Quality & Safety Committee

Wed 24 May 2023, 09:00 - 12:00

Virtually via Microsoft Teams

Agenda

09:00 - 09:05
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

1.2. Apologies for Absence

Information *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

1.3. Declarations of Interest

Information *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

09:05 - 09:50
45 min

2. SHARED LISTENING & LEARNING

2.1. Listening & Learning Story - Neonatal Services

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

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

2.2 Spotlight Presentation on Cancer QSC 24 May 2023.pdf (12 pages)

2.3. Care Group Spotlight Presentation - Primary & Community Care

Discussion *Ana Llewellyn, Care Group Nurse Director*

2.3a Primary Care Communities report (003) (003) QSC 24 May 2023.pdf (17 pages)
2.3b Primary & Community Care Group Spotlight Presentation QSC 24 May 2023.pdf (15 pages)

09:50 - 09:55
5 min

3. CONSENT AGENDA

3.1. FOR APPROVAL

3.1.1. Unconfirmed Minutes of the meeting held on 16 March 2023

Decision *Jayne Sadgrove/Vice Chair/Chair of the Quality & Safety Committee*

3.1.1 Unconfirmed Minutes QSC 16 March 2023 Final QSC 24 May 2023.pdf (18 pages)

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

Decision *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

3.1.2 Unconfirmed In Committee Minutes QSC 27 March 2023 Final QSC 24 May 2023.pdf (3 pages)

3.1.3. Quality & Safety Committee Annual Report

Decision *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

- 3.1.3a Quality and Safety Committee Annual Report 24 May 2023.pdf (2 pages)
- 3.1.3b Appendix 1 Quality Safety Committee Annual Report 2022 to 2023 QSC 24 May 2023.pdf (11 pages)

3.1.4. Ratification of Urgent Committee Chairs Action - Policy Approval

Decision *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

- 3.1.4a Request for Ratification of UCA Policy Approval QSC 24 May 2023 v2.pdf (3 pages)
- 3.1.4b PATH 02 (CPWG approved 20th March 2023) QSC 24 May 2023.pdf (43 pages)

3.1.5. All Wales Model Policy for Consent to Examination for Treatment

Decision *Dom Hurford, Executive Medical Director*

- 3.1.5a Policy Approval Cover Paper - Consent Policy QSC 24 May 2023.pdf (3 pages)
- 3.1.5b Consent Policy-New Template-Revised+Updated 25 April 2023 QSC 24 May 2023.pdf (118 pages)

3.1.6. Policy for the provision of Intraoperative Cell Salvage

Decision *Dom Hurford, Executive Medical Director*

- 3.1.6a Policy Approval Cover Paper - Intraoperative Cell Savage QSC 24 May 2023.pdf (4 pages)
- 3.1.6b Policy for the provision of Intraoperative Cell Salvage March 2023 amended QSC 24 May 2023.pdf (42 pages)

3.2. FOR NOTING

3.2.1. Action Log

Information *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

- 3.2.1 Action Log QSC 24 May 2023.pdf (8 pages)

3.2.2. Annual Cycle of Business

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

- 3.2.2a Committee Cycle of Business - Cover Paper QSC 24 May 2023.pdf (2 pages)
- 3.2.2b Quality Safety Committee Cycle of Business QSC 24 May 2023.pdf (4 pages)

3.2.3. Forward Work Programme

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

- 3.2.3 Quality & Safety Committee Forward Work Programme QSC 24 May 2023.pdf (4 pages)

3.2.4. Human Tissue Act Progress Report

Information *Dom Hurford, Medical Director*

- 3.2.4a Human Tissue Act Progress Report QSC 24 May 2023.pdf (8 pages)
- 3.2.4b Appendix 1 HTA-TEM-017 Post Mortem inspection report template QSC 24 May 2023.pdf (12 pages)
- 3.2.4c Appendix 2 HTA Report QSC 24 May 2023.pdf (3 pages)

3.2.5. WHSSC Quality & Patient Safety Committee Chairs Report

Information *Dilys Jouvenat, Independent Member*

- 3.2.5a WHSSC QPSC Chairs report QSC 24 May 2023.pdf (10 pages)
- 3.2.5b WHSSC QPSC Chairs report 18 April 2023 QSC 24 May 2023.pdf (32 pages)

3.2.6. Infection, Prevention & Control End of Year Update

Information *Greg Dix, Director of Nursing*

- 3.2.6 IPC Highlight Report end of year position QSC 24 May 2023.pdf (4 pages)

3.2.7. Quality Governance – Regulatory Review Recommendations and Progress Updates

Information *Greg Dix, Director of Nursing*

3.2.7 HIW regulatory report-May 23-Approved FINAL QSC 24 May 2023.pdf (7 pages)

3.2.8. Cancer Services Annual Report

Information *Dom Hurford, Medical Director*

3.2.8 Cancer Services Annual Report QSC 24 May 2023.pdf (12 pages)

3.2.9. RADAR Committee Highlight Report

Information *Dom Hurford, Medical Director*

3.2.9 RADAR Committee Report QSC 24 May 2023.pdf (23 pages)

09:55 - 10:00
5 min

4. MAIN AGENDA

4.1. Matters Arising Not Contained within the Action Log

Discussion *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

10:00 - 10:10
10 min

5. GOVERNANCE

5.1. Organisational Risk Register – Risks Assigned to Quality & Safety Committee

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

5.1a Organisational Risk Register - May 2023 - QSC.pdf (5 pages)
5.1b Appendix 1 - Master Organisational Risk Register - Post ELG Approval.pdf (10 pages)

5.2. Healthcare Inspectorate Wales Action Plan Tracker - Prototype

Discussion *Greg Dix, Director of Nursing*

5.2 HIW New Prototype tracker-May 2023-Final Approved QSC 24 May 2023.pdf (6 pages)

10:10 - 11:50
100 min

6. IMPROVING CARE

6.1. Maternity & Neonates Services Improvement Programme

Discussion *Greg Dix/Director of Nursing/Sallie Davies, Deputy Medical Director*

6.1a Programme Highlight Report - FINAL Board 24.5.23 QSC 24 May 2023.pdf (13 pages)
6.1b Maternity PREM 2022 Report - QSC 24 May 2023.pdf (5 pages)

6.2. Ty Llidiard Progress Report

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

6.2 Ty Llidiard QSC 24 May 2023.pdf (11 pages)

6.3. Mental Health In-Patient Improvement Progress Report

Discussion *Ana Llewellyn, Care Group Nurse Director*

6.3 MHLD HIW Inspections QSC 24 May 2023.pdf (10 pages)

6.4. Quality Dashboard Report

Discussion *Greg Dix, Director of Nursing*

- 6.4a Quality Dashboard Report QSC 24 May 2023.pdf (24 pages)
- 6.4b Delivery Unit Compliance summary Alerts QSC 24 May 2023.pdf (2 pages)
- 6.4c Delivery Unit Compliance summary Notices QSC 24 May 2023.pdf (4 pages)

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

Discussion *Richard Hughes, Deputy Director of Nursing*

- 6.4.1 ED Spotlight Report Falls and Pressure Ulcers QSC 24 May 2023 v1.1.pdf (24 pages)

6.4.2. Lessons Learnt - Learning and actions following a death in Maesteg Hospital

Discussion *Richard Hughes, Deputy Director of Nursing*

- 6.4.2 Lessons Learnt Maesteg Incident QSC 24 May 2023.pdf (5 pages)

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

Discussion *Greg Dix, Director of Nursing*

- 6.4.3 Executive Director Independent Members Walkrounds-Jan-March 23 QSC 24 May 2023.pdf (9 pages)

6.5. Care Group Highlight Reports

Discussion *Care Group Nurse Director Leads*

- Planned Care
- Unscheduled Care
- Mental Health & Learning Disabilities
- Children & Families
- Diagnostics, Therapies, Pharmacy and Specialities

- 6.5a Planned Care QSRE Highlight Report May 23 (final) QSC 24 May 2023.pdf (3 pages)
- 6.5a Appendix 1 Planned Care Highlight Report QSC 24 May 2023.pdf (1 pages)
- 6.5b Highlight Report USC May 2023 QSC 24 May 2023.pdf (6 pages)
- 6.5c MHLD Highlight Report QSC 24 May 2023.pdf (5 pages)
- 6.5d Children and Families Care Group Highlight Report QSC 24 May 2023.pdf (6 pages)
- 6.5d APPENDIX A - Maternity Neonates Assurance Framework QSC 24 May 2023.pdf (2 pages)
- 6.5e DTPS QSRE Highlight Report QSC 24 May 2023.pdf (5 pages)

6.6. Report from the Chief Operating Officer

Discussion *Gethin Hughes, Chief Operating Officer*

- 6.6 COO's Report on Overarching Issues QSC 24 May 2023.pdf (9 pages)

6.7. Learning From Events Backlog – Progress Report

Discussion *Greg Dix, Director of Nursing*

- 6.7 Learning From Events Report QSC 24 May 2023.pdf (4 pages)

6.8. Development of a CTM Allied Health Professionals & Healthcare Science Strategy

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

- 6.8 CTM AHP HCS Delivery Plan QSC 24 May 2023.pdf (5 pages)

11:50 - 11:55
5 min

7. ANY OTHER BUSINESS

7.1. Highlight Report to Board - Verbal

Information *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

7.2. How Did we do in this meeting

Discussion *Jayne Sadgrove, Vice Chair/Chair of the Quality & Safety Committee*

11:55 - 12:00
5 min

8. DATE AND TIME OF NEXT MEETING - TUESDAY 18 JULY AT 9:00AM

12:00 - 12:00
0 min

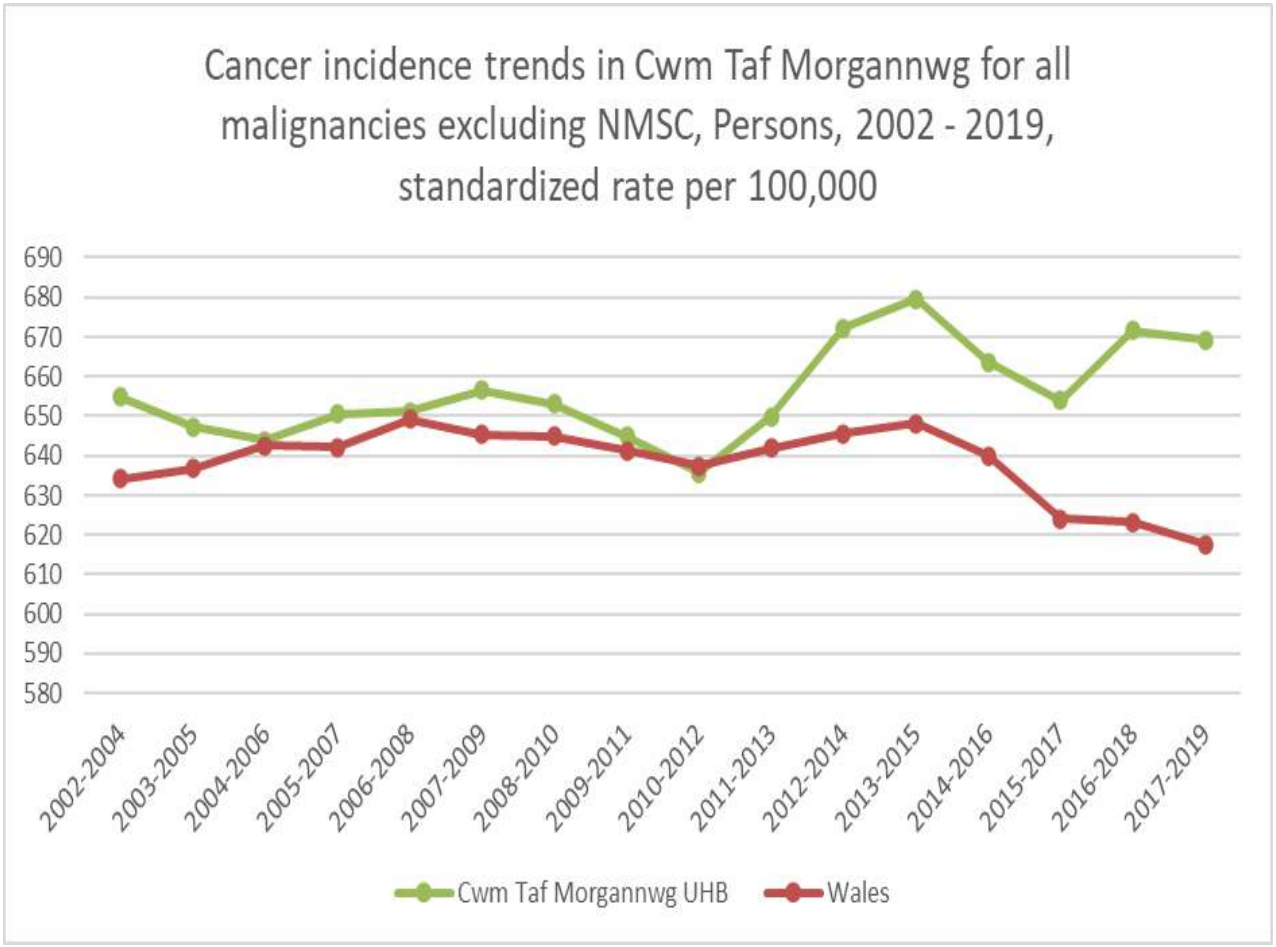
9. CLOSE OF MEETING

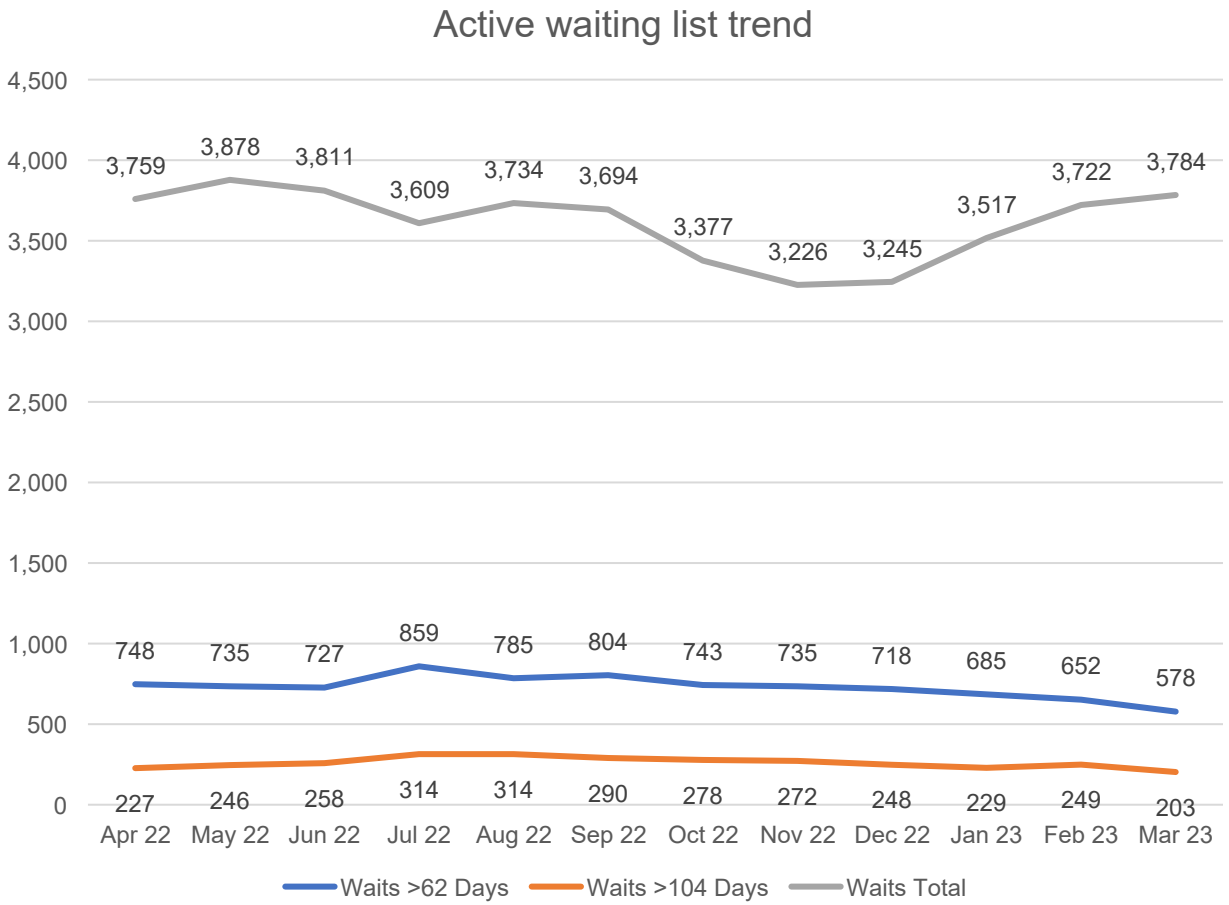
(Agenda item)	24/05/2023	Quality and safety committee	Spotlight on cancer

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Dawn Casey
Presented By:	Dawn Casey
Approving Executive Sponsor:	Greg Padmore Dix
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	Not applicable

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	As outlined in the presentation
Related Health and Care Standard	Governance
Has an EQIA been undertaken?	No this is an overview of current activity
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Improving Care

Current cancer performance





Potential impact of longer waits

- People decompensate and become too poorly for optimal treatment
  - Potential poorer outcomes and/or poorer quality of life for individual
  - Increase cost to NHS/pressure on workforce
  - Increase complaints

- Very anxious time for patient

Supporting people through the pathway; assessment and monitoring

- Holistic needs assessments
- Breach reports
- Cancer harm reviews
- Peer reviews/national audits
- National and local patient experience surveys and focus groups
- Quality assurance framework

Highlights from the WCPES 2023

Q61. Overall how would you rate your care?

Responses for Cwm Taf Morgannwg

0	3	0%
1	4	0%
2	3	0%
3	5	1%
4	11	1%
5	22	3%
6	23	3%

8.75
overall rating of care

Health Board Comparison

Health Board Average	5,848	9
Cardiff and Vale	875	9
Aneurin Bevan	1,164	9
Cwm Taf Morgannwg	840	9
Swansea Bay	708	9
Hywel Dda	855	9
Betsi Cadwaladr	1,313	9
Powys	93	8

Any healthboard with a low base will be hidden in this chart

Scores Over Time - Cwm Taf Morgannwg

-0.15
Change 2016-2021

Directly comparable

Qualitative feedback;

I have had and continue to receive the best care and attention anyone could ask for. I will be forever grateful".

"I was pleased with the care I have received. The staff who I have been involved with have made the situation as easy as possible for me."

"The only real issue was with initial diagnosis. The GP sent me for an MRI but some admin breakdown meant it was lost. It was only arranged when I chased it up, some three months were lost due to this."

"My spouse was with me during all visits. At our initial appointment a key worker was present and we were given a card. However they was based in two hospitals and contacting them was not easy. We tried once and left a message, but received no response. Fortunately we had no further need to contact them. You probably could use more staff!"

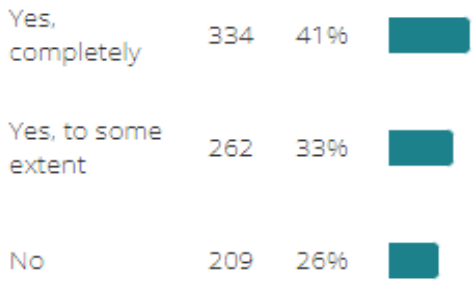
Supporting people through the pathway; action

- Holistic Needs assessments + Key worker
- Band 4 support
- Information and support Service
- Welfare benefits advice service
- Clinical psychologist + third sector counselling offers + mindfulness

Information and support

– Q29. Did your healthcare team discuss with you or give you information about the impact cancer could have on your day to day activities (for example, your work life or education)?

Responses for Cwm Taf Morgannwg

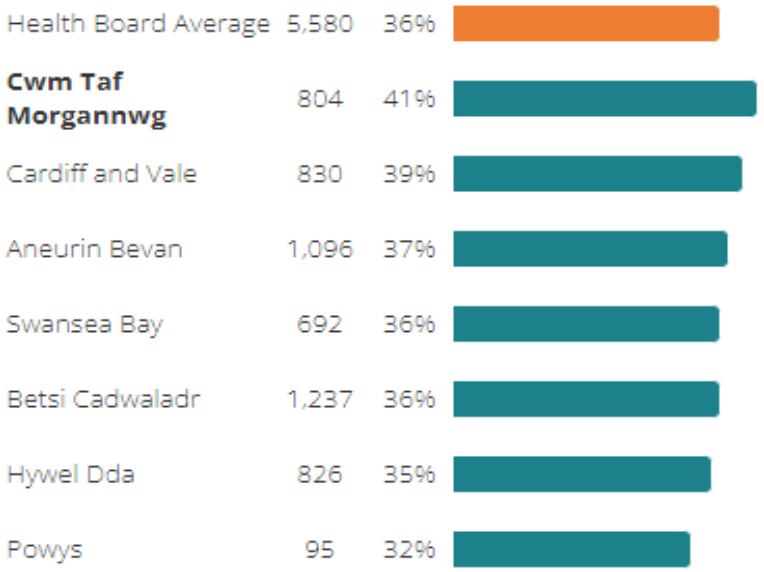


41%

of respondents agreed completely that they had a discussion, or were given information about the impact cancer could have on their day to day activities

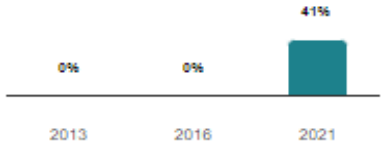
Results above based on 805 responses. Those answering "Don't know / can't remember" (69) excluded from base size/percentage calculation. 874

Health Board Comparison



Any healthboard with a low base will be hidden in this chart

Scores Over Time - Cwm Taf Morgannwg



n/a

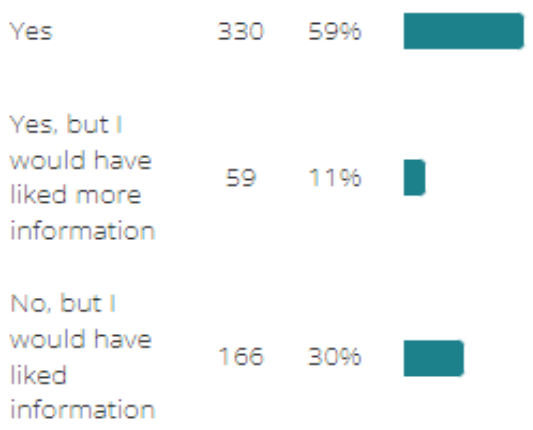
Change 2016-2021

Not comparable

Financial support

– Q30. Did your healthcare team give you information about how to get financial help or any benefits you might be entitled to?

Responses for Cwm Taf Morgannwg

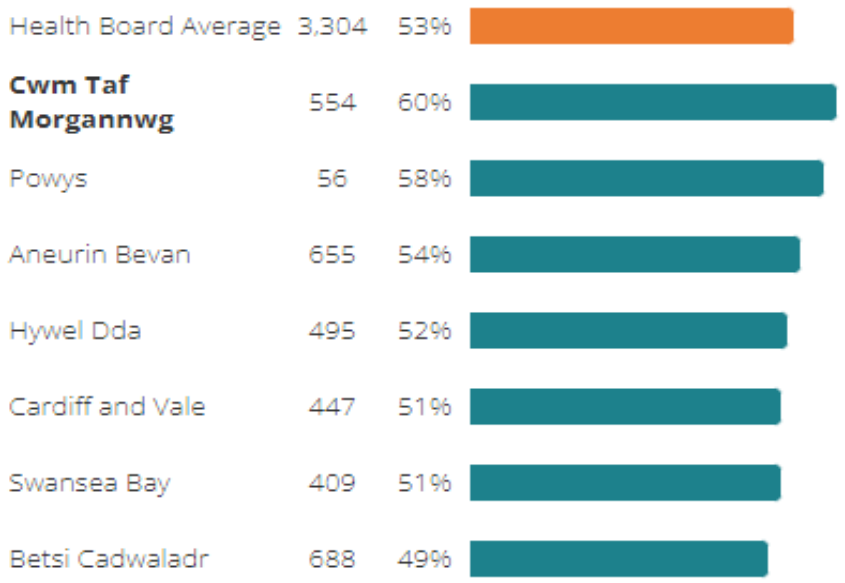


59%

of respondents said they were given enough information on how to get financial support or any benefits they were entitled to

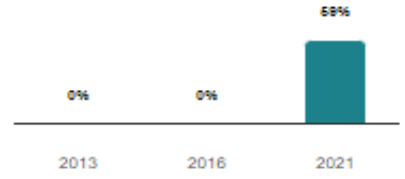
Results above based on 555 responses. Those answering "It was not necessary" (280), "Don't know / can't remember" (40) excluded from base size/percentage calculation. 875 responses in total.

Health Board Comparison



Any healthboard with a low base will be hidden in this chart

Scores Over Time - Cwm Taf Morgannwg



n/a

Change 2016-2021

Not comparable

Supporting people through the pathway; action

- New Teenage and Young adult outreach service
- New Malignancy of Unknown Origin/Cancer of Unknown Primary out reach service
- New Hepatacellular carcinoma outreach service
- Macmillan and coalfields regeneration project
- Tenovus call back (post treatment and while waiting)
- 3 Ps
- Building internet site

Challenges

- Large numbers of waiting well
- Literacy/digital literacy/individual requirements
- Developing the prehabilitation offer locally
- Cancer harm reviews in the new structure
- Reinstating the cancer patient experience surveys on line (Civica)

Recommendation:	The Board or Committee are asked to: Note the summary of current activity and the identified challenges

AGENDA ITEM
2.3

QUALITY & SAFETY COMMITTEE

PRIMARY CARE AND COMMUNITY CARE GROUP

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lucie Williams Head of nursing Primary care, RTE and Bridgend Communities Fiona Wood, Head of Nursing, Merthyr/Cynon Primary Care & Communities Jane Armstrong, Clinical Director, Primary & Community Care
Presented by	Ana Llewellyn, Care Group Nurse Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
ACT	Acute Clinical Team, Bridgend
AMaT	Audit Management and Tracking System
ANTT	Aseptic Non Touch Technique
ANP	Advanced Nurse Practitioner
BBV	Blood Borne Virus
BBE	Bare Below the Elbow
BBHS	Bladder & Bowel Health Service
CAPU	Community Acquired Pressure Ulcers
COSHH	Control of Substances Hazardous to Health
COVER	Coverage of Vaccination Evaluation Rapidly
CVCs	Community Vaccination Centres
CLiP	Clinical Learning in Practice
DHCW	Digital Health and Care Wales
DN	District Nursing
DNS	Diabetes Nurse Specialist
D2RA	Discharge to Recover and Assess
EoLC	End of Life Care
ETR	Electronic Test Request
GA	General Anaesthetic
GDS	General Dental Services
GMS	General Medical Services
HH	Hand Hygiene
HCSW	Health Care Support Worker
HoNs	Heads of Nursing
HES	Hospital Eye Service
HMP	His Majesty's Prison
IPC	Infection Prevention and Control

LoS	Length of Stay
OOH	Out of Hours
OGEP	On the Ground Education Programme
PCC	Primary Care & Communities
POWH	Princess of Wales Hospital
PPV	Post Payment Verification
QIP	Quality Improvement Project
RN	Registered Nurse
RTE	Rhondda Taf Ely
SCD	Special Care Dentistry
SNS	Specialist Nursing Services
TEPs	Treatment Escalation Plans
UDA	Unit of Dental Activity
UHW	University Hospital of Wales
UPCC	Urgent Primary Care Centre
USW	University of South Wales
VBHC	Value Based Health Care
WCP	Welsh Clinical Portal
WLOC	Welsh Levels of Care
YBN	Y Bwthyn Newydd
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon

1. SITUATION/BACKGROUND

1.1 The Health Board's Quality and Patient Safety Governance Framework provides clear guidance related to the type of information, data and analysis required to triangulate and help inform decision making in relation to care and service delivery.

This report had been prepared to provide the Committee with details of the key issues considered by the Primary and Communities Care Group, provided within Cwm Taf Morgannwg University Health Board. The data used to inform this report has been sourced from the DATIX Risk Management system and

the Care Group's governance team. The time period included in the report is from 1st March 2023- 31st March 2023.

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

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

2.1. The development of a governance dashboard to enable each service area to identify and understand all governance issues and being able to triangulate each area collaboratively.

2.2. The RN workforce remains an issue, particularly in YCC where there are a number of vacant RN posts coupled with sickness absence. The nursing leadership team are exploring alternative options including overseas recruitment, and pre-registration workforce development initiatives (links made with USW to increase student nurse placements throughout nurse training). A streamlining event is in the process of being arranged for YCR & YCC.

2.3. The medical staffing model in YCC continues to present a challenge and whilst a number of interim solutions have been implemented, a permanent solution is required.

3. QUALITY AND PATIENT SAFETY GOVERNANCE FRAMEWORK

3.1. The PCC Care Group Quality, Safety, Risk and Patient Experience meetings are in place to be held bi-monthly which is attended by a wide representation of all services within the CSG, supported by the Senior Quality and Safety manager.

3.2. The IPC team are engaged with regularly and monitor any IPC related issues on site. This is done in conjunction with Estates and Facilities where required.

3.3. There are multiple quality initiatives being undertaken within each service within the care group, all of which are progressing as planned. This includes but is not limited to the implementation of the Band 4 workforce across District Nursing communities, introduction of the OneList App, implementation of the D2RA pathways, and the Orizon Digital Technology pilot study.

3.4. The Senior Nurses for Community Hospitals continue to undertake daily Safe2Start meetings with ward managers to ensure safety is maintained across site for all wards. This S2S process has evolved and is an adapted version of the same process in the acute site, and has been particularly valuable in informing the efficient use of resources across site to share any workforce related risks across site. Additionally, the DN service is in the process of piloting a weekly S2S safety huddle to undertake demand and capacity planning for the week ahead.

3.5. Daily PSAG board rounds have been through a period of evolution with some minor changes to operational function (change of time, introduction of a format for discussion) which have helped the flow processes in YCC and YCR. The board rounds are undergoing a process of review and refinement so that they are providing value to the MDT.

3.6. Governance process to be mapped and framework to be implemented for HMP Parc Prison.

3.7. Governance framework to be implemented for the Discharge Areas managed by the Band 3 HCSWs within YCC.

4. QUALITY ASSURANCE

4.1. CLINICAL INCIDENTS

The number of open clinical incidents have increased on the new Datix system. Our Senior Nursing team are working closely with their team leaders and ward managers with working towards timely investigation and progress of open incidents, with support from our patient safety team. The number of clinical incidents closed across Communities has increased each month, which provides assurances of timely investigation. Further work is required to support timely investigation particularly given Duty of Candour.

The primary category of incidents for Community Hospitals are falls and the primary category for District Nursing is pressure ulcers. Pressure Ulcer scrutiny panels remain a weekly occurrence for District Nursing due to the high number of PU reports incidents. Falls MDT scrutiny panels are arranged when appropriate.

Over the last 2 months, there has been two avoidable pressure ulcers and no avoidable falls.

Communities incidents

Incidents	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Number of Incidents Reported	315	319	338	341	337	318	386	229	290	270	326	289
Total Patient Safety	292	302	325	324	313	298	372	214	267	248	322	270
No Harm	40	48	48	52	67	43	60	46	53	40	55	36
Low	169	175	163	183	161	164	206	108	136	128	196	163
Moderate	81	75	104	85	82	86	104	60	71	77	57	109
Severe	2	2	6	4	3	4	2	0	4	2	4	4
Death	0	2	4	0	0	1	0	0	1	1	0	0
Total Non-Patient	12	13	8	14	21	17	9	9	18	15	13	16
No Harm	2	5	2	6	8	3	5	4	5	3	5	5
Low	7	7	4	5	10	13	3	2	9	9	6	8
Moderate	3	1	1	3	3	1	1	2	3	3	3	3
Severe	0	0	1	0	0	0	0	1	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total Organisational Incidents	11	4	5	3	3	3	5	6	6	7	1	3
No Harm	6	4	3	1	1	1	2	2	1	2	0	2
Low	1	0	1	2	2	1	2	1	5	4	1	0
Moderate	3	0	1	0	0	1	1	3	0	1	0	1
Severe	1	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Open Incidents on Legacy System	152	79	60	6	6	6	6	6	6	6	6	6
Total Number of Open Incidents on DCIQ System	319	412	529	569	427	650	667	433	737	625	744	664
New Incident	86	99	74	112	94	140	112	107	136	71	141	71
Management review/Make it safe plus	28	54	122	160	116	166	169	152	161	143	113	132
Under Investigation	108	124	169	143	92	174	186	57	282	275	276	240
Awaiting Closure	97	135	164	154	125	170	200	117	158	136	214	221
Closed	152	324	630	938	1559	1729	1830	1496	2605	2710	3089	3034

Primary Care Incidents

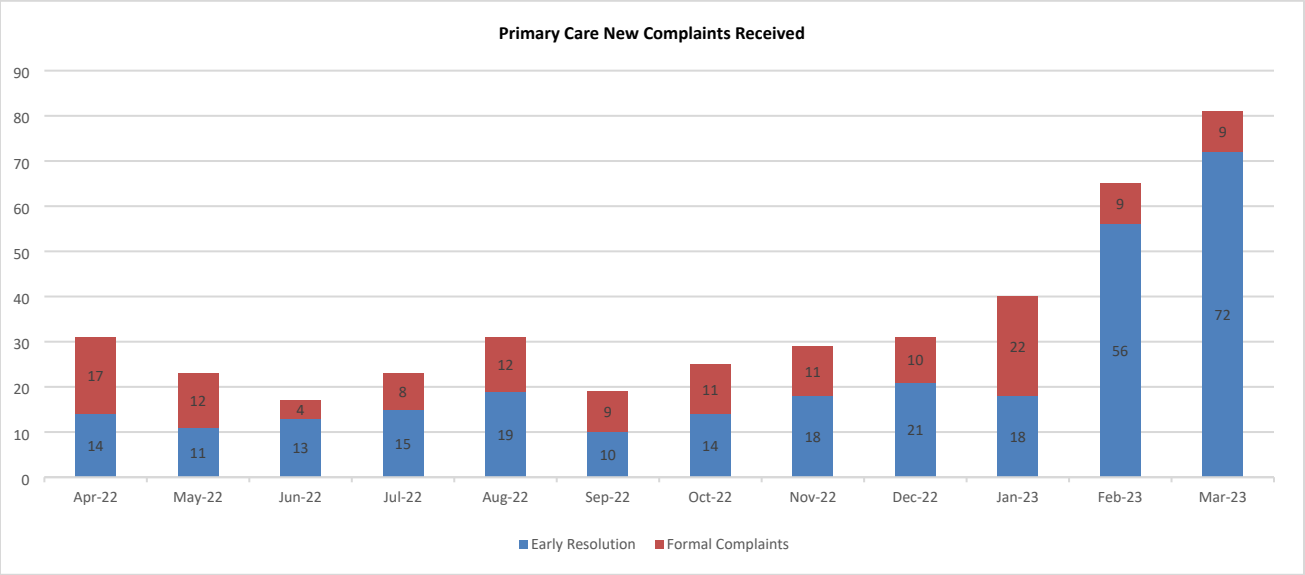
Incidents	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Number of Incidents Reported	4	9	9	12	3	9	25	23	22	22	22	30
Total Patient Safety	2	6	6	10	2	7	19	16	18	17	17	23
No Harm	0	2	0	6	2	4	9	10	8	9	11	8
Low	1	3	2	2	0	3	8	2	5	6	6	5

Moderate	0	1	2	0	0	0	2	3	3	2	0	8
Severe	1	0	1	2	0	0	0	0	0	0	0	0
Death	0	0	1	0	0	0	0	1	2	0	0	2
Total Non-Patient	1	2	2	2	0	1	5	5	2	1	5	5
No Harm	1	1	1	1	1	1	4	2	0	0	1	1
Low	0	1	1	1	0	0	0	2	2	4	2	1
Moderate	0	0	0	0	1	0	1	1	2	0	2	3
Severe	0	0	0	0	0	0	0	0	2	0	0	0
Death	0	0	0	0	0	0	0	0	2	0	0	0
Total Organisational Incidents	1	1	1	0	1	1	1	2	2	1	0	2
No Harm	0	1	1	0	1	1	1	1	2	1	0	0
Low	1	0	0	0	0	0	0	1	0	0	0	2
Moderate	0	0	0	0	0	0	0	0	0	0	0	0
Severe	0	0	0	0	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of Open Incidents on Legacy System	151	83	48	33	6	3	3	3	3	3	3	0
Total Number of Open Incidents on DCIQ System	6	15	23	31	35	59	68	79	127	115	139	160
New Incident	1	4	8	12	14	35	40	49	57	62	76	81
Management review/Make it safe plus	0	1	2	2	3	3	3	3	5	3	4	4
Under Investigation	2	3	4	5	5	6	8	6	7	13	13	16
Awaiting Closure	3	7	9	12	13	15	17	21	33	37	46	59
Closed	0	2	3	4	8	10	14	17	25	28	37	45

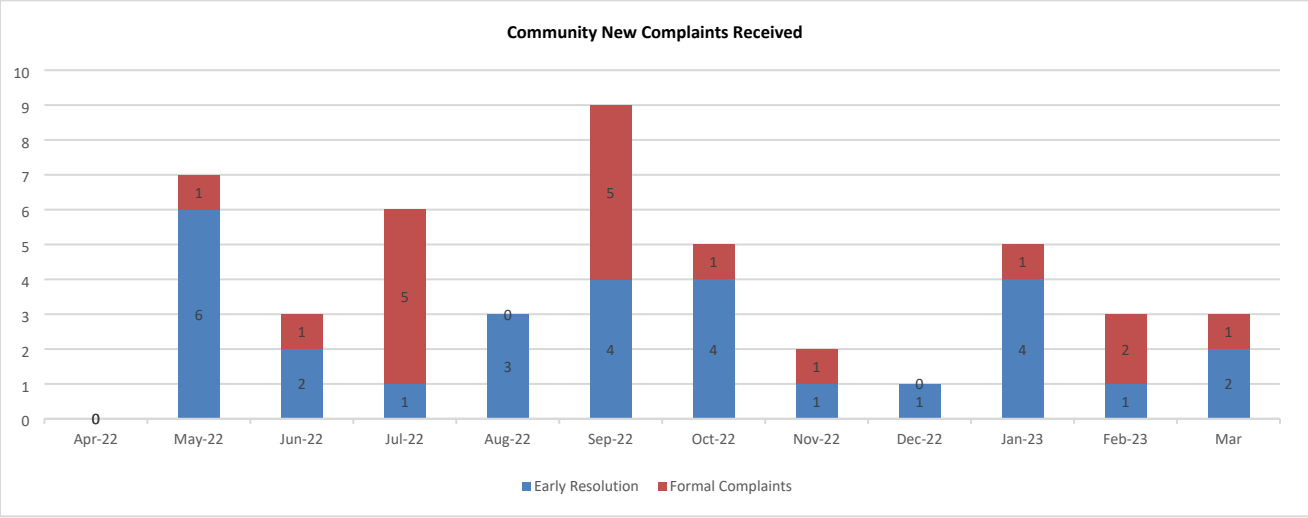
4.2 CONCERNS

There has been 1 new formal concern submitted for Communities. Communities continue to report a 100% compliance response rate.

Primary Care



Communities



4.3 LRI'S/NRI'S

There are five legacy 'serious incidents' still outstanding in Bridgend Communities, all Covid related and being reviewed as part of the nosocomial work.

There is 1 open LRI for CHC team due to staffing risk at a care home in RTE.

There are 2 open NRI's – 1 for Bridgend following a fall and subsequent death (2019) and 1 for Merthyr & Cynon DN service due to pressure ulcer development.

There is also an RCA outstanding for Bridgend (Ysbyty'r Seren) in relation to a fall. This is being reviewed and will follow PTR process.

Once all reported incidents are approved, learning will be shared with all PCC services across CTM to reduce the risk of reoccurrence.

4.4 OMBUDSMAN

No new Ombudsman cases have been received during this period for Communities.

5. RISK MANAGEMENT

A complete review has been undertaken across PCC Care Group of all open risks. This review has ensured that appropriate risks have a robust process in place for escalation and management. Across the Care Group we do not have any high risks at present. The top 5 risks are scored at level 12:-

- RN staff deficit, largely through vacancies, across YCC remains a significant and ongoing risk to patient safety and quality (site is currently operating at 52.4% of total funded establishment). Safety is being risk managed by Senior Nurse and Ward Managers through the movement of resources to areas of greatest need and use of bank/agency staff. Nursing leadership team are exploring various workforce development initiatives to improve recruitment and have also linked up with the People Services team to explore strategies for retaining staff.

- Medical staffing model remains a significant and ongoing risk. This is being monitored on a weekly basis by the CSG Manager.

- Dedicated transport to support the DN team visit patients at home during times of extreme weather. Transport has always been supported by Facilities but this can no longer be supported.

- The IT system still utilised in Bridgend, causes risks and issues when clinical staff who work in RTE and M&C and provide cover in Bridgend are unable to access WCP

- ANP vacancies across the service and this has resulted in the service being consolidated to just weekdays while recruitment into posts and induction is completed. The situation is being reviewed on a 4 week basis.

