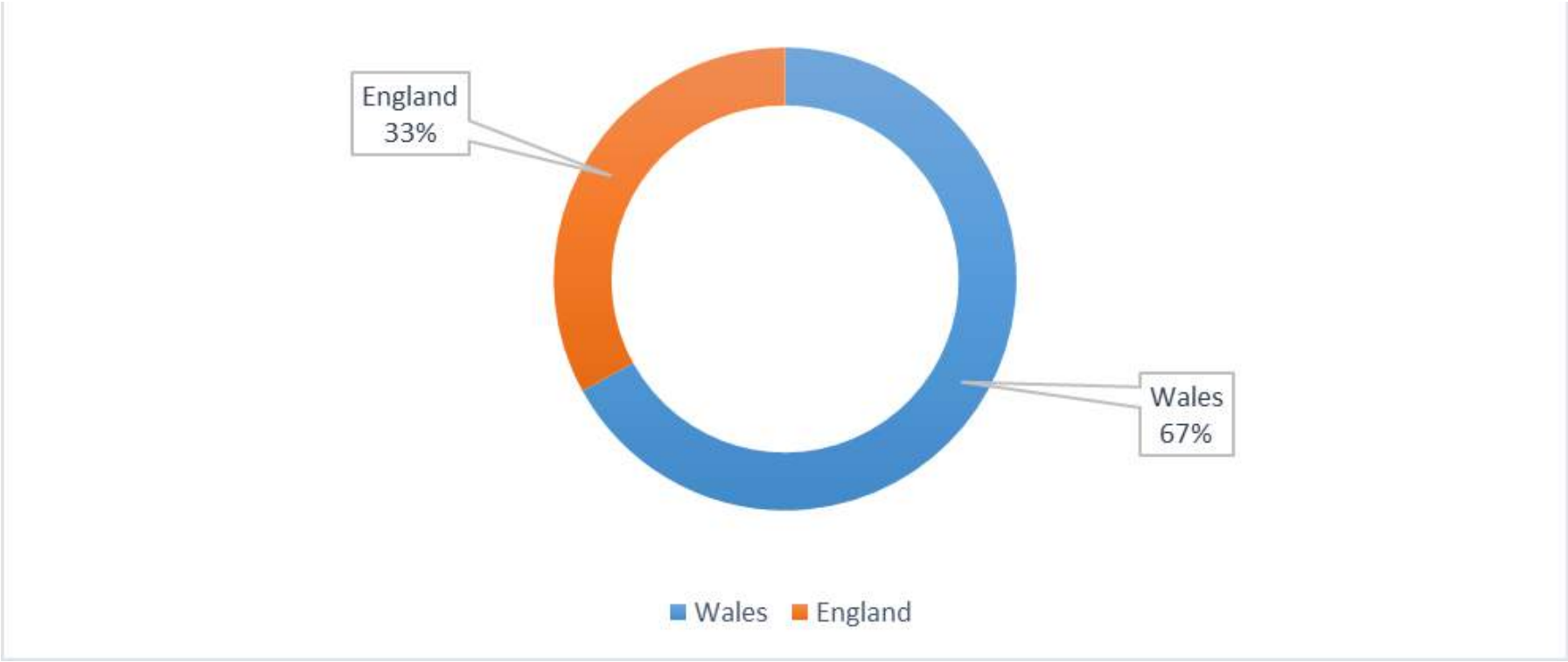


Figure 10 shows the distribution of male and female patients receiving assurance on 31 March 2023 within each tier of service.

GEOGRAPHIC DISTRIBUTION

Of the 359 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March 2023, 62% (224) were placed in Wales and 38% (135) were placed in England as shown in Figure 11 below.



GEOGRAPHIC DISTRIBUTION

Figure 12 shows the comparison of patients who have received assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework over the past 9 years in Wales and England. This years' number of patients matches the highest recorded in the last 9 years, 359 patients in 2017, with a higher proportion placed outside of Wales than that year. 45% of female patients were placed in England in comparison to only 34% of male patients.

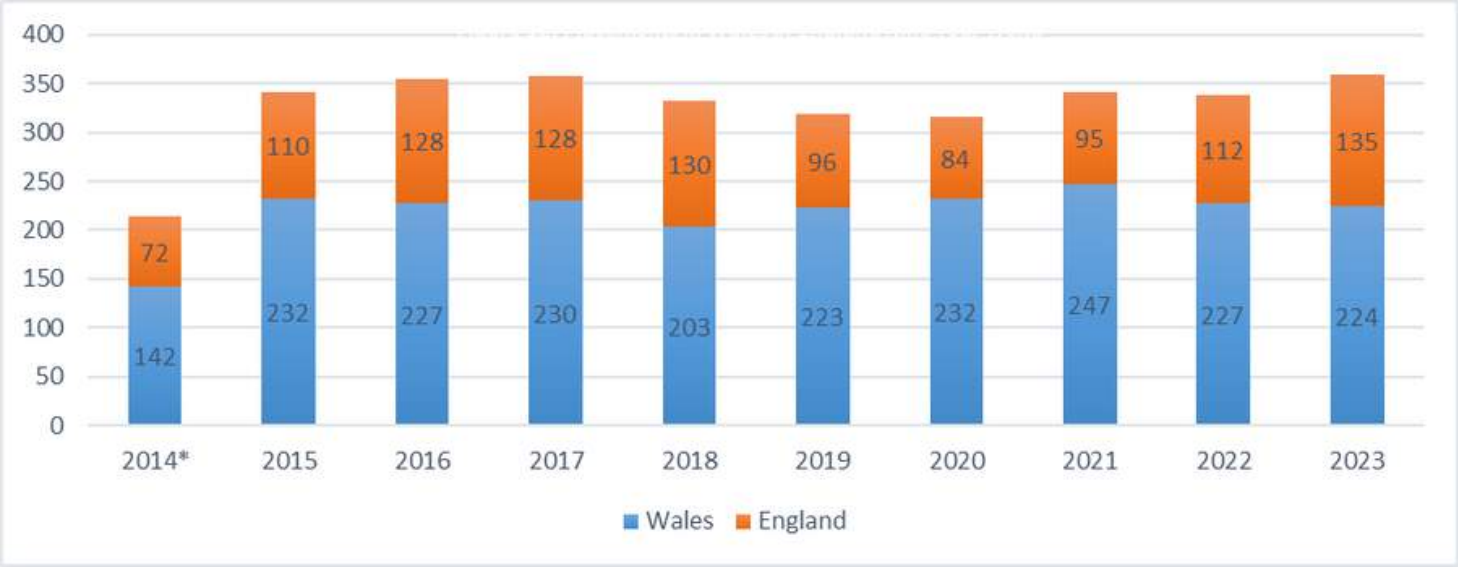


Figure 12: Placements in Wales or England Nine Year Trend

DISTANCE

The Quality Assurance and Improvement Service want to ensure that the National Collaborative Frameworks, wherever possible and with due regard for quality, provide placements that are as close as possible to the patients community of choice. Within the placement process we mandate that the commissioner enters a 'significant postcode' for the patient and distance to the provider is calculated from this geographical point. 204 (57%) patients were admitted to a provider less than 50 miles from the significant postcode, an increase of 11% on last year. 48 (13%) patients who were placed between 50 and 100 miles from the significant postcode, a decrease of 5% on last year. 107 (30%) patients are more than 100 miles from the significant postcode, a decrease of 6% on last year. Overall this indicates a positive significant shift in placements being made closer to the patient's significant postcode.

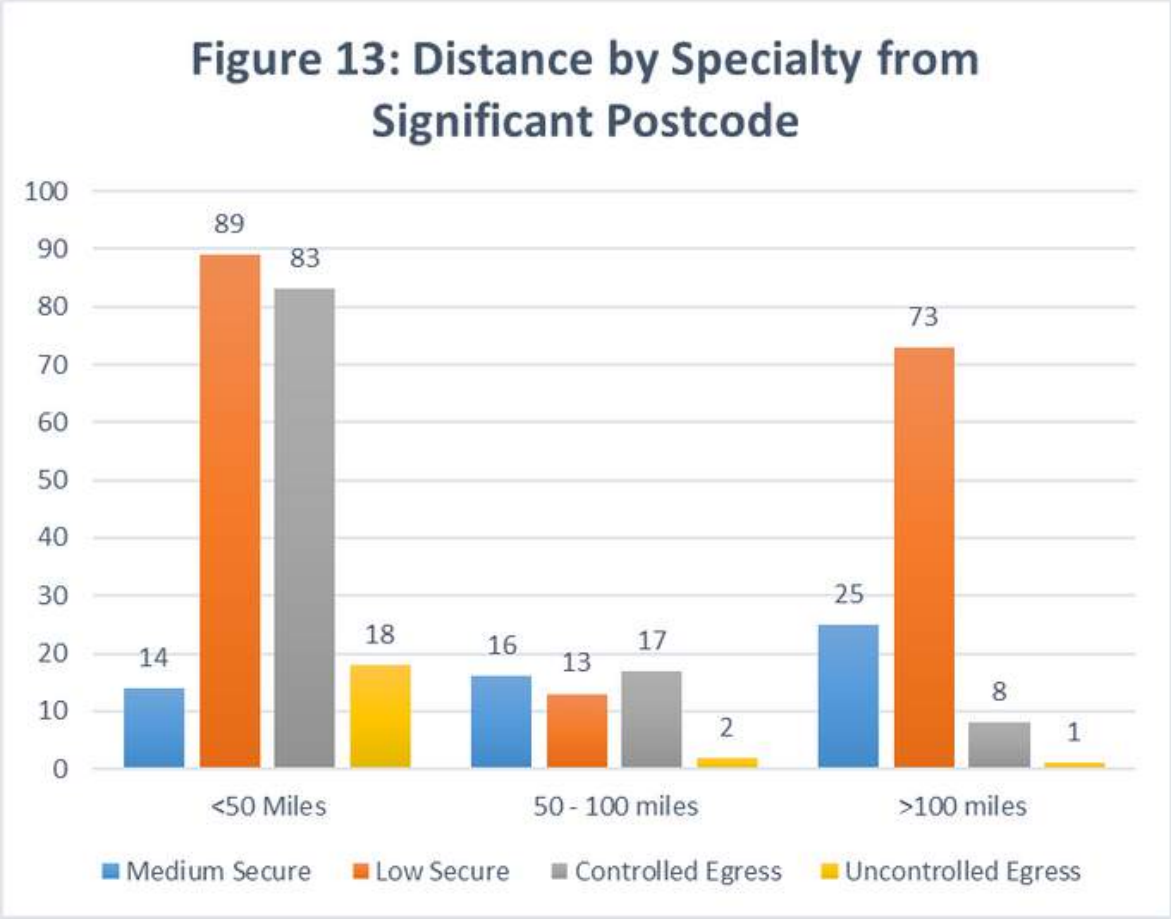


Figure 13 illustrates the distance by tier of service from the significant postcode.

DISTANCE

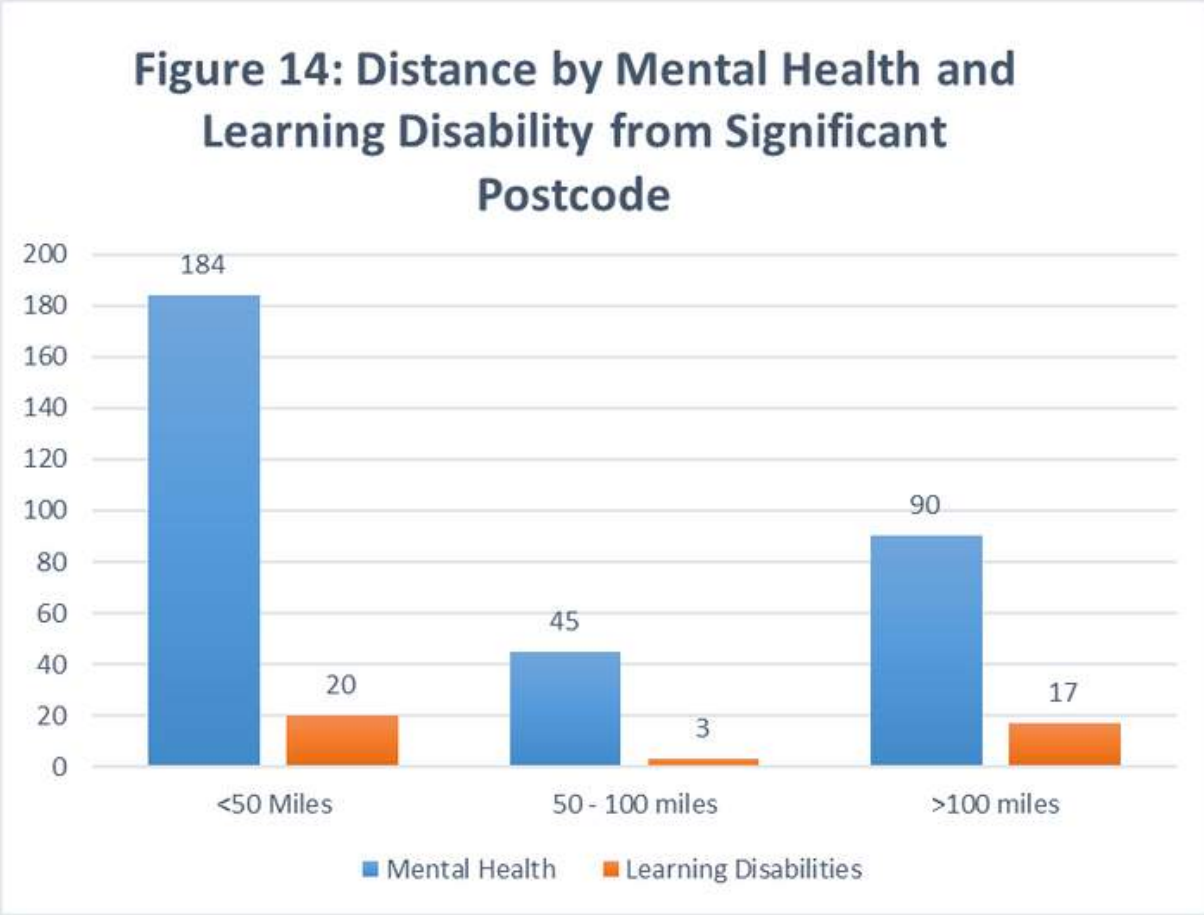


Figure 14 illustrates distance from significant postcode by Mental Health / Learning Disability placements less than 50 miles, between 51 and 100 miles and over 100 miles from the significant postcode from 1 April 2022 to 31 March 2023.

COMPLETED LENGTH OF STAY

Of the 314 patients who were discharged from the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework (Adults only) between 1 April 2021 and 31 March 2022, the total lengths of stay with their final provider (patients may have been admitted from another provider) prior to discharge were:

- 25% (79) patients had a length of stay less than 6 months compared to 20% (44) patients in 2021-22.
- 23% (73) patients had a length of stay between 6 months and 1 year compared to 24% (53) patients in 2021-22.
- 28% (87) patients had a length of stay between 1 and 2 years compared to 31% (68) patients in 2021-22.
- 12% (40) patients had a length of stay between 2 and 3 years compared to 13% (27) patients in 2021-22.
- 8% (26) patients had a length of stay between 3 and 5 years compared to 6% (13) patients in 2021-22.
- 2% (5) patients had a length of stay between 5 and 7 years compared to 4% (9) patients in 2021-22.
- 1% (4) patients had a length of stay between 7 and 10 years compared to 2% (4) patients in 2021-22.

PROVIDING ASSURANCE

The NHS Quality Assurance Improvement Service is part of the National Collaborative Commissioning Unit and works as a national team in partnership with NHS Wales Shared Services Partnership: Procurement to performance-manage nationally collaboratively commissioned commercial framework providers.

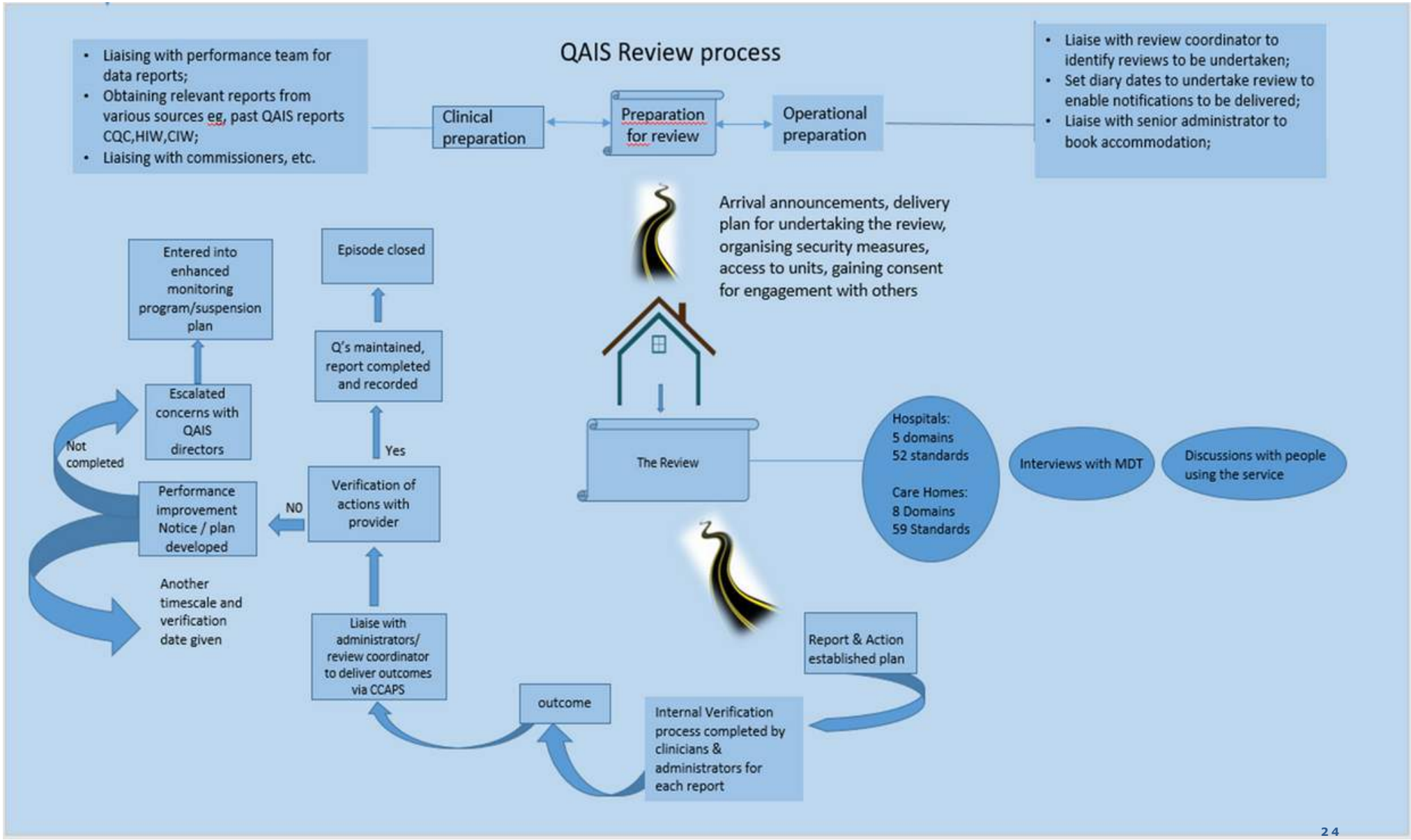
PROVIDING ASSURANCE

Figure 18 below shows an overview of our quality assurance process and how we award our quality certificates.

Figure 18 An overview of our quality assurance process

PROVIDING ASSURANCE

Figure 18a below depicts the QAIS review process in some additional detail.



MAINTAINING THE QUALITY OF CARE - Focus on Patient Experience

The introduction of the new framework has allowed QAIS to take a more patient-informed approach with each review seeking an in depth consultation with Welsh service users. We use this as an opportunity to facilitate additional focus on matters that are important to our patients.

Below is an example of the information received whilst meeting a patient on a site visit:

"On entering the ward QAIS were given a warm welcome and initially spent time with the Welsh patient without staff present, this was equally encouraged by staff and seen as a positive opportunity by the patient to be open and free to speak with QAIS.

The patient explained to QAIS that they feel supported by staff and feel encouraged to develop functional skills which can be utilised for more independent living in the future such as activities of daily living, vocational skills and socially interactive skills.

The patient continued by stating they feel encouraged to discuss and request unescorted leave in the community and that they spend a substantial amount of time in the community accessing the parks and exercising within the local area. They referred to having had their unescorted leave revoked the day prior to QAIS visiting, this was due to them having utilised their unescorted leave to visit the library which they understood is required to be contracted into leave prior to leave being agreed. QAIS cross referenced this with staff who reiterated what the patient had said and that it was due for discussion at the next MDT which was the following day, all parties appeared agreeable to the process and the actions taken.

Following on from the 1:1 conversation QAIS were given a tour of the ward and surrounding facilities, the patient asked if they could be involved in this process and staff encouraged the patient to take a lead role. The patient embraced this opportunity and when we approached their bedroom asked if they could demonstrate their interest in music and in particular mixing songs into one another using a mixing deck. Staff demonstrated a balanced approach to supporting the patient and were very empowering and encouraging, whilst being respectful yet direct with their expectations; for example time management when progressing onward to the next area of the building. This enabled the patient to manage their expectations and structure their interaction with QAIS, it worked really well and supported the patient to know when to show QAIS the next area.

QAIS were shown where the flats are located, we then moved along to the outdoors Occupational Therapy (OT) led building where the patients can access a tuck shop and pool table, in additional to sports on television and music as desired, the patient explained they also have evening activities and games such as bingo."

MAINTAINING THE QUALITY OF CARE - Focus on Patient Experience

Next the patient led QAIS to the garden and explained some of the ideas around planting certain seeds, and the though put into planning what they do in the garden area alongside OT.

The patient said they felt there was a genuine interest from staff to be supportive and enable patients to identify their own future aspirations, this was reflected when QAIS observed staff with patients, and when seeing their meaningful weekly records.

The patient was asked if the use of agency staff effects the standard of care they receive, the patient stated they see the same faces which for them ensured the standard remained consistent.

Throughout the audit QAIS were encouraged to see such enthusiasm, both from patients and staff alike. The environment would benefit from some decorating, but QAIS were assured works have been agreed and are due to start. This was evidenced by new windows in the patient's bedroom and an acknowledgement that other areas are due to be undertaken in the foreseeable future.

At the end of the site tour, QAIS spoke to the patient about their aspirations and the patient was clearly involved in plans to enable them to progress onward, and toward a more stepped down independent facility in the future. It is notable that QAIS were unable to ascertain a patient experience from the other Welsh patient, this was due to them utilising their escorted leave to a local beach to engage in therapeutic meaningful activity.

MAINTAINING THE QUALITY OF CARE

It is a requirement of providers to maintain the standards of care as set out in the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework. Under the new framework there are 5 core outcome areas containing a total of 52 bespoke Welsh Standards based on best evidence, experiential learning and good clinical practice. QAIS completed 44 Hospital site audits covering 63 individual units between 1 April 2022 and 31 March 2023.

Figure 19 details the average achievement for each of the 5 Core Outcome areas within the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework audited during the year.

Core Area	Average achievement
Effective Care & Teatment	79%
Dignity, respect, empowerment and patient centred values	94%
Skilled and Compassionate Staff	77%
Safe & Therapeutic Environment	92%
Robust Governance & a learning organisation	89%

Figure 19: Overall average achievement of standards by framework Core Outcome Area

MAINTAINING THE QUALITY OF CARE

Improvement Action

QAIS completed 44 Hospital site audits covering 63 individual units between 1 April 2022 and 31 March 2023. 285 issues were found relating to standards.

The outcome of the 44 reviews were that 26 (59%) units required one or more remedial actions and 18 (41%) units did not require any remedial action. The 26 units where one or more remedial actions were each issued a 'Performance Improvement Plan'. Across all Performance Improvement Plans there were a total of 207 individual actions (an example of which is shown in Figure 20).

Standard	Core Service Requirements	Outcome (level 1 or 2)	Assurance Required	Provider evidence of completion	QAIS Verification
3.3	Staff are appropriately recruited, inducted trained, qualified, equipped, supported and supervised for the services they provide.	Level 2	Whilst percentages for supervision and training have improved, sustained and embedded improvement is required to be evidenced	Sustained improvement evidenced.	Verified: 31.03.23

Figure 19

Under the new framework the provider is issued with a draft report detailing any actions and assurances required that QAIS has measured against each of the standards. If the matters are rectified and clearly evidenced within the given timeframe then this is verified and the improvement is noted in our final reports.

MAINTAINING THE QUALITY OF CARE

Figure 19.1 details the average achievement for each of the 52 specific standards within the 5 Core Outcome areas of the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework audited during the year.

Standard	Average attainment
Care and Treatment Plan 1.1	45%
Risk Assessment 1.2	75%
Meaningful & Appropriate Activities 1.3	84%
Regular MDT 1.4	66%
Good Clinical Practice - Medication 1.5	68%
Medication/Intervention failure - Rationale 1.6	82%
Admission Physical Examination 1.7	80%
Planned Leave procedure 1.8	86%
CAMHS ONLY Young person's education and wellbeing needs 1.9	100%
CAMHS ONLY Effective handover to adult services 1.10	100%
Patient involvement in Care & Treatment Plan 2.1	75%
Patient Needs - Equality Act 2.2	95%
Patient right to confidentiality 2.3	100%
Manner of the use of restrictive interventions 2.4	77%
Patient involvement in meetings concerning care 2.5	98%
Rationale for medication and intervention 2.6	91%
Patient access to care and treatment plans 2.7	98%
Patient provided with information about the service 2.8	98%
Independent Mental Health Advocacy 2.9	100%
Contact and Connection to community, home, family & friends 2.10	98%
Access to reflective, faith/multi-faith and pastoral care 2.11	98%
Staff able to raise concerns on services 2.12	98%
Patient and staff welfare, safety and wellbeing 3.1	57%
Staff recruitment, training, qualification, supervision 3.2	64%
Safe skill mix 3.3	84%
Unit responsibility and access to doctor 3.4	100%

Standard	Average attainment
Key worker allocation 3.5	64%
Use of bank and agency staff 3.6	91%
Appropriate environment of care 4.1	55%
Appropriate internal security and control measures 4.2	86%
Appropriate living spaces 4.3	98%
Medication storage, dispensing and authorisation 4.4	86%
Appropriate seclusion/time out/intensive care facilities 4.5	91%
Quiet Area 4.6	95%
Secure perimeter 4.7	98%
Food and drink 4.8	98%
Appropriate access to internet, telephone, secure storage of property 4.9	95%
Signage 4.10	95%
Resuscitation equipment storage 4.11	100%
Regulated heating and ventilation 4.12	93%
Designated outdoor spaces 4.13	100%
Exercise space, equipment and programmes 4.14	100%
Robust governance 5.1	84%
Reporting and learning from incidents 5.2	100%
Complaint records and actions 5.3	95%
Patient and family views on service 5.4	95%
Unplanned discharge procedures 5.5	98%
Clinical records 5.6	66%
Access to policies, processes, guidance and instructions 5.7	98%
Effective audit systems 5.8	84%
Patient rights and consent 5.9	91%
Adequate equipment and training in its use 5.10	80%

Figure 19.1

MAINTAINING THE QUALITY OF CARE

Focus on lower average achievement areas:

"1.1 Care and Treatment Plan" (45% of unit visits found that the provider met this standard at first review):

The standard states that – 'A contemporary Care and Treatment Plan(s) should always be present in the patient's notes which has been developed and reviewed in accordance with the Mental Health (Wales) Measure 2010, good clinical practice, professional standards and national and local guidance and based on appropriate evidence based assessment and formulation tools and processes. The plan(s) must identify one or more outcomes for each identified mental health, wellbeing and physical health need and one or more interventions to be undertaken and / or maintained to achieve these outcomes and record any needs which remain unmet.'

Example of QAIS reporting following site visit:

"Care plans are rarely signed by patients and there is limited evidence of patient involvement. The hospital is clearly in transition in terms of management and care plans that have been written more recently are stronger in terms of evidencing patient involvement.

There is evidence of duplication and cutting and pasting of previous care plans with dates changed.

Similarly, there is a date for the next side effects monitoring review that precedes the date of the care plan written.
Several care plans have the previous date of writing crossed out and replaced by a more recent date. Again, this suggests that they are cut and pasted with no change.

There is no restraint care plan for a patient who was restrained daily for the purpose of receiving medication. The specifics with regards relapse are not clear in relapse plans reviewed.

With regards review, there is often a date when reviewed but no qualification with regards to what has changed and what the outcome for the review is other than "no change".

Given this is a rehab facility, there is an expectation that reviews demonstrate small but clear progress on a regular occasion."

The example suggests a lack of detail and accuracy provided, and attention to the importance of the Care and Treatment Plan, and whilst this is a more detailed example that demonstrate the level of scrutiny that QAIS has applied to ensure patient safety, the common issues that relate to providers not meeting the standard on first visit are more commonly easily addressed. The lower percentage is predominately due to providers not using the required Welsh template Care and Treatment Plan. As such the QAIS are considering a number of approaches to communicate with all providers to use the correct documents for all of our patients in accordance with the Mental Health (Wales) Measure 2010.

MAINTAINING THE QUALITY OF CARE

Focus on lower average achievement areas:

“3.1 Patient and staff welfare, safety and wellbeing” (57% of unit visits found that the provider met this standard at first review)
The new framework standard states that – ‘The health, safety, welfare and wellbeing of the Patient and Staff is promoted and protected through staff culture, levels, skills, induction, training, supervision and management.’

Example of QAIS reporting following site visit:

‘A recent safeguarding incident involved a nurse clearly providing detrimental care to a patient which exacerbated their poor mental health resulting in a restraint incident. Clinical governance minutes suggests an apathy at times with regard to risk by staff e.g. Risk items were identified by staff but not removed. Supervision and training percentages require improvement.’

The importance of staff capability and culture and its impact on patients is closely monitored by QAIS and always highlighted within reports where necessary. Difficulties remain within this area, particularly around appropriate training, due to a growing reliance on bank and agency staff due to staff shortages and illness. This issue is clearly recognised by the majority of providers who continue to work with QAIS to mitigate the issue and improve patient safety. Our reporting of such factors allows Commissioners and Care Co-ordinators to be well informed when making choices around placement of Welsh patients.

“4.1 Appropriate environment of care” (55%)
The new framework standard states that – ‘The environment of care is of an appropriate design and fit for purpose in terms of cleanliness, comfort, safety, security and maintenance.’

Whilst ageing estates and the practicalities of adhering to developing standards is noted as a challenge, QAIS continues to work with service providers to ensure that the environment of care is of an appropriate design and fit for purpose in terms of cleanliness, comfort, safety, security and maintenance.

Where issues have been identified remedial action has been required through our Performance Improvement Plans and resulted in prompt response.

Quality Assurance Rating

The QAIS have developed a bespoke Quality Assurance Rating System. The system ensures providers make every effort to maintain a rating of three quality marks ('Qs'), which in turn allows organisations to view any potential provider's overall quality rating when commissioning a placement.

Figure 21 demonstrates the Quality Assurance Rating for a unit at the point of placement for the 240 patients admitted between 1 April 2022 to the 31 March 2023 by Health Board and Welsh Health Specialised Services Committee in comparison with previous years. In order to ensure that providers are incentivised to maintain quality and offer best value, the process of the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework encourages commissioners, where clinically appropriate to do so, to place patients with the highest ranked provider.

- 96% (231) of patients in 2022-2023 were placed with a provider that maintained 3Qs. By comparison this was 97% in 2021-2022.
- Zero patients in 2022-2023 was placed with a provider that maintained 2Qs. By comparison this was 1% in 2021-2022.
- 4% (9) of patients in 2022-2023 were placed with a provider that maintained 1Q. By comparison this was 2% in 2021-22

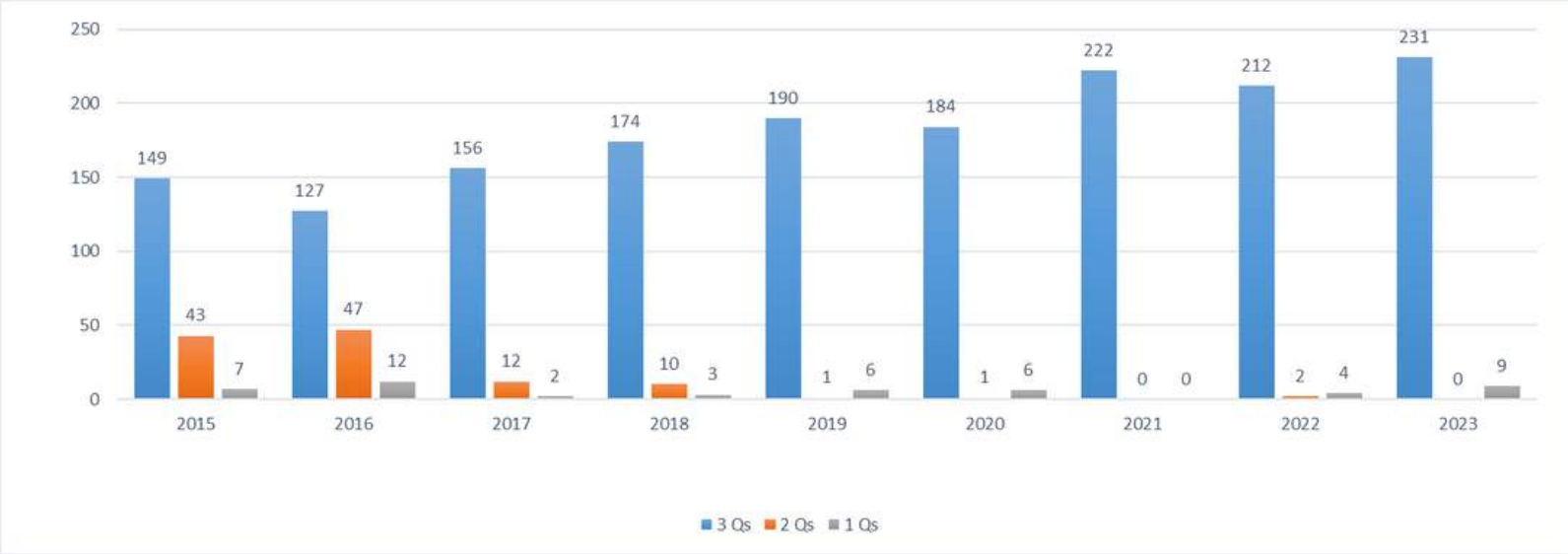


Figure 21: Placements by Quality Assurance Rating over Eight Years

Quality Assurance Rating

In relation to placements with non 3Q providers, the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework encourages placements with the highest quality provider available at that time, although this may not always occur because of commissioner practice, bed availability, distance from home or a particular patient need (e.g. Acquired Brain Injury). The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework placement process ensures reasons for not placing a patient with a 3Q hospital are recorded. 9 patients were placed with a providers with a 2Q or 1Q rating.

Placement with Top Five Ranked Providers

The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework continues to use a 'quality first, distance and value ranked provider model. The provider units with vacant beds are ranked by their current quality assurance rating (3Q ranked higher than 2Qs etc.). The providers all achieving the same Quality Assurance Rating are ranked by value and distance to each unit from a 'significant postcode for the patient' (inputted by the commissioner) displayed. The figure below illustrates admissions to the top 5 ranked providers from 1 April 2022 and 31 March 2023 by commissioning organisation.

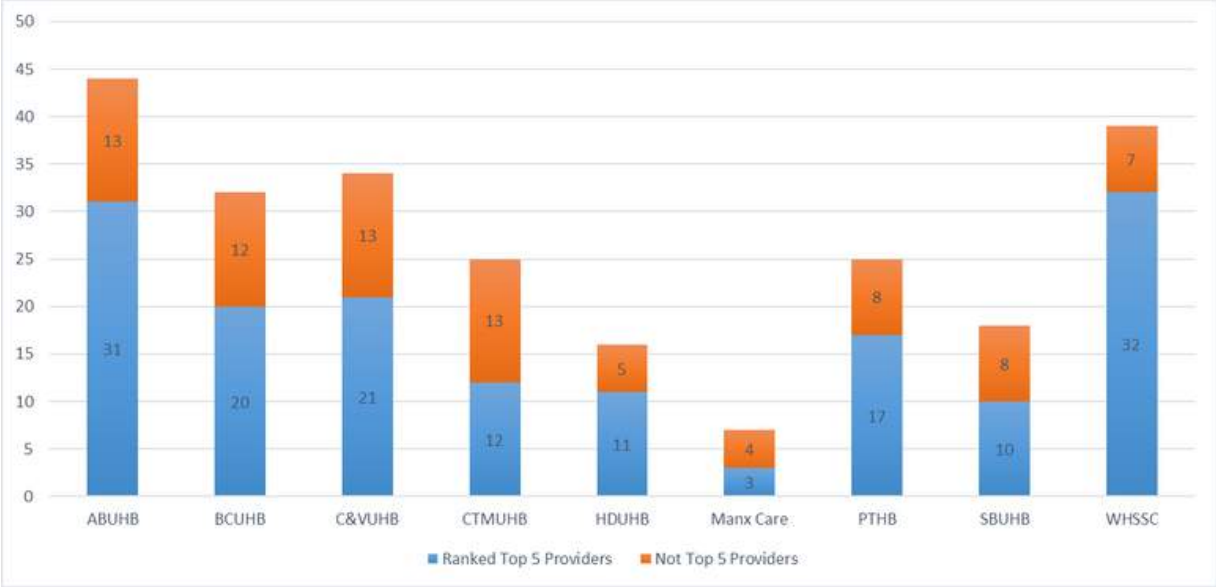


Figure 22: Admissions to Top Five Ranked Providers 1 April

70% (31 of 44) of patients placed with a top 5 provider by Aneurin Bevan University Health Board
63% (20 of 32) of patients placed with a top 5 provider by Betsi Cadwaladr University Health Board
62% (21 of 34) of patients placed with a top 5 provider by Cardiff and Vale University Health Board
48% (12 of 25) of patients placed with a top 5 provider by Cwm Taf Morgannwg University Health Board
69% (11 of 16) of patients placed with a top 5 provider by Hywel Dda University Health Board
68% (17 of 25) of patients placed with a top 5 provider by Powys Teaching Health Board
56% (10 of 18) of patients placed with a top 5 provider by Swansea Bay University Health Board
82% (32 of 39) of patients placed with a top 5 provider by Welsh Health Specialised Services Committee.

Respecting Privacy, Dignity, Equality, Diversity and Human Rights

A fundamental requirement of good patient care is the respect of each individual's privacy, dignity, equality, diversity and human rights. The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework sets out specific requirements forthis area, whichmust be maintained byproviders and areaudited during each hospital review. Figure 23 shows the average achievement for the specific new standards in 2023.

Standard	% Achievement
The Patient is enabled, encouraged and empowered to develop and review their Care and Treatment Plan(s).	75%
The Patient's needs in respect of the Equality Act 2010 are identified and addressed.	95%
The Patient is informed of their right to confidentiality, and its limitations, as soon as possible after admission.	100%
Any restricted interventions such as, but not limited to, physical interventions, seclusion, time out, observations and restricted access/egress are used as interventions of last resort for the minimum period necessary after positive support interventions have been attempted and in line with Good Clinical Practice, professional standards and national and local guidance and with due consideration of the self-respect, dignity, privacy, cultural values and individual needs of the Patient.	77%
That the Patient is enabled and encouraged to participate in all meetings concerning their care and that language used in the meetings attended by the Patient is clear, non-technical and the Patient is given assistance to understand the information if necessary.	98%
The rationale, desired effects and possible side effects/risks for all medications, interventions or restricted interventions are clearly documented, discussed and, where possible, agreed with Patient, Carer and Local Care Team prior to commencement. If requested this information is presented in written form to the Patient and Carer.	91%
Each Patient has access to a copy of their Care and Treatment Plan and individual activity plan which records all planned leave periods, therapy sessions and scheduled activities for the subsequent week.	98%
Patients are provided with as much information as is possible about the service that is providing their in-patient treatment. This includes a unit guide offering clear information about the service along with a comprehensive induction to the Unit environment and processes that is undertaken as soon as possible after admission. The service will also provide information on the process for making suggestions and compliments as well as information about accessing safeguarding leads, inspectorates, commissioners and QAIS.	98%
Patients are enabled and encouraged to access, where appropriate, Independent Mental Health Advocacy, Independent Mental Capacity Advocacy and/or advocacy.	100%
Patients are enabled and encouraged to contact and connect to their local community, home areas, family carers, friends and peers with due regard for risk, safety, best interests and confidentiality.	98%

Respecting Privacy, Dignity, Equality, Diversity and Human Rights

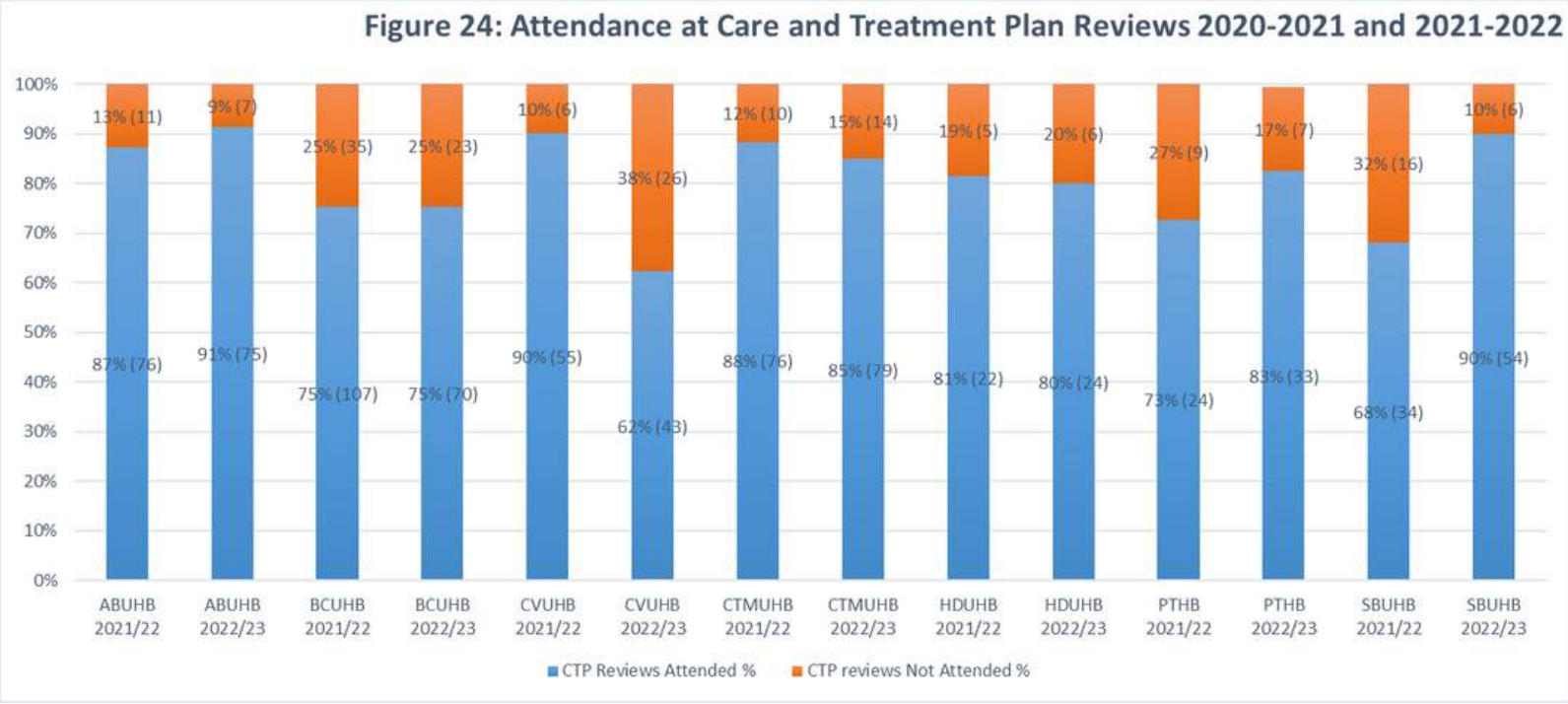
Patients have access to appropriate reflective, faith or multi-faith facilities and pastoral care.	98%
Staff are able to raise any concerns on quality of the services they provide without prejudicing their current employment and are informed of the rights and duty of whistleblowing during induction and on an annual basis.	98%
The health, safety, welfare, wellbeing and privacy of the Patient is promoted and protected through internal security and control measures whilst supporting the maximisation of personal freedoms.	86%
Patients have access to an individual single sex bedroom, single sex toilet with ensuite facilities and bathing facilities accessed via a single sex route. Also, female patients have access to a single sex lounge area. Wherever possible and following appropriate risk assessment, the Patient's bedroom accommodates individual needs and preferences.	98%
Medication is stored, dispensed and authorised in line with policy and Good Clinical Practice and professional standards. The positioning of the dispensary and examination room will protect the privacy and dignity of Patients and enable private conversations between staff and Patients accessing these rooms or having medications dispensed.	86%
A designated, purposely designed, decorated and equipped low-stimulus area/quiet area is available, without a television or telephone, and distant from communal areas.	95%
The Patient has access to internet, telephone facilities, call system and secure storage of personal property with due regard to risk, privacy and best interests.	95%
The health, safety, welfare, wellbeing and privacy of the Patient is promoted and protected through robust governance arrangements, guidance, polices, operational systems and processes	84%
The Patient is informed about their rights on admission or as soon as possible soon after and at a maximum interval of two calendar months or on request. The Patients consent, or refusal to consent, is documented prior to any disclosure of clinical information considering best interests and confidentiality.	91%

The main identified areas of concern that were identified were Patient Involvement in Care and Treatment Plans (75%) and the manner of the Use of Restrictive Interventions (77%) and these will be monitored closely in the coming year.

Care Coordination

It is vital that care coordinators receive electronic notifications of incidents and are able to be contacted by the QAIS to discuss individual issues. In order to facilitate this, it is a requirement to record the name of the patients care coordinators(s) when making a placement. In 2022-23, 100% of patients had details of a care coordinator recorded. The NHS Wales QAIS monitors the attendance at Care and Treatment Plan reviews in order to provide assurance to commissioning organisations that they are compliant with the Mental Health (Wales) Measure 2010. The numbers contained within the figure have been validated by commissioners and providers. Following a Care and Treatment Plan review, the provider is required to record whether it was attended by the care coordinator and / or other Health Board representative. We recognise that some visits by care coordinators would have been subject to the restrictions in place during the pandemic. Figure 24 illustrates the attendance or non-attendance* by either a care coordinator and/or other representative from Wales at the Care and Treatment Plan reviews held between 1 April 2022 and 31 March 2023.

Attendance at Care and Treatment Plan Reviews



*Please note that non-attendance at reviews does not signify a complete absence of patient contact, as professionals may have visited the patient at other times.

ENSURING SAFE AND EFFECTIVE CARE

Information Requirements

To ensure that the NHS maximises the use of technology, it will become increasingly important that a 'Once for Wales' approach is adopted. Organisations that are able to share information effectively and efficiently will be able to adopt new innovative models of care, and deliver high quality, sustainable and outcome based services for the people of Wales.*

Commissioning Care Assurance and Performance System

The technology used by the QAIS is the Commissioning Care Assurance and Performance System (CCAPS). CCAPS provides a 'one stop' information portal, proactively alerts commissioners to issues, supports the performance management of providers and is an enabler for assurance.

CCAPS is a system developed in partnership with the NHS Wales Informatics Service in 2015. It is an enabler of the National Collaboratively Commissioned Frameworks, which provides standardised information with the functionality to connect all users from different organisations to support NHS Wales to proactively performance-manage providers.

Commissioning Care Assurance and Performance System (CCAPS)

CCAPS support individuals by:

Giving a choice of care setting.
Providing assurance on the expected quality of care. Monitoring health and wellbeing improvement.
Ensuring prompt response to any complaints, incidents / safeguarding concerns.

CCAPS support providers by:

Standardised commissioning process
Displaying and the ability to update bed availability
Facilitating the reporting of concerns to commissioners and care coordinators

CCAPS support commissioners by:

Sharing intelligence on care providers.
Matching a care setting to a patients' needs.
Knowledge about a care setting's quality.
Evidencing the care received for the cost incurred.
Empowers commissioner decision.*

Digital Health and Care Wales

Digital Health and Care Wales (previously NHS Wales Informatics Service) is contracted to develop and support the day-to-day running of CCAPS.

Of the 1534 currently registered users, the table below displays system usage between 1 April 2022 and 31 March 2023.

Service	Registered users	Logged on to CCAPS 2022-23
NHS	365	72
Provider	1098	227
Local Authority	67	12
Regulator (Health Inspectorate Wales)	4	1
Total	**1534**	**312**

The total number of users has risen significantly (57%) since the last reporting period particularly across NHS, Provider and Local Authority with over 400 new registrations 2022-23.

QAIS Support Desk

We host the CCAPS Support Desk and provide assistance to CCAPS users; the Support Desk recorded a 25% increase in requests from 1 April 2022 and 31 March 2023, 1572 recorded calls in total. Of these1567 were classed as low priority, 5 medium priority and 0 high priority.

Secure File Sharing Portal

The NHS Wales Secure File Sharing Portal is a national system that enables the safe, sure and swift transfer of patient identifiable information between organisations over the internet. Hosted by NHS Wales Informatics Service and administered by the QAIS.

The QAIS aims to support a 'paperless NHS' by optimising the available technology to safely transfer and receive patient identifiable information between Welsh commissioners and National Collaborative Framework providers.

The main objectives are to:

- Ensure sensitive data cannot be intercepted, corrupted or misplaced.
- Enable the sharing of sensitive information and commercially sensitive information.
- The sharing of large volume information.
- Enables information to be shared instantly.
- Enables communication between the QAIS, Providers, Local Health Boards, Local Authorities and 3rd party organisations inside and outside of NHS Wales.
- Eliminate postage costs.

The number of users accessing and utilising the system continues to grow, and as of the 31 March 2023, there were 539 unique users from health, local authorities and providers of care, from the previous year 430, which is an increase of 25%. During the reporting year, there were 8,678 packages / emails transferred between organisations across all categories this is an increase from 7,498 in 2021-22. Figure 26 below shows the number of registered users by category on the 31 March 2022.

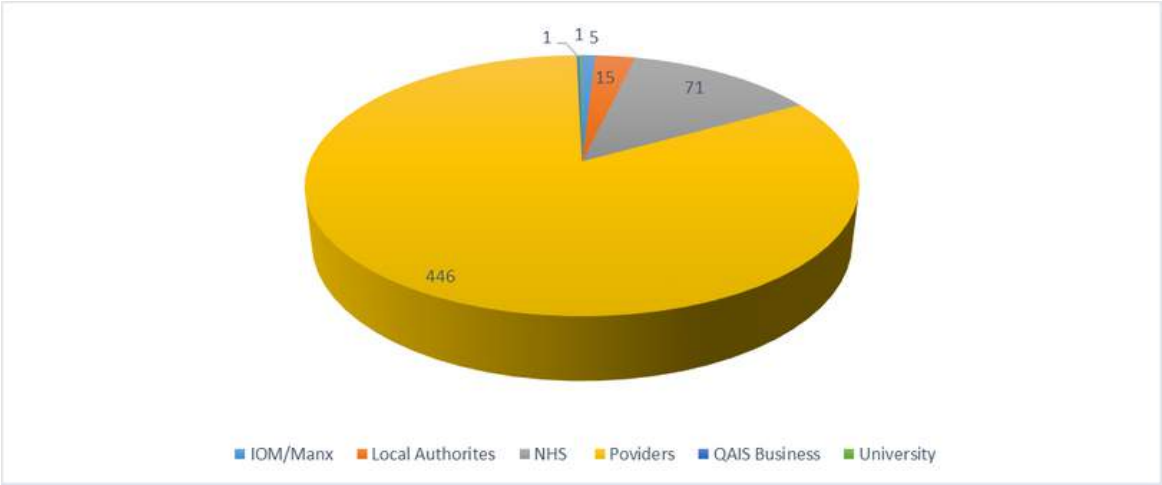
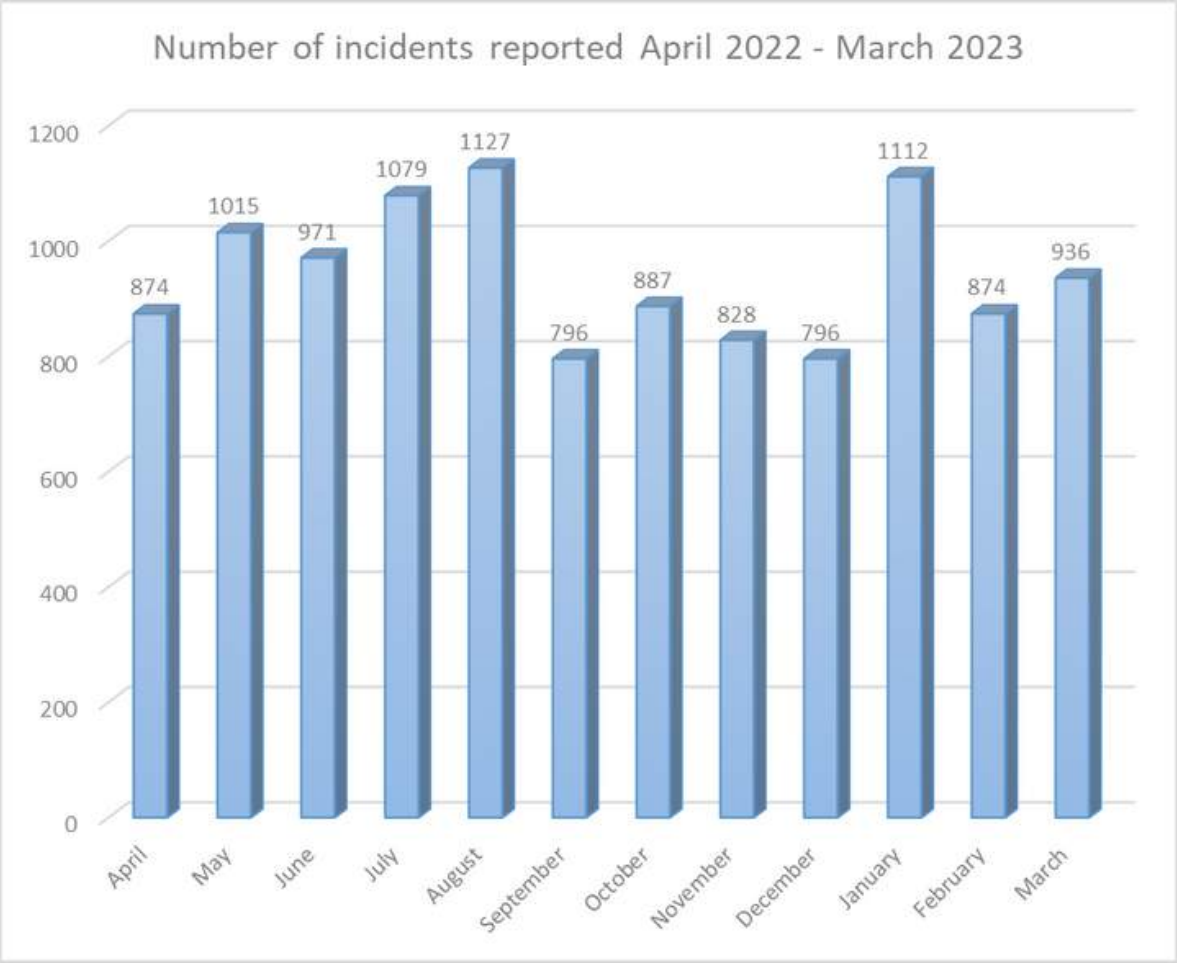


Figure 26. Number of users by category

Incidents

All reported incidents involving patients receiving assurance under the Adult Hospital Framework are monitored by the QAIS to highlight areas requiring intervention, remedial action or improvement.

The launch of the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework in April 2022 required a new matrix of incident reporting based around the new core outcomes measures. 11,295 incidents were reported in the year.

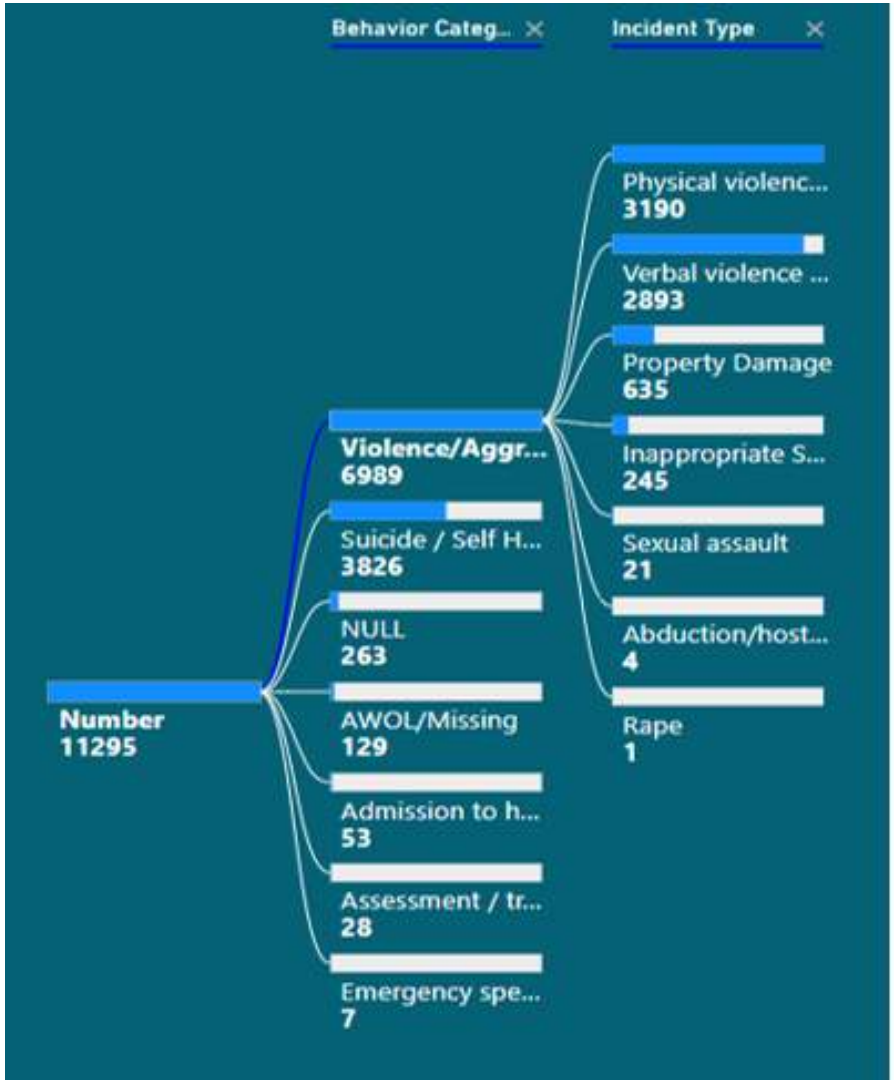


No Harm	**5280**
Low Harm	**3110**
No Harm (impact not prevented)	**2478**
Moderate Harm	**396**
Severe Harm	**21**
Death	**6**

Incidents

The new system has been designed with the intention to be more intuitive and descriptive for the inputter. It also allows QAIS to use the received information to form a more effective intelligence-led approach.

Behaviour Category	No. of incidents
Violence/Aggression	6989
Suicide/Self Harm	3826
AWOL/Missing	129
Admission to Hospital for assessment /treatment - physical health/illness	53
Assessment/Treatment at ED - physical health/illness	28
Planned Restrictive Intervention relating to treatment or procedure	233
Assessment/Treatment at ED - Accident/Incident not related to behavioural or clinical incident	11
Incorrect administration of planned treatment/medication	6
Emergency Specialist onsite treatment - accident/incident	4
Admission to Hospital for assessment /treatment - accident/incident	3
Emergency Specialist onsite treatment - Physical Health/Illness	7
Any error or lapse in legal documentation affecting validity of detention under MH Act	3
Any error or lapse in legal documentation affecting s17 leave arrangements	1
Omitted planned treatment/medication	1
Patient refusal of treatment leading to harm	1



Complaints

All reported complaints are monitored by the QAIS to highlight areas of investigation or improvement. Complaints are monitored at a patient, unit, hospital and provider level. In 2022-23 there were a total of 247 complaints, a 4% reduction on the previous reporting year (256). Reported complaints by patients receiving assurance under the new Framework are now categorised against a bespoke 36-point matrix of nine complaint areas with sub-categories in each.

The most significant increase in complaints were seen in the areas of staff attitude and Behaviour of another patient. All other areas remained the same or reduced.

- 4% (11) were classed as Hotel Services in 2022-23 compared to 7% in 2021-22.
- 44% (108) were classed as Attitude / Behaviour of Staff in 2022-23 compared to 40% in 2021-22.
- 10% (25) were classed as Behaviour of other Patient in 2022-23 compared to 4% in 2021-22.
- 4% (11) were classed as Communication in 2022-23 compared to 9% in 2021-22.
- 10% (25) were classed as Patient Property in 2022-23 compared to 10% in 2021-22.
- 22% (55) were classed as Clinical Treatment in 2022-23 compared to 21% in 2021-22.
- 1% (3) were classed as Legal in 2022-23 compared to 4% in 2021-22.
- 3% (8) were classed as Hospital Protocols in 2022-23 compared to 5% in 2021-22.
- 0.5% (1) was classed as Equality & Diversity in 2022-23 compared to 0% in 2021-22.