KEY METRICS OF CONCERN

In addition to the risk register, the concerns for Primary Care and Communities are:

- RTE DN service; the urgent requirement to increase ANTT compliance.
- YCC - high number of patients continue to require enhanced supervision, this coupled with the low staffing levels is a key concern.
- YCC – an audit of Treatment Escalation Plans has identified an urgent need to strengthen documentation.
- Reduced Specialist Immunisation nursing capacity which is impacting on the team's ability to maintain/improve uptake across CTM.
- @Home Service - reduced administration and nursing capacity due to vacant posts.
- BBHS – Europe wide shortage with the supply of some catheters/urinary appliances & accessories – this is impacting on the CTM wide prescription service in that the service is having to substitute equipment for those products out of stock. Patients have to wait for stock – this includes the DACS (dispensing chemist) and high street chemists.
- GP and independent contractor sustainability
- Dental contract reforms
- OCP process and staff recruitment.
- Uncertainty about funding to the optometry pathways.
- Change of IT system in GP OOH

6. PATIENT EXPERIENCE

We are actively encouraging feedback via the Have Your Say questionnaires by placing QR codes in areas of high footfall on clinical sites, at ward entry areas and also on the front cover of patient held community records.

7. LEARNING AND QUALITY IMPROVEMENT

GMS

- DHCW alerted the Primary care team that a practice had been deleting unread referral update messages totalling approximately 500. The Primary Care team are currently leading a full investigation of all deleted messages to detect any potential patient harm. The PC team have a

series of feedback meetings with the practice, along with an action plan. A full report along with mitigating actions and lessons learnt will be provided to board following completion of the review.

- Practice development visits are almost complete with a full report expected by June 2023. Interim feedback has been reassuring with no immediate or significant new concerns.
- GP contract Q4 access template submissions are due by 28th April 2023. Full achievement including collaborative discussion on reflective learning is expected. ACD work continues to be progressed. At the time of reporting GP, Pharmacy and Optometry collaborative membership has started, with dental and nursing not yet formed.
- All CTM GP practices are using electronic test requesting. CTM average of 93% for requesting tests (Wales average 85%).
- Alignment of all enhanced services across CTM.
- Review of all shared care protocols to begin with meds management

CLUSTERS

- The Clinical Nurse Specialist for Homeless and Vulnerable Adults has now been made into a permanent role within Primary care, following the outstanding success of the role. A band 6 outreach nurse has recently been appointed to work within the role to develop care, service developments and strengthen relationship across Primary and Community Care.
- Options are underway to look at the future of the frailty nurses within Taf Ely cluster. The funding ends in March 2024

COMMUNITY DENTAL SERVICE

- Both specialist orthodontists have recently retired and leave their post at the end of May/June. Discussions have begun to mitigate the gaps in service. Options include recruitment and also distribution of patients to neighbouring HB's.
- Special care dentistry vacant post have now been appointed to, and due to commence work in June 2023. Priority of their work plan is to establish a full SCD service in CTM and identify GA lists to treat to backlog of patients currently waiting.

GDS & DTU

- Dental Year End Process- Delay in guidance being sent to practices, due to uncertainties nationally on the process to be used for monitoring. There will be varied HB YE processes in place across Wales due to local mitigation being applied.

- Exec approval received 03/04/23 for local mitigation to be applied in CTM. Local mitigation will support the reduction of large reclaims to avoid any further practice closures/reductions/revert to UDA contract.
- 100% of practices have confirmed their intentions for 23/24 with regards to GDS Contract reform. This is excellent progress of the team to enable service provision and planning. So far this composes of:

  - 5 x UDA contracts
  - 8 x Contract Reform not working with HB to source urgent patients
  - 38 x Contract Reform working with HB to source urgent patients. This may change when YE guidance is shared.

OPTOMETRY

- **IPOS.** Confirmation received that the scheme will receive direct funding from WG from April 23. Recent audit demonstrated that 96% of all urgent patients treated via IP remain within the primary care services, without onward referral.
- **Diabetic Retinopathy Pathway** scheme has received transformation funding for a second year. 75% of patients seen under scheme no longer need to be seen within a hospital setting.
- Patient outcome reviews for the Glaucoma scheme are currently being undertaken by HES, initial results show of 97 reviews: 50% x returned into HES, 32% x monitored within practice, 9% x discharged. Additional tests to be undertaken in practice from April 23 will increase the number of patients monitored within practice and will reduce the number of patients returning into HES by a further 25%.
- The Glaucoma pathway has currently been suspended due to funding. A bid has been submitted to planned care, and still awaiting an outcome.

GP OOH

- The GP out-of-hours clinical administration/call-handling system is due to be replaced in November 2023, while the contract with the existing supplier is due to expire 31st December 2023. If for any reason this does not take place as planned, this could result in a need to renew the provider of the existing system (and potentially a three year tie-in) and or a dual running of the two systems. There are a number of additional costs associated with this.

RHONDDA UPCC

- Rhondda Urgent Primary Care Service ended on 31/3/2023 with a clear exit plan. Phase 3 evaluation and a peer review are due in May 2023. A total of 14,870 patients received assessment/treatment by the service in 12 months.

DISTRICT NURSING SERVICE

- New 8a, band 7 and band 4 posts have been appointed across CTMUHB (non-recurrent funding) to modernise the DN workforce to meet current demands in the community. Band 4 training programs in place and competency framework being devised.
- Engaged in Community Acquired Pressure Ulcer Collaborative which aims to reduce the prevalence of community acquired pressure ulcers.
- New documentation being printed and rolled out across all teams, inclusive of use of Purpose T for pressure ulcer risk assessment.
- DN night service to be aligned to one service and sit within the Communities structure
- CAPU project training tool introduced for educational purposes for agency staff
- Ongoing work regarding the DN specification and action plan.
- DN teams working with bereavement lead in relation to drafting the Care of the Deceased policy in the Community.
- DN self-assessment work ongoing.
- DN principles submission work completed for this quarter
- Demand and Capacity work ongoing.
- Student Nurse core induction programme now embedded as part of student nurse placements within DN service. Feedback remains very positive
- Peer Nurse Advocate post (DN service) delivering restorative clinical supervision for Team Leaders, early feedback is positive.
- CIVICA work ongoing across CTM DN service to improve CIVICA data quality and standardisation of CIVICA use.
- WLOC scores (acuity scores) being collected through CIVICA scheduling for each DN visit as part of national work stream.

SPECIALIST NURSING SERVICES - COMMUNITIES

- QIP commenced to align catheterization equipment usage across Bridgend (in keeping with other areas across the organisation). This will not only standardise catheter management across the organization but will promote individualised care planning.

- BBHS held up as an exemplar of best practice by UK clinical advisory board. Invited to present at this year's Association for Continence Advice annual conference (May 2023). The team have been commended for their unique and holistic approach in relation to the management of Bladder & Bowel conditions.
- VBHC Improvement Project (OGEP) launched March 2023. Education delivered to District Nursing service aiming to promote clinically effective and prompt management of Chronic Oedema. The project has commenced within Merthyr Tydfil and will be implemented across all localities.
- TVS has successfully rolled out a new CTM wide Pressure Ulcer grading algorithm which has been distributed to all HoNs to assist with accurate grading of pressure ulcers. Evidence of improvement will be monitored through the pressure ulcer scrutiny panels.
- Senior Nurse for Specialist Immunisation service awarded a Lifetime Achievement award for a range of vaccination related initiatives.
- Fluenz project which aims to improve uptake in 3 year olds has proved very successful. Initiative has been published in "Vaccine" journal.
- Specialist Immunisation Team attended a Connecting Communities 25 year celebration of Interlink. This enabled the team to network and make further plans regarding face-to-face training sessions.
- COVER Report Data (uptake of scheduled childhood vaccination) for the last quarter shows that CTMUHB continues to do well mainly (95%> uptake) to deliver vaccinations up until the age 4 years. Work ongoing to maintain this as well as additional work to pick up those that have not had their scheduled vaccinations by age 4.
- National Lymphoedema Peer Review completed (February 2023) – Action plan developed and is showing good progress against key recommendations

NURSING SERVICES-PRIMARY CARE

- A new referral Spirometry service for Primary care is in the process of being scoped for the whole of CTM, following the success on the mobile bus. This would enable quality assured spirometry testing for patients in need for diagnosis and management of certain long term respiratory conditions.
- COSHH and Risk Assessment training set up for nursing teams. Leads having continued input and mentorship for the H&S agenda.
- Mandatory training compliance is 92.4% and appraisal of staff at 94.1.
- Numerous messages of gratitude for all specialist nursing teams received.

YSBYTY CWM CYNON

- QIP completed on Ward 3, YCC. Piloted new Orizon Ontex Ltd continence product (first in UK & Europe to pilot product). Positive clinical outcomes in relation to patient care (bladder & bowel management, natural waking, skin care and general bladder/bowel care awareness). Evaluation due May 2023. Ward 3 management and staff have been commended for supporting the project.
- Self-administration of medication pilot completed on Ward 2, YCC. Evaluation to be completed. Staff commended for supporting the pilot.
- Student Nurse core induction programme now embedded as part of student nurse placements within YCC. Feedback remains very positive
- Executive Director of Nursing walkaround (Jan 2023) – wards received positive feedback.
- Mental Health Matters presence on wards undertaking activities with patients with good effect.
- Daily Board Rounds/Safe2Start fully embedded across all four wards.
- Functional Rehabilitation plans for patients also implemented across four wards.
- D2RA implementation continues across the YCC site, however it is acknowledged that further training is required for ward staff.
- Linked up with People Services to address recruitment and retention issues, and in the process of implementing a number of workforce development initiatives.
- AMaT audit compliance against eight key areas remains excellent across wards. Of particular note is compliance against IP&C requirements such as environment, uniform and BBE/HH.

YSBYTY CWM RHONDDA

- D2RA project group set up with ToR in place and expert support.
- Implementation of OneList app is helping track the journey of patients throughout their hospital stay to ensure effective steps towards discharge are being taken.
- Safe2Start embedded as daily practice to inform sharing of resource across site to maintain safety on all 4 wards.
- Workforce planning exercise planned to target longstanding issue with Registered Nursing vacancies.
- Ward Assurance audits being undertaken monthly.
- Community Hospital Performance Dashboard in development.
- YCR engaged with UHW vascular team in relation to the vascular patient pathway; to review and reduce the LoS.
- Stroke – YCR nurse leadership team part of the overall CTM Stroke work being undertaken

- Ward C3, YCR – has achieved 90% as a ward with training compliance
- Wards have achieved 98% PDR compliance (total for site)
- YCR ward teams and RTE DN teams to work in partnership with Citizen's Advice for support to both patients and staff.
- Executive walkaround Ward B2, YCR – immediate feedback was positive.
- Staff Well-being initiatives commenced this month with a walking club being introduced.

PALLIATIVE CARE SERVICES

- YBN, POWH – legionnaire outbreak – Risk assessment completed and actions implemented in agreement with IPC and Estates
- Day units being reviewed and a new model to be implemented in line with current needs of the population.

HMP PARC PRISON

- Governance process being reviewed and scoped.
- SNS to engage and scope required services
- Ombudsman learning (2016) shared, for review and implementation of required actions.
- CTM wide operational meeting arranged to include all departments
- Weekly governance meetings arranged
- Monthly scrutiny governance meetings in place
- Increased use of "spice" amongst inmates detected. Mitigating and education actions put in place to attempt to reduce.

WARD 21, POWH

- Review of Ward 21, POW (Llynfi) undertaken to align staffing model to Community Hospitals
- Staff Well-being initiatives commenced this month with both knitting and gardening clubs in Bridgend

8. IMPACT ASSESSMENT

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

9. RECOMMENDATION

9.1. The Quality and Safety Committee is asked to **NOTE** the content of this Report.

Primary Care and Communities Care Group

April 2023

Quality Improvement

YCR and YCC OneList app and D2RA: OneList app being used to inform discharge planning processes & follow inpatient journey. D2RA undertaken to develop a Community hospital Bed model.
Ward 21, POW: nursing establishment review undertaken benchmarked across other community hospital wards.
Visits to community settings: visit undertaken by exec walkaround to Ward B2, YCR and YCC Wards 1-4.

HMP Parc Prison: commencement of governance framework.
Palliative Care services – review commenced on the 'day unit' services previously offered and a new model

Self-administration of medication pilot completed on Ward 2, YCC. Evaluation to be completed.

Band 4 role in DN service: B4 assistant practitioners in post as part of WG work.
Demand and Capacity work: a significant amount of work is being undertaken to understand Demand & Capacity across the service, this has not been undertaken in Wales as yet.
Community Acquired Pressure ulcers – project ongoing with a training tool for education for bank and agency staff.

Autumn vaccination campaign planning: Community hospital sites planning to support the vaccine program in Autumn.
District Nursing by night service: alignment of one CTM service to support quality of care being delivered.
CTM wide DN documentation now rolled out following project and alignment of paperwork across the service

QIP completed on Ward 3, YCC. Piloted new Orizon Ontex Ltd continence product (first in UK & Europe to pilot product). Positive clinical outcomes in relation to patient care (bladder & bowel management, natural waking, skin care and general bladder/bowel care awareness). Evaluation due May 2023.

Quality Improvement Continued
Specialist Nursing Services

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COVER Report Data (uptake of scheduled childhood vaccination) for the last quarter shows that CTMUHB continues to do well mainly (95%> uptake) to deliver vaccinations up until the age 4 years. Work ongoing to maintain this as well as additional work to pick up those that have not had their scheduled vaccinations by age 4.

National Lymphoedema Peer Review completed (February 2023) – Action plan developed and is showing good progress against key recommendations

Senior Nurse for Specialist Immunisation service awarded a Lifetime Achievement award for a range of vaccination related initiatives at this years annual Welsh Immunisation Conference.

A number of quality initiatives were presented at the conference including:-

- Developing an Immunisation support team – a sustainable workforce initiative
- Support for individuals with a Learning Disability receiving a Flu vaccine.

Quality Improvement

- **Special Care Dentistry consultant** interviews in February were successful, 2 candidates appointed. Priority to establish a full SCD service in CTM and identify GA lists to treat backlog of patients waiting for treatment under GA & clinics for sedation.

- Continued work on 6 Goals - Navigation HUB project board set up to produce and implement a standardised Navigation Hub approach, inclusive of implementation, workforce and communication plans that reflects examples of good practice from models elsewhere in the UK.
- Phase 3 evaluation of UPCC report as part of the 6 Goals for Urgent & Emergency Care to be undertaken after service is disbanded

Spirometry referral service being developed for primary care following national recommendations.

- GMS: ALL practices now using electronic test requesting. 8 x practices <90% usage. CTM average currently 93% (Wales 85%)
- Access – Q4 template submissions due by 28.4.23. GMS Team expect full achievement from CTM practices
- PPV reporting – no new issues identified
- Practice development visits completed and no major concerns identified.

- Harmonisation of enhanced services across all of CTM. This will bring inline Bridgend practices
- Accreditation of GMS practices to provide the Diabetes Enhances service almost complete
- Programme of work with meds managements to update shared care protocols

Quality Improvement

- **IPOS:** Recent audit demonstrated that 96% of all urgent patients treated via IP remain within primary care and stop onward referral to GP/eye casualty.
- **Diabetic Retinopathy Pathway-** scheme has received transformation funding for a 2nd year. 75% of patients seen under scheme no longer need to be seen within a hospital setting.
- **Glaucoma**-Patient outcome reviews currently being undertaken by HES, initial results show of 97 reviews: 50% x returned into HES, 32% x monitored within practice, 9% x discharged

- **HMP Parc**: Increase use of Spice resulting in increase in medical emergencies, increase in self-harm, debt and assault. Rish identified and introduction of Spice clinic to target frequent users
- Development of risk sharing information meeting with drug strategy team
- Prompt medication reviews held OOH to ensure risky medication is reduced/stopped.

- **HMP Parc**: Poor uptake for COVID booster (42%) Flu uptake 30%. Work to improve uptake for 2023 include revamping the radio advert, Iman's will promote after Friday prayers and incentive to offer men from the director.
- Work underway for the introduction of crisis phone line to mirror 111 press 2

Top 3 successes – Primary Care

- Transfer of Prison health over to Primary Care.

- Tracey Evans, Clinical Nurse specialist for homeless and vulnerable adults-shortlisted for RCN nurse of the year 2022. Award ceremony in June 2023.

- Planned care recovery funds successfully set up weekend and mobile spirometry clinics, and subsequent joint working with Hywel Dda, Respiratory innovation Wales and Lifescience Hub to continue with quality spirometry testing. Over 700 patients tested.

Top 3 successes - Communities

- **Modernised workforce in the DN service**
  - Peer Nurse Advocate
  - Diabetes CNS
  - Assistant Practitioners.

- **D2RA pathways**
  - Implementation of D2RA pathways across Community wards, reducing LoS

- **Clinical Incidents**
  - Reduction in the number of incidents closed each month continues across Communities.

Note: In addition to the above success, a number of services have received national recognition for a range of patient safety & quality improvement initiatives including the Bladder & Bowel Health Service and the Specialist Immunisation Service.

Top 3 challenges – Primary Care

- Sustainability of GP workforce and independent practices
  - *Regular team meetings to access "at risk" practice, with offers of support*
- Financial challenge and OCP process creating uncertainty and vacancies within the care group
- Decision by LMC to not support restarting of spirometry within practice following COVID. This is due to non core contract status and IPC concerns.

Top 3 challenges – Communities

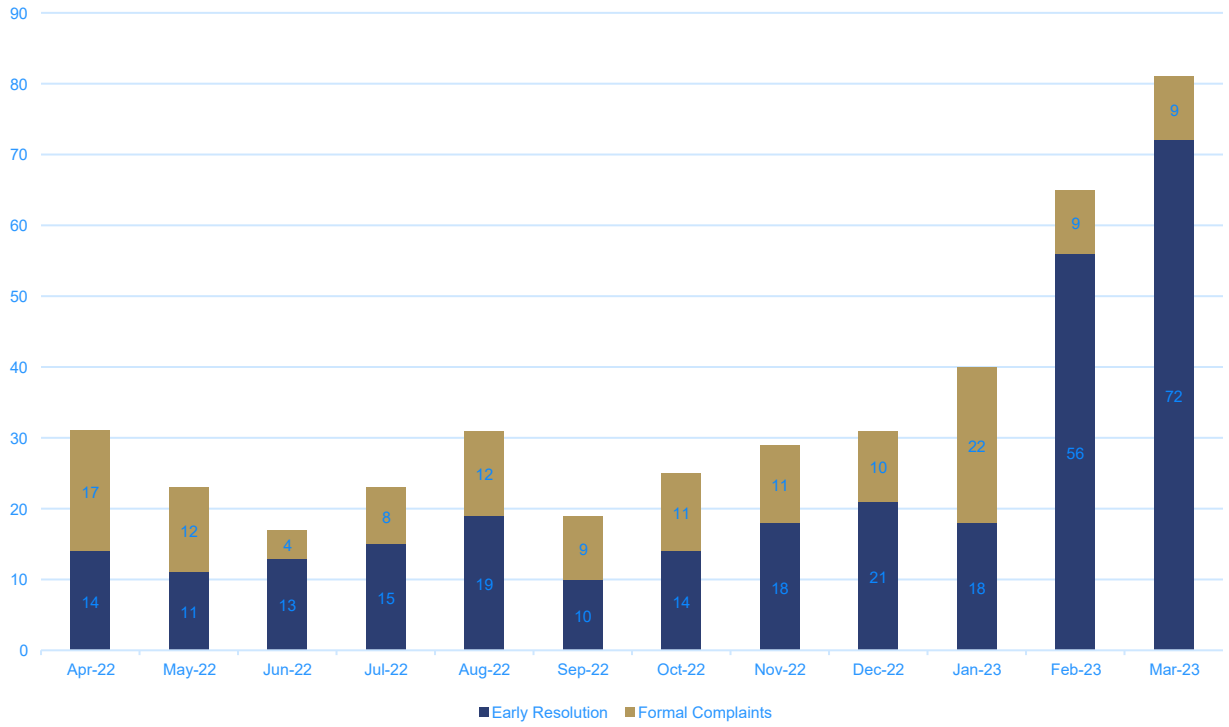
- **Workforce issues**
  - RN staffing vacancies across all ward areas
  - YCR wards – 12 wte (20%)
  - YCC wards – 22.44 wte (39.8%)

- **Medical staffing model in YCC**
  - Medical staffing cover remains an ongoing challenge.

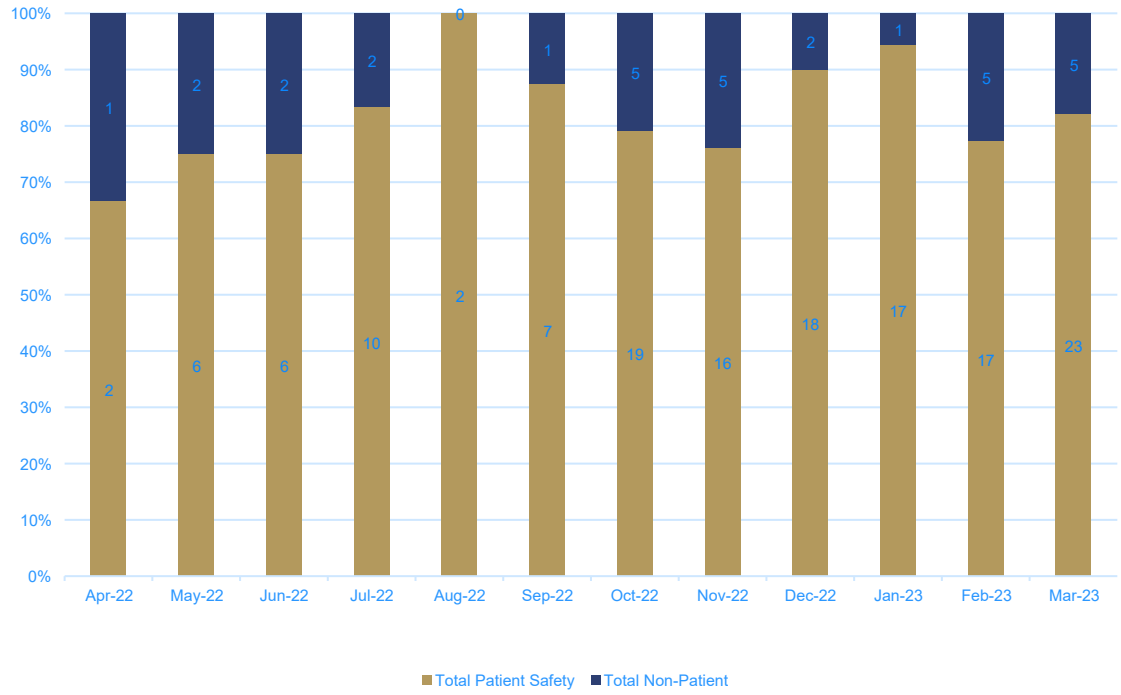
- **Workforce issues**
  - ACT team in Bridgend – due to number of current ANP vacancies

Governance highlights – Primary Care

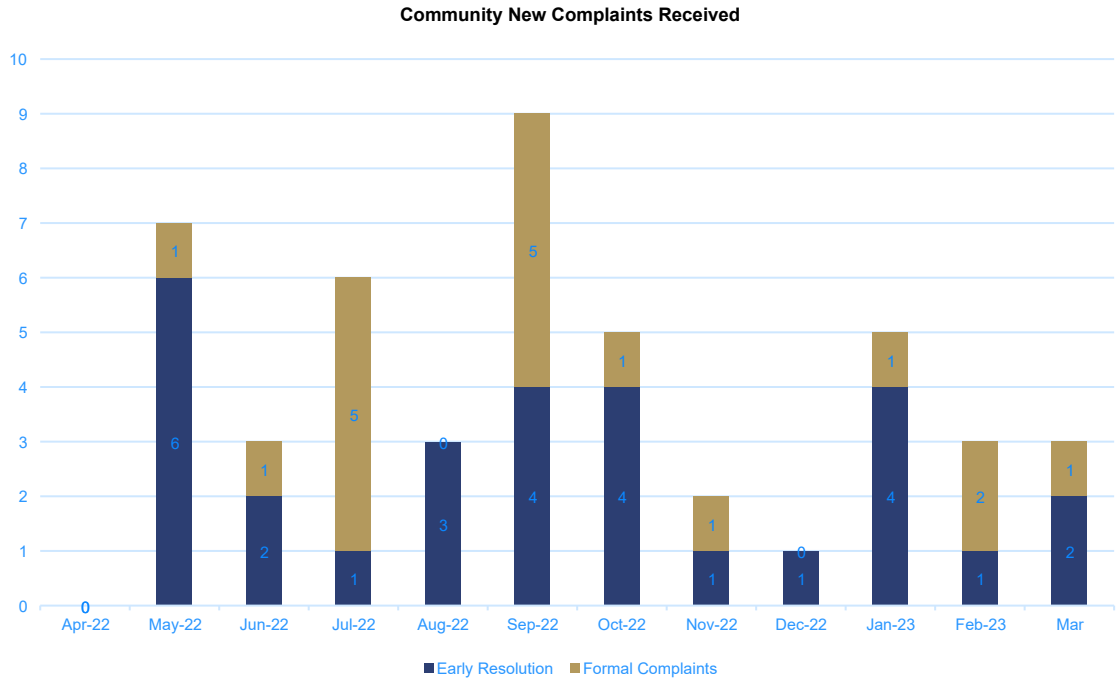
Primary Care New Complaints Received

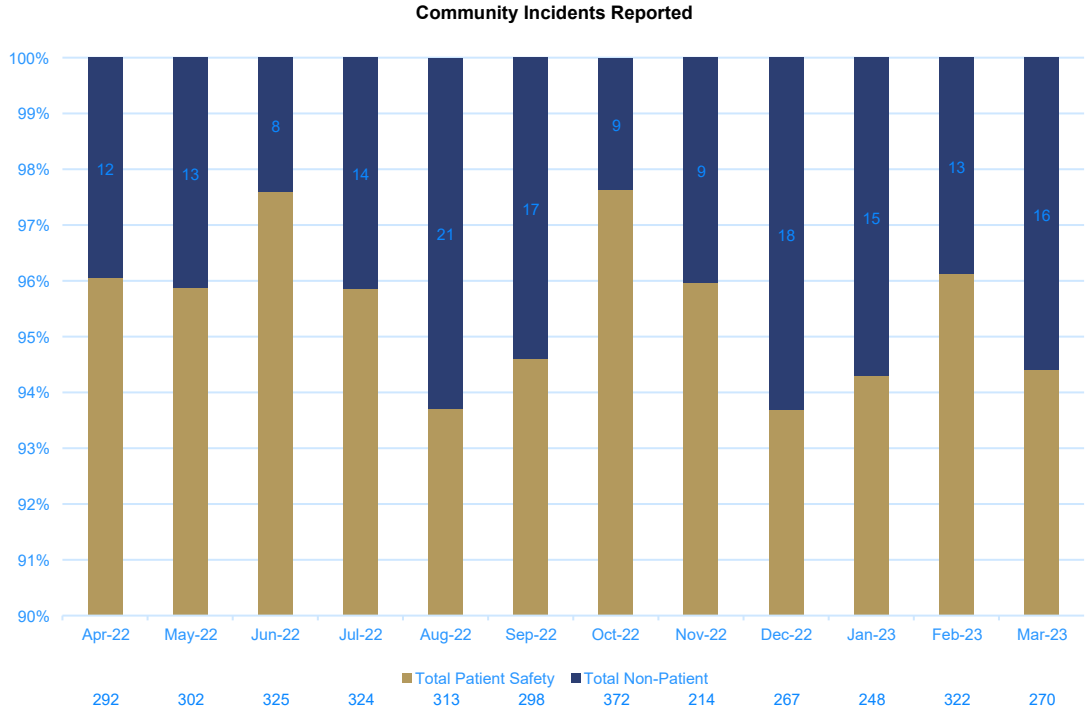


Primary Care Incidents Reported



Governance highlights – Communities





Concerns – Primary Care & Communities

	Bridgend Community Hospital	Bridgend Community Nursing	Merthyr & Cynon Community Hospital	Merthyr & Cynon Community Nursing	Rhondda & Taf Community Hospital	Rhondda & Taf Community Nursing	Primary Care	Palliative Care
Complaints								
Number of new complaints received	0	1	0	0	0	0	81	0
Early Resolution	0	2	0	0	0	0	72	0
Formal Complaints	0	1	0	0	0	0	9	0
Number of enquiries received	0	0	0	0	0	0	5	0
Number of Formal Complaints closed	0	0	0	0	0	1	17	0
Upheld	0	0	0	0	0	0	5	0
Partly Upheld	0	0	0	0	0	0	0	0
Not upheld	0	0	0	0	0	1	8	0
Not Investigating	0	0	0	0	0	0	0	0
Consent not Received	0	0	0	0	0	0	0	0
Discontinued	0	0	0	0	0	0	0	0
Withdrawn	0	0	0	0	0	0	4	0
Escalated to Formal Complaint	0	0	0	0	0	0	0	0
Advice Given	0	0	0	0	0	0	0	0
Issue resolved	0	0	0	0	0	0	0	0
Information provided	0	0	0	0	0	0	0	0
Referred to appropriate department	0	0	0	0	0	0	0	0
Of the Formal complaints closed, number responded to within 30 Working days	0	0	0	0	0	1	8	0
Complaints compliance response rate	Nil	Nil	Nil	Nil	Nil	1	47%	Nil
Number of Formal Complaints Open	1	0	1	0	1	1	44	0
Within 30 working days	0	0	0	0	0	1	8	0
Over 30 working days	0	0	1	0	1	0	28	0
Over 6 months	1	0	0	0	0	0	8	0

Top 3 risks - Primary Care

- **No red risks, all risks fall moderate.**
- Sustainability of general practice.
- Dental contract reform and end of year mitigation.
- Introduction of new IT system “Salus”, to replace Adastra which will cause cost pressure and logistical pressure.

Top 3 risks – Communities

1. RN staffing ay YCC Hospital and Medical staffing model.

2. Dedicated transport to support the DN team visit patients at home during times of extreme weather. Transport has always been supported by Facilities but this can no longer be supported.

3. ACT – ANP vacancies across the service.

Agenda Item Number: 3.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety Committee held on the 16 March 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Sallie Davies	Deputy Medical Director
Lauren Edwards	Executive Director of Therapies & Health Sciences (In part)
Hywel Daniel	Executive Director for People (In part)
Gethin Hughes	Chief Operating Officer (In part)
Dom Hurford	Medical Director (In part)
Julie Denley	Deputy Chief Operating Officer
Greg Dix	Executive Director of Nursing
Cally Hamblyn	Assistant Director of Governance & Risk
Stephanie Muir	Assistant Director of Concerns & Claims (In part)
Suzanne Hardacre	Director of Midwifery
Sarah Fox	Head of Midwifery & Gynaecology (In part)
Gwion Williams	Service User (In part)
Ana Llewellyn	Primary Care, Community and Mental Health - Care Group Nurse Director
Carole Tookey	Planned Care - Care Group Nurse Director
Emma James	Unscheduled Care – Care Group Nurse Director
Kellie Jenkins-Forrester	Head of Concerns & Business Intelligence
Chris Beadle	Head of Operational Health, Safety & Fire (In part)
Gaynor Jones	Royal College of Nursing (RCN) Convenor (In part)
Sara Utley	Audit Wales (In part)
Vanessa Davies	Healthcare Inspectorate Wales
Lisa Love-Gould	Clinical Director of Allied Health Professionals (In part)
Stephen Sarasin	Clinical Director, Planned Care
Alex Brown	Clinical Director, Unscheduled Care (In part)
Melanie Barker	Assistant Director of Therapies & Health Sciences
Hannah Wilton	Chief Pharmacist
Kathrine Davies	Corporate Governance Manager

Observing:

Mark Abraham	Head of Commissioning Mental Health and Learning Disabilities

Unconfirmed

Agenda Item

1.0 PRELIMINARY MATTERS

1.1 Welcome & Introductions

In opening the meeting, J Sadgrove, Committee Chair provided a welcome to all those present, particularly those joining for the first time, those observing and colleagues joining for specific agenda items. The format of the proceedings in its virtual form were also noted by the Committee Chair.

1.2 Apologies for Absence

Apologies for absence were received from:

- James Hehir, Independent Member

1.3 Declarations of Interest

No interests were declared

2.0 SHARED LISTENING AND LEARING

2.1 Listening & Learning Story

S Fox and G Williams shared the Listening & Learning Story with Members of the Committee. G Williams shared their experience of using the Gynaecology Services whilst transitioning as a Transgender patient and highlighted issues in relation to communication from staff whose responses appeared to be dismissive. G Williams advised that they received a genuine and caring response following the concerns raised. Members noted that following the concerns raised, consideration had been given to amending the name of the department and the patient had met with Clinicians virtually to discuss concerns so that lessons could be shared across the department.

The Committee Chair and D Jouvenat extended their thanks to G Williams for sharing their story, which had highlighted how important it was to speak out.

G Dix advised that he was the Executive Lead for LGBTQ matters within the Health Board and added that the Health Board had recently launched its Trans Toolkit for the Trans Community and Staff. G Dix advised that he would welcome a discussion with G Williams outside the meeting so that they could share any reflections as to whether the toolkit could be strengthened further. G Williams welcomed the invitation to discuss further.

The Committee Chair expressed her apologies for the experiences that G Williams had faced, however, recognised how by sharing their lived experience it was helping to change things within the Health Board. G Williams advised that they appreciated the effort and the care that had been provided in relation to listening to the concerns that had been raised.

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

Action: Discussion to be held with G Williams outside the meeting in relation to the Trans Toolkit to determine whether the toolkit could be strengthened further.

Unconfirmed

2.2 Care Group Spotlight Presentation – Mental Health & Learning Disabilities

A Llewellyn shared the presentation with Members which provided an overview of recent and legacy Healthcare Inspectorate Wales inspections that had been undertaken on the Mental Health Services within the Health Board. Members noted that key themes had been identified and in response a robust improvement programme was now in place to address the issues raised.

The Committee Chair extended her thanks to A Llewellyn for presenting the comprehensive report.

P Roseblade thanked A Llewellyn for the report and for being so candid in her presentation, she also drew attention to the request for support in relation to the Single Care record and sought clarity as to what support was required. A Llewellyn advised that it would be helpful if Independent Members could support the decision making required in relation to the implementation of the Welsh Community Care Information System (WCCIS) and added that multiple systems were in place at present which was challenging. Members noted that the Team were working to mitigate the risk.

The Committee Chair advised that extensive discussions had been held on this important matter at the Digital & Data Committee and the Mental Health Act Monitoring Committee and added that having a single care record for patients within Mental Health was vital and until this was in place the Health Board would continue to run at risk which was why this had been escalated to the risk register. Members noted that a discussion was held at the Digital & Data Committee as to whether there were existing systems within the Health Board which could be rolled out further if progress was not made with WCCIS.

J Denley advised that she was pleased to learn of the discussions held at Digital & Data Committee and advised that the digital ambitions for the Health Board were significant given the challenging financial positon being faced by the organisation and highlighted the importance of a single integrated clinical system within Mental Health. The Committee Chair advised that this was a fundamental system which the Committee fully supported and suggested that the Committee highlighted this matter as an area for escalation in the Committee Highlight Report to Board.

P Roseblade advised that whilst she agreed that implementation of a single care record was a priority and that this would be an exceptionally good use of funding, it was not within the Independent Members remit to dictate how funding was distributed across the Health Board and added that this would be the responsibility of the Executive Team. The Committee Chair advised that it was the Committee's role to highlight areas of risk to the Board and it would be the risk that the Committee would highlight to the Board. D Jouvenat agreed with the approach suggested.

Unconfirmed

G Dix advised that this issue had been discussed a number of times by the Executive Team when working through the priorities within the financial plan recognising also the frequency that it has also been identified as an area of concern within e Healthcare Inspectorate Wales Reviews, in this regard he welcomed the inclusion of this issue within the alert/escalate section of the Committee Highlight Report to Board. The Committee Chair added that patients were being treated with partial information available within their records which was a significant risk that needed to be mitigated.

C Donoghue acknowledged A Llewellyn's candid reflections of the impact of moving staff to other areas to address immediate issues in a particular area and how these decisions need to be considered in terms of their residual impact.

Following discussion, the Committee Chair welcomed the work that had been undertaken in relation to legacy reporting and sought clarity as to whether learning was being shared in relation to the issues identified. A Llewellyn confirmed that learning was being shared and added that the Care Group structure provided a positive vehicle for delivery.

In response to a question raised by the Committee Chair in relation to whether the Improving Care Board (ICB) had now been set up and into which forum this would report into, A Llewellyn advised that the first meeting of the ICB had been held and work-stream leads had now been identified. Members noted that the Care Group Quality, Safety and Risk Experience Group would also maintain oversight of the activity being undertaken by the ICB and added that Healthcare Inspectorate Wales reviews was a standing item on the agenda for the Care Group Quality, Safety & Risk Experience meetings.

Resolution: The presentation was NOTED.

Action: Following discussion, it was agreed that regular reports on this matter would be presented to the Committee.

Action: The risk relating to the implementation of the Welsh Community Care Information System to be highlighted as a matter of escalation to the Board within the Committee Highlight Report.

Action: Mental Health In-Patient Improvement Progress Reports to be presented to future meetings from May 2023 onwards.

2.3 Care Group Spotlight Presentation – Unscheduled Care

E James shared the presentation with Members which provided an update on the following key areas;

- Minor Injury Unit at Ysbyty Cwm Cynon;
- Ambulance Delays and Immediate Release Policy;
- Process for patients with a head injury leaving the emergency department without being seen;

Unconfirmed

- Healthcare Inspectorate Wales visit to Ward 5 Princess of Wales Hospital; and
- Response to the Health & Safety concerns at Princess of Wales Hospital and fire evacuation simulation.

In response to a question raised by G Jones as to whether there were plans in place to move the Minor Injuries Unit back into their original area which had been purpose built for the unit, E James confirmed that this was a priority area for the team to address to ensure the service was being delivered from the appropriate space. S Sarasin advised that if the unit was moved back into its original area, discussion would need to be held in relation to the location of the fracture clinic. The Committee Chair recognised how many dependencies there were in relation to service location.

E James advised that significant improvement had been made in relation to ambulance delays and immediate release protocols with a significant amount of work undertaken with clinical leads across sites in relation to the key principles of the immediate release policy. P Roseblade commented on the high level data that had been included in the presentation in relation to ambulance handover performance and advised that the Committee would need to see the data for each individual hospital which showed the numbers for requested for immediate release and number agreed. Following discussion, E James agreed to circulate this information to Members outside of the meeting and agreed to include the data in future iterations of the report.

In relation to patients that did not wait following attendance at the Emergency Department with a head injury, E James advised that a review had been undertaken following assurance being sought by Committee members at a previous meeting. E James confirmed that protocols and principles were in place across all three sites regarding this and steps were now being taken to develop a standardised template across the Health Board.

Members noted the outcome of the Healthcare Inspectorate Wales visit to Ward 5, Princess of Wales Hospital which identified three key areas for immediate assurance, which included medication storage safety, fire risk assessments and access to mandatory training. Members noted that an action plan had now been received which identified a further 16 recommendations and noted that progress against the action plan would be reported to the Care Group Quality, Safety & Risk Experience meeting. E James advised that the Care Group would also be reviewing any open and outstanding actions from previous inspections.

In response to a question raised by N Milligan in relation to compliance for resuscitation and manual handling training, E James confirmed that significant improvement had been made in these areas and further work was being undertaken as to how staff can access and attend training, which included the provision of training within clinical areas. H Daniel advised that there was a number of mandatory training packages that could be undertaken without having to attend a classroom and added that discussions would need to be held with staff as to what training could be undertaken online. H Daniel advised that

Unconfirmed

there were training capacity issues in place at present and added that discussions were taking place as part of the Integrated Medium Term Plan process in relation to training capacity.

The Committee Chair drew attention to the issues that had been identified in relation to working locks on medication cupboards and fridges seeking clarity as to how this was being addressed across the whole of the Health Board given that this was not the first time this issue had been identified by Healthcare Inspectorate Wales. G Dix advised that this was also an issue across the whole of Wales and added that compliance is now captured as part of the safe to start quality framework and advised that Heads of Nursing were now undertaking quality checks regarding this matter which should hopefully improve the position moving forwards.

A discussion was held in relation to the Health & Safety concerns that had been raised by the Chief Executive of NHS Wales in relation to the management of boarded patients in fire evacuation routes being a breach of health and safety regulations. Members noted that a robust risk assessment had since been undertaken with Health & Safety colleagues and E James advised that whilst it was the ambition of the Care Group to deliver high quality care, there would be occasions where decisions would need to be made in extremis measures where patients may need to be boarded into a non commissioned area.

The Committee Chair advised that this issue had been highlighted as a matter of escalation within the Health, Safety & Fire Sub Committee Highlight report. D Jouvenat advised that a discussion was held at the sub-committee in relation to placement of beds on wards that had not been officially designated as patient bays and a number of concerns were raised by Members regarding this.

N Milligan recognised the challenges faced by the service in terms of balancing risk but expressed her concerns in relation to areas such as fire i.e. the ability to respond effectively to a fire where non-commissioned areas have been utilised. G Jones queried if staff were appropriately trained in evacuation given the low compliance in relation to fire training.

P Roseblade recognised the challenging balance of risk in terms of assessing whether the greatest risk would be on the ward with the boarded patients, patients having to wait longer to be seen within the Emergency Department or for patients who were waiting at home for an ambulance.

H Daniel advised that it was evident that further work was required on this matter from a clinical and Health & Safety perspective and added that there would be a requirement to comply with regulations, with fire exits needing to be kept clear at all times. H Daniel reminded Members that the Health Board has a number of active fire orders placed on some of the Health Board sites and added that he would not feel comfortable as an Executive Director to accept the risk of covering a fire exit and added that in addition to Welsh Government, South Wales Fire & Rescue had also contacted the Health Board in relation to this particular matter. A Brown advised that it would be helpful if there could be a

Unconfirmed

steer as to what the Health Board would be least comfortable with as an organisation when considering these risks.

In response to a query raised by the Committee Chair as to whether this matter would be discussed again by the Executive Team, G Dix advised that this was an issue recognised by the Executive Team as one that requires monitoring and action in light of the difficult and challenging service decisions that are required to be made on a daily basis.. G Dix welcomed suggestions by colleagues to support any further discussions around mitigating the risk. .

Following discussion, the Committee Chair advised that the Committee would need to formally record its concerns in relation to the risks that the Health Board were trying to manage and added that this would need to be included as an area for escalation in the Committee Highlight Report to Board. The Committee Chair encouraged the Executive Team to continue to consider the position moving forwards.

N Milligan made reference to staff having the confidence to report on any issues they felt uncomfortable with and expressed the importance that staff did not feel threatened when they felt the need to report on any areas of concern.

The Committee Chair extended her thanks to E James for sharing the presentation and added that there would be some items that would require ongoing discussion.

Resolution: The presentation was **NOTED**.

Action: 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.

Action: Concerns raised by Committee Members in relation to the boarding of patients in non-commissioned areas to be escalated to the Board within the Committee Highlight Report.

3 CONSENT AGENDA

C Donoghue confirmed that she had received responses to the queries raised prior to the meeting.

3.0 For Approval/Noting

3.1.1 Unconfirmed Minutes of the Meeting held on the 24 January 2023

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

3.1.2 Unconfirmed Minutes of the In Committee Meeting held on the 30 January 2023

Unconfirmed

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

3.1.3 Children & Young People 16-17 year's Acute Admission Policy

Resolution: The Policy was **APPROVED.**

3.1.4 Chairs Urgent Action – Policy Approvals

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

3.1.5 Independent Member Walkround Protocols

G Dix confirmed that he had received some helpful feedback from C Donoghue and the Executive Team regarding this protocol and advised that some amendments would now need to be made to the report. G Dix agreed to re-circulate the document once amendments had been made.

Resolution: The proposal was **SUPPORTED.**

Action: Report to be re-circulated to Members once amendments had been made.

3.2.1 Committee Action Log

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

3.2.2 Annual Cycle of Business

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

3.2.3 Quality & Safety Committee Forward Work Programme

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

3.2.4 Quality Governance – Regulatory Review Recommendations and Progress Updates

The Committee Chair confirmed that some of the areas highlighted within the report had been discussed as part of the care group presentations earlier in the meeting and added that she noted the ongoing reporting of recommendations was a system in development.

Resolution: The Report was **NOTED**.

3.2.5 Clinical Audit Quarterly Report and Clinical Audit Annual Plan

The Committee Chair welcomed the report which identified the ongoing work and the submission of good practice case studies and added that she appreciated the pressures being faced by the Clinical Audit Team.

Unconfirmed

Resolution: The report was **NOTED**.

3.2.6 Radiation Safety Committee Highlight Report

The Committee Chair welcomed the report and the ongoing compliance with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Resolution: The report was **NOTED**.

4. MAIN AGENDA

4.1 Matters Arising not considered within the Action Log

There were no further matters arising identified.

5. GOVERNANCE

5.1 Organisational Risk Register – Risks Assigned to the Quality & Safety Committee

C Hamblyn presented the report and highlighted the key matters for Members attention.

C Donoghue made reference to Risk 5036 which related to Pathology services unable to meet current workload demands and sought clarity as to whether it was right to reduce the risk score in light of the financial climate. C Donoghue also identified the need to improve the robustness of the mitigating actions for some risks. C Hamblyn advised that engagement had been undertaken with Care Group Leads in relation to risks and of the need to review the risks where the mitigating action had remained stagnant. Members acknowledged that this improvement activity would take time but that there was commitment from the Care Groups to take this forward.

N Milligan drew attention to Risk 4732and 4721 which had not been reviewed for a number of months, and requested that a review was undertaken of both risks.

P Roseblade made reference to Risk 4071 and sought clarity on what was meant by decreased and whether this meant that waits were getting worse for those patients not in the longs waits as priority was being given to the long waiters. P Roseblade also added that she felt the risk needed to make reference to the Welsh Government intervention status in relation to Cancer.

P Roseblade made reference to Risk 4080 and sought clarity as to whether this risk related to Junior Doctors as there was a different risk in relation to Senior Medical Staff that had been de-escalated. P Roseblade also made reference to Risk 4743 and advised that an update had not been provided against this risk since December 2022 and also made reference to Risks 3131 and 4908 where the risk score had decreased even though the key mitigating actions were still

Unconfirmed

underway. C Hamblyn advised that she would be happy to leave Risks 3131 and 4908 on the register if members did not feel assured in regards to removing them.

The Committee Chair made reference to the Medical Records risk and advised that a draft report in relation to this risk had been received at the Digital & Data Committee and added that she had requested that the risk was revisited in relation to its description and mitigation around quality and safety implications. C Hamblyn confirmed that she had discussed this risk with the risk lead and added that an update would be included in the next iteration of the report.

C Hamblyn agreed to address the queries with the relevant risk leads and the Committee Chair advised that she looked forward to receiving responses outside the meeting.

Resolution: The report was **NOTED**

Action: Responses to queries raised against a number of risks to be shared with Members outside the meeting.

5.2 Health, Safety & Fire Sub Committee Highlight Report

D Jouvenat presented the report and highlighted the matters that had been included in the alert/escalate section, which included concerns raised in relation to low levels of compliance being achieved in relation to staff attending fire safety training sessions. Members noted that the Sub Committee also received two Audit Reports which had been allocated a reasonable assurance rating.

N Milligan advised that in relation to the concerns raised regarding placement of beds, this not only affected patient dignity and safety, but staff safety also. N Milligan added that in the event of a cardiac arrest, the inappropriate placement of beds would likely result in a manual handling incident given that staff would not have the appropriate space to manually handle a patient. N Milligan advised that ensuring the dignity for both patients and staff was vitally important.

In response to concern expressed by G Jones regarding the way in which patients were being cared for, C Donoghue advised that this matter was not being taken lightly by Members of the Board and stressed the need of determining where the greatest risks were. N Milligan recognised the challenges being faced in reaching these difficult decisions but noted that it would be remiss of Members not the raise their concerns. The Committee Chair commented as to whether the balance of risk was right when decisions were being made.

G Jones reiterated her concern that it had been found acceptable to place patients in inappropriate spaces and added that patients needed to be cared for in a safe environment. The Committee Chair stressed that this matter was being taken very seriously and would not be ignored.

Unconfirmed

G Dix acknowledged that the position was unacceptable and advised that he would be grateful to receive any advice and ideas from Committee Members as to how the risks could be further mitigated in these very challenging times. Members noted that the Heads of Nursing and Assistant Directors of Nursing were regularly attending wards to facilitate difficult discussions with staff in relation to maintaining the safety of patients in the best possible way. G Dix added that he had raised concerns previously at this Committee and the Board in relation to this matter and that he recognised that these difficult decisions when made presented unacceptable standards of care.

N Milligan suggested increased engagement with staff as to how they feel patients could be safely boarded on wards could be initiated, with any suggestions made taken forward.

J Denley advised that these were some of the most difficult discussions that she had been involved in and advised that work was being undertaken in relation to providing a solution, for example, the introduction of the Navigation Hub. Members noted that the Operations Team shared the concerns expressed by Committee Members.

E James advised that she had discussed these concerns with N Milligan last week and advised that the senior team were now present on sites given the concerns raised by staff of the difficult decisions they were having to make. E James provided assurance that patients would not be placed in the recess areas in windows and if boarding was initiated patients would be placed in the middle of the bay.

The Committee Chair recognised the significant concerns highlighted during the discussion and the importance of escalating them to Board through the Committee Highlight Report. The Committee Chair recommended this as an area for consideration at a future Board Development Session.

Resolution: The report was **NOTED.**

6. IMPROVING CARE

6.1 Maternity Services & Neonates Improvement Programme

S Hardacre presented the report and highlighted the key matters for the attention of Committee Members. Members noted that all immediate make safe recommendations had now been achieved, the programme was due to come to an end on 31 March 2023 and that Clinical Quality Improvement Leads were now in place within Maternity & Neonatal services.

In response to a question raised by P Roseblade as to how the first risk on the risk register would be mitigated assuming that no funding would be available given the current financial position for the Health Board, S Hardacre advised that the team had been able to identify alternative ways in relation to redesigning roles and added that the Care Group had identified the majority of the opportunities without requiring additional funding.

Unconfirmed

In response to a comment made by P Roseblade in relation to some of the data within the report not correlating with other reports on the agenda, for example, the number of concerns and incidents being reported, S Hardacre advised that she would undertake a review of the metrics to ensure that alignment of data was achieved.

The Committee Chair welcomed the ongoing work and the improvements that had been made and advised that she looked forward to receiving further updates on this matter.

Resolution: The report was **NOTED.**

Action: 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.

6.2 Ty Llidiard Tier 4 CAMHS Inpatient Unit Report

A Llewellyn presented the report and advised that there was continued and sustained improvement being made.

P Roseblade welcomed the report which she found to be informative and positive and sought clarity as to what was needed in order to completely de-escalate the service. A Llewellyn advised that there were a number of actions that still required completion and added that the Welsh Health Specialised Services Committee (WHSSC) still had concerns in relation to referrals and the acceptance of referrals, which had been noted in the WHSSC Quality & Patient Safety Committee Highlight report that had recently been received.

The Committee Chair also welcomed the report and advised that it was positive to note that young people were being actively involved in their care. The Committee Chair extended her thanks to staff for all of the work being undertaken to deliver the improvements in the care being provided.

Resolution: The report was **NOTED.**

6.3 Quality Dashboard

S Muir presented the report and highlighted the key matters for the attention of the Committee.

In response to a query raised by P Roseblade regarding the statement made on page 2 of the report regarding a 30 working target, S Muir confirmed that this should read 30 working *day* target.

P Roseblade made reference to paragraph 2.2 on page 5 of the report and the paragraph that commenced with the sentence *This is reflected in that of the 4258 incidents* and advised that she found it difficult to understand what this paragraph was saying. P Roseblade also advised that she thought it had been agreed at the last meeting that the provision of incident data would be paused

Unconfirmed

until the Datix issues were resolved and added that there were a number of dates contained within the report that said 2021 where it should have read 2022. P Roseblade further highlighted that there were consistency issues within the report in terms of some of the data presented, particularly in relation to absconsions, where in one section it advises that these were increasing and in another section it states that they were decreasing.

S Muir committed to reviewing the points raised by P Roseblade with the team. K Jenkins Forrester advised that in relation to paragraph 2.2 contained on page 5 of the report, she would review the wording of this section and added that in relation to absconsions, she believed that the overall trend was that these incidents were decreasing, but again would review the position to confirm this was the case.

G Dix advised that the Team had reflected on discussions held at the last meeting in relation to the content and format of the report and advised that the length of the report had reduced significantly since the last meeting. G Dix added that the report would be amended further ahead of the next meeting with more detail included within the report in relation to service to board reporting. G Dix welcomed the further comments made during today's meeting and invited any further comments from Independent Members regarding the content of the report.

In relation to a query raised by the Committee Chair in relation to the specific Community Pharmacy Form referenced on page 7 of the report, and whether the form was going to be changed to include the harm field, K Jenkins-Forrester advised that this issue had been escalated on an All Wales basis and confirmed that the form would now be amended from 1 April 2023.

The Committee Chair made reference to the Delivery Unit Dashboards which had been appended to the report and advised that these would be considered further during the discussion held in relation to the Care Group Highlight reports.

G Dix made reference to the Welsh Cancer Patient Experience Summary contained within Appendix 2 which highlighted positive reflections as to how some cancer patients felt in relation to the care being provided to them.

The Committee Chair welcomed the significant improvement in compliance in relation to Patient Safety Solutions and extended her thanks to L Mann, the previous Assistant Director of Quality & Safety for ensuring that momentum was taken to address these issues. The Committee Chair added that she looked forward to the ongoing development of the dashboard.

Resolution: The report was **NOTED**

Action: Review to be undertaken to the data discrepancies contained within the report and the wording of paragraph 2.2 on page 5 of the report.

Unconfirmed

6.3.1 Thematic Spotlight Presentation – Falls and Pressure Ulcers

Members noted that a request had been made to defer this item to the May 2023 meeting of the Committee.

6.3.2 Care Group Highlight Reports

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

Planned Care

The Care Group report for Planned Care was received and noted.

Unscheduled Care

The Care Group report for Unscheduled Care was received noting the change to the 111 process for the Minor Injuries Unit at Ysbyty Cwm Rhondda and that a walk in service would be provided from 1 April 2023. Members noted that an update on progress would be included in the May 2023 Care Group Highlight Report.

C Donoghue welcomed the shared learning that had been undertaken and sought clarity as to what the term Annex B meant. E James advised that Annex B's were the joint learning investigations that were undertaken with colleagues from the Welsh Ambulance Services NHS Trust in relation to delays at the front door. Members noted that this process created an opportunity for learning to be shared across the system in relation to ambulance handover delays and whether any harm had been caused to patients as a result.

Children and Families.

The Care Group report for Children and Families was received and members noted that an options paper has been developed as part of a national review of ITU/HDU cots and a response was now awaited form the Welsh Health Specialised Services Committee. Members recognised the progress made in relation to Post Menopausal bleeding and that a clinic was being held in March to clear the backlog.

Diagnostics, Therapies, Pharmacy and Specialties

The Care Group report was received and Members noted that the Home Office licence in relation to the Parc Prison service was now in place following a significant amount of work undertaken by the Pharmacy Team to achieve Home Office compliance. G Hughes and D Hurford extended their thanks to H Wilton for her dedication and commitment to resolve the licensing issues and members noted that lessons learnt were in the process of being considered.

Unconfirmed

C Donoghue welcomed the positive feedback that had been received from the recent Human Tissue Authority inspection and was pleased to note that this would be shared as an example of good practice.

In concluding this item, the Committee Chair extended her thanks to C Tookey for all of the support she had provided to the Committee over the last couple of years and wished her all the very best in her retirement.

Primary & Community Care

The Care Group report was received and Members noted that the issues in relation to quality data were discussed earlier in the meeting.

Mental Health & Learning Disabilities

The Care Group Highlight report was received. Members noted that the areas highlighted within the alert/escalate section were discussed earlier in the meeting.

The Committee Chair advised that the Committee had noted the areas for escalation and added that Members would expect to receive updates on progress at the next meeting.

6.4 Report from the Chief Operating Officer

J Denley presented the report and highlighted the key matters for the attention of the Committee. G Hughes advised that the Health Board continued to have no declines in red release of ambulances and extended his thanks to the Emergency Department Teams for the work undertaken to achieve this position. The Committee Chair advised that a detailed discussion was held earlier in the meeting in relation to balancing risk against quality of care. P Roseblade welcomed the positive news in relation to red release performance.

In response to a query raised by C Donoghue as to whether a review was required by the Committee in relation to the deterioration in performance in skin and lung cancer, G Hughes provided assurance that the pathway in relation to lung cancer was robust and there were no concerns at present. In relation to skin cancer, G Hughes advised that he was confident that the Team had plans in place to address the position. G Hughes added that the two areas which were of concern were Lower GI and Urology and advised that a significant amount of activity had been undertaken in relation to endoscopy bookings where a number of changes had been made in relation to internal efficiency and leadership roles within Urology. Members noted that it would take time to embed the changes made in order to improve performance.

G Hughes advised that there were significant concerns in relation to delayed transfers of care from the Health Board's Hospital sites and added that Welsh Government were now leading a piece of work with Local Authority colleagues as to how this could be addressed. G Hughes advised that the Health Board

Unconfirmed

would need to consider how it could further engage with Local Authority colleagues in light of the challenges being faced.

P Roseblade sought clarity as to what Independent Members could do to support this position. G Hughes advised that it would be helpful if a discussion could be held with the Political Leaders within the Local Authorities to make them aware of the impact upon our population. The Committee Chair advised that it may be helpful to have a further discussion on this at Board Development and that she would discuss this proposal with the new Chair.

The Committee Chair advised that she was pleased to see the reduction in waiting times within Paediatric Neurodevelopmental services as a result of the investment made.

The Committee Chair extended her thanks to J Denley and G Hughes for presenting the report.

Resolution: The report was **NOTED.**

Action: Committee Chair to have a discussion with the new incoming Health Board Chair in relation to Discharge Delays and whether this could be a future topic for discussion at a Board Development Session.

6.5 Stroke Services Progress Report

L Edwards presented the report and highlighted the key matters for the attention of the Committee. Members noted that Healthcare Inspectorate Wales had recently undertaken a visit to Ward 5 and whilst positive feedback was received, it was noted there was still a significant amount of work required.

P Roseblade made reference to the action plan which appeared to be quite optimistic in relation to completion dates. P Roseblade advised that transparency was required and if a completion date could not be achieved and suggested that dates be struck through with a new date identified. P Roseblade also proposed that it would be helpful if each of the actions could be linked to the Quality Improvement Measures where applicable.

In response to a query raised by P Roseblade as to whether the arrangement with Bristol for 24/7 access to thrombectomy was definitely going to commence, L Edwards advised that whilst there had been some recruitment issues, it was expected that this service would go live and should make a significant difference to thrombectomy rates.

G Hughes advised that there had been significant success in achieving an increase to Level B in relation to Stroke Sentinel National Audit Programme (SSNAP) at Prince Charles Hospital as a result of the Team working really hard to maintain access to a stroke bed at the hospital. Members noted that the back door remained challenging, particularly at Ysbyty Cwm Rhondda. G Hughes extended his thanks to L Edwards for her leadership in this matter.

Unconfirmed

The Committee Chair welcomed the report and the progress that had been made to date.

Resolution: The report was **NOTED.**

Action: Future iterations of the action plan to reflect realistic target dates for completion and each action to be linked to the Quality Improvement Measures where applicable.

6.6 Mortality Indicators and Mortality Reviews

S Davies presented Members with the report and highlighted the key matters for the attention of the Committee. Members noted that as of April 2023, community deaths would now need to be reported in addition to Hospital deaths and noted that the position would need to be monitored to determine what impact this would have on the team who were already stretched in terms of capacity.

In response to a query raised by the Committee Chair, S Davies confirmed that a review would be undertaken to identify whether there were any thematic lessons for learning and where focus needed to be placed moving forwards.

Resolution: The report was **NOTED.**

6.7 RADAR Committee Highlight Report

Members noted that this report would be presented to the next meeting once it had been presented through internal governance processes.

Resolution: The update was **NOTED.**

7. ANY OTHER BUSINESS

There was no other business to report.

7.1 HIGHLIGHT REPORT TO BOARD

C Hamblyn advised that given the time constraints it would not be possible to produce a written Highlight Report for the March Board meeting. It was therefore agreed that a verbal update would be provided to the Board in relation to the matters requiring escalation, with the written report being presented to the May meeting of the Board.

7.2 HOW DID WE DO IN THIS MEETING TODAY?

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

- It was felt that there had been enough time in the meeting to discuss all that was needed to be discussed;

Unconfirmed

- Sufficient time had been given to priority issues at the start of the agenda which had enabled Members to spend less time on the papers that had been included later on in the agenda;
- It was important that Members guard themselves from repetition, with a number of reports containing the same issues. It was important to have the right discussion at the right time;
- Presenters need to be more succinct when presenting reports, and highlight just one or two main points from the report;
- Discussions had been held previously in relation to duplication and sharing of the same report at various committees. It was felt that this demonstrated triangulation and that shared work was being undertaken alongside shared learning;
- It was felt the Care Group Highlight Report section worked well.

The Committee Chair advised that she felt a stronger feeling of service to Board reporting from today's meeting with the voices from front line staff heard much more clearly. The Committee Chair advised that this would continue to be developed further so that the use of Committee Members time could be used more effectively. The Committee Chair advised that it was evident that all members of staff were committed to identifying solutions with not one member of staff being complacent. The Committee Chair extended her thanks to all staff for their efforts and added that she did not underestimate the challenges being faced by everyone.

8. DATE AND TIME OF THE NEXT MEETING

The next meeting would take place at 9:00am on Tuesday 16 May 2023. An In Committee session would also be held on Monday 27 March 2023 at 2:00pm.

Unconfirmed

Agenda Item Number: 3.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 27 March 2023 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Lauren Edwards	Executive Director of Therapies & Health Sciences
Hywel Daniel	Executive Director for People
Gethin Hughes	Chief Operating Officer
Richard Hughes	Deputy Director of Nursing
Anthony Gibson	Deputy Medical Director
Cally Hamblyn	Assistant Director of Governance & Risk
Ana Llewellyn	Care Group Nurse Director
Julie Denley	Deputy Chief Operating Officer
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:

- Dilys Jouvenat, Independent Member
- Greg Dix, Executive Director of Nursing
- Dom Hurford, Executive Medical Director

1.3 Declarations of Interest

2 MAIN AGENDA

2.1 Unconfirmed Minutes of the In Committee held on 30 January 2023.

Resolution: The Minutes were **NOTED**.

Unconfirmed

2.2 Action Log

The action log was received and discussed.

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

2.3 External Review of Practice into Care of a Patient by Cwm Taf Morgannwg Health Board and Rhondda Cynon Taf County Borough Council

A Llewellyn presented the item highlighting the key matters arising from the External Review of Practice undertaken. She noted that a multi-agency action plan will be developed in response to the review findings which will be shared with the Committee as appropriate.

The Committee Chair extended her thanks to A Llewellyn for presenting the report and advised that she looked forward to receiving further updates on this matter.

Resolution: The report was **NOTED**.

2.4 Healthcare Inspectorate Wales Mental Health Service Inspection Glanrhyd Hospital

A Llewellyn presented the report and highlighted the key matters for the attention of the Committee. Members noted that a high level discussion had been held on this matter at the public session of the Committee held on 16 March 2023 as at that stage the reports had not been published.

The Committee Chair advised that the report had highlighted a number of thematic issues and noted that an improvement programme had been established to address the issues raised. Following discussion, it was agreed that progress reports would be shared with Committee Members at each public session from May 2023 onwards.

The Committee Chair extended her thanks to A Llewellyn for presenting the report.

Resolution: The report was **NOTED.**

Action: Progress reports to be shared at the public session of the meeting from May 2023 onwards.

2.5 Critical Care Framework Proposal

A Gibson presented Members with a verbal update on the current position in relation to proposals around the Critical Care Framework highlighting the key matters for Members attention and the next steps that will be taken to progress this activity

Unconfirmed

The Committee Chair extended her thanks to A Gibson for presenting the update and advised that she looked forward to receiving a further update at the next meeting.

Resolution: The update was **NOTED.**

2.6 HBSUK Validation Quality Concerns & Mitigations

R Hughes presented Members with the report and highlighted the key matters arising out of the validation exercise by HSBUK, which concluded on the 31st March 2023. It was noted that any lessons identified as part of the validation activity will form the basis of a lesson learnt report.

The Committee Chair extended her thanks to R Hughes for presenting the report and noted that there were lessons that needed to be learnt from this matter.

Resolution: The report was **NOTED.**

3. ANY OTHER BUSINESS

The Committee Chair extended her thanks to colleagues for presenting their respective reports.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting would take place on Wednesday 31 May 2023 at 2.00pm

Unconfirmed

AGENDA ITEM
3.1.3

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2022-2023

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Jayne Sadgrove, Chair of the Quality & Safety Committee
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	ENDORSE FOR BOARD APPROVAL

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report *"setting out its activities during the year and detailing the results of a review of its performance".*

1.2 This annual report from the Quality & Safety Committee details the activities and performance for the Committee for the reporting period 2022-2023.

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

2.1 The Committee Annual Report at Appendix 1, summarises the key areas of business activity undertaken by the Committee from April 2022 – March 2023 and highlights activity for further consideration over the next 12 months.

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

3.1 Please refer to Appendix 1 for the full detail contained within the report.

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Committee are being asked to **ENDORSE FOR BOARD APPROVAL** the Committee Annual Report.

Appendix 1

Quality & Safety Committee

Committee Annual Report 2022-2023

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QUALITY & SAFETY COMMITTEE
ANNUAL REPORT 2022-2023

1. FOREWORD

I am pleased to be able to commend to you this annual report, which has been prepared for the attention of the Board and reviews the work of the Committee for the financial year 2022-2023.

During the year, I have been supported by James Hehir, Nicola Milligan, Dilys Jouvenat, Patsy Roseblade and Carolyn Donoghue who have contributed their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my sincere thanks to all the officers of the Committee for their commitment in supporting the Committee in discharging its responsibilities through robust reporting. I would particularly like to extend my thanks to colleagues within the Corporate Governance Team for the support they provided me throughout the year. I also wish to record my appreciation for the support and contribution given by the Internal Audit team at the NHS Wales Shared Services Partnership (NWSSP), by Audit Wales, Healthcare Inspectorate Wales and Delivery Unit colleagues.

Going forward the Committee will continue to pursue a full programme of work covering quality and safety of care for our population together with matters affecting the health and safety of our workplaces with the aims of promoting learning and further strengthening the governance and assurance arrangements of the Health Board.

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Jayne Sadgrove
Chair of the Quality & Safety Committee
Cwm Taf Morgannwg University Health Board (CTMUHB)

2. INTRODUCTION

The purpose of the Quality & Safety Committee "the Committee" is to provide assurance to the Board on the provision of workplace health & safety and safe and high quality care to the population we serve, including prevention through public health, primary and secondary care.

The Committee has embraced the new Strategic Goals in how it manages its agenda to ensure that its activity supports the **'CTM2030: Our Health, Our Future'** Strategy and the **Values and Behaviours** of the Health Board.

The Committee meets every other month, with the key function to provide scrutiny on behalf of the Board on all matters relating to Quality and Safety.

A key area of the Quality Improvement work continues to be focussed on the Health Board's response to the concerns raised in 2019 regarding failings in maternity services. The service and Maternity Improvement Team has continued to deliver improvements during 2022-2023 with a regular report on improvement activity received by the Committee.

During 2022-2023, targeted focus was paid to Ty Llidiard service improvements following concerns raised by the Welsh Health Specialised Services Committee and on Mental Health Services following reviews undertaken by Healthcare Inspectorate Wales. The Committee were also sighted on programmes of improvement in relation to Prince Charles Hospital, Stroke Services and the Minor Injuries Unit at Ysbyty Cwm Cynon.

3. ROLE, MEMBERSHIP, ATTENDEES AND COMMITTEE ATTENDANCES

3.1 ROLE

The role of the Committee is to advise and assure the Board on whether there are effective Quality & Safety arrangements in place – through the design and operation of the Health Board system of assurance – to support it in its decision taking and in discharging the accountabilities for securing the achievement of the Health Board objectives in accordance with the standards of good governance determined for the NHS in Wales.

The Committee's Terms of Reference are reviewed annually and are available via the following link: https://cwmtafmorgannwg.wales/how-we-work/standing-orders/

3.2 MEMBERSHIP

The membership of the Quality & Safety Committee comprises of six Independent members, enabling the Committee to provide robust scrutiny and assurance to the Board independently of the management decision-making processes.

A summary of the Independent membership during 2022-2023 is outlined in table 1 below:

Table 1 – Composition & Membership of the Quality & Safety Committee Apr 2022-March 2023

Name	Period
Members	
Jayne Sadgrove (Committee Chair) Independent Member	April 2022 – March 2023
James Hehir Independent Member	Apr 2022 - March 2023
Nicola Milligan Independent Member	Apr 2022 – March 2023
Dilys Jouvenat Independent Member	April 2022 -March 2023
Patsy Roseblade Independent Member	April 2022 – March 2023
Carolyn Donoghue Independent Member	April 2022 – March 2023

3.3 ATTENDANCE AT QUALITY & SAFETY COMMITTEE 2022-2023

During the year, the Committee met on six occasions. All meetings were quorate and were well attended as shown in Table 2 below:

Table 2 - Meetings and Member Attendance 2022-2023

In Attendance	24 May 2022	19 July 2022	20 Sept 2022	15 Nov 2022	24 Jan 2023	16 Mar 2023	Total
Independent Members							
Jayne Sadgrove (Chair of the Committee)	✓	✓	✓	✓	✓	✓	**6/6**
Dilys Jouvenat – Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Nicola Milligan – Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
James Hehir – Independent Member	✓	✓	✓	✓	✓	x	**5/6**
Patsy Roseblade Independent Member	✓	✓	✓	✓	✓	✓	**6/6**
Carolyn Donoghue - Independent Member	✓	✓	✓	✓	x	✓	**5/6**

3.4 ATTENDEES

The Committee's work is informed by reports provided by leads within CTMUHB, Cwm Taf Community Health Council, Healthcare Inspectorate Wales, Audit Wales, Internal Audit and the Delivery Unit. Although not members of the Committee, colleagues from these areas are invited to attend each meeting of the Quality & Safety Committee. Invitations to attend the Committee meeting are also extended, where appropriate and on an 'ad hoc' basis, to specific staff when reports which relate to their specific area of responsibility are being discussed.

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4. QUALITY & SAFETY COMMITTEE BUSINESS

The Quality & Safety Committee provides an essential element of the Health Board's overall assurance framework. All meetings continued to be held virtually via Microsoft Teams during 2022/2023 with continued use of the Consent Agenda. Any items included on the consent agenda were considered by Members prior to each meeting, with Members provided with the opportunity to raise questions prior to the meetings regarding the reports. All reports included on the Main Agenda were discussed during each meeting. The Quality & Safety Committee agenda broadly follows a standard format, comprising of specific sections, and the activity of the Committee during 2022/2023 is outlined in Appendix 1 of this report.

Links with Other Committees/Boards
Key risk areas from the Quality & Safety Committee are highlighted at full Board by the Committee Chair via the Committee highlight report.

At each meeting, if any Committee referrals are identified, the Chair of the Committee or the Corporate Governance Lead will ensure that the following questions are captured to ensure a referral is managed effectively:

- What are you referring?
- Why are you referring?
- What is the outcome you are anticipating from this referral?

During the course of 2022-2023, the following items were referred to the Quality & Safety Committee from other Committees

- Internal Audit Follow Up Review - Patient Pathway Appointment Management Process – Audit & Risk Committee requested that updates on progress were included in the Chief Operating Officers Report.

5. ACTION LOG

In order to monitor progress and any necessary follow up action, the Committee has developed an Action Log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and from the Committee to the Board.

6. GOVERNANCE

The effectiveness of the Committee is monitored through the following key governance activity:

- Annual Review of the Terms of Reference & Operating Arrangements
- Committee Annual Report
- Highlight Reports from the Committee to the Health Board meetings
- Annual Committee Effectiveness Self-Assessment Survey
- Annual Cycle of Committee Business

The Corporate Governance Team maintain a "Committee Effectiveness Tracker" to ensure the above activity is undertaken at the appropriate times during the year.

Committee Annual Self-Assessment

The Committee is in the process of completing its Annual Self-Assessment for 2022-2023, any learning and themes identified following the assessment will be presented to the Committee for review and consideration.

7. ASSURANCE TO THE BOARD

The Quality & Safety Committee considers that on the basis of the work completed by the Committee during 2022 - 2023, there are effective measures in place that have delivered against its agreed Terms of Reference.

The forward work programme for 2023-2024 and beyond, ensures that the Committee retains scrutiny on key areas of activity, not exclusive to but including the following:

- Listening and Learning Stories (Patient and Staff)
- Learning lessons and sharing best practice
- Maternity & Neonate Services oversight and scrutiny
- Quality Governance arrangements
- Compliance with the Nurse Staffing Levels (Wales) Act
- Quality improvement initiatives
- Scrutiny of any Regulatory and Inspectorate Body reports
- Consideration of the Audit Wales Structured Assessment feedback to consider how best to manage and prioritise the volume of the Committees business.
- Monitoring the activity considered by the Health, Safety & Fire Sub Committee established in August 2019

In addition the Committee Chair will meet with the lead officers and the Chair of the Board to discuss progress of the work of the Committee.

The Annual Cycle of Committee Business has continued to be presented to each meeting of the Committee during 2022/2023, alongside the Forward Work Programme. This supports and helps identify the key areas of focus for the Committee and is one of the key components in ensuring that the Committee is effectively carrying out its role. It also facilitates the management of agendas and Committee business.

8. LINKS WITH OTHER COMMITTEES

The Quality & Safety Committee will continue to have close links, and share risks with other Committees of the Board, particularly the Audit & Risk

Committee, Planning, Performance & Finance Committee and the People & Culture Committee.

As a Sub Committee of the Quality & Safety Committee, regular highlight reports are received from the Health Safety & Fire Sub Committee.

Through either specific meetings or the regular Independent Member meetings there is an opportunity for Committee Chairs to support the work of each of the Committees they Chair, share learning and avoid duplication. All Committee Chairs have access to Committee Highlight Reports to the Board.

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APPENDIX 1

1. Consent Agenda

During 2022 – 2023 the following items were received on the Consent Agenda for Approval/Endorsement:

- Quality & Safety Committee Annual Report 2021/2022;
- Quality & Safety Committee Annual Cycle of Business;
- Facilities Policy - Security Policy;
- Estates Policies - PAT Testing Policy;
- Quality & Safety Committee Terms of Reference;
- Children & Young People 16-17 year's Acute Admission Policy;
- Chairs Urgent Action - Policy Approvals;
- Independent Member Walkround Protocols.

During 2022 – 2023 the following items were received on the Consent Agenda for Noting/Information:

- Committee Forward Work Programme;
- Quality & Safety Committee Annual Self-Assessment;
- WHSSC Quality & Patient Safety Chairs Report;
- Audit Wales/Healthcare Inspectorate Wales Joint Review of Quality Governance – Summary of Progress made – April 2022;
- Welsh Ambulance Services NHS Trust - Patient Experience Reports;
- Community Acquired Pressure Ulcer Improvement Plan Update and Measurement Strategy;
- Quality Governance - Regulatory Review Recommendations and Progress Updates;
- Controlled Drug Accountable Officer Annual Report;
- GAP Analysis Children's Community Nursing Service;
- GIRFT Review of Cwm Taf Morgannwg University Health Board February 2022;
- Human Tissue Authority Act Progress Reports;
- WHSSC Quality & Patient Safety Committee Annual Report;
- Putting Things Right Annual Report;
- RADAR Committee Highlight Reports;
- Clinical Audit Quarterly Report and Annual Plan;
- Individual Patient Funding Request Annual Report;
- Learning Disabilities 6 Monthly Progress Report;
- Community Health Council National Surveys and Quality Monitoring Reviews;
- Incident Management Framework - Listening, Learning & Improving Safety;
- Health & Care Standards Annual Report;
- Radiation Safety Committee Highlight Reports;
- Thematic Review of the feedback received from the Community Health Council - Primary Care;
- Transition and Handover from Children to Adults Health Services;
- Health & Care Standards Annual Report;
- National Prescribing Indicator (NPI) Annual Report;

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- Clinical Education Annual Report;
- Annual Review 2021/22 – Welsh Risk Pool and Legal & Risk Services;
- Safeguarding & Public Protection Annual Report

2. Main Agenda

During 2022 – 2023 the following items were received:

- Patient Experience/Listening & Learning Stories;
- Sepsis Compliance Improvement Plan;
- Organisational Risk Register - Risks Assigned to the Quality & Safety Committee;
- Concerns, Redress, Claims & Inquests – Actions arising from Internal Audit & Welsh Risk Pool Reviews (also received via the consent agenda on occasion);
- Health, Safety & Fire Sub Committee Highlight Reports (also received via the consent agenda on occasions when no issues to escalate);
- Maternity & Neonates Services Improvement Programme;
- Presentation of PREMS (Patient Reported Experience Measures);
- Maternity Services Self-Assessment Against Ockenden 2022 Recommendations;
- RCOG Recommendations Closure Report;
- Maternity Metrics Report;
- Quality Dashboard Report;
- Spotlight Report on Patient Falls;
- Report from the Chief Operating Officer;
- Planned Care Recovery – Presentations;
- Cancer Services Annual Report;
- Stroke Services Progress Report;
- National Nosocomial Covid-19 Programme - CTM Update (also received on the consent agenda on occasion);
- Response to 'Improving Care, Improving Lives' National Care Review for Inpatients with a Learning Disability;
- Infection, Prevention & Control Committee Highlight Reports (routinely received on the consent agenda – added to main agenda when items for escalation had been identified);
- Digitisation of the Nursing Care Record;
- Prince Charles Hospital Neonatal Deep Dive Review Update
- NHS Delivery Unit Findings Report: CTMUHB Maternity and Neonatal Services Serious Incidents Assurance Review & Board Systems and Processes for Reporting, Management and Review of Patient Safety Incidents;
- Ty Llidiard Progress Report;
- Quality & Performance of Service Provision HMP and Young Offenders Institute Parc;
- Dental Contract Reform;
- Development of a Quality Strategy;
- Patient Falls and Absconsions Lessons Learnt Report;
- Covid 19 Inquiry Preparedness;

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- Assurance on the Health Board's plan to improve monitoring and reporting in relation to Continuing Healthcare (CHC) and Funded Nursing Care (FNC) activity;
- Annual Letter 2021/2022 – Public Services Ombudsman for Wales;
- NCCU Quality Assessment and Improvement Service - Annual Quality position statement;
- Datix Cymru - Assurance Report;
- Learning from Mortality Reviews/Mortality Indicators Report;
- Civica - People's Experience Feedback System;
- Peer Review of Urgent Primary Care (Out of Hours and UPCC) In CTMUHB;
- Ward Based Nursing Assurance Report;
- Learning From Events Reports - Progress Report;
- CTMUHB Quality and Safety Framework 2022-2025;
- Deep Dive into CAMHS;
- Liberty Protection Safeguards Preparation;
- Child T - Child Practice Review;
- Care Group Spotlight Presentation - Mental Health & Learning Disabilities;
- Care Group Spotlight Presentation - Unscheduled Care;

Integrated Quality & Safety Exception Reports were received up to September 2022 from the following areas:

- Bridgend Integrated Locality Group;
- Merthyr & Cynon Integrated Locality Group
- Rhondda Taff Ely Integrated Locality Group;
- Primary Care Directorate.

The Health Board implemented a new organisational structure during 2022-2023 and reporting changed from Integrated Locality Group reports to a Care Group Structure. Care Group Highlight Reports were received from the following areas:

- Planned Care;
- Unscheduled Care;
- Children & Families;
- Diagnostics, Therapies, Pharmacy & Specialities;
- Primary Care and Community;
- Mental Health & Learning Disabilities.

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AGENDA ITEM
3.1.4

QUALITY & SAFETY COMMITTEE

RATIFICATION OF URGENT COMMITTEE CHAIR'S ACTION - POLICY APPROVAL

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
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**
Urgent Chair's Action	Circulated 29/03/2023	SUPPORTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of the report is to seek ratification of a policy which was approved under Chair's Urgent Action between Quality & Safety Committee meetings.

1.2 On this occasion the Chairs Urgent Action was seeking approval of the Policy for the Sensitive Disposal of Pregnancy Remains which is explained further in Section 2.

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

1.3 The Policy for the Sensitive Disposal of Pregnancy Remains is relevant to all practicing Clinical staff in mortuaries, maternity, gynaecology, early pregnancy units, community clinics, emergency departments, theatres, facilities, hospital chaplains.

2.2 It provides a prescribed plan for staff to follow, which should not be deviated from. This Policy presents the overarching principles and standards for the development of localised Standard Operating Policies (SOPs).

2.3 The Policy ensures that all pregnancy remains of less than 24 weeks gestation resulting from all circumstances of loss of pregnancy, are disposed of in a sensitive, dignified and timely manner.

2.3 With the support of the Chair the request seeking urgent support for approval of the policy was circulated on 29 March 2023. This resulted in the following responses indicating support from Committee members:

- Jayne Sadgrove, Vice Chair and Chair of the Quality & Safety Committee;
- Carolyn Donoghue, Independent Member;
- James Hehir, Independent Member;
- Dilys Jouvenat, Independent Member;
- Patsy Roseblade, Independent Member.

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

3.1 Chairs Urgent Action was sought ahead of the Quality & Safety Committee due to the need to implement the policy as soon as possible.

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)	Effective Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not relevant to the ratification of Urgent Chair's Action

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining our Future

5. RECOMMENDATION

5.1 The Quality & Safety Committee is asked to **ratify the approval** of the request for urgent Chair's action in relation to policy approval for the Policy for the Sensitive Disposal of Pregnancy Remains.

Policy for the sensitive disposal of pregnancy remains (PATH 02)

Document Type:	Clinical Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Dr Paul D Davies, Designated Individual HTA
Executive Sponsor:	Executive Medical Director
Approved By:	**Clinical Policy Group (Clinical Procedures, Guidelines Only)**
Approval / Effective Date:	11th August 2022
Review Date:	11th August 2025
Version:	Final

Target Audience:

People who need to know about this document in detail	Clinical staff in mortuaries, maternity, gynaecology, early pregnancy units, community clinics, emergency departments, theatres, facilities, hospital chaplains
People who need to have a broad understanding of this document	Clinical managers
People who need to know that this document exists	All staff involved in the development of Health Board Policies.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: 12/1/11**
	Outcome: approved
Welsh Language Standard	No
Date of approval by Equality Team:	
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidence based, and accessible care

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

COMPONENTS:

A policy must contain the following components and must also be written to include the values and behaviours of the organisation wherever relevant:

It is accepted that for Clinical Policies and or other Written Control Documents (Procedures, Guidance etc.) the policy components below may not all be relevant.