This represents a significant overall improvement and QAIS continue to monitor and explore options to maintain this improvement in partnership with service providers.

Safeguarding

The QAIS monitor all potential safeguarding concerns involving patients receiving care under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework. These safeguarding concerns are subsequently validated by local safeguarding teams, as either meeting their local safeguarding threshold ('confirmed'), or not ('unconfirmed'). In 2022-23, 15% (100) of the 675 reported safeguarding concerns were validated as confirmed and 85% (575) as unconfirmed.

Safeguarding concerns can be sexual abuse, physical abuse, neglect, financial abuse and emotional / psychological abuse.

- 14% (14) recorded and confirmed as sexual.
- 37% (37) recorded and confirmed as physical.
- 36% (36) recorded and confirmed as neglect.
- 2% (2) recorded and confirmed as financial.
- 11% (11) recorded and confirmed as emotional / psychological.

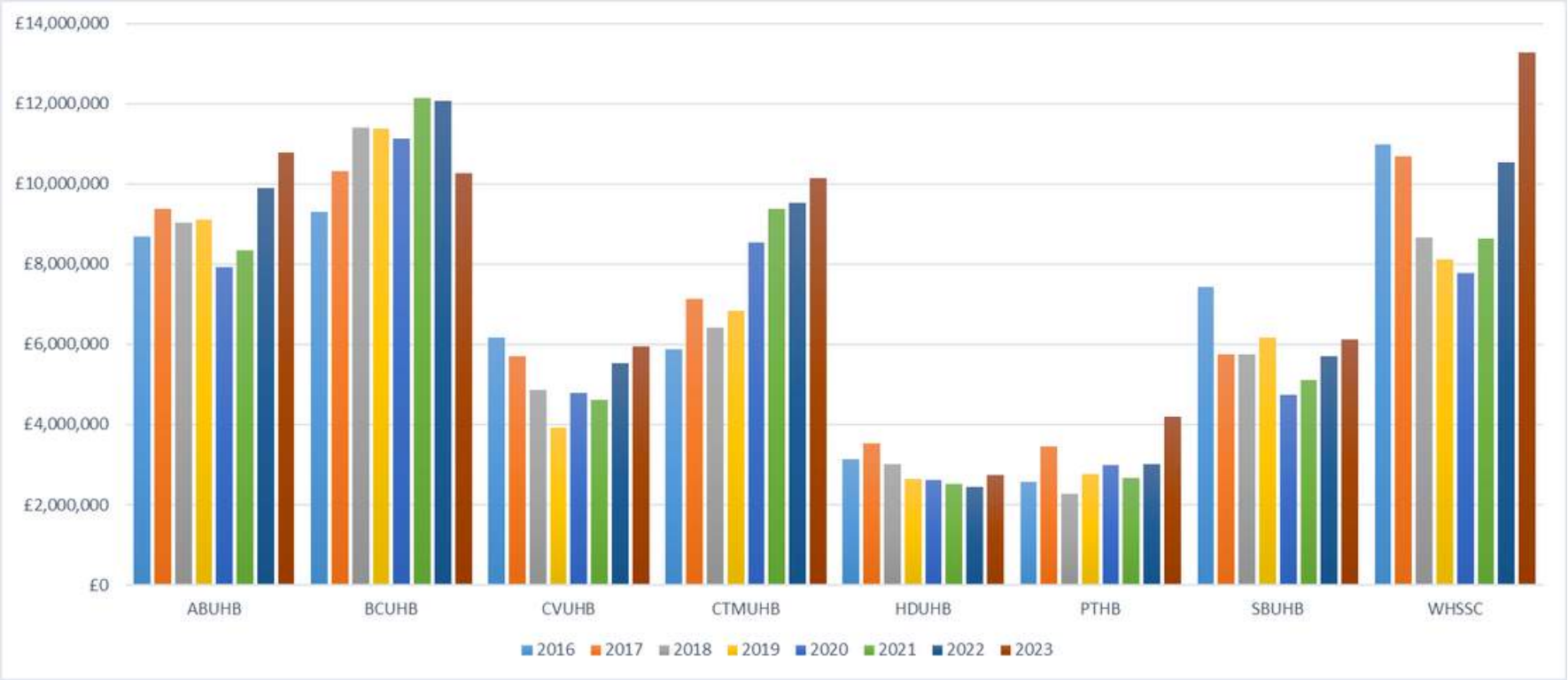
When notified of a safeguarding concern the QAIS contacts the provider to ensure immediate and appropriate actions have been taken.

Expenditure

As at the 31 March 2023, NHS Wales spend through the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework was an annualised cost of £63,486,274. Figure 34 below shows the spending by commissioning organisation over the previous 8 years.

ABUHB £10,783,515 | BCUHB £10,264,524 | C&VUHB £5,948,174 | CTMUHB £10,143,369 | HDUHB £2,742,988 | PTHB £4,198,436 | SBUHB £6,112,448 | WHSSC £13,292,821

Commissioning organisation	ABUHB	BCUHB	CVUHB	CTMUHB	HDUHB	PTHB	SBUHB	WHSSC	Overall
% change on 21/22	8.9%	-14.9%	7.56%	6.37%	11.82%	39.14%	7.21%	26.11%	8.1%



FINANCIAL APPROACHES

Figure 35 shows the spend by commissioning organisation of the last nine years in £millions. This year's figure shows an increase of £4.8m (8.1%) on the previous year and an increase of £9.4m (22%) since 2014-15.

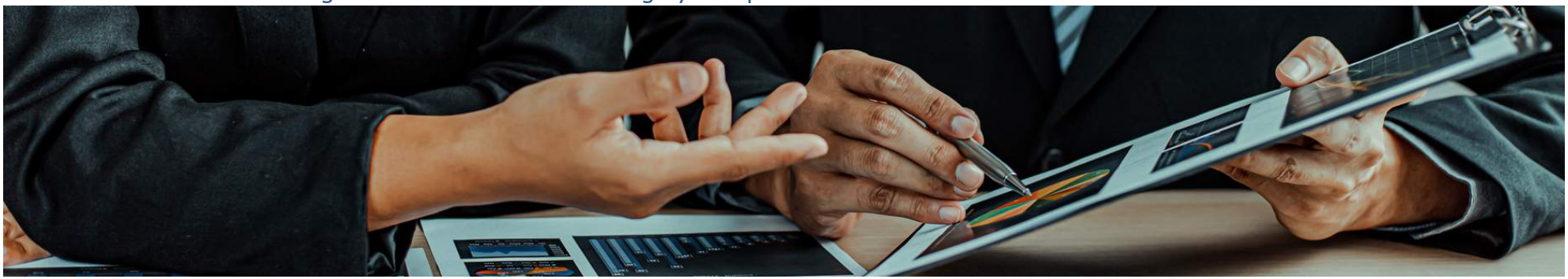
2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
£52.2M	**£54.1M**	**£55.9M**	**£51.7M**	**£50.9M**	**£50.5M**	**£53.8M**	**£58.7M**	**£63.5M**

Figure 35: Spend on Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework (ADULT ONLY)

The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework delivers a 'four track price approach' to apply continuous pressure on providers to deliver, for NHS Wales, quality care at best value through a legally compliant and controlled mechanism. These four approaches are costs included in price, competitive price ranking, regular price refreshes and consistent pricing.

Costs Included in Price: The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework includes a bespoke NHS Wales specification detailing the services to be provided at a set day price. 1:1 is always included in the daily rate. The changes we have made means that 1:1 is not included for patients who are admitted on those levels and are included for a time limited period if place on enhanced observations after admission. Additional staffing costs were running at many millions prior to the introduction of a National Collaborative Commissioning Framework being established and are now incorporated into the day price.

Competitive Price Ranking: The Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework uses a 'quality then cost' approach to provide a competitive mechanism between providers of care who are meeting the quality standard. Providers all achieving the same quality assurance rating are then ranked by price, with the lowest price provider ranked above those with higher cost. This enables a highly competitive environment.



FINANCIAL APPROACHES

Regular Price Refreshes: The Adult Hospital Framework has inbuilt periodic 'price refresh' points, where every 6 months providers can reduce prices and every 18 months where providers can adjust their prices upwards or downwards (with caveats). These points enable the regular request for price increases, normal to commissioned services, to be replaced with a continuous dialogue where, on behalf of NHS Wales. The National Collaborative Commissioning Unit and Shared Services Procurement work with providers to understand market pressures, national and local cost demands and other cost influences to ensure providers understand the need to deliver care at best value and to ensure procured services are being delivered.

Consistent Pricing: All price charges (see previous page) apply to current as well as future placements. This enables real cash releasing savings to be delivered and 'loss leader' pricing to be discouraged, this approach has realised cash releasing saving for the NHS. The approach also protects against the chaos seen in other commissioned markets where there are numerous prices applied for placements, even on the same ward, due to the mix of historic and current applied prices making real price comparison unachievable.

SECTION 3

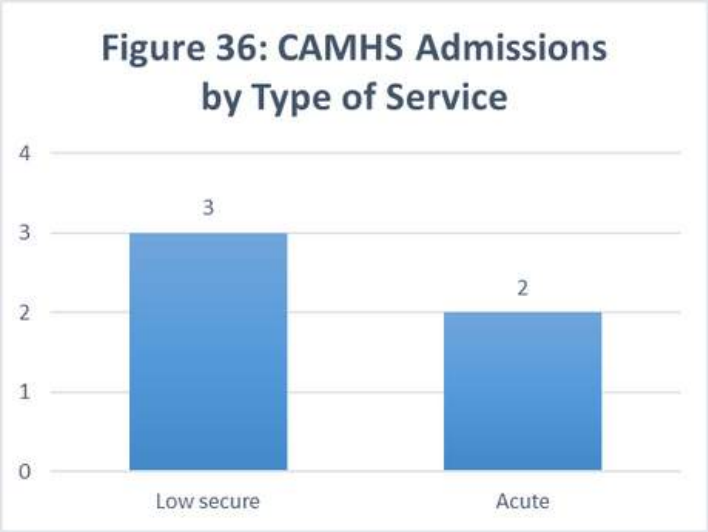
Child Adolescent Mental Health Service (CAMHS) Low Secure and Acute Non-NHS Wales Hospital Services under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework

OVERVIEW AND TRENDS FOR CAMHS HOSPITAL FRAMEWORK

There were 6 companies, 8 sites and 17 units providing 32 CAMHS Lots under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework on 31 March 2023. The Map shows the approximate geographical position of hospitals caring for CAMHS patients.

CURRENT STATE

On 31 March 2023, there were 5 patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework, as shown in Figure 36 below, which is 1 less than 2021/2022.



Between the 1 April 2022 and 31 March 2023, there were 15 new placements, 4 in Low Secure service and 11 in Acute service.

Type of service

Admission to a CAMHS inpatient facility will usually be considered when the level of risk, complexity and/or acuity of the persons need cannot be safely or appropriately managed in the community. Young people may, or may not, be detained under the Mental Health Act to receive inpatient care. Inpatient services cover a range of support to effectively manage the differing need, complexity and acuity of young people with mental ill-health and neurodevelopmental diversity, these services can be grouped into types such as:

- Low secure: These services care for young people who present with needs requiring care in environments which can provide significant levels of physical, relational and procedural security. Young people may present with ‘forensic’ or ‘complex non-forensic’ needs.

- Psychiatric intensive care: These services care for young people with short term behavioural disturbance which cannot be contained within a general service. Behaviour, may include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition.

- General/Acute: These services, normally called ‘General Adolescent Units’, provide assessment and treatment for young people with acute or longer term treatment needs within a controlled environment without the need for enhanced physical or procedural security measures.

OVERVIEW AND TRENDS FOR HOSPITAL FRAMEWORK (CAMHS)

Figure 37 shows the activity (total CAMHS admissions and discharges) of the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework in the three full years it has been in operation. It shows the reduction in activity in each of the years of operation.

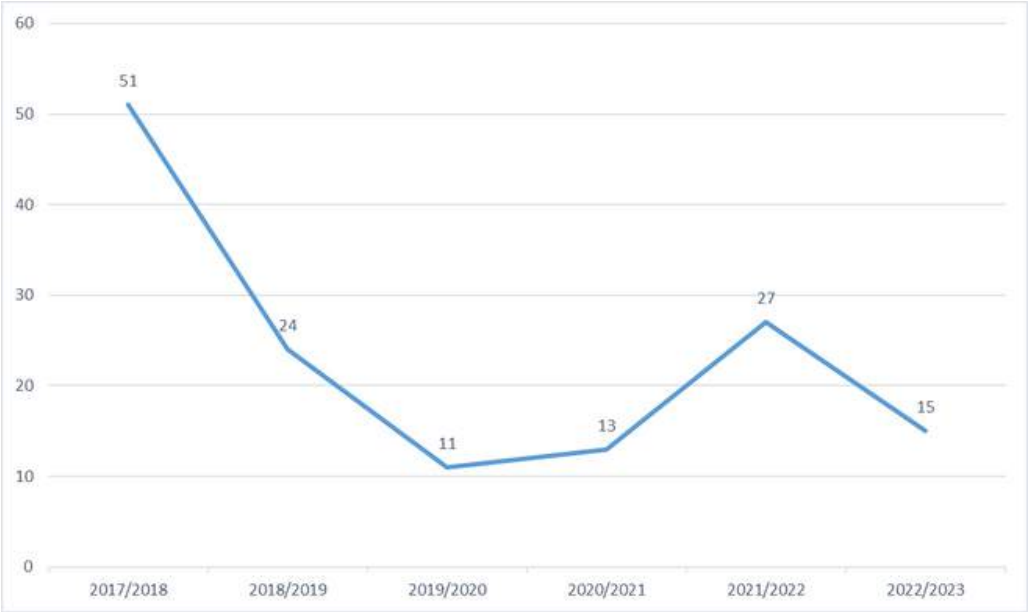


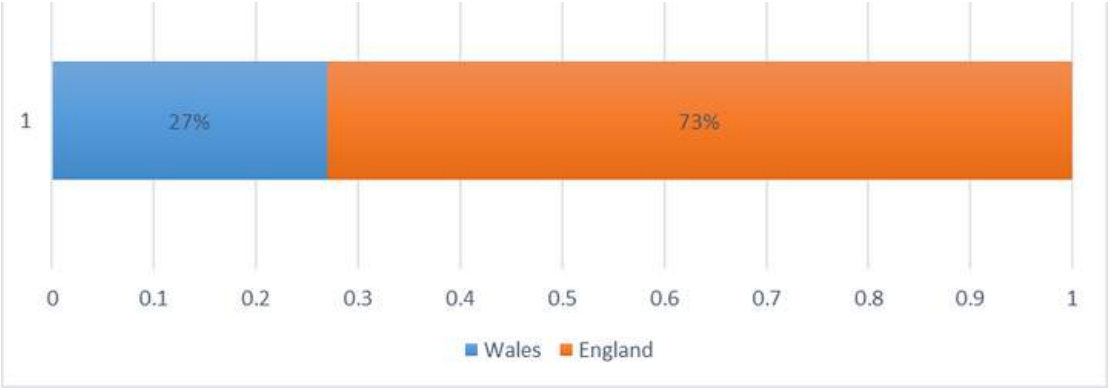
Figure 37: CAMHS Hospital Framework Activity 2017-2023

Effective management of externally placed Children and Young People (CYP) is crucial to that person's positive experience and recovery. When CYP are supported, in a meaningful way whilst being managed in external placements robust therapeutic engagement and relationships develop, augmenting the opportunity for seamless transition between services. This promotes ongoing collaborative discussions between the CYP, families and professionals engaged in their care, facilitating safe and timely repatriation or discharge. The QAIS noted that there is a high level of restraints. The QAIS require assurance that staff utilise restraint as a last resort and that after every restraint the young person is debriefed and this is documented. The QAIS has requested providers to provide assurance that there is a process in place in regards to reporting and communicating with external teams and all reporting completed as required in line with the All Wales Framework CCAPS.

OVERVIEW AND TRENDS FOR HOSPITAL FRAMEWORK (CAMHS)

Country of placement

Mapping CAMHS patients receiving assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework shows that 73% of patients were cared for in England and 27% were cared for in Wales on 31 March 2023.



Distance from significant postcode

The QAIS want to ensure that the National Collaborative Frameworks, wherever possible and with due regard for quality, provide placements that are as close as possible to the patients community of choice. Within the placement process, we mandate that the commissioner enters a 'significant postcode' for the patient and distance to the provider is calculated from this geographical point.

- 2 (13%) patients were admitted to a provider less than 50 miles from the significant postcode (increase from 5% last year).
- 6 (40%) patients who were placed between 50 and 100 miles from the significant postcode (increase from 23% last year).
- 16 (47%) patients are more than 100 miles from the significant postcode (decreased from 72% last year).

Whilst overall placement numbers were lower this year the figures represent a general shift towards placements closer to significant postcode.

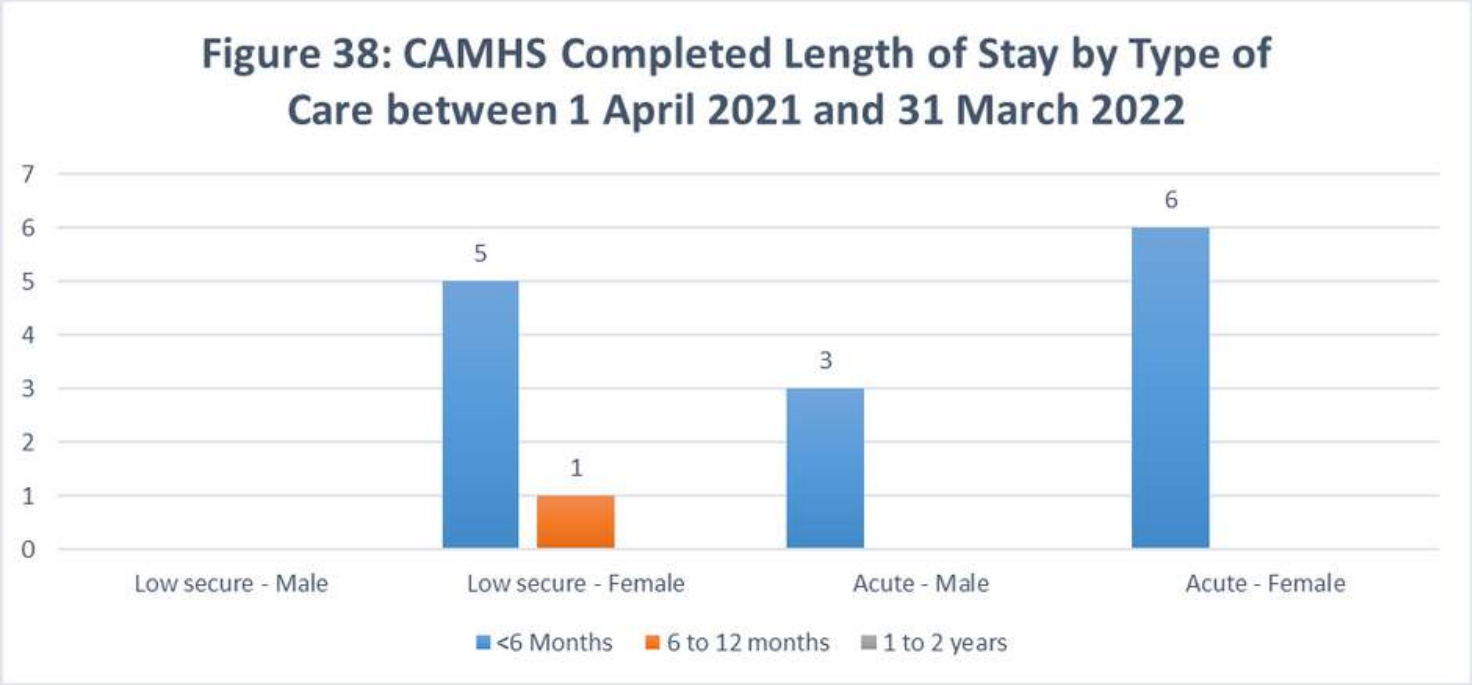
OVERVIEW AND TRENDS FOR HOSPITAL FRAMEWORK (CAMHS)

Length of stay

A total of 16 patients received assurance under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework and 15 were discharged between 1 April 2022 and 31 March 2023.

A total length of stay with their final provider prior to discharge as shown in Figure 38 was:

- 93% (14) patients had a length of stay less than 6 months.
- 7% (1) patient had a length of stay between 6 - 12 months.
- 0 patients had a length of stay between 1 and 2 years.



MAINTAINING THE QUALITY OF CARE

It is a requirement of providers to maintain the standards of care as set out in the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework. Under the new framework there are 5 core outcome areas containing a total of 52 bespoke Welsh Standards based on best evidence, experiential learning and good clinical practice. 312 individual standards were audited between 1 April 2022 and 31 March 2023.

OVERVIEW AND TRENDS FOR CAMHS HOSPITAL FRAMEWORK

Out of the 6 reviews 4 (67%) maintained with no further action required and 2 (33%) were issued with required actions. 1 of the cases the Provider provided assurance all the remedial actions had been rectified within 20 days and the other, the Provider provided assurance within 2 months.
Normally when any remedial action has not been rectified within the designated timeframe than a ‘supervised Performance Improvement Plan’ is issued and the providers ‘3Q’ Quality Assurance Rating is adjusted to reflect the severity of the deficit.

Quality Assurance Ratings

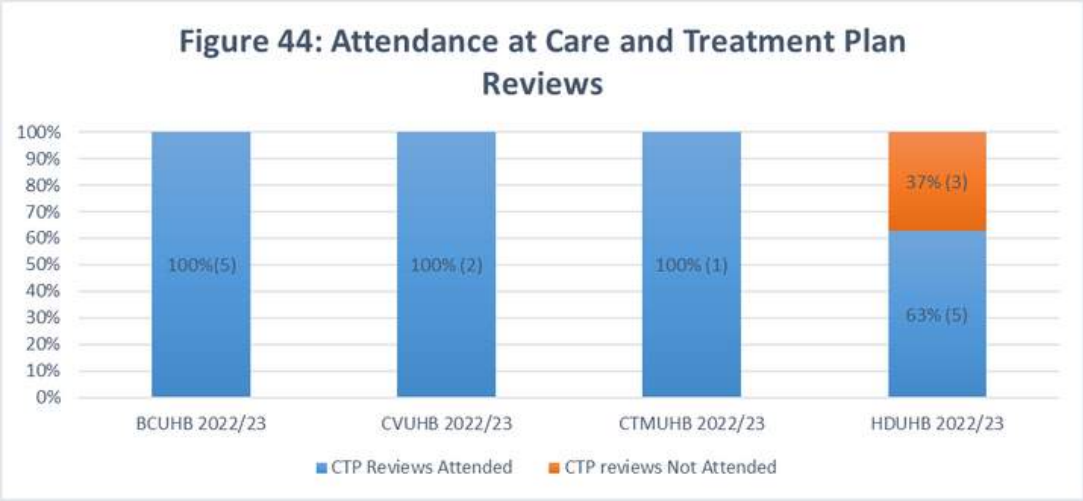
There were 16 patients admitted between 1 April 2022 and 31 March 2023 and 100% of patients were placed with a provider that (at the time of placement) had a ‘3Q Quality Assurance Rating’.

Care Coordination

It is vital that care coordinators receive electronic notifications of incidents and are able to be contacted by the QAIS to discuss individual issues. In order to facilitate this is a requirement to record the name of the patients care coordinators(s) when making a placement. In 2022-23, 100% of patients had details of a care coordinator recorded.

Attendance at Care and Treatment Plan Reviews

There were 16 Care and Treatment Plan (CTP) reviews for during the 1 April 2022 to 31 March 2023. Figure 44 illustrates the attendance or nonattendance* by either a care coordinator and / or other representative from Wales at the Care and Treatment Plan reviews held between 1 April 2022 and 31 March 2023.



*Please note that non-attendance at reviews does not signify a complete absence of patient contact, as professionals may have visited the patient at other times.

INCIDENTS

There were a total of 928 incidents involving Young People receiving services under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework between 1 April 2022 and 31 March 2023. Of these incidents:

- 468 or 51% were classed as negligible. 457 or 49% were classed as minor.
- 7 or 1% were classed as moderate.

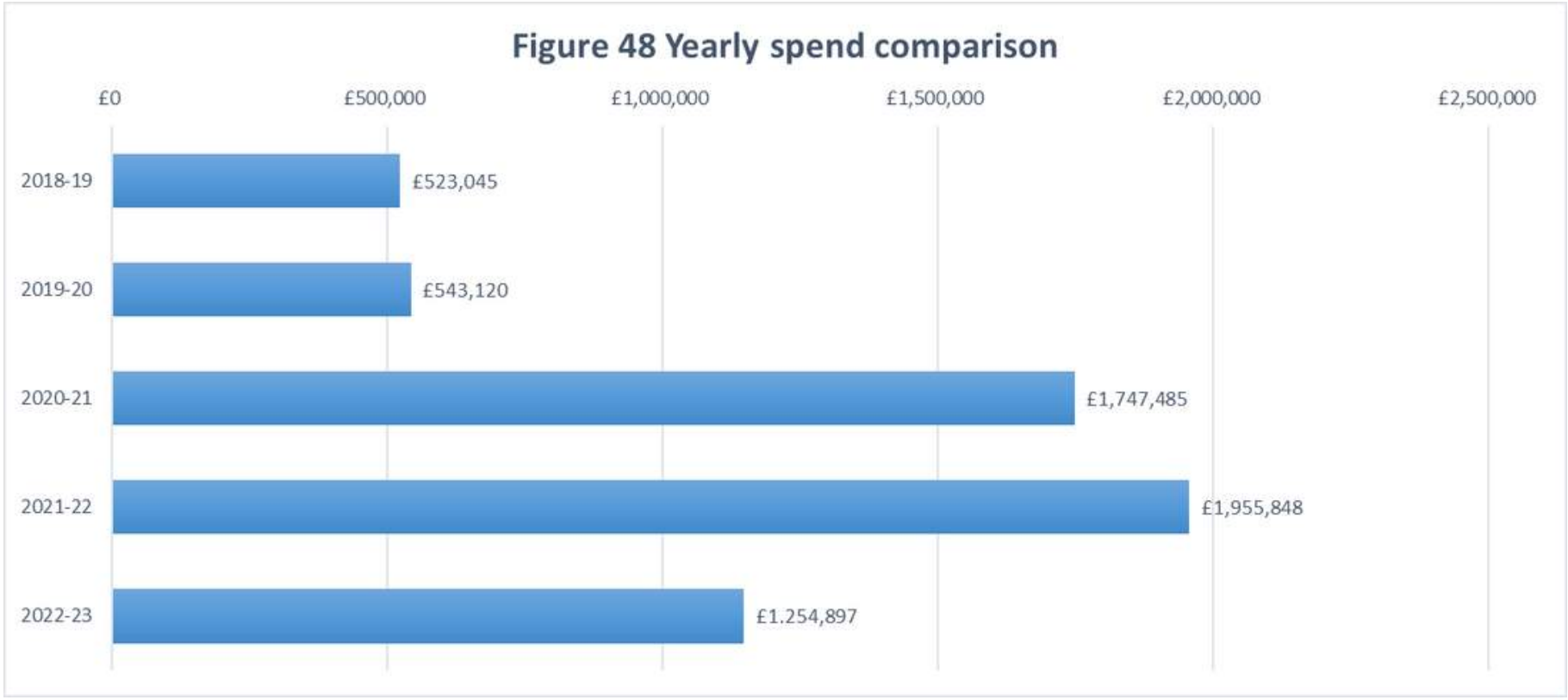
Complaints

There were 15 complaints reported under the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework (CAMHS only) between 1 April 2022 and 31 March 2023. There were 4 complaints reported in 2021/22 and 3 in 2020/21. 9 of these complaints related to attitude of staff, 4 related to clinical treatment, 1 relating to protocols and procedures and 1 regarding patient property. 13 of these complaints were received from one patient at 1 unit and 2 at another unit. Some concerns raised by patients would have been resolved through internal reporting processes.

CAMHS Hospital Framework Expenditure

As at the 31 March 2023, the Welsh Health Specialised Services Committee spend through the Adult Mental Health Learning Disability / Child and Adolescent Mental Health Hospitals Framework (CAMHS only) was an annualised cost of £1,254,897 shown in Figure 48 below.

Refer to page 47 for the financial approaches for the Adult and CAMHS hospital framework.



SECTION 4

National Collaborative Framework Agreement for Adults in Mental Health Learning Disabilities Care Homes (With and without Nursing)

NATIONAL OVERVIEW AND TRENDS

Providers

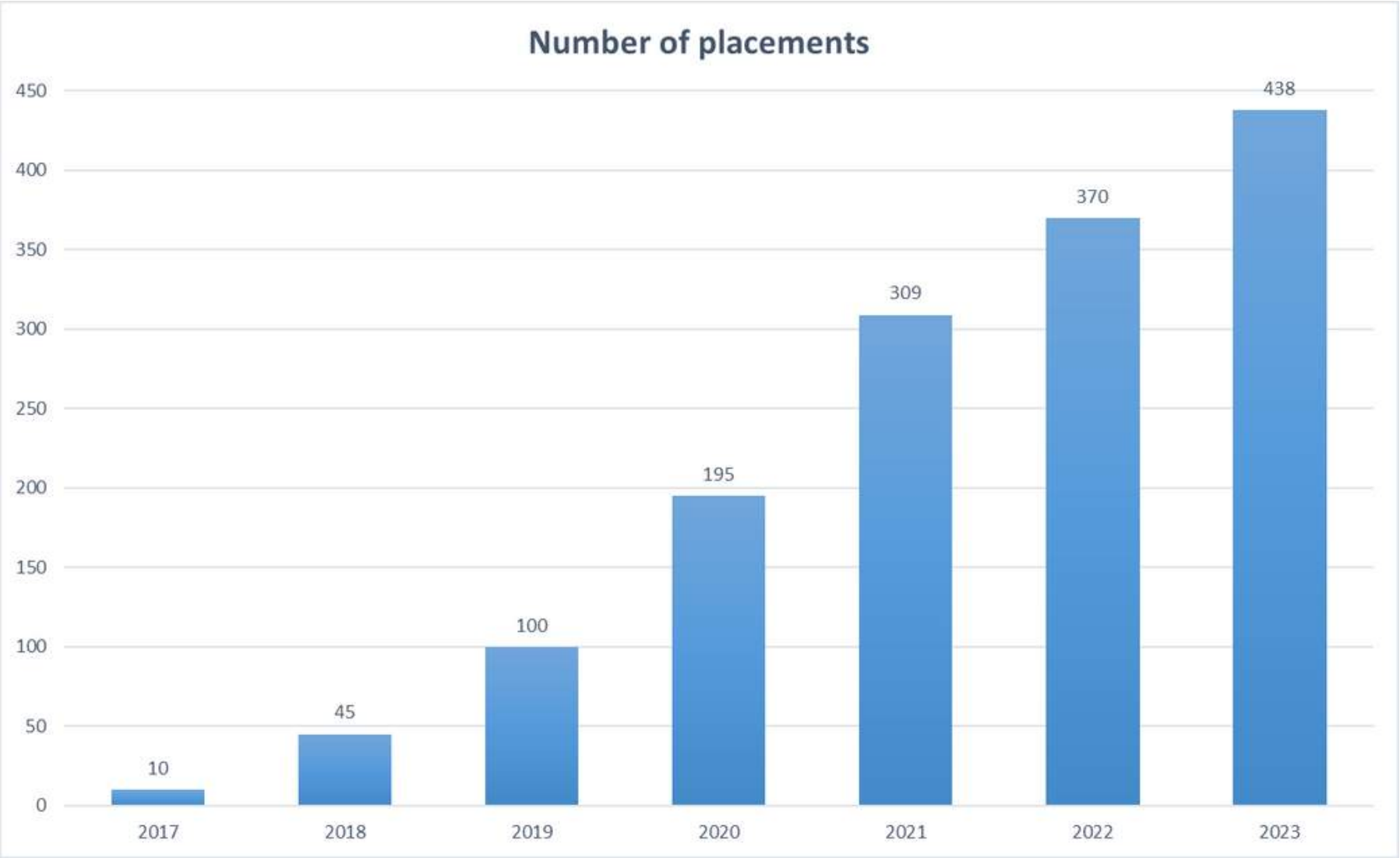
On the 31 March 2023, there were 92 providers and 640 units providing or able to provide services as part of the Care Home Framework.

The Map shows the approximate geographical position of care homes on the Framework.

NATIONAL TRENDS

On the 31 March 2023 there were 438 Welsh residents receiving assurance under the Care Home Framework. This compares to 370 residents from the previous year, equating to an 18% increase.

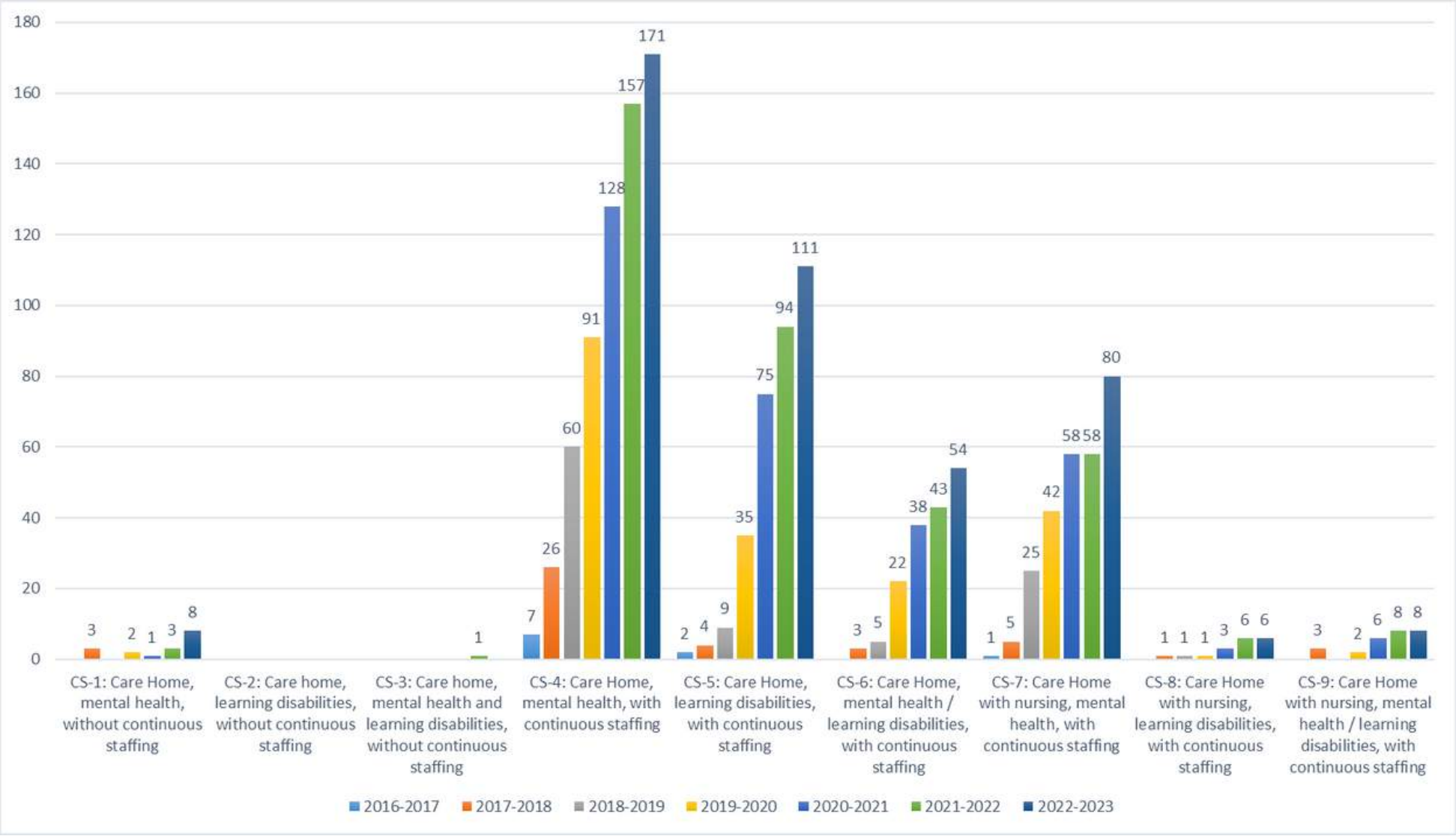
There were 128 new admissions and 66 discharges between April 2022 and March 2023.



NATIONAL OVERVIEW

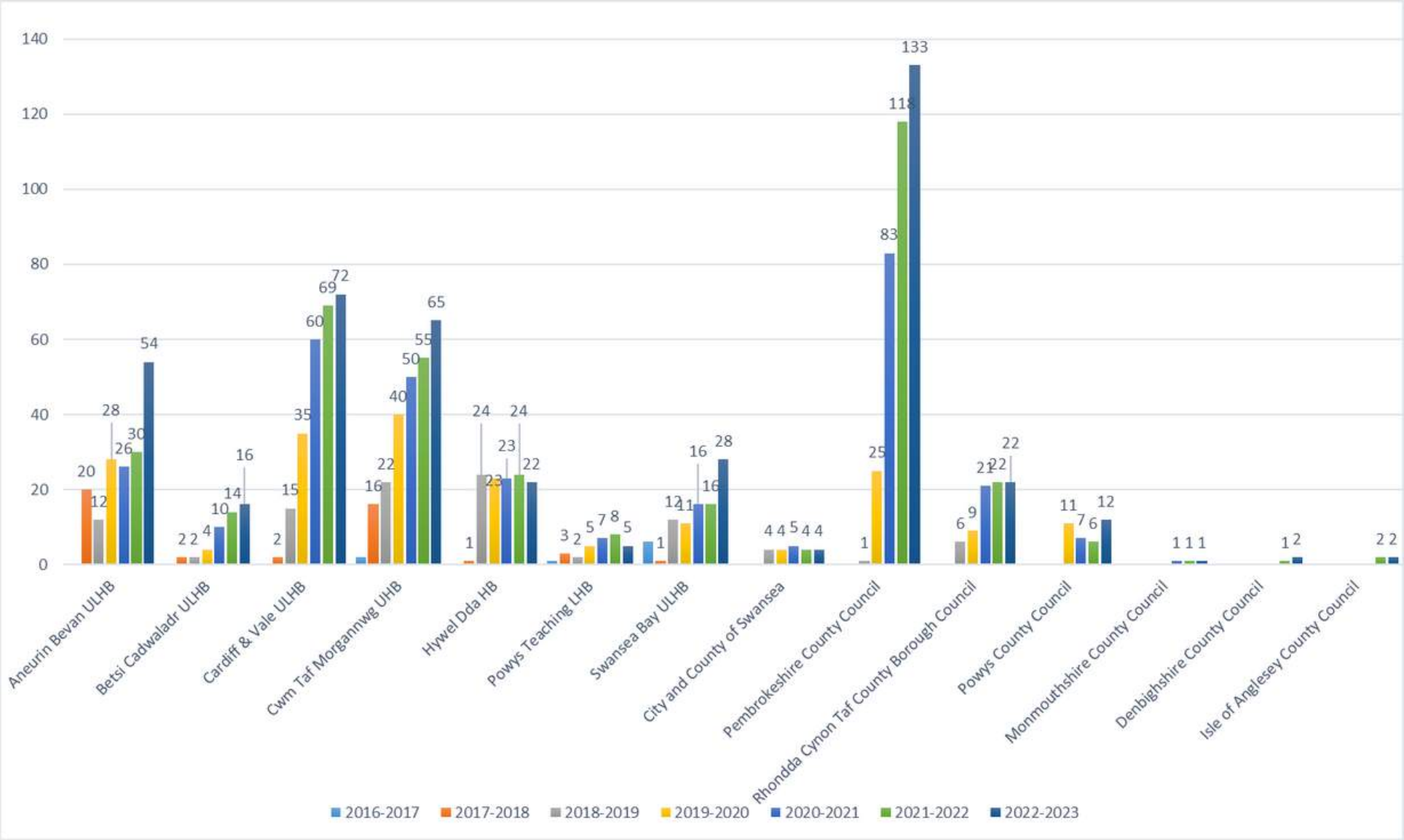
There are nine different types of services that can be commissioned through the Care Home Framework.

Figure 50 illustrates the number of placements by type of service from 1 October 2016 to 31 March 2023.



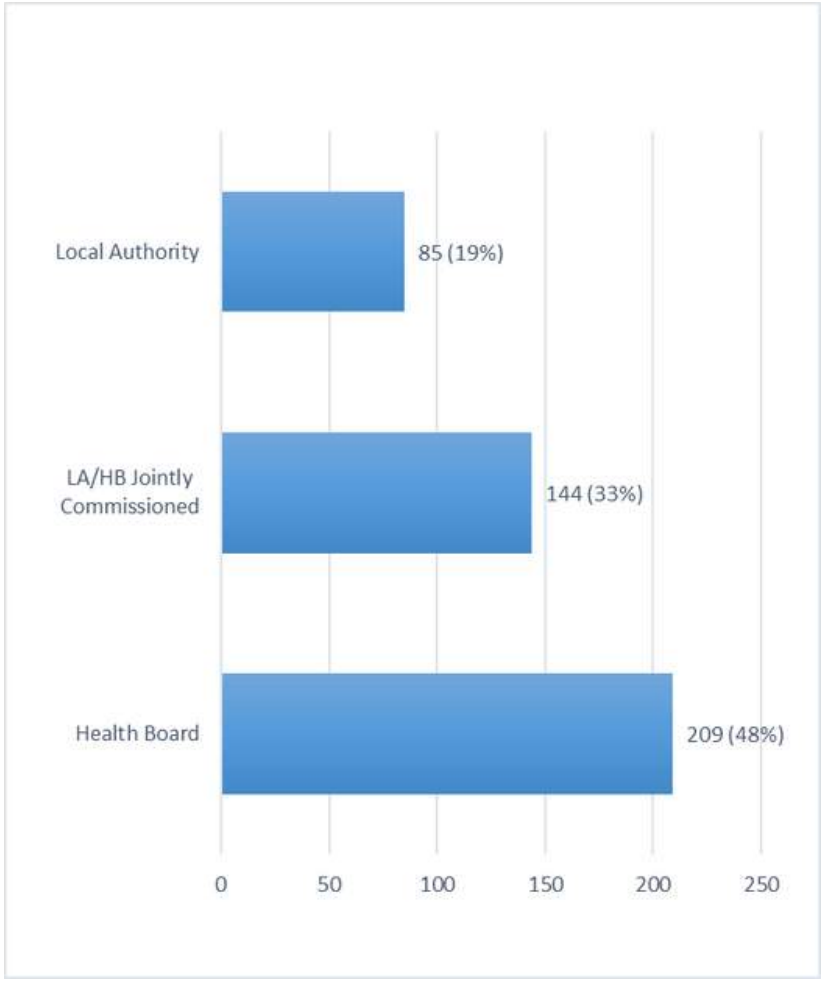
NATIONAL OVERVIEW

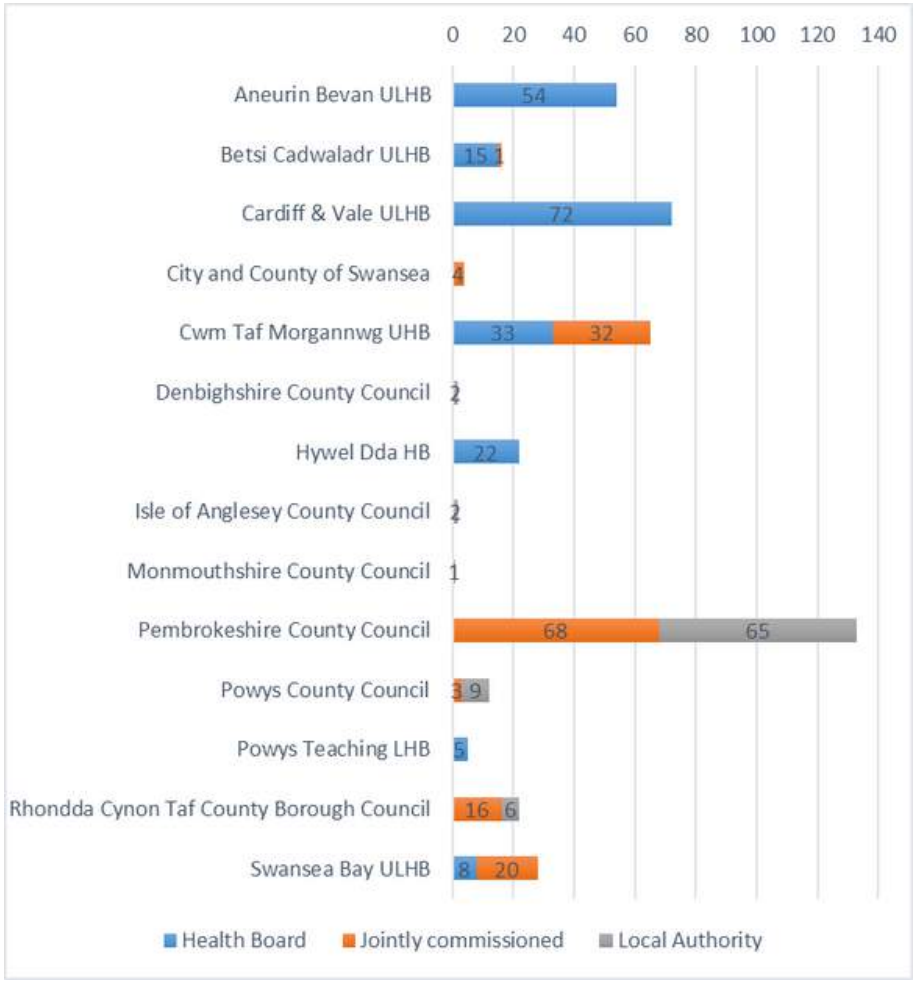
The 'Lead Commissioner' 'is the commissioning organisation who requests placement for a 'jointly commissioned' (both health and local authority) resident. The figure below shows the placements by the lead commissioning organisation from 1 October 2016 to 31 March 2023.



NATIONAL OVERVIEW

The figure below illustrates that of the 438 Welsh residents receiving assurance on 31 March 2023 under the Care Home Framework, 19% of residents had a Local Authority, 33% had both Local Authority and Local Health board whilst 48% had a Health Board as lead commissioner which represents a shift of 1% funding from LA to HB on the previous year (joint commissioning was 33% in 2021-22).

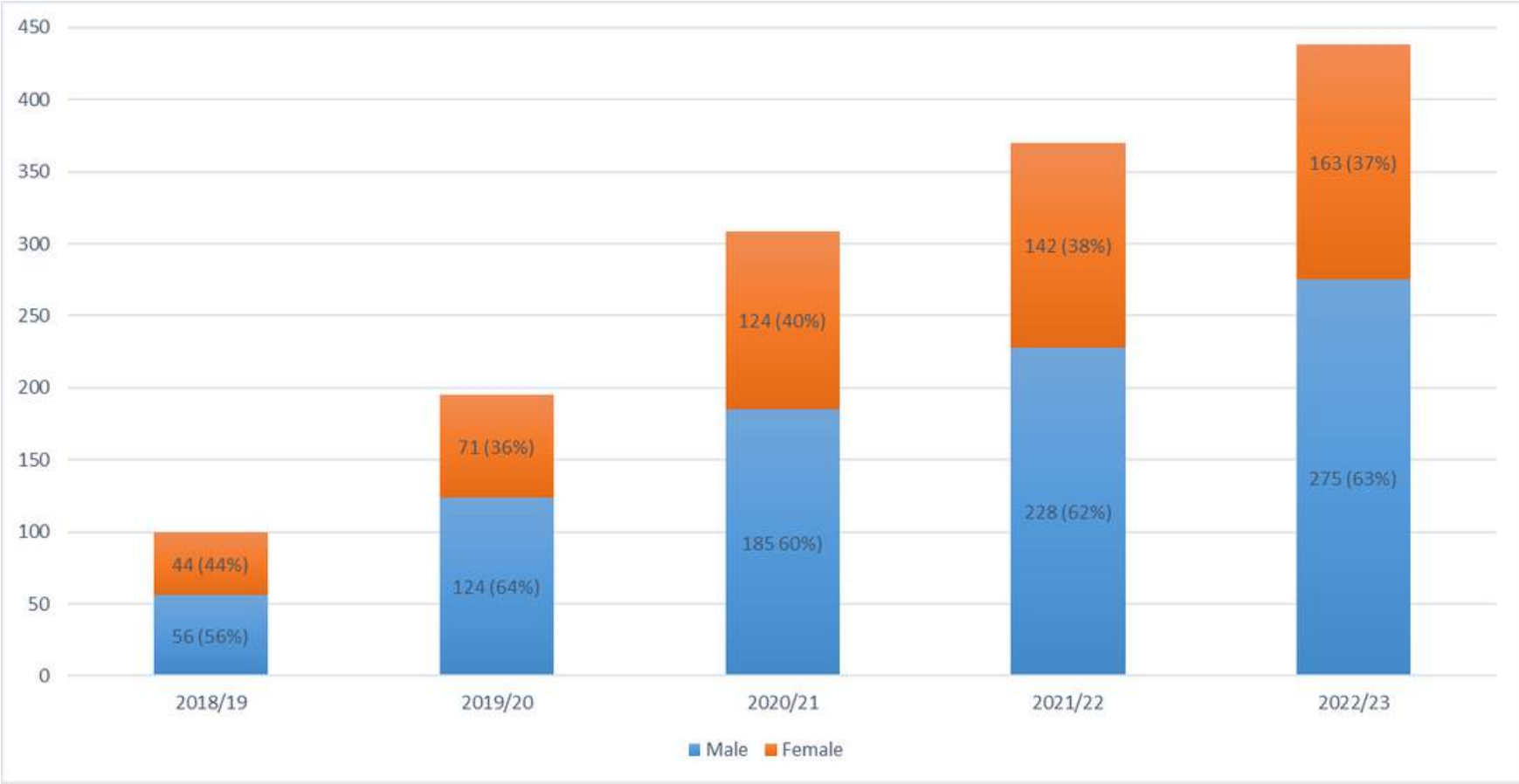




Specific organisation commissioning placements between 1 April 2022 and 31 March 2023

MALE AND FEMALE DISTRIBUTION

Of the 438 residents receiving assurance under the National Collaborative Framework on the 31 March 2022, 63% (275) were male and 37% (163) were female. The figure below shows the distribution of male and female residents receiving assurance compared to previous years.



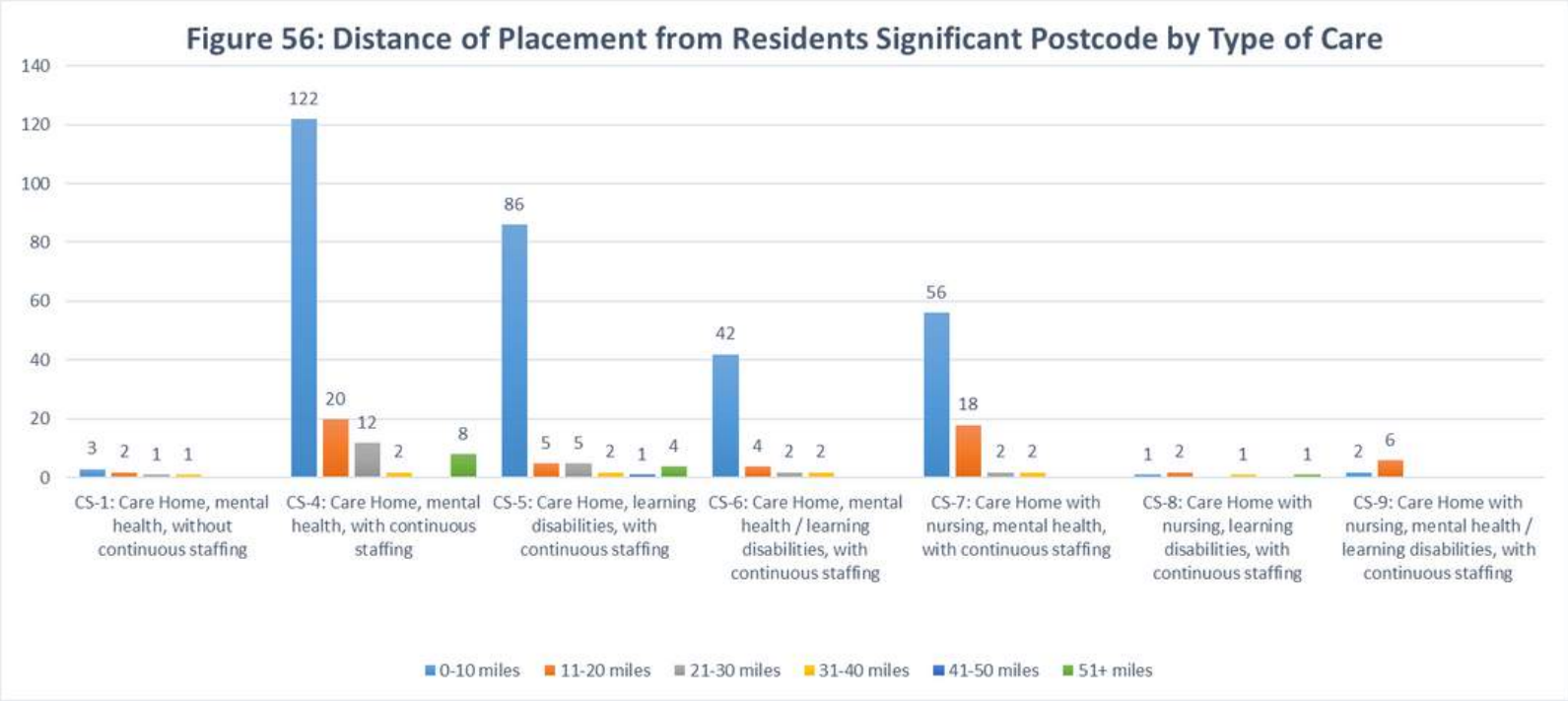
Of the 438 patients receiving assurance under the Care Home Framework on the 31 March 2023, 99% (433) were placed in Wales and 1% (5) were placed in England.

Since 2021-22 the number of patients placed in care homes located in Wales has increased by 19% and the number of patients placed in care homes located in England has remained the same.

DISTANCE FROM SIGNIFICANT POSTCODE

The QAIS want to ensure that the National Collaborative Frameworks, wherever possible and with due regard for quality, provide placements that are as close as possible to the residents community of choice. Within the placement process, we mandate that the commissioner enters a 'significant postcode' for the resident and distance to the provider is calculated from this geographical point. Figure 56 shows the distance of placement from the significant postcode by type of care.

- 75% of residents received care between 0-10 miles.
- 14% of residents received care between 11-20 miles.
- 5% of residents received care between 21-30 miles.
- 2% of residents received care between 31-40 miles.
- 1% of residents received care between 41-50 miles.
- 3% of residents received care of 51+ miles from the significant postcode.



MAINTAINING THE QUALITY OF CARE

Between 1 April 2022 and 31 March 2023, 7,316 individual standards were reviewed. The table below details the average achievement for each of the eight areas of standards within the Care Home Framework.

Standard Area	2020-21	2021-22	2022-23
THE PROVIDER SUPPORTED THE RESIDENT TO BE SAFE	93%	96%	91%
THE PROVIDER SUPPORTED THE RESIDENT TO FEEL AT HOME	96%	96%	97%
THE PROVIDER SUPPORTED THE RESIDENT AND THE RESIDENTS COMMUNITY TO VALUE EACH OTHER	95%	97%	99%
THE PROVIDER SUPPORTED THE RESIDENT TO BE HEALTHY	95%	99%	98%
THE PROVIDER SUPPORTED THE RESIDENT TO RECOVER AND STAY WELL	81%	93%	93%
THE PROVIDER SUPPORTED THE RESIDENT TO PROGRESS AND MOVE ON	85%	88%	90%
OPERATIONAL AND IT REQUIREMENTS	85%	92%	95%
REGULATORY COMPLIANCE	91%	96%	97%

QUALITY ASSURANCE REVIEWS

The QAIS planned, co-ordinated and completed visits to 124 Care homes belonging to 35 different providers between 1 April 2022 and 31 March 2023. These visits covered 208 Care settings (CS1 – CS9) during which 7316 reviews of standards took place.

This accounts for 19% of the care homes on the Care Home Framework where a Welsh resident had been admitted.

The outcome of the 124 care homes reviews were that 52 (42%) care home required one or more remedial actions and 72 (58%) did not require any remedial action. These figures depict a decrease in requirement for remedial action of 8% on the previous year.

The 52 care homes where one or more remedial actions were each issued a 'Performance Improvement Notice'. Across all Performance Improvement Notices there were a total of 326 individual actions (example shown in Figure 58 below).

Area: Medication		
Care Standard	Audit Outcome	Assurance Required
On occasion of the failure to provide, or for the Resident to accept or receive any individual prescribed medication, the rationale for this is clearly documented	A number of examples were noted where medication identified on the MAR was not signed as being administered in line with the directions. For example, Laxido was prescribed daily for one individual but not given - no rational was recorded on the MAR.	Key staff who administer medication have been booked on further medication training as well as completing medication assessment booklets. This includes observations from deputy and manger to ensure compliance.

Figure 58: Example of a Care Home Framework Improvement Action

Of the 124 reviews, 72 (58%) maintained their Q's and 52 (42%) required further actions to be completed. In 38 of the cases the provider provided assurance all the remedial actions has been rectified within 28 days.

In 14 (11%) cases the provider did not provide assurance that one or more remedial actions had been rectified and therefore a supervised performance improvement plan was issued resulting in the providers 3Q quality assurance rating being adjusted to reflect the severity of the deficits.

Care Home Reviews - Themes

Deficiencies were commonly found in specific areas, as per the framework standards:

1.14: Ensuring the environment of care is safe, accessible, well-maintained, and homely.
2.12: Providing safe, comfortable, and pleasant premises with suitable light, heat, and ventilation.
5.1: Meeting Residents' needs through appropriate interventions, staffing, qualifications, and training.
6.2: Documenting positive outcomes, timescales, and interventions in care plans.
6.8: Ensuring accurate and complete Care and/or Clinical Records are accessible to Residents.
7.7: Reporting Resident, Carer, or Staff Complaints on a monthly basis.

Environmental inspection and premises safety were common issues, potentially related to ageing estates and resource allocation.Staffing, including skill set, pre-admission assessment, and pay, was a concern for some care homes.

Medication management under Standard 5.2 also raised issues, and it's essential to explore whether nurse-led care homes face particular challenges.

The documentation of care plans requires improvement, with emphasis on including the resident's view and clear, measurable objectives.

F*or providers, we might advise a more robust approach to addressing environmental issues in line with Standards 1.1.3 and 2.12. Implementing necessary changes in a timely manner is crucial. Exploring local services' support network for out-of-area residents, especially during crisis situations, can enhance care coordination.*

Clarity on what constitutes a good care plan for homes and hospitals should be communicated to providers for consistency and improved documentation.

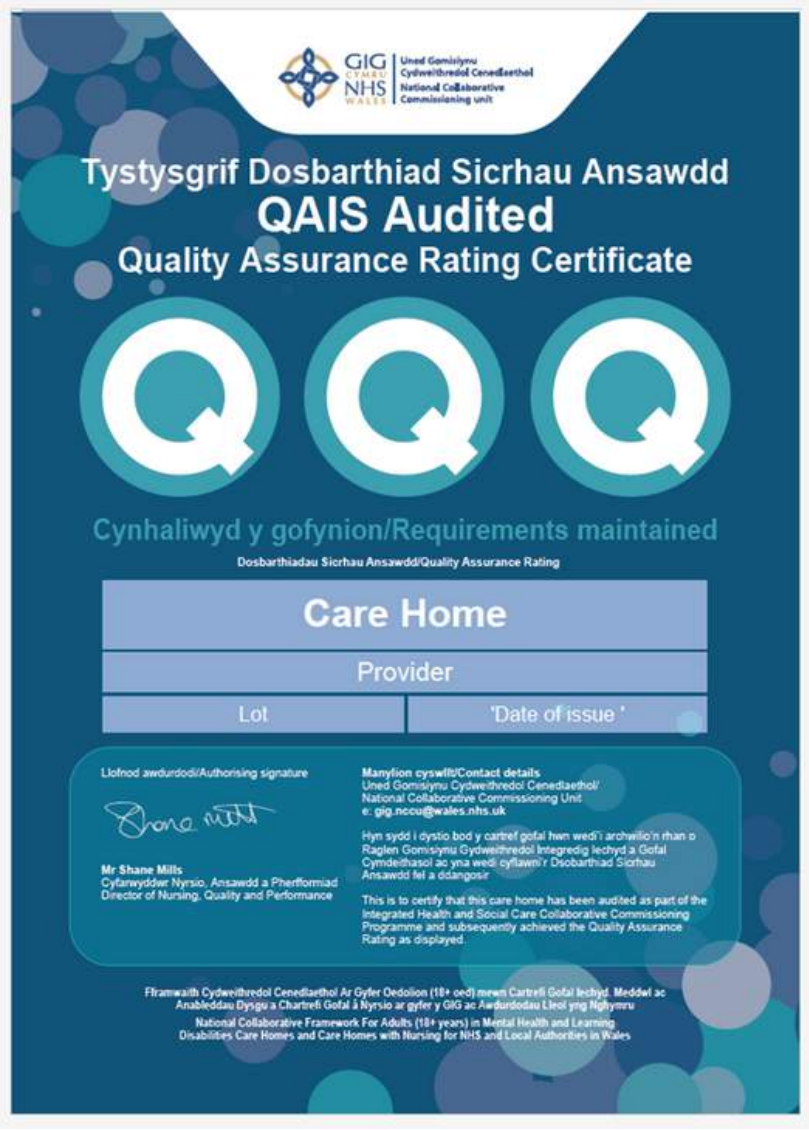
Our ongoing commitment to quality assurance and improvement will guide us in supporting providers to enhance their services and achieve better outcomes for patients and residents.