For guidance on Clinical Policy Development please contact:

CTM_ClinicalPolicies@wales.nhs.uk

For guidance on Non Clinical Policy Development please contact:

CTM_Corporate_Governance@wales.nhs.uk

Or visit the Policy Author Page on SharePoint:

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APPENDICIES

INTRODUCTION

1. POLICY STATEMENT

A policy is a high level overall guide, which sets the boundaries within which action will take place, and should reflect the philosophy of the organisation or department.

It provides a prescribed plan for staff to follow, which should not be deviated from. This Policy presents the overarching principles and standards for the development of localised Standard Operating Policies (SOPs).

Cwm Taf Morgannwg University Health Board ensures that all pregnancy remains of less than 24 weeks gestation resulting from all circumstances of loss of pregnancy, are disposed of in a sensitive, dignified and timely manner.

2. SCOPE OF POLICY

This policy applies to all areas of the Health Board in which an early loss of pregnancy may occur. It applies specifically to:

- Maternity, Labour and Gynaecology
- Theatres
- Bodywise clinics within the RCT & MC area
- Early Pregnancy Units
- Emergency Departments
- Pathology
- Mortuary
- Spiritual care team

Each area should develop their own Standard Operational Procedures or Care Pathways to support the implementation of this policy.

3. AIMS AND OBJECTIVES

The emphasis throughout this policy is on the woman's wishes as it relates to tissue from her body and her confidential health information. The Part A Consent form must be signed by the woman and the same healthcare professional who signed Part B. Part B certification must be completed by the midwife/nurse practitioner or medical practitioner looking after the woman (see section 6.5). These forms must accompany pregnancy remains on transfer to the Mortuary Department and Mortuary staff will check the following;

a. The person signing the form has indicated that they have had the opportunity ask questions and thus given enough information to enable them to understand what their options are through signing the relevant section

b. To ensure they have the right to give instruction e.g. a signature from a partner with a different surname will not be accepted. This has been stipulated by the crematoria as part of the workable agreement.

All references to 'partner' are general in its interpretation and would include same-sex/civil partner and surrogate partner.

Adherence to the principles of equality, dignity and human rights will be of paramount importance.

Information should be given in such a way that does not make assumptions about people's previous experience.

Every effort will be made to communicate in a manner appropriate to the woman, both verbally and in writing in order to meet specific communication needs (e.g. if they have a sensory loss) and language needs (e.g. if they wish to communicate in Welsh or any other language). The All Wales Standards for Accessible Communication for People with Sensory Loss and the Health Board Policy on Accessing an Interpreter would be particularly relevant.

4. RESPONSIBILITIES

This policy is applicable to all clinical staff within the scope set out in Section 2. Clinical staff have a personal responsibility for ensuring the policy is adhered to and where there are concerns these are escalated immediately to line managers for advice, both in and out of hours.

5. DEFINITIONS

The policy upholds the guidelines set out by The Royal College of Nursing, the Still birth and Neonatal Death Society (SANDS), The Human Tissue Authority (HTA) and the Institute of Cemetery & Crematorium Management (ICCM). It also complies with the Equality Act 2010.

This policy should be read in conjunction with the Cultural Toolkit which can be found on the Equality and Diversity site on Sharepoint.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 Introduction

The limit of viability for fetal survival outside the womb is currently set at 24+0 weeks gestation (House of Commons 2007). Fetal demise within the uterus, prior to 24+0 weeks gestation, is referred to as an early loss of pregnancy and are not registered as a still birth (Still birth Act 1992).

NHS England (2014) definition of loss;

- Early loss (first trimester) – loss of pregnancy up to 13 weeks gestation
- Late loss (second trimester) – loss of pregnancy between 13 and 24 weeks gestation
- Stillbirth (third trimester) – loss at 24 weeks gestation and above

On the basis of its potential to develop into a human being, the fetus/baby is entitled to respect, according it a status broadly comparable to a living person.

Early loss of pregnancy may result in tissue relating to the loss of pregnancy that may not actually contain discernible fetal tissue. The HTA does not recognise that the tissue is any different to any other body tissue and states that no consent is required for disposal but recommends that such tissue is disposed of sensitively in accordance with the woman's wishes anyway, due to the woman's loss rather than the nature of the tissue.

Subsequently, fetal remains of less than 24 weeks gestation are referred to on the whole as 'pregnancy remains' and cannot be disposed of as clinical waste. Cwm Taf Morgannwg University Health Board has an obligation to dispose of pregnancy remains in a sensitive, dignified and ethical manner.

The policy refers solely to the care, rights and privileges of the woman. It is not intended to be disrespectful to the duty of care to the father, same sex partner or other partner if different to the father, or other family members, whether there be mutual agreement or dissent in regard to any action relating to the loss of pregnancy or subsequent arrangements. Information relating or provided to the woman may only be given to her partner with her permission.

A loss of pregnancy at any stage can affect parents and partners profoundly and sensitive and supportive care is required. It is important to recognise that the needs of individuals and the circumstances surrounding loss of pregnancy can vary widely and therefore flexibility in the application of this policy may be required (e.g. specific cultural requirements) within the parameters defined by legislation and professional guidelines.

Women should be given the same choices for disposal of pregnancy remains as for a still born child as far as possible and the options should be explained to them in a clear and sensitive manner taking account of their communication needs and any language barriers, both verbally and in writing by appropriately trained health professionals. It is acknowledged that women sometimes do not wish to be involved in the arrangements for disposal and it is important to respect their wishes. Some however return to enquire about their loss months or years later so it is important to ensure that records are kept with regards to disposal.

6.2 Principles of care

This policy is applied in all cases of early pregnancy loss including ectopic pregnancies, miscarriages, early intrauterine fetal death, molar pregnancies, pregnancy remains obtained during surgical procedures for miscarriage or termination, termination for fetal abnormality and the termination of pregnancy requested solely by the woman

Staff will be aware of this policy and the practice of sensitive disposal in Cwm Taf Morgannwg UHB and will be prepared to discuss the issues with women or couples requesting such information

Staff will be able to provide technical, procedural, emotional, cultural and spiritual support on a 24 hour basis. Nursing, Midwifery and spiritual support are available on request to any woman, partner or relative as well as professional and emotional support for any staff member involved with the care of a woman experiencing pregnancy loss.

The woman will be informed of the options available for funeral arrangements as well as the options for support offered by the spiritual care team and the options for sensitive disposal offered by Cwm Taf Morgannwg UHB.
Where possible, the woman will be fully informed about their own condition and the cause of the pregnancy loss will be explained to them taking account of communication and language needs and cultural issues.

Emotional, psychological and spiritual support (on a multicultural basis) will be made available in order to assist the grieving process of the woman or partner and immediate family.

The use of language will be sensitive to all involved and where appropriate, the term 'baby' or 'pregnancy remains' rather than 'fetus' will be used in verbal or written communication with the family unless instructed otherwise by the family.

Sensitivity should be shown towards the woman's cultural or religious background in that consideration will be given to her traditions, customs for hygiene, diet, ritual cleansing and preparation of the pregnancy remains in preparation for burial or cremation.

All pregnancy remains will be handled with respect and buried or cremated with dignity. If clinical incineration is chosen as the method of disposal this will be conducted as sensitively as possible.

Confidentiality will be respected at all times.

The needs of Cwm Taf Morgannwg University Health Board staff will be recognised through;

- Induction, training and competence
- Opportunities for counselling / debriefing
- Consultation on the review of the process defined in this policy.

6.3 Terminology

HTA	Human Tissue Authority – an organisation that supports public confidence by ensuring that human tissue is stored and disposed of in a dignified and legal manner.
HTARI	Human Tissue Authority Reportable Incident
DI	Designated Individual named on the HTA licence. They are the person under whose supervision the licenced activity is authorised to be carried out.
PD	Person Designated named on the HTA licence, supplementary to the DI in the governance framework. This person will often act at a local level to support the DI.
Early pregnancy loss	In the context of this policy relates to pregnancy remains from a pregnancy up to 24 weeks gestation. NHS England (2014) definition of loss; • Early loss (first trimester) – loss of pregnancy up to 13 weeks gestation • Late loss (second trimester) – loss of pregnancy between 13 and 24 weeks gestation • Stillbirth (third trimester) – loss at 24 weeks gestation and above
Stillbirth	An infant of greater than 24 weeks gestation dying before or during delivery.

Neonatal death	An infant dying within 28 days of delivery or when the fetus / baby had a recordable heartbeat at the time of delivery (regardless of gestational age), requiring separate entries in the medical notes of the time of delivery and the time that the heart beat ceased.
Fetus / fetal remains	Any fetus or fetal remains which are identifiable either visually or by histological examination.
Pregnancy remains	All remains and tissue resulting from an early loss of pregnancy up to 24 weeks gestation.
Family	Any relatives or friends that the may wish to involve in her loss.
Client	A person who experiences pregnancy loss who may not wish to be referred to as the woman who gave birth.
Termination of pregnancy	The induced loss of a fetus or baby for any reason.
Green burial	Burial of remains outside of a cemetery.
RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital

6.4 Summary of procedures

All women will be kept fully informed about their pregnancy loss and the present and future consequences for their own health and for intended pregnancies. Appropriate advice and health education will be given both in discussions with the woman and in writing before leaving the hospital.

Sadness and distress is frequently experienced during early pregnancy loss and will require emotional support. Staff specifically trained and experienced to provide this must be available in the event of any discussion with the woman in regard to her emotional care and the practical options for sensitive disposal of her baby / fetus. The Spiritual Care Service offers open and non-judgemental support to all, regardless of their personal faith or belief system.

Depending on the circumstances surrounding the pregnancy loss and the gestational age, the woman may be offered the opportunity of spending time with the baby as outlined in the appropriate care pathway.

Women should be informed that sight of their baby after they leave hospital is not recommended as a consequence of post mortem changes in appearance.

It is important to note that all baby/fetus remains must be transferred to the Mortuary in the first instance even where there has been an indication from the women that they wish to make private arrangements. This ensures traceability and governance.

In cases of an emergency or elective pregnancy loss (<24wks) it is important that patients are provided with the relevant information booklet depending on their gestation. The booklets are:

a. ***"Practical arrangements following pregnancy loss under 16 weeks"***

b. ***"Practical arrangements following pregnancy loss 16 - 24 weeks"***

This booklet should be provided to read before any approach from clinicians to explain and seek consent using the Part A form *"**Consent for respectful disposal of pregnancy loss remains under 24 weeks gestation".*** This will provide the patient with time to digest the information before informed consent is taken using the Part A form and ask questions if needed. Under NO circumstances should consent be gained before the patient is fully able to provide an informed choice. If a patient has taken medication which may mean that their judgement is impaired, consent MUST be taken once the medication effects have worn off and they can make an informed choice NOT before.

A note in the clinical record that the booklet has been provided to the patient is also important. In the uncommon event where the patient does not wish to receive the booklet or perhaps not engage with consent, that should also be noted in the clinical record.

6.4.1 Photography

Photographs may be taken for family use or for medical purposes in line with the appropriate care pathway and Health Board Policy. Photographs for family use must be taken whilst the baby is on the ward: photographs taken days after the death are not suitable for family reference.

6.4.2 Post mortem examination

When a post mortem examination is determined to be clinically desirable by the Consultant Obstetrician, the woman will be informed of the process for post mortem examination and the requirement for informed consent. Every opportunity will be provided for the woman to express her views, feelings or concerns without undue pressure to conform to the post mortem request. Cultural issues will be taken into account wherever possible.

Information relating to the post mortem process will be conveyed to the woman by trained and experienced health professionals, ideally the consultant in charge of the woman's care, senior nursing or midwifery staff. Only those staff who have attended the relevant training provided by Cardiff and Vale University Health Board can obtain consent for post mortem examination. The signatures of these individuals are held on a central database by Cardiff & Vale University Health Board for cross checking to ensure validity of consent. The process of gaining written maternal consent will be documented in the appropriate care pathway.
Post mortem examinations are carried out at the University Hospital of Wales (UHW) and pregnancy remains must be transferred to the Fetal Pathology Department at UHW with appropriate paperwork as soon as possible after delivery.

The remains must be taken to the mortuary at each site with all appropriate paperwork before transfer to UHW and must not be sent direct by any other department. The mortuary staff prepare the remains for transport and arrange transfer to UHW via a contracted funeral director in accordance with standard operating procedures.

6.4.3 Private funeral arrangements

Statutory and local regulations for burial and cremation are complex. Women wishing to conduct their own funeral arrangements will be referred to an appropriate and suitably qualified individual for assistance and information relating to the funeral arrangements and the policy for the Health boards care of the pregnancy remains, prior to their release to a contracted funeral director.

The pregnancy remains must be transported to the mortuary as per this policy with correct and complete certification. The remains will be placed in formal saline (embalmed) and then packaged in a sturdy container that is suitable to present to the funeral director. The process takes approximately three days and the mortuary staff will contact the funeral director (supplied by the woman's care team) when the remains are ready for collection.

Exceptions to the above may occur if the woman specifically requests that the remains are not to be embalmed. The remains must be transported to the mortuary as per this policy with correct and complete certification. The remains will be packaged in a sturdy container that is suitable to present to the funeral director. The process takes approximately an hour, depending on staff availability and the mortuary staff will contact the funeral director (supplied by the woman's care team) when the remains are ready for collection. In this situation, the woman and funeral director must be made aware that the remains will deteriorate rapidly and must be dealt with at the soonest opportunity.

The CTMUHB mortuary service assumes managerial responsibility for the respectful storage and preparation of pregnancy remains prior to collection by a contracted funeral director.

The mortuary service will discuss the storage and collection process with suitably trained health care professionals on the woman care team and contracted funeral directors. Under no circumstances should the woman or her family be put in direct contact with the mortuary services.

6.4.4 Women wishing to take pregnancy remains home

It is the policy of this Health Board that staff will not make an unsolicited offer to parents to take pregnancy remains home.

Women sometimes request to take pregnancy remains home to transfer to a funeral director at a later date or perform 'green burial'. 'Green burial' is used to describe the process of the woman dealing with the remains privately without the assistance of a funeral director.

If such a request is made, the consultant in charge of the woman care must record their assent for such action in the woman's medical notes.

The pregnancy remains must be transported to the mortuary as per this policy with correct and complete certification. The remains will be placed in formal saline (embalmed) and then packaged in a sturdy container that is suitable to present to the woman. The process takes approximately three days and the mortuary staff will inform the woman's care team when the remains are ready for collection by a suitably qualified health professional.

Exceptions to the above may occur if the woman specifically requests that the remains are not to be embalmed. The remains must be transported to the mortuary as per this policy with correct and complete certification. The remains will be packaged in a sturdy container that is suitable to present to the woman. The process takes approximately an hour, depending on staff availability and the mortuary staff will inform the woman's care team when the remains are ready for collection by a suitably qualified health professional. In this situation, the woman must be made aware that the remains will deteriorate rapidly and must be dealt with at the soonest opportunity.

Under no circumstances should the woman be referred to the mortuary services to collect the remains and nor should any transfer of remains to the woman take place within the pathology directorate or mortuary premises.

The remains should be collected from the mortuary by a suitably qualified health professional who will sign an appropriate chain of custody documentation (Appendix C) to be stored in the mortuary. The remains will be transferred to the woman in a suitable environment as arranged by their care team. Appropriate chain of custody documentation must be signed upon release to the woman and kept in their medical notes. Pregnancy remains must never be released to anybody other than the woman.

The chain of custody documentation must contain a disclaimer to state that the recipient has an obligation to dispose of the pregnancy remains in a lawful manner. SANDS, a bereavement support charity (https://www.sands.org.uk/), provide a range of suitable and sensitive templates which may be used.

6.4.5 Health Board communal cremation of pregnancy remains

Written and informed consent must be obtained from the woman to proceed with a Health Board communal cremation of their pregnancy remains. Recorded verbal consent will not be accepted. The crematoria require written consent and expect that the Health Board has obtained it. All other methods of disposal are the under the direction of the Designated Individual but communal cremation is carried out under crematorium regulations.

The mortuary service assumes managerial responsibility for the respectful communal cremation of pregnancy remains at local crematoria to each hospital site. Cremations are communal and no individual ashes are recoverable to the woman. Cremations are carried out on a two monthly schedule at each crematorium; see Appendix A.

Pregnancy remains received by the department up to approximately ten days before the next scheduled cremation date will be cremated on that date. Pregnancy remains received within ten days of the next scheduled cremation date may not be ready for that cremation date and may be prepared for the following cremation date. The Health Board aims to cremate pregnancy remains within 3 months of the date of delivery.

The mortuary staff will discuss the cremation process with suitably trained health care professionals within the woman's care team. Under no circumstances should the woman or her family be put in direct contact with pathology or mortuary services.

Women undergoing a termination of pregnancy for non-medical reasons will be informed of the Health Boards policy for the disposal options available to them for their pregnancy loss and invited to discuss any questions or concerns they may have. They will be asked to provide consent for their choice of disposal, with their care team, prior to their admission for the termination.

Women undergoing a home termination of pregnancy will be informed of the Health Boards policy for the disposal options available to them for their pregnancy loss & invited to discuss any questions or concerns they may have. They will be asked to provide consent for their choice of disposal, with their care team, at the point where they provide consent for their procedure / medication. In the case of home termination, the woman is given the option of returning their pregnancy remains to the hospital to proceed with their chosen disposal option through the Health Board or disposing of them responsibly at home.

The site of cremation will be chosen by the woman. If no choice is made, the cremation will be made at Glyntaff Crematorium for remains arriving at RGH mortuary and at Llwydcoed Crematorium for remains arriving at PCH mortuary and at Coychurch Crematorium for remains arriving at POW mortuary, as a default.

The following scenarios will have full oversight by the Designated Individual or Persons Designated for Mortuary Services. Mortuary staff will bring to the attention all such cases before actions are taken for disposal;

a. **Where a women has declined to discuss options and/or receive information for informed consent,** this will be respected and the Health Board will proceed with the clinical incineration of the pregnancy loss remains after 60 days of the date of delivery. Providing there is evidence that the women;

- Has been told that the information is available and there is a record of such in the clinical notes
- There is a clear indication in the clinical notes that the women has declined to discuss options

No letter is required by the Designated Individual.

b. **Where the woman has indicated 'undecided'** and indicated they have received the booklet (*Practical Arrangements following a pregnancy loss under 16 or 24 weeks*) and has not responded within 60 days then the Health Board will proceed to clinical incineration

No letter is required by the Designated Individual.

c. **In the event of non-collection for private arrangements**, the Designated Individual will write to the woman 30 days after the date of delivery; to request the person act upon their original wishes and also inform them that the Health Board will continue with clinical incineration should they not take action regarding private arrangements within 30 days of receipt of the letter.

6.4.6 Health Board clinical incineration of pregnancy remains

Clinical incineration may be used where the woman makes this choice or does not want to be involved in the decision. Where the woman has chosen clinical incineration, it is important that the woman fully understands the clinical incineration process and how this differs from cremation. The pregnancy loss will be dealt with in a sensitive manner as much as practically possible.

Recorded verbal consent will not be accepted and only in exceptional circumstances and with full involvement of the relevant Persons Designated and the Designated Individual.

Clinical incineration can take place at any time and the Health Board aims to perform this method of disposal within 60 days of the date of delivery. The remains are respectfully prepared and placed in a designated, sealed anatomical waste container, separated from other clinical materials within the Mortuary Department. They are then sent for clinical incineration with the Health Boards contracted supplier and ashes are not retrievable.

6.4.7 Spiritual care services

Spiritual care is available to clinical staff and families upon request.

The spiritual care team offer an open and non-judgemental 24/7 support service for pregnancy loss to all concerned, regardless of their personal faith or belief system. The team are available in the event that families would like their baby blessed and /or named before they leave the hospital.

6.4.8 Confidentiality and storage of records

All staff will uphold patient confidentiality in accordance with Cwm Taf Morgannwg UHB policy. All crematorium, local authority and hospital records are governed by rules of strict confidentiality.

'Pregnancy Loss Register' books will be maintained to record and track all pregnancy losses in Maternity, Gynaecology and Obstetrics, Emergency Departments, Theatres, Early Pregnancy Units and the mortuaries at POW, PCH and RGH.

A unique identification number allocated by the mortuary to each pregnancy remains and associated paperwork, including the 'Certificate of Medical Practitioner in Respect of Disposal of Pregnancy Remains', will be retained within the Health Board for 50 years. This practice not only protects the identities of parents whose cases are subject to confidentiality under The Abortion Act 1967 but ensures equality in the treatment of the remains in accordance with ICCM (2011) The sensitive disposal of fetal remains: If only aborted pregnancy remains are anonymised, it distinguishes them from the non-aborted pregnancy remains and may result in them being viewed / treated differently.

The mortuary service will maintain an electronic spreadsheet for the tracking and disposal of pregnancy remains at each site and the unique identification number may be used to trace the method of disposal with accuracy.

6.4.9 Certification of pregnancy remains

The delivery of pregnancy remains to the cellular pathology or mortuary services will be certified by a fully completed **'Certificate of Midwife/Nurse Practitioner or Medical Practitioner in Respect of Disposal of Pregnancy Remains' PART B FORM** (Appendix B). The Part B Form must be completed by a medical practitioner or a suitably qualified midwife or nurse practitioner.

The application and consent for sensitive disposal section and list of property **'Consent for respectful disposal of pregnancy loss remains under 24 weeks gestation' PART A FORM must be completed** by the woman or on their behalf by the same person who completed the 'Certificate of Medical Practitioner in Respect of Disposal of Pregnancy Remains' Part B Form. The signature of the women will indicate that informed consent has been achieved unless the box 'Undecided' is chosen.

Certification for pregnancy remains arising from a termination of pregnancy must be completed by a suitably qualified practitioner and is usually carried out in advance of the procedure. The expected date of termination may be entered into the date of delivery section along with the estimated gestational age at the point of termination.

The Health Board accepts full responsibility for the certification process and the mortuary service must be satisfied that the pregnancy remains can be released for cremation or disposal without further enquiry.

Failure to complete this form will result in the pregnancy remains being reported to the Head of Midwifery, Gynaecology and Sexual Health services, as private funeral or Health Board cremation / incineration arrangements cannot proceed lawfully without this document.

Where the presence of a heartbeat or respiratory effort at the time of delivery is recorded in the medical notes, the subsequent death of the baby must be recorded as a neonatal death, regardless of gestational age or development. Neonatal death is not covered in this policy.

6.4.10 Transfer of pregnancy remains to the mortuary services.

All containers and forms should be labelled with the Woman's identifiers in accordance with the Pathology Directorate Request form and sample labelling policy (QMS020). Collection pots must be labelled on the body of the pot, not on the lids which carry risk of being crossed over.

Any blankets, clothes teddies etc. must be placed in a sealed plastic bag, labelled with the woman's identifiers and sent with the container and paperwork. They will be reunited with the remains after the embalming process when preparing for sensitive disposal.

Appropriate documentation must accompany the pregnancy remains and transportation must take place in a dignified manner. No pregnancy remains will be disposed of as clinical waste. Cellular pathology request forms must not be sent with pregnancy remains for sensitive disposal only.

All pregnancy remains must be entered into the 'Pregnancy Loss Register' books, available in Maternity, Gynaecology and Obstetrics, Emergency Departments, Theatres, Early Pregnancy Units by the person completing the certification, before transfer to the mortuary.

The pregnancy remains will be transported by suitably trained and competent health professionals to the mortuary at each site immediately after delivery. The mortuary can be accessed 24 hours per day via the delegated Porter. Switchboard must be contacted to request a porter who is trained and competent for mortuary access to accompany the transfer. The pregnancy loss register must be taken to the mortuary with the remains and appropriate paperwork and the details transcribed into the pregnancy loss register held in the mortuary with the name and date of the person performing the transfer. The remains will be placed on the appropriate shelf inside a designated and temperature monitored fridge for pregnancy remains.

The mortuary team will check the mortuary pregnancy loss register daily and cross check with the remains in the fridge. The remains and paperwork will be checked and any omissions or errors will be reported as an incident via DATIX and directly to the Head of Midwifery, Gynaecology and Sexual Health Services. Such issues will be dealt with immediately to enable progression of the sensitive disposal / investigative pathways.

Pregnancy remains requiring post mortem: The remains must be placed in an opaque container with a sealed water tight lid. No formalin, saline or fluid of any kind should be added to the container as this may interfere with post mortem investigations if required. If a discernible fetus and placenta is present (for post mortem investigation), the placenta should be placed in a sealed specimen bag and placed in the same container with the fetus. If the fetus is in a bassinet, the placenta should be placed in a sealed container with the bassinet.

Appropriate documentation must accompany the pregnancy remains and transportation must take place in a dignified manner.

6.4.11 Cellular pathology department / mortuaries

The Cellular Pathology department and mortuaries at each site are licenced by the HTA to store autopsy tissue which includes pregnancy remains.

The mortuary services will assume responsibility for the reception, storage and sensitive disposal of all pregnancy remains with appropriate and correct paperwork.

Any pregnancy remains not accompanied by appropriate and correct paperwork will be reported as per section 6.5.

The mortuary will ensure that the pregnancy remains are dealt with appropriately according to standard operational procedures.

Pregnancy remains for sensitive disposal are treated with formal saline (embalmed) for three days to slow the rate of decomposition whilst awaiting cremation / collection by a funeral director. During this time they are stored separately in a designated fridge for pregnancy remains and are checked daily.

Pregnancy remains for post mortem investigation will be transferred as per section 6.5.2.

Pregnancy remains accompanied with cellular pathology request form for investigation will be transferred to the cellular pathology department at RGH, see section 6.6.

All movements of pregnancy remains after receipt into the mortuary are recorded in the electronic pregnancy remains records for each site.

6.4.12 Transfer of pregnancy remains to the crematorium

Pregnancy remains will be placed in communal containers specified for cremation prior to transportation to the relevant crematorium. All transfers to the crematoria are documented and tracked.

6.4.13 Cremation process

The crematorium takes responsibility for the remains once they are delivered. Health Board arranged communal cremation is carried out on the same day as receipt. All ashes recovered are scattered in a recorded location – see appendix A. Individual ashes are not available to return to the woman following a health board cremation. This process will be audited by Senior Mortuary staff on a scheduled basis.

6.4.14 Service agreement

The Health Board and crematoria hold an annually reviewable contract for the sensitive disposal of pregnancy remains. This is stored with the records of consent and cremations within the Health Board.

6.5 Cellular pathology investigations

The histology laboratory is only to be sent gestational material for cellular pathology investigation under two circumstances:

- **ERPC or tubal ectopics where the purpose is to confirm the presence of gestational material.**

- **Gestational material where there is a genuine suspicion of molar pregnancy or trophoblastic disease.**

Where material is attached to a placenta then both material/placenta are sent together for examination.

Cellular pathology request forms accompanying such specimens should include the specimen type, the examination required and the supporting clinical details. **Patient consent for their surgical procedure and / or any resultant histological examination request is the responsibility of the clinical team and is separate and distinct from the certification and consent required for sensitive disposal.**

Specimens for cellular pathology investigation will be transferred to the cellular pathology department at RGH from the mortuaries at the three sites. Cellular pathology investigation may be outsourced where required. The PART A & PART B

forms (Appendix B) and will be retained in the mortuary potentially performing the disposal of any after the investigation.

Fetal tissue identified at a macroscopical stage of a histology investigation will not be sampled and will be stored for sensitive disposal. The reminder of the sample may be sampled for histological investigation.

If fetal tissue is identified at a microscopical stage, all wet tissue, blocks and slides will be retrieved and prepared and stored for sensitive disposal.

Pregnancy remains cover the 'grey area' where the woman has had an early loss of pregnancy and tissue relating to the loss of pregnancy is sent to histology but no discernible fetal tissue is found. The HTA does not recognise that the tissue is any different to any other body tissue and states that no consent is lawfully required for disposal but recommends that they are disposed sensitively in accordance with the Woman wishes anyway, due to the Woman loss rather than the nature of the tissue.

In order to uphold these guidelines the Health Board has to ensure that all pregnancy remains are sensitively disposed as per the consent paperwork (as if there were fetal tissue present). This includes the Woman choice to have a private arrangement including green burial (tissue returned to her).

There are however differences in the disposal of 'pregnancy remains' and 'fetal tissue' following a cellular pathology investigation, which the woman should be made aware of:

- If fetal tissue is detected in a histology sample, **all** preparations (blocks and slides) which may contain the remains are retrieved and sent for sensitive disposal.

- The HTA states that preparations for pregnancy remains where no discernible fetal tissue is identified, are considered as part of the womans diagnostic record and should remain as such. Therefore, only 'left over' wet tissue which is not used for the diagnostic process will be sensitively disposed. If there is no tissue left over, there will be no tissue to sensitively dispose of. This difference is important and the care team should inform the woman of this so she has realistic expectations, particularly where she has opted for return of tissue to herself.

- All histology wet tissues have to be retained for 4 weeks post authorisation so pregnancy remains undergoing histology investigation will not enter the sensitive disposal until much later than pregnancy remains for sensitive disposal only. This may result in the next scheduled cremation being missed. The woman may need to be aware of this if planning to attend memorial services etc. and it will be the responsibility of the care team to discuss it with her.

6.6 Training Implications

The following personnel are responsible for ensuring compliance with this policy and should develop their own training policy and records to support this:

- Persons Designated
- Ward management
- Clinical department management
- Laboratory management
- Mortuary management

It is also the responsibility of each individual employee to ensure that they comply with the standard operating procedures or care path ways relating to this policy.

6.7 Review, Monitoring and Audit Arrangements

This policy requires review and update on a 3 yearly basis.

Regular audits are made by the wards and departments to monitor compliance with policy and related SOPs.

Regular audits are made to ensure completion of the pregnancy loss registers and correlation of the ward / departmental registers to the mortuary pregnancy loss register.

There are persons designated (PDs) appointed by the DI in all areas where pregnancy loss is managed within the health board. PDs will be responsible for reporting HTARIs as they occur in their areas and will meet on a regular basis with the DI.

6.8 Managerial Responsibilities

The following personnel are responsible for ensuring compliance with this policy and should develop their own SOPs, training policy and records to support this:

- Designated Individual
- Persons Designated
- Ward management,
- Clinical department management
- Laboratory management
- Mortuary management

They must also ensure that their staff are informed of any updates and changes to the policy.

It is the responsibility of each individual employee to ensure that they comply with the standard operating procedures or care path ways relating to this policy.

6.9 Retention or Archiving

The mortuary service will maintain an electronic register for the disposal of pregnancy remains and the unique identifier may be used to trace sensitive disposal with accuracy. This and all documentation related to the sensitive disposal process will be stored for a minimum of 50 years.

6.9.1 Non Conformance

Non conformance with this policy may cause delays and distress to stakeholders and may result in disciplinary action for staff.

Non conformities will be incident reported on the DATIX reporting site and as a HTARI on the HTA web portal where appropriate.

6.9.2 Equality Impact Assessment Statement

Once the Policy has been assessed each document should have one of the following statements:

Either

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

Or

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).

7. EQUALITY IMPACT ASSESSMENT STATEMENT

This policy originated in 2011 and has been refined to reflect that CTMUHB now includes the Princess of Wales Hospital and there has been clarifications made in terms of consent.

The original EIA can be perused in Appendix E.

8. REFERENCES

Royal College of Nursing (2015) managing the disposal of pregnancy remains: Guidance for Nursing and Midwifery Practice. Publication code 005347

ICCM: Institute of Cemetery & Crematorium Management (2015) The sensitive disposal of fetal remains.

The Abortion Act 1967

Stillbirth and neonatal death society (SANDS) (2016): Pregnancy loss and the death of a baby. Guidelines for professionals 4th edition. www.uk-sands.org

Human Tissue Authority (2015) Guidance on the disposal of pregnancy remains following pregnancy loss or termination.

Human Tissue Authority (2016) Code B Post Mortem Examination Standards and Guidance.

GETTING HELP

Any questions in relation to this Policy please refer to the Designated Individual for the HTA within CTMUHB.

9. RELATED POLICIES

A number of localised Standard Operating Procedures reflecting the standards of this document are located in the following departments;

- Maternity
- Gynaecology / EPU
- Theatres
- Emergency Departments

10. INFORMATION, INSTRUCTION AND TRAINING

It is important that clinical managers ensure all staff are trained and competent in this Policy. Support for such training can be sought from the Mortuary Department, Bereavement Midwives and Designated Individual for the HTA.

11. MAIN RELEVANT LEGISLATION

The policy upholds the guidelines set out by The Royal College of Nursing, the Still birth and Neonatal Death Society (SANDS), The Human Tissue Authority (HTA) and the Institute of Cemetery & Crematorium Management (ICCM). It also complies with the Equality Act 2010.

APPENDIX A Schedule of cremation and support services

Schedule of cremation and support services (Service Level Agreements only)

Site	PCH	RGH
Crematorium	Llwydcoed	Glyntaff
Scheduled cremation date	3rd Thursday of every: February April June August October December	2nd Thursday of every: February April June August October December
Memorial service	3rd Friday of every: February April June August October December Held at 10am on the Friday after Llwydcoed cremation at the PCH chapel	2nd Friday of every: February April June August October December Held at 10am on the Friday after Glyntaff cremation at the RGH chapel
Paper work check	Crematorium staff visit the mortuary to collect the paperwork the week before cremation date	Crematorium staff visit the cellular pathology department to collect the paperwork the week before cremation date
Transport	DL Evans and Son funeral services collect the remains early morning of cremation date from mortuary PCH	DL Evans and son funeral services collect the remains early morning of cremation date from cellular pathology department RGH
Ashes – womans / families must be informed that communal ashes recovered from cremation are scattered at:	Llwydcoed crematorium infants section (Aberdare) on the same day as cremation	Cefn Y Parc cemetery infants section (Llantrisant) on the same day as cremation

APPENDIX B - PART A AND PART B FORMS

PART A: Consent for respectful disposal of pregnancy loss remains under 24 weeks gestation

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

WOMANS INFORMATION	
Hospital No.	D.O.B
Surname:	
First name(s):	
Address:	
Post Code:	NHS No.

This form enables you to consent for the respectful disposal of pregnancy remains delivered before the 24th week of gestation of the person named below. For each section please **INITIAL** the relevant box(s).

Hospital	Ward	Date

- I confirm that I have had the opportunity to the read ***'Practical arrangements following a pregnancy loss under 16 / 24 weeks'*** booklet
- I have had an opportunity to ask questions about the disposal options.
- Any questions I have asked have been answered to my satisfaction.

Initial ☐

Consent for disposal: Please Initial ONE option only

A. Communal Cremation at; **Initial** ☐

☐ Glyntaff Crematorium ☐ Llwydcoed Crematorium ☐ Coychurch Crematorium

B. Private Arrangements ☐ Cremation ☐ Burial ☐ Green Burial **Initial** ☐

Appointed Funeral Director_____

C. Undecided ☐ Contact Tel Number of the woman _____ **Initial** ☐

Please be aware that if you are unable to make a choice before you go home, you will be required to return to the hospital where you delivered your baby to provide us with consent within 30 days. Unfortunately it is not possible to gain consent over the phone.

Please note: If you do not wish to have either Communal Cremation or make your own Private Arrangements then an option of **Clinical Incineration** is available as explained in the booklets; ***'Practical arrangements following a pregnancy loss under 16 / 24 weeks'*** **Initial** ☐

If this is your choice please indicate you wish to consent to Clinical Incineration by your initial.

Details of person giving consent

I have discussed the options above with my care team and hereby make an application for the option I have chosen, in respect of my pregnancy remains. I thus indicate my consent by signing this application. I acknowledge that it is not possible to recover any individual ashes following communal cremation or clinical incineration.
I understand that if I remain undecided or not organised Private Arrangements for cremation/burial and have not informed the hospital of my decision within 30 days, then the Health Board will proceed with a clinical incineration within 60 days of the date of delivery.

PRINT NAME:	
SIGNATURE:	DATE:

Details of Registered Health Care professional obtaining consent

PRINT NAME:	SIGNATURE
POSITION:	DATE:
GMC/NMC Number:	CONTACT NUMBER:

PART B: Certificate of Midwife/Nurse Practitioner or Medical Practitioner in Respect of Pregnancy Remains

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

TO BE COMPLETED BY A REGISTERED MIDWIFE, NURSE OR MEDICAL PRACTITIONER

This is to certify that I have examined the pregnancy remains of;

Woman's name

On | date | at | time | the pregnancy was of a gestation up to and

no more than | gestation | of weeks and that the foetal remain showed no signs of life

Declaration of Health care professional	
NAME:	SIGNATURE
GRADE/POSITION:	DATE:
GMC/NMC number:	Contact Number:
The above signatory must be either the medical practitioner, registered nurse or registered midwife who primarily cared for the women. In some cases a Declaration can be made by the Head of the Clinical Unit.	

Notification of further investigation	
A. Histology	
B. **Cytogenetic Investigation**- NOTE: All Wales Medical Genetics Service general request form http://www.wales.nhs.uk/sites3/Documents/525/Cytogenetics%20From%20UKAS%20LOGO.pdf	
C. **Post Mortem Examination –** NOTE: The Consent for a Post-Mortem Examination of a Fetus & Baby form must be completed with the family **And;** Request for fetal and perinatal post mortem examination form	

Property: Please list all property sent with the pregnancy remains:

Mortuary use only

Unique Identifier	Initial	Date & Time

Appendix C – Transfer of pregnancy remains: Chain of custody form.

Mortuary Services
Cwm Taf Morgannwg University Health Board

Chain of custody form for pregnancy remains

The pregnancy remains relating to specimen number / unique ID …….. have been transferred:
From ……...[department/ward] at ……..…[site]
To ……..…….
on ……..……[date] at ……..[time].
For the following reasons:
……
…

Signatures

Staff releasing remains:
Print name……Signature:……

Collected by:
Print name:……Signature:……

Under the Human Tissue Act (2004), the recipient has an obligation to dispose of human remains in a lawful and responsible manner. The Health Board takes no responsibility for the remains once they have left the hospital premises.

This form must be retained within the department releasing the remains or within the patient notes.

Appendix D

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Your ref:/eich cyf:

Our Ref:ein cyf:

Date/dyddiad:

Tel/ffon: 01685 728593

Fax/ffacs: 01443 443335

Email/ebost: CTM_PMService@wales.nhs.uk

Dept/adran: CTMUHB Mortuary and Bereavement services

CTMUHB Mortuary and bereavement services

Address

Dear (name of woman / client)

Re: (identifier or name of baby, if applicable)

Following your pregnancy loss dated (insert date) we would like to re-iterate our condolences to you and your family.

According to our records you signed a certificate indicating your wishes for private arrangements with respect to your pregnancy loss. Although this option was chosen at this time, there has been no further action or correspondence from you with regards to the plans you wish to have carried out.

Under the Human Tissue Act (2004) we cannot continue to store your pregnancy loss in the department without consent, therefore we are making contact with you today to clarify if you still wish to make your own private arrangements. If this is still the option that you would like, I would encourage you contact us to see how we are able to assist you with this. I have to make you aware that unless we have further instructions from you regarding the sensitive disposal of your pregnancy loss , we will have no alternative but to proceed with clinical incineration after (insert date).

Dr Paul D Davies

Designated Individual for the Human Tissue Authority (HTA), Cwm Taf Morgannwg University Health Board

Appendix E - Equality Impact Assessment

Approved 12th January 2011 as part of the Policy for the Management, Identification and Authorisation of Policies and Procedures – Operational 1 January 2011

All Public Sector bodies have a legal duty to undertake an equality impact assessment (EqIA) as a requirement of the equality legislation.

EqIA's provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

The process itself ensures that individual staff, managers and teams think carefully about, and record, the likely impact of their work on staff, patients and other members of the community.

The need for collection of evidence to support decisions and for consultation mean the most effective and efficient EqIA is conducted as an integral part of policy development, with the EqIA commenced at the outset.

The documentation consider the effects that decisions, policies or services have on people on the basis of their gender, race, disability, sexual orientation, religion or belief, age, Welsh Language and human rights. Assessing impact across a broad range of equality dimensions (not just those required by law), helps organisations to embed equality and human rights and assist them in the delivery of their services.

Policies will not be approved by the Board/Sub Committee of the Board without a completed EqIA Report.

For further information or advice, contact the Diversity, Equality & Standards Manager on 01443 744800.

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence. (Refer to the Step-by-Step Guide for additional information).

Step 1 – Preparation		
1.	**Title of Policy** - what are you equality impact assessing?	Policy for the sensitive disposal of pregnancy remains
2.	**Policy Aims and Brief Description** - what are its aims? Give a brief description of the Policy (The What, Why and How?)	The policy provides guidelines to ensure that Cwm Taf Morgannwg UHB performs the handling and disposal of pregnancy remains with respect, dignity and sensitivity.
3.	**Who Owns/Defines the Policy?** - who is responsible for the Policy/work?	Pathology Directorate
4.	**Who is Involved in undertaking this EqIA? -** who are the key contributors and what are their roles in the process?	Equality Manager, Directorate Manager, Cellular Pathology and Mortuary Service Manager (author).
5.	**Other Policies** - Describe where this Policy/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA?	Welsh Language policies, Accessing an Interpreter, All Wales Guidelines on Accessible Information and Communication for People with Sensory Loss, Equality Policy.

Step 1 – Preparation		
6.	**Stakeholders** - Who is involved with or affected by, this Policy?	Patients, families, clinicians, medical staff, nurses, midwives, clinical support staff, technical and professional staff.
7.	**What might help/hinder the success of the policy?** These could be internal or external factors.	Inadequate training and communication. Difficulty with yearly update. Staff need to be aware of Equality issues and take them into account.

Form Two – Information Gathering

Is the policy relevant to the public duties relating to each equality strand. Tick as appropriate.							
	Race	Disability	Gender	Sexual Orientation	Age	Religion Belief	Welsh Language
Is the policy relevant to “eliminating discrimination and eliminating harassment?”	√	√	√	√	√	√	√
Is the policy relevant to “promoting equality of opportunity?”	√	√	√	√	√	√	√
Is the policy relevant to “promoting good relationships and positive attitudes?”	√	√	√	√	√	√	√
Is the policy relevant to “encouragement of participation in public life?”							
In relation to disability, is the policy relevant to “take account of difference, even if it involves treating some individuals more favourably?		√					

The Human Rights Act contains 15 rights, all of which NHS organisation have a duty to act compatibly with and to respect, protect and fulfil. The 7 rights that are particularly relevant to healthcare are listed below. For a fuller explanation of these rights and other rights in the Human Rights Act please refer to Appendix A: The Legislative Framework.

Consider the relevance of your Policy to these Human Rights and list any available information to suggest the Policy may interfere with, or restrict the enjoyment of these rights.

The right to life

Unborn children are not covered by the Human Rights Act, however the questions below have been applied to the mother's situation.

The right not be tortured or treated in an inhuman or degrading way

The emphasis on treating the fetus or baby with dignity and sensitivity.

The right to liberty

The right to a fair trial

The right to respect for private and family life, home and correspondence

Reference is made to the Woman family and their needs particularly in relation to emotional support.

The right to freedom of thought, conscience and religion

The Woman wishes are respected in relation to disposal of the pregnancy remains, cremation or funeral arrangements. Specific religious or cultural issues would be taken into account and accommodated wherever possible.

The right not be discriminated against in relation to any of the rights contained in the Human Rights Act

Equality Strand	Evidence Gathered
Race	Cultural issues would be taken into account in relation to death. Language needs would be accommodated.
Disability	Communication and information needs would be taken into account.
Gender	The emphasis of the document is on the mother / client but the needs of the partner and family would also be considered.

Sexual Orientation	Recognition of same sex relationships is taken into account.
Age	The document would particularly relate to women of childbearing age. Could specific sensitivity be shown to very young mothers and equally older mothers who would both have particular issues?
Religion or Belief	Particular religious beliefs or rituals would be respected and accommodated wherever possible
Welsh Language	If a service user wished to communicate in welsh, this would be accommodated wherever possible

Form 3: Assessment of Relevance and Priority

Equality Strand	Evidence: Existing evidence to suggest some groups affected. Gathered from Step 2. (See Scoring Chart A)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C)
Race	2	2	4
Disability	2	2	4
Gender	2	2	4
Sexual Orientation	2	2	4
Age	2	2	4
Religion or Belief	2	2	4

Welsh Language	**2**	**2**	**4**
Human Rights	**2**	**2**	**4**

Scoring Chart A: Evidence Available

3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact

-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact Decision

-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

FORM 4: (Part A) Outcome Report

Policy Title:	Policy for the sensitive disposal of pregnancy remains of less than 24 weeks of gestation
Organisation:	Cwm Taf Morgannwg UHB
Name: **Title:** **Department:**	 Equality Manager Workforce & OD
Summary of Assessment:	There are a significant number of Equality issues relevant to this policy and these have been noted through the assessment of this policy and the policy amended accordingly. The policy must be read in conjunction with the other documents listed in Section 5 and the cultural toolkit will be of particular relevance.
Decision to Proceed to Part B Equality Impact Assessment:	No Please record reason(s) for decision The policy now meets the requirements of the Equality Act 2010.

Action Plan You are advised to use the template below to detail any actions that are planned following the completion of Part A or Part B of the EqIA Toolkit. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual adverse impact, as well as any arrangements to collect data or undertake further research.					
	Action(s) proposed or taken	**Reasons for action(s)**	**Who will benefit?**	**Who is responsible for this action(s)?**	**Timescale**
What **changes** have been made as a result of the EqIA?	Amendments to the policy draft: 1. Section 3: Clarity on why this policy has emphasis on the mothers wishes. 2.Sections 3, 6.2: Clarity on definition of 'partner' 3.Sections 3, 6.2, 6.3 : Further detail on specific communication needs such as language and sensory loss. 4. Section 5: Compliance with Equality act 2010 included.	To ensure that all Cwm Taf Morgannwg University Health Board patients are treated with equality, respect and sensitivity. To ensure that the policy is clear and justified to all that may read / use it.	Cwm Taf Morgannwg University Health Board patients, families, staff, clients and stakeholders.	Cwm Taf Morgannwg University Health Board Staff	Changes applied to policy with immediate effect.

	5.Sections 6.2, 6.3, 6.5, 6.5.2 : inclusion of cultural requirements and considerations 6.Section 6.5.7: Clarification of why all pregnancy remains are anonymised for crematoria record keeping. 7. Section 3: Inclusion of sensitivity, communication and consideration with regards to the of age of the mother, learning disabilities and mental health issues.				
Where a Policy may have differential impact on certain groups, state what arrangements are in place or are proposed to **mitigate** these impacts?	N/A	N/A	N/A	N/A	N/A

Justification: For when a policy may have adverse impact on certain groups, but there is good reason not to mitigate.	N/A	N/A	N/A	N/A	N/A
Describe any **mitigating actions** taken?	N/A	N/A	N/A	N/A	N/A
Provide details of any actions planned or taken to **promote equality**.	N/A	N/A	N/A	N/A	N/A

Date:	17/7/14
Monitoring Arrangements:	Three yearly review with continued renewal of service agreement with crematoria
Review Date:	May 2021
Signature of all Parties:	Equality manager, W+OD Service manager Cellular Pathology

Appendix F - Training Impact Assessment

If training requirements are identified a policy training impact assessment is to be completed and forwarded to the Workforce and Organisational Development Directorate

1. Will training be required as a result of the policy?

Yes	Proceed to question 2
No	If no, please state how this policy will be communicated within the UHB

2. Please complete the following information relating to training

Course/ policy title	Ad-hoc talks and courses arranged in each relevant department
Course type	Unknown
Reference to KSF/NMC Dimensions	Unknown
Target Audience (refers to scope of policy)	Clinicians, medical staff, nurses, midwives, clinical support staff, technical and professional staff
Course / policy training objectives	Training must ensure that all staff dealing with pregnancy remains are aware of the circumstances, requirements and procedures to arrange sensitive disposal.
Course / policy training content	Training must include awareness of this policy and access to documentation to ensure sensitive disposal can take place. Content will vary according to local standard operating procedures.
Duration of course / programme	Variable
Name of trainer (or policy lead)	Variable
Approximate cost of providing training	Unknown
Please embed lesson plan, link to e-learning, presentation or other relevant learning material	TBA

AGENDA ITEM
3.1.5

QUALITY & SAFETY COMMITTEE

All Wales Model policy for consent to examination or treatment (Adapted by Cwm Taf Morgannwg University Health Board to include local guidance where stated)

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mr Kevin Conway- Consultant Vascular Surgeon & CTMUHB Consent Lead and Consent Lead for CTMUHB Dr Paul D Davies, ADO and HTA Designated Individual
Presented by	Dr Paul D Davies, ADO and HTA Designated Individual
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**
Human Tissue Authority	24/02/2023	SUPPORTED
Mr Kevin Conway	06/03/2023	SUPPORTED
Clinical Policies Group	17/05/2023	SUPPORTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This Policy was adopted from an all-Wales approach to Consent in 2019.

1.2 This Policy has recently been reviewed by the Human Tissue Authority as part of its scheduled inspection of Cwm Taf Morgannwg University Health Board and our compliance with the Human Tissue Act (2004).

1.3 The Human Tissue Authority found a minor shortfall within this overarching Policy and to rectify this shortfall the Designated Individual has amended the Policy and now presents to the Quality & Safety Committee for approval on behalf of the Consent Lead Mr Kevin Conway.

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

2.1 Engagement on this Policy and Procedure has taken place with the Human Tissue Authority and the Consent Lead for Cwm Taf Morgannwg University Health Board.

2.2 The policy has been reviewed against the standards set by the Human Tissue Act (2004) and is consistent with legislation.

2.3 Organisational values and behaviours have been reflected within the policy.

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

3.1 In response to the feedback from the Human Tissue Authority Section 9 of the Policy (from page 66 – 71) there is now more content, clarification and updated hyperlinks in relation to care of the deceased and consent.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	More clarity on legal implications of Human Tissue Act and consent
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: Safe Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	EQIA completed with no impact identified
Legal implications / impact	Yes (Include further detail below)
	Advice for changes provided by the Human Tissue Authority who regulate the legal standards within the Human Tissue Act (2004)
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee is asked to **APPROVE** the changes within the revised All Wales Model policy for consent to examination or treatment (Adapted by Cwm Taf Morgannwg University Health Board to include local guidance where stated)

5.2 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site. It will also be shared with other Health Boards in Wales who have a similar Policy.

All Wales Model Policy for Consent to Examination or Treatment

Document Type:	Clinical Policy
Ref:	CLP 01
Author:	All Wales Consent Group/Consent Lead for CTMUHB
Executive Sponsor:	Executive Medical Director
Approved By:	**Quality & Safety Committee**
Approval / Effective Date:	
Review Date:	
Version:	2.1

Target Audience:

People who need to know about this document in detail	All Healthcare professionals employed by, or working for, Cwm Taf Morgannwg University Health Board who are involved in consenting patients for procedures within CTMUHB
People who need to have a broad understanding of this document	Clinical Managers employed by, or working for, Cwm Taf Morgannwg University Health Board who are involved in consenting patients for procedures within CTMUHB
People who need to know that this document exists	Directors and Executive leads employed by, or working for, Cwm Taf Morgannwg University Health Board who are involved in consenting patients for procedures within CTMUHB

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:**
	Outcome:
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

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

Contents

Glossary

AC	**Approved clinician (Supplementary guidance only)**
ADRT	**Advance Decision to Refuse Treatment**
BMA	**BMA – British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
CoP	**Court of Protection**
CTO	**Community Treatment Order (Supplementary guidance only)**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxy-ribo Nucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**

HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**
IMHA	**Independent Mental Health Advocate (Supplementary guidance only)**
ICSI	**Intracytoplasmic sperm injection**
IVF	***In vitro* fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	**Montgomery v Lanarkshire NHS Health Board**
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
SCT	**Supervised Community Treatment (Supplementary guidance only)**
SOAD	**Second Opinion Doctor (Supplementary guidance only)**
WHC	**Welsh Health Circular**

Foreword

The Supreme Court ruling in Montgomery v Lanarkshire Health Board [2015] fundamentally changed the legal framework for consent to examination and treatment in the UK, focusing the consent process on the specific needs of the individual patient.

Existing best practice guidance from the General Medical Council (GMC) and other regulatory bodies, already highlighted the importance of individual autonomy and the active involvement of an informed patient in a shared decision-making process. The Montgomery judgement closed the gap between the legal and regulatory frameworks. The practical implications for clinical practice are clear, but so too is the legal framework.

The core part of this Policy provides general guidance on consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England. Guidance is also incorporated for decision-making when patients temporarily or permanently lack capacity. Supplementary guidance is provided for specific scenarios which may be encountered in Obstetrics and Gynaecology or Mental Health settings.

We recognise that this is a lengthy policy document, but wanted to provide a detailed point of reference for healthcare professionals covering different situations they may encounter in their clinical practice. This policy also refers to the recently updated 'Guide to Consent for Examination or Treatment', produced by the Welsh Assembly Government, which provides a detailed overview of the current legal framework.

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
    - the patient must have the mental capacity to make the relevant decision about their treatment or care
    - consent must be given voluntarily
    - he or she must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:

- All reasonable treatment options
- All of the intended benefits and material risks.
- Any requirement to take and retain tissue samples, photographs etc
- The presence of any trainees or students
- The use of any experimental techniques
- Any requests for further information or clarification should be met
- Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or
- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or

- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or

- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention
- Seeking consent can be delegated to an appropriately trained colleague
- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional
- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances
- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes
- A signature on a consent form does not prove that valid consent has been obtained
- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick* competent can give consent
- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted
- If a competent child consents to treatment, a parent **cannot** over-ride that consent
- If a competent child refuses necessary treatment, legal advice should be sought
- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)
- If you doubt whether a patient has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:

    - They have an impairment or disturbance that affects the way their mind or brain works; and
    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made

- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:

    - **Understand** the information relevant to the decision
    - **Retain** the information long enough to make a decision
    - **Use or weigh up** the information as part of a decision-making process
    - **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they would take into account if they were able to do so

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) must be instructed where decisions are needed about serious medical treatment (including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

What about refusal of treatment?

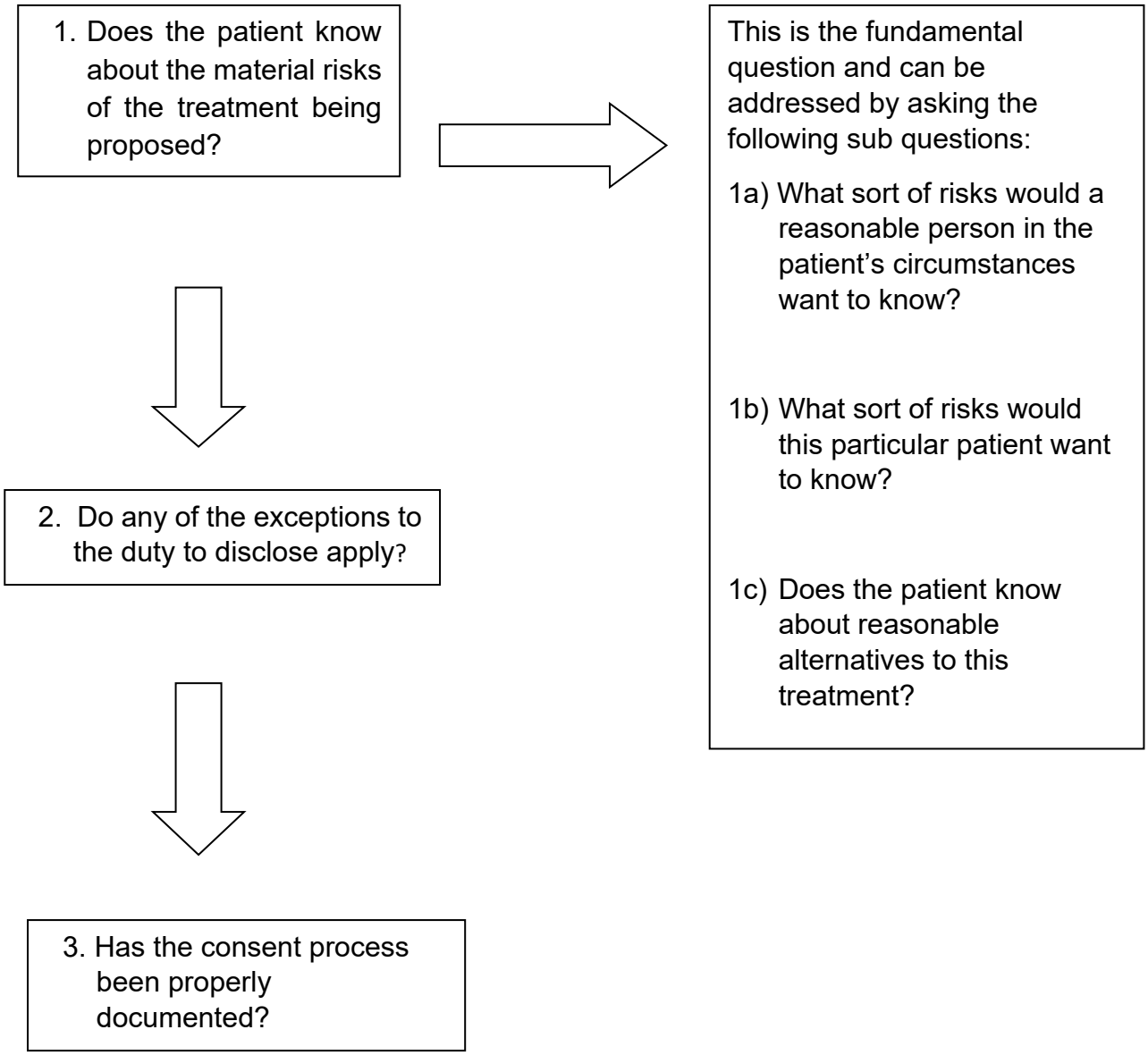
- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)
- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the foetus. If a woman in labour refuses treatment seek urgent legal advice
- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**
- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1. This Health Board recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the Health Board and healthcare staff may be liable to legal action if valid consent is not obtained.

2. Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent and can be found on the NHS Wales Governance E-manual at: http://www.wales.nhs.uk/governance-emanual/patient-consent/**.** The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this Health Board should comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

3. While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

4. A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

What consent is – and isn't

5. Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given his or her **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

6. Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

7. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

8. In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

9. In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA Code of Practice. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the

MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

10. When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

11. Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals. Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.

12. When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

13. The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the healthcare professional's clinical knowledge.

14. The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient's best interests in accordance with MCA 2005. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

15. Cultural diversity issues should be actively considered whilst obtaining patient's consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex. Please refer to local organisational policies and guidelines.

16. If there is any doubt or uncertainty in relation to particular consent issues please contact **Mr Kevin Conway- Consultant Vascular Surgeon via Switchboard in his absence please contact Mr Parin Shah Consultant Surgeon**.

2. Documentation

17. Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical notes as necessary) or within an entry in the patient's medical notes. (See chapter 3).

18. Where the signing of a consent form is not required, healthcare professionals must document the consent process followed within an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

19. It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

20. It is rarely a legal requirement to seek written consent[1],but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
- the procedure involves general/regional anaesthesia or sedation;
- providing clinical care is not the primary purpose of the procedure;
- there may be significant consequences for the patient's employment or personal life;
- the treatment is part of a project or programme of research approved by this Health Board (see chapter 17 of this policy).

[1]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

21. If you are in doubt about whether a procedure requires written consent, then the safest course of action is to complete an appropriate consent form.

22. It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written, verbal or implied) should be appropriate to the procedure concerned.

23. Abbreviations should never be used on consent forms.

24. Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

25. A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

26. There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or Gillick competent children:
- **Consent Form 2** for parental consent for a child under 16 who is not Gillick competent

27. The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

28. The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4** - Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

29. Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under a LPA or a CAD is giving consent then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered to this person.

30. Form 4 requires healthcare professionals to document why the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in his or her best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of what is in the patient's best interests) the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes

Patient information leaflet

31. Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

32. Consent Forms 1 and 2 and Form 4 can be ordered via the Oracle system

Procedure/condition specific consent forms

33. Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements set down in the Welsh Language Act.

34. Health Boards must develop clear guidance on the development of procedure specific consent forms which must be approved through appropriate governance arrangements.

3. When should consent be sought?

35. Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

36. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

37. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

38. All clinical staff should have regard to the ruling in the case of Montgomery v Lanarkshire Health Board[2] given on 11th March 2015.

39. Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

[2] https://www.supremecourt.uk/decided-cases/docs/uksc_2013_0136_judgment.pdf

40. This standard of consent is similar to that required in GMC Guidance – Good Medical Practice 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[3].

41. Healthcare professionals must be satisfied that:

- The patient knows and understands all the material risks of the proposed treatment;
- The patient is aware of all reasonable alternatives;
- He/she has taken reasonable care to ensure that the patient understands all of the relevant information
- Valid exceptions to the duty to disclose apply.

42. The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that he or she prefers not to know the risks;
- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing
- Consent is not required as the patient lacks capacity and urgent treatment is required.

43. The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the Montgomery case and is also available online[4].

[3] http://www.gmc-uk.org/guidance/good_medical_practice.asp

[4] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

Single stage process

44. In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

45. If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

Two or more stage process

46. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that the patient still wants to go ahead[5]. A careful record of the information provided and the related discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

47. Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process (either in Welsh or English). They may be

[5] https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/

invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure;
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period;
- the patient's responsible clinician has changed since the form was signed.

48. Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

49. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

50. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

51. The patient's consent may be obtained by post, as this gives the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure,

at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on his or her behalf (unless provided for in accordance with the MCA – see chapter 8 of this policy) and under parental responsibility: if the competent child or young person wishes the parent to take the decision for them). MCA -

52. Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean section even if they have received sedation – see paragraph 274 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient's care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient's medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient's medical notes it is found that the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient's medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interest decisions.

Seeking consent for anaesthesia

53. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

54. Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

55. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

56. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give his or her consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

57. A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

58. The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

59. If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

60. Issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act are discussed in chapter 18 of this policy.

4. Provision of Information

61. The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example blood transfusion or the removal of particular tissue.

62. Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

63. To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 56 above) as well as information about the procedure itself.

64. The information provided should be tailored to the individual patient.

65. The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in

order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context, the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If and EiDO information leaflet has been used, its name, number and date can be documented.

66. Patient information in different formats and languages must be made available.

Communication Issues

67. A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

68. Where appropriate those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient.

Provision for Welsh speaking patients

69. Every effort should be made to ensure that the language preference of the patient is offered, established, recorded, acted upon and relayed to others within the Health Board. Welsh must be treated no less favourably than English. Whenever possible discussions with Welsh speaking patients regarding consent should be conducted with Welsh speaking healthcare professionals.

Please refer to local guidance- Accessing an interpreter and Welsh Language translation policy Version 2 also the All Wales Welsh Language Standards May 2019 available on CTMUHB SharePoint site.

70. The All Wales consent forms provided with this policy (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients;
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient; and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met.

Provision for patients whose first language is not English or Welsh

71. This Health Board is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's language, an interpreter should always be used when seeking consent from the patient (except for minor, routine procedures). It is not appropriate to use children or family members to interpret for patients who do not speak English.

Please refer to Local guidance- Accessing an interpreter and Welsh Language translation policy Version 2 available on CTMUHB SharePoint site.

Access to more detailed or specialist information

72. Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets.

Access to healthcare professionals between formal appointments

73. After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information. Patients should be provided with appropriate contact details at the time of their appointment.

74. The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

75. Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

76. Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent?

77. The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. He or she will be held responsible in law if the validity of consent is subsequently challenged.

78. Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

79. Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g. where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

80. It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

81. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, discuss with Mr Kevin Conway – Consultant Vascular Surgeon via Switchboard

82. The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations where they have undertaken formal training and their competency has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary

Completing consent forms

83. The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

84. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

85. Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

86. In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

87. A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be

obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

88. Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

89. It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

90. On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with Capacity – Refusal of treatment

Right to refuse treatment

91. An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the *Mental Health Act 1983* (see chapter 13 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

92. An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However in cases of doubt, healthcare professionals should always seek legal advice.

93. If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

94. Where a patient has refused a particular intervention, the healthcare professional must ensure that he or she continues to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

95. If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on

request be prepared to transfer the patient's care to that healthcare professional.

96. Whilst a patient has the right to refuse treatment this does not mean that they have the right to require a particular course of treatment.

Self-harm and attempted suicide

97. Cases of self-harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

98. If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then he or she should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

99. Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage him or her to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

100. The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

101. It is important to remember that not all Jehovah's witnesses refuse blood products. Most practising Jehovah's Witnesses who do will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

102. Further information can be found at the following:

- Royal College of Surgeons (2016) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's Witnesses and other patients who decline transfusion.
- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*.
- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*.

UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*.

- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

103. Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the Health Board
- The local Hospital Liaison Committee for Jehovah's Witnesses.

7. Treatment of children and young people

104. When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

105. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

106. Careful consideration should be given to whether the child is competent to give his or her consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (Gillick competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

107. Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

108. It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is Gillick competent.

Children who are not competent to consent to treatment

109. If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

110. Healthcare professionals need to make reasonable enquiries as to who holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

111. Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989 (which applies to both children and young people) sets out the persons who may have responsibility for a child.

Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when he/she is married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order

- by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
- by obtaining a residence order
- by marrying the mother and agreeing with her that he will assume parental responsibility
- marrying the mother and upon his application to the court
- by adopting the child

- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother
- a local authority in whose favour a care order has been made[6]
- a person who has been granted an emergency protection order
- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002
- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990
- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002
- the court in wardship procedures
- some same-sex partners in certain situations

[6]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

112. If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

113. Consent is usually only needed from one person holding parental responsibility, However there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes
- non-therapeutic male circumcision
- hotly contested issues of immunization.

114. Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

115. When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

116. It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility in not available, consent with directions, must be obtained from the Family Division of the High Court.

117. A healthcare professional should not rely on the consent of a parent if he or she has any doubts about whether the parent is acting in the best interests of the child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

118. For forensic examinations different rules may apply.

Young people (age 16 to 17 years) without capacity to consent to treatment

119. Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

120. Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide (Please contact Mr Kevin Conway- Consultant Vascular Surgeon via Switchboard for advice within CTMUHB)

121. Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as "Gillick" competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent. In such circumstances legal advice should be sought. See Appendix C.

122. Where a child has refused treatment, and a decision is made to give treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

123. Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

124. If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

Young people aged 16 and 17 who refuse life-sustaining treatment

125. Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C.

126. The management of a young person in an emergency situation, who is likely to die or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

127. The courts have often commented that such a situation does not detract from the loving and responsible reputation of the parents involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

128. When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

129. Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

130. A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

131. In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the MCA. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

132. When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

133. The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

134. In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of his or her behavior. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment should be carried out and the healthcare professional must be able to justify their conclusions.

135. It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

136. Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having

assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

137. A patient lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent.

138. The MCA provides that a patient with an "impairment or disturbance" is unable to make a decision if they are unable to do one or more of the following:

a) understand the information relevant to the decision; or

b) retain that information; or

c) use or weigh that information as part of the process of making the decision; or

d) communicate his or her decision, whether by talking, using sign language or any other means.

139. If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

140. The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

141. Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

142. Where there is any doubt about a patient's capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the Mental Capacity Act 2005 and the assessment must be recorded e.g. using Form 4.

143. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

144. In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

145. Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

146. A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

147. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

148. An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

149. An ADRT is **not** valid if the individual:

a) was under 18 years of age when it was drawn up; or

b) did not have capacity when the decision was made; or

c) was acting under duress; or

d) has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or

e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or

f) creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

150. Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRT made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may be a medical advancement which the patient was unaware of at the time he or she made the advance decision, which could significantly improve their condition.

151. There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes

152. If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

153. An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

154. An ADRT cannot authorise anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

155. It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

156. If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

157. If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

158. A healthcare professional will not be acting unlawfully if he or she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved to be invalid/ not applicable.

159. If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

160. If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should

happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

161. An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

162. Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or her professional judgement acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in his or her best interests.

163. Further information about ADRT is available in chapter 9 of the MCA Code of Practice.

Decisions made in the patient's best interests

164. In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if he or she had capacity, rather than what that professional believes to be in his or her best interests. The healthcare professional must make all reasonable efforts to ascertain:

- the patient's past and present wishes and feelings,
- any beliefs and values that would be likely to influence the patient's decision, and

- any other factors that the patient would be likely to consider if they were making the decision.

165. Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable him or her to do so.

166. A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

167. They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted a LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient.

168. The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

169. If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

170. If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgement that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, he or she is not bound to do so.

Temporary incapacity

171. Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

172. It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 144 to 160). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

173. LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints

a person to act as an attorney to make decisions about a person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see the sealed (OPG stamp) LPA document to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

174. If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA Code of Practice.

175. When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

176. Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

177. As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can he or she direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

178. Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those instructions. However a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the interests of the patient, he or she should refer the matter to the Public Guardian.

179. A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

180. If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with the Health Board in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example a care home or a long stay hospital and under the Deprivation of Liberty

Safeguards.)

181. The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see his or her relevant health records.

182. Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

183. Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks
- where there is a choice of treatments, a decision as to which one to use is finely balanced or
- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

184. Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

185. The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision

- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed.

186. Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)
- cases involving organ or bone marrow donation by a patient who lacks capacity to consent;
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)
- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient.

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought

187. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision and that the clinical decision

to withdraw CANH is reasonable in the circumstances, given the diagnosis, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to this Health Board. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed clinical record (covering many specified matters) and also full note of all discussions, meetings and reasons for decisions reached. Legal advice can be sought to support the decision.

188. The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral, although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

189. Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.

http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

190. Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

191. The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

192. The Human Tissue Act Codes of Practice and Standards issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. The Codes and Standards can be found on the following link. Codes of Practice, standards and legislation | Human Tissue Authority (hta.gov.uk)

193. The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

194. The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

195. However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken

from a patient in their lifetime continues to be treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent.

196. Consent is required to store and use tissue removed from the living for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation.

197. The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

198. In the Health Board written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project.

Consent to post mortem examinations

199. Standard Operating Procedure Reference:- MCON titled:-Consent post mortem arrangements should be referred to for necessary details available via Pathology.

200. If a post mortem examination is ordered by the coroner, the consent of relatives is not required.

201. Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient died. In some circumstances it may be appropriate to limit the examination to

a particular region of the body.

202. All post mortems are carried out under an HTA licence held by the Health Board for Adults and at Cardiff & Vale University Health Board for persons less than 18 years of age under their HTA Licence. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying relationship". Thus the appropriate consent for a post-mortem examination means the following: the person in life, however, if there is no consent or refusal known to this procedure in life, consent can be obtained from the nominated representative of the deceased.

203. If there is no nominated representative, then consent can be obtained from the person in the highest qualifying relationship with the deceased prior to death.

204. The ranked list of person(s) in a qualifying relationship is;

a) spouse or partner (including civil or same sex partner). The HT Act states that, for these purposes, a person is another person's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship;

b) parent or child (in this context a child may be of any age, but must be competent if under the age of 18, and means a biological or adopted child);

c) brother or sister;

d) grandparent or grandchild;

e) niece or nephew;

f) stepfather or stepmother;

g) half-brother or half-sister;

h) friend of long standing.

205. The request for a hospital post-mortem should be made by the Clinician who has been trained and is competent in the consent seeking

procedure. The Clinician, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

206. For further information on post mortems please see the following documents available on the Human Tissue Authority website (https://www.hta.gov.uk/);

a) Human Tissue Authority Code of Practice A – Guiding Principles and the Fundamental Principles of Consent (May 2020)

b) Human Tissue Authority Code of Practice & Standards B – Post Mortem Examination (April 2017)

c) Human Tissue Authority Standards & Guidance B – Post Mortem Examination (September 2022)

207. Under the Human Tissue Act, consent is needed for the removal, storage and use of material from the deceased for all scheduled purposes, as listed below;

a) anatomical examination;
b) determining the cause of death;
c) establishing after a person's death the efficacy of any drug or other treatment administered to them;
d) obtaining scientific or medical information, which may be relevant to any person including a future person;
e) public display;
f) research in connection with disorders or the functioning of the human body;
g) transplantation;
h) clinical audit;
i) education or training relating to human health;
j) performance assessment;
k) public health monitoring; and
l) quality assurance.

208. Although consent is not required for a coroner's post-mortem examination, consent is required under the Human Tissue Act for the

storage or use of tissue, for scheduled purposes once the coroner's purposes are complete. See the Code of Practice on Post-mortem examination for further guidance as referenced above. Where an adult has given valid consent for any particular donation or the removal, storage or use of their body or tissue for scheduled purposes to take place following their death, then that consent is sufficient for the activity to be lawful, subject to any other legislative requirements (for example, written consent or death certification). Where an adult has refused to give consent this cannot be revoked after their death.

209. If an adult did not consent to, or specifically refused, any particular donation or use of their body or tissue for scheduled purposes prior to their death, their relatives should be asked whether a nominated representative (or an appointed representative in Wales) was appointed to take those decisions.

210. A nominated representative may be empowered to consent to the carrying out of a post-mortem examination and to the removal, storage or use of the tissue for any of the scheduled purposes. They cannot consent to use of the body for anatomical examination or public display. The appointment of a nominated representative may be general or limited to certain activities.

211. The appointment of a nominated representative and its terms and conditions may be made orally or in writing. The Human Tissue Act sets out the requirements for a valid appointment. The appointment of a nominated representative may be revoked at any time.

212. If a person appointed more than one nominated representative, only one of them needs to give consent unless the terms of the appointment specify that they must act jointly.

213. If the nominated representative(s) does not consent to an activity, this cannot be overridden by other individuals, including relatives. Where they do give consent, but relatives object, it is advisable to ensure that appropriate consultation and discussion takes place between all those involved; there may be circumstances where the activity for which consent is given does not proceed.

214. The nomination may be disregarded if no one is able to give consent under it. This includes situations where it is not practical to communicate with the nominated representative within the time available if the consent is to be acted upon. In the event that a nomination is disregarded, consent may be given by a person in a 'qualifying relationship'. For organ and tissue donation in England this situation is slightly different. Further information can be found on the Human Tissue Authority website (https://www.hta.gov.uk/) and the following Code F;

- Human Tissue Authority Code of Practice F (Part 2) – Donation of Solid Organs and Tissue for Transplantation: Deceased organ and tissue donation (May 2020)

215. Under the Human Tissue Act, children cannot appoint nominated representatives and therefore provisions related to seeking consent from nominated representatives do not apply.

216. If, prior to their death, the deceased person had not indicated their consent (or refusal) to post-mortem examination or removal, storage or use of their tissue for scheduled purposes and had not appointed a nominated representative, then consent may be given by someone who was in a 'qualifying relationship' with the deceased person immediately before their death.

Transplantation - Living Donation

217. The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - Deceased organ donation

218. Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - ode - Human Transplantation Wales Act 2013 - Draft changes to capture change to opt out system in England August 2018 (hta.gov.uk) This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

219. Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

220. This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

221. Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes.
- For use in teaching, training or assessment of fellow healthcare

professionals and students or other appropriate groups e.g. at a conference.

- For use in clinical research.
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet.
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury, for further information please read the Health Board Policy OP04 Closed Circuit Television Policy.

222. Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is this Health Board policy that written consent must always be obtained prior to making a visual or audio recording of a patient or their art work for any of the purposes described in paragraph 208 (for exceptions see paragraph 215 below).

223. Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 224).

224. If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

225. When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure.
- give patients adequate information about the purpose of the recording when seeking their permission.

- make recordings only when you have appropriate consent or other valid authority for doing so.
- ensure that patients are under no pressure to give their permission for the recording to be made.
- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.
- do not participate in any recording made against a patient's wishes.
- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible in the recording.
- ensure that the recording does not compromise patients' privacy and dignity.
- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.
- make appropriate secure arrangements for storage of recordings.

226. Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:

- understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Health Board.
- understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain.
- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.
- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should be

written in language that is easily understood. If necessary, translations should be provided.

- have signed a consent form.

227. After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording.
- recordings are used only for the purpose for which patients have given consent.
- patients are given the chance, if they wish, to see the recording in the form in which it will be shown.
- recordings are given the same level of protection as with patient's medical notes against improper disclosure.
- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

228. Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks (writing in the margins of an x-ray, for example):

- Images taken from pathology slides
- X-rays
- Laparoscopic or endoscopic images
- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be accompanied by verbal or written information which may enable inadvertent identification of the patient)
- Recordings of organ functions
- Ultrasound images

Children and young people

229. Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law to be competent and can give permission to recordings themselves, unless they lack capacity.

230. In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

231. In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

232. If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record cannot be used as evidence, unless, at a later date, the patient changes their mind. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Foetal loss, stillbirth and neonatal death

233. Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on

behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

234. If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

235. When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

236. As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

237. The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - Recordings made as part of clinical care, or as potential evidence

238. If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - Recordings made for education and publication

239. If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then

recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

240. Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

241. Patients have the right to withdraw consent for the use of their audio or visual records at any time. This should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

242. The above information is drawn from the GMC guidance: Making and using visual and audio recordings of patients (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

Please refer to the Health Boards procedure for safe storage and disposal of recordings which can be found in OP04 Closed Circuit Television policy

Telemedicine

231. Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

- it is not the same as seeing a healthcare professional in a face-to-face meeting
- the information/diagnosis received may be compromised by the technology
- they have a right to decline review via telemedicine

Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to Specific procedures

Consent to screening

232. Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening;
- the likelihood of positive/negative findings and possibility of false positive/negative results;
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process;
- any significant medical, social or financial implications of screening for the particular condition or predisposition;

follow up plans, including availability of counselling and support services.

233. If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to Cosmetic Treatments (surgical and non-surgical)

234. From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: http://www.gmc-uk.org/static/documents/content/Guidance_for_doctors_who_offer_cosmetic_interventions_080416.pdf

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

235. Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

236. When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test.

237. If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

238. It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: http://www.bsgm.org.uk/media/39563/consent_and_confidentiality_2011_1_.pdf.

13. Withholding or withdrawing life – sustaining treatment

General

239. The GMC guidance Treatment and care towards the end of life: good practice in decision making (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

240. A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient or those with an interest in the welfare of the patient, where that patient lacks mental capacity to be involved in the decision.

241. Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

242. Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See reference in paragraphs 164 - 171 above.

243. There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

244. Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any relevant change in a patient's circumstances.

Prolonged disorder of consciousness

245. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see paragraphs 186 and 187 above.

246. Additional information is available from:

- Royal College of Physicians – Prolonged disorders of consciousness: national clinical guidelines - 2015
- BMA (2007) Withholding and withdrawing life-prolonging medical treatment: guidance for decision making, 3rd edition.
- GMC (2010) Treatment and care towards the end of life: good practice in decision making.
- An Interim Guidance document produced in December 2017 by the GMC, BMA and RCP entitled "Decisions to withdraw clinically-assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden-onset profound brain injury".

14. Medical treatment of patients with a mental disorder

Basic principles

247. This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder.

248. The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

249. Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24and 25 for further information about consent and the Mental Health Act 1983.

250. Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

251. The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable him/her to understand:

- the nature, purpose, likely and intended effects of the treatment,
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment.

252. A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

253. Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

254. Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

a. patients detained under the Mental Health Act 1983,

b. informal patients who possess capacity to consent to treatment, and

c. informal patients who lack capacity to consent to treatment.

a. Patients detained under the Mental Health Act 1983

255. Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

256. Medical treatment for mental disorder (except treatments under s57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss4 (4) (a), 5(2), 5(4), 35, 135, 136, 37(4)), and

the proposed medical treatment falls within the provisions of

  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment),
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA.

b. Informal patients who possess capacity to consent to treatment

257. Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

c. Informal patients who lack the capacity to consent to treatment

258. An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

259. Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in his or her best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm.

260. If a patient who lacks capacity to consent to treatment appears to be

objecting to treatment, then consideration should be given to detaining the patient under the MHA.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

261. Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

262. The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

263. Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the treatment of the mental disorder' for example:

- Nasogastric feeding a patient with anorexia nervosa (*Re KB (Adult)*(1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

264. The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming herself or those which alleviate the symptoms of the disorder (B v Croydon HA [1995])

265. If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

266. Any research undertaken within the Health Board must be registered with the Health Board's Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced. Please contact the Research and Development department in Cwm Taf Morgannwg UHB on CTMUHB_RD@wales.nhs.uk **or RGH extension 73421 who will be able to advise further.**

267. Consent to clinical trials is covered by the 'Medicines for Human Use Regulations (2004)

268. The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

269. Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

270. There are strict rules within the MCA concerning the involvement of people who lack capacity in research. (See MCA Code of Practice and Welsh Government's Guide to Consent for Examination and Treatment). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. [Please contact the Research & Development Team if you

wish to discuss further].

271. Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where treatment may benefit the patient.

Consent to research and innovative treatment in children

272. The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best interests.

273. Health Board staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether or not the proposed research will take place in an emergency setting.

16. Training

Safeguarding people Training 1 day across the organisation this covers capacity and consent. This also covers the MCA and its principles, Advocacy, LPA etc. These courses are Mandatory for anyone who has direct contact with people across the age range.

Please look at available dates on ESR or contact the local Learning and Development department.

Supplementary Guidance

17. Consent in obstetrics and gynaecology

Pregnant women

274. A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to herself and/or her foetus(es). Any treatment involving the foetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean section (including refusal)

275. If a caesarean section is required, the standard Consent Form 1 must be used. Women in labour can consent to a caesarean section even if they have received sedation.

276. It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean section will be offered. A pregnant woman with capacity may refuse a caesarean section, even if "the consequence may be the death or serious handicap of the child she bears, or her own death" (Court of Appeal Re MB). In other words a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the foetus any legal rights, therefore a caesarean section cannot be authorised by a Court against a competent woman's will and action cannot be taken in the best interests of the pregnant woman or the foetus. In this situation all advice given to the woman should be recorded in her notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that she understands the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of her refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean section to be the most

appropriate course and that the patient has refused consent for a caesarean section.

277. If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

278. There have been a number of cases where doubts have arisen, for various reasons, as to a woman's capacity to make a valid decision about a caesarean section. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

279. Where there is any doubt about a woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or her unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean section (or any other intervention) and it has been demonstrated (in line with the Mental Capacity Act) that she lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out. The out of hours number to make an urgent referral for an urgent decision please contact 0207 947 6000. In the case of Re S, the Court of Appeal laid down general principles that should be applied in future cases. If the mother lacks capacity, avoiding the foetus' death may be seen by the Court as being in the best interest of the mother.

280. Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean section may be carried out if it is in her best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant women is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

281. Men and women requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the advantages, disadvantages and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

282. Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

283. Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that the reversal operations of in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are rarely provided by the NHS.

284. People requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

285. Written consent must be obtained for vasectomy, and the man should be advised to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and his partner before vasectomy, so they can make informed decision about additional contraceptive methods.