Care Co-ordination

It is vital that care co-ordinators receive electronic notifications of incidents and are able to be contacted by the QAIS to discuss individual issues. In order to facilitate this is a requirement to record the name of the residents care coordinators(s) when making a placement. In 2022-23, 100% of residents had details of a care co-ordinator recorded.

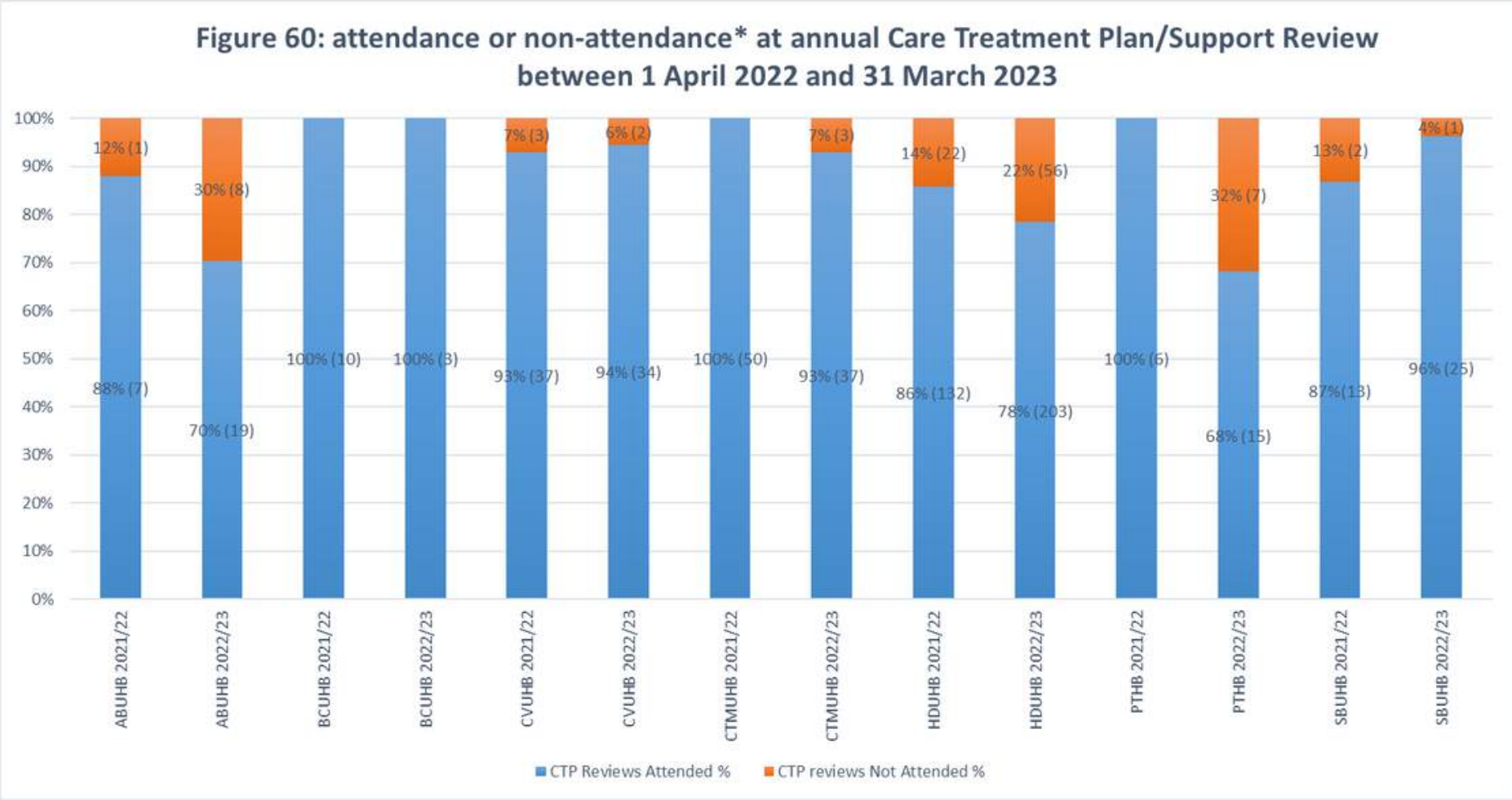
Quality Assurance Ratings

There were 128 placements commissioned between 1 April 2022 and 31 March 2023 as part of the Care Home Framework. Of those placed 100% of residents were placed with a provider who had maintained the ‘3Q’ Quality Assurance Rating. Figure 59 shows the residents placed with a provider who had maintained the '3Q' Quality Assurance Rating.



ATTENDANCE AT CARE TREATMENT PLAN / ANNUAL SUPPORT PLAN REVIEWS

There were 413 recorded Care Treatment Plan / Annual Support Plan Reviews between 1 April 2022 and 31 March 2023. Figure 60 illustrates the attendance or non-attendance* by either a care co-ordinator and / or other representative from Wales at these reviews held between 1 April 2022 and 31 March 2023.



*Please note that non-attendance at reviews does not signify a complete absence of resident contact, as professionals may have visited the resident at other times.

INCIDENTS

There was a 4.3% reduction in incidents (5656) reported compared with the previous year (5908) involving residents receiving assurance under the Care Home Framework. To be able to compare numbers more accurately (as certain types of services or providers may have more residents) we calculate the denominator by 'how many days a bed in a care home was occupied by a Welsh resident'. This is called 'occupied bed days'. The numbers are then multiplied by 1000 to produce balanced score using 1000 occupied bed days as benchmark. Of these incidents 2,825 or 50% were classed as negligible, 2,305 or 41% were classed as minor, 423 or 7.5% were classed as moderate, 73 or 1% were classed as severe and 30 or 0.5% were classed as critical.

Incident Type	Negligible	Minor	Moderate	Severe	Critical	Total Number of Incidents	Per 1000 occupied bed days
Perpetrator of Disruptive, physically aggressive behaviour, Violence	842	1173	76	2	2	2095	13.44
Perpetrator of verbal abuse, threats or bullying	948	606	86	9	2	1651	10.59
Self-harming behaviour / Suicide	218	191	72	5	1	487	3.12
Resident Injury resulting from an accident or incident or is unexplained.	315	113	30	3	3	464	2.98
Access, admission, transfer, discharge (including missing Resident) - AWOL	94	29	35	8	1	167	1.07
Victim of Disruptive, physically aggressive behaviour and violence	140	22	1			163	1.05
Resident Illness			85	42	21	148	0.95
Medication	92	32	9	0	0	133	0.85
Victim of verbal abuse threats or bullying	61	29	9	1	0	100	0.64
Perpetrator of Sexual abuse / sexual violence	54	33	12	0	0	99	0.64
Illicit Substance use or possession	32	56	3	0	0	91	0.58
Victim of Sexual abuse / sexual violence	9	8	3	2	0	22	0.14
Resident Injury or Harm resulting from any act or omission relating to Care and Treatment, Clinical Procedure or intervention.	13	2	2	1	0	18	0.12
Documentation, Record keeping, Data and legal, and property.	6	4	0	0	0	10	0.06
Breach of terms of residence	1	7	0	0	0	8	0.05
Total	2825	2305	423	73	30	5656	36.29

INCIDENTS

The figure below compares incidents per 1000 occupied bed days (note the 18% increase in the number of residents placed) and comparison of Incidents from Last Year by Type of Incident per 1000 Occupied Bed Days

	2021-22	2022-23	Difference
Total Incidents	5,908	5656	-252
Incident Type	Number of incidents per 1000 occupied bed days		
Perpetrator of Disruptive, physically aggressive behaviour, Violence	17.4	13.4	-4.0
Perpetrator of verbal abuse, threats or bullying	11.8	10.6	-1.2
Self-harming behaviour / Suicide	5.5	3.1	-2.4
Resident Injury resulting from an accident or incident or is unexplained.	2.4	3	+0.6
Access, admission, transfer, discharge (including missing Resident) - AWOL	1.1	1.1	-
Victim of Disruptive, physically aggressive behaviour and violence	1.5	1	-0.5
Resident Illness	0.7	1	+0.3
Medication	1.1	0.9	-0.2
Victim of verbal abuse threats or bullying	0.9	0.6	-0.3
Perpetrator of Sexual abuse / sexual violence	0.6	0.6	-
Illicit Substance use or possession	0.8	0.6	-0.2
Victim of Sexual abuse / sexual violence	0.1	0.1	-
Resident Injury or Harm resulting from any act or omission relating to Care and Treatment, Clinical Procedure or intervention.	0.1	0.1	-
Documentation, Record keeping, Data and legal, and property.	0.1	0.1	-
Breach of terms of residence	0.2	0.1	-0.1

INCIDENTS

The figure below illustrates the number of incidents by service type and by 1000 occupied bed days and Incidents by Type of Care Home and 1000 Occupied Bed Days.

Care setting	Negligible	Minor	Moderate	Severe	Critical	Total Number of Incidents	Per 1000 occupied bed days
CS-1: Care Home, mental health, without continuous staffing	22	12	11	-	-	45	0.29
CS-3: Care Home, mental health/ learning disabilities, without continuous staffing	2	19	6	-	-	27	0.17
CS-4: Care Home, mental health, with continuous staffing	713	470	245	35	14	1477	9.48
CS-5: Care Home, learning disabilities, with continuous staffing	1268	1399	62	2	2	2733	17.53
CS-6: Care Home, mental health / learning disabilities, with continuous staffing	343	268	61	10	2	684	4.39
CS-7: Care Home with nursing, mental health, with continuous staffing	345	100	23	21	11	500	3.21
CS-8: Care Home with nursing, learning disabilities, with continuous staffing	47	7	3	1	-	58	0.37
CS-9: Care Home with nursing, mental health / learning disabilities, with continuous staffing	85	30	12	4	1	132	0.85
Total	**2825**	**2305**	**423**	**73**	**30**	**5656**	36.29

INCIDENTS

The figure below illustrates the number of incidents by service type and by 1000 occupied bed days compared to last year and comparison of Incidents from Last Year by Type of Care Home and per 1000 Occupied Bed Days

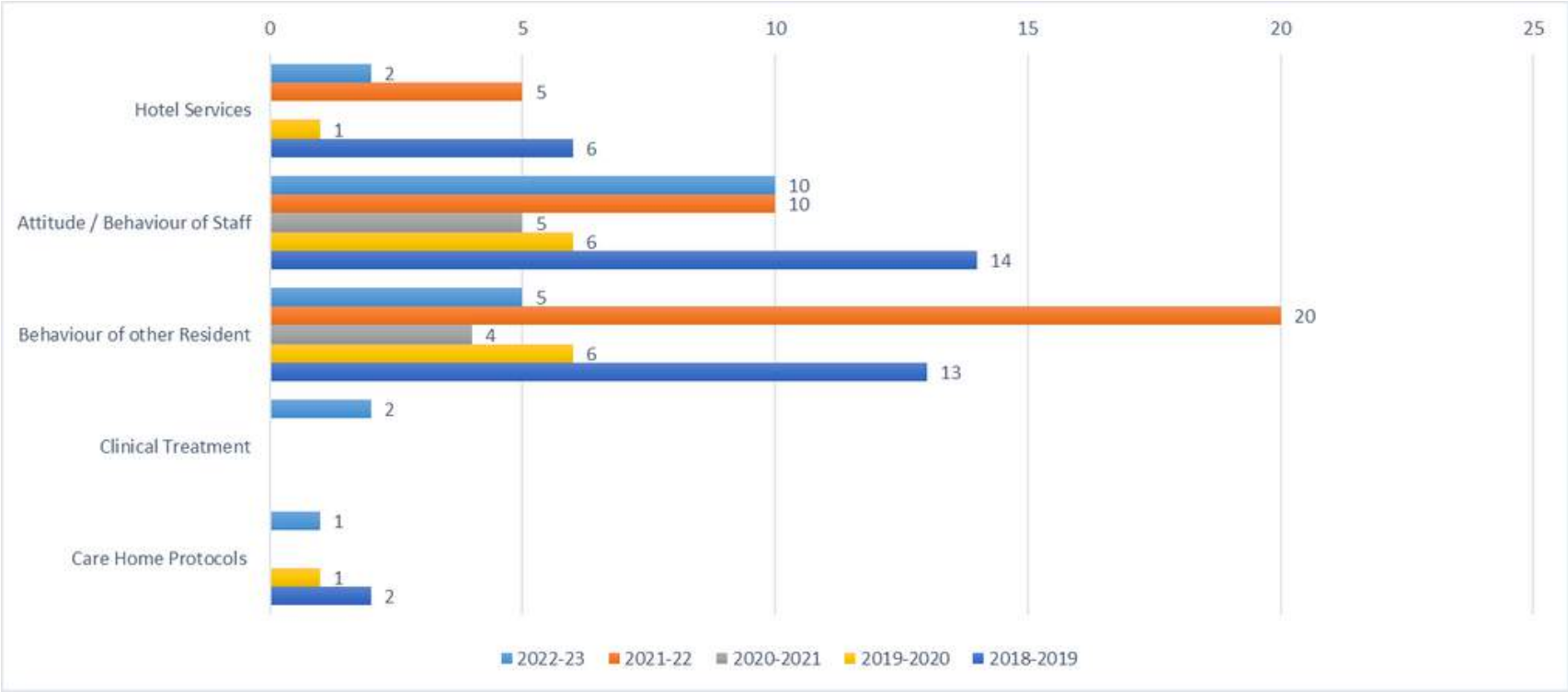
	2021-22	2022-23	Difference
Total Incidents	5,908	5656	-252
Service Type	Number of incidents per 1000 occupied bed days		
CS-1: Care Home, mental health, without continuous staffing	0.05	0.3	+0.25
CS-3: Care Home, mental health/ learning disabilities, without continuous staffing	0.11	0.2	+0.09
CS-4: Care Home, mental health, with continuous staffing	6.24	9.48	+3.24
CS-5: Care Home, learning disabilities, with continuous staffing	25.23	17.53	-7.7
CS-6: Care Home, mental health / learning disabilities, with continuous staffing	8.20	4.39	-3.81
CS-7: Care Home with nursing, mental health, with continuous staffing	3.24	3.21	-0.03
CS-8: Care Home with nursing, learning disabilities, with continuous staffing	0.71	0.37	-0.34
CS-9: Care Home with nursing, mental health / learning disabilities, with continuous staffing	0.61	0.85	+0.24

COMPLAINTS

The figure below details the 20 complaints reported from the 1 April 2022 to 31 March 2023 for each of the nine complaint titles by residents receiving assurance as part of the Care Home Framework. Complaints are categorised against a bespoke 53 point matrix of nine complaint areas with sub categories in each and monitored by the QAIS to highlight areas of investigation or improvement.

The graph shows that a total of 20 complaints were reported between 1 April 2022 and 31 March 2023, a decrease of 26% from the 38 reported last year.

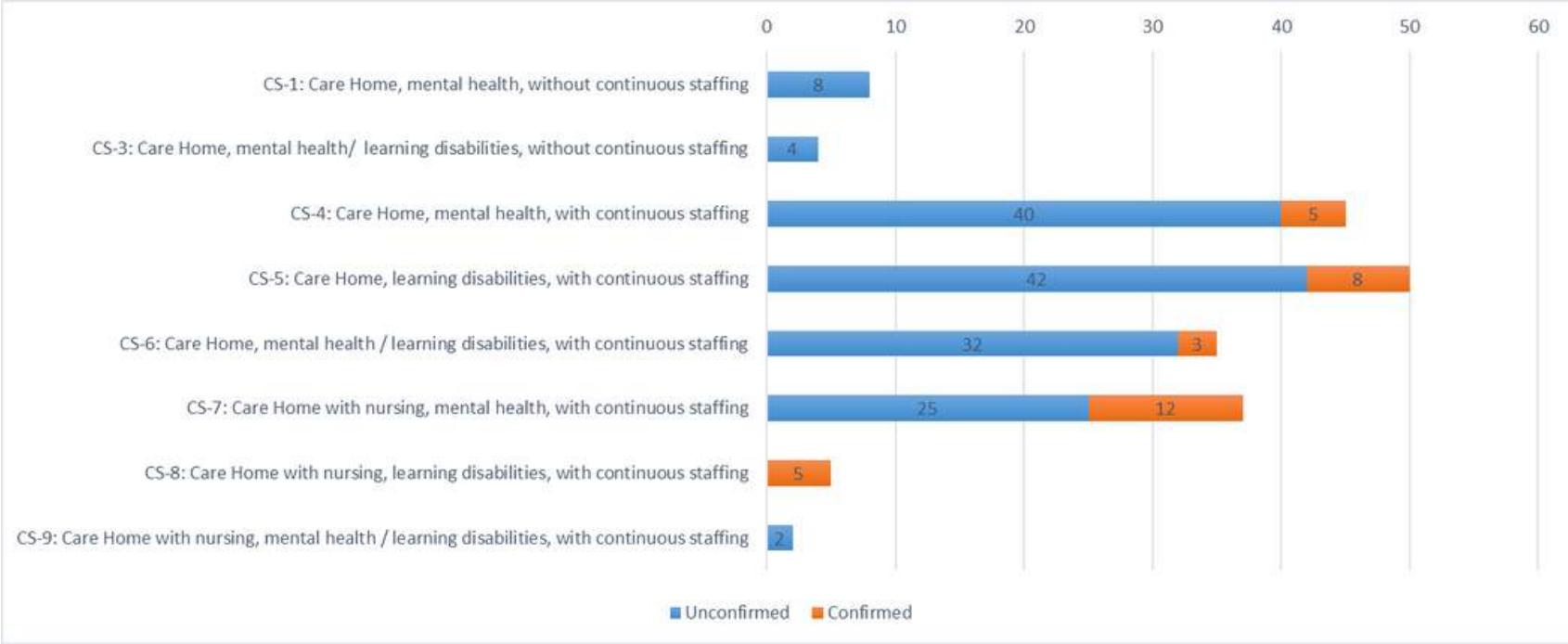
- 25% (5) were classed as Behaviour of other resident in 2022-23 compared to 53% (20) in 2021-22.
- 50% (10) were classed as Attitude / Behaviour of Staff in 2022-23 compared to 26% (10) in 2021-22.
- 10% (2) were classed as Clinical Treatment in 2022-23 compared to 5% (2) in 2021-22.
- 10% (2) were classed as Hotel Services in 2022-23 compared to 13% (5) in 2021-22.
- 5% (1) were classed as Care Home Protocols in 2022-23 and an increase from 0 in 2021-22
- No complaints recorded for Legal, Communication, Equality & Diversity and Patient Property in 2022-2023



SAFEGUARDING

The figure below illustrates the 186 safeguarding concerns reported to local safeguarding teams that involved residents receiving assurance under the Care Home Framework between 1 April 2022 to 31 March 2023.

These safeguarding concerns are subsequently validated by local safeguarding teams, as either meeting their local safeguarding threshold ("confirmed"), or not ("unconfirmed"). Between 1 April 2022 and 31 March 2023 33 (18%) of concerns were confirmed and 153 (82%) were unconfirmed.



Safeguarding concerns can be physical abuse, sexual abuse, psychological abuse, financial or material abuse, discriminatory abuse and neglect and acts of omission.

- 11% (20) were classed as Sexual in 2022-23 compared to 7% (19) in 2021-22.
- 48% (89) were classed as Physical in 2022-23 compared to 44% (111) in 2021-22.
- 23% (42) were classed as Neglect in 2022-23 compared to 19% (49) in 2021-22.
- 3% (6) were classed as Financial in 2022-23 compared to 4% (9) in 2021-22.
- 15% (29) were classed as Emotional/Psychological in 2022-23 compared to 26% (66) in 2021-22.

RESIDENT CARE OUTCOMES

The QAIS has developed six resident level outcome measures called Resident Care Outcomes (RCOs). These are collated, analysed and verified by the QAIS for each resident quarterly in order to:

- Ensure positive individual outcomes are the focus of the care provision.
- Compare outcome achievement across providers delivering similar care.
- Provide an indication of the issues that may require remedial action.
- Indicate where there is potential to improve the effectiveness of care.

Each RCO is accompanied by 'achievement guidelines', an example of which is shown below for the sixth RCO 'The Provider supported the Resident to progress and move on'. The provider reports the outcome through CCAPS if the RCO been achieved.

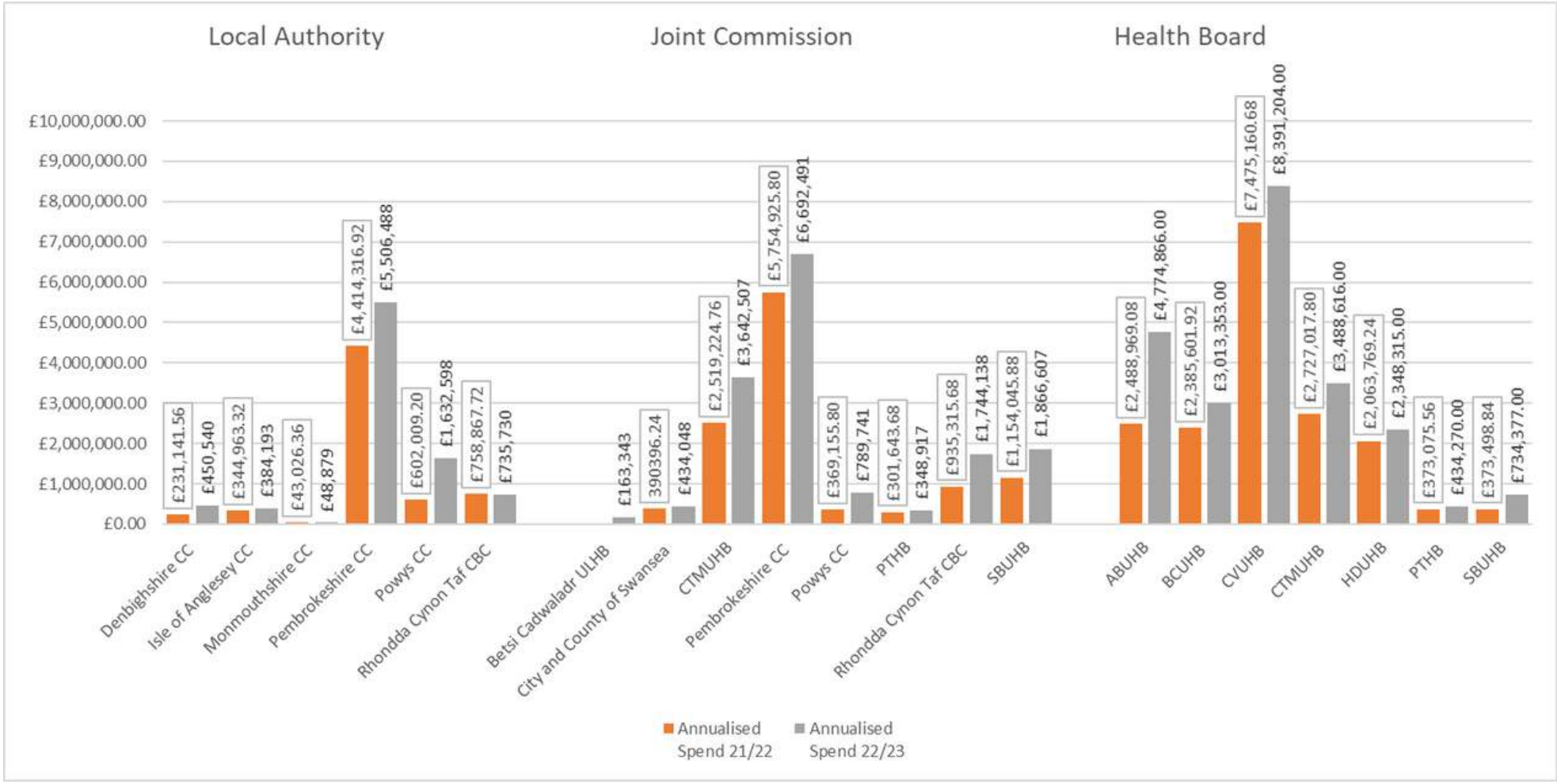
There are six RCOs that are reported every three months for each resident.

The table below shows the percentage of RCO Achievement Compared to Last Year.

	% of RCOs recorded as achieved	
Resident Care Outcomes	2021-22	2022-23
THE PROVIDER SUPPORTED THE RESIDENT TO BE SAFE	98%	98%
THE PROVIDER SUPPORTED THE RESIDENT TO FEEL AT HOME	99%	97%
THE PROVIDER SUPPORTED THE RESIDENT AND THE RESIDENTS COMMUNITY TO VALUE EACH OTHER	97%	99%
THE PROVIDER SUPPORTED THE RESIDENT TO BE HEALTHY	98%	98%
THE PROVIDER SUPPORTED THE RESIDENT TO RECOVER AND STAY WELL	99%	93%
THE PROVIDER SUPPORTED THE RESIDENT TO PROGRESS AND MOVE ON	98%	90%

Expenditure

As at the 31 March 2023, NHS Wales spend through the Care Home Framework was an annualised cost of £47.6M an increase/decrease of 33% on the previous year. The figure below shows the spend by framework type over the last four years.



SECTION 5

Other work requested or commissioned from the Quality Assurance Improvement Service

OTHER WORK REQUEST OR COMMISSIONED FROM THE QAIS

Although the main role of the Quality Assurance Improvement Service is to manage the National Collaborative Frameworks, different organisations within Wales have also commissioned the service to undertake a number of different types of reviews. In this last review period, the QAIS has undertaken:

Primary Care Mental Health Review

The scope of this National Review was to provide a greater understanding on:

- Key themes for providing mental health support in Primary Care.
- Demand and activity.
- Variation in NHS Primary Care Mental Health Service provision.
- Third sector mental health support at Primary Care level.

ACKNOWLEDGEMENTS

For further information on the work of the National Collaborative Commissioning Unit, NHS Wales Quality Assurance and Improvement Service, Commissioning Care Assurance Performance System (CCAPS) or any other details contained within this statement contact:

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Parc Nantgarw,
Cardiff
CF15 7QZ

Tel: 01443 744928
Email: GIG.NCCU@wales.nhs.uk
Website: www.nccu.nhs.wales/qais

This report is also available in Welsh

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 25 July 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Natasha Bold	Highly Specialist Speech & Language Therapist (In part)
Sarah Dunkerley	Observing
Dom Hurford	Medical Director
Sallie Davies	Deputy Medical Director
Lauren Edwards	Executive Director of Therapies & Health Science (In part)
Gethin Hughes	Chief Operating Officer (In part)
Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Cally Hamblyn	Assistant Director of Governance & Risk
Richard Hughes	Deputy Executive Director of Nursing
Mary Self	Care Group Medical Director - MHLD
Emma James	Nurse Director, Unscheduled Care Group
Suzanne Hardacre	Director of Midwifery
Mohamed Elnasharty	Clinical Director (In part)
Nigel Downes	Assistant Director of Quality & Safety
Becky Gammon	Head of Nursing Professional Standards & Education (In part)
Lucie Williams	Head of Nursing, Primary Care & Communities
Sharon O'Brien	Planned Care - Care Group Nurse Director (In part)
Claire O'Keefe	Head of Safeguarding
Sarah Follows	Service Director, Unscheduled Care Group (In part)
Lisa Love-Gould	Clinical Director of Allied Health Professionals (In part)
Alex Brown	Clinical Director, Unscheduled Care (In part)
Kellie Jenkins Forrester	Head of Concerns and Business Intelligence
Stephanie Muir	Assistant Director of Concerns & Claims
Gaynor Jones	Staff Side Representative
Paul Dalton	Head of Internal Audit
Brian Hawkins	Chief Pharmacist, Medicines Governance (In part)
Emma Walters	Corporate Governance Manager

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;
- Ana Llewellyn, Care Group Nurse Director (Primary Care, Community and MHLD);
- David Miller, Care Group Medical Director (Primary Care & Community);
- Hannah Wilton, Chief Pharmacist;
- Julie Denley, Deputy Chief Operating Officer;
- Stephen Sarasin, Care Group Medical Director (Planned Care);
- Chris Beadle, Assistant Director Health, Safety & Fire;
- Hywel Daniel, Executive Director for People.

1.3 Declarations of Interest

There were no additional interests declared.

2.0 SHARED LISTENING AND LEARING

2.1 Listening & Learning Story

N Bold shared the Listening & Learning Story with Members of the Committee which related to the impact of the Building Blocks for Communication Project which had been carried out by the Paediatric Speech & Language Therapy Service over the last year. The Committee Chair extended her thanks to N Bold for sharing the story.

L Love-Gould also extended her thanks to N Bold for the presentation and advised that she was aware of the work being undertaken by the Speech and Language Therapy Team and that the Team were looking at a Train the Trainer Project in terms of increasing the scale and reach of this activity.

L Edwards echoed the comments made and advised she felt incredibly proud of the profession. L Edwards added that the presentation had shown that challenging the traditional model could offer improved experiences and outcomes for parents and their children and added that there was learning to be gained by other services within the Health Board from the model and approach being taken. In response to a question raised by L Edwards as to how the Team were planning on spreading the effectiveness of the approach being taken to give people confidence to try things differently, N Bold advised that options were being explored in relation to Train the Trainer to enable Building Blocks to be put in place within the Community. Members noted that Local Authority

colleagues had been really engaged with the project, with a number of Local Authority staff attending practitioner training to enable them to be better placed to run the parent workshops within the community. Members noted that families were valuing this approach more compared to the direct approach and noted that families who had already participated in this project were starting to see benefits. N Bold advised that the Team were planning on sharing the story with other families and added that a range of leaflets were in place regarding the project.

S Hardacre welcomed the presentation and asked whether the Team needed support from the Children and Families team in relation to engagement with parents and added that the Team would be more than happy to help if required. S Hardacre sought clarity as to whether any assessments were undertaken of parental literacy in relation to the workbooks that were being provided. N Bold advised that the workbooks being provided were an additional resource which enhanced the work being undertaken by the Team within the interactive sessions. Members noted that whilst the workbooks contained lots of graphics in addition to text, further consideration could be given to accessibility.

J Sadgrove welcomed the update which she had found to be a thoughtful, considered and welcomed service improvement. J Sadgrove advised that she was aware that the Team had presented at the Improvement CTM conference recently and encouraged the Team to keep sharing their story.

D Hurford also extended his thanks to N Bold for sharing the story and recognised that a significant amount of dedication and hard work had been put into this project. D Hurford advised that whilst focus tended to be placed on Acute site matters, focus also needed to be placed on the significant work being undertaken across the Health Board to improve services. D Hurford also added that consideration needed to be given moving forwards regarding inclusive forms of communication being offered to patients, for example, sign language.

The Committee Chair advised that it was evident that Members felt very positive regarding the presentation shared and the work being undertaken by the Team and added that there were some learning points identified that could be shared more widely. The Committee Chair advised that the Committee looked forward to hearing more about the project in the future.

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

2.2 Care Group Spotlight Presentation – Diagnostics, Therapies, Pharmacy and Specialties

L Love-Gould presented the report and highlighted the key matters for Members attention.

G Jones referred to the statement made that there was a small risk of urgent suspected cancers being missed at triage and sought clarity as to the reasons why these had been missed. L Love-Gould advised that this was in relation to

Clinical Haematology Consultant cover and the acknowledgement that with reduced staffing, there may be a risk that some urgent suspected cancers could be missed. L Love-Gould provided assurance that this had not occurred as appropriate Consultant cover was now in place. G Hughes added that the newly appointed Clinical Director for Pathology was undertaking a piece of work with Consultant Haematologists to ensure that processes and pathways for cancer were being followed and to ensure that capacity within Haematology was being used more effectively, which would help mitigate the risk.

The Committee Chair recognised that there were a significant range of issues being covered within the report and advised that she felt reassured following the presentation that the issues were being addressed. The Committee Chair advised that it would be helpful if future reports could include the impact of the measures that had been put into place to address the issues highlighted.

G Hughes provided an update on the challenges that had been experienced in relation to performance regarding the waiting times for Non-Obstetric Ultrasound, with the waiting list being in excess of 9000 patients waiting. Members noted that as part of planned care recovery, some additional funds had been agreed to support this. Members noted that all staff had now returned to work following a period of sickness absence as a result of Repetitive Strain Injuries and noted that a recent review of the current position indicated that 1600 patients had been removed from the waiting list since May 2023 following treatment received. G Hughes advised that a plan was in place to remove the backlog by the end of the year. Members noted that the MR backlog had reduced even further to 1000 patients waiting for treatment.

J Sadgrove recognised that the report demonstrated the pressure all services were under and added that Members were grateful to staff for working hard to ensure they keep innovating and exploring alternative approaches to help move things forward, which was greatly appreciated.

J Sadgrove made reference to the Obstetric Ultrasound and Repetitive Strain Injury issue and advised that a patient story had been received at the Maternity and Neonatal Improvement Board held recently which related to the experience of a female patient with high BMI, who had a difficult experience in the way in which staff had spoken to her. J Sadgrove advised that she was aware that the Team were undertaking some work in relation to addressing patients appropriately, whilst recognising the challenge being faced by Clinicians. S Hardacre advised that the issues identified within the patient story would be addressed by the Team and advised that the Team were more widely seeing extra additional surveillance having a significant impact nationally, particularly in relation to gap and grow and foetal surveillance wellbeing. Members noted that this was being explored and escalated to Welsh Government as part of the Maternity & Neonatal Safety Support Programme. S Hardacre advised that there were various models of Midwifery led Sonography across Wales and added that she would welcome a discussion with L Love-Gould as to how this could be developed further within Cwm Taf Morgannwg.

The Chair extended her thanks to L Love-Gould for presenting the report and for the work being undertaken by the Team.

Resolution: The presentation was **NOTED.**

Action: Future reports to include the impact of the measures that had been put into place to address the issues highlighted.

3. CONSENT AGENDA

The Committee Chair asked Members if there were any items on the consent agenda that they wished to move to the main agenda for discussion.

P Roseblade made reference to agenda item 9.2.6a – Regulatory Review Recommendations and Progress Update relating to Healthcare Inspectorate Wales (HIW), which made reference to a whistleblower who had made direct contact with HIW and was then encouraged to come back to the Health Board to discuss their concerns. In response to a question raised by P Roseblade as to whether the individual did come back to the Health Board to discuss their concerns and whether the outcome was amicable, R Hughes advised that whilst it can often be difficult to establish the identity of individuals who had raised concerns due to anonymity, the engagement exercise undertaken afterwards sometimes allowed individuals to make contact with the Health Board to discuss their concerns. R Hughes advised that it was standard practice for HIW to recommend that staff discuss their concerns with the Health Board and advised that he believes that the individual had raised no further issues.

P Roseblade made reference to agenda item 9.2.6b which related to the Home Office Controlled Drugs License Tracker and advised that the report identified that a significant number of areas within the Health Board were now applying for Home Office Licenses and sought clarity as to the reasons behind this. B Hawkins advised that this had arisen due to a change in the interpretation of the Home Office Guidance and license requirements, which had been interpreted in a different way by Health Board's previously. Members noted that following discussion with Welsh Government and the Home Office, there had now been a change in the interpretation as to what is required for a Home Office License, which would apply to all Health Board's in Wales, which had resulted in a change of process and the application for licenses across a range of services within the Health Board.

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.

J Hehir made reference to the update provided in relation to LINC and sought clarity as to whether there were any plans in place to review the contractual process to draw out any lessons that could be learnt and address the concerns identified in recent national digital procurement activity. G Hughes advised that work was being undertaken in this area and added that the Chief Executive would be discussing this matter at the next NHS Leadership Meeting. Members noted that there were significant challenges in the way in which IT procurement was undertaken in Wales and noted that work was being undertaken with colleagues within Digital Healthcare Wales to address this. Members noted that lessons learnt were being addressed across a range of programmes. J Hehir recognised the sensitivities and dependencies regarding this matter which were quite transparent.

In response to a query raised by P Roseblade as to whether the LIMS contract was ending before the LINC contract and whether this posed a risk in relation to the possibility of an intervening period with no cover, G Hughes advised that whilst there was no risk with LIMS, there were risks in relation to the Radiology Programme which would be discussed further at the In Committee Board taking place on the 27 July.

In response to a query raised by P Roseblade as to when an improvement would be seen in relation to Ophthalmology Follow Ups not Booked rates, G Hughes acknowledged that the process for following up patients within Ophthalmology was not as robust as it could be and added that support was being received from the Getting it Right First Time (GIRFT) Team to address this. Members noted that initial feedback received from Clinical Leads is that a range of recommendations were likely to be proposed, which included how Glaucoma patients were being followed up and the need to focus on the patients at highest risk. Members noted that a further update on Ophthalmology would be provided as part of the Planned Care Group Highlight Report.

P Roseblade referred to the reference made within the report to a Stroke bed unit at the Royal Glamorgan Hospital (RGH) and advised that she thought that patients who presented to Royal Glamorgan with suspected stroke were transported to either Princess of Wales (POW) or Prince Charles Hospitals (PCH) for specialist stroke treatment. G Hughes confirmed that there were no stroke beds at the Royal Glamorgan Hospital and confirmed that if a patient does self-present at RGH with suspected stroke they would be transferred to PCH or POW.

P Roseblade made reference to page 7 of the report and sought clarity as to what the Welsh Health Specialised Services Committee Cot Configuration consultation related to. G Hughes confirmed that this related to the consolidation of Neonatal Intensive Care Unit cots and added that following a consultation by WHSSC of the reconfiguration of cots, the Health Board would

lose its NICU status which would mean that babies requiring Neonatal Intensive Care would either transfer to the University Hospital of Wales or Singleton Hospital for treatment. Members noted that the Health Board were fully supportive of this change from a strategic perspective and noted that a further review was being undertaken on the longer-term sustainability of Special Care Baby Unit services.

P Roseblade referred to page 8 of the report which made reference to 15 Band 5 Registered Nurse vacancies within the Mental Health Unit which appeared to be a significant number and sought clarity as to what percentage of staff this related to. G Hughes agreed to confirm the position outside the meeting.

Resolution: The report was **NOTED**.

Action: Confirmation to be provided as to what percentage of staff the 15 Band 5 Registered Nurse vacancies within the Mental Health Unit equated to.

5.2 CARE GROUP HIGHLIGHT REPORTS

5.2a Planned Care Group Highlight Report

S O'Brien presented the report and provided Members with a specific update in relation to Ophthalmology. Members noted that a focussed piece of work had been undertaken by the Team in relation to Follow Ups Not Booked within Macular and work was also being undertaken in relation to Glaucoma. Members noted that processes and assurances were being put into place in relation to the patients that need to be reviewed, and noted that in relation to Duty of Candour, patients were being informed when needed as to whether there had been any significant harm. Members noted that the Team were also ensuring that for any historic Root Cause Analysis, processes had been put into place to undertake cluster reviews. S O'Brien advised that additional hours had been secured for a Consultant who would be reviewing each case and prioritising appointments in relation to Macular patients. Members noted that funding had also been secured to appoint Band 7 Nursing staff to undertake harm reviews and funding had also been secured to employ a Family Liaison Officer to undertake engagement with families. S O'Brien advised that the Team had recently reviewed the Healthcare Inspectorate Wales Action Plan, which was an ongoing action plan dating back to 2016, to ensure that the actions that had been marked as green could remain at green status or whether they required further update. Members noted that this was a significant piece of work which would require appropriate workforce to be in place to manage the challenge moving forwards.

P Roseblade advised that she found it difficult to understand as to when a likely improvement would be seen but understood that this may not be possible to predict at present. P Roseblade also advised that she found it difficult to follow the tables due to a formatting issue and noted that this may be down to the way in which documents were being uploaded to Admincontrol.

S O'Brien highlighted a significant risk to Members that had not been included within the report due to timing issues. Members noted that there had been issues with the supply of endoscopy disinfectant liquid as a result of a quality checking issue which has resulted in the Health Board being unable to use some of the bottles of disinfectant that had been produced. Members noted that this resulted in a supply issue across Wales and resulted in the cancellation of all planned and urgent endoscopies within the Health Board. An All-Wales response was put into place, with a Gold, Silver, Bronze Command approach being undertaken. Members noted that work was being undertaken with Procurement to ensure that the Health Board had sufficient supply to last three days at a time. S O'Brien advised that unfortunately the Health Board was still managing this issue and sadly procedures were still being cancelled. Members noted that the issue had been escalated to the Chief Nursing Officer and noted that the Team would continue to mitigate and escalate on a daily basis. S O'Brien advised that she hoped that the issues would be resolved within the next week.

In response to a query raised by P Roseblade as to whether the issues had now been resolved in relation to the fridge containing Controlled Drugs which did not have a lock on it, S O'Brien confirmed that this issue had now been resolved. Members noted that feedback was being received from Managers that, as a result of some of the estates issues, environment audits were dipping, which was being addressed as and when issues arise.

Resolution: The report was **NOTED.**

5.2b Unscheduled Care Group Highlight Report

E James presented Members with the report and highlighted the key matters for Members attention.

L Edwards welcomed the investment being made into Same Day Emergency Care (SDEC) services and sought clarity as to whether confidence was in place that planned work would be completed by November for the SDEC area. S Follows advised that whilst there was aspiration that the environment would be handed over in November, she was not confident now that this date would be achieved given that the project was still in the design phase. Members noted that a weekly working group had been established to track and monitor progress. G Hughes advised that this was discussed at length at the Capital Programme Board held recently and added that from a capital perspective the Team were still working towards a November timeline, with tenders being fixed around this timeline and expressed the importance of agreeing the design as soon as possible, given that this would be a significant improvement to the management of patients at Prince Charles Hospital.

J Sadgrove welcomed the sustained improvement in red release and recognised the significant amount of work undertaken by staff to achieve this position, which was greatly appreciated.

In response to confirmation sought by the Committee Chair that the boarding of patients in front of fire exits at Princess of Wales Hospital was not replicated on other sites, G Hughes advised that the only site that had an issue with boarding of patients in front of fire exits was the Princess of Wales Hospital and confirmed that whilst there continued to be a requirement to board patients, patients were not being boarded in front of fire exits across any of the Health Board sites.

Resolution: The report was **NOTED.**

5.2c Children & Families Care Group Highlight Report

S Hardacre presented Members with the report and highlighted the key matters for Members attention.

The Committee Chair reflected on her recent visit to the Special Care Baby Unit at Princess of Wales Hospital where the Team had highlighted the moves they had to undertake in and out of the unit which had been challenging. The Committee Chair advised that the Team were excellent and had been clearly working under very challenging circumstances.

Resolution: The report was **NOTED.**

5.2d Mental Health & Learning Disabilities Care Group Report

Dr Mary Self presented the report and highlighted the key matters for the attention of Members.

C Donoghue referred to the issues being experienced in relation to CPR training and sought clarity as to whether this was because of lack of staff within the department to attend the training or the lack of training sessions available. Dr Self advised that this was because of the lack of training sessions available, with the team committed to resuming the levels of training following the suspension of all face-to-face training during the Covid -19 pandemic. Members noted that whilst the Team had a plan in place to address this, the number of staff requiring training was significant. G Dix confirmed that whilst the Resuscitation Team were undertaking Demand and Capacity activity, there was also a very high DNA rate that needed to be addressed, with some courses having a DNA rate of up to 40%. G Dix advised that the Demand and Capacity exercise should be completed by the end of July and advised that he would be happy to provide an update at the next meeting.

L Edwards advised that Members should note that most staff would have attended training previously and this would just be a renewal of training for staff.

Resolution: The report was **NOTED.**

Action: Update to be provided to the next meeting in relation to the outcome of the Demand & Capacity exercise undertaken by the Resuscitation Team in relation to CPR training compliance

5.2e Primary & Community Care Group Highlight Report

L Williams presented the report and highlighted the key areas for the attention of Members.

L Love-Gould advised that she shared the concerns highlighted in the report regarding the loss of funding for Neuro-Psychology support which would have an impact on patient's activation levels for rehabilitation and other therapy services and added that at present there doesn't appear to be a solution as to how this can be addressed.

In response to a query raised by J Hehir as to whether a timeline was in place for the review of quality and safety governance processes regarding Parc Prison and how this would be monitored by the Health Board, L Williams advised that processes, measurement and frameworks were in place which were being monitored on a weekly and monthly basis, with updates regularly being provided into the Care Group Quality meetings. L Williams advised that she was not confident that this piece of work would be completed within three months and added that it would likely take six months to complete. G Dix advised that Cardiff & Vale UHB had recently sought support from the Health Board in relation to undertaking some joint work with Cardiff Prison to address some of the challenges they had been experiencing.

The Committee Chair advised that she was pleased to see a number of staff achieving awards which needed to be congratulated.

Resolution: The report was **NOTED**.

6. DELIVERING OUR PLAN

6.1 Quality Dashboard

N Downes presented Members with the report and highlighted the key areas for Members attention. N Downes drew attention in particular to a draft report received from the Public Service Ombudsman for Wales which related to care and treatment in relation to a missed appendicitis. Members noted that a number of issues had been identified and an action plan had been developed to address the issues. N Downes advised that a discussion had been held with the Communications Team to prepare in readiness of the report being published, which was likely to be August. The Committee Chair requested that this report was shared with Members at the September meeting.

P Roseblade referred to page 7 of the report and the update provided in relation to closed patient safety incidents. P Roseblade advised that the report stated that incidents classed as catastrophic, or death were not directly related to an

intervention by the Health Board and advised that she felt it would be helpful if some structure could be given to this. P Roseblade advised that she would also find it helpful if it could be identified what percentage was directly attributed to the Health Board and what percentage was not directly attributed. N Downes advised that he would be happy to provide a response to the question raised regarding percentages outside the meeting.

P Roseblade sought clarity that if an incident classed as catastrophic or death was directly attributed to the Health Board, what would the rationale/reason be for this and sought confirmation as to whether this would need to be raised with the Coroner. D Hurford advised that if an incident was catastrophic, multiple reviews would be undertaken and would proceed straight to a Stage 3 Mortality Review and added that the Coroner would also be informed. Members noted that steps would be taken to ensure sharing of learning to prevent any further reoccurrence of the incident.

R Hughes provided Members with a verbal update on the work being undertaken to address patient falls. R Hughes confirmed that he had met with N Milligan to discuss the points of clarification she had sought at the meeting held on 24 May 2023. Members noted that work was being undertaken to establish a Harm Free Care Board and discussions were being held with Executive colleagues as to the governance that needed to be in place. Members noted that the remit of the group would be to review issues relating to falls and to identify key themes. Members noted that discussions were also being held nationally in relation to the possibility of collaborative working in relation to falls.

The Committee Chair commented that whilst she did not underestimate the challenge to address this position, she did not consider that sufficient assurance had been received to determine that any impact was being seen from the action plans that had been put into place and sought clarity as to when the impact would be seen. G Dix advised that the Health Board's total falls rate per 1000 bed days was in line with other Health Board's as well as falls leading to serious harm. G Dix advised that the Health Board would always see an increase in falls in some of the elderly care and mental health wards and added that there needed to be a balance of not restricting patients in relation to their rehabilitation and advised of the need to ensure there was no increase in falls which lead to severe harm. G Dix advised that work would continue to be undertaken on harm events and added that periodic updates would be presented to the Committee on the work being undertaken. G Dix added that a collaborative approach was being undertaken as opposed to undertaking pockets of improvements. L Love-Gould advised that as part of the Allied Health Professionals in Primary Care bid, the Team were trying to develop a Falls Clinic and had already discussed this development with a number of service areas.

Resolution: The report was **NOTED**.

Actions: Public Services Ombudsman for Wales Report in relation to care and treatment of a missed appendicitis to be shared with Members at the September meeting.

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.

7. DELIVERING OUR IMPROVEMENT PROGRAMMES

7.1 Maternity & Neonates Reports

7.1.1 Maternity & Neonates Metrics

S Hardacre presented the report and highlighted the key matters for Members attention.

D Jouvenat commented that she was pleased to see the Quality Improvement work that was being undertaken and advised that she had recently attended an event at Ysbyty Cwm Rhondda and was impressed by all the projects that had been put forward by staff.

Resolution: The report was **NOTED**.

7.1.2 Maternity Quality Improvement Annual Update 2022-2023

S Hardacre presented the report.

Resolution: The report was **NOTED.**

7.2 Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

L Edwards presented the report and advised that the service had recently been de-escalated to Level 2 which reflected the incredible work that had been undertaken by the Team. Members noted that there was a plan in place for complete de-escalation once the remaining six actions had been completed. The Chair welcomed the positive news in relation to the de-escalation and looked forward to receiving a further update at the September meeting.

Resolution: The report was **NOTED.**

7.3 Mental Health In-Patient Improvement Progress Report

Dr M Self presented the report and highlighted the key matters for Members attention.

The Committee Chair welcomed the news that the action plan submitted to Healthcare Inspectorate Wales had now been approved.

P Roseblade referred to paragraph 1.3 in the report which made reference to bespoke inspections of service of concerns and not understanding the outcome until August and sought clarity as to what this related to. Dr Self advised that there had been some legacy Healthcare Inspectorate Wales (HIW) Action Plans

from previous reports that had not been fully implemented and advised that these action plans had now been incorporated into the new action plan.

In response to a query raised by J Hehir as to whether a timeline was now in place as to when the need for a Single Electronic Record would be resolved, Dr Self advised that this related to WCCIS and advised that a programme of work was now in place and a meeting of the WCCIS Operational Group had now been held. Members noted that the system would be piloted in a few areas with plans to roll out fully over the next 18 months. Members noted that whilst the timescale was ambitious the team were confident that they would be able to achieve this.

J Sadgrove advised that she was pleased to see that real focus was in place regarding the variety of workstreams that were necessary to make improvements happen across Mental Health Services and advised that she was particularly encouraged to hear that L Edwards had taken the Executive Lead role in this area. J Sadgrove advised that she also found it helpful that the agenda for the Quality & Safety Committee had been restructured to enable the Committee to receive regular reports in relation to improvement programmes of work so that progress could be monitored.

Resolution: The report was **NOTED.**

7.4 Stroke Services Progress Report

S Follows presented the report and highlighted the key areas for Members attention.

P Roseblade sought confirmation as to whether she was correct in thinking that within the £500k that had been allocated to fund stroke services, £370k of this was being used to fund a service that was already in place, and therefore the only additional investment was £130k. L Edwards advised that notification had been received that external funding that was being used to support the Early Supported Discharge was being withdrawn. A review was now being undertaken of the service as a whole, with some additionality being put into place and some restructuring being undertaken to ensure the whole of the CTM footprint could be covered.

P Roseblade expressed concern that given the update provided earlier that funding for Neuro-Psychology was being withdrawn and now the funding for Early Supported Discharge (ESD) was being withdrawn, this did not paint a positive picture. L Edwards confirmed that the position was challenging. L Love-Gould advised that given the withdrawal of ESD funding this would mean that there would be no service within the Health Board. Members noted that the funding had not previously applied to Bridgend and noted that there had never been an ESD services provided in Bridgend previously.

In response to a query raised by P Roseblade in relation to timings associated with Thrombolysis and Thrombectomy, D Hurford advised that in relation to

Thrombolysis, there is a period of an hour for the CT scan to be undertaken, and then 45 minutes from the CT scan for Thrombolysis to start. D Hurford advised that a different timeline was in place for Thrombolectomy which was a surgical procedure and could only be undertaken at a dedicated site in Bristol and was not offered anywhere in Wales at present.

The Committee Chair referred to page 6 of the report which highlighted that the Delivery Unit would be undertaking a review of self-presenters and sought clarity as to whether this would be helpful. S Follows advised that part of this review would be exploring how patients were being communicated with and how patients could be directed to the most appropriate sites and advised that there may be some benefits to this piece of work being undertaken.

In response to a question raised by J Hehir as to whether there were any other dependencies, apart from finance and staffing, in relation to the provision of a 24/7 service, S Follows advised that there were challenges in relation to the recruitment of Stroke Consultants and added that alternative models of staffing were now being explored. Members noted that recruitment issues were also being experienced within other Health Board areas. G Hughes added that J Hehir was referring to a 24-hour Thrombectomy Service which was only being provided from Bristol at present. G Hughes advised that in order to provide a Stroke service that is appropriate for the Health Board's population, a significant reconfiguration of services would be required in partnership with another Health Board. Members noted that the Health Board could not continue to deliver the configuration of services currently in place. J Hehir recognised that whilst the Health Board wants to provide an excellent service, there were some constraints regarding service provision.

Resolution: The report was **NOTED.**

8. GOVERNANCE, ASSURANCE AND RISK

8.1 Organisational Risk Register – Risks Assigned to the Quality & Safety Committee

C Hamblyn presented Members with the report. The Committee Chair welcomed the update provided and recognised the significant amount of work that had been undertaken.

In response to a query raised by P Roseblade regarding risk 4772 and reference made to CBW presses, C Hamblyn confirmed that this related to laundry services.

P Roseblade made reference to risk 4458 which related to ED metrics and advised that she felt conflicted regarding this risk as whilst the impact of the risk had been reduced from 5 to 4, the Health Board was still not achieving the 15 minute handover or achieving 4 hour and 12 hour performance targets, however, she could also see the logic in the risk not be classed as a catastrophic consequence. P Roseblade also added that it would be helpful if the risk register

could be provided in excel to make it easier for Members to navigate. C Hamblyn confirmed that an excel version of the risk register was available and added that the Team had not closed risk 4458 and advised that this was being captured within Risk 3826 which had been expanded to capture a number of ED metrics. G Hughes provided assurance that the consequence and likelihood of risks was constantly being reviewed and re-evaluated. E James also provided assurance this the risk was under regular review and advised that if any issues arose then these would be escalated.

Resolution: The report was **NOTED.**

8.2 Datix Cymru Assurance Report

K Jenkins-Forrester presented the report and highlighted the key matters for Members attention. Members noted that incident reporting figures had returned to expected levels and noted that moving forwards any variations in incident reporting would be highlighted within the Quality Dashboard report. The Committee Chair asked Members to consider whether they required any further updates on this matter moving forwards.

Resolution: The report was **NOTED**

8.3 Mortality Assurance Report

D Hurford presented the report and advised that a focussed piece of work was being undertaken in relation to the cause of death notification process and added that work was being undertaken to put in place an agreed process which has parity across all three District General Hospital sites. Members noted that the Bereavement Officers across all three sites would be asked to start gathering data using set questions which would then provide the information required. Support had been sought from ICT colleagues to create a template for the recording of data. D Hurford advised that whilst he was not yet in a position to provide information as to where the increased deaths were, he could provide assurance that this process would be in place shortly.

J Sadgrove welcomed the report which clarified the concerns that had been raised at Board and advised that the Board would now need to be made aware that this had been discussed at Quality & Safety Committee and that Members had been assured of the position.

Members agreed to receive a further update on progress in three months.

Resolution: The report was **NOTED.**

Actions: Board to be made aware that a discussion had been held in relation to Mortality Data and assurance had been provided that processes were being put into place to address the position.

Further update on progress to be presented to the Committee in three months.

8.4 Healthcare Inspectorate Wales Action Plan Tracker

N Downes presented the report and highlighted the key matters for the attention of the Committee. The Committee Chair welcomed the report which was clear and provided a good level of assurance.

Resolution: The report was **NOTED.**

8.5 Liberty Protection Safeguards Progress Report

C O'Keefe presented the report and highlighted the key matters for Members attention.

J Hehir referred to the proposal being made to outsource to an external agency to address the backlog and sought clarity as to how long the contract would be in place for and how the Team would ensure appropriate oversight and governance was in place to ensure the agency was delivering. C O'Keefe advised that this had been discussed in detail and provided assurance that the tender process had been rigorous and had clearly set out what was expected by the Health Board in relation to delivery and outcomes. Members noted that the Quality Assurance and Governance aspects would be managed by the Deprivation of Liberties Safeguards Team. R Hughes provided further assurance that he would continue to receive the final reports alongside the Executive Director of Nursing for approval prior to the reports being actioned.

In response to a query raised by the Chair as to when the Committee would be receiving a further update, C O'Keefe advised that she would provide a further update to the Committee in November 2023.

Resolution: The report was **NOTED.**

Action: Further update on progress to be presented to the November 2023 meeting of the Committee.

8.6 Covid 19 Public Inquiry Preparedness

C Hamblyn presented the report and highlighted the key matters for the Committee's attention. Members noted that significant level of resource was required to ensure the Health Boards preparedness to respond to the inquiry and noted that a meeting would be held shortly with the Chief Executive to discuss resource challenges.

Resolution: The report was **NOTED.**

9. CONSENT AGENDA

9.1 FOR APPROVAL – The following items were approved by the Committee

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

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

9.1.3 **Volunteer Service Policy**

9.1.4 **Concerns Policy – Deferred to the September meeting**

9.1.5 **Rapid Tranquilisation Policy**

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

9.1.7 **Health, Safety & Fire Sub Committee Highlight Reports**

9.2 **FOR NOTING – The following items were NOTED by the Committee.**

9.2.1 **Action Log**

9.2.2 **Committee Annual Cycle of Business**

9.2.3 **Forward Work Programme**

9.2.4 **WHSSC Quality & Patient Safety Committee Chairs Report**

9.2.5 **Putting Things Right Annual Report**

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

9.2.7 **Clinical Audit Quarterly Report**

9.2.8 **Radiation Safety Committee Annual Update**

9.2.9 **Nosocomial Investigation Update Report**

9.2.10 **Recovery Plan Hep B and Hep C**

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

9.2.12 **Concerns Final Internal Audit Report and Action Plan**

10. **ANY OTHER BUSINESS**

J Hehir advised that he wished to extend his thanks to J Sadgrove, who was attending her last meeting of the Committee today. J Hehir advised that J Sadgrove had Chaired the Committee in excellent style over the last few years and added that the progress that had been made by the Committee under her Chair had been significant. J Hehir added that the quality of reports being

received had improved significantly and advised that J Sadgrove had played a significant role to ensure this happened. The Committee Chair also echoed the comments made by J Hehir and extended her thanks to J Sadgrove for all of the support she had provided to the Committee.

J Sadgrove extended her thanks to Committee Members who had provided helpful scrutiny in a positive way and also extended her thanks to Executive Colleagues and their Teams who had worked hard to make all the changes required and advised that she would miss everyone within the Health Board.

10.1 Highlight Report to Board - Verbal

Members noted that this would be drafted outside the meeting by the Committee Secretariat.

10.2 How did we do in this meeting?

The Committee Chair asked Members to consider the questions posed and added that she would welcome feedback outside the meeting as to how Members felt the meeting went today.

10.3 Identification of Future Spotlights and Thematic Presentations

The Committee Chair asked members to consider any future items for discussion and provide feedback outside the meeting.

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

- Critical Care Reconfiguration

11. DATE AND TIME OF NEXT MEETING – THURSDAY 21 SEPTEMBER 2023 AT 8:30AM

12. CLOSE OF MEETING

Agenda Item Number: 9.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 25 July 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Gethin Hughes	Chief Operating Officer
Lauren Edwards	Executive Director of Therapies & Health Science
Sallie Davies	Deputy Medical Director
Anthony Gibson	Assistant Medical Director
Cally Hamblyn	Assistant Director of Governance & Risk
Emma Walters	Corporate Governance Manager (Committee Secretariat)

Agenda Item

1 PRELIMINARY MATTERS

1.1 Welcome & Introductions

The Chair **welcomed** everyone to the In Committee meeting of the Quality & Safety Committee.

1.2 Apologies for Absence

Apologies for absence were received from:

- Hywel Daniel, Executive Director for People

1.3 Declarations of Interest

There were none.

2 MAIN AGENDA

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

Resolution: The Minutes were **NOTED**.

2.2 Action Log

The action log was received and discussed.

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

2.3 Critical Care Reconfiguration

A Gibson presented the report and highlighted the key matters for the attention of the Committee in relation to the arrangements for the next phase of the Critical Care Reconfiguration and an update on medical recruitment.

Resolution: The report was **NOTED**.

3. ANY OTHER BUSINESS

There was no other business to report.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on Tuesday 21 September 2023 at 1.30pm.

AGENDA ITEM
9.1.3

QUALITY & SAFETY COMMITTEE

USE OF MEDICINES POLICY

Date of meeting	21/09/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Huw Carson, Principal Pharmacist Quality and Safety
Presented by	Huw Carson, Principal Pharmacist Quality and Safety
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Circulated to Medical Director, Nursing Director, Director of Medicines Management and their senior teams	23/03/2023	SUPPORTED
Clinical Policies Approval Group	29/08/2023	SUPPORTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 CTMUHB doesn't have a Medicines Policy which could be subject to criticism during an external audit

1.2 This policy is effectively a directory of medicines policies. This policy does not provide any real new content or policy direction but it will however make it easier to find all policies or procedures that are to do with the use of medicine

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

2.1 Engagement on this Policy and Procedure has taken place with senior management of nursing/medical and medicines management.
2.2 This Policy is effectively a directory of policies
2.3 A real effort has been made to engage to 'locate' policies and procedures that are in effect in CTMUHB to ensure that all relevant policies/procedures are easily available.
2.4 This is an active and evolving policy. Relevant Medicines Management policies will be added to this framework policy as they are approved. A clause in section 6 of the policy 'Implementation/Policy Compliance' states:

As new relevant policies and procedures are ratified by the Health Board, this policy and the related links will be updated. This will be done by agreement of at least 2 of the following, without the need for this policy to go through formal consultation and update:

- Clinical Director Pharmacy and Medicines Management
- Chief Pharmacist Medicines Governance
- Principal Pharmacist- Quality and Safety

Updates agreed by the above process will be noted in section 9 of this policy

2.5 Therefore when new relevant policies are written this policy will be updated
2.6 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.
2.7 Organisational values and behaviours have been reflected within the policy
2.8 This policy was reviewed at the Clinical Policies Approval Group previously and it was agreed that a plan of who would write the outstanding policies and timeframes would be added. This has now been done.