286. Whilst the consent of the partner is not needed before sterilisation, or any other procedure, clinicians may, however, wish to discuss the proposed treatment with the spouse or partner, provided the patient agrees.

287. Non theraputic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

288. It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

289. Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

290. The HFEA 1990 as amended makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to the storage of the gametes.

291. Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

292. The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. The husband or putative father's authority is not legally required.

293. If a woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary and the need for a health care professional to see products of conception or to perform a subsequent scan to ensure the termination is complete. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage if the patient changes her mind between the first and

second stages of the procedure.

294. If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if she changes her mind before completing the procedure.

295. Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act, 1967) to indicate that he is in agreement with the need for the termination. The woman will receive counselling in advance of the procedure and will then be scanned to assess gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

296. Clinicians are advised to seek legal advice (see Appendix C) where:

- a woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of her pregnancy; or
- a woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy
- a partner wishes to over-rule a decision to terminate a pregnancy

Histological examination and disposal of non-viable foetal products

297. Consent should always be obtained with regard to the histological examination and disposal of non-viable foetal products up to the age of 24 weeks gestation.

18. Treatment in a Mental Health setting

S57 MHA: Treatment requiring capacity, consent and a second opinion

298. Section 57 treatments include surgical operations that destroy brain tissue or destroy the functioning of brain tissue, and the surgical implantation of hormones for the purpose of reducing male sex drive. S57 applies to all patients, whether or not they are subject to the MHA.

299. Treatment under s57 can only be given if all three of the following requirements are met:

- the patient consents to the treatment,
- a second opinion appointed doctor (SOAD) and two other people appointed by Healthcare Inspectorate Wales (HIW) certify the patient has the capacity to consent to the treatment and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient on form CO1.

S58 MHA: Treatment requiring consent or a second opinion

300. The approved clinician (AC) in charge of treatment must obtain the valid consent of any patient before the administration of medicine by any means after three months, unless such medicine is being administered under s62 (emergency treatment).

301. There can only be one 3 month period for s58 treatment in any continuous period the patient is subject to detention. This includes a patient detained under s2 which is immediately followed by detention under s3 and the patient is then discharged onto s17A (supervised community treatment) followed by the patient being recalled and having the Community Treatment Order (CTO) revoked and again discharged onto s17A.

302. When the patient has given valid consent to take s58 type treatment form CO2 must be completed by the AC in charge of the treatment. All medicines must be designated by their classes (as described in the BNF) rather than individually. Moreover, the doses may be entered as within BNF limits, but specific doses must be included when the BNF limit is being exceeded. Any new addition to the classes of drugs requires a Form CO2 to be completed by the AC in charge of the treatment. A contemporaneous entry must be made in the clinical record to document the discussion between the AC and the patient at which consent was given. A copy of the completed Form CO2 must be attached to the current prescription card.

303. The patient may at any time, subject to s62, withdraw consent before the completion of the treatment (see s60 MHA).

304. Where a detained patient withdraws consent or refuses consent to the proposed treatment with medication under s58 the AC must trigger the safeguards of a second opinion from a SOAD appointed by HIW. The same safeguard of a second opinion will apply to detained patients unable to consent to treatment under s58 of the Act.

305. It is the responsibility of the SOAD to arrange to examine the patient and consult a minimum of two 'statutory consultees' (i.e. one of who is a registered psychiatric nurse and the other who is someone who has been professionally involved in the medical treatment of the patient) prior to making a clinical decision about treatment.

306. The SOAD and the two statutory consultees must record the outcome of their assessment in the patient's clinical notes. The AC in charge of the treatment should inform the patient of the decision of the SOAD.

307. The SOAD, if he concurs with the AC's treatment plan, will complete the appropriate new Form CO3 authorising the proposed treatment plan.

308. In the case of medication, the SOAD's Form CO3 will specify the classes of drug/drugs dosage (mostly within BNF limits) and the route of administration. A copy of the Form CO3 must be attached to the current prescription card and the clinical records with the original to be sent to the MHA Administrator's Office.

S58A: Electroconvulsive Therapy (ECT)

309. Section 58A applies to ECT and medication administered as part of ECT. It applies to all detained patients and to all patients who are under 18 years whether or not they are a detained patient.

310. The written consent of all patients with capacity to consent to receiving ECT must be obtained, whether or not they are subject to s58A. A record of the discussion with the patient and of the steps taken to confirm that the patient has capacity to consent should be made.

311. Patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose, and likely effects.

312. The key differences from s58 are that:

- ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition (s58A(1)(a) and (2) and s62(1)(a) and (1A) MHA),
- no patients under the age of 18 can be given ECT unless a SOAD has certified that the treatment is appropriate, and
- there is no initial 3 month period during which a certificate is not needed.

S58A (3) Detained adult patients with capacity to consent to ECT

313. The AC in charge of treatment or a SOAD can certify on Form CO4 that the patient has attained the age of 18 and is capable of understanding the nature, purpose and likely effects of ECT and has consented to that treatment.

314. The original Form CO4 must be sent to the MHA administrator with a copy kept for the clinical record and one to go with the patient to the ECT department each time the patient is to receive the treatment. The patient may withdraw consent at any time. The certificate would not be valid if the patient subsequently lacks the capacity to make that decision during the course of treatment.

S58A (4) Detained or informal children and young people with capacity to consent to ECT

315. For children and young people ECT may be given if the patient has consented and a SOAD has certified, on Form CO5, in writing:

- that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it; and
- that it is appropriate for the treatment to be given.

S58A (5) and (6) Patients who lack capacity to consent to ECT

316. Patients who lack capacity to consent to treatment may be given ECT if a SOAD has certified in writing:

- that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but
- that it is appropriate for the treatment to be given; and
- that giving the patient the treatment would not conflict with:
- an advance decision which the SOAD is satisfied is valid and applicable, in accordance with s25 of the MCA; or
- a decision made by a donee or deputy or by the Court of Protection.

317. The SOAD must complete form CO6.

318. The SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. One shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner. Furthermore, neither shall be the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question.

S60 Withdrawal of consent

319. Patients treated in accordance with s57, s58 or s58A may withdraw their consent to that treatment at any time. Fresh consent for the implementing of procedures as required by those sections will then be required before further treatment can be carried out or reinstated, except as provided for under the urgent treatment provisions within s62.

320. Where the patient withdraws consent he or she should receive a clear explanation:

- of the likely consequences of not receiving the treatment;
- and in the case of s58 treatments that a second medical opinion under Part 4 of the Act may or will be sought, if applicable, in order to authorise treatment in the continuing absence of the patient's consent; and
- of the power of the approved clinician in charge of the treatment to begin or continue urgent treatment under s62, if applicable.

321. The patient's withdrawal of consent and explanations given to the patient in light of that withdrawal of consent must be clearly documented in the patient's case notes.

S62 Treatment not requiring consent

322. The consent of a patient subject to s56 i.e. most detained patients subject to the exceptions described in para 9(a) is not required for the administration of urgent treatment under s62. The forms of treatment are expected to include only those authorised under s58 and s58A .In urgent situations, such treatments can be administered without a second opinion. Whenever s58 or 58A type treatment is administered under s62, a simultaneous request must be made for a second opinion.

323. The same principle applies to a patient who has consented to take medication and then withdraws his consent after the three month period. HIW will be requested to arrange for the visit of a SOAD. Where the treatment is urgent, s62(2) may be used to continue with the

treatment plan if the AC in charge of the treatment considers that discontinuance of the treatment or treatment under the plan would cause serious suffering to the patient.

324. There is no statutory prescribed form to record the use of treatment under s62, but a local record form should be completed each time s62 is used to treat a patient.

S63 Treatment not requiring consent

325. Section 63 authorises medical treatment for mental disorder without consent and includes treatments that may alleviate the underlying causes of mental disorder, but not including treatments covered by s57, s58 or s58A, provided the treatment is given by or under the supervision of the AC in charge of treatment.

Advance Decisions to Refuse Treatment

326. A patient with a mental disorder is able to make a valid and applicable ADRT, as long as they have mental capacity at the time the advance decision is made. The fact that a patient was/is detained under the Mental Health Act when the ADRT advance decision was made does not render him/her incapable.

327. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 or 4A of the Mental Health Act 1983 and consent is not required. An ADRT can override the provisions in s57 of the Act, but not those contained in s58, s62 and s63. In respect of ECT (s58A), a valid and applicable ADRT would prevent a SOAD from issuing a certificate but would not necessarily prevent the AC in charge of the treatment from giving urgent ECT treatment as described in s62.

328. Chapter 8 of this document provides more information in relation to advance decisions.

PART 4A Treatment of patients on a Community Treatment Order (CTO) not recalled to hospital

329. The purpose of a community treatment order (CTO) is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm to the patient or others.

330. Only patients who are detained in hospital for treatment under s3 of the MHA or are unrestricted part 3 patients (i.e. s37 without a s41) can be considered for a CTO.

331. Patients not recalled to hospital include patients on a CTO who are in hospital if they have been admitted informally.

CTO Patients (aged over 16 years) with capacity to consent to treatment

332. Compulsory treatment cannot be given to a patient on a CTO who has not been recalled to hospital and who has capacity to consent or refuse treatment and is refusing. There are no exceptions to this rule, even in emergencies.

333. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto a CTO.

334. The Responsible Clinician completes form CO8 for s58 and s58a for patients with capacity to consent to treatment who are consenting to treatment.

335. A new CO8 form will need to be completed if there is a change of responsible clinician.

336. The Part 4A certification requirement does not apply if the treatment is immediately necessary and the patient has capacity to consent to it and does consent to it.

S64D Adult CTO patients lacking capacity to consent to treatment

337. A person is authorised to give medical treatment for mental disorder to a CTO patient who lacks capacity to consent to treatment if the following conditions are met:

- before giving the treatment, the person takes reasonable steps to establish whether the patient lacks capacity to consent to the treatment;
- when giving the treatment, he reasonably believes that the Supervised Community Treatment (SCT) Order patient lacks capacity;
- he has no reason to believe that the patient objects to be given the treatment; or he does have reasons to believe that the patient so objects, but it is not necessary to use force to give the treatment;
- he is the approved clinician in charge of the treatment, or the treatment is given under the direction of that clinician; and
- giving the treatment does not conflict with an advance decision which he is satisfied is valid and applicable, or a decision made by a done or deputy of the CoP.

338. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto supervised community treatment.

339. The Responsible Clinician must request a SOAD, who completes form CO7, if a patient lacks capacity to consent to s58 or s58A treatment.

340. Before giving a Part 4A certificate, the SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. Of those persons s/he shall consult:

- at least one shall be a person who is not a registered medical practitioner; and
- neither shall be the patient's responsible clinician or the person in charge of the treatment in question.

341. The Part 4A certification requirements do not apply if the treatment is given in accordance with s64G (emergency treatment in patients lacking capacity), or the treatment is immediately necessary and a donee or deputy or the Court of Protection consents to the treatment on the patient's behalf.

S64G Emergency treatment for CTO patients lacking capacity or competence

342. A practitioner is authorised to give emergency treatment to a patient who lacks capacity to consent to treatment, and who is subject to a CTO, if the following conditions are met:

- the practitioner reasonably believes that the patient lacks capacity to decide or is not competent to consent to it;
- the treatment is immediately necessary; and
- if it is necessary to use force against the patient in order to give the treatment; the treatment needs to be given to prevent harm to the patient; and the use of such force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.

343. The responsible clinician will fill in the appropriate form.

What does 'immediately necessary' mean?

344. Treatment is immediately necessary if:

- It is immediately necessary to save the patient's life; or
- It is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or
- It is immediately necessary to alleviate suffering by the patient and is not irreversible or hazardous; or

- It is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

345. However, ECT may only be given in an emergency if it is immediately necessary to save the patient's life or to prevent a serious deterioration of the patient's condition.

S64E Child CTO Patients (aged under 16)

346. Medical treatment may be given when there is authority to give it and the certificate requirements are met.

347. Certification is not needed for the first month after discharge onto the CTO or if it is immediately needed and the child is competent to consent to the treatment.

S64F Child CTO patients lacking competence to consent to treatment

348. A person is authorised to give medical treatment for mental disorder to a patient subject to a CTO under the age of 16 years if the following conditions are met:

- the person takes reasonable steps to establish whether the patient lacks competence to consent to the treatment;
- he reasonably believes that the child lacks competence to consent to the treatment;
- he has no reason to believe that the patient objects to being given the treatment, or he does have reason to believe that the patient so objects, but it is not necessary to use force to give the treatment; and
- he is the approved clinician in charge of the treatment; or the treatment is given under the direction of that clinician.

CTO patients recalled to hospital

349. CTO patients who are recalled to hospital are subject to s58 or s58A. Certification for s58 or s58A type of treatment is needed unless:

- less than one month has passed since the patient was discharged onto the CTO;
- the s58 or s58A treatment is already explicitly authorised for administration on recall by the Part 4A certificate; or
- if the AC in charge of the treatment considers that discontinuance will cause the patient serious suffering, he may continue with the treatment pending a fresh certificate.

350. For more detailed information regarding Community Treatment Orders, please refer to chapter 24 of the HA 1983 Code of Practice for Wales, 2016.

Appendix A - Link to current consent forms in use in this organisation

CTM Consent Model

Appendix B - Useful contact / link details

(e.g. risk managers, training managers, clinical governance leads and clinical ethics committees)

- Kevin Conway CTM UHB Consent Lead
- Lydia Thomas CTM UHB Head of Quality and Patient Safety Central Patient Care and Safety Team
- Mandeep Toor Clinical Practice Educator for MCA, DoLS & LPS, Safeguarding Team
- Advocacy Service is Advocacy Support Cymru, Charterhouse, Links Business Park, Fortran Road, St Mellon's Cardiff CF3 0LT Tel No. 02920 540444.

Appendix C – How to obtain legal advice

If you need to obtain legal advice or apply for a court ruling in relation to a complex consent issue you should contact NWSSP Legal and Risk in office hours 02920 903700 further details can be found at the end of this section. You should ensure that you have all the relevant information about the case to hand so that you can brief legal services / the solicitor appropriately. You should keep a clear record of the legal advice you have been given.

Where a decision is made to apply to a court, the lead clinician should, as soon as possible, inform the patient and his / her representative of the decision and of his or her right to be represented at the hearing. The patient's solicitor should be informed immediately and, if practicable, should have a proper opportunity to take instructions and apply for legal aid where necessary.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent;

b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent;

c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)

d) all other cases where there is dispute about whether a particular treatment will be in a patient's best interests (including cases

involving ethical dilemmas in untested areas).

NHS Wales: Legal Services - Contact Details (updated May 2019)

All clinical negligence claims continue to be managed solely by NHS Wales Legal & Risk Services.

Out of hours or for anything urgent please contact by phone, as below:

Mark Harris: Tel 029 20903743 (urgent/OOH: 07801 505739)

For non-urgent matters, the lead solicitors at NHS Wales Legal & Risk Services for individual areas are listed below. During normal business hours, please ring the office land line in the first instance.

Property – Rashmi Charkrabarti/Kirsty Ellis

Contract and Commercial Law – Andrew Evans/Marcia Donovan

Litigation - Anne-Louise Ferguson/Mark Harris/Andrew Hynes

Governance and Inter-Agency and General Health Law Advice – Mark Harris/Gemma Cooper

Risk Product Liability and Health and Safety – Anne-Louise Ferguson/Mark Harris

Mental Health Act and Mental Capacity Act – Gavin Knox/David Kaged/Gaynor Kynaston

Employment –Sioned Eurig/Daniela Mahapatra/Clare Primett

Contact Information

Mark.Harris@wales.nhs.uk 029 20903743 (for urgent enquiries 07801 505 739)
Anne-Louise.Ferguson@wales.nhs.uk 029 20903769 (for urgent enquiries 07789 648 350)
Gemma.Cooper@wales.nhs.uk 029 20903727 (for urgent enquiries 07825 587 005)
Gavin.Knox@wales.nhs.uk 029 20903713 (for urgent enquiries 07966 971 768)
Andrew.Hynes@wales.nhs.uk 029 20903741 (for urgent enquiries 07554 008 478)
Sioned.Eurig@wales.nhs.uk 029 20903762 (for urgent enquiries 07843 388 075)

Daniela.Mahapatra@wales.nhs.uk 029 20903763 (for urgent enquiries 07734 722 356)
Clare.Primett@wales.nhs.uk 029 20903759 (for urgent enquiries 07765 888 552)
Rashmi.Chakrabarti@wales.nhs.uk 029 2090 4146 (for urgent enquiries 07725 607 807)
Kirsty.Ellis@wales.nhs.uk 029 2090 3742 (for urgent enquiries 07983 461 457)
Andrew.Evans2@wales.nhs.uk 029 2090 2264 (for urgent enquiries 07807 776 436)
Marcia.Donovan@wales.nhs.uk

Address
NWSSP Legal and Risk Services
4th Floor
Companies House
Crown Way
Cardiff
CF14 3UB
Fax 029 20904146
Website: http://howis.wales.nhs.uk/sites3/home.cfm?orgid=255

Appendix D - Assessing and documenting Gillick Competence in Under 16s

Assessment of Gillick competence should document the following[7]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[7] BMA - Children and Young People Toolkit

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example if your treatment involves sedation or general anaesthesia. In this case, you will then be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary on things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a "doctor in training" – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. For some procedures you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decisions to refuse treatment

Some people chose to make "advance decisions" refusing certain care or treatment (sometimes referred to as "living wills" or "advance directives"). If you have made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example to record changes to a skin lesson. You will always be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication,

research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don't go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) so that you can make an informed decision

What are the key things to remember?

It's your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

Cwm Taf Morgannwg University Health Board has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?

- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or style of life, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the ward sister or senior therapist who will be able to

assist and, hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet "Putting Things Right". This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

Cwm Taf Morgannwg Community Health Council can be contacted as follows:

Cwm Taf Morgannwg Community Health Council

10 Maritime Offices,

Woodland Terrace,

Pontypridd

CF37 1DZ

E-mail: Enquiries.CwmTafCHC@waleschc.org.uk

Tel: 01443 405830

Data Protection Act/General Data Protection Regulations (2016) or any subsequent legislation having the same effect

FROM

Under current Data Protection Legislation, we are committed to protecting the privacy of patient information. If you require an explanation of why information is needed, or how you can access information or your health records, please contact [insert details of the local process]. You are entitled to receive a copy but should note that a charge will usually be made. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

TO

Under current Data Protection Legislation, we are committed to protecting the privacy of patient information. You can view a copy of the NHS Wales Privacy Statement at https://cwmtafmorgannwg.wales/privacy-statement-for-patient-information/.

If you require an explanation of why certain information is needed please contact [*contact address for relevant clinician etc*.]. If you would like to know how you can access your information or your health records, please email the Medical Records Department at CTT_Medrecordrequest@wales.nhs.uk. You are entitled to receive a copy of your medical records and there are no fees for this service. You should also be aware that in certain circumstances your right to see some details in your health records may be limited in your own interest or for other reasons.

If you require further electronic copies of this publication please access the NHS Wales Governance E-Manual at: http://www.wales.nhs.uk/governance-emanual/patient-consent/

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AGENDA ITEM
3.1.6

QUALITY & SAFETY COMMITTEE
POLICY FOR THE PROVISION OF INTRAOPERATIVE CELL SALVAGE

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Geraint Rees, Consultant Anaesthetist
Presented by	Dom Hurford, Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Clinical Policies Approval Group	20/03/2023	ENDORSED FOR APPROVAL

ACRONYMS	
SHOT	Serious Hazards of Transfusion
HSC	Health Service Circular
ICS	Intraoperative Cell Savage

1. SITUATION/BACKGROUND

Whilst allogeneic (donated) blood is an essential adjunct to health care, it is an expensive and limited resource (subject to the threat of future shortages) and can present a source of risk for patients, in particular the

risk of "wrong blood" incidents as reported by the Serious Hazards of Transfusion (SHOT)[1] scheme.

The Health Service Circular (HSC), "Better Blood Transfusion: Safe and Appropriate Use of Blood" (2007) and subsequent National Blood Transfusion Committee publication, "Patient Blood Management: An evidence-based approach to patent care" (2014, England only) recommend that in order to make transfusion safer, provide better information for patients, avoid inappropriate blood transfusion and to ensure the best treatment, the patient must be at the heart of decisions made about blood transfusion.

Both publications recommend that effective alternatives to allogeneic blood transfusion be explored, including the appropriate use of autologous blood transfusion techniques such as Intraoperative Cell Salvage (ICS).

ICS is used routinely in some areas of surgical practice. The technique involves aspirating blood lost within the surgical field into a collection reservoir. Blood is mixed with an anticoagulant solution containing either heparin or citrate to prevent clotting. A modified aspiration line is used to deliver the anticoagulant to the tip of the suction. As blood enters the collection reservoir it is filtered to remove large particulate debris. The salvaged blood is then centrifuged and washed to produce red blood cells suspended in saline for reinfusion to the patient. The waste products (plasma, platelets, anticoagulant etc.) are removed during processing and the washed red blood cells are transferred to a reinfusion bag. When used appropriately, by adequately trained staff, ICS is a simple, safe and cost-effective method of reducing allogeneic transfusion.

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

2.1 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.2 The following have been engaged in the consultation

- Medical Director
- Nursing Director
- Consultant Lead for Transfusion (HTC)
- Clinical Lead for ICS
- Theatre lead for ICS
- Theatre trainer for ICS
- Directorate Manager for Theatre
- Transfusion Practitioner
- Jehovah's Witness Hospital Liaison
- Maternity Governance (Across all three sites of CTM)

2.3 Organisational values and behaviours have been reflected within the policy.

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

Only minor typographical amendments were made as a result of the various consultation stages.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	See Policy
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	EIA is underway and if there are any recommendations that require amendment to the policy it will be brought back to the Committee for approval
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee are asked **APPROVE** the Policy for the provision of Intraoperative Cell Savage.

5.2 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

Policy for the provision of Intraoperative Cell Salvage

Document Type:	Clinical Policy
Ref:	(For Non-Clinical References – Contact: CTM_Corporate_Governance@wales.nhs.uk For Clinical References – Contact: CTM_ClinicalPolicies@wales.nhs.uk
Author:	Dr Geraint Rees Consultant Anaesthetist
Executive Sponsor:	Choose an item.
Approved By:	Choose an item.
Approval / Effective Date:	(01/03/2023)
Review Date:	(00/00/0000)
Version:	

Target Audience:

People who need to know about this document in detail	All Staff involved with or likely to be involved with delivering cell salvage or involved in the care of a patient receiving cell salvage. (eg Operating Department Practitioners, anaesthetists, Surgeons, midwives, nursing staff) All staff and departments involved with blood management services Hospital Transfusion committee
People who need to have a broad understanding of this document	Medical Director Nursing Director Consultant Lead for Transfusion Clinical Lead for ICS Theatre lead for ICS Theatre trainer for ICS Directorate Manager for Theatre Transfusion Practitioner Jehovah's Witness Hospital Liaison
People who need to know that this document exists	All staff involved in the development of Health Board Policies.

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date:** **Outcome:**
Welsh Language Standard	Choose an item.
Date of approval by Equality Team:	(00/00/0000)
Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.


MAE EIN GWERTHOEDD YN EIN HELPU NI I FOD AR EIN GORAU
#CTMareingorau
RYDYN NI'N GWRANDO, YN DYSGU AC YN GWELLA
WE LISTEN, LEARN AND IMPROVE
RYDYN NI'N TRIN PAWB Â PHARCH
WE TREAT EVERYONE WITH RESPECT
RYDYN NI I GYD YN CYDWEITHIO FEL UN TIM
WE ALL WORK TOGETHER AS ONE TEAM
OUR VALUES HELP US BE AT OUR BEST
#CTMatourbest

Guidance

This guidance has been adapted from the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidance template 2016, whilst also referring to 2018 Association of Anaesthetists guidelines: cell salvage for perioperative blood conservation 2018.

All references to Cell Salvage (CS), Intraoperative Cell Salvage (ICS), Postoperative Cell Salvage (PCS) and combined systems (ICS/PCS) in this policy, relate to WASHED systems only (unless otherwise stated).

This policy does not relate to the use of unwashed cell salvage systems e.g. postoperative autologous wound drains or combined unwashed ICS/PCS devices.

This policy has been written to support the implementation and use of washed ICS. It may also be applicable when washed ICS devices are used in the pre and/or postoperative environment (e.g. Accident and Emergency, recovery, ward etc) and for devices specifically designed for combined washed ICS/PCS.

Contents

1 Introduction

Whilst allogeneic (donated) blood is an essential adjunct to health care, it is an expensive and limited resource (subject to the threat of future shortages) and can present a source of risk for patients, in particular the risk of “wrong blood” incidents as reported by the Serious Hazards of Transfusion (SHOT) scheme.

The Blood Health National Oversight Group (BHNOG) was established in 2017 to oversee the implementation of the Blood Health Plan for Wales.

The following is taken from the NHS Wales Blood Health Plan 2021. ‘Blood and blood component transfusions are essential, life saving treatments used everyday within NHS Wales. Transfusion however is not a risk free procedure and there is always a possibility of transfusion reactions or transmission of infection. It is therefore critical that blood and blood components are only given when needed and where no other suitable alternative exists.’

As part of BHNOGs implementation of the Blood Health Plan, Cell Salvage (CS) is seen as an integral part of delivering this through patient blood management.

Intraoperative cell salvage (ICS) is used routinely in some areas of surgical practice. The technique involves aspirating blood lost within the surgical field into a collection reservoir. Blood is mixed with an anticoagulant solution containing either heparin or citrate to prevent clotting. A modified aspiration line is used to deliver the anticoagulant to the tip of the suction. As blood enters the collection reservoir it is filtered to remove large particulate debris. The salvaged blood is then centrifuged and washed to produce red blood cells suspended in saline for reinfusion to the patient. The waste products (plasma, platelets, anticoagulant etc) are removed during processing and the washed red blood cells are transferred to a reinfusion bag. When used appropriately, by adequately trained staff, ICS is a simple, safe and cost-effective method of reducing allogeneic transfusion.

2 Policy Statement

Utilising appropriate alternatives to blood transfusion is cost-effective and complies with clinical governance requirements.

The collection and re-infusion of autologous red blood cells provides an important contribution to reducing the demand for allogeneic blood. However, it is only one aspect of a strategic approach to safe and appropriate transfusion practice.

3 Aims

The use of cell salvage will be based on an individual patients' risk/benefit and that clinical judgement by the clinicians involved in that persons care is exercised. Therefore, the aim of this policy is to provide information that will allow clinicians to utilise ICS in a safe and effective manner and to safely identify suitable patients undergoing elective and / or emergency surgical procedures where ICS could be used.

4 Objectives

The objectives of this policy are to provide a rational and practical framework on which to maximise patient safety during ICS by:

- Promoting safer transfusion as part of clinical governance responsibilities.
- Assisting clinical staff in the identification of patients and procedures considered suitable for ICS and outlining the indications and contraindications.
- Assisting clinical staff to provide appropriate advice on options for treatment, particularly where patients are anxious about risks associated with donor blood.
- Providing clear written information about the risks and benefits of autologous transfusions from blood salvaged intraoperatively.
- Assisting clinical staff to minimise avoidable/potential risks of autologous transfusions from blood salvaged intraoperatively.

5 Responsibilities

Overall responsibility for the provision of ICS is under the remit of the Hospital Transfusion Committee (HTC). A clinical lead for the trust must be identified who reports to the HTC. There must also be a coordinator for cell salvage at each site that CS is used (usually an ODP), who oversee a competence-based training programme for all involved staff. Data collection and audit is usually done via the transfusion practitioners.
Responsibilities associated with ICS include:

- Prescribing responsibilities.
- Labelling responsibilities.
- Individual responsibilities.
- Documentation responsibilities.

Prescribing Responsibilities
Salvaged blood reinfusion should be prescribed / authorised by the responsible clinician on the documentation approved by the Organisation.

Labelling Responsibilities
The reinfusion bag should be labelled as soon as is reasonably practical (i.e. when the patient is in theatre or as soon as the processing set is loaded if a "collect only" system has been used initially). If a "collect only" system has been set up, it is recommended as best practice that the collection reservoir is labelled, this label can then be transferred to the reinfusion bag when the processing set is loaded. The patient details should be handwritten on the label from the patient's identification band (attached to the patient) and include the following:

- Full name.
- Date of birth.
- Unique identification number.
- Expiry date and time of the salvaged blood.
- The statement "Untested Blood –"For Autologous Use Only"[11].

Addressograph labels should not be used because of the known associated risks[5].

Individual Responsibilities
Individual staff must ensure that they are adequately trained and competent in the use of the ICS system and their individual responsibilities according to their area of work i.e. operator, anaesthetic, scrub, recovery and ward staff. Individual staff should ensure they are adequately trained and competent in the use of ICS in each of the specialities they work in. Staff should not use equipment for which they have not been trained and competency assessed.

Documentation Responsibilities

Staff should ensure that documentation (including all appropriate labelling) accurately reflects the ICS process. The documentation record should include:

- The ICS audit form (Appendix I).
- The autologous transfusion label should be completed and attached to the reinfusion bag.
- At the time of reinfusion of the salvaged blood, the peel out section on the autologous transfusion label should be completed and attached in the appropriate place in the patient's clinical records on the 'All Wales Transfusion Record (AWTR)'.
- Appropriate labelling of heparin saline anticoagulant or citrate (ACD-A) at the start of the procedure.
- Bedside pre-transfusion checks and patient observations prior to and during ICS blood reinfusion should be performed and recorded in the same way as for the transfusion of allogeneic blood (Blood Transfusion Procedure for Prince Charles Hospital and Associated Sites – Merthyr & Cynon Locality & Blood Transfusion Procedure for Royal Glamorgan Hospital and Associated sites – Princess of Wales Bridgend policies)
- Additional observations are at the discretion of the clinical staff based on an individual patient assessment.
- Adverse incidents should be documented in the patient's clinical records and reported as in section 12.

6 Training

- Key personnel should be identified in each clinical area as a contact for communication and training. This person will usually be the ODP lead for ICS within each hospital, who will maintain training records of staff who have received training in the use of the ICS device (a copy of this record may be sent to the Clinical Lead for ICS for central collation).

- Theoretical and practical training must be undertaken, and staff must be competency assessed before they set up or operate ICS equipment without supervision. (See the ICS competency Assessment Workbook below)

- Individual staff should receive training in the indications, contraindications and technical differences specific to their speciality/specialities. If a member of staff moves from one speciality to another, it is good practice for training needs to be identified and addressed prior to the staff member using ICS in their new clinical environment.

- Staff carrying out ICS for Jehovah's Witness patients requesting continuous connectivity should have received training and have been competency assessed in preparing the equipment and blood for reinfusion in accordance with the patients' religious beliefs, prior to carrying out the procedure. See appendix IX and the Association of Anaesthetists 2018 guidance.

- An ICS Competency Assessment Workbook is available via the Transfusion Practice section of the JPAC website, at: www.transfusionguidelines.org.uk (see also Appendix II). It is strongly recommended that once assessed as competent, individuals keep an ongoing log (similar to that in the ICS Competency Assessment Workbook) of all the ICS procedures they carry out.

- Operators have a professional responsibility / accountability to ensure they are up to date and competent in relation to their practice. Where practical supervised training during real cases is ideal, however this might not be possible. As such regular training (such as using out of date blood form blood bank) is expected to be undertaken annually.

- Update training is recommended under the following circumstances:
  - Any reasonable length of time without practical use of the ICS device.
  - A learning need is identified by an individual member of staff or supervisor.
  - Changes in the product from the manufacturer or a change in the product due to the Organisation trialling/purchasing new products.
  - Changes to national and/or local guidelines relating to any aspect of autologous transfusion (including changes to the Organisation's Blood Transfusion Policy).
  - Following an incident or error.

Individual Responsibilities

Individual staff should ensure that they are adequately trained and competent in the use of the ICS system used and their individual responsibilities according to their area of work, i.e. operator, anaesthetic, scrub, recovery and ward staff.

7 Indications and Patient Selection

- Cell salvage is indicated in any surgical procedure, either planned or urgent, where the benefit results in the reduction or complete avoidance of allogeneic red cell transfusion.

  Procedure related factors:
  - Collection of blood for potential cell salvage ('collect only' mode) should be considered for surgical procedures where the blood loss may exceed 500ml (or > 10% of the calculated total blood volume in adults, or > 8ml/kg (>10% of the calculated total blood volume) in children weighing > 10kg.

  Patient related factors:
  - Refusal of allogeneic blood.
  - Difficulty in obtaining compatible allogeneic blood.
  - Patients with a low haemoglobin.
  - Increased risk of bleeding.

  Each patient presenting for surgery will have a greater or lesser risk of bleeding and consequently a varying threshold for requiring a transfusion. Any decision to use cell salvage should therefore be made on an individual patient basis.

- Patient selection for ICS is at the discretion of the surgeon and anaesthetist caring for the patient.

- If the surgical procedure to be carried out is associated with any of the contraindications as listed in section 8, the potential risks and hazards should be discussed with the patient and their agreement to undergo ICS documented in the patient's clinical records.

- **Indications for Cell Salvage in obstetrics**

  The association of anaesthetists guidelines recommend that Cell Salvage is not used routinely for caesarean section based on the current evidence, be it elective, urgent or emergency.

  However, Cell salvage should be considered in 'collect only' mode in patients who are anaemic before surgery or if there is unanticipated ongoing bleeding during surgery. If a decision is made to use it because a woman declines autologous transfusion or significant blood loss is anticipated, the risk and benefits should be discussed with the woman.'

  Also, the Association of Anaesthetists do not recommend routine use of double suction or Leucodepleted Filters (LDFs) in obstetric practice.

The NICE guidance "Intraoperative blood cell salvage in obstetrics" recommends that "whenever possible, the woman understands what is involved and the theoretical risks, and agrees (consents) to have the procedure". When obtaining formal consent for a caesarean section, the obstetrician or anaesthetist should discuss the advantages and risks of ICS with the woman and document clearly her agreement to undergo the procedure. Such detailed consent may not be practicable in an emergency, in which case the use of ICS should be fully discussed with the mother following the procedure.

Patient selection for ICS is at the discretion of the obstetrician and anaesthetist caring for the woman. The type of obstetric cases that could be considered for selection include:

- **Emergency situations**
  - Ruptured ectopic pregnancy
  - Placental abruption
  - Any emergency caesarean section where there is:
    - An anticipated blood loss of >1000mls

  Or where any of the following are present:
    - Risk factors for bleeding
    - Low pre-operative Haemoglobin
    - Rare blood group / multiple antibodies
    - The woman has objections to receiving allogeneic blood but has consented to receiving cell salvage blood
    - Surgical management of postpartum haemorrhage

- **Elective situations**
  - Women with an anticipated blood loss of >1000ml e.g. placenta accreta, placenta praevia, large uterine fibroids, coagulation disorders, multiple (three or more) repeat caesarean sections and/or other predictable causes of Major Obstetric Haemorrhage (MOH).
  - Women who for religious or other reasons refuse allogeneic blood and have consented to the use of Intraoperative Cell Salvage in elective or emergency bleeding situations or in significant anaemia[8]

- **RhD immunisation**
  The association of anaesthetists noted 'there is evidence of fetomaternal haemorrhage [with ICS], which supports the concerns regarding increased risk of haemolytic disease in future pregnancies' and 'emphasises the need for strict adherence to anti-D guide-lines in units using CS'

  This policy suggests following the trust's "Guideline for the use of Anti-D Immunoglobulin in Rhesus Negative Women' or the BCSH guideline for the use of anti-D immunoglobulin for the prevention of

haemolytic disease of the fetus and newborn can be found with the following link.
https://onlinelibrary.wiley.com/doi/full/10.1111/tme.12091

- **Cell Salvage after vaginal delivery**
  There is very little data on the use of cell salvage after vaginal delivery and the practicalities of its use in this situation may make it difficult. However one study suggests its potential, with red cell fetal contamination and bacterial contamination comparable to that of caesarean sections. Given this, prophylactic antibiotics should be given. The use of leucodepleted filters in this particular scenario is not covered by any guidelines. LDF's are generally encouraged in contaminated fields, however given the slow infusion rates their use in life threatening haemorrhage may not be practical.

  In summary, although there is little data recommending its use, there is also little data suggesting it unsafe, and when faced with a life threatening haemorrhage a pragmatic approach to its use is justifiable.

8 Contraindications, controversial areas and warnings

The risk/benefit ratio of ICS should be assessed for each individual patient by the surgeon and anaesthetist responsible for the patient's care.

Contraindications

ICS should not be used in the following situations:

- Patient refusal
- Heparin induced thrombocytopenia when heparin is the anticoagulant of choice (a citrate containing anticoagulant solution may be used instead).
- Lack of trained/competent staff

Controversial Areas

- **Infected and contaminated fields (Association of Anaesthetists: cell salvage for perioperative blood conservation 2018)**

  '**There is no absolute contraindication to ICS in this setting**. Its use is, however, controversial, because ICS might (theoretically) worsen sepsis by introducing infective agents and toxins recovered in the operative field. Conversely, CS reduces exposure to allogeneic blood, which may increase the incidence of postoperative infection through immunomodulation [Washing of collected blood and the use of LDFs removes most bacteria, but this effect is probably dependent on the level of contamination. There is no conclusive evidence that CS worsens sepsis, prognosis or the risk of other specific complications when used in contaminated fields, including major trauma surgery. We recommend that the use of cell salvage in cancer surgery and infected fields should be considered on a case by case basis. Whenever possible, patients in whom cell savage is used should be counselled and asked whether they consent to the procedure being used. Leucodepletion filters should be used for blood re-infusion.'

- **Cancer surgery (Association of Anaesthetists: cell salvage for perioperative blood conservation 2018)**

  Despite theoretical concern, **there is no absolute contraindication to CS in cancer surgery.** Its use is controversial because malignant cells are often present in the operative field, can be found in salvaged blood and may, theoretically, metastasise after re-infusion. Circulating malignant cells are often present in cancer patients undergoing surgery, regardless of CS use, and very few of these cells are thought capable of causing metastases. The number of malignant cells in salvaged blood can be reduced by the use of LDFs, with no apparent adverse effect on the quality of the product. The use of LDFs has not

been shown to be associated with either bradykinin or leukotriene generation in cell-salvaged blood. Cell salvage may reduce or eliminate exposure to allogeneic blood, which has been associated with immunosuppression and cancer recurrence. One major disadvantage of LDFs is that the rate of flow through them is considerably slower, and therefore clinicians may need to assess the benefit of quicker transfusion without a LDF vs. its use. In summary, despite theoretical risks and benefits, there is no conclusive evidence that CS can induce metastases or affect cancer prognosis. The theoretical risk of inducing metastatic spread (unproven) is offset by reduced allogeneic transfusion and immunomodulation, which is proven. As a result, many clinicians do offer cell salvage to patients undergoing major cancer surgery. The Working Party (Association of Anaesthetists) recommends that potential risks and benefits should be discussed with patients before cancer surgery, and specific consent obtained.'

Guidance on the use of ICS in radical prostatectomy and radical cystectomy is available from NICE.

The decision to use ICS in the presence of malignant disease should be made by the surgeon and anaesthetist in consultation with the patient.

- **Obstetrics (Association of Anaesthetists: cell salvage for perioperative blood conservation 2018)**

'Obstetric haemorrhage is a significant cause of maternal mortality and the leading cause of maternal morbidity in the UK. National surveys show that CS is a resource that is being used more frequently in UK obstetric units. Re-infusion rates and cost effectiveness are variable and directly associated with larger volumes of blood loss. Despite the growing availability of equipment and safety endorsements for its use, challenges remain in providing CS in an obstetric surgical setting. Haemorrhage associated with emergency operative delivery is often not predictable, rapid and occurs out of hours.
The SALVO trial (cell salvage during caesarean section: a randomised controlled trial) is the largest study to date (n = 3054) examining the role of CS in caesarean section. SALVO did not find a significant difference in donor transfusion rate in caesarean section or a cost benefit argument for routinely setting up a complete collection and re-transfusion system. However, institutional level costs are still dependent on case volume, expected levels of blood loss per case and initial investment costs. Use of strategies such as swab washing to improve collection rates should be considered to contribute to the complex analysis of cost effectiveness locally. Furthermore, although SALVO's exploratory analysis in cases of malplacentation did not demonstrate effectiveness, the trial cannot be used to justify or refute the use of CS in cases of anticipated torrential haemorrhage. As in previous studies, there is evidence of fetomaternal haemorrhage, which supports the concerns regarding increased risk of haemolytic disease in future pregnancies.
The group (Association of Anaesthetists) recommends further research on the long-term consequences of allo-immunisation to RhD and other red cell antigens following the use of CS and emphasises the need for strict adherence to anti-D guidelines in units using CS.

Use of leucocyte depletion filters and the requirement for separate suction for blood have now been questioned by some advocates of the technology A double suction technique – one waste sucker for amniotic fluid and another sucker attached to the cell salvage device for suctioning any blood lost – may reduce initial contamination, although in-vitro evidence consistently demonstrates that the cell salvage/filtration process can effectively remove plasma phase elements of amniotic fluid whatever the initial load.
Use of leucocyte depletion filters (LDF) should be considered but these slow re-infusion rates and evidence for their effectiveness in this setting is mixed. Because they are adhesion filters, blood cannot be forced through them and they may become saturated during use, requiring replacement, and have the potential to cause bradykinin-mediated hypotension.

The Working Party (of The Association of Anaesthetists) decided not to recommend routine use of double suction or LDFs in obstetric practice.

Therefore, the Working Party recommends that CS is not used routinely for caesarean section based on the current evidence, be it elective, urgent or emergency.