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

3.1 Only minor typographical amendments were made as a result of the various consultation stages.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	No (Include further detail below)
	To follow
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Quality and Safety Committee are asked **APPROVE** the Use of Medicines Policy

5.2 The Quality and Safety Committee are asked to **APPROVE** the principal that this policy may be updated without the need to come back to Clinical Policy group/Quality and Safety Committee as documented in section 2.4 of this document

5.3 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

Use of Medicines Policy

Document Type:	Clinical Policy
Ref:	CTM-MM-UoM
Author:	Huw Carson- Principal Pharmacist- Quality and Safety
Executive Sponsor:	Executive Medical Director
Approved By:	Choose an item.
Approval / Effective Date:	(00/00/0000)
Review Date:	(00/00/0000)
Version:	

Target Audience:

People who need to know about this document in detail	All CTM staff members who use medicines (e.g. prescribing, administering, supplying etc.)
People who need to have a broad understanding of this document	All CTM staff members who use medicines (e.g. prescribing, administering, supplying etc.)
People who need to know that this document exists	Senior managers with responsibility for provision of medication

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome:** This policy has been screened for relevance to Equality. No potential negative impact has been identified.
Welsh Language Standard	No
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

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

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1. Policy Statement

The Use of Medicines policy is an overarching policy which brings together and references all Cwm Taf Morgannwg University Health Board (CTMUHB) policies related to the use of medicines

2. Scope of Policy

This policy applies to all staff members who use medicines within CTMUHB

3. Aims and Objectives

The Policy sets out a framework to promote the safe and secure systems for controlling and handling of medicines in the hospitals and clinics operated by CTMUHB as part of an overall medicines management process

This policy aims to bring together all policies and procedures to do with medicines in one place. There will be links to the relevant policies and procedures.

4. Responsibilities

The Policy reflects current working arrangements, practices and legislative requirements. It provides for safe, effective and efficient practice.

In addition to this Policy, healthcare professionals must abide with the current version of their relevant professional documents. If any circumstances arise such that this Policy cannot be applied then the prime consideration will be the safe and effective treatment of any patient concerned. Any practices outside of this policy must be authorised by the Medical Director or the Executive Nurse Director.

5. Definitions

Definition of terms where required

Policy - a written statement of intent, setting out the way in which an issue is to be managed by the Health Board. They are underpinned with evidence based procedures and guidelines and are mandatory, binding staff to follow them. They require an Equality Impact Assessment

Procedures / Standard Operating Procedures - set out a series of actions which, when taken in a required order, will achieve a desired outcome. Procedures set out the operational processes to be followed to meet the objectives of the policy. They must include reference of any researched evidence used.

6. Implementation/Policy Compliance

This policy brings together all policies and procedures to do with medicines in one place.

Please see section 10. Policies for the Medicines Management Policies

As new relevant policies and procedures are ratified by the Health Board, this policy and the related links will be updated. This will be done by agreement of at least 2 of the following, without the need for this policy to go through formal consultation and update:

- Clinical Director Pharmacy and Medicines Management
- Chief Pharmacist Medicines Governance
- Principal Pharmacist- Quality and Safety

Updates agreed by the above process will be noted in section 9 of this policy

Where policies are either not yet written/ in the process of being written, these will be referred to here but no link will be possible.

7. Equality Impact Assessment Statement

This policy has been screened for relevance to Equality. No potential negative impact has been identified.

8. References/ Main Relevant Legislation

Medicines Act 1968. [Online]. London: The Stationery Office. [Accessed 17/11/2022]. Available from: https://www.legislation.gov.uk/ukpga/1968/67/contents

The Human Medicines Regulations 2012. [Online]. London: The Stationery Office. [Accessed 17/11/2022]. Available from: https://www.legislation.gov.uk/uksi/2012/1916/contents/made

Royal Pharmaceutical Society of Great Britain: The Standards for Hospital Pharmacy Services [Online]. [Accessed 17/11/2022]. Available from: https://www.rpharms.com/recognition/setting-professional-standards/hospital-pharmacy-professional-standards/the-standards

All Wales Clinical Pharmacy Operating Guideline v1. All Wales Chief Pharmacists, Quality and Patient Safety Delivery Group. December 2019.

9. Summary of updates

Name of Policy	Policy Number	Why change made (e.g. new policy, update etc)	Date of change	Name of responsible person

10. Policies and procedures

10.1 Prescribing of medicines

This policy sets out the governance arrangements for prescribing within the health community served by Cwm Taf Morgannwg University Health Board (CTMUHB)

Prescribing should follow the All Wales Prescription Writing Standards.

Link to Policy- There is currently no approved CTMUHB Policy/ procedure. A policy is currently being prepared by the Medicines Management Department Governance and Clinical Services Team. Target: 1 October 2023

10.1.1 Non-medical prescribing policy

This policy sets out the governance arrangements for non-medical prescribing within the health community served by Cwm Taf Morgannwg University Health Board (CTMUHB). It provides the framework to deliver the organisation's strategic goals for non-medical prescribing.

The policy must be implemented in conjunction with the Welsh Government (WG) Guidance "Non medical prescribing in Wales – Guidance February 2015" 1 where full details of the legislation and professional requirements are laid out. The guidance is found on the AWMSG website: http://www.awmsg.org/

Link to Policy: Non-medical prescribing Policy MM153a NB This policy is out of date- new policy out for consultation. Deadline: 1 October 2023

10.1.2 Neonatal Prescribing Procedure

The purpose of this document is to detail the prescribing procedure to be followed for medicines for neonatal patients in any setting. It should be read in conjunction with the All Wales Prescription Writing Standards which gives guidance on good prescribing practice for ALL prescriptions.
Link to Policy: Neonatal Prescribing Procedure MM241

10.2 Transcribing

Transcribing is the copying of medicines information for the purposes of administration, it cannot be used in place of prescribing to issue or add new medicines or alter/change original prescriptions. Transcribing is not prescribing. It is not covered by the Medicines Act, or Human Medicines Regulations 2012.

Link to Policy - There is currently no approved CTMUHB Policy/ procedure. A policy is currently being prepared by the Medicines Management Department Clinical Services Group. Target: 1 October 2023

10.3 Medicines Procurement

This policy/procedure details the process for ordering and obtaining medication in CTMUHB

Link to Policy - There is currently no approved CTMUHB Policy/ procedure. A policy is currently being prepared by the Medicines Management Department Logistics Group. Target: 1 October 2023

10.4 Ordering by wards/ departments, dispensing, supply and delivery of medication

Details of the process for dispensing, supplying and delivering medication in CTMUHB.

Link to Policy - There is currently no approved CTMUHB Policy. A policy is currently being prepared by the Medicines Management Department Clinical Services Group. Target: 1 October 2023
Link to Procedures- Each pharmacy site has their own in house SOPs. This will be reviewed to see whether a single HB procedure should be created

10.5 Administration

The purpose of this procedure is to ensure the safe administration of medicines to patients within Cwm Taf Morgannwg University Health Board (CTMUHB) by giving staff clear guidance and an understanding of the reasons underpinning the procedure. The procedure applies to medicines administration by UHB staff in secondary care settings.

Link to procedure: Administration of Medicines Procedure

10.5.1 Self administration

Self-administration of insulin allows greater independence and enables participation in self-care and decision making in partnership with clinicians. This self-administration procedure is considered in conjunction with national and local policies on medicine storage and administration.

Link to policy- Policy for the Self administration of Medicines Scheme for Adult Inpatients of Community Hospital/Care of the Elderly (COTE) wards with Cwm Taf Morgannwg University Health Board

Link to procedure(s) Insulin Self Administration Procedure

10.5.2 Covert administration

This procedure describes the responsibilities of practitioners when considering the use of covert medication. This is the term used when medication is administered in a disguised format without the knowledge or consent of the patient receiving it, i.e. in food or drink. The procedure sets out a series of conditions that must be satisfied before administering covert medication and defines the process to be followed.

Link to procedure: Procedure For The Covert Administration Of Medication In Adults

10.6 Medicines reconciliation

Medicines reconciliation is the process of identifying the most accurate list of a patient's current medication and comparing it with the list currently in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications accurately communicated

Ensuring completion of medicines reconciliation, for patients who require it, is the responsibility of all healthcare professionals involved with managing the patient's medication (i.e. pharmacist, pharmacy technician, nurse and doctor).

Link to Policy – The All Wales Multidisciplinary Medicines Reconciliation Policy is in use in CTMUHB

Link to procedure There is not currently a CTM procedure for medicines reconciliation. A procedure is currently being prepared by the Medicines Management Department Clinical Services Group. Target: 1 October 2023

10.7 Storage/ security of medication

Background

The purpose of this procedure is to ensure the safe, secure and appropriate storage of medicines and pharmaceutical products in the in-patient hospitals of Cwm Taf Morgannwg University Health Board.

Link to procedure Medicines Storage in Hospitals Procedure NB procedure is out of date. A procedure is currently being prepared by the Medicines Management Department Governance Team. Target: 1 October 2023

10.8 Disposal of medication

Background

All medication must be disposed of safely in accordance with the Health Board waste disposal policy and the Hazardous Waste Regulations. The purpose of this procedure is to ensure the safe and appropriate disposal of medication within Cwm Taf Morgannwg University Health Board.

Link to procedure There is NOT currently CTM procedure for disposal of medication. A procedure is currently being prepared by the Medicines Management Department Clinical Services Group. Target: 1 October 2023

10.9 Discharge medication

The purpose of this policy/procedure is to ensure safe supply of medication at discharge

Link to policy/procedure There is NOT currently CTM policy/procedure for discharge of medication. Policy/procedure will be added here when it is published. A policy/procedure is currently being prepared by the Medicines Management Department Clinical Services Group. Target: 1 October 2023

10.9.1 Nurse Led discharges

Link to procedure (s)

Nurse led discharges- A procedure for nurse-led discharges is currently out for consultation

10.10 Controlled Drugs

10.10.1 Wards and Departments

The purpose of this procedure is to ensure the ordering, storage, administration to patients and destruction of controlled drugs is safe, secure, is auditable and complies with current legislation and guidance within the acute and community care wards and departments of Cwm Taf Morgannwg Health Board (CTMUHB).

Link to procedure: Management of CDs within Wards and Departments Procedure

10.10.2 Theatres and ICU

The purpose of this procedure is to ensure the ordering, storage, administration to patients and destruction of controlled drugs is safe, secure, is auditable and complies with current legislation and guidance within theatres and intensive care units (ICUs) within Cwm Taf Morgannwg University Health Board (CTMUHB).

Link to procedure: Management of CDs within Theatres and ICU in Secondary Care

10.11 PGDs

This procedure gives practical guidance and details the process to be followed within CTMUHB when considering the need for, the development, implementation, use and review or updating of Patient Group Directions (PGDs). It includes details of the criteria to be included in the PGD in order that the clinical practice it supports is within the law and has the approval of CTMUHB.

Link to Policy: Supply and Administration of Medicines Using Patient Group Directions Policy
Link to procedure: Supply and Administration of Medicines Using PGDs Procedure

10.12 Unlicensed medicines

The Policy covers the use of medicines without a Market Authorisation and the use of licensed medicines outside their Market Authorisation (off label) within Cwm Taf Morgannwg University Health Board. The policy does not apply to products used in clinical trials, extemporaneous preparations or extemporaneously prepared syringes used in palliative care, or extemporaneously prepared medicines prepared at the bedside and subsequently administered via an enteral feeding tube.

Link to Policy: Unlicensed Medicines Policy NB policy is out of date. A policy is currently being prepared by the Medicines Management Department Quality Assurance Team. Target: 1 October 2023
Link to procedure: A procedure is currently being prepared by the Medicines Management Department Quality Assurance Team. Target: 1 October 2023

10.13 Access to Medicines policy

Purpose is to provide guidance on how to access medicines (including NIVE/ High Cost Drugs, formulary process, approval of medication, IPFR)
Link to procedure: A policy is currently being prepared by the Medicines Management Department Access to Medicines Team. Target: 1 October 2023

10.14 Clinical trials

In May 2004 the Medicines for Human Use (Clinical Trials) Regulations came into force. These impose legal standards on the conduct of all interventional clinical trials involving medicines.

The purpose of this document is to outline the responsibilities of individuals involved in conducting clinical trials of investigational medicinal products (CTIMPs) within the Health Board and to ensure that procedures are in place to comply with the regulations and relevant guidelines and directives e.g. Good Clinical Practice (GCP) for clinical trials.

Link to Policy: Investigation Medicinal Products Management Policy NB policy out of date. A policy is currently being prepared by the Medicines Management Clinical Trials Team. Target: 1 August 2023

10.15 Medical gas cylinders

This policy covers handling and management arrangements for medical gas cylinders which are defined as medicines supplied in gas form in a pressurised container. The cylinders are also referred to as 'bottles'. It does not cover the medical application of the gases concerned or 'piped' gasses.

Link to Policy: Medical Gas Cylinder Policy NB policy out of date. A policy is currently being prepared by the Medicines Management Aseptic Services team and the Medical Gas Group. Target: 1 October 2023

10.16 Medicines Alerts/ recalls

The purpose of this procedure is to detail the actions that the Medicines Management Department will undertake following receiving a Welsh Government medicine alert or recall

Link to procedure- Medicines Management Drug Alerts/ Recalls Procedure

10.17 Medicines Shortages

The purpose of this procedure is to detail the actions that the Medicines Management Department will undertake following receiving a Welsh Government Shortage notice

Link to procedure- Medicines Management Shortages Procedure

10.18 Security of controlled stationery

Background

Prescription form theft and misuse is an area of concern for NHS Wales as stolen or abused forms can be used to obtain medicines illegally. Most patients legitimately obtain a signed prescription

form from an authorised prescriber for a medical condition. However a small minority may attempt to obtain prescription forms illegitimately to acquire drugs, particularly Controlled Drugs for recreational use or medical items, or to sell the prescription forms illegally so that others might obtain drugs. Stolen prescription form stationery, forged prescriptions and drugs that are fraudulently obtained from a forged prescription are likely to be sold for substantial financial gains.

Link to Policy - There is currently no approved CTMUHB Policy/ procedure. A policy is currently being prepared by the Medicines Management Department Governance Team. Target 1/11/23

Agenda Item
9.1.4

Quality & Safety Committee

CTMUHB SAFEGUARDING POLICY

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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 Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Safeguarding executive Group	27/07/2023	Endorsed for Approval

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 In view of Child T's Child Practice Review, the Cwm Taf Morgannwg University Health Board Safeguarding policy has been revised to ensure it reflects learning. This includes professional curiosity and non-accidental injuries. Revisions have been made to ensure that colleagues managing safeguarding concerns 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 of all care groups, safeguarding specialists, an independent member of the board and National Safeguarding Service through the Safeguarding Executive Group.

2.2 The policy contains information on key safeguarding and public protection issues, with guidance on appropriate recognition and referral of safeguarding concerns.

Name Title	***Date Consulted/Completed***
Equality Impact Assessment	30/08/2023
Informal Consultation with interested parties	April & May 2023
Formal Consultation	July 2023
Committee – For approval	Safeguarding Executive Group 27/07/2023

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

3.1 In response to the consultation the following amendments have been made:

- Named Doctor contact details have been added, along with further clarity around the referral process.

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: This policy is relevant to all practitioners and members of our community. It does not discriminate, 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' 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 Safeguarding 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

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:	Claire O'Keefe – Head of Safeguarding
Executive Sponsor:	Executive Nurse Director
Approved By:	**Management Board (Non Clinical Procedures Only)**
Approval / Effective Date:	(April 2023)
Review Date:	(01/04/2026)
Version:	1

Target Audience:

People who need to know about this document in detail	
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.

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

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

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1. PURPOSE

To ensure that all staff who work within Cwm Taf Morgannwg University Health Board (CTMUHB) understand their responsibilities in relation to safeguarding children and adults at risk and in need of public protection.

This document will guide CTMUHB Staff in understanding their statutory duties. It discharges these duties by working within regional partnership arrangements and complying with both UK Government and Welsh Government legislation, Codes of Practice and National Safeguarding Procedures.

The focus of this policy will be to protect children and adults at risk of abuse, harm or neglect. This will also include working proactively to prevent harm, abuse or neglect to children and adults who could become at risk.

2. POLICY STATEMENT

This framework will support CTMUHB in discharging is statutory duties, complying with national legislation frameworks, underpinning good practice in all aspects of safeguarding. This will provide assurances to CTMUHB that it is fulfilling the statutory duties of the Social Services and Wellbeing (Wales) Act 2014, Working together to Safeguard People and are working to National standards set out within the Wales Safeguarding Procedures.

3. PRINCIPLES

To enable the UHB to fulfil these duties safely and competently it has the following Strategic Objectives:

- To ensure there are effective measures in place to safeguard people and protect children and adults at risk.

- To ensure there is effective inter-agency co-operation in planning and delivering services and sharing information.

4. SCOPE

This policy applies to **ALL** staff, including bank, agency, students, contractors, volunteers and trainees, who work within Cwm Taf Morgannwg University Health Board. Everyone has a 'duty to report' safeguarding concerns regardless of a persons status, profession or authority.

Safeguarding involves working collaborately with our partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm. Actively preventing them from becoming at risk of abuse, neglect and exploitation.

Public Protection aims to prevent harm to vulnerable groups within society. Any individual can require safeguarding at any point in their life.

What is Abuse?

The Social Servcices and Wellbeing Wales (Act) 2014 (SSWBA) defines abuse as physical harm or threat of physical pain or injury. Abuse can also be verbal, psychological, emotional, sexual or financial and which may occur in any setting.

What is neglect?

Neglect is defined as a failure to meet a persons basic physical, emotional, social or psychological needs, which is likely to result in an impairment of the persons wellbeing.

What is exploitation?

Exploitation, in its widest definition, means getting someone to do something that they do not want to do for personal gain. Within the context of safeguarding the term exploitation is used to encapsulate all situations whereby a persons vulnerability is exploited, resulting in some form of abuse or harm to be caused to them. This includes sexual, criminal and financial exploitation.

Definition of Terms

4.1 Children

A child is defined by the Children Act 1989 as anyone less than 18 years of age.

A 'child at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as a child who:

a) Is experiencing or is at risk of abuse, neglect or other kinds of harm; and
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs).

Safeguarding children is the responsibility of everyone working in the Health Board. This includes children who are patients/clients or who are visitors to the Health Board as well as the children of any adults who are patients/clients.

4.2 Procedural Response to the Unexpected Deaths in Childhood PRUDiC

This guidance sets out a minimum standard for the multi-agency response to the unexpected death of a child or young person up to the age of 18 years. The procedures should be implemented in **ALL** unexpected child deaths. Full guidance is accessible through CTMUHB intranet pages under the category of Safeguarding and Public Protection.

4.3 Non- Accidental Injury (NAI)/Suspected Physical Abuse (See appendix 4)

Non-accidental injury (NAI) can be any abuse inflicted on a child by a caregiver that is not consistent with the account of its occurrence. This includes injuries that result from deliberate actions against a child or a failure to prevent injury.

Non-accidental injury can be a term used to refer to many different types of injury of abuse. For example; bone fractures, skull fractures, smothering, poisoning, bruising, burn, torn frenulum and infant death (N.B. this is not an exhaustive list). Either with no explanation or with an explanation that medical professionals do not accept.

An injury, should never be interpreted in isolation! It must always be assessed in the context of the child's medical and social history. Therefore any concerns should be **reported** immediately to MASH and ensure robust information sharing throughout the safeguarding process. A Health representative should **always** attend any strategy meeting to ensure all available information is shared.

4.4 Adults at Risk

An 'adult at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as an adult who:

Is experiencing or is at risk of abuse or neglect;

Has needs for care and support (whether or not the Local Authority is meeting any of those needs); and as result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. This may include:

- Those who have learning difficulites
- Mental health including dementia
- Person with support or care needs
- Physically frail or chronic illness
- Physical or sensory disability
- Misuse of drugs or alcohol

An adult at risk of abuse can be dependent on a varied number of circumstances. Referring to Wales Safeguarding Procedures and seeking advice from the Multi Agency Safeguarding Hub (MASH) or the corporate safeguarding team can support effective and timely decision making.

4.5 Statutory Duty to Report

From April 2016 the Social Services & Wellbeing (Wales) Act 2014 introduced the statutory duty for all who work for the UHB as a 'relevant partner' to report to the Local Authority any concerns for a child or an adult who may be at risk.

All those working in any capacity for CTMUHB must take positive and decisive action when witnessing incidents, have concerns or receiving information which alleges abuse of inappropriate delivery of care for a child or an adult deemed as vulnerable or at risk. Advice can be obtained directly from their line manager, MASH Health, Safeguarding Specialists or the Corporate safeguarding team.

4.6 Deprivation of Liberty Safeguards (DoLS)

DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. This includes where detention under the Mental Health Act 1983 is not appropriate at that time.

Mental Capacity Act (MCA): Staff are required to understand the implications of the Mental Capacity Act 2005 and the Mental Capacity (Amendment) Act 2019 how to implement it in their clinical practice.

4.7 Liberty Protection Safeguards (LPS)

The Liberty Protection Safeguards will provide protection for people aged 16 and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements.

The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty.

4.8 Multi Agency Public Protection Arrangements (MAPPA)

The Criminal Justice Act 2003 underpins MAPPA. This is designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies involved with those offenders, to work together in partnership to manage and risk assess these individuals.

4.9 Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 definitions are:

- Gender Based Violence – Violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation;

- Female Genital Mutilation (FGM) - is the partial or total removal of external female genitalia for non-medical reasons. It is illegal in the UK and is considered child abuse.

- Forced Marriage - 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);

Domestic Abuse means, abuse where the victim of it is or has been associated with the abuser. This can be committed by an intimate partner, ex-partner, spouse, civil partner or family relative. This is in line with the Home Office's definition of domestic abuse as any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can be physical, sexual, psychological, emotional or financial abuse.

The Domestic Abuse Act 2021 defines behaviour as "abusive" if it consists of any of the following;

(a) physical or sexual abuse;
(b) violent or threatening behaviour;
(c) controlling or coercive behaviour;

(d) economic abuse (see subsection (4));
(e) psychological, emotional or other abuse;

Children are often the victims of domestic abuse, as they can see or hear the abuse related to either the victim, perpetrator or both. Is reliant on the victim or perpetrator to provide care and support.

Domestic abuse adversely affects the health and wellbeing of the population within the CTMUHB footprint. Identifying abuse and violence and supporting early intervention can be effective in the prevention of escalation, and can support timely and appropriate support.

Health board professionals will be able to identify violence, domestic abuse and sexual violence and must be confident to ask about these issues as set out in the Ask and Act Guidance (2017). **"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.

Health board professionals will be able to identify high risk victims and understand their responsibilities to notify and refer into the Multi agency Risk Assessment conference (MARAC). Details of how to refer to MARAC are available on the Health Boards safeguarding intranet pages.

It is recognised that colleagues within CTMUHB may be experiencing domestic abuse, it is important that this is recognised and colleagues are signposted to appropriate support and advice.

LIVE FEAR FREE HELPLINE – 0808 8010 800 TEXT – 0786 007 7333

4.10 FEMALE GENITAL MUTILATION (FGM)

FGM comprises all procedures that involve partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons.

The practice of FGM is recognised internationally as a violation of the human rights of girls and women (WHO, 2023). Key facts include;

- FGM is mostly carried out on young girls between infancy and age 15 years.

- More than 200 million girls and women alive today have undergone FGM in 30 countries in Africa, the Middle East and Asia where FGM is practiced.

- FGM can result in long term consequences for female health

It is illegal for a British National or permanent resident to have FGM, or to help someone trying to do this. If you are concerned that a person you are working with (or their children) may be at risk of FGM this **must** be reported to social services.

4.11 CARE EXPERIENCED CHILDREN/LOOKED AFTER CHILDREN

Children and young people who are looked after by the Local Authorities are among the most socially excluded groups within society. They have significantly increased health needs in comparison to children who are not looked after. CTMUHB has a legal responsibility under the Social services and Wellbeing (Wales) Act 2014 in relation to planning, commissioning and delivery of health services to meet the needs of this vulnerable cohort.

Health Board staff have an opportunity to support their health needs by being vigilant to risks associated with care experienced children. **Effective information sharing,** including when necessary appropriate **referrals,** can act as a protection against any identified risks and reduce inequlaities.

Children can be Looked After up until the age of 18 (Children Act 1989). Where this is can be in a variety of places including foster carers residential homes, with parent's relatives, or unregulated placements. When treating children and young people in the absence of parental **consent**, it is important to ensure that any consent sought is provided from the person acting as the legal parent for this child.

4.12 CONTEST/PREVENT/CHANNEL

CTMUHB and employees have a duty to report concerns in relation to those young people or adults who they believe are involved or have potential to being drawn into terrorism (Counter Terrorism and Security Act 2015).

CONTEST is the government strategy that looks at four work streams, to;

Prevent - To stop people becoming terrorists or supporting terrorism

Pursue - To stop attacks, this is the police responsibility

Protect - CTMUHB will support this in strengthening protection by ensuring that the environment and people are aware of risks and through secure work practices.

Prepare - To mitigate the impact of a terrorist attack.

Prevent strategy aims to prevent people either supporting or becoming involved with terrorism. This will include the early identification of vulnerable individuals that may be exploited for terrorist activities and are in need of safeguarding. CTMUHB will be aware of the duty to report and the reporting process with available referral forms currently placed on the Health Board's intranet.

Channel forms part of the Prevent strategy; it is a multi-agency approach to indentifying individuals at risk, assess the nature and extent and develop a support and intervention plan.

4.11 MODERN SLAVERY AND TRAFFICKING

Defined as the recruitment movement harbouring or receiving children, women or men through the use of force, coercion and abuse of vulnerability, deception or other means through the purpose of exploitation (2017).

Modern slavery impacts on both the physical and emotional health of an individual, they will have very little access to health resources therefore early identification and intervention can hugely impact on victims. CTMUHB staff in both primary and secondary settings need to be aware of this crime and its exisistance within the local community.

5. LEGISLATION & NHS REQUIREMENTS

CTMUHB has to comply with the relevant legislation, external standards and good practice guidance:

- 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]
- Children Act 1989 and 2004
- Mental Capacity Act 2005 and amended in the Mental Health Act 2007
- Mental Capacity (Amendment) Act 2019
- Modern Slavery Act 2005
- s325 Criminal Justice Act 2003 [Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency]
- Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015
- s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police]
- Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour]
- Domestic Abuse Act 2021
- Human Rights Act 1998
- Data Protection Act 1998 / GDPR
- Sexual Offences Act 2003
- Mental Health Act 1983
- The United Nations Convention on the Rights of the Child (UNCRC)
- Duty of Quality Act (2023)
- Duty of Candour (2023)

6. PROCEDURES

6.1 Safeguarding Children and Adults Wales Safeguarding Procedures

https://safeguarding.wales/ (app available)

The Procedures describe in detail how they will support staff and detail actions to be taken at all stages of the child and adult protection process. They are available via the Health Board Intranet on the Safeguarding & Public Protection site.

6.2 Cwm Taf Morgannwg Safeguarding Board Policies & Procedures

All multi-agency safeguarding policies and procedures are approved By the Safeguarding Board. They are available via their website at:

Professionals | Safeguarding, Cwm Taf Morgannwg (cwmtafmorgannwgsafeguardingboard.co.uk)

6.3 Individual Roles & Responsibilities to Safeguard Children & Adults at Risk all staff must know who to contact to express concerns and how to report those concerns to the Local Authority (see appendix 1&2)

If it is believed the child or adult is/or may be at risk, this must be **reported immediately by telephone** to the relevant Local Authority in the Multi-Agency Safeguarding Hub (**MASH**). If there is **immediate risk** then the police should also be contacted along with MASH.

The telephone report must be **confirmed in writing** within 24 hours using the C1/A1 Forms (available on SharePoint). The reporting of concerns should be discussed with the child's parents and the child as appropriate to their age and understanding. All efforts should be made to obtain consent, however it is not

needed for a child protection referral. It is important to ensure that the **voice of the child** is heard and their views and wishes are captured. Any referral form should be submitted to;

CTHBMASHReferrals@wales.nhs.uk

Consent is required for an adult at risk referral, this should be obtained from the adult where possible. Should the Adult at risk lack capacity then a discussion attempt should be made with the family or next of Kin. The **exception** to this is if such a discussion would place the child/adult at greater risk of harm.

A referral **can be** made **without consent** where there is an identified overriding public interest. This should be clear within the referral document, along with the identified concern.

If you have not been notified of the **outcome** of your report within **10 working days** you must contact the Local Authority again. If you are **not satisfied** with the response from the Local Authority you must discuss this with the Health Board's Safeguarding Team. **[See Appendix 1 & 2]**

All staff must discuss any **uncertainty** about concerns or **differences of opinion** with the Health Board's Safeguarding Team If they are **unavailable** the concern must be discussed with the relevant Local Authority in the Multi-Agency Safeguarding Hub (**MASH**).

After this discussion a **decision** must be made as to whether or not the child or adult meets the definitions of a child or adult at risk. If it is believed that the child or adult is **not at risk** consider if they would benefit from additional services and with their **consent** and make the appropriate referrals to Early Help Services.

6.4 PROFESSIONAL CURIOSITY

This is a where a professional explores and understands what is happening to a child or adult a risk rather than making assumptions, or taking a single source of information and accepting it at face value.

In terms of safeguarding, it is exploring every possible indicator of abuse or neglect and to assess its impact on child or adult at risk. Applying professional curiosity can inform decision making, add valuable insight into safeguarding discussion actions and outcomes.

Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received. It means:

• testing out your professional hypothesis and not making assumptions

• triangulating information from different sources to gain a better understanding of individuals and family functioning

• getting an understanding of individuals' and families' past history which in turn, may help you think about what may happen in the future

• obtaining multiple sources of information and not accepting a single set of details you are given at face value

• having an awareness of your own personal bias and how that affects how you see those you are working with

• being respectively nosey

Top Tips

6.5

- Question your own assumptions about how individuals/families function and watch out for over optimism
- Recognise your own feelings (for example tiredness, feeling rushed or illness) and how this might impact on your view of a child/adult/family on a given day
- Think about why someone may not be telling you the whole truth • Demonstrate a willingness to have challenging conversations
- Address any professional anxiety about how hostile or resistant individual/families might react to being asked direct or difficult questions
- Remain open minded and expect the unexpected
- Appreciate that respectful scepticism/nosiness and challenge are healthy. It is good practice and ok to question what you are told
- Recognise when individuals/adult repeatedly do not do what they said they would and named this and discuss with them
- Understand the cumulative impact of multiple or combined risk factors, e.g. domestic abuse, drug/alcohol misuse, mental health)
- Ensure that your practice is reflective and that you have access

PROFESSIONAL CHALLENGE

Professional challenge is an integral part of safeguarding, where there are any idendified concerns, it is possible they can be resolved by discussion and negotiation between practitioners. Occasionally this can difficult within hierarchical teams, often found in health settings. For example, should a concern be raised and following a discussion with a senior colleague who does not share the same concern.

If the person who had the initial concern remains worried, it is essential that they are empowered to act on this concern. Health colleagues can be supported through their Line Manager, contacting MASH or the Corporate Safeguarding team, who can advise appropriately and if required take the safeguarding concern forward.

6.6 ESCALATING CONCERNS

This is the process of escalating safeguarding concerns further through the formal organisational process and can be supported through the Corporate Safeguarding Team.

Concerns Regarding Interagency Safeguarding Practice (CRISP) can be raised by following the Cwm Taf Morgannwg Safeguarding Board process.

All staff members who wish to escalate safeguarding concerns should directly contact the MASH Health Team, CNS Safeguarding or a member of the Corporate Safeguarding Team. Raising concerns early can prevent escalation in issues protecting the public from harm.

6.7 PROFESSIONAL CONCERNS

Part 5 of the Social Services and Wellbeing Act states that if the behaviour of a member of staff in or out of work causes you concern, and may pose a risk to children or adults at risk, you have a duty to act on these concerns. The Wales Safeguarding procedures set out how concerns should be managed.

Managing cases under these procedures applies to a wider range of allegations than those in which there is reasonable cause to believe a child or adult at risk is suffering, or is likely to suffer harm. It also applies to concerns that might indicate that a person is unsuitable to continue to work with children or adults at risk in their present position or in any capacity. It should be used in all cases in which it is alleged that a person who works with children or adults at risk has:

•*Behaved in a way that has harmed or may have harmed a child or adult at risk*
•*May have committed a criminal offence against a child or adult at risk or that has a direct impact on the child or adult at risk*
•*Behaved towards a child, children or adults at risk in a way that indicates they are unsuitable to work with both children and adults*

It can be difficult to determine what may fall into the category of "unsuitable to work with children or adults at risk". The employer should consider whether the subject of the allegation or concern has:

•*Been the subject of criminal procedures that indicate a risk of harm to a child or adult at risk*

•*Caused harm or possible harm to a child or adult at risk and there is a risk in the working, volunteering, or caring environment*

•*Contravened or continued to contravene their agency's Safeguarding Policy and Procedures*

•*Failed to understand or comply with the need for clear personal and professional boundaries in the work place*

•*Behaved in a way in their personal life which could put children and adults at risk of harm*

•*Behaved in a way that undermined the trust placed in them by virtue of their position*

•*Children who are subject to Child Protection Procedures*

•Has caring responsibilities for an adult who is subject to Adult Protection Procedures

When considering the application of these procedures a number of factors should be considered. Some concerns could be considered as poor professional practice and may be more appropriate to be dealt with via agencies' own internal processes or through providing appropriate advice, guidance or training.

If any criminal or safeguarding concerns regarding a staff member are identified, either in a persons professional capacity or private life, these must be discussed with MASH or the Corporate Safeguarding Team. Consideration for a part 5 referral can be made if required. The Safeguarding Team will act in accordance with Cwm Taf Morgannwg Safeguarding Board's procedures, for 'Managing Allegations Made against Professionals'.

When allegations of abuse are made against a member of staff, whether contemporary in nature, historical or both, the matter will be reported to the Local Authority to investigate, just as any other concern about possible abuse.

During the management of any professional concern the Manager will be required to complete a risk management plan and submit to CTHBMASHReferrals@wales.nhs.uk and Human resources. In addition, they may be required to make a referral to the appropriate professional body or Disclosure Barring Service (DBS).

6.8 Deprivation of Liberty Safeguards Procedures [DoLS]
Cwm Taf Safeguarding Board Policy and Procedures for DoLS 2017

The Safeguarding Board Procedures describe in detail the actions to be taken at all stages of the Deprivation of Liberty Safeguards process.

They are available via the Health Board Intranet on the Safeguarding & Public Protection site.

6.9 Multi Agency Public Protection Arrangements [MAPPA]

Cwm Taf Morgannwg has a UHB Policy for MAPPA which includes the Procedures.

The policy is available via the Health Board Intranet on the Safeguarding & Public Protection site.

6.10 Violence Against Women Domestic Abuse Sexual Violence Procedures [VAWDASV]

Cwm Taf Morgannwg UHB has Guidance to support victims of violence against women, domestic abuse and sexual violence and to promote their safety whilst they are in contact with Cwm Taf Morgannwg University Health Board (CTMUHB) staff. It explains the processes and procedures that staff will use to identify and respond to violence against women, domestic abuse & sexual violence. This may include staff members who may be identified as victims along with relevant Human Resources policies and guidance.

The guidance is available via the Health Board Intranet on the Safeguarding & Public Protection site.

6.11 Information Sharing

Information must be shared in accordance with the General Data Protection Regulation (GDPR) and the common law duty of confidentiality. However, there are circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the practitioner deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others. Information shared should be necessary for the purpose and should also be proportionate.

7. TRAINING

Safeguarding and Public Protection training is vital in protecting our service users, their families and our communities from harm.

Safeguarding training is available both on a single agency and a multi-agency basis in line with the UHB Safeguarding Training Strategy. Mandatory safeguarding compliance is the responsibility of individual pracitioners. Care Group compliance will be monitored at the Safeguarding Operational Groups and reported to the Safeguarding Executive Steering Group. The following levels of training are identified within the Royal College of Nursing Intercolligiate Document.

Level 1: This level is equivalent to the core safeguarding/child protection training across all organisations working with children and young people and is for all healthcare staff regardless of place of work.

Level 2: Non-clinical and clinical staff who, in their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children.

Level 3: All clinical staff working with children, young people and/or their parents/carers and/or any adult who could pose a risk to children and who could potentially contribute to assessing, planning, intervening and/or evaluating the needs of a child or young person and/or parenting capacity (regardless of whether there have been previously identified child protection/safeguarding concerns or not).

The Royal College of Nursing Intercollegiate Document and National Safeguarding Training Standards (2022) both define competency requirements for all NHS staff.

7.1 Children and Adults at Risk

All staff must receive training in how to safeguard and promote the welfare of children and adults at risk. They need to be alert to potential indicators of abuse or neglect, including for the unborn child, and know how to act upon their concerns in line with Safeguarding Board Procedures. They must also know how to contact the Health Board's Safeguarding Team to access appropriate advice and support.

7.2 Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)

The Welsh Act places a statutory duty on the UHB to train all staff in line with the National Training Framework for VAWDASV. Group 1 training is **mandatory** for all staff. Group 2 training is available to allow practitioners to have more in-depth knowledge of VAWDASV. All health board staff following training will have a clear understanding of their role in identifying concerns, where to get advice and support if they have a concern. Be able to signpost and for these required to attend group 2 training make appropriate referrals.

7.3 Mental Capacity Act (MCA, 2007) and Mental Capacity (Amendment) Act (2019)

The MCA is law in England and Wales and places a statutory duty on the UHB to train all staff about the MCA.

- Level 1 training is aimed at individuals who may have potential/actual contact with patients, e.g. Porters, Domestic staff, Catering Staff, Admin Staff etc.
- Level 2 is aimed at Health Care Assistants, Physiotherapy Technician, Speech and Language Therapy Technicians, Occupational Therapist Technicians etc.
- Level 3 is aimed at Qualified Professionals – Nurses, Occupational Therapists, Psychologists, Speech and Language Therapists, Social Workers, and Doctors etc. This will be planned as mandatory e- learning modules for level 1 &2, and tailored training relevant to their specialities for level 3.

7.4 Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS)

All qualified staff require Level 3 training to understand the Deprivation of Liberty Safeguards and how to apply it into their everyday practice. Following this training staff will need to be able to identify and request an Urgent authorisation or request for a standard authorisation.

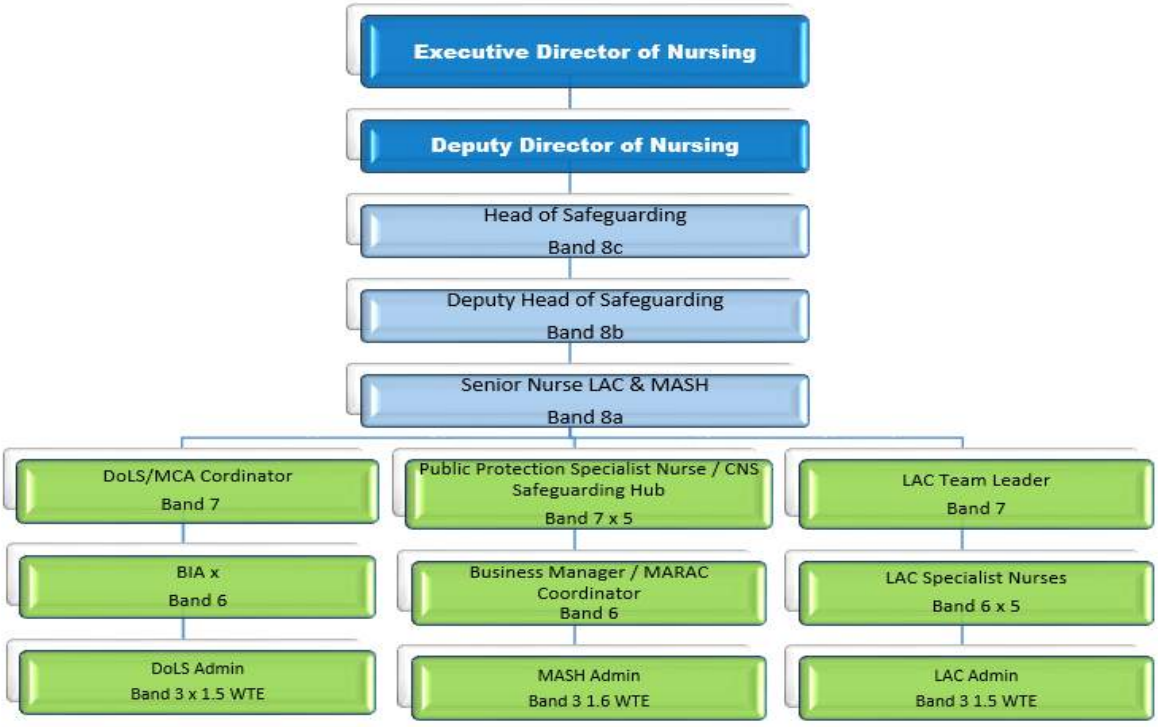
The CTMUHB Safeguarding Training Framework is available on the intranet safeguarding and public protection pages.

8. CORPORATE RESPONSIBILITIES

8.1 UHB Governance & Reporting Arrangements

The UHB Governance & Reporting Structure is outlined below. Each Directorate in the UHB has representation on the two Safeguarding Groups who links in with their Directorate Clinical Governance process.

8.2 Lines of Accountability Corporate Safeguarding Team



8.3 Corporate Safeguarding Responsibilities
Chief Exeutive

As a accountable officer the Chief Executive has an overall responsibility for ensuring CTMUHB has appropriate guidance an policies in place , this must comply with legislation, meet mandatory requirements and provide services that are safe evidenced based and sustainable.

Deputy Chief Executive Officer:
CTMUHB Executive lead for safeguarding

Deputy Director of Nursing: CTMUHB lead for NMC referrals

Head of Safeguarding:

Strategic lead responsibility for key aspects of the Health Board's Public Protection and Safeguarding Statutory Responsibilities. They will support the provision of mandatory safeguarding training in CTMUHB, and ensure that staff have access to specialist safeguarding advice and support.

Deputy Head of Safeguarding:
Operational and Strategic responsibilities for key aspects of the Health Board's Public Protection and Safeguarding Statutory Responsibilities

Senior Nurse for MASH & Looked After Children:
Operational lead responsibility for key aspects of the Health Board's Public Protection and Safeguarding Statutory Responsibilities.

Nurse Specialists Public Protection:
Work within Cwm Taf Morgannwg Multi-Agency Safeguarding Hub (MASH) & UHB Designated Lead Managers for Adult Protection.

Looked After Children's Team:
Oversee and undertake health assessments and health care planning for Children Looked After

Deprivation of Liberty Safeguards and Mental Capacity Act 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 who provides scrutiny and assurance to the Board.

Independent Board Member/Vulnerable Adults:
A member of the Safeguarding Executive Group who provides scrutiny and assurance to the Board.

8.4 Lead Roles in Safeguarding

In addition to the Corporate Safeguarding Team there are a number of staff who have specific responsibilities for safeguarding. Clinical supervision for their safeguarding work is provided by the Head of Safeguarding or the Senior Nurse Public Protection.

CNS Midwife for Vulnerable Women and Child Protection:
CTMUHB Named Midwife for Safeguarding Children.

CNS Safeguarding Nurse for Child Protection Medical Hub:
Named nurse responsible for planning and supporting the implemention of Child Protection Medicals undertaken at the Hub at Royal Glamorgan Hospital.

CNS Adoption & Looked After Children:
Nurse Specialist for Adoption & Looked After Children.

Localities:
The Children and Families Care Group have seven Clinical Nurse Specialists who provide child protection safeguarding supervision, support and advice to the Health Visiting, School Nursing and Paediatric services.

Named Doctor Child Protection:
The named doctor supports all activities necessary to ensure that the organisation meets its responsibilities to safeguard/protect children and young people. Overall responsibility for the Safeguarding Hub.

Named Doctor for Adoption & Looked After Children:
The named doctor provides strategic and clinical leadership. In relation to the roles and responsibilities to ensure UHB meet their obligations for looked after children. This will include advice and support all specialist LAC professionals across UHB.

9. REVIEW, MONITORING & AUDIT ARRANGEMENTS

This policy will be reviewed every three years or earlier if indicated.

The Annual Report for Safeguarding and Public Protection will be submitted to the Safeguarding Executive Group, the Quality, Safety & Risk Committee and presented to the Board.

10. RETENTION OR ARCHIVING

This policy will be available via the UHB Intranet on the Safeguarding & Public Protection site. The Corporate Safeguarding Team will retain all previous versions of this policy for future reference.

This policy will be version controlled.

11. NON CONFORMANCE

Conformance with this policy will be monitored on a regular basis; non-conformance may be subject to an internal review.

12. EQUALITY IMPACT ASSESSMENT STATEMENT

This Policy has been subject to a full equality assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy (see Equality Impact Assessment Action Plan).

13. CONTACTS

All staff who require advice and support in relation to any safeguarding issue should contact one of the following:

Safeguarding Team

Head of Safeguarding – Claire O'Keefe – 07557 549634
Deputy Head of Safeguarding – Nadine Long – 07786 660415
Senior Nurse MASH/LAC – Nicola Jones -
MASH Health Team - 01443 742949 /01656 643630
Child Protection Medical Hub – 07917491337
Named Doctor Safeguarding – Matthew O'Baid - 01656 752661

Local Authority MASH

RCT/Merthyr Children	01443 743730
RCT/Merthyr Adults	01443 743730
Bridgend Children	01656 642320
Bridgend Adults	01656 642477

Out of Hours Emergency Duty Team 01443 743730

Emergency Duty Team Email address;
SocialWorkEmergencyDutyTeam@rctcbc.gov.uk

MASH Health
CTHBMASHReferrals@wales.nhs.uk

Cwm Taf Morgannwg UHB Safeguarding Children Referral Flowchart

Practitioner has concerns for a child where there is evidence or suspicion of abuse or neglect

Practitioner may wish to discuss with:

- **Police in an emergency or immediate risk of harm**
- **Line Manager**
- **A member of the Corporate Safeguarding team**
- **CNS Safeguarding/MASH Health (01443 742949/01656 643630)**
- **Children Services/Emergency Duty Team (Merthyr/RCT 01443 742949) (Bridgend 01656**

Please record your discussions, actions and decision making.

Making a referral to children services
Discuss with parents unless unsafe to do so

Practitioner refers to children services by telephone:
Merthyr/RCT 01443 742949
Bridgend 01656 642320
Emergency Duty Team 01443 743730

Please record your discussions, actions and decision making.

Please ensure that other services are aware of child protection concerns. i.e. Health Visiting, School Nurse, GP, CAMHS etc

Practitioner must follow up telephone referral by submitting a C1 as soon as possible or within 24 hours
CTHHBMASHReferrals@wales.nhs.uk
SocialWorkEmergencyDutyTeam@rctcbc.gov.uk

MASH/IAA should acknowledge receipt of referral and decide on next course of action.

A Health representative should be present at any strategy meeting to share all available information. This includes out of hours when MASH health are unavailable.

NB – Please ensure that the child remains in a place of safety while appropriate checks are made with partner agencies.

CWM TAF Morgannwg UHB
Adult at Risk Flowchart

YES

NO

IS THE PERSON IDENTIFIED AN ADULT?

→ Refer to Children's Service

↓

Is there evidence or suspicion of abuse or neglect?

→ Consider Health & Social Care Needs.

↓

Does the person need Care & Support?

↓

Is the person **unable** to protect him / her self against abuse or neglect?

→ This person is **not an Adult at Risk** as identified under the Social Services & Wellbeing (Wales) Act 2014.

Ensure safety & consider social / health care needs.

← This person **is an Adult at Risk** as identified under the Social Services & Wellbeing (Wales) Act 2014

The Act imposes a new duty on relevant partners to report to a L.A if it is suspected that an adult is an Adult at Risk

Does the person identified **lack mental capacity** to understand their situation?

← Act in **their** best interest. **Consult with family/ Advocate**.

↓

Is this a serious crime?
Is the person at immediate risk?

← **In Emergency call the Police on 999**

Deal with the immediate risks & then report to ***M.A.S.H***

↓

Does the person **consent** to the safeguarding process? Are they happy for their information to be shared with the relevant authorities?

→ Are there any other **adults at risk** or **children** potentially affected?

Is there an overriding public interest?

If concerned seek advice or report to **M.A.S.H.**

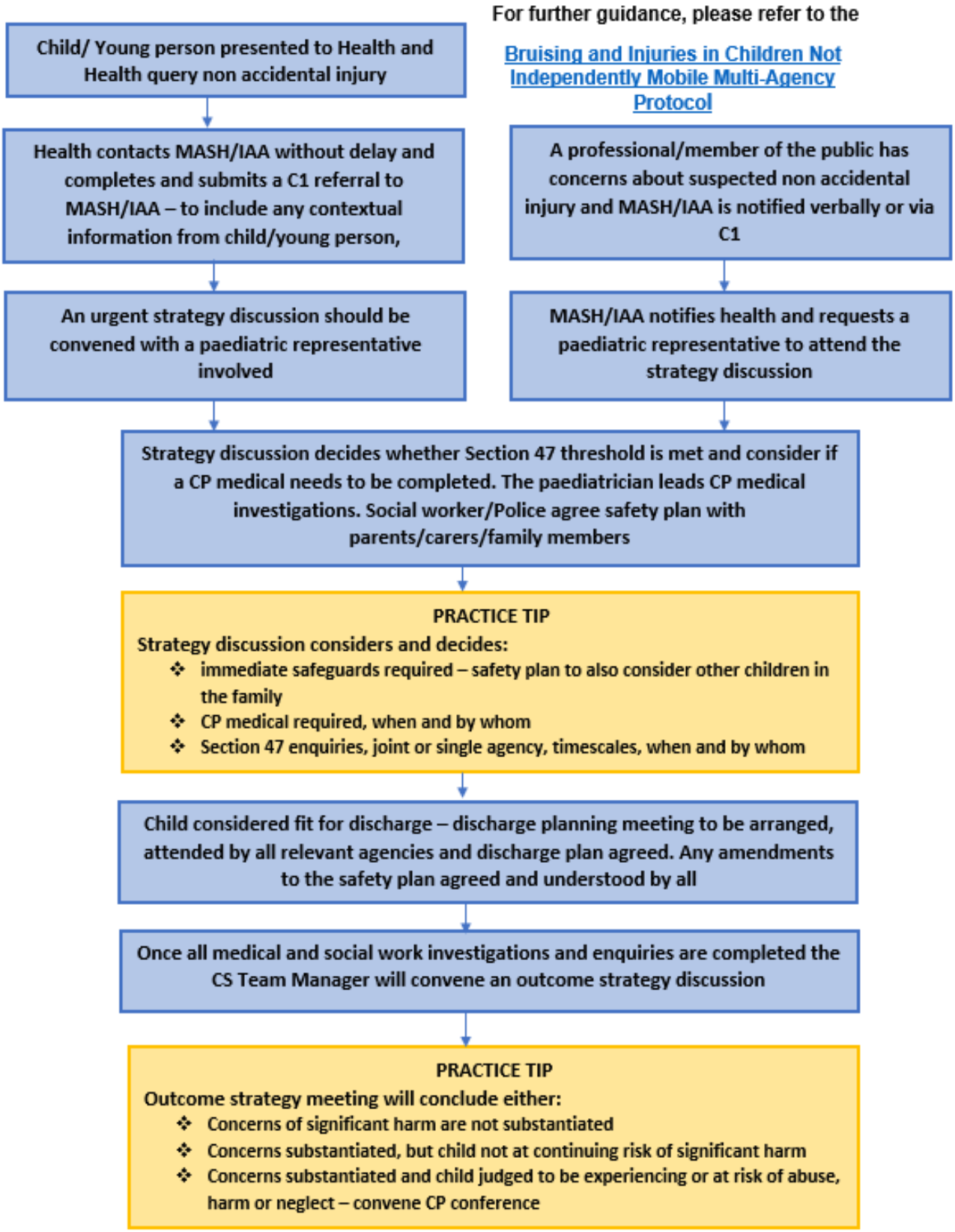
← Contact M.A.S.H
8:30 am -5 pm
Mon-Fri
Taf: 01443 743730

For Out of Hours Emergency Duty Team
01443 743730

Complete **A1** Report Form within **24 hrs.**
Send to: **cthbmashreferrals@wales.nhs.uk**

MULTI AGENCY SAFEGUARDING PROCESS IN CASES OF SUSPECTED/CONFIRMED NON-ACCIDENTAL INJURIES

This process relates to any new concerns



Agenda Item
9.1.5

Quality & Safety Committee

Proposed Process for the Approval of Clinical Policies and Guidelines within Cwm Taf Morgannwg University Health Board	
Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Esther Flavell, Assistant Medical Director Quality & Safety
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 Approval

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Operational Management Board	14/06/2023	Endorsed for approval
Acronyms / Glossary of Terms		
NICE	National Institute for Health and Care Excellence	
QIA	Quality Impact Assessment	
EIA	Equality Impact Assessment	
IA	Impact Assessment	
WCD	Written Control Document	

1. Situation /Background

1.1 In accordance with the Health Board's 'Policy on Policies' all written control documents i.e. policies, procedures, strategies, protocols and guidelines need to be formally ratified by an appropriate forum prior to it becoming operational.

1.2 The scope of this report is limited to **Clinical** written control documents (WCDs).

1.3 The current process for approving Clinical Policies is multistep and can result in the delay in implementation, disengagement, the use of 'draft' documents, and items not being appropriately ratified.

1.4 The current process sees Clinical WCDs reviewed at a monthly meeting, chaired by the Assistant Medical Director for Quality & Safety. The group comprises a panel of interested parties who scrutinise and provide feedback on submitted policies. This can be an arduous and lengthy process and could be streamlined to facilitate an easier process whilst maintaining assurance that the scrutiny is robust and safe.

1.5 The purpose of this report is to propose a more efficient and effective process of approval.

2. Specific Matters for Consideration

2.1 The following outlines the proposed process of the approval of Clinical WCDs within the Health Board.

2.2 Proposed Clinical Policy route for approval

- If Care Group specific then the relevant Clinical Care Group Director would review and endorse for onward approval (i.e. Paediatrics policy considered by the Children and Family Care Group).
- If Health Board wide then the Assistant Medical Director for Quality & Safety would review and endorse for onward approval.
- The policy would then be received at the Operational Management Board for approval. The Medical Director or appropriate Medical deputy would need to be present.
- Final and formal ratification and approval at Quality & Safety Committee through submission of a highlight report with links to policies that have been considered via the above steps.

2.3 Proposed Clinical Procedures, Strategies and Guideline route for approval

- If Care Group specific then the relevant Clinical Care Group Director would review and endorse for onward approval.
- If Health Board wide then the Assistant Medical Director for Quality & Safety would review and endorse for onward approval.
- The Clinical Guideline/Procedure would then be received at the Operational Management Board for approval. The Medical Director would need to be present.

2.4 National Clinical Policies and Guidelines

- Once the relevant Clinical Executive Director has determined it is appropriate for direct adoption then the Health Board will adopt any guideline or procedure guide published by a national recognised body (for example Royal Colleges, NCIE, Regional groups).

- The document should be received at the Operational Management Board and Quality & Safety Committee 'for noting'.

3. Key Risks / Matters for Escalation

3.1 The proposed approach allows the Care Groups to review and approve policies first, and then present directly to Operational Management Board without further delay.

3.2 Care Group would determine that the Quality Impact Assessment, Equality Impact Assessment, and Sustainability Impact Assessment are all completed on the WCD as appropriate prior to seeking approval.

3.3 The result of these changes would be a streamlined system that remains robust in its consideration of Clinical WCDs and complies with Standing Orders.

3.4 In exceptional circumstances where urgent approval is required, the route to approval could be expedited with the agreement of the relevant Chair.

3.5 If supported the 'Policy on Policies' would be amended to reflect this process.

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 *(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)) /*	Effective If more than one applies please list below:

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	
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: positive impact 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:	If no, please include rationale below: Not necessary for this process
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 **APPROVE** the proposed process for the approval of Clinical Policies and Guidelines within the Health Board.

6. Next Steps

6.1 Adoption of process across care groups

6.2 Disseminate process to care group leads for implementation and disbanding of the Clinical Policies Advisory Group

Appendix 1

Checklist for cross speciality policies

There are many policies where more than one specialty is involved. Examples include female incontinence, where therapies, Gynaecology and Urology are involved. All specialities need to be aware and have input into policy development that involves their area of expertise.

This checklist can be used to ensure all stakeholders are consulted in the process where a new policy is developed or existing updated.

1. Author of policy states the primary care group and identifies other care groups that require input. Contact made with other care groups to inform and ask for input and a contact for discussion.

2. Policy developer writes policy after discussion with their own care group as detailed in the main guidance.

3. Once the policy is written, guidance is sought from the other stakeholders and agreement on content reached.

4. The policy is then taken through each relevant care group for discussion as per guidance in main document.

Example

Policy for management of female incontinence

Primary policy written by Gynaecology in children and families care group.

Initial contact made with Urology in planned care and Physiotherapy in therapies care groups

Policy written as per guidance in main document and taken to relevant care groups for comment.

Policy also goes to planned care and therapies for comment and discussion. Comments taken into account and evidence of discussion with each group documented.

Policy taken forward in usual way as per new guidance.

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 September 2023)
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	January 2024	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Medical Director to ensure interim timelines were put into place for the Task & Finish Groups referred to in relation to Risk 4080.	Medical Director	January 2023 Was August 2023 Now September 2023	**In Progress** Collaborative discussions have been ongoing for CTMUHB to align rates with Aneurin Bevan UHB's rate card. This has been discussed at Exec level and finical controls have been considered. An updated paper is due to be tabled at

					an ELG in September for official approval.
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 September 2023 - Awaiting a revised**

					action log update from the Chief Operating Officer
6.1	16 March 2023	**Maternity Services & Neonates Improvement Programme** Review to be undertaken of the metrics included within the report to ensure they aligned with data contained within other reports, for example, the number of concerns and incidents being reported.	Director of Midwifery	24 May 2023 Now 21 September 2023	**In progress** The Team continue to monitor their incident / concerns reporting weekly and triangulate the information between service, DATIX and the Q&S weekly dashboard that is sent through
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 Resuscitation Team in relation to CPR training compliance	Executive Director of Nursing	21 September 2023 **Now 21 November 2023**	**In progress** An update will be included in the report being presented to the November 2023 meeting.
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	Assistant Director of Quality & Safety	21 September 2023	**In progress** A verbal update will be provided by the Assistant Director of Quality & Safety at the September 2023 meeting.

		with Members at the September meeting			
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	**In progress** A verbal update will be provided during the presentation of the Quality Dashboard report.
8.3	25 July 2023	**Mortality Assurance Report** Further update on progress to be presented to the Committee in three months	Medical Director	21 November 2023	**In progress** Further report to be presented to the Committee at its meeting on 21 November 2023

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 September 2023)
5.2.1	24 January 2023	**Learning From Events Reports** Progress report to be presented to the Committee in three months.	Assistant Director of Concerns & Claims	24 May 2023 Further report to be presented to 21 September 2023 meeting	**Completed but Ongoing** Report received at the meeting held on 24 May 2023. Progress report to be presented to the meeting being held on 21 September 2023. This is being captured within the forward work programme.
5.3	24 January 2023	**Datix Cymru Assurance Report** Report on progress to be presented to the Committee in 3-6 months.	Head of Concerns & Business Intelligence	25 July 2023	**Completed** Report received at the meeting held on 25 July meeting. Further updates on progress to be included in the Quality Dashboard report.
6.7	24 January 2023	**Liberty Protection Safeguards** Report to be shared with Committee Members later in the year on progress being made in this area.	Head of Safeguarding	25 July 2023	**Completed but Ongoing** Report received at the meeting held on 25 July 2023. Further report on progress to be received at the meeting being held on 21 November 2023. This is being captured within the forward work programme.
6.5	16 March 2023	**Stroke Services Progress Report** Future iterations of the action plan to include	Director of Therapies & Health Sciences	25 July 2023	**Completed but Ongoing** Report received at the meeting held on 25 July 2023. Reports to be received

		realistic target dates for completion and each action to be linked to the Quality Improvement Measures where applicable.			quarterly moving forwards which is being captured within the Annual Cycle of Business. Next report due 21 November 2023.
5.1	24 May 2023	**Organisational Risk Register** Comments raised by Members in relation to the content of the risk register to be considered by the Assistant Director of Governance & Risk outside the meeting.	Assistant Director of Governance & Risk	25 July 2023	**Complete and Ongoing** Risks updated for the July iteration of the organisational risk register. Further work is ongoing with risk leads to strengthen mitigating actions in terms of outcomes and timeframes.
6.4	24 May 2023	**Quality Dashboard** Update to be included in the next iteration of the report as to the reason behind the high number of falls being experienced at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda Members to share any further comments as to how the content of the quality dashboard could be progressed further.	Deputy Director of Nursing Committee Members	25 July 2023	**Completed** Verbal update provided by the Deputy Director of Nursing as part of the Quality Dashboard report at the meeting held on 25 July 2023. Periodic updates to be presented via the Quality Dashboard Report. Open offer to Members to share comments on how the quality dashboard report could be progressed further.

6.4.1	24 May 2023	**Emergency Department Spotlight Presentation – A Review of Falls and Pressure Ulcers** Further report to be presented to the Committee in due course clarifying the points that had been raised.	Deputy Director of Nursing	25 July 2023	**Completed** Verbal update provided by the Deputy Director of Nursing as part of the Quality Dashboard report at the meeting held on 25 July 2023.
2.3	24 May 2023	**Care Group Spotlight Presentation – Primary Care and Communities** Updates on progress to be included in future iterations of the report in relation Safe to Start More detail to be provided to Committee members outside the meeting in relation to the practice that had been deleting unread referral update messages.	Care Group Nurse Director – Primary Care and Community	25 July 2023 Now 21 September 2023	**Completed and Ongoing** Future reports will include updates on Safe to Start. Update provided to Members in relation to the deletion of unread referral update messages in the action log update provided at the July meeting.
5.1	25 July 2023	**Report from the Chief Operating Officer** Confirmation to be provided as to what percentage of staff the 15 Band 5 Registered Nurse vacancies within the Mental Health Unit equated to	Chief Operating Officer	21 September 2023	**Completed** The following update was shared with Members by email outside the meeting: Since the report was written there has been further work to review nursing vacancies across the MHLD Care Group. The RGH Mental Health Unit has 6 wards and

					there are currently 25 wte Band 5 vacancies and this is a vacancy rate of 47% of all Band 5s in the establishment. This compares to a Care Group Band 5 vacancy rate of 37%. Workforce colleagues are currently engaged in a programme of work to review reasons for leaving at RGH. In addition there is a care group programme of work to review nursing establishments as part of Phase 1 of the Nursing Workforce Plan. This phase is due to be completed by the end of September.
6.5	24 May 2023	**Care Group Report – Unscheduled Care** Timescales for the improvement plan that was being developed following the Infection Prevention Control (IPC) environmental review to be identified.	Unscheduled Care Group Nurse Director	31 July 2023	**Completed** Update has been included in the Care Group Highlight Report submitted to the September meeting.
6.4.3	24 May 2023	**Executive Director and Independent Member Quality Patient Safety**	Director of Nursing	25 July 2023 Now August 2023	**Completed and Ongoing** During the Patient Safety Walkrounds a collective agreement on highlighting

		Walkrounds January – April 2023 Report to be amended to reflect that it would be the responsibility of the Executive Director to agree actions for improvement with the relevant Care Group Lead and not the Independent Member.			any areas of improvement and any areas of excellence for wider sharing is made by the Executive Director, Independent Member and Ward Manager. The ownership and accountability for taking actions forward sits with the Care Group. This process will be confirmed in the Walkround report being presented to the November 2023 meeting.
2.2	25 July 2023	**Care Group Spotlight Presentation – Diagnostics, Therapies, Pharmacy and Specialties** Future reports to include the impact of the measures that had been put into place to address the issues highlighted.	Care Group Nurse Director	21 September 2023	**Completed** Report has been strengthened for the September 2023 meeting.
8.3	25 July 2023	**Mortality Assurance Report** Board to be made aware that a discussion had been held on relation to Mortality Data and assurance had been provided that processes were being put into place to address the position.	Committee Chair	27 July 2023	**Completed** Verbal update was provided to the Board at the meeting held on 27 July 2023. Update has also been included in the Committee Highlight report to Board being presented to the meeting being held on 28 September 2023

Agenda Item
9.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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	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 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	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))*	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: 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	Director of Nursing	Annually											⚑	
Welsh Ambulance Services NHS Trust Patient Experience Report	Director of Nursing	Quarterly	⚑				⚑		⚑				⚑	

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
Update has been included in the Unscheduled Care Group Highlight Report for July 2023							Deferred to July 2023							
Infection, Prevention & Control Committee Exception Reports	Director of Nursing	As and when required												
Infection, Prevention & Control Report (Annual Report and Mid-Year Update)	Director of Nursing	Bi-Annually					End of year update				Annual Report		Mid Year update	
Quality Governance – Regulatory Review Recommendations and Progress Updates (to include Healthcare Inspectorate Wales, Delivery Unit, Community Health Council)	Director of Nursing	All regular meetings when needed												
Healthcare Inspectorate Wales Action Plan Tracker	Director of Nursing	All regular meetings (from May 2023 onwards)												
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					Will be discussed at In Committee 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												
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually												
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually												

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	25 July 2023	Aug 2023	21 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
GOVERNANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
IMPROVING CARE														
Maternity & Neonates Services Improvement Programme	Director of Nursing/Medical Director	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Quality Dashboard to include: • Delivery Unit Performance Dashboards; • Care Group Quality & Safety Highlight Reports; • Updates from the Shared Listening & Learning Forum	Director of Nursing	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Care Group Spotlights Presentations	Director of Nursing/Chief Operating Officer	All regular meetings *(2x Care Groups per meeting)*	⚑		⚑		⚑		⚑		⚑		⚑	
Thematic Spotlight Presentations	Director of Nursing/Chief Operating Officer	All regular meetings as required	⚑		⚑		⚑		⚑		⚑		⚑	
Report from the Chief Operating Officer *(to include Planned Care Improvement Programme Progress Report (to include Follow Up Outpatients Not Booked and Harm Reviews)*	Chief Operating Officer	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
Stroke Services Progress Report	Director of Therapies & Health Sciences	Bi-Annually Now Quarterly			⚑				⚑				⚑	
Mortality Indicators and Mortality Reviews	Director of Public Health/Medical Director	Bi-Annually			⚑								⚑	
Ty Llidiard Progress Reports	Director of Therapies & Health Sciences	All regular meetings	⚑		⚑		⚑		⚑		⚑		⚑	
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually							⚑ Defer to Sept 2023		⚑			
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Director of Nursing	Annually	⚑											
Mental Health In-Patient Improvement Progress Reports Agreed following discussion at the In Committee Quality & Safety Committee that this matter would need to be reported to all regular meetings from May onwards.	Director of Nursing	All regular meetings					⚑		⚑		⚑		⚑	

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**
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Learning From Events Backlog – Progress Report	Assistant Director of Concerns & Claims	**In progress** Report received and discussed at the meeting held on 24 January 2023. A further update on progress was presented to the May 2023 meeting. Members requested a further update on progress to be presented to the 21 September 2023 meeting **– On agenda**
Email Request from the Assistant Director of Governance & Risk	Additional Item	A National Review of Consent to Examination & Treatment Standards in NHS Wales - Final Welsh Risk Pool Report	Executive Medical Director	Planned for May 2023 – Deferred to July 2023. Now Deferred to 21 September 2023. **On agenda**
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 January 2024**
Assistant Director of Governance & Risk advised of this email verbally	Additional Item	Clinical Policies Approval Process	Medical Director	Planned for 25 July 2023 – Now deferred to 21 September 2023. **On agenda**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
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	Planned for 21 November 2023
Email request received from the Director of Midwifery	Additional Item	MBRRACE response to the 2021 Perinatal Mortality	Director of Nursing	Planned for 21 September 2023 – **On agenda for the In Committee session.**
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.**
Email Request received from the Chief Executive requesting this item be added to the agenda	Additional Item	Ombudsman Wales Report – Groundhog Day 2: An Opportunity for Cultural Change in Complaint Handling	Director of Nursing	Planned for 21 September 2023 – **On agenda**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
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	Planned for 21 September 2023 – **On agenda**
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.
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	To be included in the Chief Operating Officers update for 21 September 2023 – **On agenda**
Email request from the Assistant Director of Governance & Risk	Additional Item	Quality Governance Arrangements Joint Review Follow-up	Director of Nursing	Planned for 21 November 2023
Email request received from the Patient Care & Safety Business Manager	Additional Item	Safeguarding Policy – For approval	Director of Nursing	Planned for 21 September 2023 – **On agenda**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email request from the Medical Directors Office Business Manager	Additional Item	Introducing the Use of NHS Numbers for Patients Accessing Sexual Health Services	Medical Director	Planned for 21 November 2023
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
Email Request received from the Head of Concerns and Business Intelligence	Additional Item	Internal Audit Review – National Incident Framework	Director of Nursing	Planned for 21 September 2023 – **On agenda**
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	Planned for 21 November 2023
Identified as an item for discussion at the Executive Leadership Group held on 21 August 2023	Additional Item	Raising Concerns Process	Medical Director	Planned for 21 September 2023 – **On agenda**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Request received from the Medical Director to add this to the agenda	Additional Item	Irradiated Blood Alerts	Director of Digital	Planned for 21 September 2023 – **On agenda**
Request received from the Head of Nosocomial Investigation Team	Additional Item	Delivery Unit (NHS Executive) Interim Learning Report	Executive Director of Nursing	Planned for 21 September 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
Email request from the Director of Corporate Governance following discussion held at Health, Safety & Fire Sub Committee raising this as an area of concern	Additional Item	Datix Cymru – Assurance Report	Director of Corporate Governance	**Completed** Report received and discussed at the meeting held on 25 July 2023. Further updates on progress to be included in the Quality Dashboard report.
Action agreed at the meeting held on the 24 January 2023	Additional Item	Spotlight Report on Emergency Care Incidents – Pressure Ulcers and Falls	Deputy Director of Nursing	**Completed** Verbal update presented to Members at the meeting held on 25 July 2023. Future updates to be included within the Quality Dashboard report.
Email Request from the Volunteer Manager	Additional Item	Volunteer Service Policy – For approval	Executive Director of Nursing	**Completed** Policy presented and approved at the meeting held on 25 July 2023
Email request received from the Medical Directors Office	Additional Item	Rapid Tranquilisation Policy	Medical Director	**Completed** Policy presented and approved at the meeting held on 25 July 2023
Email Request received from the Interim Director of Public Health	Additional Item	Recovery Plan Hep B and Hep C	Interim Director of Public Health	**Completed** Report received and noted at the meeting held on 25 July 2023

Email Request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	Welsh Risk Pool Claims Final Internal Audit Report and Action Plan	Director of Nursing	**Completed** Report received and noted at the meeting held on 25 July 2023
Email Request received from the Assistant Director of Concerns, Legal Services, Clinical Audit & Informatics	Additional Item	Concerns Final Internal Audit Report and Action Plan	Director of Nursing	**Completed** Report received and noted at the meeting held on 25 July 2023

WHSSC Joint Committee
19 September 2023
Agenda Item 4.8.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Kate Eden**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**16 August 2023**

Summary of key matters considered by the Committee and any related decisions made

- **WHEELCAIR SERVICES DEEP DIVE PRESENTATION AND PATIENT STORY**

A presentation outlining the functions of the Posture and Mobility service and the services it provides for children, young people and adults who require long term wheelchair use was received. Members noted the actions in place to reduce the current waiting times of over 52 weeks to zero by December 2023. The increased waiting times were a direct result of the COVID Pandemic and the backlog created due to the service being closed during that period.

Members received an informative patient story about a young girl, Ellen, who presented to the service initially with extremely complex issues and no experience of independent movement having never rolled, crawled or operated a wheelchair by herself. Despite this, Ellen was insistent on trying a powered wheelchair to gain more independence in her everyday life. Members noted the challenges Ellen faced due to her presentation, posture and dyskinesia and how the services used innovative thinking to overcome the issues by adapting a wheelchair to suit her posture and using the Drive Deck Platform to assess the best way she could drive it independently.

The presentation;

- Explored Referral to Treatment Time (RTT) between 2019/2022 and 2022/2023 and the first quarter of 2023/2024; and
- Explained the actions that were being taken to help reduce waiting lists.

QPSC noted;

- The Welsh Government RTT performance measures,
- Trajectories for 2023/2023,
- Key Performance Indicators; and
- Quality standards.

The challenges and achievements across the three centres were highlighted.

2.0 WELSH KIDNEY NETWORK (WKN) PRESENTATION

Members received a presentation outlining the impact of kidney disease and treatment options for patients with advanced kidney failure. Members noted the significant commitment required for patients undergoing Haemodialysis in the Dialysis Unit and the work that the WKN had undertaken to increase the uptake of home therapy using value based healthcare to improve access for patients as well as employing welfare benefits officers to assist patients in navigating the benefits system to access available financial assistance.

Members also noted the main role of the WKN as the commissioner for all adult kidney specialised services in Wales. The presentation explained the structure and role of WKN and highlighted the current commissioning responsibilities as;

- Haemodialysis (HD),
- Home HD,
- Peritoneal dialysis,
- Transplantation,
- Vascular access

3.0 WELSH KIDNEY NETOWRK REPORT

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 5 July 2023 and WKN Board meeting on 3 August 2023. There were 11 items on the current WKN risk register. One risk related the pressure on the Transplant Follow up Service had been closed.

Members noted that the Network Manager post would be advertised shortly which should decrease the current staffing risk and the updates to the limited outpatient dialysis capacity risk in Swansea which should be resolved once the new units open.

The Patient Story attached as an appendix to the report provided an account of a renal patients experience with the services following two failed transplants and how the team supported them to carry out self-care dialysis at home despite initial anxieties.

4.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a

summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

The main issue to note was the improved traction on the performance issues within the All Wales Lymphoma Panel service. The Escalation meetings continue to monitor progress against the action plan. It is anticipated that during the next escalation meeting in September 2023 there will be a recommendation to reduce the level of escalation due to the good work being undertaken.

North Wales Plastic Surgery service remains an area of concern and WHSSC continue to work with the Welsh Government escalation arrangements. WHSSC continue to attend the Task and Finish Group as an advisor and members noted that the Harm review is progressing. Members noted that as part of the harm review patients had been categorised and prioritised and those categorised as urgent have already been seen.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach maximum waiting times for treatment at Swansea Bay UHB and this remained a concern for WHSSC. The service remains in escalation Level 2 with a delivery plan in place.

- **Neurosciences**

Members noted that two new risks scoring above 15, both relating to Deep Brain Stimulation commissioned from North Bristol NHS Trust, had been added since the last report. A progress meeting has been scheduled for 21 September 2023 and a further update will be provided at the next QPSC meeting.

- **Cardiac**

Members noted the updates against the two services which currently remained in escalation level 2; Cardiff and Vale UHB (CVUHB) Cardiac Surgery Service;

- The planned repatriation of Cardiothoracic Surgery to UHW, initially scheduled for September 2023, is likely to be delayed and the actions that had been paused pending the relocation have been discussed with the HB at the July Cardiac Service Risk, Recovery and Assurance meeting.
- A formal escalation review is scheduled to take place in October 2023 when the outstanding actions will be discussed.

Swansea Bay UHB (SBUHB) Cardiac Surgery Service;

- Escalation monitoring continues to take place via bi-monthly meetings,
- SBUHB continue to make excellent progress against the action plan and the team will be considering the potential for further de-escalation at the next meeting in October 2023 subject to the National Adult Cardiac Surgery Audit Report (NACSA 2023).

- **Women & Children**

Members noted the five service areas with risks scoring 15 and above;

  - Paediatric Intensive Care,
  - Paediatric Surgery,
  - Neonatal,
  - Paediatric Cardiac Surgery; and
  - Wales Fertility Institute (WFI) – IVF.

- Mitigating actions are in place for each of the services with Paediatric Surgery, Paediatric Intensive Care and the Wales Fertility Institute all being managed through the WHSSC escalation process.

- **Fertility Service South Wales**

Members noted that a number of concerns had been raised following a relicensing inspection by the Human Fertilisation and Embryology Authority (HFEA) of the Women's Fertility Institute (WFI) in Neath Port Talbot Hospital, which was undertaken in January 2023. The first escalation meeting is due to be scheduled and further feedback will be shared subsequently.

- **Paediatric Surgery**

The service remains in Escalation Level 3 and the Risk remains on the CRAF. Members noted the issues in relation to the waiting list and the actions in place to improve the situation. It was noted that CVUHB have provided assurance that they will meet the contract volumes by December 2023 and they have provided a revised demand and capacity plan and waiting times trajectory and this is being monitored on a weekly basis. Members expressed their continued concern in relation to Paediatric Surgery waiting times and requested further assurance.

Overall waiting times have decreased to meet the Ministerial waiting time of 104 weeks. However, because this relates to children WHSSC have requested further significant reduction to 52 weeks over the next year. Outsourcing arrangements to NHS England and the private sector will remain in place to support this.

- **Paediatric Intensive Care Unit (PICU)**

The Paediatric Intensive Care service remains in escalation Level 2 due to concerns regarding capacity, staffing levels, quality and contract monitoring. In line with the WHSSC Escalation Framework clear objectives have been set for improvement and an action plan was received on 1 June 2023. Further investigations into pressure damage sustained on the unit are on-going. WHSSC have written to CVUHB requesting further assurance regarding the concerns raised into the pressure damage incidents. A response from the Executive Nurse Director (END) has been received advising that the Executive team in CVUHB had been sighted on the full report which is due to be presented to the HB Quality, Patient, Safety and Experience (QPSE) Committee on 26 September 2023. The full assurance report with relevant actions will then be shared with WHSSC and submitted to WHSSC QPSC in October 2023.

Health Inspectorate Wales has written to the Chief Executive Officer (CEO) of CVUHB after a whistle blowing letter outlining concerns relating to the Paediatric Critical Care Unit (PICCU). Members noted the response provided by the Executive Director of Nursing confirming that detailed analysis was being undertaken and highlighting the significant pressures the services are currently experiencing. Once that analysis has been completed the results will be shared with QPSC.

- **Mental Health & Vulnerable Groups**

Members noted that there was currently only one Mental Health service in escalation. Ty Llidiard has been de-escalated to Level 2 and FACTS has been de-escalated completely. Ty Llidiard in particular had made excellent progress over the last 12 months.

The committee received an update regarding the rise in Eating Disorder (ED) adult placements, many of them being placed out of area. A review with the Clinical Gate Keepers is taking place to understand the rationale for the significant increase over the last six months. A Deep Dive into ED services will be brought back to QPS for further discussion.

WHSSC continue to participate in the Children and Young People's Gender Identity Service transformation programme and NHS England (NHSE) have prepared letters to issue jointly from NHSE and NHS Wales to all those on the waiting list relevant by age. These will be available bilingually.

Members noted that the First Minister made a visit to the Mother and Baby Unit in Tonna in July which received positive feedback.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the improved position concerning the risk related to sustainability and delivery of the IF service in CVUHB due to workforce issues. The HB remain committed to providing this services.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation level. Members noted the three services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 2 in July 2023,
- Paediatric Surgery C&VUHB remains in escalation level 3 since March2023,
- Wales Fertility Institute (WFI) – IVF has been escalated to Level 3.

Members provided very positive comments on the report and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report at ***Appendix 1***

4.2 CRAF Risk Assurance Framework
Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

4.3 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update
A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period June to July 2023 was presented to the committee.

4.4 Incident and Concerns Report
Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. Members noted the 8 new incidents that had been reported since the last update and the actions taken in line with the governance process within the relevant HBs.

An in-depth review of the women and children's incidents was included. Members noted the additional detail following the Deep Dive into Women and Children's services outlined within the report, as requested by members during the last QPSC meeting for further assurance. No themes or issues were identified.

A public report has been issued from the Ombudsman looking at how complaints are handled and the recommendations will be considered at the QPSC Development Day to ensure it ties into the Duty of Candour and Quality going forward.

Members noted the content of the report.

4.5 Report from the WHSSC Policy Group
A report outlining the summary of activity of the Policy Group was received and members noted the 40 policies currently in development across the services. The Policy Group also reports this to Management Group for further assurance.

4.6 Quarterly Newsletter
The WHSSC Quarterly Newsletter in Welsh and English versions was received and members noted the work outlined within the paper. The newsletters are attached as ***Appendix 2.***

4.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 18 July 2023,

- Welsh Health Circulars on Research Matters and Withdrawal of WHC Annual Quality Standards,
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above. Members continued to express their concern over Paediatric Surgery waiting times and requested more information in relation to the waiting times trajectories. Further assurance was requested on pressure sores in CVUHB Paediatric Intensive Care Unit.

Members also wanted to highlight the inspiring patient story received and the comprehensive update received on the work of ALAC. In addition a very informative presentation from the WKN was provided.

Carolyn Donoghue new Independent Member (IM) for WHSSC has been appointed as the new WHSSC QPSC Chair.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

- Quality Newsletter English and Welsh (***Appendix 2 & 3***)

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	24 October 2023 at 10.00hrs

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

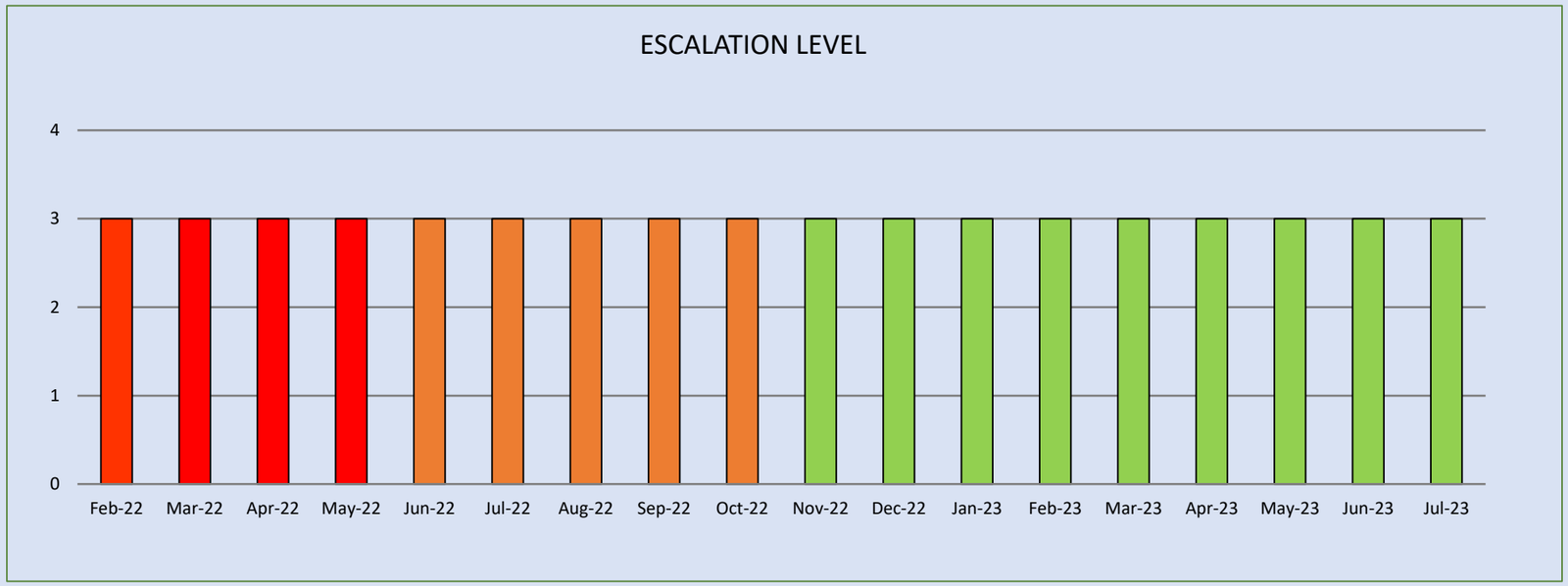
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed

To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

- **July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22 2023 the outcome is not confirmed as yet.**
- **There may be delay to the initial intended timeline as the case goes through the scrutiny process. Once the outcome of the WG process is known, the timeline can be confirmed.**

Executive Director Lead: David Roberts
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23, 12/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

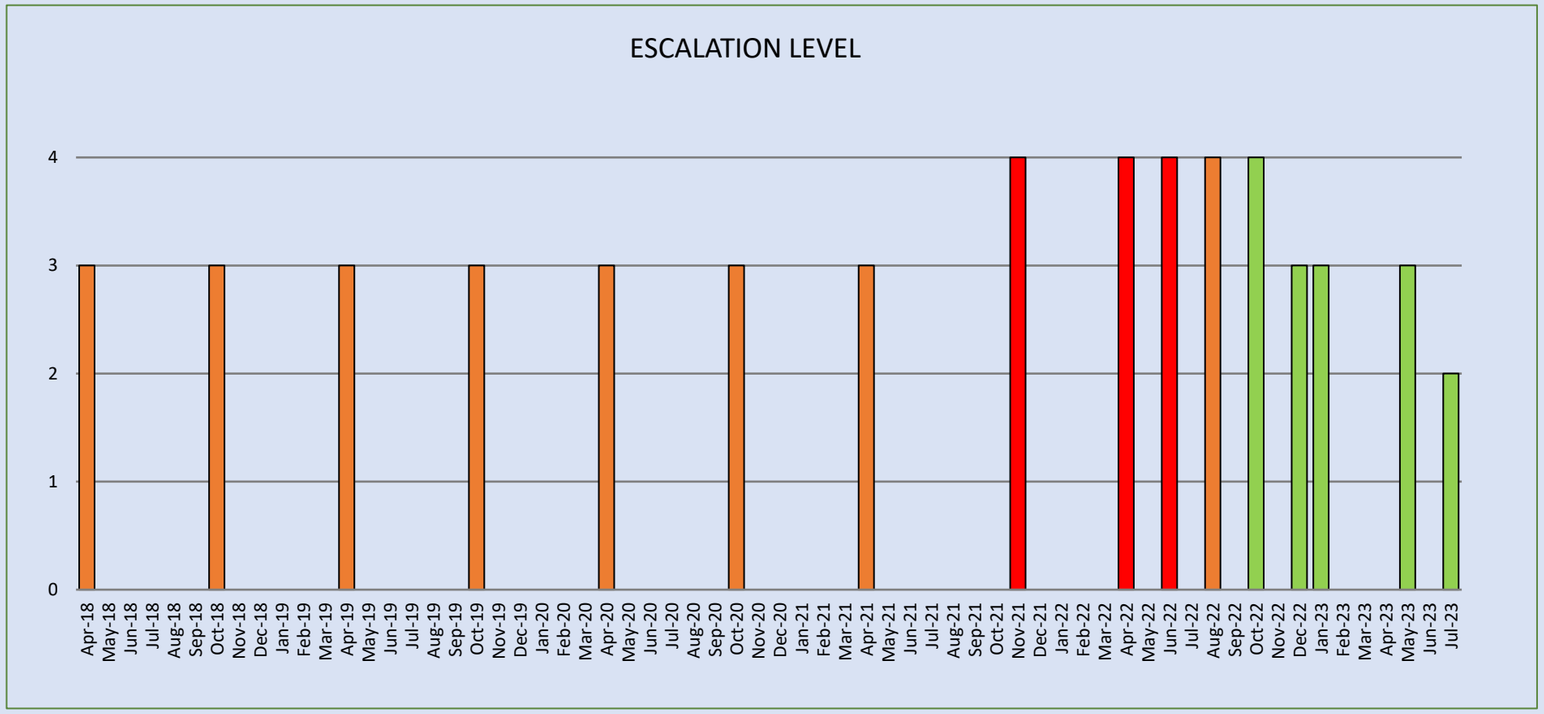
Service in Escalation: Ty Llidiard

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3
July 2023 - WHSSC escalation	De-escalated to level 2

Rationale for Escalation Status :
De-escalated to level 2.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.
September 2022 - Recruitment plan underway with all vacancies out to advert; interview dates arranged.
December 2022 - This service has been de-escalated to Level 3 as agreed by CDGB on 14th December.
July 2023 – The Service has been de-escalated to Level 2 in June 2023

Actions:

Action	Lead	Action Due Date	Completion Date
Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
Service specification action plan agreed.	Senior Planner		Completed March 22
Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
Reviewed service specification.	Senior Planning Manager		Completed
Monitor training status of the staff by QAIS.	Shane Mills		Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	Actions outstanding to be completed by Sept 23
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Completed June 23

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.
July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments
May 23 - There has been no change to the Ty Llidiard escalation status and no meetings have been held pending a report from NCCU next meeting planned for June 12th.
July 23 – Report received from NCCU and resulted in de-escalation Level 2 in June 2023. 6 Actions outstanding to be completed by September 2023. Further escalation meeting scheduled for 7th August 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023 & 26/07/23
Date Last Reviewed by Quality & Patient Safety Committee: 14/06/2023

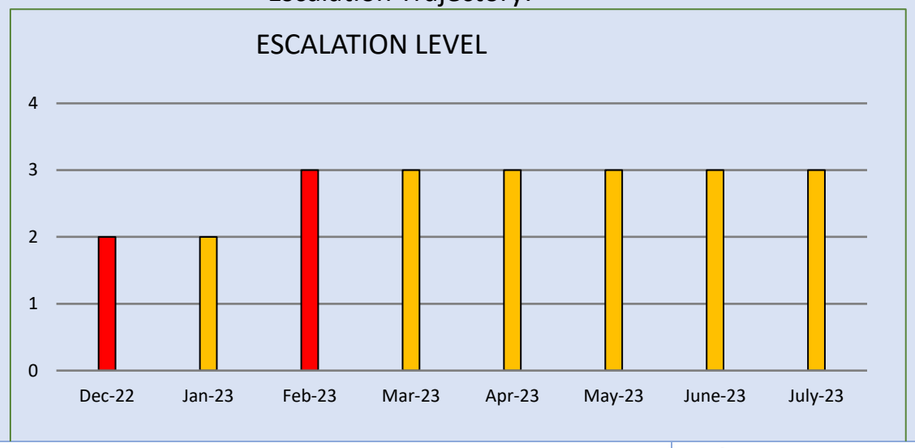
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ July 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The original plan does not deliver contracted volume,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in implementing a number of new pilot schemes and securing additional capacity. Service is on-track to meet contracted volumes by December 2023. Reprofiling the waiting times projections is being undertaken by the HB for sharing in August.

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.
May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:

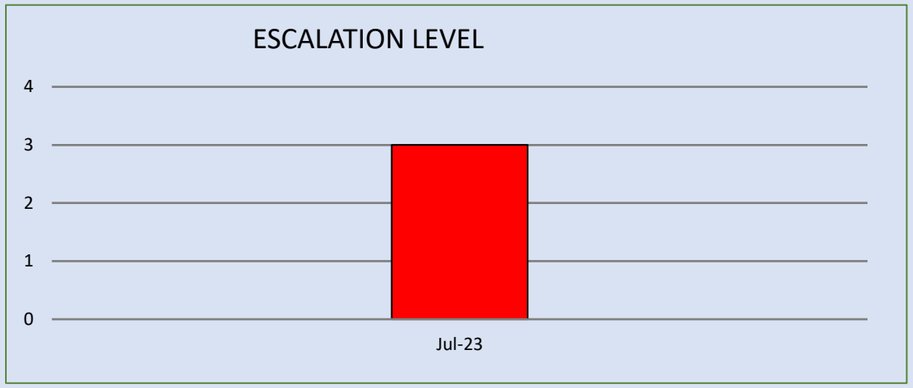
Service in Escalation: Wales Fertility Institute

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:
A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service.

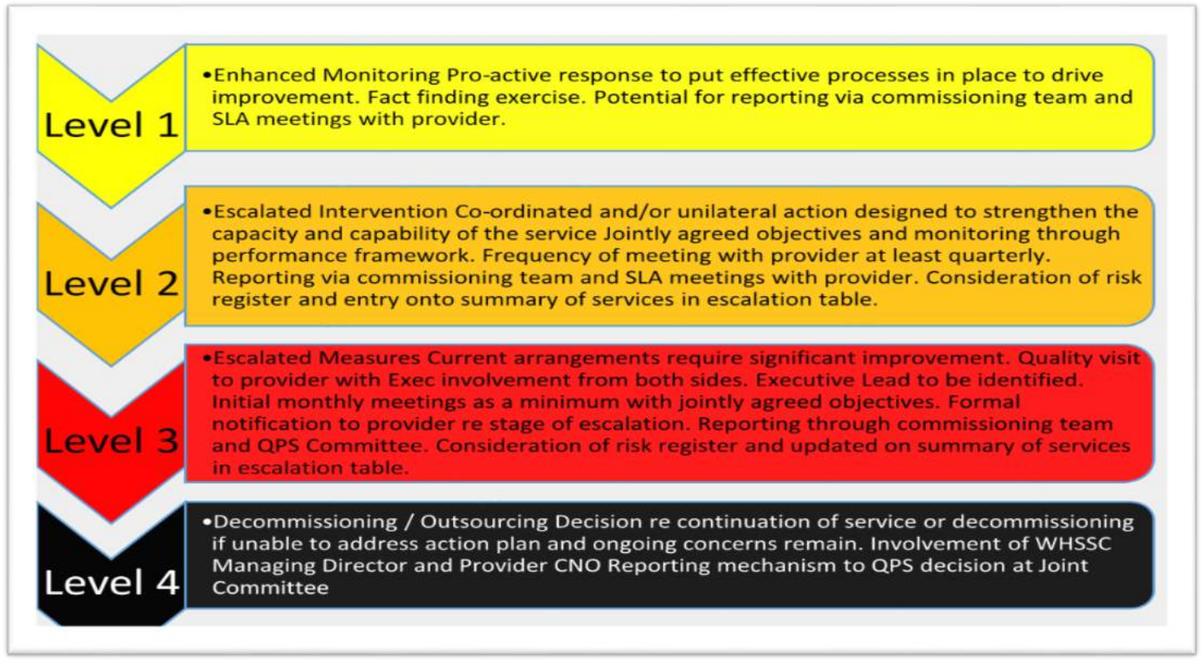
Actions:

Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to exec	Assistant Specialised Planner	7th August 2023	
Monthly escalation meeting	Assistant Specialised Planner	Monthly	
Quality visit	Assistant Specialised Planner	September 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7th August 2023	

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation. The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue: 1. De-commissioning of the service 2. Outsourcing from an alternative provider. This may be permanent or temporary 3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider. Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level. At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.



SERVICES IN ESCALATION

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Welsh Health Specialised Services Commissioning

NEWSLETTER

4th Edition, Spring/ Summer 2023

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

This is the 4th edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsltter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from WHSSC are provided both in Wales and in England; this will only provide a snapshot of our work. Permission has been provided for the content included.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

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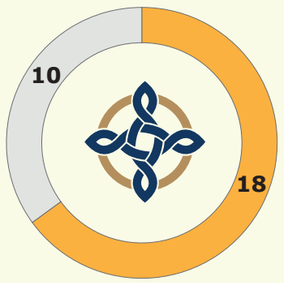
WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Reporting

WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

Between the periods of January to June 2023, there were ***18*** Patient Safety Incidents and ***10*** Early Warning Notifications logged.



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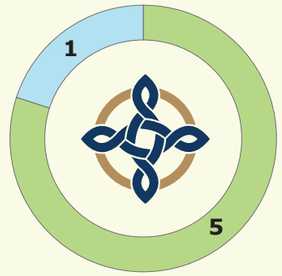
Early Warning Notifications

18

Incidents

Between the periods of January to June 2023, there were ***5*** Patient Safety Incidents and ***1*** Early Warning Notifications logged.



1

Early Warning Notifications

5

Incidents

Concerns

Incidents

Putting Things Right

Complaints

Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

GIG CYMRU NHS WALES

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 4 2022-23 and Quarter 1 2023-24:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPRF Panel
January 2023	7	9
February 2023	2	12
March 2023	1	12
April 2023	0	14
May 2023	8	12
June 2023	7	11

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Rare Disease Day - 28th February 2023

On Rare Disease Day, a new App was unveiled by Health and Social Services Minister Eluned Morgan. The Care and Respond app has been developed in Wales by Science & Engineering Applications Ltd, in collaboration with various patient groups and the NHS, with Welsh Government funding to support clinical decision making in cases of emergency and other time critical situations.

The Welsh Government is currently implementing the Wales Rare Diseases Action Plan, and funding the UK's first SWAN (Syndrome Without a Name) Clinic, based at the University Hospital of Wales, in Cardiff.

Care and Respond

Click the picture to be taken to the Care and Respond website.

Scan the QR code/ click on it to be taken to the Wales Rare Diseases Action Plan 2022-2026.

Medical Devices Swansea Bay's Rehabilitation Engineering Unit (MPCE)/Artificial Limb and Appliance Service (ALAS)

Swansea Bay's Rehabilitation Engineering Unit (MPCE) recently had an article published in Scope, the member magazine of the Institute of Physics and Engineering in Medicine (IPEM).

The article reflects the approach in Swansea to achieving Medical Devices Regulations compliance through implementation of quality management systems within individual services (including Swansea's Artificial Limb and Appliance Service), and direction and coordination through the Health Board wide 'MDR Assurance Group'.

The work of the Health Education and Improvement Wales (HEIW) MDR Group is also referenced, plus how Swansea has recently collaborated with BCUHB regarding 'MDR Preparedness' and the benefits of cross-Health Board collaboration (i.e. sharing of specialist knowledge, efficient ways of working, aligned approaches) to reduce the corporate and operational risks, including of commissioned services.

Scan the QR code/ click on it to be taken to the Summer edition of Scope which features this excellent article (page 32)!

QuicDNA

From left to right: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

QuicDNA is a clinical trial that will evaluate the benefits of an innovative liquid biopsy test in people with suspected lung cancer. The trial will look at how the use of the liquid biopsy test earlier in the diagnostic process could improve and speed up diagnosis, reduce the time between diagnosis and treatment, and eventually inform how the technology can be used for other types of cancer.

The Minister for Health and Social Services Eluned Morgan MS visited the Institute of Medical Genetics at University Hospital of Wales to learn more about the launch of the QuicDNA clinical trial.

QuicDNA was presented by Sian Morgan at the Thoracic Education Event hosted by Wales Cancer Network on 19th May. In the future, QuicDNA has the potential to provide a simple, accessible and reliable means of investigating suspected cancer, screen asymptomatic cancer patients and less invasive monitoring for cancer recurrence.

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Living Donor Transplant

Dr Doruk Elker, Clinical Lead for Transplantation has shared the fantastic success of the Living Kidney Donor (LKD) Transplant Program.

41 living kidney donor transplants were completed in the 2021/22 financial year and is the highest number of living donor transplants the team have done in Cardiff in a decade! In addition, 5 living donor nephrectomies were completed, of which four were non-directed altruistic donors. Two children were transplanted in Bristol after the donor and recipient work-ups were completed in Cardiff. The team are encouraged that this strong activity will continue as there are 14 LKD transplants already booked until mid-July with many more in the planning stages.

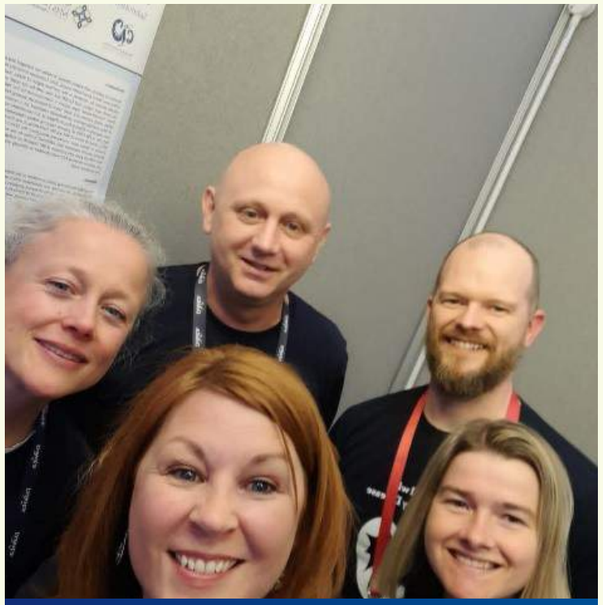
> “Congratulations to the Live Donor team and the wider transplant team for their dedication and commitment to make this happen for the patients and their families.”
>
> We also thank our Nephrology colleagues for educating CKD patients and their families about the benefits of living kidney donation and referring them in a timely fashion. This is reflected in the latest NHSBT report which demonstrates that Cardiff Transplant Unit has the highest rate of pre-emptive living donor kidney transplants in the UK.”
>
> **Dr Elker**

An amazing achievement, we are sure you will agree!

UK Kidney Conference

The Welsh Kidney Network were one of the many exhibition stands represented at the UK Kidney Association's 'UK Kidney Week' (UKKW) event which is an annual occurrence and the largest UK Conference event for Kidney Professionals. 2023's event was hosted at the ICC Newport on the 5th-7th June.

This was the first time that this national event had been hosted in Wales and a number of the WKN's clinical leads were able to promote the excellent work going on across our nation, from Transplantation to Home Therapies, Digital infrastructure to Workforce audits. This, alongside the Welsh Minister for Health and Social Care services' Key Note speech in which the WKN were highly commended, led to a number of delegates visiting the Network's exhibition stand during the event.



From left to right: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Our Kidney Network is built on quality, best practice, technology and innovation, placing patients at the heart of everything we do.

Rhwydwaith Arennau Cymru
Welsh Kidney Network

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

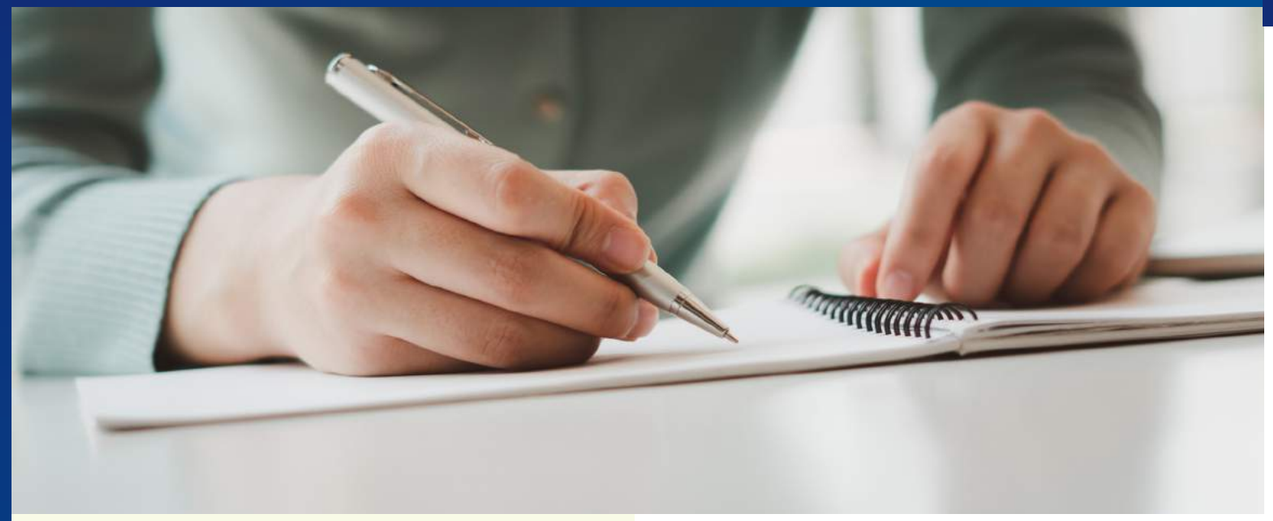
International Nurses Day and International Day of the Midwife

WHSSC Patient Care and Quality Teams displayed memorabilia to celebrate International Nurses Day and International Day of the Midwife collectively. A massive thank you to Theresa Williams of the Patient Care Team for baking cupcakes and Welsh cakes!

The Walton Centre

The Walton Centre have launched a six stage process The 'Six WALTON Steps' highlighting their vision of an excellent Patient and Family Journey. Through feedback, they have developed a shared vision for the ideal patient and family experience at The Walton Centre and included initiatives such as pet therapy across the trust, music sessions and Easter eggs delivered by the senior nursing team on Easter Sunday.

Duty of Quality



The Duty of Quality forms part of The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and WHSSC demonstrate how they are meeting the Act:

Domains of Quality (**STEEEP**)
Framework to assess quality and guide improvement.

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Person- centred

Evidencing the Duty of Quality

- Make use of existing performance, outcome and delivery indicators and measures where possible
- Patient and staff experience, information and stories
- Reports from inspectorate and licensing bodies
- Consideration of national clinical audits, reports, inquiries

Reporting to support Annual Quality Report

- Bimonthly QPS Chairs Report to Joint Committee
- Summary of Services in Escalation Trajectory
- Quarterly bilingual Quality newsletter
- Six monthly Innovation & Improvement Report
- QPS & WHSSC Annual Report
- Integrated Commissioning Plan (ICP)
- Incorporate STEEEP into all reporting templates
- Quarterly report to QPS to monitor progress

Scan the QR code/ click on it to be taken to The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023.

South Wales Blood and Marrow Transplant (SWBMT) Programme

St David's Day 2023 marked the 40th anniversary of the first stem cell transplant performed in Wales on 1st March 1983.

A celebratory event was held on 24th June to honour Dr Jack Whittaker who started the transplant programme, as well as other key founding members.

Dathlu 40 mlynedd: 1983-2023
Celebrating 40 years: 1983-2023
TGMDC SWBMT 40

FAST Stroke Campaign

Awareness campaign ran at the end of April and included TV, video on demand, radio and social media advertising, as well as coverage in the Welsh media. The campaign aimed to raise awareness of the signs of stroke and increase knowledge of stroke as a medical emergency.

Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Increased awareness of the FAST acronym has been shown to lead to patients seeking prompt help for stroke symptoms. Early treatment not only saves lives but results in a greater chance of a better recovery.

Thoracic Education Event

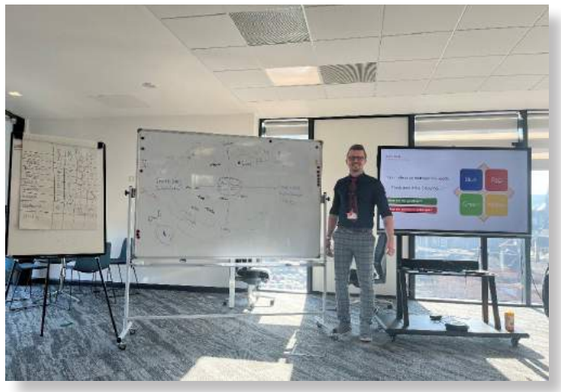
The Wales Cancer Network held the Annual Welsh Thoracic Oncology Group Education Event on Friday 19th May and was attended by a wide range of MDT members. Among the topics presented were Lung Cancer Screening, Sublobar Resections, Robotics and Genomics.

A big thank you to Rhiannon Parker, Events Manager for The Wales Cancer Network for providing the pictures!

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru | Wales Cancer Network

Patient Care and Quality Team Development Day

WHSSC Patient Care and Quality Teams attended a Team Development Day in February in collaboration with Transport for Wales (TfW). Mark Hector, Training and Development Manager at TfW was an excellent Facilitator in the Jigsaw Discovery Tool and the Team look forward to future collaboration opportunities!

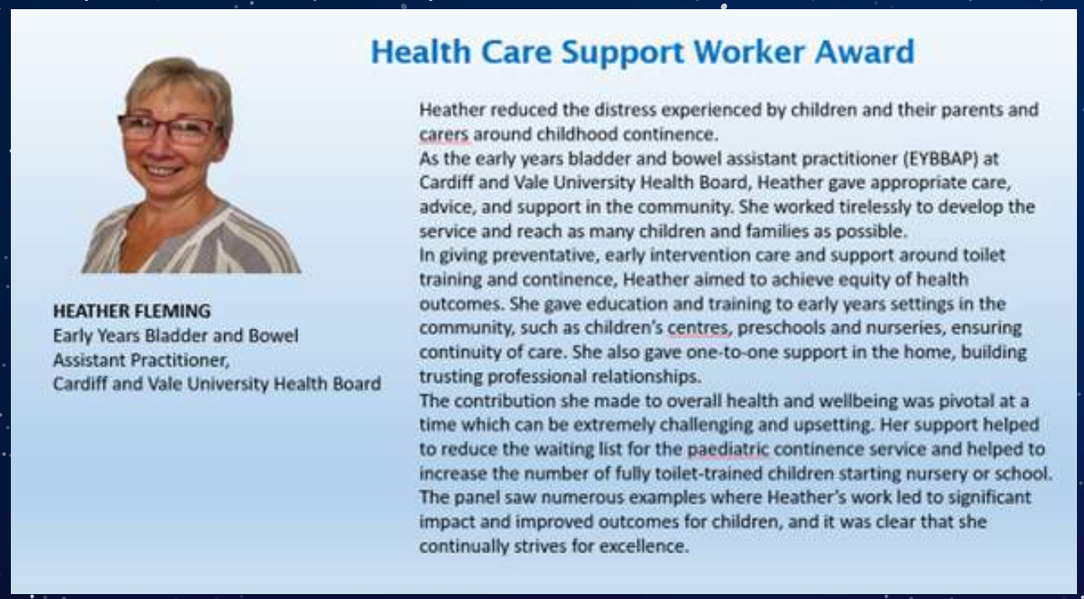


RCN Awards 2023

From left to right: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

The annual Royal College of Nursing awards took place on 29th June at City Hall, Cardiff. WHSSC sponsors the Health Care Support Worker (HCSW) award and a number of WHSSC staff attend the award ceremony along with Kate Eden (Chair). The award is open to any Health Care Support Worker who is delegated work directly by a Registered Nurse, Midwife or Health Visitor in any setting, who has demonstrated commitment to providing high standards of nursing and midwifery care.

A huge congratulations to the winner, Heather Fleming, and also to the runner-up, Kelly Brown!



Health Care Support Worker Award

HEATHER FLEMING
Early Years Bladder and Bowel Assistant Practitioner,
Cardiff and Vale University Health Board

Heather reduced the distress experienced by children and their parents and carers around childhood continence.
As the early years bladder and bowel assistant practitioner (EYBBAP) at Cardiff and Vale University Health Board, Heather gave appropriate care, advice, and support in the community. She worked tirelessly to develop the service and reach as many children and families as possible.
In giving preventative, early intervention care and support around toilet training and continence, Heather aimed to achieve equity of health outcomes. She gave education and training to early years settings in the community, such as children's centres, preschools and nurseries, ensuring continuity of care. She also gave one-to-one support in the home, building trusting professional relationships.
The contribution she made to overall health and wellbeing was pivotal at a time which can be extremely challenging and upsetting. Her support helped to reduce the waiting list for the paediatric continence service and helped to increase the number of fully toilet-trained children starting nursery or school.
The panel saw numerous examples where Heather's work led to significant impact and improved outcomes for children, and it was clear that she continually strives for excellence.

WHSSC - Newsletter *4th Edition, Spring/ Summer 2023*

Quick Round up of Commissioning Teams

Mental Health and Vulnerable Groups

5 year Mental health strategy ongoing. Review of current services and further development of these underway.

Women and Children's

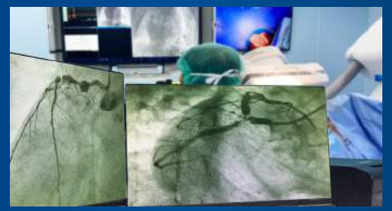
IVF Service Improvement and Innovation Day currently being planned.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic, Inherited Bleeding Disorder and Immunology Service Improvement and Innovation Days are currently being planned.



Cardiac

Evaluation and actions being taken forward from service developments such as dashboards for clinical practice reporting.

Intestinal Failure

Ongoing work being undertaken with the recently formed IF commissioning team and as a result of the IF review and Service Improvement and Innovation Day.

Specialised Services

Strategy is underway.

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Welsh Health Specialised Services Committee

Recognition of Significant Events and Thank you's

"

An excellent news story was published - The North Wales Adolescent Service (NWAS) has been awarded a Kitemark!

The National Participation Standards Kitemark, which is awarded by youngsters, is achievable for organisations who prove they are achieving against the National Standards.

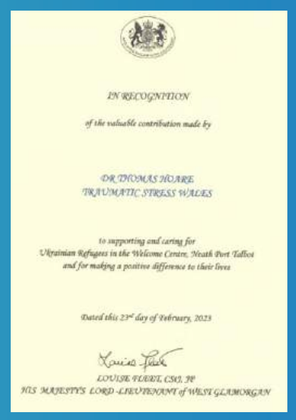
Scan the QR code/click on it to be taken to the news story!

"

Dr Thomas Hoare received recognition from the Lord Lieutenant of West Glamorgan and Penny Nurse, Project Manager for Traumatic Stress Wales said

"Congratulations Tom – this is well deserved and you should be VERY proud."

The entire team here at WHSSC agree!



IN RECOGNITION

of the valuable contribution made by

DR THOMAS HOARE
TRAUMATIC STRESS WALES

to supporting and caring for
Ukrainian Refugees in the Welcome Centre, Heath Port Talbot
and for making a positive difference to their lives

Dated this 23rd day of February, 2023

LOUISE FURST, CSO, JP
HIS MAJESTY'S LORD-LIEUTENANT of WEST GLAMORGAN

Useful Links

Adult Congenital Heart Disease (ACHD) Newsletter

The Winter and Spring versions of the ACHD Newsletter are available here:

PDF

Click the PDF to open the document.

PDF

HEIW Nursing Workforce Plan Newsletter

HEIW produce a quarterly Workforce Plan Newsletter and the Spring edition is now available.

Scan the QR code/ click on it to be taken to the newsletter.

Mesothelioma UK Magazine

Mesothelioma UK are a support group who publish a quarterly magazine and the latest edition and archive can be accessed here:

Scan the QR code/ click on it to be taken to the newsletter.

Perinatal Mental Health Network Newsletter

The April Perinatal Mental Health Network Newsletter is available here:

Scan the QR code/ click on it to be taken to the newsletter.

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Welsh Health Services Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Whssc.nhs.wales

Spring/Summer 2023

For queries or detail on any aspect within this Newsletter, contact **Adele Roberts,** Head of Patient Safety and Quality, or **Leanne Amos**, Quality Administration Support Officer.

Email: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Comisiynu Gwasanaethau Iechyd Arbenigol Cymru

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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

CYLCHLYTHYR

4ydd Argraffia, Gwanwyn/ Haf 2023

Dyma'r 4ydd rhifyn o'r cylchlythyr Ansawdd gan dîm Gwasanaethau Iechyd Arbenigol Cymru yng Nghymru. Ein cynllun yw cyhoeddi'r rhain bob chwarter i ategu adroddiadau a data a ddarparwyd eisoes drwy wahanol fforymau i Fyrddau Iechyd Cymru.

This Newsltter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

Mae hwn yn rhoi trosolwg o rywfaint o'r gwaith yr ydym yn ymwneud ag ef, ac yn cyflwyno rhai o'r uchafbwyntiau o safbwynt comisiynu. Darperir gwasanaethau a gomisiynir gan PGIAC yng Nghymru ac yn Lloegr; bydd hwn yn rhoi cipolwg ar ein gwaith yn unig. Rhoddwyd caniatâd ar gyfer y cynnwys sydd wedi'i gynnwys.

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

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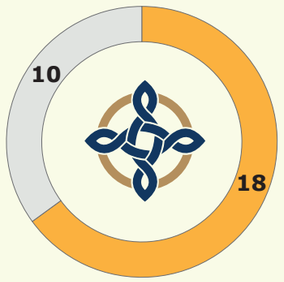
PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Adrodd

Nid yw PGIAC yn ymchwilio i ddigwyddiadau ond mae'n gyfrifol am gefnogi'r ymchwiliadau i'r rhain ochr yn ochr â monitro ac adrodd i'r Byrddau Iechyd. Mae PGIAC yn gyfrifol am sicrhau bod gwasanaethau diogel yn cael eu darparu a sicrhau bod gan dueddiadau neu themâu sy'n codi o bryderon gynlluniau gweithredu sy'n cael eu cwblhau ac sy'n cefnogi dysgu. Mae PGIAC yn hwyluso monitro parhaus gwasanaethau a gomisiynir ac yn gweithio gyda darparwyr pan fydd materion yn codi.

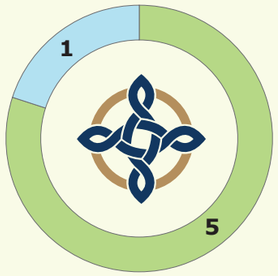
Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***18*** Digwyddiad Diogelwch Cleifion a ***10*** Hysbysiad Rhybudd Cynnar.



10 Hysbysiadau Rhybudd Cynnar

18 Digwyddiadau

Rhwng y cyfnodau o fis Ionawr i fis Mehefin 2023, cofnodwyd ***5*** Digwyddiad Diogelwch Cleifion a ***1*** Hysbysiad Rhybudd Cynnar.



1 Hysbysiadau Rhybudd Cynnar

5 Digwyddiadau

Pryderon

Digwyddiadau

Gweithio i Wella

Cwynion

Gall pryderon a godir gyda PGIAC gynnwys ymateb uniongyrchol gan y sefydliad neu gynnwys ymateb ar y cyd â'r Bwrdd Iechyd sy'n comisiynu neu efallai y bydd angen i PGIAC ofyn i'r Bwrdd Iechyd ymateb yn uniongyrchol.

GIG CYMRU NHS WALES

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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Diweddariad gan y Tîm Gofal Cleifion IPFR (Ceisiadau Cyllido Cleifion Unigol)

Mae'r Tîm Gofal Cleifion yn derbyn ac yn rheoli ceisiadau cyllido cleifion unigol am ofal iechyd sydd y tu allan i'r ystod gytunedig o wasanaethau.

Trosolwg o Geisiadau Cyllido Cleifion Unigol a broseswyd yn Chwarter 4 2022-23 a Chwarter 1 2023-24:

	Nifer y Ceisiadau a drafodwyd fel Camau Gweithredu Cadeiryddion	Nifer y Ceisiadau a drafodwyd gan Banel IPFR Cymru Gyfan
Ionawr 2023	7	9
Chwefror 2023	2	12
Mawrth 2023	1	12
Ebrill2023	0	14
Mai 2023	8	12
Mehefin 2023	7	11

Diwrnod Clefydau Prin - 28ain Chwefror 2023

Ar Ddiwrnod Clefydau Prin, dadorchuddiwyd Ap newydd gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan. Datblygwyd yr ap Gofal ac Ymateb yng Nghymru gan Science & Engineering Applications Ltd, mewn cydweithrediad ag amrywiol grwpiau cleifion a'r GIG, gyda chyllid gan Lywodraeth Cymru i gefnogi'r broses o wneud penderfyniadau clinigol mewn achosion o argyfwng a sefyllfaoedd eraill sy'n hanfodol o ran amser.

Ar hyn o bryd mae Llywodraeth Cymru yn gweithredu Cynllun Gweithredu Clefydau Prin Cymru, ac yn ariannu Clinig SWAN (Syndrome Without a Name) cyntaf y DU, sydd wedi'i leoli yn Ysbyty Athrofaol Cymru, yng Nghaerdydd.

Care and Respond

Cliciwch ar y llun i fynd â chi i wefan Care and Respond.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Gynllun Gweithredu Clefydau Prin Cymru 2022-2026.

Dyfeisiau Meddygol Uned Peirianneg Adsefydlu Bae Abertawe (MPCE)/ Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS)

Yn ddiweddar, cyhoeddwyd erthygl yn Scope, sef cylchgrawn aelodau'r Sefydliad Ffiseg a Pheirianneg mewn Meddygaeth (IPEM) gan Uned Peirianneg Adsefydlu Bae Abertawe.

Mae'r erthygl yn adlewyrchu'r dull yn Abertawe o gyflawni cydymffurfiaeth Rheoliadau Dyfeisiau Meddygol (MDR) drwy weithredu systemau rheoli ansawdd o fewn gwasanaethau unigol (gan gynnwys Gwasanaeth Aelodau Artiffisial a Chyfarpar (ALAS), a chyfeiriad a chydlynu drwy 'Grŵp Sicrwydd MDR' ledled y Bwrdd Iechyd.

Cyfeirir hefyd at waith Grŵp MDR Addysg a Gwella Iechyd Cymru (AaGIC), yn ogystal â sut mae Abertawe wedi cydweithio'n ddiweddar â Bwrdd Iechyd Prifysgol Betsi Cadwaladr (BIPBC) ynghylch 'Parodrwydd ar gyfer MDR' a manteision cydweithredu ar draws Byrddau Iechyd (h.y. rhannu gwybodaeth arbenigol, ffyrdd effeithlon o weithio, dulliau cyd-alinio) i leihau'r risgiau corfforaethol a gweithredol, gan gynnwys gwasanaethau a gomisiynwyd.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i rifyn yr Haf o Scope sy'n cynnwys yr erthygl ardderchog hon (tudalen 32)!

QuicDNA

O'r chwith i'r dde: Charles Janczewski, Dr Magda Meissner, Eluned Morgan MS, Sian Morgan

Mae QuicDNA yn dreial clinigol a fydd yn gwerthuso buddion prawf biopsi hylif arloesol mewn pobl sydd ag amheuaeth o ganser yr ysgyfaint. Bydd y treial yn edrych ar sut y gallai defnyddio'r prawf biopsi hylif yn gynharach yn y broses ddiagnostig wella a chyflymu'r diagnosis, lleihau'r amser rhwng diagnosis a thriniaeth, ac yn y pen draw hysbysu sut y gellir defnyddio'r dechnoleg ar gyfer mathau eraill o ganser.

Ymwelodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol, Eluned Morgan AS, â'r Sefydliad Geneteg Feddygol yn Ysbyty Athrofaol Cymru i ddysgu mwy am lansiad treial clinigol QuicDNA.

Cyflwynwyd QuicDNA gan Sian Morgan yn y Digwyddiad Addysg Thorasig a gynhaliwyd gan Rwydwaith Canser Cymru ar 19 Mai. Yn y dyfodol, mae gan QuicDNA y potensial i ddarparu dull syml, hygyrch a dibynadwy o ymchwilio i ganser a amheuir, sgrinio cleifion canser asymptomatig a monitro llai ymledol ar gyfer dychweliad canser.

PGIAC - Cylchlythyr *4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023*

Trawsblaniad Rhoddwyr Byw

Mae Dr Doruk Elker, Arweinydd Clinigol Trawsblannu wedi rhannu llwyddiant gwych Rhaglen Trawsblannu Rhoddwyr Arennau Byw (LKD).