Cell salvage should be considered in 'collect only' mode in patients who are anaemic before surgery or if there is unanticipated ongoing bleeding during surgery. If a decision is made to use it because a woman declines autologous transfusion or significant blood loss is anticipated, the risk and benefits should be discussed with the woman.'

- **Trauma/Orthopaedics (Association of Anaesthetists: cell salvage for perioperative blood conservation 2018)**

'Intra-operative CS should be considered in all patients undergoing orthopaedic or trauma surgery when blood loss is expected to be > 500 ml. If bone cement is used, then CS should not be used while cement is being applied and can be resumed when the cement is fully set. For revision surgery, when metalwork may be in situ, such as previously instrumented spinal surgery, there is evidence that standard 40 micron filters do not eliminate the smallest fragments of titanium, so caution should be exercised. However, we (Association of Anaesthetists) still recommend that CS is considered in such cases, with the proviso that standard suction is used until the surgical field has been irrigated and all metal fragments removed. Also, CS should not be used while the surgical field is contaminated with antibiotics, iodine or topical clotting agents, but its use may be resumed once these have been washed away.'

- **Paediatrics (Association of Anaesthetists: cell salvage for perioperative blood conservation 2018)**

In many cases the volume of blood collected may not be of sufficient quantity to be processed. 'The Working Party (Association of Anaesthetists) recommends that CS should be considered at least in 'collect only' mode when

blood loss > 8 ml/kg (equivalent to approximately > 10% of total blood volume) is anticipated and the child's weight is > 10 kg.

- **Sickle Cell Disease** (see below)

Warnings

- ICS should be temporarily discontinued when substances not licensed for Intravenous (IV) use are used within the surgical field and could potentially be aspirated into the collection reservoir. The standard theatre suction should be used to aspirate the surgical field and the wound should be irrigated with copious IV normal saline (0.9% NaCl) before resuming ICS.

  Examples of non-IV materials that should not be aspirated into the ICS system include:
  - Antibiotics not licensed for IV use.
  - Iodine.
  - Topical Clotting Agents.
  - Orthopaedic Cement.

- **Gastric/pancreatic secretions** should not be aspirated into the system as they may cause enzymatic haemolysis and are not reliably removed by the washing procedure.

- **Pleural effusions** should not be aspirated and should be drained prior to cell salvage. However, blood which subsequently accumulates in the pleural space may be aspirated.

- **Sickle Cell disease (SCD)** - There are concerns relating to the use of ICS in patients with SCD (homozygous disease) and current national guidance does not cover these patients. The underlying concern is the possibility that cell salvage blood re-administered to the patient in question will sickle and further reduce oxygen-carrying capacity. Limited case reports describe no useable red blood cells recovered with a high percentage of cells showing characteristic sickle shape under light microscopy after processing. As such this document cannot support its use in those with homozygous sickle cell disease.

  Sickle cell trait (or carrier – heterozygous) is a relative contraindication - Several reports have been published describing successful cell salvage use in patients with sickle cell trait (or carrier – heterozygous), although one study has shown as much as 50% sickled cells after processing of sickle cell trait blood. Again current national guidance does not cover this situation.

  Therefore the decision to use cell salvage in the presence of sickle cell trait should be made on an individual patient basis and where possible appropriate informed consent should be taken before its use. It may be advisable to perform

a blood film of salvaged blood to assess the amount of sickling present and advice should be sought from Haematology.

Cautions

- The use of Hartmann's Solution will inhibit the action of citrate based anticoagulants (e.g. ACD) if used as an irrigant or wash solution. IV normal saline (0.9% NaCl) should be used as the wash solution

- Air will be present in the primary reinfusion bag when it is still connected to the cell salvage device or when it has been disconnected but air has not been evacuated. Where possible, all air should be evacuated from the primary reinfusion bag prior to reinfusion. Manufacturers advise NOT to use a pressure cuff as there is a risk of air embolus and some devices may also detect a back pressure if the reinfusion line is open.

- Manual mode – It is recommended that ICS devices are not run in manual mode as this may lead to reduced quality, insufficient washing of the final red blood cell product and the possible reinfusion of potentially harmful contaminants e.g. heparin. ICS devices should be run in automatic mode wherever possible. Manual mode should only be used when the benefits of doing so outweigh the risks e.g. emergency situations where the need to reinfuse the red cells quickly outweighs the risks associated with running the device in manual mode.

9 Patient Information

- Patients considered likely to have ICS during planned surgery should receive information about ICS before their operation. The process should be discussed with the patient pre-operatively whenever possible and the discussion documented in the patient's clinical records. Written information may be useful – for example the Patient Information Leaflet "Please Ask About Cell Salvage" (Appendix IV).

- For patients undergoing emergency surgery, the use of ICS is at the discretion of the surgeon and anaesthetist responsible for the patient's care when it cannot be discussed with the patient prior to surgery.

10 Conditions for Using ICS

Use of the ICS Equipment

- The ICS system should be used in accordance with the manufacturer's guidelines (Appendix V).
- All procedures should be carried out in accordance with the hospital's ICS policy and procedural documents.
- The ICS system should be routinely run in automatic mode (see Cautions - section 8).
- Contraindications should be considered as per this document.
- All staff that set up or operate ICS systems should receive theoretical and practical training and should have completed the ICS Competency Assessment Workbook (Appendix II).
- Staff should comply with hospital policies for infection control, management of sharps and blood transfusion.
- Clean / non-touch / aseptic technique should be used as appropriate, to reduce the risk of infection.

Anticoagulant

- The type of anticoagulant used should be documented in accordance with organisational policy.
- Anticoagulant prepared by the operator (e.g. heparin saline) should be labelled clearly to avoid error.

Wash Solution

- IV normal saline (0.9% NaCl) should be used as the wash solution.
- The minimum wash volume, as outlined in the manufacturers' guidelines (Appendix V) for the size of the centrifuge bowl in use and the type of surgical procedure, should be used in all but the most urgent situations.

Swab Washing

- Blood soaked swabs should be soaked in IV normal saline (0.9% NaCl).
- Gently compress the swabs to express any residual solution before discarding.

- Aspirate the swab wash solution into the cell salvage reservoir using the suction line.

- Consider evacuating the swab wash every 2 hours to avoid stagnation; it should not be left for more than 6 hours without processing.

Labelling

- All salvaged blood should be labelled.

- Labels should be handwritten. Pre-printed "addressograph" labels should not be used.

- Labelling information should include:
  - Full name.
  - Date of birth.
  - Unique identification number.
  - Expiry date and time of the salvaged blood.
  - The statement "Untested Blood – For Autologous Use Only"[11].

- To avoid errors in patient identification, an autologous transfusion label, such as that in appendix VI, should be completed at the patient's side when the patient has arrived in theatre i.e. the reinfusion bag should not be pre-labelled prior to the patient's arrival in theatre or labelled after the patient has left theatre. The patient's details must be taken from the identification band attached to the patient and not from any clinical records or charts that may be present in the operating theatre. All fields on the label should be completed in full.

- If the system has been set up as a "collect only" system (collection reservoir and aspiration and anticoagulant line only), the collection reservoir should be labelled in accordance with the above instructions for labelling a reinfusion bag. If a processing set is subsequently loaded into the machine, the autologous label on the collection reservoir should be transferred onto the reinfusion bag immediately or a new label completed (as above).

Re-infusion

- ICS may be set up as a "closed-circuit" system. Blood is aspirated from the surgical field, processed and transferred to a reinfusion bag. The reinfusion bag is simultaneously connected to the patients IV cannula via an appropriate filter. The person administering the reinfusion adjusts the rate at which the red cells are reinfused using a clamp on the administration set and by adjusting the height of the reinfusion bag. A pressure cuff should not be applied, to increase the flow rate, because of the risk of air embolism. The same reinfusion bag may fill and empty many times during an operation.

- Alternatively, ICS may be set up without simultaneous connection of the reinfusion bag to the patient (as above). In this case, the reinfusion bag is disconnected from the ICS device when it is full or at the end of the surgical

procedure and is subsequently connected and reinfused to the patient as in the "closed-circuit" system.

- A filter, appropriate to the type of surgery, should be used for reinfusion. A blood administration set containing a 200µm filter is suitable in most cases. Alternatively, a 40µm microaggregate blood filter can be used. A leukocyte depletion filter can be considered during reinfusion for cancer surgery and when blood is salvaged from an infected field. When ICS is proposed to be used in such cases, an explanation should be given to the patient of the potential risks and benefits and specific consent should be obtained. (Association of Anaesthetists 2018)

- Reinfusion of the salvaged blood should follow standard blood transfusion practice. The responsible clinician should authorise salvaged blood for reinfusion in the same manner as for allogeneic blood.

- The patient details on the reinfusion bag must be carefully checked against the details on the identification band attached to the patient before connecting the reinfusion bag to the patient. Positive Patient Identification must be confirmed prior to reinfusion commencing.

- The reinfusion of salvaged blood should be documented in the appropriate section of the patient's clinical record ('All Wales Transfusion Record (AWTR)'). The autologous transfusion label, as in Appendix VI, contains a peel out section which should be completed at the time of reinfusion and can be used for this purpose.

Storage

- ICS blood must not be stored.

- The reinfusion bag should be kept beside the patient at all times.

- The reinfusion bag must not be placed into a refrigerator.

Expiry

- The collection, processing and reinfusion of salvaged blood should be completed within the timeframes as recommended by the manufacturer. This should be in accordance with guidance from the American Association of Blood Banks (AABB) and the Organisation's Transfusion Policy.

The AABB Guidelines state the expiry times for cell salvaged blood as follows:

  - Intraoperative Cell Salvage: 4 hours from the completion of processing (applicable for both washed ICS and combined washed ICS / PCS devices during the intraoperative phase).
  - Postoperative Cell Salvage: 6 hours from the start of collection (applicable when intraoperative cell salvage devices are used to salvage blood postoperatively and for combined washed ICS / PCS devices during postoperative cell salvage).

- For ICS, processing should begin as soon as there is sufficient blood in the collection reservoir. The expiry time is calculated as 4 hours from the completion of processing.

- For combined washed ICS/PCS devices, two separate expiry times should be recorded using the guidance above. One for blood salvaged intraoperatively and one for blood salvage postoperatively.

- Any blood that has not been transfused within the timeframe specified in the guidelines should be disposed of in accordance with local policy for dealing with liquid bio hazardous waste.

- These time frames are in-use limits and not “shelf life” storage limits. ICS blood must not be stored away from the patient.

Documentation

- The collection and reinfusion of salvaged blood should be accurately documented on an appropriate form such as that in Appendix I.

- The use of a generic autologous transfusion label is recommended (Appendix V; the peel out section of the label is completed and attached to the patient’s clinical record upon reinfusion of the salvaged blood.

- Adverse incidents and Serious Adverse Events should be documented / reported (see Section 13).

- Bedside pre-transfusion checks and patient observations prior to and during autologous blood reinfusion should be performed and recorded in the same way as transfusion of allogeneic blood - in accordance with the Organisation’s Blood Transfusion Policy. Additional observations are at the discretion of the clinical staff based on an individual patient assessment.

- The Organisation should ensure that adequate records are retained in all cases where ICS is used.

Disposal of used ICS equipment

- Following use, all ICS disposable equipment should be disposed of in accordance with the Organisation’s Health and Safety Policy for disposable of equipment contaminated with blood.

Cleaning and Disinfection of ICS Machines

- Following use, the cell salvage machine should be cleaned in accordance with the manufacturers’ guidance and the Organisation’s Infection Control Policy), including procedures for cleaning equipment following high risk cases.

- Following contamination of the equipment internally, the equipment should be removed from use, identified as a potential biohazard and referred to the manufacturer.

Maintenance of Equipment

- All ICS equipment should be serviced regularly in accordance with the manufacturer's recommendations. A maintenance record and fault log (Appendix VI should be kept for each machine.

11 The Management of Massive Reinfusion

As with the transfusion of large volumes of allogeneic red cells, the return of large volumes of salvaged red blood cells will coincide with the depletion of platelets and clotting factors associated with massive blood loss.

In the event of a massive reinfusion of salvaged red blood cells, it is vital to consider the need for additional appropriate transfusion support e.g. platelets, fresh frozen plasma and cryoprecipitate.

Staff should be alert to a large blood loss into the collection reservoir and report this to the surgeon and / or anaesthetist.

12 Adverse Event Reporting

- Technical problems with the ICS device should be reported to the manufacturer.

- Serious Adverse Events must be reported to the clinical lead for ICS and the Organisation's Transfusion Practitioner. Any adverse events relating to the ICS device must be reported via the DATIX system. Additionally, where appropriate, reporting to the relevant external bodies should be undertaken e.g. Serious Hazards of Transfusion (SHOT), Medicine and Healthcare Products Regulatory Agency (MHRA), especially if the incident has led to, or were it to occur again could lead to, death, life-threatening illness or injury. Other minor safety or quality incidents (caused by human error) should also be reported as these can help demonstrate trends or highlight inadequate manufacturing or supply systems, instructions and / or training[12].

- Adverse events should be documented in the patients' clinical records.

- Examples of Adverse Events include:
    - Severe reaction on reinfusion of salvaged blood.
    - Non-labelling / incorrect labelling of salvaged blood.
    - Equipment malfunction.
    - Communication failure leading to inappropriate reinfusion of the salvaged blood e.g. contamination occurred within the surgical field and this was not communicated to the operator / anaesthetist.

Reporting of ICS incidents to SHOT is encouraged. The SHOT data collection form can be downloaded at: http://www.shotuk.org/sabre/. Once completed, this should be forwarded to the Hospital Transfusion Team or the ICS lead clinician.

13 Resources

The provision of safe ICS requires adequate resources for the formal, documented training of all staff who set up or operate the equipment and for the regular maintenance and prompt repair of all ICS equipment.

14 Implementation and Distribution of the Policy

- This policy document should be circulated to all relevant personnel and implemented in all areas which may be involved in ICS e.g.
    - Medical Director
    - Nursing Director
    - Consultant Lead for Transfusion
    - Clinical Lead for ICS
    - Theatre lead for ICS
    - Theatre trainer for ICS
    - Directorate Manager for Theatre
    - Transfusion Practitioner
    - Jehovah's Witness Hospital Liaison

- The procedure document will be reviewed at timely intervals and when new information becomes available.

- Guidance on and queries relating to the document should be addressed to the Organisation's clinical lead for ICS.

15 Acknowledgements

- Maria Roberts, Transfusion Practitioner, Welsh Blood Service/ Cardiff and Vale HB for her original Postoperative Cell Salvage procedure document on which this policy has been based.

- The members of the UK Cell Salvage Action Group.

- Royal Brompton & Harefield NHS Trust – Policy for the provision of Perioperative Red Cell Salvage.

- St Mary's NHS Trust – Obstetric Intraoperative Cell Salvage Guidelines[15].

- Association of Anaesthetists: cell salvage for perioperative blood conservation 2018

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Appendix I

Audit Proforma

Example of an Audit Proforma for Intraoperative Cell Salvage

All Wales Intraoperative Cell Salvage Data Collection Form

This form should be completed for every intraoperative cell salvage procedure EVEN if the blood collected is not processed

Please complete in BLOCK CAPITALS

DO NOT write on anything placed on top of this form

1. Hospital Details

Name of Hospital

2. Patient Details

Hospital/NHS Number	Age at time of surgery
Surname	
First Name	
D.O.B	☐ Male ☐ Female
Address Addressographs may be used (top copy only)	

3. Procedure Details

Name of procedure	*(tick one)* ☐ Elective ☐ Emergency	*(tick any that apply)* ☐ Malignancy ☐ Obstetrics ☐ Infected fields ☐ Trauma ☐ Jehovah's Witness
Date of operation / /		
Surgeon		
Anaesthetist	*(tick one)* ☐ In hours ☐ Out of hours	
Cell Salvage Operator(s)		

4. Cell Saver Equipment Used

Machine *(tick one)*	☐ CATS ☐ Cell Saver Elite ☐ Autolog ☐ Electa ☐ Other *(specify)* ☐ Cell Saver 5 ☐ OrthoPat ☐ BRAT ☐ Xtra	
Disposables used	Collection Reservoir ☐ Yes ☐ No Processing Set ☐ Yes ☐ No	Please affix disposable lot number stickers in this space
Anticoagulant *(tick one)*	☐ ACD-A (citrate) ☐ Heparin	
Reinfusion Filter *(tick one)*	☐ 40µ filter ☐ Leucodepletion filter ☐ None ☐ Lipid Filter ☐ Other *(specify)*	

5. Salvaged Blood Volume Details

Was the collected blood processed? ☐ Yes ☐ No *(If no, go to Section 6)*

Processing Details

Intra-op processed (ml)		Time collection started	
Anticoagulant used (ml)		Time re-infusion started	
Swab wash used (ml)		Was the processed blood reinfused to the patient? ☐ Yes ☐ No *(If no, please complete Section 6)*	
Irrigation used (ml)			
Total volume of RBCs (ml)		If yes, what volume of blood was reinfused (ml)?	

Additional Information

Was ICS continued into the postoperative period (wound drainage)? ☐ Yes ☐ No

If yes, what volume of processed wound drain blood was reinfused to the patient (ml)?

6. Reason If Blood Was Not Processed/Reinfused

☐ Inadequate volume collected ☐ Training purposes ☐ Technical/Procedural problem *(Section 7)* ☐ Patient died

7. Technical Problems

Technical	☐ Machine	☐ Bowl	☐ Harness	☐ Software
Procedural	☐ Operator error	☐ Communication failure	☐ Training issue	☐ Unforeseen circumstance
Other *(please specify)*				

8. Total No. of Allogeneic Units Transfused During Hospital Stay

Red cells		Platelets (adult dose)	
FFP		Other	
Cryoprecipitate			

9. Hb

	g/L	Date
Pre-Op Hb		
Discharge		

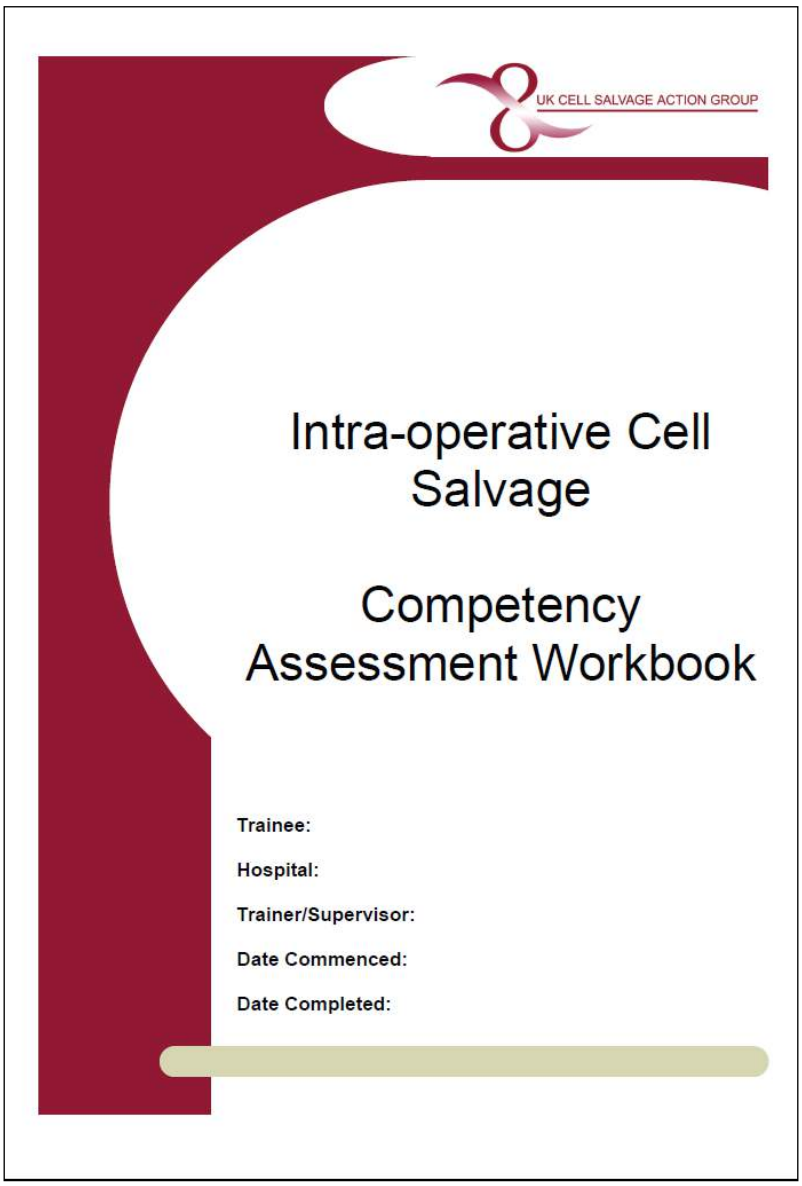
Top Copy – Hospital **Bottom Copy – Welsh Blood Service**

All Wales ICS Form Version 7 Revised May 2014

Appendix II

Intra-operative Cell Salvage Competency Assessment Workbook

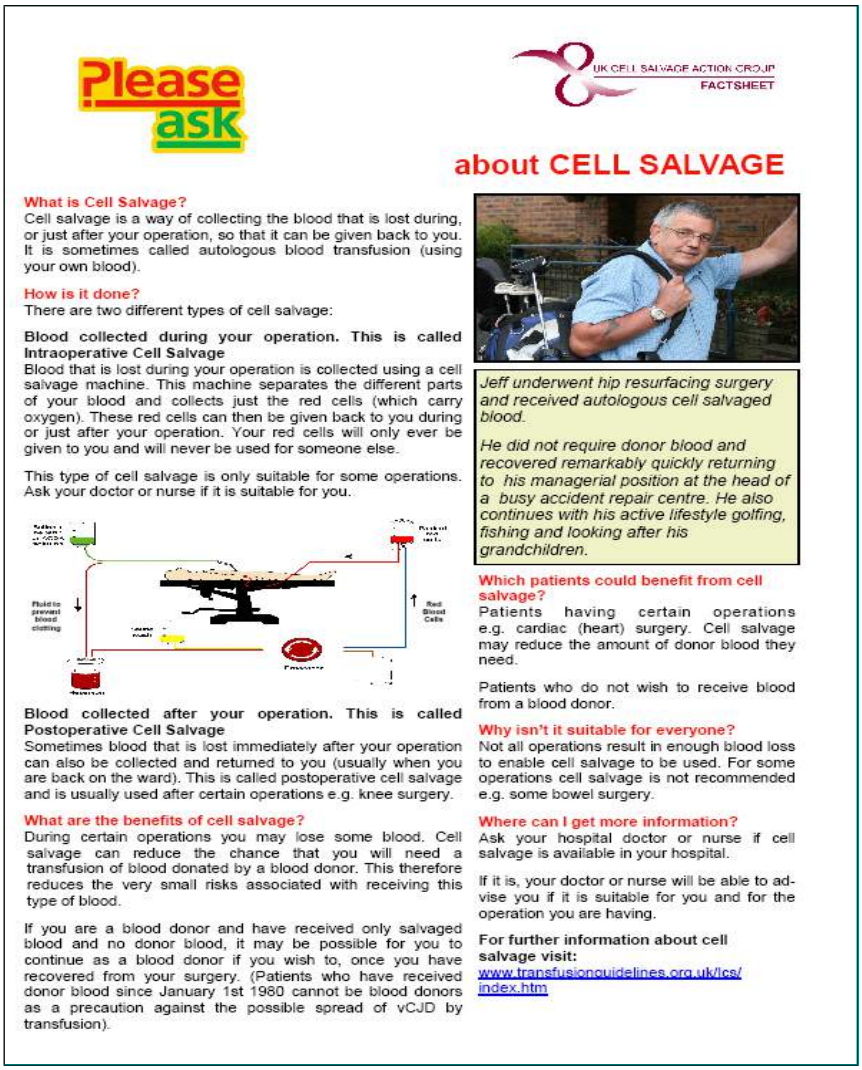
The Intraoperative Cell Salvage Competency Assessment Workbook is available via the Transfusion Practice section of the JPAC website, at: www.transfusionguidelines.org.uk or for hospitals in England, the distribution hub, at: https://ww3.access-24.co.uk/Login.aspx?ReturnUrl=%2fWebSite%2fStock%2fHome%2fStock.aspx
User names and passwords are available from your RTC Administrator or NHSBT Customer Service Support Team (01865 381042).



Appendix III

"Cell Salvage" Patient Information Leaflet

The following patient information leaflet can be downloaded at:
http://www.transfusionguidelines.org.uk/transfusion-practice/uk-cell-salvage-action-group/patient-factsheet



Please ask

UK CELL SALVAGE ACTION GROUP
FACTSHEET

about CELL SALVAGE

What is Cell Salvage?
Cell salvage is a way of collecting the blood that is lost during, or just after your operation, so that it can be given back to you. It is sometimes called autologous blood transfusion (using your own blood).

How is it done?
There are two different types of cell salvage:

Blood collected during your operation. This is called Intraoperative Cell Salvage
Blood that is lost during your operation is collected using a cell salvage machine. This machine separates the different parts of your blood and collects just the red cells (which carry oxygen). These red cells can then be given back to you during or just after your operation. Your red cells will only ever be given to you and will never be used for someone else.

This type of cell salvage is only suitable for some operations. Ask your doctor or nurse if it is suitable for you.

Blood collected after your operation. This is called Postoperative Cell Salvage
Sometimes blood that is lost immediately after your operation can also be collected and returned to you (usually when you are back on the ward). This is called postoperative cell salvage and is usually used after certain operations e.g. knee surgery.

What are the benefits of cell salvage?
During certain operations you may lose some blood. Cell salvage can reduce the chance that you will need a transfusion of blood donated by a blood donor. This therefore reduces the very small risks associated with receiving this type of blood.

If you are a blood donor and have received only salvaged blood and no donor blood, it may be possible for you to continue as a blood donor if you wish to, once you have recovered from your surgery. (Patients who have received donor blood since January 1st 1980 cannot be blood donors as a precaution against the possible spread of vCJD by transfusion).

Jeff underwent hip resurfacing surgery and received autologous cell salvaged blood.

He did not require donor blood and recovered remarkably quickly returning to his managerial position at the head of a busy accident repair centre. He also continues with his active lifestyle golfing, fishing and looking after his grandchildren.

Which patients could benefit from cell salvage?
Patients having certain operations e.g. cardiac (heart) surgery. Cell salvage may reduce the amount of donor blood they need.

Patients who do not wish to receive blood from a blood donor.

Why isn't it suitable for everyone?
Not all operations result in enough blood loss to enable cell salvage to be used. For some operations cell salvage is not recommended e.g. some bowel surgery.

Where can I get more information?
Ask your hospital doctor or nurse if cell salvage is available in your hospital.

If it is, your doctor or nurse will be able to advise you if it is suitable for you and for the operation you are having.

For further information about cell salvage visit:
www.transfusionguidelines.org.uk/ics/index.htm

Appendix IV

Manufacturers' Guidelines

https://www.haemonetics.com/-/media/files/cell-saver-manuals/120745-ie-aa-pdf.pdf

Appendix V

Autologous Transfusion Label

The following autologous transfusion label is available from your device manufacturer.
N.B. cable ties or equivalents are not provided.

AUTOLOGOUS TRANSFUSION
Untested Blood
For AUTOLOGOUS use only

Complete this section and affix to the reinfusion bag / system

Unique patient ID Nº.....
Last name .....
First name .....
DOB .....
Operator name (Print) .....
Expires / Reinfuse by: Date.....Time.....

(Calculate expiry time in accordance with national & manufacturer guidelines and local policy)

Type of autologous blood: (*Delete as appropriate)
Intra-op Cell Salvage (Washed/Filtered*) ☐
Post-op Cell Salvage (Washed/Filtered*) ☐
Other: ..... ☐

Transfusion Record
Complete this section and affix in clinical record. Enter date/time/signature below, each time the reinfusion bag/system is connected to the patient

Unique patient ID Nº.....
Full name .....
Type of **autologous** blood: (*Delete as appropriate)
Intra-op Cell Salvage (Washed/Filtered*) ☐
Post-op Cell Salvage (Washed/Filtered*) ☐
Other-..... ☐

Checked & administered by			
Reinfusion started (date/ time)			
Reinfusion stopped/end time			

Total volume reinfused ..... mls

Version 3 April 2015

STOP!

Label and reinfuse in accordance with national and manufacturer guidelines and local cell salvage / transfusion policies.

DO NOT separate autologous blood from the patient

DO NOT refrigerate

Before reinfusion :

1. Confirm the patient's identification (where possible ask the patient to state their NAME and DOB)
2. Check the information on the label matches the information on the patient identity band

No identity band - No transfusion

3. Check the 'expires/reinfuse by' date **and** time of the blood
4. If any details do not match, **Do not transfuse**
5. If a transfusion reaction is suspected, STOP the reinfusion and seek medical advice
6. Repeat steps 1 - 5 each time the reinfusion bag/system is reconnected to the patient

Reverse of adhesive label

Original design by UK Cell Salvage Action Group

Appendix VI

Fault log

Intraoperative Cell Salvage Machine Fault Log

Machine: _____

Serial Number: _____

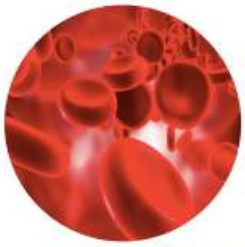
Date	Nature of Fault	Manufacturer Contacted (Y/N)	Corrective Action	signature

Appendix VII

Transfusion Leaflets

Please see below:
https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/23998/inf1580-1-receiving-a-blood-transfusion-print-friendly.pdf

Page 1 of 7



Information for patients and their families, carers and guardians

Receiving a Blood Transfusion

Important information for all patients who may need a red cell, platelet or plasma transfusion.

Additional supplementary information for individual blood components, specific patient groups and younger children can be accessed via your local transfusion service.

BH-08: Issue 1
Effective: 01/07/2021 Review Date: 01/07/24

Appendix IX
Cell Salvage in Jehovahs Witness Patient Requesting Continuous Connectivity

UK CELL SALVAGE ACTION GROUP
TECHNICAL FACTSHEET

CELL SALVAGE IN JEHOVAH'S WITNESS PATIENTS

ICS Technical Factsheet Number 6

AREA of APPLICATION

Jehovah's Witnesses (JW) regard blood as sacred. On the basis of this deeply held core value, they decline treatment with allogeneic (donor) blood (red cells, white cells, platelets, and plasma).

With regard to autologous transfusion JW patients make a personal decision whether or not to accept such. Autologous transfusions that may be acceptable include all forms of perioperative/intraoperative blood salvage (cell salvage), haemodilution and postoperative blood salvage. While machines, systems and arrangements vary, each patient will decide how his/her own blood will be handled in the course of a surgical procedure, medical test, or current therapy. Predeposit (PAD) is not acceptable to Jehovah's Witnesses.

Among those prepared to accept autologous procedures, some may specifically request that the system be set up to allow for continuous connectivity. In such cases, the details outlined below should prove helpful. If no such specific request is received, then the equipment/machinery may be used in the usual way providing informed consent has been obtained (informed consent for autologous techniques should be obtained for all patients where it is intended that they be used).

STAFF

The patient's surgical team and all staff involved in the cell salvage process.

PROCEDURE:

Setting up continuous connectivity
Although there will be technical differences between devices, the same general principles apply.

1. Set up the machine for collection and processing with standard disposables (in bowl-based machines consider using a low volume bowl to reduce blood stasis).

2. Prime the circuit with saline ensuring that saline enters the reinfusion bag and the collection reservoir (remember to account for this volume when recording the final reinfusion volume).

3. Attach an appropriate blood administration set to the reinfusion bag. Prime the administration set and connect to the patient via a cannula for reinfusion. Once established, the connection between the patient and the reinfusion bag must not be broken. (Figure 1).

Version 3 Reviewed October 2012

4. Whilst surgery is ongoing, administer the saline at the slowest rate possible to maintain patency of the cannula until processed blood is available.

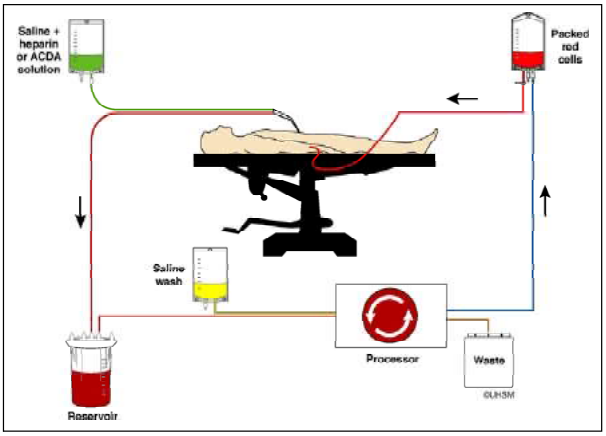


Figure 1. Representation of a continuous circuit

Special requirements

In some cases a leucocyte depletion filter may be needed for reinfusion of the salvaged blood. A standard giving set should be set up with a 3-way tap in line before blood collection begins. The giving set should be primed with saline to complete the circuit. When a volume of blood is ready to be reinfused, the leucocyte depletion filter can be spiked into the second reinfusion port on the reinfusion bag and primed. This is then attached to the 3-way tap, without breaking the circuit. Likewise, because the filters have a maximum throughput of 450mls, a new filter can be added if necessary by replacing the original giving set while leaving the original filter connected. (Figure 2).

The filter should <u>not</u> be flushed with saline after filtration of the salvaged blood

When blood loss is rapid, the flow rate through the filter may not be sufficient to transfuse large volumes of blood quickly. Using a filter in each port will double the flow rate. During management of life threatening haemorrhage in a JW patient, if the reinfusion rate of salvaged blood is too slow, even when using two leucodepletion filters, it may be necessary to make a clinical decision to isolate the leucodepletion filter from the circuit and replace with a standard blood administration set, so that blood can be transfused rapidly to prevent exsanguination. This must be done without breaking the circuit in order to maintain continuity.

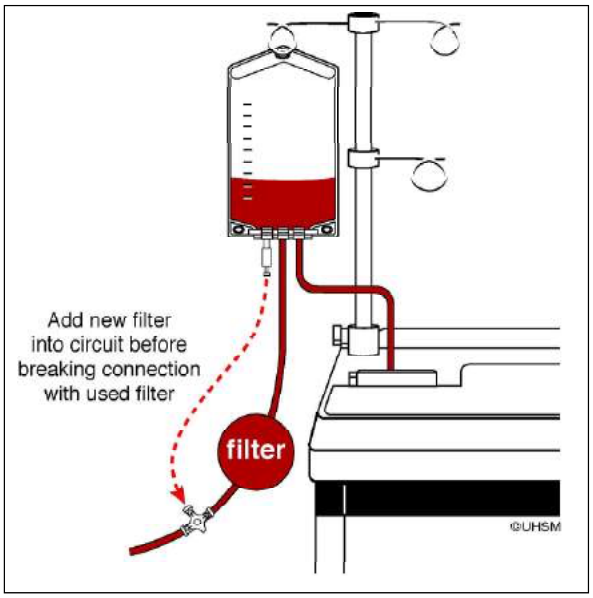


Figure 2. Replacing a filter without breaking continuity

This fact sheet has been verified by representatives of the Jehovah's Witness community.

The information contained in this ICS Technical Factsheet has been sourced from members of the UK Cell Salvage Action Group (UKCSAG) and is generally agreed to be good practice. The UKCSAG does not accept any legal responsibility for errors or omissions.

Version 3 Reviewed October 2012

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 May 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	Ongoing	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Medical Director to ensure interim timelines were put into place for the Task & Finish Groups referred to in relation to Risk 4080.	Medical Director	January 2023 **Now August 2023**	**In Progress** The All Wales Rate Card is yet to be agreed Nationally. A paper proposing a localised Rate Card is being developed with finance colleagues engaged as an interim solution. This will be presented through the relevant committees for

					approval. Work is also being undertaken to combine workforce related risks on the Risk Register.
2.1	24 January 2023	**Listening & Learning Story** Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Director of Nursing	To be agreed	**In progress** Date to be agreed
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	**On agenda** Report is on the agenda for the May 2023 meeting.
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	18 July 2023	**In progress** Forward work programme updated
6.3	24 January 2023	**Quality Dashboard** Spotlight Report on Pressure Ulcers and Falls at the next meeting of the Committee.	Deputy Director of Nursing	March 2023 Now 24 May 2023	**On agenda** Added to the forward work programme for March 2023. Now Deferred to May 2023
6.7	24 January 2023	**Liberty Protection Safeguards**	Head of Safeguarding	18 July 2023	**In progress**

		Report to be shared with Committee Members later in the year on progress being made in this area.			Progress report to be presented to the 18 July 2023 meeting.
2.2	16 March 2023	**Care Group Spotlight Presentation – Mental Health & Learning Disabilities** The risk relating to the implementation of the Welsh Community Care Information System to be highlighted as a matter of escalation to the Board within the Committee Highlight Report.	Committee Chair	30 March 2023/25 May 2023	**In progress** Verbal update on this escalation provided to the Board at the meeting held on 30 March 2023 meeting. Written update has been included in the Highlight Report being presented to the May Board
2.2	16 March 2023	**Care Group Spotlight Presentation – Mental Health & Learning Disabilities** Mental Health In-Patient Improvement Progress Reports to be presented to future meetings from May 2023 onwards.	Mental Health & Learning Disabilities Care Group Nurse Director	24 May 2023	**On agenda** Added to the annual cycle of business as a regular item.
2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Data to be shared with Members outside the meeting in relation to	Care Group Nurse Director – Unscheduled Care	24 May 2023 **Now 18 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

		ambulance handovers to include the data for each individual hospital for the numbers for requested for immediate release and number agreed.			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.
2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Concerns raised by Committee Members in relation to the boarding of patients in fire evacuation routes to be escalated to the Board within the Committee Highlight Report.	Committee Chair	30 March 2023/25 May 2023	**In progress** Verbal update on this escalation provided to the Board at the meeting held on March 2023 meeting. Written update has been included in the Highlight Report being presented to the May Board
3.1.5	16 March 2023	**Independent Member Walkround Protocols** Report to be re-circulated to Members once amendments had been made.	Director of Nursing	24 May 2023	**In progress** Amended report re-circulated to Members on 10 May 2023 for review. Comments to be returned by 24 May 2023.
5.1	16 March 2023	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee**	Assistant Director of Governance & Risk	24 May 2023	**In progress** Partial response sent to Committee members. Risks 4071 and 4908 have been updated within the May

		Response to queries raised against a number of risks to be shared with Members outside the meeting.			iteration of the Risk Register. Updates still required regarding Risks 4732 and 4721
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 18 July 2023**	**In progress** Work is being undertaken with Patient Safety colleagues to ensure that the information held locally reflects the information being held corporately. Director of Midwifery will be meeting with the Assistant Director of Quality & Safety to discuss this in greater detail. Local Governance leads are fully engaged in ensuring this matter is addressed.
6.3	16 March 2023	**Quality Dashboard** Review to be undertaken to the data discrepancies contained within the report and the wording of paragraph 2.2 on page 5 of the report.	Assistant Director of Concerns and Claims	24 May 2023	**On agenda**
6.5	16 March 2023	**Stroke Services Progress Report** Future iterations of the action plan to include realistic target dates for completion and each action to be linked to the Quality	Director of Therapies & Health Sciences	18 July 2023	**In Progress** Report to be updated for the meeting due to take place on 18 July 2023.

		Improvement Measures where applicable.			

PREVIOUSLY REPORTED Completed Actions					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at May 2023)
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Update to be provided to a future meeting of the Committee in relation to progress being made in relation to the Welsh Community Care Information System.	Nurse Director – Mental Health Care Group	16 March 2023	**Completed** Update on progress being made in relation to the Welsh Community Care Information System was included in the Mental Health & Learning Disabilities Care Group report presented to the March 2023 meeting.
6.4	15 November 2022	**Report from the Chief Operating Officer** Further discussion to be undertaken outside the meeting on reporting to Planning, Performance & Finance Committee and the Quality and Safety Committee as whilst duplication should be avoided between Committees this should be	Assistant Director of Governance & Risk	January 2023 Now March 2023 Now April 2023	**Completed** Board Development discussion held on 20 April 2023.

		balanced with Members being provided with sufficient information/evidence to allow for detailed scrutiny and gaining of assurance			
7	15 November 2022	**Any Other Business** Report to be presented to the next meeting in relation to the position regarding the use of controlled drugs.	Medical Director	16 March 2023	**Completed** Update included in the Quality Dashboard report presented to the March 2023 meeting.
9	15 November 2022	**How Did we do in this meeting today?** Discussion to be held outside the meeting in relation to duplication of reports to Committee meetings	Assistant Director of Governance & Risk	January 2023 Now March 2023 Now April 2023	**Completed** Board Development discussion held on 20 April 2023
6.3	24 January 2023	**Quality Dashboard** Response from Local Authority Leaders to be shared with Committee members once received following the submission of a letter outlining the Health Board's concerns in relation to delays being experienced with the transfer of patients out of hospital.	Chief Operating Officer	March 2023	**Completed** Correspondence was not sent regarding this matter. Joint LA/HB meetings will be held to pursue joint working initiatives and planning for next winter
6.4	16 March 2023	**Chief Operating Officers Report**	Committee Chair	24 May 2023	**Completed** Discussion held with the UHB Chair who will be including

		Committee Chair to have a discussion with the new incoming Health Board Chair in relation to Discharge Delays and whether this could be a future topic for discussion at a Board Development Session.			this topic in a future Board Development session.
5.1	15 November 2022	**Organisational Risk Register – Risks Assigned to the Quality & Safety Committee** Update to be sought from the Risk Lead in relation to Risk 4512, Care of Patients with Mental Health Needs on the Acute Wards as to how the scoring against this risk would be reduced and what had changed to reduce the scoring	Nurse Director – Mental Health Care Group Nurse Director – Care Group Unscheduled Care	24 January 2023 Now 16 March 2023 Now 24 May 2023	**Completed** This risk has been reviewed and is proposed for closure in the May 2023 iteration of the Organisational Risk Register. See agenda item 5.1
2.1	16 March 2023	**Listening & Learning Story** Discussion to be held with G Williams outside the meeting in relation to the Trans Toolkit to determine whether the toolkit could be strengthened further.	Director of Nursing	24 May 2023	**Completed** Director of Nursing met with G Williams on 11 May 2023

AGENDA ITEM
3.2.2

QUALITY & SAFETY COMMITTEE

QUALITY & SAFETY COMMITTEE ANNUAL CYCLE OF BUSINESS

Date of meeting	24 May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Emma Walters, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Corporate Governance
Approving Executive Sponsor	Chief Executive
Report purpose	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

1.2 The Cycle of Business covers the period 1 January 2023 to 31 December 2023.

1.3 Any changes made to the Annual Cycle of Business since the last meeting have been identified in red.

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

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

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

3.1 Please refer to **Appendix 1** – Quality & Safety Committee Cycle of Business for further detail. Any changes have been identified in red.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

Quality & Safety Committee

Cycle of Business

(1st January 2023 – 31st December 2023)

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

The Cycle of Business covers the period 1st January 2023 to 31st December 2023.