Cwblhawyd 41 trawsblaniad rhoddwyr arennau byw ym mlwyddyn ariannol 2021/22 a dyma'r nifer uchaf o drawsblaniadau rhoddwyr byw y mae'r tîm wedi'u gwneud yng Nghaerdydd mewn degawd! Yn ogystal, cwblhawyd 5 neffrectomi rhoddwr byw, ac roedd pedwar ohonynt yn rhoddwyr anhunanol heb eu cyfeirio. Cafodd dau o blant eu trawsblannu ym Mryste ar ôl i'r rhoddwyr a'r derbynnydd gael eu datblygu yng Nghaerdydd. Anogir y tîm y bydd y gweithgaredd cryf hwn yn parhau gan fod 14 trawsblaniad LKD eisoes wedi'u bwcio tan ganol mis Gorffennaf gyda llawer mwy yn y camau cynllunio.

"Llongyfarchiadau i'r tîm Rhoddwyr Byw a'r tîm trawsblannu ehangach am eu hymroddiad a'u hymrwymiad i wneud i hyn ddigwydd i'r cleifion a'u teuluoedd."

Rydym hefyd yn diolch i'n cydweithwyr Neffroleg am addysgu cleifion clefyd cronig yn yr arennau (CKD) a'u teuluoedd am fanteision rhoi arennau byw a'u cyfeirio mewn modd amserol. Adlewyrchir hyn yn adroddiad diweddaraf Gwaed a Thrawsblaniadau'r GIG (NHSBT) sy'n dangos mai Uned Trawsblannu Caerdydd sydd â'r gyfradd uchaf o drawsblaniadau arennau rhoddwyr byw rhagataliol yn y DU."

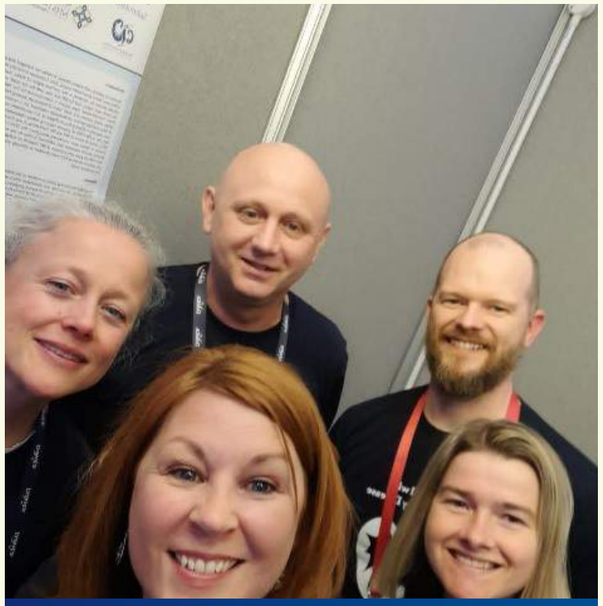
Dr Elker

Cyflawniad anhygoel, rydym yn siŵr y byddwch yn cytuno!

Cynhadledd UK Kidney

Roedd Rhwydwaith Arennau Cymru yn un o'r nifer o stondinau arddangos a gynrychiolir yn nigwyddiad 'UK Kidney Week' (UKKW) Cymdeithas Arennau'r DU sy'n ddigwyddiad blynyddol a'r digwyddiad Cynhadledd fwyaf yn y DU ar gyfer Gweithwyr Proffesiynol Arennau. Cynhaliwyd digwyddiad 2023 yn ICC Casnewydd ar 5 - 7 Mehefin.

Dyma'r tro cyntaf i'r digwyddiad cenedlaethol hwn gael ei gynnal yng Nghymru a gallodd nifer o arweinwyr clinigol y Rhwydwaith Arennau Cymru (WKN) hyrwyddo'r gwaith rhagorol sy'n digwydd ar draws ein cenedl, o Drawsblannu i Therapïau Cartref, Seilwaith Digidol i archwiliadau Gweithlu. Arweiniodd hyn, ochr yn ochr â Phrif araith Gweinidog Iechyd a Gofal Cymdeithasol Cymru, lle canmolwyd WKN yn fawr, at nifer o gynrychiolwyr yn ymweld â stondin arddangosfa'r Rhwydwaith yn ystod y digwyddiad.



O'r chwith i'r dde: Sarah McMillan, AnnMarie Pritchard, Richard Davies, Jonathan Matthews, Jennifer Holmes

Mae ein rhwydwaith arennau wedi'i adeiladu ar ansawdd, arfer gorau, technoleg ac arloesedd, gan osod cleifion wrth wraidd popeth a wneir gennym.

Rhwydwaith Arennau Cymru
Wales Kidney Network

Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig

Roedd timau Gofal ac Ansawdd Cleifion PGIAC yn arddangos trugareddau o'r gorffennol i ddathlu Diwrnod Rhyngwladol y Nyrsys a Diwrnod Rhyngwladol y Fydwraig. Diolch yn fawr iawn i Theresa Williams o'r Tîm Gofal Cleifion am bobi cacennau bach a chacennau cri!

Canolfan Walton

Mae Canolfan Walton wedi lansio proses chwe cham, sef 'The Six WALTON Steps' sy'n tynnu sylw at eu gweledigaeth o Daith Cleifion a Theuluoedd rhagorol. Trwy adborth, maent wedi datblygu gweledigaeth ar y cyd ar gyfer y profiad delfrydol i gleifion a'u teuluoedd yng Nghanolfan Walton ac wedi cynnwys mentrau fel therapi anifeiliaid anwes ar draws yr Ymddiriedolaeth, sesiynau cerddoriaeth ac wyau Pasg a ddarperir gan yr uwch dîm nyrsio ar Sul y Pasg.

Dyletswydd Ansawdd

Mae'r Ddyletswydd Ansawdd yn rhan o Ddeddf Iechyd a Gofal Cymdeithasol (Ansawdd ac Ymgysylltu) (Cymru) 2020 ac mae PGIAC yn dangos sut maent yn bodloni'r Ddeddf:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i Ganllawiau Statudol y Ddyletswydd Ansawdd 2023 a Safonau Ansawdd 2023.

Rhaglen Trawsblannu Gwaed a Mêr Esgyrn De Cymru (SWBMT)

Roedd Dydd Gŵyl Dewi 2023 yn nodi 40 mlynedd ers y trawsblaniad bôn-gelloedd cyntaf a berfformiwyd yng Nghymru ar 1af Mawrth 1983.

Cynhaliwyd digwyddiad dathlu ar 24 Mehefin i anrhydeddu Dr Jack Whittaker a ddechreuodd y rhaglen drawsblannu, yn ogystal â sefydlwyr allweddol eraill.

Dathlu 40 mlynedd: 1983-2023
Celebrating 40 years: 1983-2023
TGMDC SWBMT 40

Ymgyrch Strôc FAST

Cynhaliwyd ymgyrch ymwybyddiaeth ddiwedd mis Ebrill ac roedd yn cynnwys y teledu, fideo ar alw, hysbysebu ar y radio a chyfryngau cymdeithasol, yn ogystal â darllediadau yn y cyfryngau yng Nghymru. Nod yr ymgyrch oedd codi ymwybyddiaeth o arwyddion strôc a chynyddu gwybodaeth am strôc fel argyfwng meddygol.

Strôc yw'r pedwerydd prif achos marwolaeth yn y DU a'r achos unigol mwyaf o anabledd cymhleth. Dangoswyd bod mwy o ymwybyddiaeth o'r acronym FAST yn arwain at gleifion yn gofyn am gymorth prydlon ar gyfer symptomau strôc. Mae triniaeth gynnar nid yn unig yn achub bywydau ond yn arwain at fwy o siawns o wellhad.

Digwyddiad Addysg Thorasig

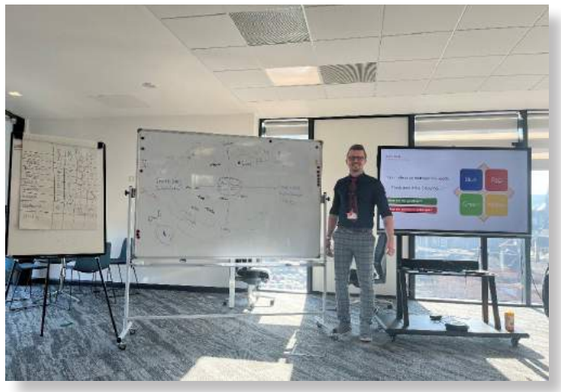
Cynhaliodd Rhwydwaith Canser Cymru Ddigwyddiad Addysg Blynyddol Grŵp Oncoleg Thorasig Cymru ddydd Gwener 19 Mai a mynychodd ystod eang o aelodau'r tîm amlddisgyblaethol (MDT). Ymhlith y pynciau a gyflwynwyd oedd Sgrinio Canser yr Ysgyfaint, Echdoriad Is-labedol, Roboteg a Genomeg.

Diolch yn fawr iawn i Rhiannon Parker, Rheolwr Digwyddiadau Rhwydwaith Canser Cymru am ddarparu'r lluniau!

GIG CYMRU NHS WALES | Rhwydwaith Canser Cymru / Wales Cancer Network

Diwrnod Datblygu Tîm Gofal ac Ansawdd Cleifion

Mynychodd Timau Gofal Cleifion ac Ansawdd PGIAC Ddiwrnod Datblygu Tîm ym mis Chwefror mewn cydweithrediad â Thrafnidiaeth Cymru (TrC). Roedd Mark Hector, Rheolwr Hyfforddi a Datblygu TrC yn Hwylusydd ardderchog yn yr Offeryn Jigsaw Discovery ac mae'r Tîm yn edrych ymlaen at gyfleoedd i gydweithio yn y dyfodol!

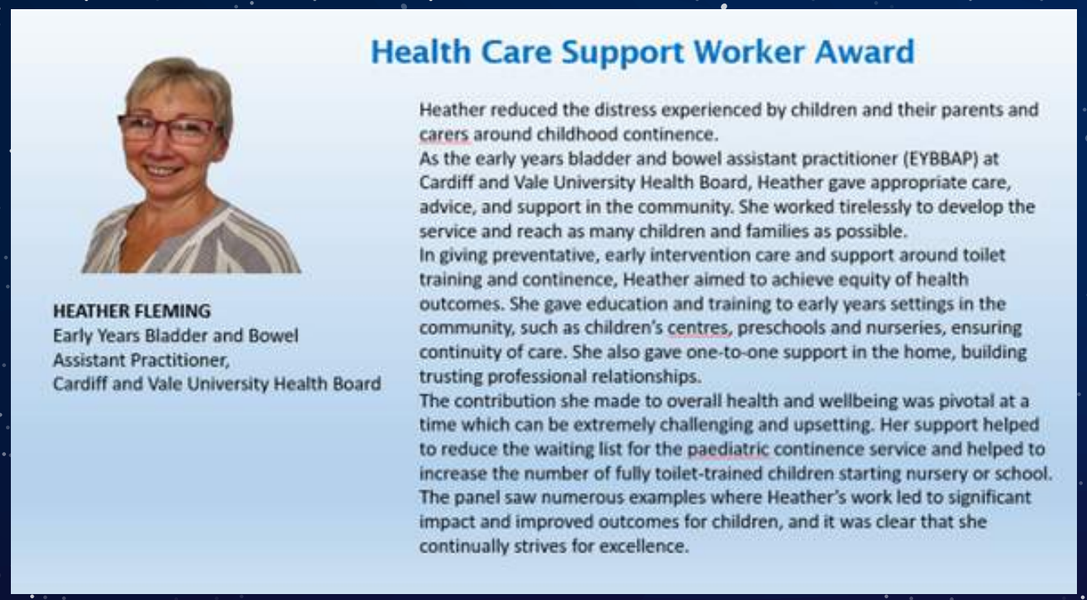


Gwobrau RCN 2023

O'r Dde i'r Chwith: Krysta Hallewell, Emma King, Debra Davies, Kate Eden, Leanne Amos, Jason Mohammad, Vicki Dawson-John, Kirsty John

Cynhaliwyd gwobrau'r Coleg Nyrsio Brenhinol blynyddol ar 29 Mehefin yn Neuadd y Ddinas, Caerdydd. Mae PGIAC yn noddi'r wobr Gweithiwr Cymorth Gofal Iechyd (HCSW) ac mae nifer o staff PGIAC yn mynychu'r seremoni wobrwyo ynghyd â Kate Eden (Cadeirydd). Mae'r wobr yn agored i unrhyw Weithiwr Cymorth Gofal Iechyd sy'n cael gwaith wedi'i ddirprwyo'n uniongyrchol gan Nyrs Gofrestredig, Bydwraig neu Ymwelydd Iechyd mewn unrhyw leoliad, sydd wedi dangos ymrwymiad i ddarparu safonau uchel o ofal nyrsio a bydwreigiaeth.

Llongyfarchiadau mawr i'r enillydd, Heather Fleming, a hefyd i'r ail, Kelly Brown!



PGIAC - Cylchlythyr 4ydd Edition, Argraffiad, Gwanwyn/ Haf 2023

Newyddion Cyflym o'r Timau Comisiynu

Iechyd Meddwl a Grwpiau Agored i Niwed

Strategaeth iechyd meddwl 5 mlynedd parhaus. Adolygiad o'r gwasanaethau presennol a datblygiad pellach o'r rhain ar y gweill.

Menywod a Phlant

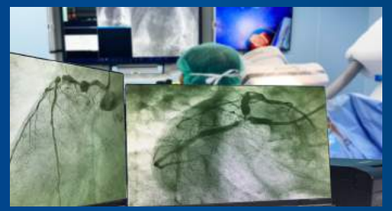
Diwrnod Gwella ac Arloesi'r Gwasanaeth IVF yn cael ei gynllunio ar hyn o bryd.

Niwrowyddorau a chyflyrau hirdymor

Strategaeth Cymru gyfan i wella canlyniadau a phrofiad cleifion sy'n cael adsefydlu arbenigol ar y gweill.

Canser a'r Gwaed

Diwrnodau Gwella ac Arloesi'r Gwasanaeth Thorasig, Anhwylder Gwaedu Etifeddol ac Imiwnoleg yn cael eu cynllunio ar hyn o bryd.



Cardiaidd

Gwerthusiad a chamau gweithredu yn cael eu datblygu o ddatblygiadau gwasanaeth fel dangosfyrddau ar gyfer adrodd ar ymarfer clinigol.

Methiant y Coluddyn

Gwaith parhaus yn cael ei wneud gyda'r tîm comisiynu Methiant y Coluddyn a ffurfiwyd yn ddiweddar ac o ganlyniad i'r adolygiad Methiant y Coluddyn a'r Diwrnod Gwella Gwasanaeth ac Arloesi.

Gwasanaethau Arbenigol

Strategaeth ar y gweill.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru

Welsh Health Specialised Services Committee

Cydnabod Digwyddiadau Sylweddol a Diolchiadau

Cyhoeddwyd stori newyddion rhagorol – Mae Gwasanaeth Glasoed Gogledd Cymru (NWAS) wedi derbyn Nod Barcud!

Gellir cyflawni'r Nod Barcud Safonau Cyfranogiad Cenedlaethol, a ddyfernir gan bobl ifanc, ar gyfer sefydliadau sy'n profi eu bod yn cyflawni yn erbyn y Safonau Cenedlaethol.

Sganiwch y cod QR/cliciwch arno i fynd â chi i'r stori newyddion!

Cafodd Dr Thomas Hoare gydnabyddiaeth gan yr Arglwydd Raglaw o Orllewin Morgannwg a Penny Nurse, Rheolwr Prosiect Straen Trawmatig Cymru.

"Llongyfarchiadau i Tom - mae hyn yn haeddiannol iawn a dylech fod yn falch IAWN."

Mae'r holl dîm yma yn PGIAC yn cytuno!

IN RECOGNITION

of the valuable contribution made by

DR THOMAS HOARE
TRAUMATIC STRESS WALES

to supporting and caring for
Ukrainian Refugees in the Welcome Centre, Neath Port Talbot
and for making a positive difference to their lives

Dated this 23rd day of February, 2023

LOUISE HUETT, CStJ, JP
HIS MAJESTY'S LORD-LIEUTENANT of WEST GLAMORGAN

Dolenni defnyddiol

Cylchlythyr Clefyd Cynhenid y Galon Oedolion (ACHD)

Mae fersiynau Gaeaf a Gwanwyn o'r Cylchlythyr ACHD ar gael yma:

Cliciwch ar y PDF i agor y ddogfen.

Cylchlythyr Cynllun Gweithlu Nyrsio AaGIC

Mae AaGIC yn cynhyrchu Cylchlythyr chwarterol Cynllun Gweithlu ac mae rhifyn y Gwanwyn bellach ar gael.

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchgrawn Mesothelioma UK

Mae Mesothelioma UK yn grŵp cymorth sy'n cyhoeddi cylchgrawn chwarterol ac mae modd cael mynediad i'r rhifyn a'r archif diweddaraf yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol

Mae cylchlythyr Rhwydwaith Iechyd Meddwl Amenedigol Ebrill ar gael yma:

Sganiwch y cod QR/ cliciwch arno i fynd â chi i'r cylchlythyr.

Comisiynu Gwasanaethau
Iechyd Arbenigol Cymru

CYLCHLYTHYR

Pwyllgor Gwasanaethau
Iechyd Arbenigol Cymru

Welsh Health Specialised
Services Committee

Whssc.nhs.wales

Gwanwyn/Haf 2023

Ar gyfer ymholiadau neu fanylion am unrhyw agwedd o fewn y Cylchlythyr hwn, cysylltwch ag **Adele Roberts,** Pennaeth Diogelwch Cleifion ac Ansawdd neu **Leanne Amos**, Swyddog Cymorth Gweinyddu Ansawdd.

E-bost: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

Cynlluniwyd gan Gyfathrebu Partneriaeth Cydwasanaethau GIG Cymru

Agenda Item
9.2.5

Quality & Safety Committee

Infection Prevention and Control Annual Report 2022 - 23

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Bethan Cradle, Lead Infection Prevention and Control Nurse
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 and Control Committee	11/07/2023	Approved

Acronyms / Glossary of Terms	

1. Situation /Background

1.1 The Infection Prevention and Control Annual Report 2022 – 23 provides detailed analysis of surveillance data, audit, education/ training and policies developed to influence and inform patient care.

2. Specific Matters for Consideration

2.1 For information and noting

3. Key Risks / Matters for Escalation

3.1 None

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 *(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))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/	No - Not Applicable

Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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 annual 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: This is an overarching annual 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)	
	Where the HB did not achieve the Welsh Government reduction expectations for reducing healthcare associated infections	
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 is asked to receive and note the IPC Annual Report for 2022 - 23

6. Next Steps

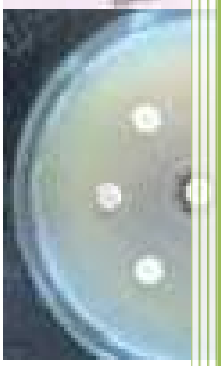
The report will now be presented to Board for information and noting.

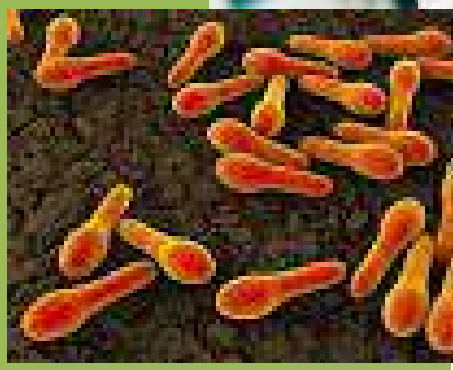
Enc. 5

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Infection Prevention & Control Annual Report 2021-2022





August 2022

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EXECUTIVE SUMMARY

Cwm Taf Morgannwg University Health Board (CTMUHB) is committed to delivering safe and effective care for all and embraces the philosophy of Cwm Taf Cares. Healthcare associated infections (HCAI) remain a key patient safety issue which results in a significant burden of disease and financial cost to the NHS in Wales. CTMUHB is committed to reducing HCAI and adopts a zero tolerance to all preventable infections. There are effective management arrangements, assurance systems and reporting processes in place to support and drive the infection prevention and control (IP&C) agenda.

We are focussed on the goal to be the best in Wales and we are making incremental changes to improve patient safety and deliver the national reduction expectations set by Welsh Government.

The Infection Prevention and Control Team (IP&CT) work across all areas in secondary care but have minimal input into improving IPC practice in primary care. As a significant proportion of the mandatory surveillance organisms are community acquired infections, a dedicated IP&CT is required to effectively deliver a sustainable integrated whole system approach to reducing HCAI.

The infrastructure continues to strengthen across the Health Board which is supported by a comprehensive range of infection prevention and control policies and procedures which act as a resource for staff.

This annual report is produced to provide detailed analysis of the surveillance data, audit, education / training and policies developed to support and direct patient care, collected and produced by the Infection Prevention & Control Team (IP&CT) for the time period from April 2021 – March 2022.

Due to the pandemic, COVID-19 response and supporting re-introduction of services has been the main focus for the IPC team for the past year and therefore some elements of the IPC agenda has not been completed fully.

Key achievements

- The IPC Team have continued to support the COVID-19 response agenda and worked collaboratively with multi professional colleagues to re-start clinical services safely.

- The IP&CT have localised national infection prevention and control and Welsh Government guidance to inform practice across CTMUHB.

- Developed and introduced local reduction expectations for the Integrated Locality Groups based on the national improvement plan for reducing healthcare associated infections

- Developed and shared monthly infographic reports with the ILG Directors to enable and support ownership of local data
- Supported and facilitated student nurse placements with the IP&CT

- Introduced IPC huddles to investigate, discuss and learn from urinary catheter associated bacteraemia

- Recruitment of additional IPC Nurses to provide a comprehensive IPC service.

Healthcare associated infections (HCAI): statistics and performance

Effective infection prevention and control (IPC) must be everybody's responsibility and be central to everyday healthcare practice. Effective IPC practice is based on the best available evidence to reduce preventable infections, improve the quality of care delivered and maximise outcomes for patients.

Welsh Government (WG) reduction expectations for April 2021-March 2022

Welsh Government published revised population based reduction expectations for five surveillance organisms: Clostridium Difficile, Staph aureus bacteraemia, E.coli bacteraemia, Klebsiella bacteraemia and Pseudomonas aeruginosa bacteraemia.

In 2021, local reduction expectations were discussed and agreed for each of the Integrated Locality Groups (ILG) based on the wider Health Board targets for reducing healthcare associated infections (HCAI). The ILG position is monitored at local IPC meetings and a monthly infographic report is produced which demonstrates the ILG and Health Board position against the targets. Assurance is provided to IPC committee.

Number and rate of *C. difficile, S.aureus* bacteraemia, *E. coli* bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia per 100,000 population, April 2021 – March 2022.

	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	154	34.46	2	0.44	118	26.23	390	86.70	81	18.01	29	6.45
All Wales	1095	34.55	33	1.67	785	24.77	2139	67.49	618	19.50	188	5.93

Data taken from Wales 2021/22 HCAI mandatory surveillance summary, April 2021 – March 2022

Lower than the same period of previous FY

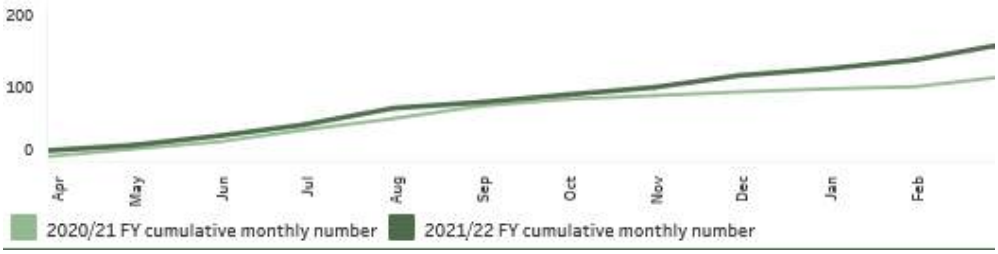
Higher than the same period of previous FY

*** 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.**

(A) *Clostridium difficile* Infection (CDI):

The reduction expectation for 2021/22 was 25 cases per 100,000 population, which equates to no more than 112 cases a year. 154 cases of C.Difficile infection were reported April 2021– March 2022. C.Difficile infection increased by 38% across CTM in 2021/22 in comparison to the previous financial year. The rate of C.Difficile infection in CTM for 2021/22 was 34.46 per 100,000 population.

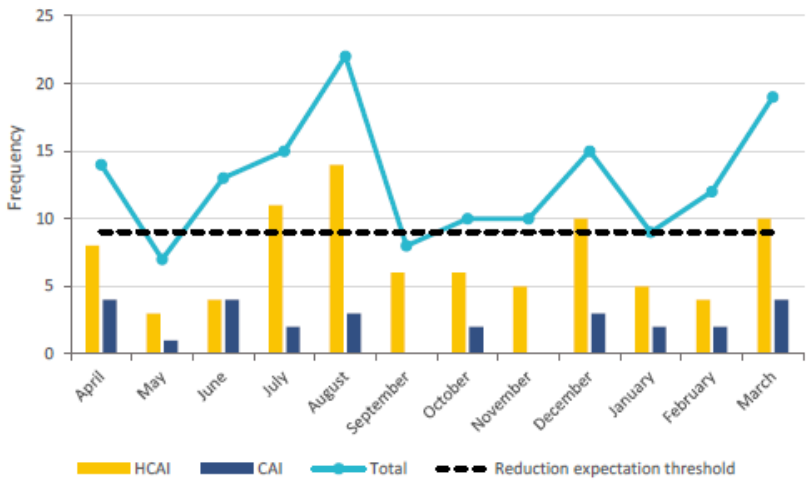
CTMUHB cumulative monthly numbers of C. difficile for April 21– March 22 against the equivalent period in 2020/21



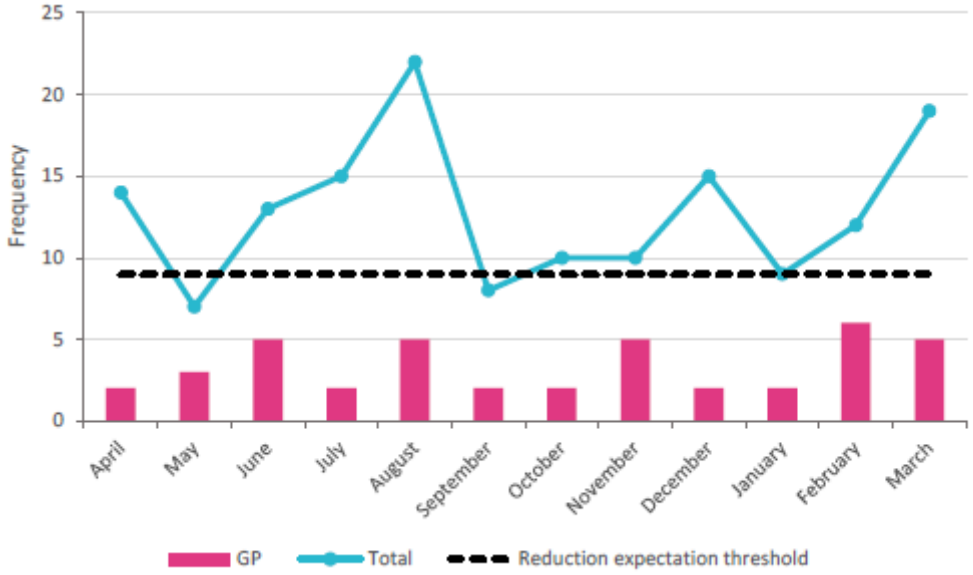
- 60% (93/154 cases) were healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 40% (61/154 cases) were community acquired infections (CAI).
- 30% (46/154 samples) were sent from GP practices - 8 HCAI and 38 CAI.

Across the health board, *C. difficile* infections were consistently above the monthly target. Increases in case identification amongst inpatients were noted between July – August 2021 and from February 2022 to the end of the financial year

Distribution of C. Difficile infections 2021/22, by type of inpatient infection (Threshold ≤9 cases/month)



Distribution of C.Difficile infections 2021/22, specimens sent from GP practices (Threshold ≤9 cases/month)



The RCA process for investigating and learning from C.Difficile cases must be strengthened in RTE and MC ILG and re-introduced in primary care. Reducing C. difficile infection in primary care is key to reducing the overall C. difficile rate.

CDI Mortality Data

A serious incident (SI) notification is submitted for all C. difficile deaths when C.Difficile is included on the death certificate.

Direct attributable cause of death (CDI on any part of death cert.)[++]

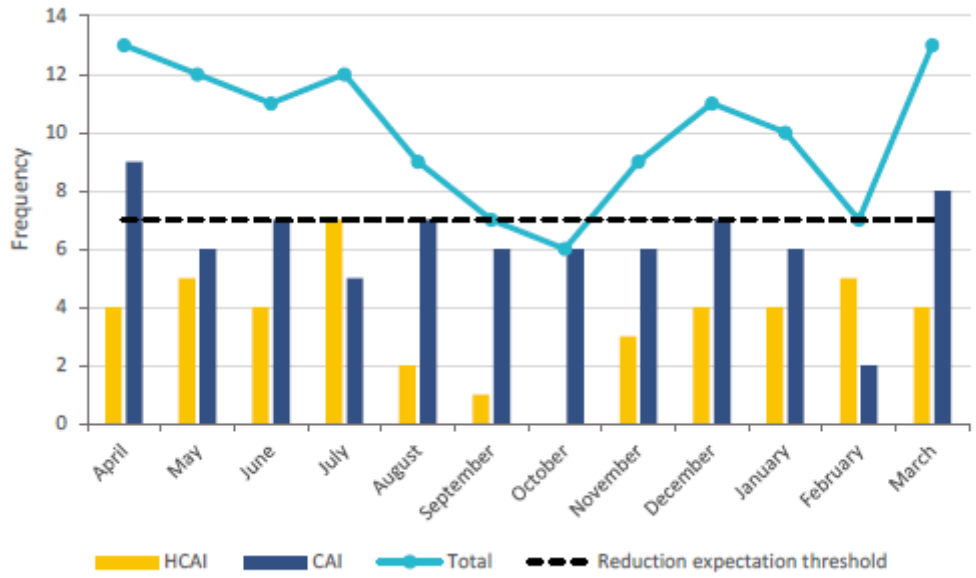
	2020/21	2021/22
RGH	2	1
PCH	2	2
POW	7	5
Total	11 (10%)	8 (5%)

(B) *Staphylococcus aureus* Bacteraemia (MSSA & MRSA)

The reduction expectation for 2021/22 was a combined target (MRSA and methicillin sensitive S.aureus) of 20 per 100,000 population, which equates to no more than 90 cases per year.

A total of 120 cases of S. aureus bacteraemia were reported April 2021 – March 2022 This is a 3% increase in comparison to the same period in the previous year. The rate of S. aureus bacteraemia in CTMUHB for April 2021 – March 2022 was 26.68 per 100,000 population.

Distribution of S.aureus bacteraemia, by type of infection (Threshold ≤7 cases/month)



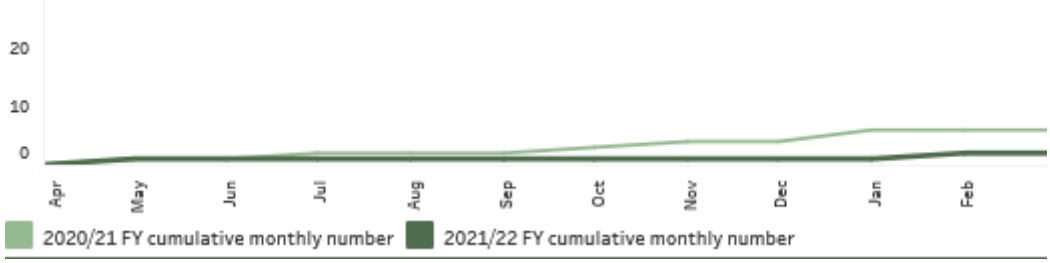
MRSA

The Welsh Health Circular (2019) 019 describes WGs zero tolerance approach to MRSA bacteraemia.

2 MRSA bacteraemia were reported April 2021 – March 2022. This is approximately -67% less than the equivalent period in 2020/21. The provisional rate of MRSA bacteraemia is 0.44 per 100,000 population.

There were no cases of MRSA bacteraemia reported in Rhondda Taf Ely or Merthyr Cynon ILG. Two MRSA bacteraemia were reported from Bridgend ILG, both were healthcare associated infections, one of which was deemed preventable.

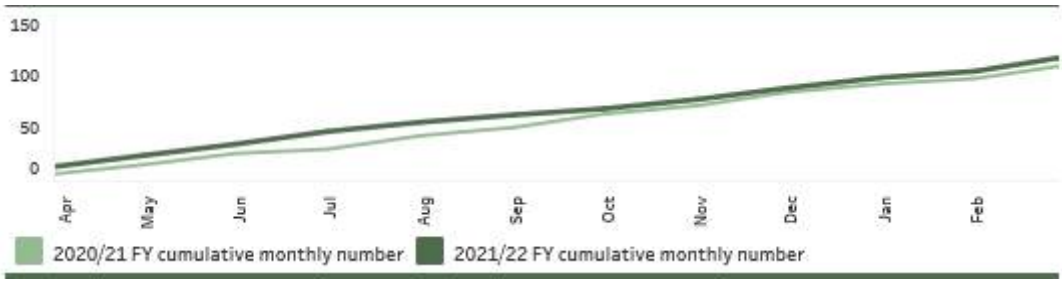
CTMUHB cumulative monthly numbers of MRSA bacteraemia April 21 - March 22 in comparison to the equivalent period in 2020/21



MSSA

118 cases of MSSA were reported April 2021 – March 2022. This is a 7% increase in comparison to the same period in 2020/21.
The rate of MSSA bacteraemia was 26.23 per 100,000 population.

CTMUHB cumulative monthly numbers of MSSA bacteraemia for April 21 to March 22 against the equivalent period in 2020/21



- 36% (42/118 cases) are healthcare associated infections based on the date of sample following admission date. Of the 42 cases, 29% (12/42) had a preventable source –
    - 9 line associated bacteraemia,
    - 2 catheter associated urinary tract infections
    - 1 Surgical Site Infection.

- 64% (76/118 cases) are community acquired infections. Of those cases, 8% (6/76) have a preventable source
    - 2 cases were attributed to a urinary catheter
    - 3 cases were attributed to an IV line
    - 1 case was attributed to a surgical site infection.

The IPC Team investigate all preventable bacteraemia and work with clinical teams to share learning from incidents to influence and improve patient care.

Further work is required to improve management of indwelling devices and develop a robust root cause analysis process to reduce preventable infections.

(C) E.coli bacteraemia

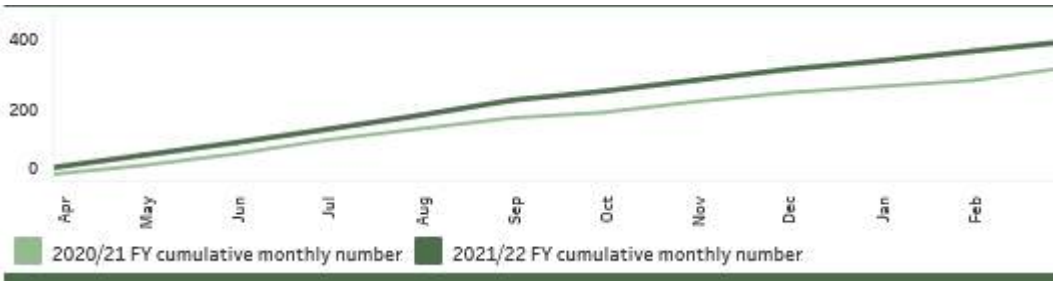
The reduction expectation for 2021/22 was 67 cases per 100,000 population, which equates to no more than 301 cases for 2021/22.

392 E. coli bacteraemia were reported April 2021 – March 2022, which is a 23% increase in comparison to the same period in 2020/21. The rate of E. coli bacteraemia for April 2021 – March 2022 was 86.70 per 100,000 population.

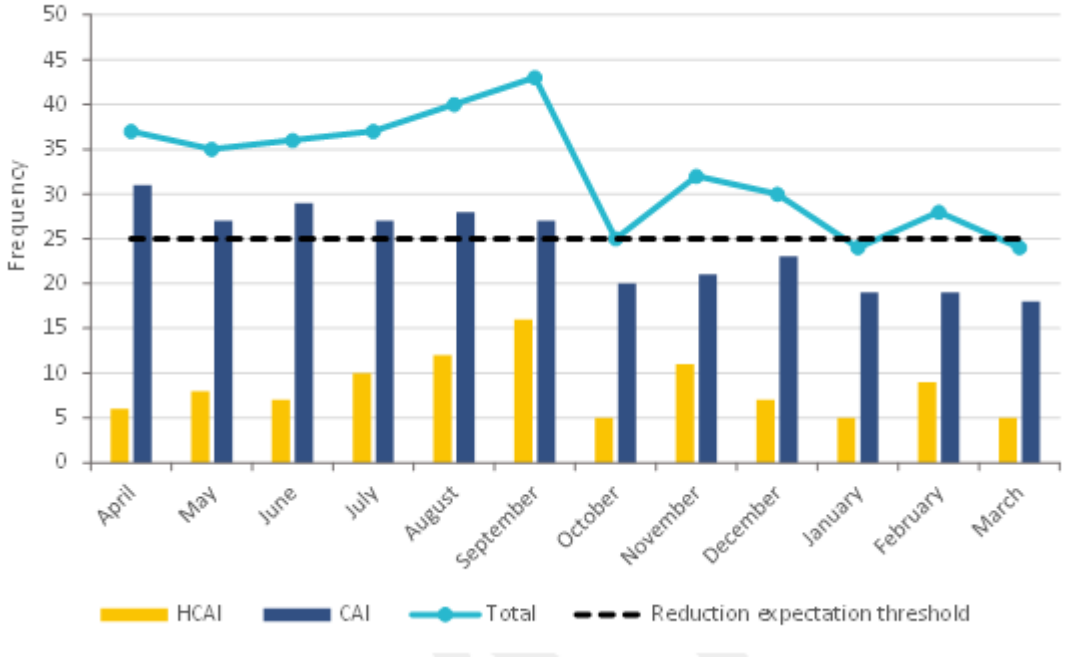
- 26% (101/392 cases) are healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
    - Of these cases, 16% (16/101) were associated with a urinary catheter.

- 74% (291/392 cases) are deemed to be community acquired infections.
    - 7% had a preventable source (20/291)
    - 18/20 cases were associated with a urinary catheter.

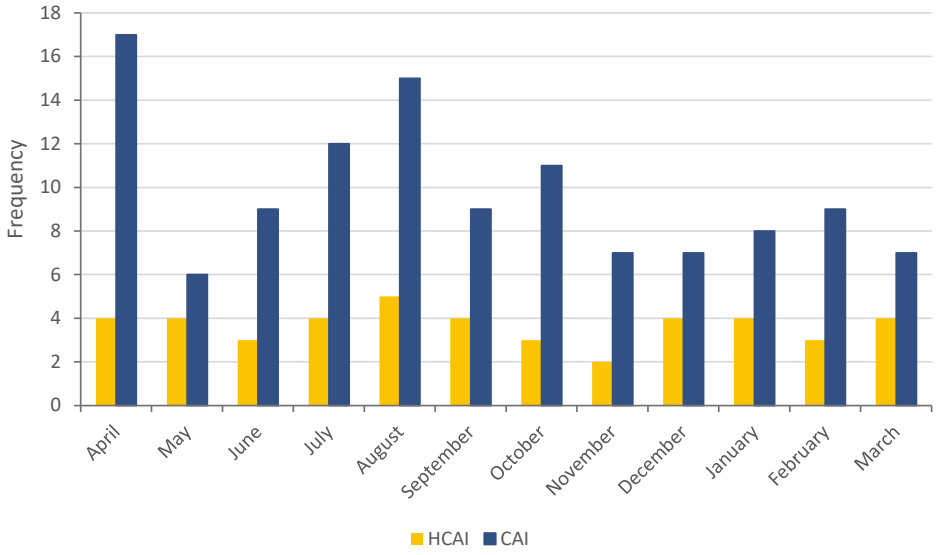
CTMUHB cumulative monthly numbers of E. coli bacteraemia for April 21 to March 22 against the equivalent period in 2020/21



Distribution of E.coli bacteraemia, by type of infection April 2021 – March 2022



Counts of E.coli bacteraemia where urinary tract infection or urosepsis was identified as the source, by type of infection. April 2021 – March 2022



(D) Klebsiella sp. bacteraemia

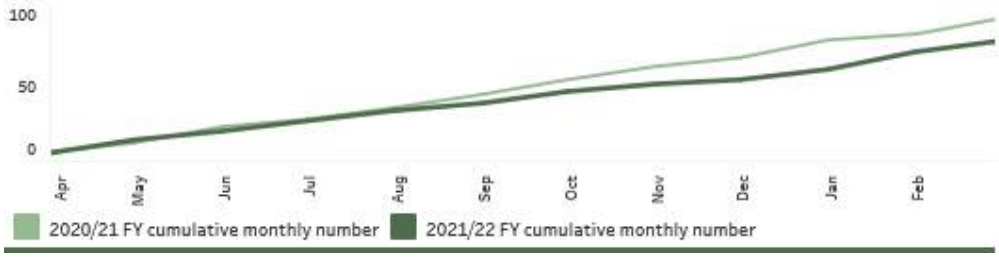
81 cases of Klebsiella bacteraemia were reported between April 2021 – March 2022 which is a 16% decrease in comparison to the equivalent period in 20/21. The rate of Klebsiella sp. bacteraemia for April 2021 – March 2022 was 18.01 per 100,000 population.

CTM achieved a lower rate than the previous financial year but did not meet the reduction expectation.

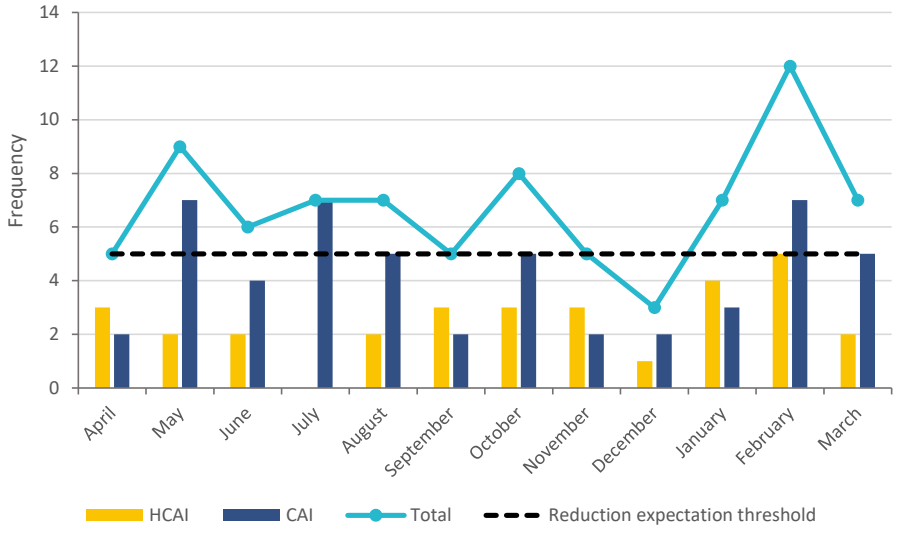
- 36% (29/81) are healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
- 17% had a preventable source
  - 2 of the cases were associated with a urinary catheter
  - 2 cases were linked to an IV device
  - 1 case was associated with a Ventilator Acquired Pneumonia (VAP).

- 64% (52/81) are community acquired infections.
- 10% (5/52) were associated with a urinary catheter.

CTMUHB cumulative monthly numbers of Klebsiella sp. bacteraemia for April 21 to March 22 against the equivalent period in 2020/21



Distribution of Klebsiella spp. Bacteraemia, by type of infection. April 2021 – March 2022

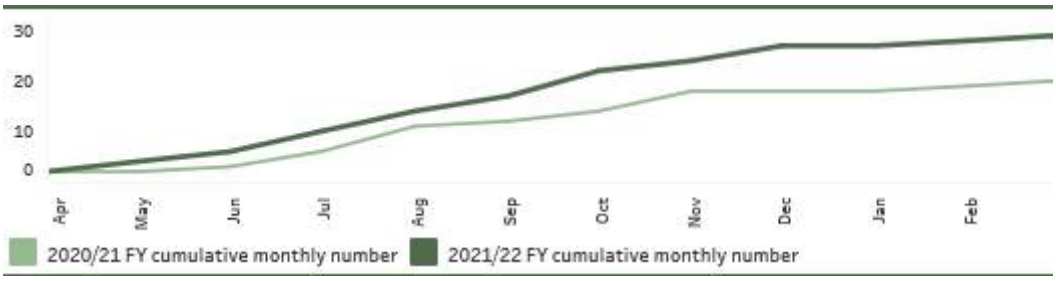


(E) Pseudomonas aeruginosa bacteraemia

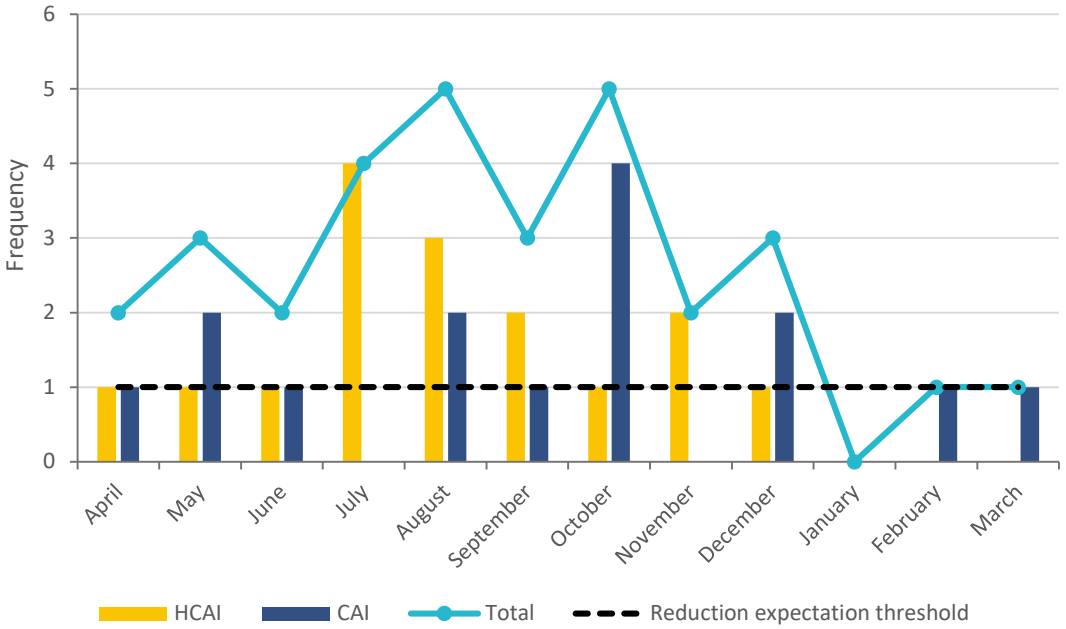
31 cases of P. aeruginosa bacteraemia were reported April 2021 – March 2022 which is a 45% increase in comparison to the same period in 2020/21. The rate of P. aeruginosa bacteraemia for April 2021 – March 2022 was 6.45 per 100,000 population.

- 52% (16/31) of the cases were deemed to be healthcare associated infections (HCAI) based on sample sent >48 hours post admission to hospital or recent admission past 4 weeks.
  - 13% (2/16 cases) were associated with a urinary catheter.
- 48% (15/31) were community acquired infections and 20% (3/15) had a preventable source.

CTMUHB cumulative monthly numbers of Pseudomonas aeruginosa for April to March 2022 against the equivalent period in 2020/21



Cumulative total *Pseudomonas* bacteraemia versus monthly target, April 2021 – March 2022.



(F) Line associated infections

There is no national surveillance scheme for monitoring blood stream infections associated with medical devices eg. IV lines, urinary catheters. In CTM, the IPC Team have investigated every case since 2011. To strengthen the investigation process and learning opportunities, multi-disciplinary IPC huddles were introduced in 2018/19. Not all cases were discussed in 2021/22 due to the COVID pandemic but this is a priority for 2022/23. The ILG are encouraged to lead the IPC huddles to improve ownership and provide opportunities for multi professional learning.

Eleven IV device associated bacteraemia were identified April 2021 to March 2022, 7 of the cases were attributed to peripheral cannulae and 4 cases were associated with central venous access devices. In addition to this, 21 clinical line infections were reported to the IPC team for further investigation. Additional work is required to re-establish the IV steering group, improve compliance with IPC and ANTT training and to strengthen the RCA/IPC investigation process to provide opportunities for multi professional learning.

3. Surveillance

Surgical Site Infection Surveillance (SSI)

Cwm Taf UHB participate in the mandatory surveillance of Surgical Site Infections (SSI) for Orthopaedic and C. section surgery. Using standardised methods allows Health Boards across Wales to analyse their SSI data and improve the quality of care delivered. National surveillance also allows hospitals/ Health Boards to benchmark performance information.

Due to the COVID pandemic, Orthopaedic SSI surveillance data has not been published for 2021/22.

C.section SSI

The CTM C.section SSI rate for 2021/22 is 8% with a 14 day SSI rate of 3%. There was no difference in SSI rates between the Princess of Wales and Prince Charles Hospital sites.

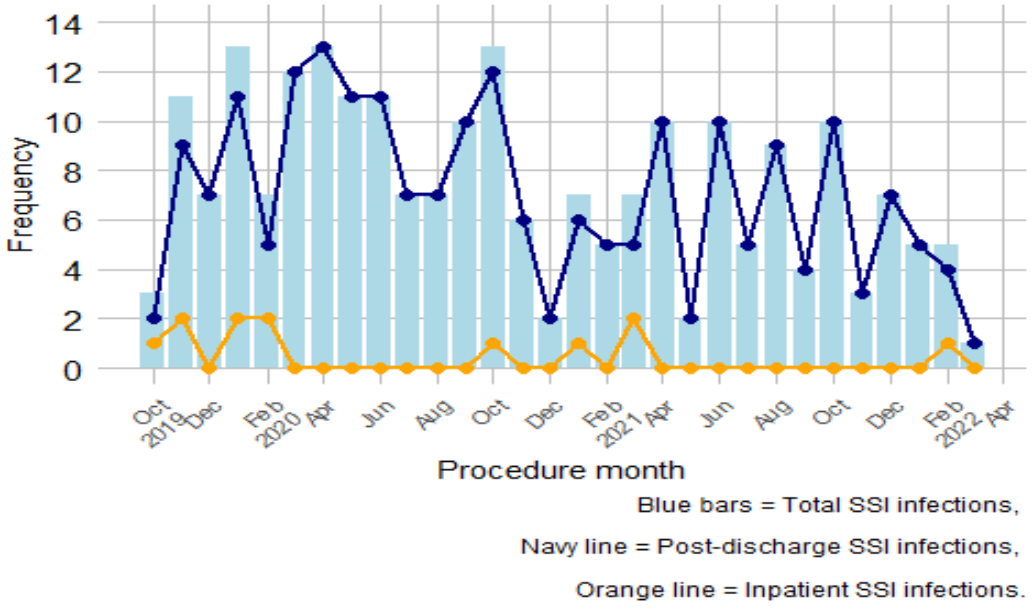
The All Wales C.section SSI rate has not been published.

CTM C.section SSI data, 2021/22

Month	Valid records (%)[1]	Inpatient SSI	Post-discharge SSI	Rate SSI (%)[2]	14 day SSI rate (%)[3]
Apr 2021	100%	0	10	10%	4%
May 2021	100%	0	2	2%	1%
Jun 2021	50%	0	10	20%	6%
Jul 2021	97%	0	5	5%	2%
Aug 2021	98%	0	9	9%	4%
Sep 2021	100%	0	4	5%	0%
Oct 2021	42%	0	10	27%	3%
Nov 2021	100%	0	3	4%	4%
Dec 2021	95%	0	7	7%	3%
Jan 2022	81%	0	5	6%	1%
Feb 2022	26%	1	4	19%	11%
Mar 2022	52%	0	1	4%	4%

1- Valid procedures: data provided for procedure and discharge dates and inpatient and post discharge SSI
2- Total SSI/valid procedures x 100: only include valid records
3- Total SSI within 14 days of procedure date/ valid procedures x 100; only includes valid records

Monthly C.section SSI, by infection type



Further work is planned to improve the surveillance systems and reporting processes to ensure the Health Board has accurate and reliable C.section SSI data to inform and influence patient care.

Critical Care Surveillance

Ventilator Associated Pneumonia (VAP) Surveillance

No data published.

4. IPC Policies Approved in 2021/22

The following Infection Prevention and Control policies/procedures and guidelines were approved at the Infection Prevention & Control Committee. All documents are accessible for staff via the Intranet.

No.	Title	IPCC Approval
IPC06	Linen Policy	June 21
IPC09	MRSA Procedure	March 21
IPC12	IPC Isolation Procedure	June 21
IPC13	Peripheral Line Protocol	June 21
IPC22	Protocol for the Management of scabies	June 21

Policies agreed at IPC committee prior to approval at other committees.

IPC23	Tuberculosis	June 21
RM19	Needlestick (sharps) Injuries Management from Occupational Exposure Procedure	Nov 21
FAC01	Housekeeping and cleanliness Policy	Oct 21
FAC14	Food Safety Policy	Jan 22
FAC21	Waste Policy	Nov 21

5. Internal Audit Programme and performance

All clinical areas are required to perform weekly hand hygiene and environmental audits. The ILG teams monitor and act on their audit findings and report to the ILG IPC meetings.

The IPC Team has a rolling annual audit programme including all clinical areas and departments for independent verifications. Audit scores and results are shared with the Ward Manager and Senior Nursing team for information and action. Infection Prevention and control training is provided to address non-compliance identified during audit process as required.

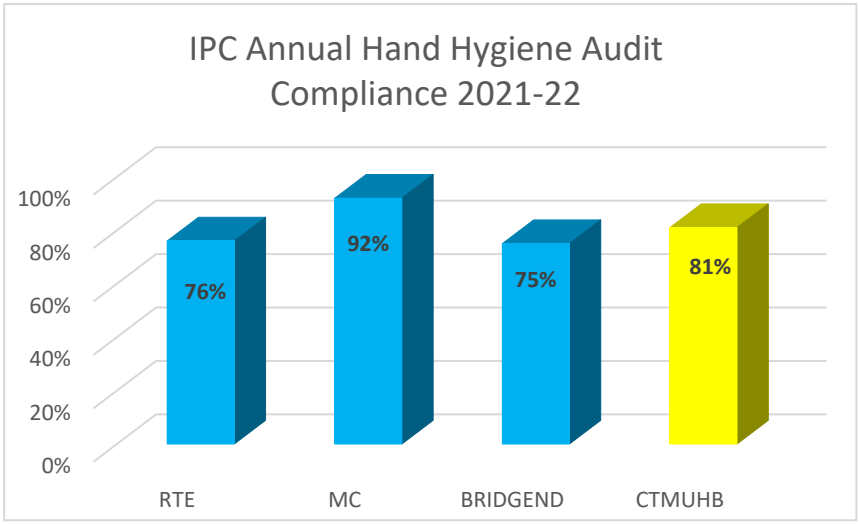
The IPC team did not complete the planned audit programme in 2021/22 due to competing demands as a result of the COVID pandemic but informal spot checks were carried out regularly during ward visits and non-compliance with IPC policies was addressed at the time of the visit.

Audit Results

The data shown below includes cumulative results of IPC verification audits across staff groups and departments in secondary care.

(A) Hand Hygiene Audits

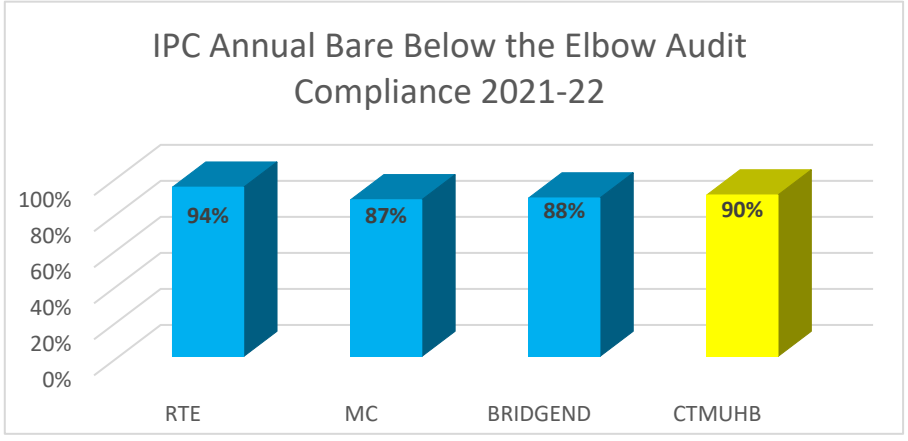
Hand hygiene audits are based on the WHO's "5 moments for hand hygiene" which is applied to all staff working in clinical areas. The graph below identifies staff group achievements and compliances at each observed moment of care during clinical intervention where hand hygiene opportunities were either observed as achieved or missed. All missed opportunities/ non-compliance is discussed with the member of staff at the time of the audit.



Hand hygiene is the single most important measure to prevent cross infection. Clinical engagement is paramount to improve compliance with hand practice. Infection prevention and control is everybody's business and all staff must practice infection prevention and control precautions at all times.

(B) Bare Below the Elbow Audit

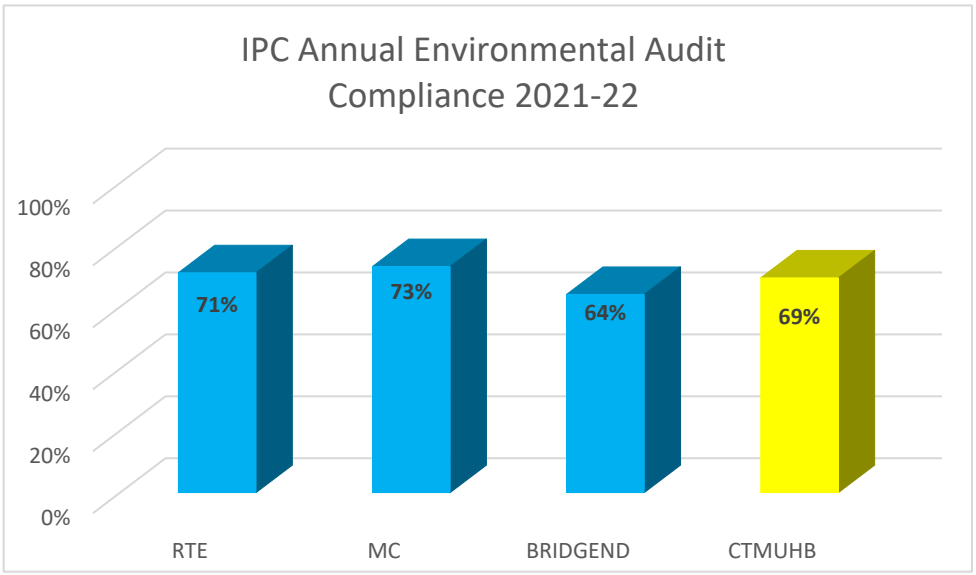
Consistent efforts have been made to improve hand hygiene practice and compliance with bare below the elbow. It is the responsibility of all clinical staff, irrespective of grade or profession to be bare below the elbow in the clinical environment.



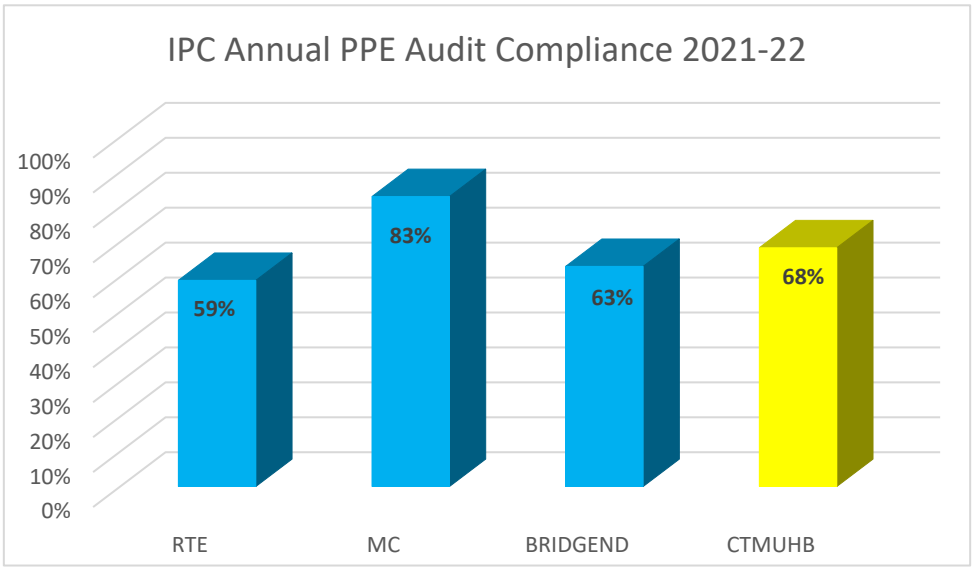
(C) Environmental Cleanliness Audits

The scores below not only reflect standards of cleaning for housekeeping and nursing staff but also includes any maintenance/ estates issues identified during the audits. Additional cleaning hours have been provided to support the COVID response.

Poor audit scores have been reported across all sites. The audit reports have been sent to nursing, housekeeping and estates colleagues as required.



(C) Personal Protective Equipment (PPE) Audits



Poor audit scores have been reported across all sites. The IPC team have provided additional training. During 2021/22, personal protective equipment has been

6. Outbreaks and Incidents

Diarrhoea and Vomiting (D&V)

Viral D&V is usually brought into the hospital from the community. It is essential that everyone is compliant with policies and procedures in order to reduce outbreaks of viral gastroenteritis on the wards. Prompt assessment and isolation is key to minimising outbreaks.

All patients should have an infection prevention and control clinical risk assessment performed on admission to identify any infection prevention and control risks.

	2020/21	2021/22
Total no of Ward Closures & Bay Restrictions (Due to Suspected / Confirmed Viral Diarrhoea and Vomiting)	6	8
No. of Patients	20	50
No. of Staff	0	15
No. of Bed Days lost	0	65

No. of Norovirus Outbreaks on Closed wards	2020/21	2022/22
Confirmed	1	1
Suspected	0	2

There was an increase in ward closures/bay restrictions due to D&V in 2021/22 compared to the previous year.

Period of Increase Incidence (PII)

6 PII meetings were held during 2021–2022. Remedial and corrective actions were identified and monitored by the ILGs, supported by the IPC Team.

Location	Period	Organism	Cases
Ward 8, POW	April - June 2021	CDI	8
Ward 6, POW & Ysbyty'r Seren	July 2021 – Feb 2022	CDI	6
School House Day Nursery, POW	September 2021	Presumptive E. coli 0157	1
POW site • Ward 15 • Ward 18 • Ward 19 • Ward 20 • Ward 5 • Ward 6 • Ward 7 • Ward 8 • Ward 9 • Ward 10 • COVID ITU • Ysbyty'r Seren	September 2021	C. difficile Toxin Positives C. difficile Toxin Negatives	20 19
Ward 4, POW	November 2021	HMPV	9
Ward 11, PCH	March 2022	CDI PII	2

Serious Incident/ No Surprises Notifications
(excludes SI notifications for CDI related deaths)

Location	Period	Organism	Total No. of Cases
Ward 8, POW	April 2021	C. difficile	5
Ward 5, PCH	July 2021	COVID19	3
Ward 6, PCH	July 2021	COVID19	3
ITU, PCH	August 2021 September 2021	• Pseudomonas • Serratia	8 5
Ward 15, POW	September 2021	COVID19	2

7. COVID – 19

Public Health Wales released a briefing in January 2020 alerting Health Board's to cases of pneumonia of unknown microbial aetiology associated with Wuhan City, Hubei Province, China. A cluster of cases had been identified which represented the emergence of a novel pathogen – COVID-19.

As the pandemic evolved during 2021/22, Public Health Wales, in line with the four nations, published IPC guidance to promote standardisation of practice across the UK. The IPC team worked collaboratively with the ILGs to deliver a robust multi professional response to COVID across CTM.

Summary

- Between 1st April 2021- 31st March 2022, 3,322 cases of COVID-19 were identified in hospitals across Cwm Taf Morgannwg University health board (CTMUHB). Of these 372 (11%) died within 28 days of the first positive specimen.
- Following recovery from the second wave of the COVID-19 pandemic (September 2020 - April 2021), combined with the successful nationwide roll-out of the COVID-19 vaccine, case numbers remained low during the first quarter of the financial year. However, confirmed cases began to rise again in July 2021. This rise aligned with the identification of new COVID-19 genomic variants of concern - Delta, which dominated the third wave (July – December 2021) and Omicron (BA.1), which dominated the fourth wave (December 2021-April 2022). Further mutations of the Omicron variant (Omicron BA.2) in March 2022 saw a resurgence of COVID-19 cases at the end of the financial year. These COVID-19 variants displayed increased transmissibility when compared to previous dominant lineages.
- 130 COVID-19 outbreaks were identified in CTMUHB hospitals between 1st April 2021- 31st March 2022. Identification of nosocomial cases (admitted to hospital for >2 days at time of first positive specimen OR positive specimen with 14 days of discharge from site) followed the same trends as those observed in community onset cases.
- Changes were made to the COVID-19 screening/isolation protocols during the financial year. The isolation period for confirmed cases and contacts were reduced from 14 days to 10 days in January 2022. Routine screening every five days for all inpatients (regardless of symptoms) was stood down on 24th March 2022.
- A COVID-19 nosocomial scrutiny panel was piloted in Rhondda Taf Ely Interim Locality Group between April - August 2021. The panel reviewed nosocomial COVID-19 cases who had died within 28 days of positive specimen. Outbreaks within the Royal Glamorgan Hospital from the second wave of the pandemic were reviewed, taking into account operational and infection prevention and control measures relevant at the time, and including available epidemiological and genomics evidence. Following guidance from the NHS Delivery Unit, this process will be

expanded to review all outbreaks of COVID-19 in all CTMUHB hospitals since the start of the pandemic. A Nosocomial Transmission Team has been appointed to progress with this work.

For full COVID report, please see Appendix 1

8. Antimicrobial Stewardship

(1) Secondary Care
(a) National Improvement Goals

There are 2 national improvement goals 2021-2023. The progress made by CTM is shown in the table below.

	Improvement Goal	CTM progress	Notes
Welsh Health Circular antimicrobial resistance (AMR) and healthcare-associated infection (HCAI) Improvement Goals 2021-23.	≥55% of antibacterial prescribing should be antibacterials in the WHO ACCESS** category – see Figure 1 below (data to end September 2021).	All 3 acute hospitals are currently meeting the target.	
	Implement the principles of 'Start Smart then Focus' (SSTF)	See Figures 2-4 below for compliance with SSTF audits. ARK charts rolled out in POWH October 2021. ARK charts not in place in PCH/RGH.	Targets to be introduced in 2022-23. Principles of SSTF will be supported by roll out of Antibiotic Review Kit (ARK) chart.

** key antibiotics which are narrow spectrum and used as first-line treatment options.

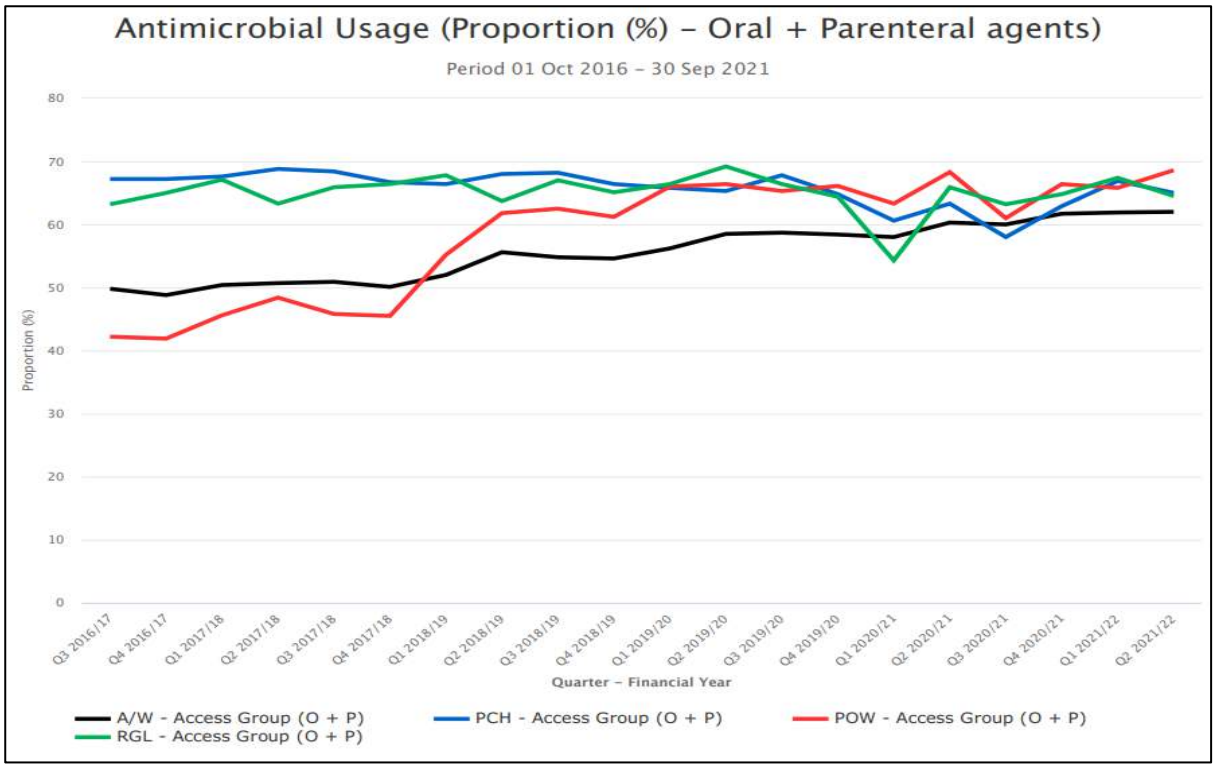


Figure 1: ACCESS group antimicrobial usage in acute sites (data to end September 2021)

Showing Hospitals for **Cwm Taf Morgannwg UHB**

Monthly audits per Unit for **Princess of Wales Hospital**

Unit	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
Acute medicine (POW)	0	0	0	0	0	0	0	0	0	0	0	8	20	20	20	20	20	20	14	20	20	10	20	20
Cardiology (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	4	6
COTE (POW)	0	0	0	0	0	1	0	0	0	0	0	0	0	17	10	12	19	16	0	1	20	7	0	25
Critical Care (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0
Endocrinology (POW)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	4	6
ENT (POW)	0	0	0	0	0	0	0	0	0	0	0	0	16	0	9	20	4	0	0	0	0	0	0	0
Gastroenterology (POW)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	7
Gynaecology (POW)	0	0	0	0	0	0	0	0	0	0	0	0	5	0	2	4	0	0	0	0	0	0	0	0
MentalHealth (POW)	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal (POW)	0	0	0	0	0	0	0	0	0	0	0	0	1	6	0	0	0	0	0	0	0	0	0	0
Obstetrics (POW)	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	1	6	0	0	0	0	0	0	0
Paediatrics (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0
Palliative care (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Respiratory (POW)	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	2	10
Stroke (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	8	0	0	0	0	0	0	4	12
Surgery (POW)	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0
T+O (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology (POW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Figure 2: POWH compliance with SSTF audits

Showing Hospitals for **Cwm Taf Morgannwg UHB**

Monthly audits per Unit for **Royal Glamorgan Hospital**

Unit	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
Acute medicine (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
COTE 1 (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
COTE2 (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
COTE-Acute (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocrinology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENT (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GIM (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynaecology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Haematology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Intensive Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MentalHealth (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Opthalmology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oral surgery (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopaedics (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Paediatrics (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Respiratory (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology (RGH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Figure 3: RGH compliance with SSTF audits

Showing Hospitals for **Cwm Taf Morgannwg UHB**

Monthly audits per Unit for **Prince Charles Hospital**

Unit	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
Cardiology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Endocrinology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ENT (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastroenterology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Medicine (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Surgery (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynaecology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Haematology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MentalHealth (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Obstetrics (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Opthalmology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oral surgery (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Orthopaedics(PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Paediatrics (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Respiratory (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stroke (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urology (PCH)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Figure 4: PCH compliance with SSTF audits

(b) Antimicrobial stewardship work programme

Antimicrobial Guidelines

The major focus of the antimicrobial stewardship team has been the merge of the Cwm Taf and POWH antimicrobial guidelines. This has involved detailed review and update of all sections of the guidelines in conjunction with clinical and microbiology colleagues. The original deadline for the complete merge and creation of a single CTM antimicrobial guideline was March 2020. This has been delayed due to the COVID-19 pandemic. The target for completion is now August 2022, to coincide with the new intake of medical staff, the team are on track to deliver this target.

Antimicrobial Ward Rounds

Antimicrobial ward rounds (Consultant Microbiologist +/- Antimicrobial Pharmacist depending on antimicrobial pharmacist availability) are key to engaging with clinical staff and embedding good antimicrobial stewardship at ward level. The following antimicrobial ward rounds are currently in place:
POWH: ITU 3 x per week; AMU 3 x per week; *C. difficile* 1 x per week.
RGH: ITU 3 x per week; AMU 1 x per week.
PCH: ITU 3 x per week; *C. difficile* 1 x per week.

***C. difficile* Root Cause Analysis**

Antibiotic prescribing is investigated in detail for all patients with healthcare-associated *C. difficile* infection. Any lessons learnt with regard to antimicrobial stewardship are communicated to clinical colleagues along with other measures put in place as necessary e.g. amendment of antimicrobial guidelines.

Restricted Antibiotics

There are protocols in place in PCH, RGH and POWH for the issue of restricted antibiotics (those requiring microbiology approval) by the pharmacy department. In addition, in POWH there is a separate, specific procedure for co-amoxiclav. In POWH, any antimicrobial prescribing outside of guidelines, without microbiology approval necessitates the pharmacist completing an antibiotic exception report, which is cascaded to the Medical Director. This is to ensure the prudent use of broad-spectrum antibiotics (WHO WATCH antibiotics) and antibiotics that should be reserved to treat resistant infections (WHO RESERVE antibiotics)

Audits

Implementing the principles of 'Start Smart then Focus' is one of the Welsh Health Circular's improvement goals for 2021-22. Targets for compliance will be introduced in 2022-23.These audits were started in POWH in June 2021. They are not yet in place in PCH or RGH due to the shortage of antimicrobial pharmacists and the lack of AMS groups in Merthyr Cynon and Rhondda Taf Ely. Implementation is planned for 22-23/23-24 when appropriate staffing resource is in place.

Education and Training
Education on antimicrobial stewardship is provided by clinical pharmacists in PCH, RGH and POWH. Audiences include pharmacists, fifth year medical students, doctors new to the Health Board and junior doctors.

ARK (Antibiotic Review Kit) Chart
The ARK chart has been in use in POWH (excluding mental health and paediatrics) since October 2021. The ARK chart supports the principles of 'Start Smart then Focus' and therefore should be a priority for the Health Board at all acute sites. The ARK chart has not been introduced in PCH or RGH due to the shortage of antimicrobial pharmacists and the lack of AMS groups in Merthyr Cynon and Rhondda Taf Ely. Implementation is planned for 22-23/23-24 when appropriate staffing resource is in place.

(2) Primary Care
(a) National Prescribing Targets

There are 3 national antimicrobial prescribing targets.

	Indicator	Target	CTM progress
All Wales Medicines Strategy Group National Prescribing Indicators 2021-22	Total antibacterial items/1000 STAR-PUs	Quarterly reduction of 5% against baseline of data from April 2019-March 2020	Target achieved based on Q4 data see section 2.1.1 below
	4C* antibacterial items/1000 patients *4C = co-amoxiclav, cephalosporins, fluoroquinolones, clindamycin.	To reduce prescribing compared with the quarter ending December 2019.	Target achieved. See section 2.1.2 below
Welsh Health Circular AMR and HCAI Improvement Goal 2021-23	Total antimicrobial volume	25% reduction from baseline year of 2013/14 by 2024 (10 year target).	The WHC AMR Improvement Goals for 2021/22 indicated that CTMUHB had met the 25% target for antimicrobial usage (25.4% reduction). However when interpreting 2020/21 data the effect of the COVID-19 pandemic must be considered as it could have impacted ion antimicrobial prescribing practices. During 21/22 we have seen an increase in antimicrobial prescribing, more in line with pre-pandemic levels. Not on track to meet target by 2023/24.

			Based on current prescribing data for the 2021/22 financial year (awaiting year end PHW report) CTMUHB prescribing reduced by 23.4% compared with 2016/17 (see fig 5) There is a risk that the HB may not be on track to meet the improvement goal

National Prescribing Indicators

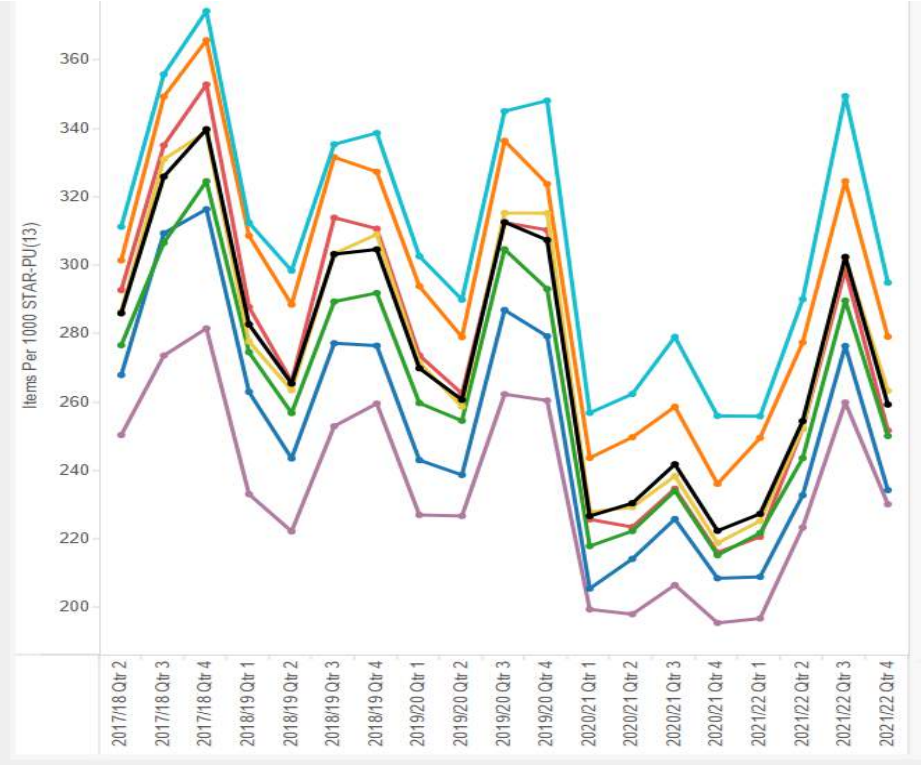
2.1 ANTIMICROBIAL STEWARDSHIP

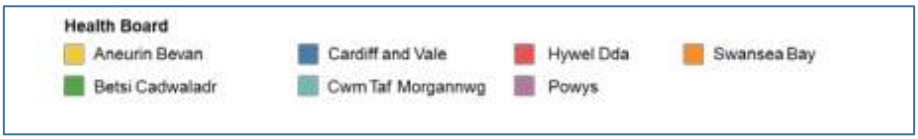
2.1.1 Total antibacterial items

Data source: NWSSP Unit of measure: Total antibacterial items per 1,000 specific therapeutic group age– sex related prescribing units (STAR-PUs).

Targets for 2021–2022: Health board target: a quarterly reduction of 5% against a baseline of data from April 2019–March 2020

	Quarter ending June		Quarter ending September		Quarter ending December		Quarter ending March	
	2021 target	2021 Actual	2021 target	2021 Actual	2021 target	2021 Actual	2022 target	2022 2Actual
CTMUHB	288	256	276	290	328	350	331	295





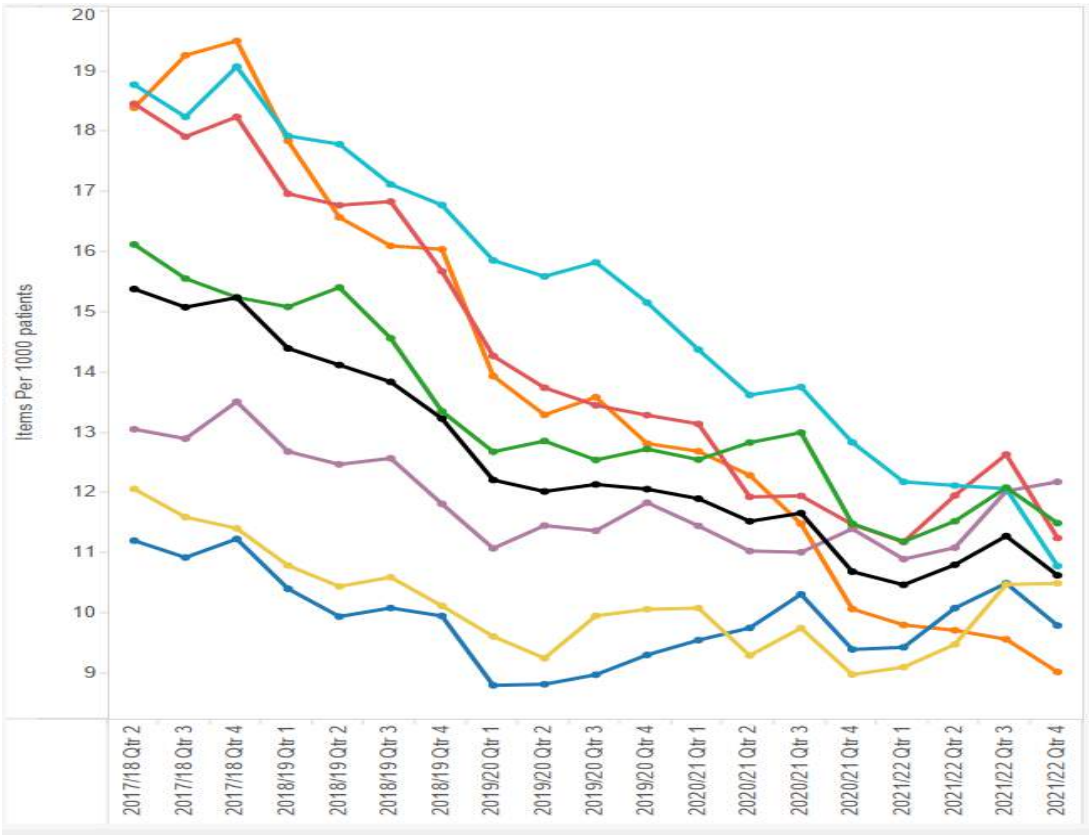
2.1.2 4C antimicrobials

Data source: NWSSP Unit of measure: Co-amoxiclav, cephalosporin, fluoroquinolone and clindamycin (4C antimicrobials) items combined, per 1,000 patients.

Targets for 2021–2022: Health board target: A quarterly reduction of 10% against a baseline of data from April 2019–March 2020

	Quarter ending June		Quarter ending September		Quarter ending December		Quarter ending March	
	2021 target	2021 Actual	2021 target	2021 Actual	2021 target	2021 Actual	2022 target	2022 2Actual
CTMUHB	14.3	12..9	14.0	12.12	14.2	12.07	13.6	10.79

Fig 6 4C Antibacterial Items Per 1000 patients



(b) Antimicrobial stewardship work programme

Antimicrobial Guidelines

The major focus of the antimicrobial stewardship team has been the merge of the Cwm Taf and POWH antimicrobial guidelines and implementation of the AWMSG updated Antimicrobial Guidelines (published March 2022). This work will be completed by August 2022.

Audits

Work has focused on completing antibiotic prescribing audits within GP practices, and the results fed-back to the prescribers along with local and national prescribing and resistance data.

A cephalexin audit was been included in the Prescribing Management Scheme for 2021/22, analysis of the audit data identified recommendations to be taken forward in 2022-23 to meet the audit standards:

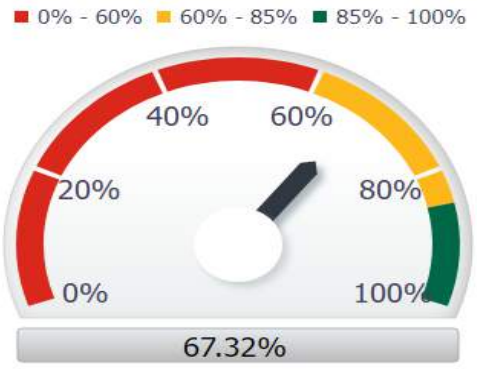
- 100% of cephalosporins prescribed were for indications specified in current CTMUHB primary care antimicrobial guidelines or on the specific advice of microbiology following test results.
- 100% of cephalosporins prescribed were in accordance with the dose & duration specified in current CTMUHB primary care antimicrobial guidelines or on the specific advice of microbiology following test results

A rosacea educational session/audit pack has been developed and will be implemented during 2022/23 and an acne pack is in development. Practices are being supported to complete the QAIF Antimicrobial Stewardship UTI Project where selected by the practice.

9. Education and Training Activities

Face to face training was reintroduced in 2021to supplement the E.learning provision. A blended approach is now available for IPC training.

The table below identifies the number of staff trained this year.



Combined Compliance % for all
3 Levels of IPC Training
Up to 31.03.22

Compliance % by Subject Level up to 31.03.22

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %
110|CSTF|Infection Prevention and Control Management Training - No specified renewal|	632	632	210	33.23%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	3679	3679	2873	78.09%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	6877	6877	4449	64.69%

Overall Combined Compliance % for each Staff Group up to 31.03.22

Staff Group	Headcount	Competencies Required	Competencies In-date	Compliance %
Add Prof Scientific and Technic	268	275	156	56.73%
Additional Clinical Services	1977	1980	1364	68.89%
Administrative and Clerical	2098	2107	1702	80.78%
Allied Health Professionals	698	803	542	67.50%
Estates and Ancillary	1222	1222	856	70.05%
Healthcare Scientists	184	200	174	87.00%
Medical and Dental	730	772	170	22.02%
Nursing and Midwifery Registered	3349	3822	2564	67.09%
Students	7	7	4	57.14%

Overall Compliance % for each ILG up to 31.03.22

ILG	Headcount	Competencies Required	Competencies In-date	Compliance %
110 Balance Sheet ILG	1	1	1	100.00%
110 Bank ILG	1	1	1	100.00%
110 Bridgend ILG	2636	2844	1867	65.65%
110 Corporate ILG	703	707	573	81.05%
110 Delivery Executive ILG	761	773	548	70.89%
110 Hosted Organisations ILG	68	69	55	79.71%
110 Merthyr & Cynon ILG	3297	3563	2271	63.74%
110 Rhondda Taf Ely ILG	3066	3230	2216	68.61%

Aseptic Non Touch Technique (ANTT)

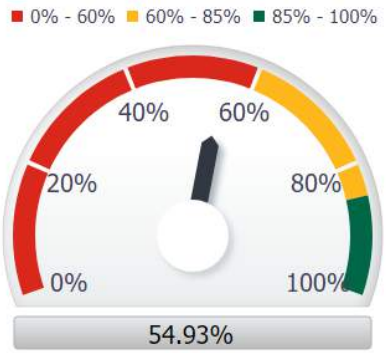
Aseptic Non Touch Technique (ANTT) is a comprehensive practice framework for aseptic technique used for all invasive procedures, from major surgery to maintenance of invasive devices and will affect every directorate and varying disciplines of staff.

All health board employees who perform aseptic procedures as part of their role must complete the ANTT e-learning package which is available via NHS learning Wales. Staff will then be competency assessed in their areas by designated ANTT trainers for the organisation.

The IP&CT have continued to coordinate and support the roll out of ANTT across the Health Board and plans to introduce ANTT training in Bridgend ILG has commenced. Responsibility for monitoring compliance and DOPS assessment has been handed to the ILG teams. The IP&CT will continue to offer support and assistance to provide training for ANTT assessors and with assessments.

The All Wales ANTT policy has been adopted by the UHB and a steering group has been set up to oversee the implementation which is ongoing in primary and secondary care.

Combined compliance % for Level 1 (e-learning) and Level 2 (workplace assessment) ANTT Training up to 31.03.22



Compliance Percentage for each of the three levels of ANTT training up to 31.03.22

Competence Full Name	Headcount	Competencies Required	Competencies In-date	Compliance %
110|MAND|Aseptic Non Touch Technique - Level 2 (Workplace Assessment) - 3 Years|	3568	3568	1095	30.69%
110|MAND|Aseptic Non Touch Technique - Level 3 (Assessor) - No Specified Renewal|	232	232	49	21.12%
NHS|MAND|Aseptic Non Touch Technique - 3 Years|	3803	3803	2954	77.68%

Combined Level 1 and Level 2 compliance % for each ILG up to 31.03.22

ILG	Headcount	Competencies Required	Competencies In-date	Compliance %
110 Bridgend ILG	124	244	97	39.75%
110 Corporate ILG	13	26	16	61.54%
110 Delivery Executive ILG	82	164	93	56.71%
110 Hosted Organisations ILG	6	12	1	8.33%
110 Merthyr & Cynon ILG	1973	3790	2046	53.98%
110 Rhondda Taf Ely ILG	1605	3135	1796	57.29%

10. Decontamination

External review

An external review of the decontamination infrastructure, governance arrangements, systems and processes and the management structure was completed in 2021. A report of the findings was presented to the Executive Team. The operational lead for decontamination is currently part of the role and responsibilities of the Deputy Lead IP&C Nurse post which is unsustainable and a risk for the HB. Further consideration is required to appoint a dedicated operational lead for decontamination as recommended in the external review.

Decontamination meetings

Local decontamination meetings have been set up in each of the ILG which provides assurance to the Decontamination committee.

POW Centralisation Scheme

The Strategic Outline Case submitted to Welsh Government has been approved and the Capital Planning team is in the process of appointing a design team to

take the project forward. It is critical for this work to progress as not continuing with this project could result in the Endoscopy department at the Princess of Wales Hospital losing their JAG accreditation.

Community Dental Services Instruments
The HB is progressing with plans to centralise decontamination of community dental instruments. The sterile services department at the Princess of Wales Hospital is decontaminating dental instruments from Dewi Sant Health Park.

Laryngoscope Handles
An updated Welsh Health Circular was published in 2020 which asks HBs to consider the environmental impact of switching to single use laryngoscope handles and asks for systems to be introduced to ensure reusable handles are decontaminated in accordance with manufacturer instructions using automated and validated systems. The Health Board continues to work towards the Welsh Health Circular.

Channelled Nasoendoscopes
The Health Board has purchased 9 channelled naso-endoscopes for use at the Princess of Wales and Royal Glamorgan Hospitals. Robust decontamination processes and standard operating procedures have been developed. The operational lead for decontamination will audit practice against the SOPs once the process has been established.

11. Challenges this year and priorities for 2022/23

Challenges faced in the past year:

- The day to day IPC work has been on hold in order for the team to focus on COVID response.
- Increased workload due to the pandemic and responding/supporting COVID outbreaks across CTM.
- Poor staffing levels due to long term sickness and vacancies.
- Unable to support primary care due to the lack of a dedicated IPC resource.
- Unable to achieve audit programme.
- Unable to progress with planned improvement work.
- The HB did not achieve the reduction expectations for reducing healthcare associated infections although fewer cases of MRSA bacteraemia and Klebsiella spp. Bacteraemia were reported.

Priorities for 2022/23 –

- Explore opportunities to introduce and provide a whole system approach for CTM across secondary, community and primary care services.
- A dedicated resource is critical to lead on the operational agenda for decontamination for Cwm Taf Morgannwg UHB.
- Appoint an IP&C Nurse to support the refurbishment and capital project schemes ongoing across the Organisation.
- Deliver a comprehensive IPC programme.
- Recommence improvement work to -
    - Develop and introduce a robust root cause analysis process for secondary and primary care to learn lessons from all cases of C.Difficile infection and preventable infections
    - Reduce preventable infections
    - Support improvements in IPC practice and roll out of ANTT
- Support maternity services to improve surveillance and reporting of C.section surgical site infections.
- Support clinical teams to reduce healthcare associated infections. Local reduction targets set and agreed with ILG Directors.

Annual and monthly reduction expectations for mandatory surveillance organisms, by ILG, 2022 – 2023

	National Target rate per 100,000	CTM targets, FY 2022/23		% reduction to meet target	Targets by ILG, FY 2022/23+					
					RTE		MC		Bridgend	
		n/year	n/month+		n/year	n/month	n/year	n/month	n/year	n/month
C. difficile	25	112.5	9	28	33	2	23	1	54	3
S. aureus bacteraemia	20	90.0	7	25	39	3	26	2	24	2
E. coli bacteraemia	67	301.4	25	25	102	8	97	8	93	7
Klebsiella spp. bacteraemia*	14	63.0	5	22	23	1	21	1	17	2
P. aeruginosa bacteraemia**	5	24.0	2	22	10	≤ 1	7	≤ 1	7	≤ 1

12. Appendix 1 – Annual COVID report

Summary

- Between 1st April 2021- 31st March 2022, 3,322 cases of COVID-19 were identified in hospitals across Cwm Taf Morgannwg University health board (CTMUHB). Of these 372 (11%) died within 28 days of the first positive specimen (Table 1).
- Following recovery from the second wave of the COVID-19 pandemic (September 2020 - April 2021), combined with the successful nationwide roll-out of the COVID-19 vaccine, case numbers remained low during the first quarter of the financial year. However, confirmed cases began to rise again in July 2021 (Figures 1, 2). This rise aligned with the identification of new COVID-19 genomic variants of concern - Delta, which dominated the third wave (July – December 2021) and Omicron (BA.1), which dominated the fourth wave (December 2021-April 2022). Further mutations of the Omicron variant (Omicron BA.2) in March 2022 saw a resurgence of COVID-19 cases at the end of the financial year. These COVID-19 variants displayed increased transmissibility when compared to previous dominant lineages.
- 130 COVID-19 outbreaks were identified in CTMUHB hospitals between 1st April 2021- 31st March 2022 (Table 3). Identification of nosocomial cases (admitted to hospital for >2 days at time of first positive specimen OR positive specimen with 14 days of discharge from site) followed the same trends as those observed in community onset cases (Figure 3).
- Please note, changes were made to the COVID-19 screening/isolation protocols during the financial year. The isolation period for confirmed cases and contacts was reduced from 14 days to 10 days in January 2022. Routine screening every five days for all inpatients (regardless of symptoms) was stood down on 24th March 2022.
- A COVID-19 nosocomial scrutiny panel was piloted in Rhondda Taf Ely Interim Locality Group between April - August 2021. The panel reviewed nosocomial COVID-19 cases who had died within 28 days of positive specimen. Outbreaks within the Royal Glamorgan Hospital from the second wave of the pandemic were reviewed, taking into account operational and infection prevention and control measures relevant at the time, and including available epidemiological and genomics evidence. Following guidance from the NHS Delivery Unit, this process will be expanded to review all outbreaks of COVID-19 in all CTMUHB hospitals since the start of the pandemic.

Data

Table 1: Summary of COVID-19 cases identified in CTMUHB hospitals, 1st April 2021- 31st March 2022

Site	RGH	PCH	POW	Community Hospitals	Total
Positive cases	1313	1024	828	157	**3322**
CAI	456	370	341	4	**1171**
Indeterminate	86	80	63	9	**238**
P-HCAI	73	72	63	13	**221**
D-HCAI	165	102	144	112	**523**
Deaths (within 28 days)	129	103	127	13	**372**

*RGH: The Royal Glamorgan Hospital; PCH: Prince Charles Hospital; POW: Princess of Wales Hospital; Community hospitals: includes Ysbyty Cwm Cynon (YCC), Ysbyty Cwm Rhondda (YCR), Glanrhyd Hospital (GH), Ysbyty George Thomas (YGT) and Ysbyty'r Seren (YS)

Figure 1: COVID-19 cases and deaths in all CTMUHB hospitals, 1st April 2021-31st March 2022, 7-day rolling average

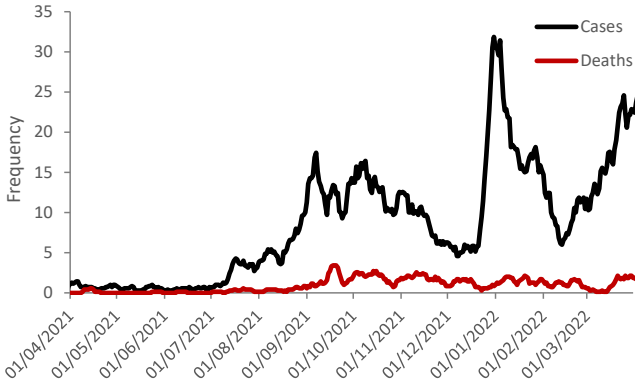
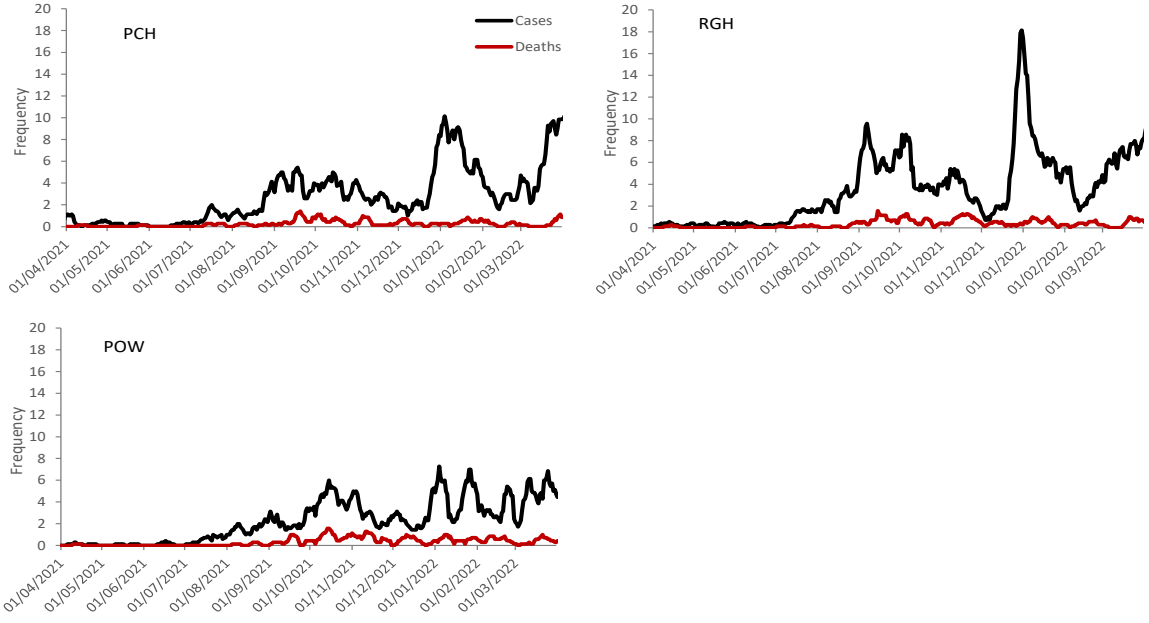


Figure 2: COVID-19 cases and deaths in district general hospitals in CTMUHB hospitals, 1st April March 2022, 7-day rolling average



*RGH: The Royal Glamorgan Hospital; PCH: Prince Charles Hospital; POW: Princess of Wales Hospital

Table 2: Nosocomial COVID-19 cases in CTMUHB hospitals, 1st April 2021 – 31st March 2022, by site and Interim Locality Group (ILG)**

	Rhondda Taf Ely ILG		Merthyr Cynon ILG		Bridgend ILG		
	RGH	YCR	PCH	YCC	POW	GH	YS
Nosocomial cases	365	45	303	74	292	10	7
Nosocomial deaths	68	4	44	7	58	0	0

* RGH: The Royal Glamorgan Hospital; YCR: Ysbyty Cwm Rhondda; PCH: Prince Charles Hospital; YCC: Ysbyty Cwm Cynon; POW: Princess of Wales Hospital; GH: Glanrhyd Hospital; YS: Ysbyty'r Seren.

** Includes cases identified post-discharge (i.e. positive specimen in the 14 days after discharge from hospital. Excludes patients for whom PCR tests initially detected low-levels of SARS-CoV-2 RNA, but repeat tests did not detect RNA.

Table 3: Summary of patient cases linked to COVID-19 outbreaks in CTMUHB hospitals, 1st April 2021 – 31st March 2022, by site and Interim Locality Group (ILG)

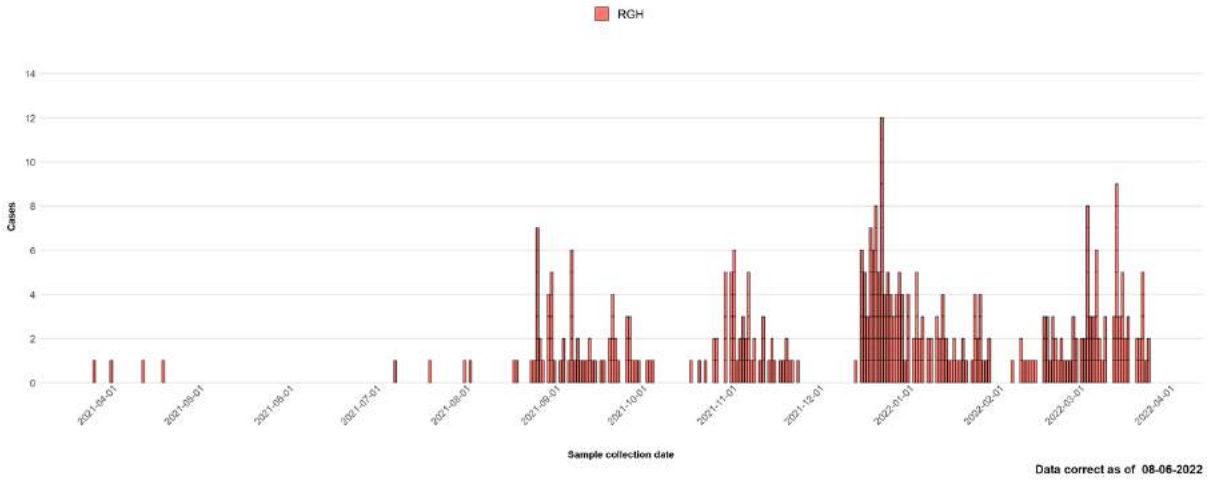
	Rhondda Taf Ely ILG		Merthyr Cynon ILG		Bridgend ILG		
	RGH	YCR	PCH	YCC	POW	GH	YS
Outbreaks identified	42	5	38	6	36	1	2
Patient cases linked to outbreaks	331	39	262	66	256	4	5
Average cases per outbreak (range)	8 (2-38)	8 (2-14)	7 (2-25)	11 (3-17)	7 (2-24)	4 (4-4)	3 (2-3)
Patient deaths (within 28 days of positive specimen)	60	4	38	5	53	0	0
Average deaths per outbreak (range)	2 (1-9)	1 (1-2)	2 (1-5)	1 (1-2)	3 (1-9)	0 (0-0)	0 (0-0)

* RGH: The Royal Glamorgan Hospital; YCR: Ysbyty Cwm Rhondda; PCH: Prince Charles Hospital; YCC: Ysbyty Cwm Cynon; POW: Princess of Wales Hospital; GH: Glanrhyd Hospital; YS: Ysbyty'r Seren.

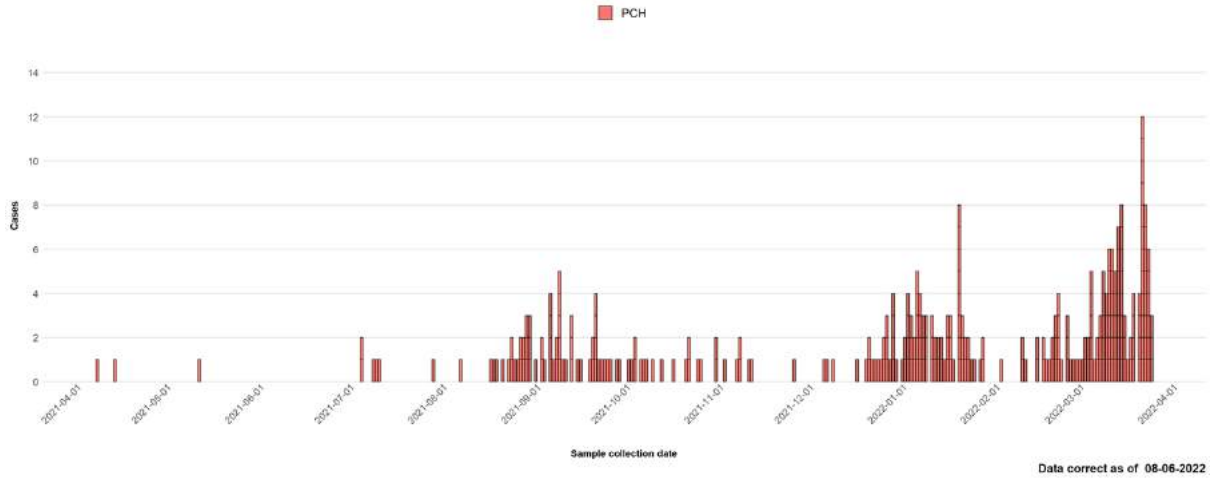
** Includes cases identified post-discharge (i.e. positive specimen in the 14 days after discharge from hospital. Excludes patients for whom PCR tests initially detected low-levels of SARS-CoV-2 RNA, but repeat tests did not detect RNA.

Figure 3: Epidemic curve of nosocomial COVID-19 cases identified in district general hospitals in CTMUHB, 1st April 2021 – 31st March 2022.

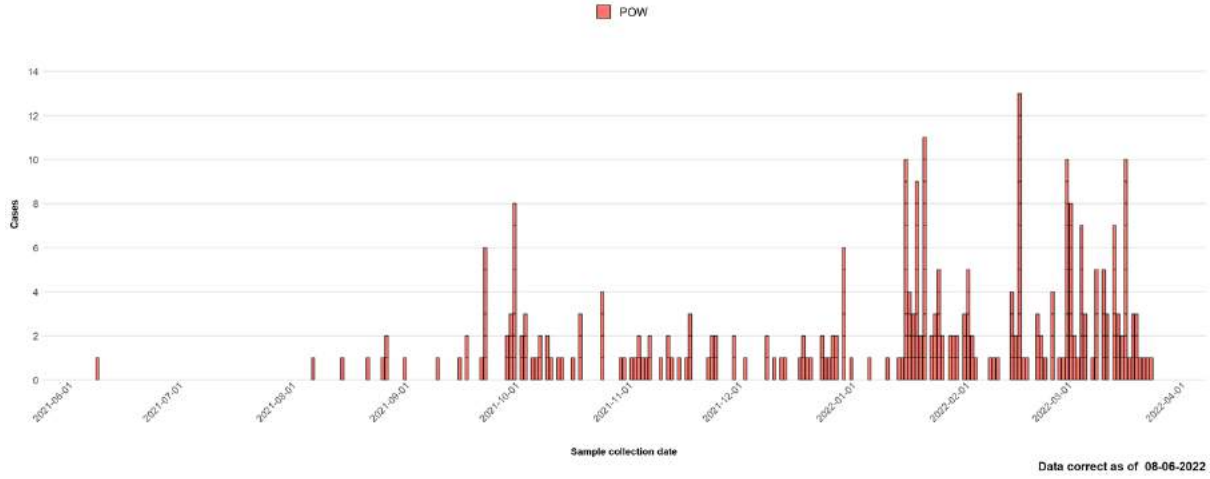
A: The Royal Glamorgan Hospital



B: Prince Charles Hospital



C: Princess of Wales Hospital



Notes on interpretation

1. Data extracted from ICNet, correct as at 08:00, 08/06/2022
2. Individuals have been de-duplicated by episodes of infection. An episode period of 90 days is applied to individuals tested for SARS-CoV-2. All tests with the same result within this time period have been de-duplicated.
3. Inpatient and discharged patients determined by availability of corresponding dates on ICNet. Please note that not all patients presenting at a site will be admitted to hospital.
4. Data from CTUs and other testing sites in the community (such as prisons, primary care practices, etc.) have not been included in this report.
5. The PHW definitions of Healthcare associated COVID-19 infection have been applied;
    a. Community associated: Symptoms present at admission or onset within 1-2 days of admission
    b. Indeterminate association: Symptom onset on day 3-7 after admission
    c. Probable healthcare-associated infection (HCAI): Symptom onset on day 8-14 after admission

d. Definite HCAI: Symptom onset after day 14 of admission

Date of admission and date of positive specimen are used to assign patient infections to these categories, as available on ICNet.

6. Deaths in COVID patients have been included if death has occurred within 28 days of first positive swab or within 7 days of death if swab was collected post-mortem.
7. On 24th March 2022, changes were made to the COVID-19 testing regime in Welsh hospitals following issue of the Welsh Health Circular WHC/2022/011. From this date, patients were tested for COVID-19 in the following scenarios: (i) all admissions to hospital; (ii) Inpatients with symptoms indicative of a respiratory/COVID-19 infection during admission; (iii) all inpatients due to be discharged to a care home. Routine asymptomatic testing of inpatients was halted and contacts of known cases to be screened for COVID-19 only if they developed symptoms

Agenda Item
9.2.6

Quality & Safety Committee

REGULATORY REVIEW RECOMMENDATIONS UPDATE RELATING TO HEALTHCARE INSPECTORATE WALES

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
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	Greg 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
BLS	Basic Life Support

1. Situation /Background

1.1 The purpose of this report is to provide the Committee with an update on Healthcare Inspectorate Wales (HIW) inspection activity since the last report presented to the committee in July 2023. This update report is based on activity between July – 31st August 2023.

An overview table has been included below in 2.1 to provide a summarised snapshot of the most recent HIW inspection activity.

All HIW Inspection activity can be accessed via the following public link**:** https://hiw.org.uk/

2. Specific Matters for Consideration

2.1 HIW inspection activity for the period July – 31st August 2023

Number of Unannounced	**1**
Number of Announced	**0**
Number of patient/staffs concerns via HIW	**1**

The one unannounced HIW inspection which is reported for this period relates to the Emergency Unit and the Clinical Decisions Unit at Prince Charles Hospital on 31 July, 01 and 02 August 2023 where HIW attended to undertake an unannounced NHS Hospital inspection.

During their inspection, HIW found areas of concern which may pose an immediate risk to the safety of patients which were relating to the checking of resus equipment and mandatory training compliance for BLS. This was discussed during the inspection feedback meeting.

Due to the seriousness of these concerns, HIW requested an update providing information and assurance of the actions which were taken or are being taken to address these patient safety concerns and ensure that patient safety is protected.

An immediate improvement plan was completed by the Planned Care, Care Group which included details of the action(s) taken or actions which are intended to take to address each of the identified findings. This improvement plan was submitted to HIW ahead of their deadline date of 14 August 2023.

The final report is expected to be published on the website of HIW on 2nd November 2023.

Whistle-blower Concern raised to HIW:

Healthcare Inspectorate Wales were contacted by a whistle-blower in relation to concerns over patient safety within the speciality of Mental Health. The letter recevied from HIW was dated 16th August 2023.

HIW encouraged the whistle-blower to contact the health board directly through the whistleblowing policy to raise their concerns directly.

The concerns raised were promptly and fully responded to by the relevant Care Group with the full response submitted to HIW.

Update on improvement plans submitted to HIW:

An updated improvement plan following the inspection to Ward 5 Princess of Wales hospital was submitted to HIW during this reporting period.

Expected publication of HIW reports:

A draft report was recevied from HIW following the HIW - National Review of Patient Flow, which focused on the journey through the stroke pathway. The health board factual accuracy response was submitted to HIW, with the final report published on their website on 7th September 2023.

Accepted Improvement plan:

Following the submission of the revised improvement plan which was developed following the HIW Review of Discharge Arrangements for Adults from Inpatient Mental Health Services within Cwm Taf Morgannwg University Health Board the Committee will be pleased to note that this plan was accepted and in-line with HIWs reviews process. The health board is expected to provide an updated plan to HIW in approximately three months' time, highlighting the progress made against the actions detailed in the improvement plan.

Primary Care inspections:
The Primary Care Community and Mental Health Care Group provide an overview of all HIW activity including the inspections within their Care Group report to Committee.

3. Key Risks / Matters for Escalation

3.1 The transition process has commenced for all HIW activity to move to the Quality Assurance and Compliance team, led by the Head of Quality Assurance and supported by the Quality and Assurance Compliance Officer. The use of the Audit Management and Tracking (AMaT) system will allow for smarter reporting and tracking of all HIW related activity.

3.2 A tracker report will also be submitted to the Quality & Safety Committee highlighting progress towards completion of the open inspection/improvement plans across the organisation.

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))*	Leadership
	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /*	Effective
	If more than one applies please list below: Efficient

Link to Domains of Quality *(Duty of Quality Statutory Guidance (gov.wales))*	Equitable 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: Report is for information on recent HIW inspection activity
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: Report is for information on recent HIW inspection activity
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 Committee are requested to **NOTE** the report.

6. Next Steps

6.1 Monitoring of HIW activity is continuous and will be reported at regular intervals to the Committee

Agenda Item
9.2.7

Quality & Safety Committee

Cwm Taf Morgannwg Individual Patient Funding Requests (IPFR) Annual Report 2022/23

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Tynan-Preece, Commissioning Manager
Cyflwynydd yr Adroddiad / Report Presenter	Philip Daniels, Director of Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Linda Prosser, Executive Director of Strategy & Transformation

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AWTTC	All Wales Toxicology and Therapeutic Committee
EU	European Union
HTW	Health Technology Wales
IPFR	Individual Patient Funding Request
PIG	Policy Implementation Group
NICE	National Institute of Clinical Effectiveness

TOR	Terms of Reference
QA	Quality Assurance
WHSSC	Welsh Health Specialised Services Committee

1. Situation /Background

1.1 This report briefs members of the decisions made by the Cwm Taf Morgannwg University Health Board (CTM) Individual Patient Funding Request (IPFR) panel during 2022/23.

1.2 The All Wales IPFR Policy was introduced in 2011 and revised in 2015 and 2017 following Ministerial reviews. Its aim is to ensure there is a fair, transparent and consistent approach to decision making across Wales for medicine and non-medicine treatments not routinely commissioned on the NHS as they are new, novel or experimental. Where a medicine or treatment has not been appraised or approved for use in the NHS in Wales, a clinician can apply for it to be made available under the IPFR process. This process allows access to treatments where there is clear evidence a patient will derive significant clinical benefit from the treatment compared to other patients and that there is evidence that the treatment will be clinically effective and represents a cost effective use of NHS resources.

1.3 The membership of the health boards IPFR panel is outlined in the All Wales IPFR policy. Within CTM, the panel membership is as follows:

Senior Public Health Medicine Consultant (Chair, under delegated authority from the Director of Public Health)

Medical Director (Vice Chair)

Head of Medicine Management

Director of Nursing

Director of Therapies

Assistant Director of Commissioning & Transformation

Lay representative (2 vacant posts)

Each member now has a delegated deputy.

1.4 The CTM IPFR panel is scheduled to meet every fortnight to ensure applications are considered in line with the required timescales requested in the application. However, the CTM panel will be cancelled if there are no IPFR applications to consider. There is also an established mechanism to consider urgent applications within 24-48 hours. For urgent/life threatening applications and when a panel cannot be convened or discussion facilitated virtually within 24-48 hours, the Chair of the IPFR panel can undertake Chairs Action. During 2022/23, the CTM IPFR panel was convened on 9 occasions, while Chairs Action was undertaken for 3 cases

1.5 There are strict timescales around the IPFR process for which the health board is audited on a quarterly basis by the Quality Assurance panel. The QA selects an IPFR case chosen at random from the All Wales IPFR database. After each QA panel, the health board will receive a formal update following each QA panel. For 22/23, the health board has performed well and has been consistent in its approach in terms of process and timelines.

1.6 **Governance Structures related to the All Wales IPFR Process**

Following the independent review of the IPFR process in Wales in 2017, a key recommendation was to 'establish a national IPFR quality function to support IPFR panels to ensure quality and consistency in decision making'. It would include facilitation, advice training and auditing of the IPFR process and have an obligation to report on the quality of processes, highlighting any concerns through the existing quality and clinical governance processes in Wales. The Quality Assurance (QA) panel was therefore established to undertake this function and is hosted by the AWTTC.

1.7 The governance structure for the established QA panel is clearly laid out in the terms of reference which were approved as part of the IPFR review through existing health board governance structures, including WHSSC and by the Deputy Chief Medical Officer for Wales for whom the group reports to. The group's role is to scrutinise a randomly selected IPFR from each IPFR panel to ensure the process had been followed in line with the All Wales IPFR Policy.

1.8 The All Wales Therapeutics and Toxicology Centre (AWTTC) plays a pivotal role in supporting IPFR panels, ensuring consistency in approach via the QA group, establishing an All Wales IPFR database which seeks to identity any cohorts thus enabling a rapid review of the evidence and possible early access to treatment, for both medicines and non-medicines, and supporting the requirement for ongoing IPFR training events.

1.9 When a patient cohort is identified through cases submitted to the All Wales IPFR database, this links with the One Wales Commissioning Process.

1.10 **Health Technology Wales (HTW)** forms part of the QA group and are alerted to any non-medicine cohorts identified via the All Wales database thus enabling them to carry out an evidence appraisal. They also provide support for rapid evidence appraisals to IPFR panels when required. During 2022/23, CTM requested 4 rapid appraisals to assist the IPFR panel decision making process. Individual clinicians can also submit a topic for consideration. In addition to rapid appraisals, HTW considered more than 80 new topic referrals from across the health and care communities and published six new HTW guidance documents in 2021/22, including its first social care guidance, as well as nine new evidence appraisal reports.

1.11 **One Wales Interim Pathways Commissioning process**

The IPFR cases considered by the CTM IPFR panel and other health boards across NHS Wales including WHSSC, is also used to inform other aspects of the AWTTC work programme, and in particular the One Wales Interim Pathways Commissioning process which has been assessing medicines since May 2016. The process has been developed to facilitate one single agreed

decision for NHS Wales on access to particular medicines for a group of patients (a patient 'cohort'). Medicines and patient cohorts are identified for the One Wales Interim Pathways Commissioning process by signals from activity in the IPFR panels, from WHSSC, the Chief Pharmacist Peer Group or clinician groups

1.1.3 Ongoing monitoring of the IPFR data has shown that soon after publication of a positive One Wales Interim Pathways Commissioning (IPC) decision, applications are no longer submitted for these indications. This positively demonstrates that the process effectively reduces the burden on IPFR panels and encourages equity of access to these medicines across Wales. During 2022/23, there have not been any IPFR cohorts identified that have led to One Wales assessments for medicines. This demonstrates that the IPFR route is being correctly used by clinicians; for those individual patients who may have clinical presentations that are different to the patient cohort.

1.1.4 The majority of the assessments are being triggered by requests from the service rather than through collection of IPFR cohort data. This may in part be due to the diversity of requests coming through IPFR but it also shows more awareness by the service of the One Wales Medicines process. In 2022-2023 there were 17 One Wales recommendations enabling access to medicines for the treatment of patients with conditions where there is an unmet clinical need.

2. Specific Matters for Consideration

2.1 IPFR data 2022/23

2.1.1 The requests submitted to the CTM IPFR panel vary in terms of complexity. The majority of applications relate to non-NICE approved/unlicensed drugs. The number of non-medicine requests received has been historically low, however a slight decrease in the number of requests was noted in 2022/23 (table 1) compared to 2021/22 (6). IPFR decisions are recorded centrally on the All Wales IPFR database.

Table 1: Requests submitted to the CTM IPFR panel 2022/23

2022/23	Approved	Not approved	Total
Medicine	16	4	20
Non medicine	1	2	3
Total	17	6	23

2.1.2 The following table details the number of Cwm Taf Morgannwg IPFR requests for the financial years 2018/19 to 2021/22, noting a slight increase in the number of applications considered in light of the Bridgend Boundary Change taking effect from April 2019.

Table 2: IPFR applications considered by the CTM panel by year.

	Approved	Not approved	Total
2018/19	9	3	12
2019/20*	12	2	14
2020/21	21	4	25
2021/22	21	7	28

*Bridgend Boundary Change April 2019

2.1.3 The Health Board has seen a slight reduction in the number of applications received in 2022/23 totalling 23.

2.2 Financial Commitment

2.2.1 The very nature of IPFR spend is unpredictable and will vary year by year due to the requests received. The table below highlights an increase in committed spend when compared to previous years, with the number of applications approved by the CTM IPFR panel decreasing slightly compared to previous years:

Table 3: IPFR financial commitment by year

Year	Total commitment (£)
2018/19	96k
2019/20*	219k
2020/21	308k
2021/22	178k
2022/23	£228k

*Bridgend Boundary Change April 2019

2.2 Amendment to Directions concerning Cross Border Directive (2011/24/EC) and the S2 funding route process

2.2.1 Following the UK's withdrawal from the European Union (EU) on 31st December 2020, the EU Directive funding route ceased. Welsh Government issued the Welsh Health Circular (2021/005) instructing Health Boards that

the EEA Directive can no longer be used by UK citizens to access healthcare treatment in the EU, (appendix 1).

2.2.2 Whilst the EU Directive funding route has ceased, S2 arrangements will continue as part of agreed reciprocal healthcare arrangements with Europe post Brexit. The S2 route enables CTM patients to apply to have their planned treatment in another EEA country at the expense of their home state. This can be in state provider or private healthcare provider that accepts an S2 certificate for which treatment will be provided under the same conditions and payment as for a resident of the country of treatment.

2.2.3 As the Directive route is no longer an option for patients to seek treatment in Europe, the Health Board had anticipated an increase in the number of S2 applications. However during 2022/23 CTM UHB received less than 5 applications, with no requests being approved for treatment in the EU. The Commissioning team will continue to closely monitor the number of S2 applications in 22/23 and escalate appropriately if the number of requests increase.

3 Key Risks / Matters for Escalation

3.1 CTM UHB representation on the All Wales IPFR panel

In order to improve health board quoracy at the All Wales IFPR panel, the Deputy Executive Director for Nursing now provides regular and consistent health board representation at the All Wales IPFR panel.

3.2 CTMUHB IPFR panel membership

Work has been undertaken in order to strengthen the membership of the CTM UHB IPFR panel. The Deputy Medical Director is now the formal deputy chair of the IPFR Panel and each core member now has a delegated deputy which has assisted greatly in ensuring the quoracy of the local IPFR panel and ensures timely consideration of IPFR cases.

3.3 Lay Representation on the CTM IPFR panel

CTM UHB is required to recruit two lay representatives to the local IPFR panel as per the IPFR TOR. There has been great difficulty in attracting suitable candidates to the role for a number of years across Wales. Renewed efforts will be made to link with Llais and external stakeholders to recruit suitable lay members.

3.4 Vacant Commissioning Support Officer post

Having been vacant since 1st August 2021, the Commissioning Team were successful in appointing a new member of staff to the role of Commissioning Support Officer, who will be responsible for the day to day management of IPFR applications, prior approval and S2 requests. The role will also provide

additional support to the wider Commissioning Team. The new member of staff took up post on 21st August 2023.

3.5 **New EU Regulations**

The Healthcare (International Arrangements) (EU Exit) Regulations 2023 came into force on 18th August 2023: The Healthcare (International Arrangements) (EU Exit) Regulations 2023 (legislation.gov.uk). The regulation places a duty on Health Boards to provide a review mechanism for S2 application and for applicants to be made aware of their ability to apply for a review. To ensure a consistent approach across NHS Wales, the IPFR Policy Implementation Group has agreed to process such requests in line with the existing review process in place for IPFR and Prior Approval request.

3.6 **Framework for Funding Healthcare abroad in exceptional circumstances**

Under the Healthcare (International Arrangements) Act 2019, the Department of Health and Social Care (DHSC) can now implement reciprocal healthcare arrangements with any global partner. DHSC has brought forward new regulations to give the Secretary of State new powers to fund healthcare abroad in exceptional circumstances, in countries where the UK has a healthcare arrangement. These changes came in to force on 18 August 2023.

Following a period of consultation, the UK Government has decided to implement the Reciprocal healthcare policy framework for the funding of healthcare abroad in exceptional circumstances - GOV.UK (www.gov.uk)

This requires health boards to inform patients of the Exceptional Circumstances policy, when S2 applications do not fulfil the criteria within the S2 policy. Patients will now have the right to apply directly to the UK Secretary of State if they consider there to be exceptional circumstances relating to their S2 application. The Secretary of State will consider the factors set out in the 'Funding healthcare abroad in exceptional circumstances' section of this framework when making discretionary funding decisions under the Healthcare (International Arrangements).

3.7 **All Wales IPFR policy**

An IPFR application considered by the All Wales IPFR panel (WHSSC) was subject to a Judicial Review in December 2021. WHSSC were tasked by Welsh Government to undertake a *de minimis* review of the All Wales IPFR policy. WHSSC proposed a number of changes however following discussion at the WHSSC Joint Committee on 18 July 2023, members of the Joint Committee informed WHSSC to engage and agree the revisions with the IPFR Policy Implementation Group (PIG). While the IPFR PIG agreed a version in July 2023, this is yet to be endorsed and implemented across Wales. It is hoped this will be completed in the next few months.

3.8 **All Wales IPFR Workshop**

AWTTC hosted the sixth annual IPFR workshop in February 2023 as a face-to-face event after holding it online during the COVID-19 pandemic. The workshop was open to IPFR panel members, IPFR teams, clinicians who complete IPFR application and those interested in learning more about the IPFR process. A total of 74 attendees were present on the day and all health boards were represented. Holding the event face-to-face provided delegates the opportunity to network and develop links across health boards. Delegates could also find out more information about the work of AWTTC, Health Technology Wales, WHSSC and the Yellow Card Centre Wales by visiting stands throughout the day. A series of presentations were made to delegates and topics covered included:

- Lessons learnt from the Judicial Review
- Factors to consider when assessing the value of interventions
- How to submit an IPFR request electronically via the IPFR database
- Collecting outcome data and how this could be approved

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 IPFR is relevant across the whole life course.
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: Learning, Improvement & Research
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: 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: There are no specific quality and safety implications related to the activity outined in 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: EQIA undertaken on an All Wales basis.
Cyfreithiol / Legal	Yes (Include further detail below)	
	Healthcare (International Arrangements) 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)	
	Workforce and financial resources are required to process and implement IPFR applications within the Health Board.	

5 Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE:**

- The contents of this report;
- The need to recruit lay representation to the CTM IPFR panel; and
- The new EU Regulations.

6 **Next Steps**

6.1 Following consideration by the Committee, this report will now be submitted to the Health Board meeting on the 28th September 2023 for noting.

Agenda Item
9.2.8

Quality & Safety Committee

Public Services Ombudsman For Wales
A Year of Change – A year of Challenge
Annual Report and Accounts 2022/2023

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester Head of Concerns & Business Intelligence
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**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
PSOW	Public Services Ombudsman for Wales

1. Situation /Background

The Public Services Ombudsman for Wales (PSOW) published their 2022/2023 Annual Report in July 2023. The report outlines all activity managed by the PSOW in relation to Public Services in Wales. A full copy of the report can be found at Annual Reports and Accounts (ombudsman.wales)

The report provides detail against three strategic aims set out by the PSOW during 2022/2023:

- Strategic Aim 1: Deliver Justice a fair, independent, inclusive and responsive complaints service.
- Strategic Aim 2: Promote Learning, Work to Improve Public Services Promote learning from complaints and stimulate improvements on a wider scale.
- Strategic Aim 3: Use Resources Wisely and Future-proof the Organisation Identify and adopt best practice. Secure value for money and services that are fit for the future. Support staff and ensure good governance which supports and challenges us.

To coincide with the publication of the annual report, the PSOW issued their annual letter to the Health Board (copy attached in appendix).

2. Specific Matters for Consideration

The report outlines that Health continues to be the subject of over 80% of the overall investigations undertaken by the PSOW, highlighting that the number of complaints about Health Boards rose by 21% (a record high) during 2022/2023. It is noted that these investigations are often lengthy and complex.

During 2022/2023 the PSOW received 2,790 new complaints, with 37% (compared to 34% in 2021/22) relating to Health. Almost a half of those complaints were about clinical treatment in hospital, with the next largest group (20%) about treatment by GPs.

Intervention refers to a complaint outcome when the PSOW decided that something has gone wrong with public services and things must be put right. This could be by making recommendations or agreeing early resolution or settlement of a complaint. The PSOW intervened this year in 30% of the complaints about Health Boards in Wales that were closed. This is the same as last year.

The PSOW further highlights that they continue to publish complaints statistics, with data now published twice a year citing that last year 5% of Cwm Taf Morgannwg University Health Board's complaints were referred to PSOW.

A summary of new complaints received by the PSOW in relation to Health Boards is provided in the table below.

Health Board	2022/23 Number	2022/23 Received per 1000 residents	2021/22 Number	% change from 2021/22
Aneurin Bevan University Health Board	166	0.28	142	17%
Betsi Cadwaladr University Health Board	225	0.33	213	6%
Cardiff and Vale University Health Board	137	0.28	89	54%
Cwm Taf Morgannwg University Health Board	134	0.30	113	19%
Hywel Dda University Health Board	104	0.27	88	18%
Powys Teaching Health Board	23	0.17	10	130%
Swansea Bay University Health Board	137	0.36	110	25%
All Health Boards	**926**	**0.30**	**765**	**21%**

The PSOW Annual letter requests that the Health Board:

- Present the Annual Letter to the Board at the next available opportunity and notify the PSOW of when these meetings will take place.
- Update the PSOW office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023.
- Continue to engage with the Complaints Standards work, accessing training for Health Board staff, fully implementing the model policy, and providing complaints data.
- Inform the PSPW of the outcome of the Health Board's considerations and proposed actions on the above matters at your earliest opportunity.

3. Key Risks / Matters for Escalation

The Annual Report references a Public Interest Report where it was determined the Health Board missed two opportunities to correctly diagnose and treat a patient's ruptured appendix, resulting in her death from sepsis in August 2020.

Information relating to PSOW cases is included in a range of reports provided throughout the Health Board, including the Quality and Safety Dashboard and the Concerns Management 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	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 *(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))*	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: ☐
	Learning from complaints and PSOW cases is essential to inform improvements in quality, safety and experience.	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: Report is a national report that applies to everyone
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	Yes (Include further detail below)
	The PSOW report is within the Public Domain and contains details regarding complaints management within the Health Board.
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

The Committee is asked to **NOTE** of the report.

6. Next Steps

Continue to monitor PSOW activity via the quality & safety dashboard, with key areas escalated to the weekly Quality & Safety Executive Meeting as required.

Respond to the PSOW by the 1st December 2023 outlining how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change?

Inform the PSOW of the outcome of the Health Board's considerations and proposed actions on the matters actions identified above at the earliest opportunity.

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Ask for: Communications
01656 641150
Communications
@ombudsman.wales

Date: 17 August 2023

Jonathan Morgan
Cwm Taf Morgannwg University Health Board
By Email only:

Annual Letter 2022/23

Dear Jonathan

I am pleased to provide you with the Annual letter (2022/23) for Cwm Taf Morgannwg University Health Board which deals with complaints relating to maladministration and service failure, and the actions being taken to improve public services.

This letter coincides with my Annual Report – "A year of change – a year of challenge" – a sentiment which will no doubt resonate with public bodies across Wales. My office has seen another increase in the number of people asking for our help – up 3% overall compared to the previous year, and my office now receives double the number of cases we received a decade ago.

Last year, I met with public bodies across Wales last year – speaking about our casework, our recommendations, and our proactive powers. The current climate will continue to provide challenges for public services, but I am grateful for positive and productive way which Health Boards communicate with my office.

Colleagues from my Improvement Team meet regularly with Cwm Taf Morgannwg University Health Board to discuss compliance with our recommendations and our complaints standards work, and we would like to pass on our thanks to Kellie Jenkins-Forrester and her team for the constructive and candid way these discussions are conducted.

926 complaints were referred to us regarding Health Boards last year – an increase of 21% compared to the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 30% of Health Board complaints - a similar proportion to previous years.

Supporting improvement of public services

Our *Groundhog Day 2: An opportunity for cultural change in complaint handling?* report issued in June, highlighted the complaint handling failings we identified in cases involving health boards across Wales during the preceding 12 months. Our recommendations to the Health Board were aimed at ensuring that, as the new Duties of Candour & Quality are introduced within your organisation, that the opportunity for a cultural change is taken - to promote openness and candour with service users and ensure there is systemic learning when things have gone wrong.

I trust that, in line with our recommendations to the Health Board, the report has or will soon be considered by your Quality & Patient Safety Committee and it will:

- review the resources available to your complaints team
- review arrangements for accurately compiling complaints data
- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis
- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling
- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

Despite the challenges of last year, we have pushed forward with our proactive improvement work and launched a new Service Quality process to ensure we deliver the standards we expect.

Last year, we also began work on our second wider Own Initiative investigation – this time looking into carers assessments within Local Authorities. This investigation will take place throughout the coming year, and we look forward to sharing our findings.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year, with more than 50 public bodies now operating our model policy. We've also now provided more than 400 training sessions since we started in September 2020.

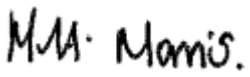
We continued our work to publish complaints statistics into a second year, with data now published twice a year and we included information about Health Boards for the first time in 22/23. This data allows us to see information with greater context – for example, last year 5% of Cwm Taf Morgannwg University Health Board's complaints were referred to PSOW.

I would encourage Cwm Taf Morgannwg University Health Board, to use this data to better understand your performance on complaints.

Further to this letter can I ask that Cwm Taf Morgannwg University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

cc. Paul Mears, Chief Executive, Cwm Taf Morgannwg University Health Board.
By Email only: paul.mears@wales.nhs.uk

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

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Appendix B - Received by Subject

Cwm Taf Morgannwg University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	4	3%
Clinical treatment in hospital	77	57%
Clinical treatment outside hospital*	5	4%
Complaints Handling	26	19%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	2	1%
De-registration	0	0%
Disclosure of personal information / data loss	1	1%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	3	2%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Nosocomial COVID	3	2%
Other	6	4%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	3	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	2	1%
Rudeness/inconsiderate behaviour/staff attitude	2	1%
Total	**134**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Cwm Taf Morgannwg University Health Board		% Share
Out of Jurisdiction	35	25%
Premature	18	13%
Other cases closed after initial consideration	42	30%
Early Resolution/ voluntary settlement*	22	16%
Discontinued	2	1%
Other Reports - Not Upheld	7	5%
Other Reports Upheld*	14	10%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	**141**	

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1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

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We are happy to accept and respond to correspondence in Welsh.

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	48	160	30%
Betsi Cadwaladr University Health Board	80	231	35%
Cardiff and Vale University Health Board	30	129	23%
Cwm Taf Morgannwg University Health Board	37	141	26%
Hywel Dda University Health Board	41	100	41%
Powys Teaching Health Board	5	23	22%
Swansea Bay University Health Board	33	134	25%
Total	**274**	**918**	30%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2022/23. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2022/23. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Heath Boards in 2022/23. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

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Dyddiad: 17 Awst 2023

Jonathan Morgan
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg
Trwy E-bost yn unig:

Llythyrau Blynyddol 2022/23

Annwyl Jonathan

Mae'n falch gennyf gyflwyno'r Llythyr Blynyddol (2022/23) i chi ar gyfer Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg sy'n ymdrin â chwynion yn ymwneud â chamweinyddu a methiant gwasanaeth, a'r camau sy'n cael eu cymryd i wella gwasanaethau cyhoeddus.

Mae'r llythyr hwn yn cyd-daro â'm Hadroddiad Blynyddol - "Blwyddyn o newid - blwyddyn o her" - teimlad a fydd, heb os, yn atseinio â chyrff cyhoeddus ledled Cymru. Mae fy swyddfa wedi gweld cynnydd arall yn nifer y bobl sy'n gofyn am ein cymorth - cynydd o 3% o'i gymharu â'r flwyddyn flaenorol, ac mae fy swyddfa bellach yn derbyn dwywaith nifer yr achosion a gawsom ddegawd yn ôl.

Yn ystod y flwyddyn ddiwethaf, cyfarfûm â chyrff cyhoeddus ledled Cymru - gan siarad am ein gwaith achosion, ein hargymhellion, a'n pwerau rhagweithiol. Bydd yr hinsawdd bresennol yn parhau i gyflwyno heriau i wasanaethau cyhoeddus, ond rwy'n ddiolchgar am y ffordd gadarnhaol a chynhyrchiol y mae'r byrddau iechyd wedi cyfathrebu â'm swyddfa.

Mae cydweithwyr o'm Tîm Gwella yn cwrdd yn rheolaidd gydag Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg i drafod cydymffurfiaeth â'n hargymhellion a'n gwaith safonau cwynion, a hoffwn ddiolch i Kellie Jenkins-Forrester a'u tîm am y modd adeiladol a didwyll y cynhelir y trafodaethau hyn.

Y llynedd, cyfeiriwyd 926 o gwynion atom ynglŷn â byrddau iechyd - cynnydd o 21% o gymharu â'r flwyddyn flaenorol. Yn ystod y cyfnod hwn, gwnaethom ymyrryd (cadarnhau, setlo neu ddatrys yn gynnar) mewn perthynas â 30% o gwynion byrddau iechyd - cyfran debyg i flynyddoedd blaenorol.

Cefnogi gwella gwasanaethau cyhoeddus

Amlygodd ein hadroddiad *Rhoi Diwedd ar yr Un Hen Gân Beunyddiol 2: Cyfle i Newid y Ffordd Rydym yn Delio â Chwynion?* a gyhoeddwyd ym Mehefin, y methiannau ymdrin â chwynion a welsom mewn achosion yn ymwneud â byrddau iechyd ledled Cymru yn ystod y 12 mis blaenorol. Roedd ein hargymhellion i'r Bwrdd Iechyd wedi'u hanelu at sicrhau, wrth i'r Dyletswyddau Gonestrwydd ac Ansawdd newydd gael eu cyflwyno o fewn eich sefydliad, y manteisir ar y cyfle ar gyfer newid diwylliannol - i hyrwyddo didwylledd a gonestrwydd ymhlith defnyddwyr gwasanaeth a sicrhau bod dysgu systemig pan fydd pethau wedi mynd o chwith.

Yn unol â'n hargymhellion i'r Bwrdd Iechyd, hyderaf fod eich Pwyllgor Ansawdd a Diogelwch Claf wedi ystyried yr adroddiad, neu y bydd yn ei ystyried yn fuan, a bydd yn:

- adolygu'r adnoddau sydd ar gael i'ch tîm cwynion
- adolygu trefniadau ar gyfer casglu data cwynion yn gywir
- ystyried a yw'r dewis i roi cyngor meddygol annibynnol i staff sy'n ymchwilio i gwynion yn cael ei ystyried fesul achos
- myfyrio ar y gwersi sydd wedi'u hamlygu yn yr adroddiad hwn wrth graffu ar eu perfformiad o ran ymdrin â chwynion
- sicrhau bod y gwersi a ddysgwyd o ganfyddiadau ac argymhellion OGCC yn cael eu cynnwys yn adroddiad blynyddol y Bwrdd Iechyd ar y Ddyletswydd Gonestrwydd ac Ansawdd.

Er gwaethaf heriau'r llynedd, rydym wedi bwrw ymlaen â'n gwaith gwella rhagweithiol ac wedi lansio proses Ansawdd Gwasanaeth newydd i sicrhau ein bod yn cyflawni'r safonau a ddisgwyliwn.

Y llynedd, dechreuom hefyd weithio ar ein hail Ymchwiliad Ehangach ar ein Liwt ein Hun - y tro hwn, yn edrych ar asesiadau gofalwyr o fewn Awdurdodau Lleol. Bydd yr ymchwiliad hwn yn cael ei gynnal drwy gydol y flwyddyn i ddod, ac edrychwn ymlaen at rannu ein canfyddiadau.

Parhaodd yr Awdurdod Safonau Cwynion ei waith â chyrff cyhoeddus yng Nghymru'r llynedd, gyda mwy na 50 o gyrff cyhoeddus bellach yn gweithredu ein polisi enghreifftiol. Rydym hefyd wedi darparu mwy na 400 o sesiynau hyfforddi ers i ni ddechrau ym Medi 2020.

Gwnaethom barhau â'n gwaith i gyhoeddi ystadegau cwynion am ail flwyddyn, gyda data bellach yn cael eu cyhoeddi ddwywaith y flwyddyn. Gwnaethom gynnwys gwybodaeth am Fyrddau Iechyd am y tro cyntaf yn 22/23. Mae'r data hwn yn ein galluogi i weld gwybodaeth gyda mwy o gyd-destun - er enghraifft, y llynedd, cyfeiriwyd 5% o gwynion Cwm Taf Morgannwg University Health Board at OGCC.

Byddwn yn annog Cwm Taf Morgannwg University Health Board i ddefnyddio'r data hwn i ddeall eich perfformiad ar gwynion yn well.

Ymhellach i'r llythyr hwn, a gaf ofyn i Cwm Taf Morgannwg University Health Board gymryd y camau canlynol:

- Cyflwyno fy Llythyr Blynyddol i'r Bwrdd yn ystod y cyfle nesaf sydd ar gael a rhoi gwybod i mi pryd y cynhelir y cyfarfodydd hyn.
- Rhoi diweddariad i'm swyddfa ynghylch sut mae'r Bwrdd Iechyd wedi cydymffurfio â'r argymhellion yn ein hadroddiad: *Rhoi Diwedd ar yr Un Hen Gân Beunyddiol 2: Cyfle i Newid y Ffordd Rydym yn Delio â Chwynion?* erbyn **1 Rhagfyr 2023.**
- Parhau i ymgysylltu â'n gwaith Safonau Cwynion, rhoi hyfforddiant i'ch staff, gweithredu'r polisi enghreifftiol yn llawn a darparu data cwynion cywir ac amserol.
- Rhoi gwybod i mi am ganlyniad ystyriaethau a chamau gweithredu arfaethedig y cyngor yng nghyswllt y materion uchod erbyn cyn gynted â phosibl.

Yn gywir,

MM· Morris.

Michelle Morris
Ombwdsmon Gwasanaethau Cyhoeddus
cc.Paul Mears, Prif Weithredwr, Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg.
Trwy Ebost yn unig: paul.mears@wales.nhs.uk

Taflen Ffeithiau

Atodiad A - Cwynion a Gafwyd

Bwrdd Iechyd	Cwynion a Gafwyd	Derbyniwyd fesul 1000 o drigolion
Bwrdd Iechyd Prifysgol Aneurin Bevan	166	0.28
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	225	0.33
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	137	0.28
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	134	0.30
Bwrdd Iechyd Prifysgol Hywel Dda	104	0.27
Bwrdd Iechyd Addysgu Powys	23	0.17
Bwrdd Iechyd Prifysgol Bae Abertawe	137	0.36
Cyfanswm	926	0.30

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Atodiad B - Cwynion a Gafwyd yn ôl Pwnc

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	Complaints Received	% share
Gwasanaethau Ambiwlans	0	0%
Apwyntiadau/derbyniadau/rhyddhau a gweithdrefnau trosglwyddo	4	3%
Triniaeth glinigol yn yr ysbyty	77	57%
Triniaeth glinigol y tu allan i ysbyty	5	4%
Ymdrin â Chwynion	26	19%
Cyfrinachedd	0	0%
Gofal Parhaus	0	0%
COVID19	2	1%
Dadgofrestru	0	0%
Datgelu gwybodaeth bersonol / colli data	1	1%
Cyllid	0	0%
Cofnodion meddygol/safonau cadw cofnodion	0	0%
Meddyginiaeth> Dosbarthu presgripsiynau	0	0%
Iechyd Meddwl	3	2%
Darparwr Annibynnol y GIG	0	0%
Gwasanaethau anfeddygol	0	0%
Covid nosocomiaidd	3	2%
Arall	6	4%
Tu Allan I Oriau	0	0%
Parcio (gan gynnwys gorfodi a beilïaid)	0	0%
Materion rhestr cleifion	3	2%
Cyfathrebu gwael/dim cyfathrebu neu fethiant i ddarparu gwybodaeth	0	0%
Gofalu am garcharorion	0	0%
Amser rhos rhwng atgyfeirio a thriniaeth	2	1%
Anghwrteisi/ymddygiad anystyriol/agwedd staff	2	1%
Cyfanswm	**134**	

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Atodiad C - Canlyniadau Cwynion
(* yn dynodi ymyrraeth)

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg		**% Share**
Tu hwnt i Awdurdodaeth	35	25%
Cynamserol	18	13%
Achosion eraill wedi'u cau ar ôl ystyriaeth gychwynnol	42	30%
Datrys yn Gynnar/Setliad Gwirfoddol*	22	16%
Wedi rhoi'r gorau iddi	2	1%
Adroddiadau Eraill – Ni Chadarnhawyd	7	5%
Adroddiadau eraill a gadarnhawyd*	14	10%
Adroddiadau er Budd y Cyhoedd*	1	1%
Adroddiadau Diddordeb Arbennig	0	0%
Cyfanswm	**141**	

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Atodiad D - Achosion lle ymyrrodd OGCC

	Nifer yr ymyriadau	nifer y cwynion a gaewyd	% o ymyriadau
Bwrdd Iechyd Prifysgol Aneurin Bevan	48	160	30%
Bwrdd Iechyd Prifysgol Betsi Cadwaladr	80	231	35%
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro	30	129	23%
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg	37	141	26%
Bwrdd Iechyd Prifysgol Hywel Dda	41	100	41%
Bwrdd Iechyd Addysgu Powys	5	23	22%
Bwrdd Iechyd Prifysgol Bae Abertawe	33	134	25%
Cyfanswm	**274**	**918**	30%

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Taflen Wybodaeth

Mae Atodiad A yn dangos nifer y cwynion a dderbyniwyd gan OGCC ar gyfer pob Bwrdd Iechyd yn 2022/23. Caiff y cwynion hyn eu rhoi mewn cyd-destun yn seiliedig ar nifer y bobl y mae pob bwrdd iechyd yn eu gwasanaethu yn ôl pob sôn.

Mae Atodiad B yn dangos categori pob cwyn a dderbyniwyd, a pha gyfran o'r cwynion a dderbyniwyd sy'n cynrychioli ar gyfer y Bwrdd Iechyd.

Mae Atodiad C yn dangos canlyniadau'r cwynion a gaeodd OGCC mewn cysylltiad â'r Bwrdd Iechyd yn 2022/23. Mae'r tabl hwn yn dangos y niferoedd, a'r gyfran y mae pob canlyniad yn ei chynrychioli ar gyfer y Bwrdd Iechyd.

Mae Atodiad D yn dangos Cyfraddau Ymyrru ar gyfer pob Bwrdd Iechyd yn 2022/23. Mae ymyrraeth yn cael ei gategoreiddio naill ai gan gŵyn a gadarnhawyd (naill ai cadarnhawyd er budd y cyhoedd neu cadarnhawyd nid er budd y cyhoedd), penderfyniad cynnar, neu setliad gwirfoddol.

ombwdsmon.cymru
holwch@ombwdsmon.cymru
0300 790 0203
1 Ffordd yr Hen Gae, CF 35 5LJ
Rydym yn hapus i dderbyn ac ymateb i ohebiaeth yn y Gymraeg.

ombudsman.wales
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0300 790 0203
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We are happy to accept and respond to correspondence in Welsh.

Agenda Item
9.2.9

Quality & Safety Committee

Incident Management Internal Audit Report

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester Head of Concerns & Business Intelligence
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**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
NRI	Nationally Reportable Incidents

1. Situation /Background

The internal audit of the implementation of the National Incident Framework was completed in August 2023.

The purpose of the review was to provide assurance that there are effective arrangements and processes in place for the implementation of the NHS Wales National Patient Safety Incidents Reporting Policy. The audit focused on Nationally Reportable Incidents (NRIs) that occurred after April 2022.

2. Specific Matters for Consideration

The review provided the Health Board with "**reasonable assurance"** in relation to implementation of the NHS Wales National Patient Safety Incidents Reporting Policy. "Reasonable Assurance is identified as some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved".

A breakdown of assurance against the objectives is highlighted in the table below.

	Objectives	Assurance
1	The Incident Management Framework aligns to WG policy and DU guidance.	Reasonable
2	Incidents are identified, captured, investigated, quality assured, approved and responded to.	Reasonable
3	Appropriate actions and learning form events takes place.	Reasonable
4	Monitoring and reporting takes place.	Substantial
5	Incidents are reported within the required timeframes.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

A detailed action plan (attached) has been developed to address the outstanding actions, with completion of all actions scheduled for November 2023. Key actions relate to:

- Review and updating of the Incident Management Framework
- Development of a training strategy and training needs analysis for Concerns & Incident Management
- Robust monitoring of incident management timescales
- Implementation of quality assurance and audit processes

3. Key Risks / Matters for Escalation

- Five recommendations were made following conclusion of the audit. One recommendation was highlighted as a high priority.
- A training needs analysis is being undertaken to identify the training requirements across the organisation, including the level / type of training required by different staff groups.
- A quality assurance checklist has been developed.
- An audit programme of new, closed and ongoing incidents is being established.
- The action plan will be regularly monitored through the Weekly Executive Led Quality & Patient Safety meeting.
- The Internal Audit Report has been presented to the Audit and Risk Committee.

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 *(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/	No - Not Applicable

Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	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 quality and safety implications. If actions arising from WRP and IA reviews are not undertaken and improvements note 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:	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) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Resource realised through the operating model re-alignment will be required to take forward this work.	

5. Recommendation

The Committee is asked to:

- Accept the Internal Audit Report and consider the managerial actions and note progress already made against these actions.

6. Next Steps

To progress with the identified actions to address to the recommendations outlined in the report.

Monitoring of recommendations will be undertaken at the Audit & Risk Committee via the Audit Recommendations Tracker.

National Incident Framework
Final Internal Audit Report

August 2023

Cwm Taf Morgannwg University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Review reference:	CTMUHB-2223-05
Report status:	Final
Fieldwork commencement:	23 January 2023
Fieldwork completion:	7 June 2023
Debrief meeting:	19 July 2023
Draft report issued:	30 June 2023 & 21 July 2023
Management response received:	8 August 2023
Final report issued:	8 August 2023
Auditors:	Olubanke Ajayi-Olaoye, Principal Auditor Emma Samways, Deputy Head Internal Audit Paul Dalton, Head of Internal Audit
Executive sign-off:	Greg Dix, Executive Director of Nursing, Midwifery & Patient Care
Distribution:	Nigel Downes, Assistant Director of Quality & Safety, Patient Care & Safety Lisa Jenkins, Clinical Lead, Serious Incidents and Complex Concerns Kellie Jenkins- Forrester, Head of Concerns & Business Intelligence
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The review sought to provide assurance that there were effective arrangements and processes in place for the application of the Welsh Government national patient safety incidents reporting policy.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- The incident management framework needs to be reviewed in light of the May 2023 NHS Executive Guidance and HB changes.
- Identification of investigating staff that require Root Cause Analysis (RCA) training.
- Evidence not always in place within Datix to support compliance with the framework.
- Action plan not monitored following submission to the Delivery Unit (DU).
- Some key stages and processes within the incident reporting cycle falling behind expectation and reasonable timelines.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Objectives		Assurance
1	The Incident Management Framework aligns to WG policy and DU guidance.	Reasonable
2	Incidents are identified, captured, investigated, quality assured, approved and responded to.	Reasonable
3	Appropriate actions and learning form events takes place.	Reasonable
4	Monitoring and reporting takes place.	Substantial
5	Incidents are reported within the required timeframes.	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Policy and procedures need to be updated	1	Design	Medium
2	Training required	1	Operation	Medium
3	Evidence to support adherence to the framework to be retained	2	Operation	Medium
4	Outcome from lessons learnt and action plan review	3	Operation	Medium
5	Timeliness of undertaking NRI reviews	5	Operation	High

1. Introduction

1.1 Our audit of the Incident Management Framework was undertaken in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board ('CTMUHB' or 'the Health Board').

1.2 The effective application of appropriate incident management policies and procedures are critical to ensuring both patient safety and operating efficiency of public sector organisations. NHS Wales organisations should maintain policies and procedures setting out the required actions for staff and independent members to follow when they identify a potential risk, or an incident has occurred.

1.3 In June 2021, an NHS Wales National Incident Reporting Policy implementation guidance document (Phase 1) was produced by the NHS Wales Delivery Unit (DU). The document applies to all NHS Wales organisations. The guidance was developed following the issue of the National Patient Safety Incidents Reporting Policy from Welsh Government (WG). The guidance replaces the serious incident section of the Putting Things Right guidance; most notably removing the term 'serious incident' from the policy. The revised approach places a greater focus on maximising learning opportunities at all levels of incident.

1.4 Whilst the DU guidance provides NHS Wales' responsible bodies with the operational detail of how reporting should occur to support implementation of the WG national Incident Reporting Policy, localised procedures are also required. As such, the CTMUHB Incident Management Framework (the 'framework') was launched June 2022. The framework guides staff in making decisions, highlighting the investigation system and future learnings that should be applied to areas within the Health Board.

1.5 The relevant lead for this review was the Executive Director of Nursing, Midwifery & Patient Care.

1.6 The potential risks considered in this review were:

- Non-compliance with relevant legislation.
- Patient harm or poor patient experience.
- Financial loss if action is taken against the Health Board.
- Reputational damage with decreased public confidence.

1.7 Our audit testing has focused on Nationally Reportable Incidents (NRIs) that occurred after April 2022.

2. Detailed Audit Findings

Objective 1: The Health Board has an Incident Management Framework which aligns to the WG policy and Delivery Unit guidance. The framework is accessible to staff and training has taken place where necessary.

2.1 National incident reporting in NHS Wales changed in June 2021, with the production of phase 1 National Patient Safety Incident Reporting Policy by Welsh

Government (WG). Following the publication of the policy, the Delivery Unit (DU) developed guidance for all NHS Wales bodies to use. This was adopted by the Health Board while further work was carried out to establish how it could safely manage the transition and ensure there was a consistency of approach and oversight of incidents meeting the new criteria. In May 2022 the CTMUHB Incident Management Framework was produced, and it was formally launched in June 2022.

2.2 Our review of the Health Board Incident Management Framework found that in the main it aligns to the WG policy and DU guidance. We identified a few areas within the DU guidance that are not clear within the framework, such as setting out the reporting lines into relevant committees and the Board. ***(Matter Arising 1 – Medium Priority)***

2.3 In May 2023, the NHS Wales Executive published a revised National Incident Policy and Guidance document. Due to the timing of our fieldwork, any changes as a result of this revised policy were not included in the current framework. The Health Board framework will need to be reviewed and updated to reflect the revised guidance. ***(Matter Arising 1 – Medium Priority)***

2.4 While the Health Board's intranet includes the Incident Management Framework and associated appendices, the documents are not easily accessible as a 'search' links to a previous version of the framework. This is the same for the 'A-Z listing' within the webpage. ***(Matter Arising 1 – Medium Priority)***

2.5 The central patient safety team have a series of Standard Operating Procedures (SOPs) for use when processing notifications that they receive. These include:

- early warnings notifications SOP;
- locally reportable incidents notification and closures SOP;
- nationally reportable incidents closures SOP; and
- pressure damage combined notification and closure SOP.

A number of the SOPs require updating to reflect the revised operating model in the Health Board, and to remove reference to staff that are no longer in post. ***(Matter Arising 1 – Medium Priority)***

2.6 There are two specific training modules for staff involved with the framework. These are:

- Datix training on how to report an incident within the system – up to three training sessions week were provided when the new system was rolled out and there continues to be weekly training sessions available and training for new users.
- Root Cause Analysis (RCA) training, for managers who undertake investigations of incidents.

2.7 The framework requires that at least one member of an investigation team is RCA trained. We tested a sample of 17 investigations and found for 11 we no member

of the investigations team had undertaken RCA training in the last two years. ***(Matter Arising 2 – Medium Priority)***

2.8 We note that a training needs analysis has been drafted which covers 'Concerns and Incident Reporting awareness' and 'Understanding the process for managing concerns and undertaking RCA training'. Once finalised, management will have a list of staff that require training.

Conclusion:

2.9 The Health Board has a detailed Incident Management Framework in place with supplementary appendices and SOPs. These are based on WG policy and DU guidance. The documents will need to be reviewed to ensure that recent changes to the Health Board's operating model and NHS Wales Executive guidance, are incorporated. The Health Board needs to continue to train staff to ensure compliance with the framework and accurate use of Datix. We have provided ***Reasonable Assurance*** against this objective.

Objective 2: Patient safety incidents are identified and captured, investigated, quality assured, approved and responded to within required timeframes.

2.10 Incidents are logged onto Datix. In April 2022, the Health Board moved to a new Datix system as part of an All-Wales initiative. As a result, incidents that remained open in the old system had to be migrated to the new system.

2.11 When initially logged on Datix incidents are assessed as either: no harm; low harm; moderate harm; severe harm; or death. Investigations into reported incidents are managed by the governance team within each of the former Integrated Locality Groups (ILGs), led by the Heads of Quality & Safety. Depending on the level of harm, staff are allocated responsibility for managing and investigating the incident case. For example, a low harm case is managed by a Ward Manager, while significant cases, whilst still investigated within the localities, will have more involvement from the central patient safety team.

2.12 The central team also has responsibility for:

- forwarding the Nationally Reportable Incidents (NRIs) to the Delivery Unit.
- checking for accuracy, adequacy and completeness of NRI notification forms, though they are not required to undertake any sign off.
- monitoring incidents relating to never events. They are also involved in their investigation.
- attending meetings where teams require support regarding the uniqueness of a reported incident.

2.13 There are a number of stages mapped out in the framework that need to be followed to ensure incidents are captured, investigated, quality assured and approved, with evidence retained in Datix. Actions include completing immediate 'make-safes', where necessary conducting rapid review meetings, completing NRI notification forms and informing the central patient safety team, generating reports and action plans following conclusion of investigations, scrutiny by a quality

assurance panel, Executive approval of a closure bundle of documents and notification to the Delivery Unit.

2.14 Using a report of NRI cases opened between April 2022 and February 2023, we tested a sample of 17 incidents from across Community Services and Surgery, Anaesthetics, Theatres & Critical Care CSG, to confirm the process undertaken in relation to meetings, investigations, approvals and quality review. We saw:

- Evidence of immediate 'make-safe' actions taking place in all cases.
- Lessons learnt and action plans were in place for incidents where the investigation had been completed.
- All pressure damage and fall incidents were reported to the pressure and fall scrutiny panels.
- All NRI forms were approved by the Executive Director, or their deputy.

2.15 However, our testing identified a number of exceptions including a lack of evidence that a rapid review meeting took place where necessary, minutes from the Scrutiny Panel and Quality Assurance Panel meetings not always being present on Datix (though in most cases we could evidence from other sources that the meetings had taken place), and Root Cause Analysis reports were not always present on Datix. Our testing in relation to timeframes has been reported on under objective 5. ***(Matter Arising 3 – Medium Priority)***

Conclusion:

2.16 The Incident Management Framework provides detail on the process to be followed when incidents occur, and our sample testing has confirmed that the process was followed. However, on some occasions documentation or information was not present to support each stage in the process. We have provided ***Reasonable Assurance*** against this objective.

Objective 3: Appropriate actions are undertaken from the 'learning from the event' and 'outcome' reports and learning is shared across the Health Board.

2.17 We have established that a number of mechanisms are in place to allow the sharing of learning across the Health Board.

2.18 On a monthly basis the central patient safety team produces a newsletter providing information such as staff incident related training dates, key patient safety learning and actions, urgent safety briefings and safety alerts. Data in relation to NRIs and LRIs and themes are also included.

2.19 From September 2022 listening and learning events have taken place approximately every six months. We saw that key themes and trends from high profile incidents are discussed.

2.20 Our testing has confirmed that for nearly all completed investigations in our sample, the lessons learnt had been captured, and in all cases, action plans were in place. In most cases we saw evidence of actions being implemented. We note that for the small number of cases where we could not confirm if all actions had

been implemented, this may be due to the incident being closed in Datix ahead of full implementation. We understand that the Health Board has expressed an interest in using the dedicated action plan module available in Datix to allow the ongoing monitoring of action plans. ***(Matter Arising 4 – Medium Priority)***

2.21 A learning repository has been set up on the Health Board's intranet and is accessible to staff. This continues to develop and we understand that lessons learnt will be in one system allowing information to be analysed by theme.

Conclusion:

2.22 The Health Board has in place a number of mechanisms to capture and then share learning from NRIs and wider. The current Datix set up makes it more difficult for action plans relating to NRIs to be followed up and monitored once the incident has been closed in Datix. We have provided ***Reasonable Assurance*** against this objective.

Objective 4: Monitoring (including the identification of themes) and reporting takes place at appropriate forums within the Health Board, with escalation where necessary.

2.23 The Health Board monitors and reports incidents in a number of ways. Every two months a patient safety quality dashboard, is taken to the Health Board's Quality and Safety Committee. Prior to the change in the operating model, the dashboard included appendices provided by each locality. However, now overarching data on the NRIs and Locally Reportable Incidents is presented and granulated information on topics such as pressure damage incidents and falls.

2.24 More locally, each former ILG holds a regular governance meeting, where an incidents tracker is reviewed. Weekly reports analyse incidents by theme, by harms and near misses. In addition, there are weekly meetings between the Heads of Quality and Safety from the localities and the lead for business intelligence. Detailed information on a range of patient safety matters including NRIs is presented along with an 'at a glance' report which provides a visual summary.

2.25 Executive led weekly patient safety meetings are also held, to which issues from the previous weekly meeting are escalated.

2.26 There is a quarterly shared listening & learning forum which is chaired by the Executive Director of Nursing, Midwifery and Patient Care, and includes a director representative from each locality. The forum:

- oversees the Health Board's framework for listening to and learning from quality and patient/staff related concerns and experiences, to ensure it is consistent with the requirements and standards set for NHS bodies in Wales;
- discusses information from the learning and sharing from different parts of the Health Board, internal newsletters and learning from external organisations.

2.27 The DU also generates quarterly dashboards at an all-Wales and Health Board level that includes data on the number of NRIs the Health Board has reported, analysed

across months, severity and location. The purpose of this reporting is to ensure good governance both on the part of the DU, responsible for the national reporting process, and individual organisational governance responsibilities in complying with the published policies and guidance.

Conclusion:

2.28 The Health Board has a structure in place that provides effective mechanisms for monitoring from a localised level up to the Quality and Safety Committee of the Board. The regularity of monitoring at a local level allows for the prompt escalation of cases where necessary. We have provided ***Substantial Assurance*** against this objective.

Objective 5: Relevant incidents, including nationally reportable incidents, are reported within the required timeframes in accordance with the national reporting requirements.

2.29 We analysed the time taken for our sample of 17 incidents to progress through the incident lifecycle. We compared the time taken against the target timeframes set out in the Incident Management Framework. We saw all 'make-safes' were within the first 72-hour target, and all had the investigation phase completed within 12 working days from the date the investigation was started. However, we also saw a number of instances where the time taken to complete some actions, far exceeded the target timeframes. For example, the time taken for an investigation to start once it had been reported, and the time taken for the NRI notification forms to be approved by localities.

2.30 The time taken for incidents to be closed on Datix after the investigation was completed varied considerably, from between 11 days to over one year. The approach to closing incidents on Datix may be inconsistent, as some incidents are closed when all actions related to the action plan have been closed, whilst others were closed on Datix at earlier stages of implementation of the action plan. This links the point raised in paragraph 2.20. ***(Matter Arising 5 – High Priority)***

Conclusion:

2.31 The processes are well defined within the framework. However, the importance of service areas taking a proactive approach to the documentation and timeliness of the incident reporting process is key. Embedding this into training sessions would help mitigate the matters we have identified. While the timeliness of the majority of the incident reporting stages that we tested were appropriate, we identified some stages within the incident reporting process that were longer than the expected and established timelines. We have provided ***Reasonable Assurance*** against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Update of policy and procedures (Design)	**Potential Impact**
The Incident Management Framework was launched June 2022. The new framework and associated documents are on the Health Board's intranet pages but they are not easy to find. We searched for 'incident management' on the intranet, which linked to the previously published incident reporting policy, guidance and investigation documents are found. Similarly, the previous policy is listed in the risk management policy section of the intranet. Furthermore, the A-Z section has an 'Incident Reporting' page, but again links to the old policy. The new framework and guidance can be found in the 'Quality Governance and Patient Safety' section of the A-Z. We are aware that since the Incident Management framework was launched, there have been changes to the operating model, with a move away from Integrated Locality Groups to Care Groups. These changes are yet to be reflected in the policy. Similarly, from our review of the Standard Operating Procedures we note they reference individuals that are no longer in post. The NHS Wales National Incident Reporting Policy Implementation guidance document (Phase 1) sets out the requirement for clear lines of reporting to relevant committees and the Board. Although our review of the monitoring and reporting of incidents has identified that the Board and relevant committees are sighted on this information, the Incident Management Framework does not make reference to how reporting will take place. In May 2023 the NHS Wales Executive published a revised National Incident policy and guidance document. Changes required as a result of this new guidance will need to be captured in any updates to the framework.	Non-compliance with the most relevant legislation. The Health Board received notification of the NHS Executive National Incident updated policy in May 2023. A task and finish group has been implemented to review the Health Boards current Incident Investigation Framework

Recommendations		**Priority**
1.1	Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	**Medium**

1.2	The Incident Management framework should be reviewed and updated where necessary to take account of the Health Boards new operating model, the recently published updated guidance and incorporate information on reporting processes.	**Medium**

Agreed Management Action		Target Date	Responsible Officer
1.1	All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	01.10.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents
1.2	The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of Candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	01.10.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents

Matter Arising 2: Training (Operation)	**Potential Impact**
A training programme is in place covering both Datix training on how to report an incident, and Root Cause Analysis (RCA) training used when investigating incidents. The Incident Management Framework states that at the investigation stage, at least one member of the investigation team must be RCA trained. From the sample of 17 cases reviewed we identified from Datix the name/s of the investigators. In 11/17 cases, we could not confirm that at least one person involved in the investigation had undertaken RCA training in the last 2 years. We acknowledge that some staff have been in post many years and are experienced and may have undertaken training previously. However, there remains a risk that staff who are not fully trained are undertaking investigations. Given WG's revised approached to incident reporting and the HB's revised Incident Management Framework and approach to shared learning, it is important to ensure all staff are fully trained on the most up to date practices and approaches. We are aware from other audit work that a training needs analysis has been drafted. This covers 'Concerns and Incident Reporting awareness' and 'Understanding the process for managing concerns and undertaking RCA training'. It is our understanding that once the training needs analysis is finalised, managers within the Care Groups will be asked to identify the staff in their areas that require training and at what level.	Non-compliance with relevant legislation.

Recommendations		**Priority**
2.1	The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend incident management training and RCA training. As part of the process of identifying staff training needs, consideration should be given to if refresher training on Datix is required.	**Medium**
2.2	In the meantime, it should be ensured that at least one member of the investigation team on cases is RCA trained.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
2.1	A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training Programme established.	01.11.23	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence
2.2	Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.09.23	Clinical Lead for Serious Incidents

Matter Arising 3: Evidence to support adherence to the framework (Operation)	**Potential Impact**
From our analysis of NRIs reported between April 2022 and February 2023, we undertook detailed testing of a sample of 17 cases from Community Services (ten cases) and Surgery, Anaesthetics, Theatres & Critical Care (seven cases). Our testing looked to evidence the key stages in the 'incident lifecycle' including investigation, quality assurance and approval process. As a result of some of our sample being at the different stages within the incident reporting process, some of the tests undertaken were not applicable. The following exceptions from the whole process were made: • 6/10 had no information in relation to the Rapid Review meeting. While we note that in certain circumstances these meetings may not be required, in the six cases identified it was not clear if the meeting was needed. • 2/17 incidents did not have a proposed investigation timeline stated on the NRI notification form. • 9/13 scrutiny panel minutes were not on Datix. However, we confirmed the panel meeting dates from other documentation. It was not clear on what the expectations were to save panel minutes to Datix. • 9/12 quality assurance panel minutes were not on Datix. Again, it was not clear on what the expectations were to save panel minutes to Datix. • 7/11 RCA reports were not on Datix. • 3/10 closed incidents had no Delivery Unit reference number entered on Datix. We also identified that the quality assurance checklist is a key document which highlights information around the tools and approaches used to evidence that incident went through the due process. From our sample of 17 cases the checklist was not always completed adequately. For instance, questions in relation to if investigators were RCA trained, or if investigation analysis tools were used, routinely had a 'yes' response, but no details of the relevant investigator or the tool/s used were not recorded.	Patient harm or poor patient experience.

Recommendations		**Priority**
3.1	Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes:	

	• Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
3.1	Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible Care Group.	01.09.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents

Matter Arising 4: Review of lessons learnt and action plans (Operation)	**Potential Impact**
We tested the same sample of 17 cases to confirm that for completed investigations lessons learnt had been documented and follow up action plans were in place. While all expected action plans were in place, for 3/14 we could not evidence that work had been undertaken to implement actions. Furthermore, it is not clear how subsequent follow up work and documented updates are undertaken on action plans following submission to the DU, at which point all documentation is saved in a PDF format to Datix. We understand that Datix has a module that could be used for capturing action plans and ongoing monitoring. This would allow for more timely closing of cases as opposed to having to wait for the majority of actions to be implemented, yet still allow the action plans to be updated as work to implement them takes place.	Patient harm or poor patient experience. Reputational damage where lessons are not learnt and similar incidents occur.

	Recommendations	**Priority**
4.1	Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the NHS Wales Executive (formerly the DU.)	**Medium**

	Agreed Management Action	**Target Date**	**Responsible Officer**
4.1	Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and upload to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.10.23	Head of Concerns & Business Intelligence

Matter Arising 5: Review of timeframes of incidents reported (Operation)	**Potential Impact**
For our sample of 17 cases we reviewed the time taken to undertake key aspects of the process and compared these to the timeframes set out in the framework. As we note in matter arising 3, due to the stage the case is at in the incident lifecycle, some testing was not relevant to some of the incidents in our sample. Our findings are as follows: • 6/10 had no evidence of a rapid review meeting. For the four where there was evidence, 1/4 was outside the 3-day target. • 2/17 cases the time taken for the incident to be reported after it occurred was 13 and 35 working days. Given that rapid review meetings should take place within 3 days, we would expect the initial reporting of incidents to have taken place timelier in these instances. • 5/16 cases an investigation did not start until more than 17 working days after it was initially reported, with the longest taking over 3 months to start. • 14/16 took longer than the 7 day target to get the NRI notification approved by the ILG. • 5/10 took over 100 working days for the incident to be closed on Datix after it was reported. While there is no target timeframe, the framework requires the investigation team to estimate a timescale for completion, based on the nature and complexity of the incident. In 4/5 of these cases the predicted timescale was 60 working days and in the remaining case the timescale had not been recorded on the notification form. • 9/10 took between one month and one year to close the investigation in Datix after the investigation was completed. The long timeframes for this may be attributed to the fact that some incidents are only closed upon implementation of all actions in their action plans, whereas others are closed irrespective of action plan completion. We also note that the date that 'make-safe' action is taken is not captured in Datix. While we saw this information within other documentation, and confirmed that all actions happened with in the 72-hour timeframe, the lack of a Datix field to capture this information makes it more difficult for the Health Board to monitor compliance with the make-safe target.	Financial loss if action is taken against the Health Board. Reputational damage with decreased public confidence.

Recommendations		Priority
5.1	Management should ensure that incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. Management should review the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce the delays. There should be an agreed mechanism in place for ongoing monitoring and reporting of the key stages within the incident life cycle.	**High**
5.2	In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	**Low**

Agreed Management Action		Target Date	Responsible Officer
5.1	A process for providing and monitoring data in relation to the timescales for reviewing, investigating and closing of incidents on a weekly basis to be established. Information in relation to Incident Management Timescales to be included as part of the Care Group dashboard development work currently being undertaken. The information will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.09.23	Head of Concerns & Business Intelligence
5.2	An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.10.23	Head of Concerns & Business Intelligence

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Internal Audit Action Plan - Concerns Management

Reference	Date added	Matters Arising	Recommendations	Priority
1,1	07.08.23	Update of Policy & Procedure (Design)	Management should ensure all out of date guidance documents are removed from the intranet and only relevant policies and procedures are made available.	Medium
1,2	07.08.23	Policy and Standard Operating Procedures	The Incident Management framework should be reviewed and updated where necessary to take account of the Health Board's new operating model, the recently published updated guidance and incorporate information on reporting processes.	Medium
2,1	07.08.23	Training (Operation)	The draft training needs analysis should be finalised and staff in Care Groups should be requested to identify who needs to attend training incident management and RCA training. As part of the process of identifying staff training needs, consideration should be given if refresher training on Datix is required.	Medium
2,2	07.08.23	Training (Operation)	Linked to recommendation 2.1 development of Training Needs Analysis. In the meantime, it will be ensured that at least one member of the investigation team on cases is RCA trained.	Medium
3,1	07.08.23	Evidence to support adherence to the framework (Operation)	Management should ensure all documentation in relation to NRIs is appropriately completed with relevant documentation saved to Datix. This includes: • Evidence of rapid review meetings taking place or confirmation that one was not required. • NRI forms capturing the proposed investigation timeline which will allow future monitoring and reporting to take place. • The quality assurance checklist recording all relevant information such as who the RCA training investigators are, as opposed to just ticking that someone is RCA trained. • All relevant fields within Datix completed as required. • Copies of the RCA report saved to Datix. • A consistent approach to the saving of panel minutes to Datix, giving consideration to if a panel reviews more than one case, the data protection implications of saving the full set of minutes to individual Datix records.	Medium
4,1	07.08.23	Review of lessons learnt and action plans (Operation)	Further work should be carried out to explore the option of accessing the action plan module in Datix, thus allowing the NRI to be closed in Datix more timely following completion of the investigation, yet still allowing the monitoring of the implementation of actions. Whilst this option is explored, it should be ensured that the action plans saved to Datix are adequately completed with evidence of actions taken to date and if necessary, a process for following up on actions following submission of the paperwork to the DU.	Medium

5,1	07.08.23	Review of timeframes of incidents reported (operation)	Management should ensure that incidents are processed within the expected timeframes as stated in the policy and framework, or within a reasonable timeframe. Management should review the key parts of the process where significant delays are occurring with a view to understanding any reasons behind the delay and revising or refining approaches to help reduce the delays. There should be an agreed mechanism in place for ongoing monitoring and reporting of the key stages within the incident life cycle.	High
5,2	07.08.23	Review of timeframes of incidents reported (operation)	In order to allowing monitoring and ensure compliance with the 72-hour timeline placed in changing the new incident to 'make safe', the make safe date should be captured within Datix.	Low

Agreed Management Action	Target Date	Responsible Officer	Progress
Cross reference to Internal Audit Action Plan for Complaints Management : Recommendation 1.1b All policies and procedures relating to Incident & Concerns Management will be uploaded to SharePoint and previous versions removed.	01.10.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	In progress
The Health Board's Incident Management Framework to be reviewed in line with the recommendation, duty of candour requirements and agreed proposal to remove reference to the Locally Reportable Incident Proforma.	01.10.23	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence	In progress
Cross reference to Internal Audit Action Plan for Complaints Management : Recommendation 3.1 A training strategy to be developed which outlines all levels of training in relation to Incident and Concerns Management for different staff groups across the Health Board. This will include a reference to Datix Cymru requirements. Following approval of the Strategy, a training need analysis will be undertaken and a training programme established.	01.11.23	Clinical Lead for Serious Incidents Head of Concerns & Business Intelligence	In progress
Ensure that a member of the Investigation Team has received the appropriate RCA Training. Remind Care Group Leads of the requirement to include one appropriately RCA trained member in the Investigation Team. Undertake checks during the Quality Assurance Process to confirm the requirement has been fulfilled. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.09.23	Clinical Lead for Serious Incidents	In progress
Reminder to be sent to all Care Groups of the need to ensure that all documentation has been uploaded to Datix Cymru. Datix Cymru Incident Management Training to include the requirement to upload all documentation to Datix Cymru. The quality assurance process will include a check that ensures all required documentation has been uploaded. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.09.23	Head of Concerns & Business Intelligence Clinical Lead for Serious Incidents	In progress
Ensure that all required staff have access to the actions module and appropriate training is provided. This will be linked to the implementation of the revised Incident Management Framework. The quality assurance process will include an assessment to confirm that an action plan has been developed and uploaded to Datix Cymru. The quality assurance checklist will be uploaded to Datix and feedback will be provided to the responsible care group.	01.10.23	Head of Concerns & Business Intelligence	In progress

A process for providing and monitoring data in relation to the timescales for reviewing, investigating and closing of incidents to be on a weekly basis to established. Incident Management Timescales Information to be included as part of the dashboard development work currently being undertaken. The information will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.09.23	Head of Concerns & Business Intelligence	In progress
An audit programme of new, open and closed incidents to be implemented to ensure that all required fields are completed in the required timescales. Feedback from the audits will be presented to the Care Group Quality & Governance Meetings and the Weekly Patient Safety Executive Meeting.	01.10.23	Head of Concerns & Business Intelligence	In progress

Update

Agenda Item
9.2.10

Quality & Safety Committee

A National Review of Consent to Examination & Treatment Standards in NHS Wales – Final Welsh Risk Pool Report

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kevin Conway, Consent Lead
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
PSCF	Procedure Specific Consent Form
ESR	Electronic Staff Record

1. Situation /Background

1.1 A National Review of Consent to Examination & Treatment Standards in NHS Wales has taken place and the report was published in March 2023. (Appendix 1 – available on request)

1.2 The clinical areas selected for the focus of the assessment were Unscheduled Orthopaedics, Elective Endoscopy, and Elective Gynaecology.

1.3 The purpose of this report is to provide assurance to the committee that the Health Board is taking action to improve on the areas with partial compliance.

2. Specific Matters for Consideration

2.1 CTMUHB were found to be **compliant** for the following standards:

- Policy Content
- Consent Process for Adults
- Consent Process for Children & Young People

2.2 CTMUHB were found to be **partially compliant** for the following standards:

- Consent forms
- Training in Consent
- Patient Information
- Monitoring of the Consent Process

3. Key Risks / Matters for Escalation

3.1 A Peer Review Audit of the Consent to Examination and Treatment Processes was carried out in April 2023, as instructed by Welsh Risk Pool. Plans are in place to repeat this on a recurring annual basis. (Appendix 2 – available on request)

3.2 The CTMUHB Consent Working Group has developed a formal documented Governance process for the development and approval of Procedure Specific Consent Forms. (Appendix 3 – available on request)

3.3 The CTMUHB Consent Working Group are developing a repository of Procedure Specific Consent Forms on SharePoint. The CTMUB Consent Working Group have approved three Health Board PSCFs based on advice from the All Wales Consent to Examination & Treatment Group.

3.4 The CTMUHB Consent Working Group continues to provide training to all appropriate staff groups. (Appendix 4 – available on request)

3.5 The CTMUHB Consent Working Group has disseminated links for Consent to Treatment information and training, including the new All-Wales E-Learning for Consent to Examination and Treatment on ESR.

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 *(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: This is an overarching update 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 update 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 contents of this report and the activity underway to improve compliance with NHS Wales Consent to Examination & Treatment Standards.

6. Next Steps

6.1 In line with the direction from Welsh Risk Pool and the All Wales Consent to Examination & Treatment Group, the CTMUHB Consent Working Group are redrafting the Health Board's consent policy.

6.2 The CTMUHB Consent Working Group are collaborating with the CTMUHB Safeguarding team to host a joint Consent/Capacity Assessment resource on SharePoint.

7. Appendices (available on request)

Links

- Launch of NHS Wales E-learning for Consent to Examination and Treatment
- WRP E-learning and Webinars on Consent
- GMC Decision Making & Consent
- ESR login

- CTM Intranet Safeguarding and Capacity Resources
- All Wales Consent to Treatment Policy

Agenda Item
9.2.11

Quality & Safety Committee

Public Services Ombudsman for Wales Groundhog Day 2: An opportunity for cultural change in Complaints Handling?

Dyddiad y Cyfarfod / Date of Meeting	21/09/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester Head of Concerns & Business Intelligence
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**
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
PSOW	Public Services Ombudsman for Wales
CTM	Cwm Taf Morgannwg
UHB	University Health Board
OCP	Organisational Change Policy

1. Situation /Background

In March 2017, the PSOW published the report 'Ending Groundhog Day: Lessons from Poor Complaint Handling. As a follow up to this report, in June 2023 the PSOW issued Groundhog Day 2: An opportunity for culture change in complaint handling? A copy of the report can be found on the PSOW website (via this link).

This is the first report issued by the new Ombudsman, Michelle Morris who in her foreword, highlights that many of the lessons identified in the first report remain relevant today.

2. Specific Matters for Consideration

The report places a focus on using complaints as an opportunity for learning, ensuring rigorous investigations are undertaken and robust complaint handling is in place.

The key themes and trends detailed in the report are summarised below:

- A lack of openness and Candour – clear evidence of maladministration or service failure not identified during local investigations
    - This suggests that there is a need for a cultural change for staff investigating complaints within NHS Wales.
- A lack of objective review of clinical care and treatment
    - Failings are not identified as part of the local peer review, however PSOW clinical advisor's views (failings) and recommendations are subsequently accepted.
    - Individual Clinicians who delivered care are involved in complaints responses.
    - It should be noted that a CTM UHB public interest report was cited as an example here.
- Importance of timeliness and good communications
    - Health Boards should understand the importance of meeting PTR guidelines.
    - Complainants should be kept well informed throughout the process.
- Acting fairly and proportionately – the need for robust investigations

- A reasoned explanation should be provided, which clearly outlines why a decision has been made and the facts that a conclusion was based on.
- When responding to a complaint, evidence from the complainant and comments from staff involved in delivering the care should be considered.

3. Key Risks / Matters for Escalation

The report concluded with a number of recommendations. These are summarised below, along with the action being undertaken by the Health Board to address the recommendation:

- Report is shared with the Health Board's Quality & Safety Committee
  The report is being shared at the Quality & Safety Committee on the 21.09.23.
- Review the resources available to complaints teams in the Health Board.
  As part of the transition to the new operating model within the Organisation, a review of the Quality & Safety Governance arrangements were undertaken. This included mapping out the resources required to manage complaints effectively within the Health Board.
  Following a period of consultation, an OCP process was completed which resulted in the centralisation of the Complaints functionality. Within the team, the case load is allocated to specific members based on Care Group (akin to a business partner model).
  This is regularly reviewed to ensure that case load allocation is maintained at a level that enables appropriate support to be provided to the Care Groups that facilitates thorough investigation and detailed quality assurance processes.

- Consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis

  All complaints are triaged and scoped on receipt into the Health Board. This includes determining if independent internal or external medical advice is required. This is subject to constant review throughout the management of the complaint. In addition to this, all complaints are subject to a thorough quality assurance process which provides a level of independence outside of the immediate clinical area.
- Reflect the lessons highlighted in this report when scrutinising their performance on complaint handling

  Following centralisation of the complaints functionality, a review of all policies and procedures associated with the management of complaints was undertaken. In addition to the learning from this report, all upheld PSOW reports are reviewed, procedures updated where required and learning shared via the Complaints Team daily huddle.

  Monitoring of complaint handling is undertaken via a number of mechanisms including the Quality and Safety Dashboard and the Weekly Executive Quality and Patient Safety Meeting.
- Ensure that lessons learned from the PSOW's findings and recommendations are included in the Health Board's annual report on the Duty of Candour and Quality

  Information relating to PSOW cases is included in the Quality and Safety Dashboard and the Concerns Management Annual Report.

  It will also be included in the Duty of Candour and Quality 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))*	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: Learning from complaints and PSOW cases is essential to inform improvements in quality, safety and experience.	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:	If no, please include rationale below: Report is a national report that applies to everyone
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	The PSOW report is within the Public Domain and contains details regarding complaints management within the Health Board.	
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

The Committee is asked to **NOTE** the contents of the report and the actions being undertaken to address the recommendations in relation to complaints management

6. Next Steps

Continue to monitor PSOW activity via the quality & safety dashboard, with key issues escalated to the weekly Quality & Safety Executive Meeting as required.