The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and committee business.

The principal role of the Committee is set out in the Standing Orders 1.0.1.

Quality & Safety Committee Cycle of Business (1st January 2023 – 31st December 2023)

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Director of Nursing	All regular meetings	✓		✓		✓		✓		✓		✓	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Action Log	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	✓		✓		✓		✓		✓		✓	
Committee Annual Report	Director of Corporate Governance	Annually					✓							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually	✓											
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually					✓ Deferred to July 2023		✓					
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	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 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							✓					
Health, Safety & Fire Sub Committee Highlight Reports	Director for People	Quarterly			✓				✓				✓	
Radiation Safety Committee Annual and Mid Year Updates	Director of Therapies & Health Sciences	Bi-Annually			✓ Deferred to May		✓ Deferred to July		✓				✓	
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			✓ Deferred to May		✓ Deferred to July		✓		✓			
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	✓						✓					
Ombudsman's Annual Letter	Director of Nursing	Annually									✓			
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					✓						✓	
GOVERNANCE														

Item of Business	Executive Lead	Reporting period	24 Jan 2023	Feb 2023	16 Mar 2023	April 2023	24 May 2023	June 2023	18 July 2023	Aug 2023	19 Sep 2023	Oct 2023	21 Nov 2023	Dec 2023
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							✓					
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Director of Nursing	Annually	✓											
Mental Health In-Patient Improvement Progress Reports Agreed following discussion at the In Committee Quality & Safety Committee that this matter would need to be reported to all regular meetings from May onwards.	Director of Nursing	All regular meetings					✓		✓		✓		✓	

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Email request from the Director of Corporate Governance following discussion held at Health, Safety & Fire Sub Committee raising this as an area of concern	Additional Item	Datix Cymru – Assurance Report	Director of Corporate Governance	**In progress** Report received and discussed at the 24 January meeting. Agreed that a progress report would be presented to the Committee in **July 2023**.
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Learning From Events Backlog – Progress Report	Assistant Director of Concerns & Claims	**On agenda** Report received and discussed at the meeting held on 24 January 2023. Agreed that a further update on progress would be presented to the **May 2023 meeting.**
Action agreed at the meeting held on the 24 January 2023	Additional Item	Spotlight Report on Emergency Care Incidents – Pressure Ulcers and Falls	Deputy Director of Nursing	**On agenda** Planned for March 2023 – The Deputy Director of Nursing has requested that this item is deferred to the **May 2023 meeting.**
Email request from the Quality & Safety Committee Chair	Additional Item	Healthcare Inspectorate Wales Action Plan Tracker – Prototype	Deputy Director of Nursing	Planned for May 2023 – **On agenda**
Agreement made at the February Agenda Planning Session	Additional Item	Patient Falls and Unexpected Exits Lessons Learnt Report	Deputy Director of Nursing	Planned for May 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 Volunteer Manager	Additional Item	Volunteer Service Policy – For approval	Executive Director of Nursing	Planned for May 2023
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 – **Now deferred to July 2023**
Email Request from the Assistant Director of Therapies & Health Sciences	Additional Item	Development of a CTM Allied Health Professionals & Healthcare Science Strategy	Executive Director of Therapies & Health Sciences	Planned for May 2023 – **On agenda**
Email request from the Medical Directors office	Additional Item	Ratification of Urgent Committee Chairs Action - Policy Approval	Assistant Director of Governance & Risk	Planned for May 2023 – **On agenda**
Email request from the Medical Directors office	Additional Item	All Wales Model Policy for Consent to Examination for Treatment	Medical Director	Planned for May 2023 – **On agenda**
Email request from the Medical Directors office	Additional Item	Policy for the provision of Intraoperative Cell Salvage	Medical Director	Planned for May 2023 – **On agenda**
Email Request from the	Additional Item	Volunteer Service Policy	Director of Nursing	Planned for May 2023 – **Deferred to 18 July 2023**

Volunteer Manager				
Email Request from the Patient Care & Safety Team	Additional Item	Concerns Policy	Director of Nursing	Planned for May 2023 – **Deferred to 18 July 2023**

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
Request from Strategic Planning & Commissioning Manager	Item deferred from November to January to allow for consultation period.	CYP 16-17 year's Acute Admission Policy – For Approval.	Strategic Planning & Commissioning Manager	**Completed** – Policy received and approved at the meeting held on 16 March 2023.
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Report to be presented to the next meeting in relation to the position regarding the use of controlled drugs.	Medical Director	**Completed** – Update provided within the Quality Dashboard report presented at the meeting held on 16 March 2023.
Email request received from the Director of Nursing on 30 December 2022	Additional Item	Macmillan Wales Cancer Patient Experience Survey – Briefing Note	Director of Nursing	**Completed** – Included as an Appendix to the Quality Dashboard report presented at the meeting held on 16 March 2023.
Email request received from the Head of Corporate	Additional Item	Independent Member Walkround Protocols	Director of Nursing	**Completed** – Report received at the meeting held on 16 March 2023.

Governance & Board Business				
Action captured at the November 2022 Quality & Safety Committee	Additional Item	Welsh Community Care Information System Progress Report	Nurse Director – Mental Health Care Group/Director of Digital	**Completed** – Update included in the Mental Health & Learning Disabilities Care Group Highlight Report received at the meeting held on 16 March 2023.
Email Request received from the Chair of the Committee	Additional Item	NHS Wales Delivery Unit Review of Primary and Secondary Mental Health Services for Children and Young People	Director of Nursing	**Completed** – Update included in the Mental Health & Learning Disabilities Care Group Highlight Report received at the meeting held on 16 March 2023.
Email request from the Assistant Director of Governance & Risk	Additional Item	Chairs Urgent Action – Policy Approvals	Assistant Director of Governance & Risk	**Completed** – Report received at the meeting held on 16 March 2023.

AGENDA ITEM
3.2.4

QUALITY & SAFETY COMMITTEE

HUMAN TISSUE ACT (2004) PROGRESS REPORT

Date of meeting	24/05/2023
FOI Status	Open/Public
Prepared by	Dr Paul D Davies, Assistant Director (Operational Support), HTA DI
Presented by	Dr Paul D Davies, Assistant Director (Operational Support), HTA DI
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
1. Executive Medical Director 2. Chief Operating Officer 3. Head of Cellular Pathology	(20/4/23)	SUPPORTED

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DI	Designated Individual
HTA	Human Tissue Act
HTAuth	Human Tissue Authority
HTARI	Human Tissue Act Reportable Incident
PLR	Pregnancy Loss Remains

1. SITUATION/BACKGROUND

1.1 CTMUHB manage a range of clinical and support services which are involved in the removal, storage, use and disposal of human tissue in the Post Mortem sector across the three main hospital sites.

1.2 CTMUHB is thus subject to the legal requirements of the HTA (2004) and regulated by the HTAuth.

1.3 The purpose of this progress report is to present the progressive work toward HTA compliance and provide assurance to the Health Board that services are legally compliant.

1.4 Whilst within CTMUHB the main focus of the relevant HTAuth standards and guidance is the Post Mortem sector, there is also specific guidance around the management of pregnancy loss (< 24 weeks) in a number of services which is subject to regulation.

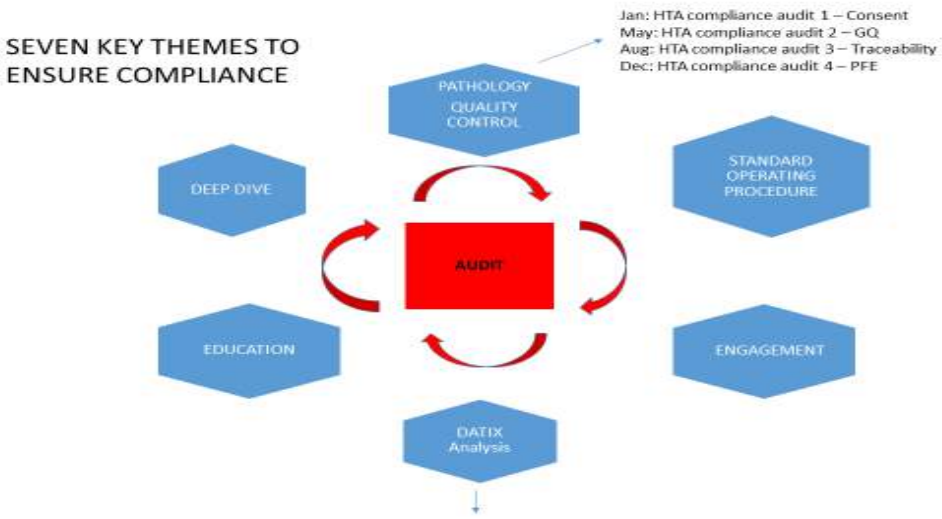
1.5 CTMUHB is licensed by the HTAuth through compliance inspections which are undertaken every four years or as required.

1.6 This report presents the findings of the most recent HTA Inspection in February 2023.

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

Quality Control

2.1 The DI was appointed by the Health Board and HTAuth in November 2020 and has worked toward strengthening the governance of compliance with the standards set out within the HTA. The focus of the DI has predominantly focused upon seven key themes;



2.2 The Quality Control Department within Pathology also have a specific role in terms of ensuring there is an annual and cyclic programme of audit around the specific standards with the HTAuth Codes, predominantly Code A (Consent) and Code B (Post Mortem).

2.3 This quality system is augmented through regular inspections of a range of services by the DI including Mortuary Departments, Maternity Services, Emergency Departments, Theatres, Early Pregnancy Units and Gynaecology Wards.

2.4 For those departments outside Pathology, the focus is mainly upon compliance with guidance regarding the sensitive disposal of PLR under 24 weeks and dignity of the deceased.

2.5 During 2021 the DI conducted 31 inspections and 39 in 2022.

2.6 The frequency of inspections at all three Mortuary departments was increased in preparedness for HTAuth inspection in February 2023.

2.7 The outcomes of each local inspection is reported to the Persons Designated for the clinical area and corrective actions put in place.

2.8 Shared learning arising from all inspections is reported widely to clinical teams and the HTA Board.

2.9 The inspection process, coupled with the quality control programme and staff training ensures the Health Board is HTA compliant.

Engagement

2.10 Engagement is key to ensuring there is compliance with the HTA and making sure there is effective communication on a number of issues such as audit findings, incident outcomes, standard operating procedure reviews, improvements in standards and seeking ideas on the development of services.

2.11 To assist this goal the Designated Individual has introduced a network of 14 Persons Designated across a wide range of services and specialities within the Health Board, focused mainly at the three HTA licenced sites; Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.

2.12 Persons Designated appointed by the DI are able to directly influence services in relation to licensable activities.

2.13 The HTA recommend that the role is supplementary within the governance framework, although the DI remains responsible for supervising the activities to be authorised by the licence.

2.14 The DI meets with the Persons Designated group every six weeks to share learning and provide support where needed.

2.15 Establishing such a wide ranging network ensures that there is support across departments. To date this has been received well.

2.16 One key area of development for engagement has been the introduction of an *Office 365* Sharepoint page specifically to support Persons Designated and relevant clinicians/ managers in relation to the HTA.

2.17 With the support of the Assistant Director of ICT this intranet portal is now operational and has been helpful as a *one stop* site for all matters related to the HTA to support departments throughout the Health Board.

2.18 For example, the following information can be found at this site for shared learning by Persons Designated and for prospective inspection by the HTA;

- Outcomes of local inspections and audit
- HTA newsletters
- Incident Trend Analysis
- Shared Learning log
- Educational Powerpoint presentations
- Estate reports on service records for the ventilation systems within the Mortuary Department

2.19 This new sharepoint page continues to be improved and developed.

Legal Compliance

2.20 The HTAuth have completed their full inspection of CTMUHB and the full report can be perused at Appendix 1.

2.21 The inspection process was undertaken in three stages;

- A Self-Assessment led by the DI in November 2022, mainly focused upon the uploading of Policies, Standards Operating Procedures, Risk Assessments and data to a secure HTA Portal
- A Teams meeting led by the HTAuth with a range of clinicians and managers focused upon assessing Consent, Tissue Traceability and Governance (February 2023)
- A two day inspection visit to all three HTA Licenced sites including Maternity Services at the Princess of Wales Hospital.

2.22 The outcome of the inspection concluded that the Designated Individual (DI) and the Licence Holder (LH) are suitable in accordance with the requirements of the legislation.

2.23 The HTA found that the Health Board had met the majority of the HTA's standards and only two minor shortfalls were found against standards for Consent and Governance and quality systems.

2.24 These related to the consent policy, recording of competency assessment for consent seekers and mortuary standard operating procedures regarding condition monitoring.

2.25 The DI and operational team resolved these matters in short order and thus the Corrective and Preventative Action Plan accompanying the final inspection report had both these minor shortfalls 'closed' at publication (Appendix 2).

2.26 The HTA also fed back 15 advisory items for the Health Board to consider within the final report.

2.27 Whilst advisory items are not classed as shortfalls against the current standards, they are important suggestions for quality improvements to service delivery.

2.28 It was indicated by HTAuth that in time some of these advisories are likely to inform future changes to statutory standards, thus it is important to consider their value in practice.

2.29 Most of the advisories are relatively practical to implement with a moderate cost impact to the Mortuary department.

2.30 Where there is a cost element to the estate it is estimated that this will cost up to 25k (Advisory Items 9, 10, 14 & 15) and potential funding is being discussed at Care Group level.

2.31 Some advisories are more strategic and will be discussed at the HTA Board for consideration on next steps. For example, Advisory Item 12 and the suggestion to consider relocating the Hub site for Post Mortems to reduce inter hospital transfers due to limited storage at the Royal Glamorgan Hospital.

Good Practice

2.32 The HTA do not publish areas of good practice within the formal inspection reports, however they did highlight a number of areas within their verbal feedback, which included;

- The dignified care provided by the Mortuary staff
- The overall governance arrangements
- The Tissue Traceability set up and work of the HTA Compliance department
- Clear and well documented follow-up of actions between HTA Board meetings
- The overall cleanliness and maintenance of the estate
- The Maternity service compliance with the HTA standards at the Princess of Wales Hospital
- The quality of the Portering staff and the overarching training manual which drives their practice
- The HTA Sharepoint Portal to support Persons Designated and their role
- The proactive and transparent engagement with the regarding service changes as well as incidents, potential incidents and corrective actions taken.

2.33 The Licence Holder and Executive Director of Therapies & Health Sciences have written to staff to thank and congratulate the team on such a successful outcome.

Annual Incident Analysis

2.34 All Datix reports which have indicated that an incident involved a deceased person and/or have key words such as "Pregnancy Loss Remains", "Death" or "Mortuary" are automatically copied to the DI.

2.35 This provides an 'early warning' system so that the DI can quickly follow-up such incidents, alert Persons Designated and support corrective actions.

2.36 All HTA related incidents are collated by the DI and presented on a quarterly basis to the HTA Board and Persons Designated and Table 1 presents data collated over the last 2 years.

2.37 The importance of collating such data is primarily to analyse trends and seek improvements in clinical / service areas which may be experiencing issues with training compliance and high staff turnover.

Table 1 HTA related incidents reported via DATIX from April 2021 to March 2023, by type and hospital site.

		PLR	Deceased	Equipment	Security	PCH	RGH	POW	Other	TOTAL	HTARI	Near-Miss
2021/22	Q1	3	9	0	0	0	2	10	0	12	1	0
	Q2	7	14	1	0	8	7	6	1	22	1	0
	Q3	11	15	2	0	10	10	8	0	28	0	1
	Q4	4	5	0	0	4	1	3	0	9	0	0
2022/23	Q1	4	4	0	3	6	0	4	1	11	0	1
	Q2	3	5	0	0	3	3	2	0	8	1	0
	Q3	6	6	0	1	5	2	6	0	13	0	1
	Q4	7	3	0	0	8	1	1	0	10	1	0

2.38 For 2021/22 there were **71** HTA related incidents including 2 HTARIs and 1 near-miss HTARI.

2.39 In 2022/23 there were **42** HTA related incidents including 2 HTARIs and 2 near-miss HTARI.

2.40 The overall reduction can be attributed to diligent follow-up and learning post incidents, general awareness raising and regular inspection and audit.

2.41 As with the audit programme, any shared learning from the outcomes of the incidents is communicated and discussed within the Persons Designated group and HTA Board.

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

3.1 The mortuary team and relevant clinical services have demonstrated excellent leadership and great aplomb to achieve the successful HTA inspection report for 2023.

3.2 The overall mortuary space capacity has improved since the commissioning of a new 85 space Unit at Prince Charles Hospital in January however the waiting list for Post Mortems continues to be challenging due to the increased volume of referrals to the Coroner.

3.3 This is currently being managed through extra Pathology sessions procured by the Coroner's Office. However this additional demand continues to pose a risk to capacity (in particular long term storage).

3.4 The Mortuary Department at the Royal Glamorgan Hospital is the main centre for Post Mortems and the storage and general post mortem room space is limited. The Pathology Directorate will be leading plans to examine the advisory item 12 from the HTA inspection and its feasibility looking ahead.

3.5 Within the two Gynaecology clinical pathways at both the Princess of Wales Hospital and Prince Charles Hospital for women experiencing early pregnancy loss it is important that the ring-fenced beds at ward level are maintained to ensure there is a 'fast-track' from Emergency Departments on presentation. This is essential to maintain dignity and safety but has been challenging to maintain over the winter pressures at the Princess of Wales Hospital.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Individual Care
	If more than one Healthcare Standard applies please list below: Governance, Leadership & Accountability Safe Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	No changes reported to services or new policies to consider
Legal implications / impact	Yes (Include further detail below)
	The Human Tissue Act is a legal requirement
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Potentially up to 25k to address advisory items such as enhanced security and new

	PLR/Infant fridge to enable the release of 4 adult fridge spaces. This is currently being discussed at Care Group level.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality & Safety Committee are requested to **NOTE** the on-going work to assure compliance with HTA standards. The continuing need to maintain our high standards is essential to ensure the Health Board is ready for an inspection from the HTAuth at any time.

5.2 The Quality & Safety Committee are requested to **NOTE** the highlighted key risks looking ahead, which may adversely impact upon HTA compliance.

Inspection report on compliance with HTA licensing standards
Inspection date: **16, 21, 22 February 2023**

Royal Glamorgan Hospital
HTA licensing number 12338

Licensed under the Human Tissue Act 2004

Licensed activities
The table below shows the activities this establishment is licensed for and the activities currently undertaken at the establishment.

Area	Making of a post-mortem examination	Removal from the body of a deceased person (otherwise than in the course of an anatomical examination or post-mortem examination) of relevant material of which the body consists or which it contains, for use for a scheduled purpose other than transplantation	Storage of the body of a deceased person or relevant material which has come from a human body for use for a scheduled purpose
Hub site **Royal Glamorgan Hospital**	Licensed	Licensed	Licensed
Mortuary	*Carried out*	*Carried out*	*Carried out*
Pathology lab	-	-	*Carried out*
Satellite site **Prince Charles Hospital**	Licensed	Licensed	Licensed
Mortuary (satellite site)	*Carried out*	*Carried out*	*Carried out*

Satellite site **Princess of Wales Hospital**	Not Licensed	Licensed	Licensed
Mortuary (satellite site)	-	*Carried out*	*Carried out*

Summary of inspection findings
The HTA found the Designated Individual (DI) and the Licence Holder (LH) to be suitable in accordance with the requirements of the legislation.

Although the HTA found that Royal Glamorgan Hospital ('the establishment') had met the majority of the HTA's standards, two minor shortfalls were found against standards for Consent and Governance and quality systems. These related to the consent policy, recording of competency assessment for consent seekers and mortuary standard operating procedures.

The HTA has assessed the establishment as suitable to be licensed for the activities specified, subject to corrective and preventative actions being implemented to meet the shortfalls identified during the inspection.

Compliance with HTA standards

Minor Shortfalls

Standard	Inspection findings	Level of shortfall
C2 Staff involved in seeking consent receive training and support in the essential requirements of taking consent		

d) Competency is assessed and maintained	Whilst regular training and refresher training is provided to those seeking consent for adult post mortem (PM) examination and consent seekers are assessed as competent through a verbal assessment, there is no system in place to formally record this assessment process. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*	**Minor**
GQ1 All aspects of the establishment's work are governed by documented policies and procedures		
a) Documented policies and SOPs cover all mortuary/laboratory procedures relevant to the licensed activity, take account of relevant Health and Safety legislation and guidance and, where applicable, reflect guidance from RCPath.	Whilst condition checking of the deceased is completed regularly and actions are taken to expedite the release of bodies from the mortuary, these practices are not recorded in an SOP as a formalised process. Furthermore, whilst there is a notice in use for funeral directors informing of the three identifiers that could be written on to the identification bands for unidentified bodies, this detail is not reflected in the admission of the deceased SOP. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*	**Minor**

The HTA requires the DI to submit a completed corrective and preventative action (CAPA) plan setting out how the shortfalls will be addressed, within 14 days of receipt of the final report (refer to Appendix 2 for recommended timeframes within which to complete actions). The HTA will then inform the establishment of the evidence required to demonstrate that the actions agreed in the plan have been completed.

Advice
The HTA advises the DI to consider the following to further improve practice:

Number	Standard	Advice
1.	C1(a)	Whilst the overarching Health Board consent policy refers readers directly to the HTA Codes of Practice to fully understand the requirements of the HT Act and HTA Codes of Practice, the link to HTA information in the policy is broken. The DI is advised to ensure the policy is fully reflective of requirements of the HT Act and the HTA Codes of Practice to ensure information continues to be available in the event links to supporting information do not function.
2.	C1(b)	Whilst there is a process in place to manage a change of consent or a withdrawal of consent for adult PM examination, the DI is advised to review the SOP for adult consent seekers for assurance it is fully reflective of the procedure that consent seekers should follow.
3.	C1(c) C1(g)	The DI is advised to liaise with the group responsible for the production of the 'All Wales' consent package and seek to have the information leaflet for relatives and the consent form in use updated with a recently reviewed date. The documents currently state '2010' which suggests this was the last review date.
4.	GQ5(a)	Whilst the HTARI SOP details the types of incidents that require reporting to the HTA, the DI is advised to update the associated guidance in the SOP to align with the relevant guidance from the HTA: Post Mortem HTA Reportable Incidents (HTARIs)
5.	GQ6(b)	Whilst all licensable activities are risk assessed, the DI is advised to consider separating health and safety risks from risks that may result in a HTARI. This may assist staff to be fully aware of all the control measures in place to mitigate the different HTARI risks as relevant detail would be in one associated document rather than across several.
6.	T1(b)	At the time of the inspection, it was noted there were a couple of occasions where staff had not signed the mortuary register following a release of a body. The inspection team were assured this was an

		oversight rather than a trend in practice following review of all registers in use. Regular audits of mortuary records are also in place which would have identified and rectified such discrepancies; however, the DI may wish to consider placing a visual reminder for staff in the area of the register to ensure they fully complete the record at the time of a release of a body.
7.	T1(g)	The DI is advised to consider training additional staff in the management of the tissue traceability system in the laboratory. Currently the establishment only have one trained member of staff completing this function.
8.	T1(h)	The establishment have recently started working with an external agency through a Service Level Agreement for the completion of PM examinations. This is to assist with reducing the number of deceased awaiting PM examination during a period of high demand on the service. Whilst the establishment have implemented a tissue traceability system for tissue transferred off site to the agencies laboratory for processing, the DI is advised to audit receipt of the tissue to ensure it has arrived as expected.
9.	PFE1(a)	The DI is advised to declutter and reorganise the consumables store in the PM room at the hub site to ensure the room can be effectively decontaminated.
10.	PFE1(d)	Whilst the external fridge condenser units at the Princess of Wales Hospital are secured in a locked and high gated area, the DI is advised to consider fully enclosing this area to reduce the risk of tampering with the units to a minimum. The door between the viewing room and body store at Prince Charles Hospital is reliant on the use of a manual lock. The DI is advised to consider alternative arrangements to reduce any risk of access to the body store should the manual lock not be deployed. Whilst an external fire door to the side of the building at the Princess of Wales Hospital was locked and is alarmed out of hours, the DI is advised to consider adding additional security measures to this door as it is situated near the bereavement offices. This would alert staff the door is open in the event hospital staff visitors to this area inadvertently use the fire door as an exit during working hours.
11.	PFE1(e)	The DI is advised to review the completion of visitor logs as part of the security audits in place.

12.	PFE2(b)	Whilst the establishment have sufficient capacity for the level of activity undertaken across all three sites, the hub site currently is the main site for the activity of post mortem examination. The hub site has less body storage capacity than the satellite sites which means that bodies are frequently transferred out to the satellite sites for storage. This is to ensure there is sufficient capacity for bodies requiring PM examination at the hub site. The DI is advised to review the current arrangements and consider whether there is an alternative arrangement that may reduce the necessity for frequent transfers from the hub site, which would then see capacity managed more effectively at this site.
13.	PFE2(c)	Whilst it appeared there was sufficient freezer storage at the time of the inspection, the DI is advised to continue monitoring freezer capacity closely based on the increasing level of demand discussed with the inspection team. In the event that capacity is deemed as insufficient, actions should be taken to address any risks of potential deterioration to the deceased from lack of freezer storage. This should also form part of the Health Board risk register to ensure oversight of actions to address any significant risks identified.
14.	PFE2(h)	The hub site very rarely receives perinatal bodies; however, this site has four adult size refrigerated storage spaces allocated for this purpose. The DI may wish to consider an alternative storage arrangement, such as acquiring an additional pregnancy remains unit, this would then free up the refrigerated spaces to assist with the management of capacity at this site.
15.	N/A	The DI is advised to consider methods to reduce the external sound level in the viewing room at the hub site. Whilst the inspection team were undertaking the visual inspection of this area, activity from other areas of the mortuary could be heard clearly which has potential to cause distress to visitors.

Background

Royal Glamorgan Hospital has been licensed by the HTA since November 2007. This was the fourth inspection of the establishment; the most recent previous inspection took place in March 2018. However, following this inspection, two CAPA follow up site visit inspections were completed in August 2018 and March 2019 for assurance the findings of this inspection were fully addressed due to the severity.

Since the previous inspection, the following changes have been made to the licensing arrangements: changes to the list of Persons Designated in 2018, 2019, 2020, 2021, and 2022. There have been changes to the CLHc in July 2019, October 2020 and the current CLHc has been in place since June 2021. The current DI has been in place since October 2020.

The name of the organization changed in May 2019 to Cwm Taf Morgannwg University Health Board. In March 2020, the Princess of Wales Hospital was added to the licence as a satellite site. There was a temporary extension to premises at the Prince Charles Hospital satellite site with the procurement of additional body storage units to manage capacity in November 2020. A further permanent extension to premises at this site occurred in January 2023 with the procurement of a designated body storage unit for 85 deceased.

Description of inspection activities undertaken
The HTA's regulatory requirements are set out in Appendix 1. The inspection team covered the following areas during the inspection:

Standards assessed against during inspection
All 72 HTA licensing standards were covered during the inspection (standards published 3 April 2017).

Review of governance documentation
The inspection team reviewed the establishment's self-assessment document provided by the DI in advance of the inspection. Policies and procedural documents relating to licensed activities were reviewed. This included cleaning records for the mortuary and PM room, records of servicing of equipment, fridge and freezer alarm testing records, ventilation reports, body and tissue traceability audits, risk assessments, meeting minutes, temperature monitoring for the storage units, reported incidents, and staff training and competency records, including induction records of visiting staff. Consent seeking policies and procedures, information for relatives giving consent and current consent forms in use for both adult and perinatal PM examination were also reviewed.

Visual inspection
The inspection team undertook a visual inspection of the premises at the hub site and both satellite sites which included the mortuary body storage areas, PM rooms (Princess of Wales satellite site is not licensed for PM activity but has retained the PM suite), viewing rooms, the laboratory where tissue retained at PM is stored and the maternity department at Princess of Wales Hospital satellite site.

Audit of records
The inspection team undertook audits of traceability for four bodies in storage at the hub site, four bodies in storage at Princess of Wales hospital satellite site and five bodies in storage at the Prince Charles Hospital satellite site. This included bodies with same / similar names, a body stored longer term and a perinatal body. Traceability details were crosschecked between the identification bands on the body, information on the door of the storage unit, the mortuary register, associated paperwork, and the electronic mortuary database. The inspection team audited more bodies at the Prince Charles hospital satellite site as a discrepancy was noted with the storage location of two bodies with the recording of the fridge location on the doors of the storage unit. This was rectified at the time of the inspection.

The inspection team observed release of bodies from all three sites, and it was noted that funeral directors arrive with an establishment release form which contains three identifiers of the deceased. This form is physically crosschecked against the information on the identification bands of the deceased. The mortuary staff and funeral director staff both confirm the identity and sign the release form as evidence the identification procedure has been completed as expected.

Audits were conducted of tissue taken at PM examination for seven cases. Information was crosschecked between the mortuary traceability documentation, Coroner's paperwork, family wishes forms, and the tissue blocks and slides being stored. Four cases were identified as being stored for a scheduled purpose with appropriate consent, one case had been returned at a later date, one case was awaiting repatriation at a later date and one case had been disposed of in line with the wishes of the family. No discrepancies were identified.

Meetings with establishment staff
The inspection team met with staff conducting processes under the licence, including the mortuary manager, mortuary staff, laboratory staff, facilities managers and portering staff, staff involved in the consent seeking process for both adult and perinatal PM examination, a pathologist undertaking PM examinations and the DI.

Report sent to DI for factual accuracy: 09 March 2023

Report returned from DI: 23 March 2023

Final report issued: 03 April 2023

Appendix 1: The HTA's regulatory requirements

Prior to the grant of a licence, the HTA must assure itself that the DI is a suitable person to supervise the activity authorised by the licence and that the premises are suitable for the activity.

The statutory duties of the DI are set down in Section 18 of the Human Tissue Act 2004. They are to secure that:

- the other persons to whom the licence applies are suitable persons to participate in the carrying-on of the licensed activity;
- suitable practices are used in the course of carrying on that activity; and
- the conditions of the licence are complied with.

Its programme of inspections to assess compliance with HTA licensing standards is one of the assurance mechanisms used by the HTA.

The HTA developed its licensing standards with input from its stakeholders. They are designed to ensure the safe and ethical use of human tissue and the dignified and respectful treatment of the deceased. They are grouped under four headings:

- consent
- governance and quality systems
- traceability
- premises facilities and equipment.

This is an exception-based report: only those standards that have been assessed as not met are included. Where the HTA determines that there has been a shortfall against a standard, the level of the shortfall is classified as 'Critical', 'Major' or 'Minor' (see Appendix 2: Classification of the level of shortfall). Where HTA standards are fully met, but the HTA has identified an area of practice that could be further improved, advice is provided.

HTA inspection reports are published on the HTA's website.

Appendix 2: Classification of the level of shortfall

Where the HTA determines that a licensing standard is not met, the improvements required will be stated and the level of the shortfall will be classified as ‘Critical’, ‘Major’ or ‘Minor’. Where the HTA is not presented with evidence that an establishment meets the requirements of an expected standard, it works on the premise that a lack of evidence indicates a shortfall.

The action an establishment will be required to make following the identification of a shortfall is based on the HTA's assessment of risk of harm and/or a breach of the Human Tissue Act 2004 (HT Act) or associated Directions.

1. **Critical shortfall:**

   A shortfall which poses a significant risk to human safety and/or dignity or is a breach of the HT Act or associated Directions

   or

   A combination of several major shortfalls, none of which is critical on its own, but which together could constitute a critical shortfall and should be explained and reported as such.

   A critical shortfall may result in one or more of the following:

   - A notice of proposal being issued to revoke the licence
   - Some or all of the licensable activity at the establishment ceasing with immediate effect until a corrective action plan is developed, agreed by the HTA and implemented.
   - A notice of suspension of licensable activities
   - Additional conditions being proposed
   - Directions being issued requiring specific action to be taken straightaway

2. **Major shortfall:**

   A non-critical shortfall that:

   - poses a risk to human safety and/or dignity, or
   - indicates a failure to carry out satisfactory procedures, or

- indicates a breach of the relevant Codes of Practice, the HT Act and other relevant professional and statutory guidelines, or
- has the potential to become a critical shortfall unless addressed

or

A combination of several minor shortfalls, none of which is major on its own, but which, together, could constitute a major shortfall and should be explained and reported as such.

In response to a major shortfall, an establishment is expected to implement corrective and preventative actions within 1-2 months of the issue of the final inspection report. Major shortfalls pose a higher level of risk and therefore a shorter deadline is given, compared to minor shortfalls, to ensure the level of risk is reduced in an appropriate timeframe.

3. **Minor shortfall:**

   A shortfall which cannot be classified as either critical or major, but which indicates a departure from expected standards.

   This category of shortfall requires the development of a corrective action plan, the results of which will usually be assessed by the HTA either by desk based review or at the time of the next inspection.

   In response to a minor shortfall, an establishment is expected to implement corrective and preventative actions within 3-4 months of the issue of the final inspection report.

Follow up actions

A template corrective and preventative action plan will be sent as a separate Word document with both the draft and final inspection report. Establishments must complete this template and return it to the HTA within 14 days of the issue of the final report.

Based on the level of the shortfall, the HTA will consider the most suitable type of follow-up of the completion of the corrective and preventative action plan. This may include a combination of

- a follow-up inspection
- a request for information that shows completion of actions
- monitoring of the action plan completion
- follow up at next routine inspection.

After an assessment of the proposed action plan establishments will be notified of the follow-up approach the HTA will take.

Corrective and preventative action (CAPA) plan

Royal Glamorgan Hospital - 12338 - Routine on 16/2/2023

Please complete the blanks below

HTA Standard	C2d - 31/5/2023	**Level of Shortfall (major or minor only)**	Minor
Short Description	Competency Assessment for Consent Seekers		
Inspection finding: Whilst regular training and refresher training is provided to those seeking consent for adult post mortem (PM) examination and consent seekers are assessed as competent through a verbal assessment, there is no system in place to formally record this assessment process. *The establishment submitted sufficient evidence to address this shortfall before the report was finalised.*			
Corrective and Preventative Action: DI has submitted a competency assessment form for adult post mortem examination consent seekers. This will be administered every two years and the expectation is 100% compliance. If not, then there would be a follow-up from the DI. Questions will change two yearly as well to keep it relevant and of course updates provided between refresher training when guidance is updated etc.			
Deadline for completion of corrective and preventative action:	31/05/2023		

HTA Use Only

Action for HTA:	Closed before final report issued. **Closed ML – 03 April 2023**
Compliance information to be submitted: A copy of the competency questionnaire for adult consent seekers was submitted on 14.03.23 and reviewed and accpeted prior to issuing the final inspection report. – **received and reviewed**	

Corrective and preventative action (CAPA) plan

Royal Glamorgan Hospital - 12338 - Routine on 16/2/2023

Please complete the blanks below

HTA Standard	GQ1a - 31/5/2023	**Level of Shortfall (major or minor only)**	Minor
Short Description	Standard Operating Procedures (SOPs)		

Inspection finding:

Whilst condition checking of the deceased is completed regularly and actions are taken to expedite the release of bodies from the mortuary, these practices are not recorded in an SOP as a formalised process.
Furthermore, whilst there is a notice in use for funeral directors informing of the three identifiers that could be written on to the identification bands for unidentified bodies, this detail is not reflected in the admission of the deceased SOP.
The establishment submitted sufficient evidence to address this shortfall before the report was finalised.

Corrective and Preventative Action:

A new SOP for condition monitoring of the deceased has been developed and relevant updates made to a number of existing SOPs and forms to integrate the importance of condition monitoring. These revisions will go through the governance process for sign off and train staff accordingly. The SOPs and related forms have been sent by the DI on 31.03.23.

The admission SOP has been updated to reflect the types identifiers of unknown deceased that should be written on the ID band at the point of admission. This includes a minimum of three points of identification.

Deadline for completion of corrective and preventative action:	31/05/2023

HTA Use Only

Action for HTA:	Closed before final report issued. **Closed ML – 03 April 2023**

Compliance information to be submitted:

The DI has provided the following documents which have been reviewed and accepted prior to finalising the inspection report:

1. SOP MMCMD - Monitoring condition of the deceased – **received and reviewed**
2. Mortuary release of deceased form – **received and reviewed**
3. SOP - Admission and clerking in of deceased – **received and reviewed**
4. Notification of death - Hazard notification form – **received and reviewed**
5. BID clerking in and transfer form – **received and reviewed**

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WHSSC Joint Committee 14
14 March 2023
Agenda Item: 4.5.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**24 January 2023**

Summary of key matters considered by the Committee and any related decisions made

Presentation – Mental Health Deep Dive

The committee received an informative Mental Health (MH) presentation which covered the following key areas:

- Mental Health Strategy – Consultation Feedback
- Secure Services Review
- Single Commissioner
- CAMHS
- Eating Disorders
- Mother and Baby Unit
- Governance and Incident Reporting

Dai Roberts (DR) explained that the majority of HBs had submitted consultation feedback and from the initial review of responses there was no firm opposition to the key elements of the MH strategy. The consultation responses would be used to inform the development of the final strategy and an implementation plan for the strategy was also under development.

Shane Mills (SM) provided a detailed overview of the Secure Mental Health review which he conducted and highlighted the general differences between High, Medium and Low Secure Services, the average lengths of stay as well as other classifications by gender, sexual orientation etc. for patients in each sector.

DR explained that the Single Commissioner Model had been to the WHSSC Joint Committee on 10 January 2023 and that Secure Mental Health Services in Wales should be commissioned by WHSSC. More detailed work needed be done to define the appropriate timescales, but the programme of work is unlikely to be completed before April 2024 at the earliest.

DR provided an update on the positive progress in relation to CAMHS and the de-escalation of Ty Llidiard to Escalation Level 3. The service had been in Escalation Level 4 for a considerable length of time. There will be a piece of work undertaken on referral management, which will be undertaken by NCCU.

In relation to Eating Disorders, interim arrangements are currently in place with

the Priory to ensure access to Eating Disorder beds for adults. A tender process is underway to secure a medium-term solution for the next 2-3 years. The long-term solution will be considered as part of the Specialised Services Strategy for Mental Health.

Several recommendations were made following the review of Tonna Mother and Baby Unit (MB) and an analysis of a permanent option is being conducted in line with the Mental Health Strategy Work.

Welsh Kidney Network (WKN)
QPS members were provided with an update around the two risks documented as they scored above 15, the first being around the financial element and possible inability to meet demands through the current budget. The second high level risk was around the limited outpatient capacity in Morriston Hospital, where there is a plan to establish two new satellite units around the Swansea area which should be running early 2024. The funding for these dialysis units had been approved by the Joint Committee during January 2023.

Ashraf Mikhail (AM) provided an update on the peer review process and gave details on the Quality Statement that was released by WG in 2022, which summarised the aims and objectives for the WKN.

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:

Cancer & Blood
Within the Cancer & portfolio and in relation to the Burns service, WHSSC were notified this week that the Mutual Aid arrangements through the Burns Network had been triggered due to a nurse staffing issue and all the arrangements with the Burns network worked appropriately.

The Corporate Directors Group Board (CDGB) had also agreed to de-escalate the PETIC service.

Neurosciences
There was a performance issue that had been a pre-COVID issue within the Neurosurgery Service, but that had now been de-escalated. Nicola Johnson (NJ) highlighted the good progress that had taken place in terms of access.

The single-handed Consultant within the Neuroendocrine Tumour service (NETS) has taken a leave of absence, but WHSSC have received assurance that contingency arrangements are in place. A Consultant from another accredited Centre is providing support and cover for these clinics.

Within the Neurosciences Commissioning Team, the Cochlear and Baha engagement was launched in December 2022 and this will close on 14 February 2023.

Cardiac
Within the Cardiac surgery services, unfortunately the escalation status has remained at the same level in both C&VUHB and SBUHB.

Following receipt of the Royal College of Surgeons (RCS) Report, it was not considered appropriate to de-escalate the service in SBUHB. WHSSC will be meeting again with the HB at an escalation meeting in February to consider the Action Plan that they have put in place to address the issues highlighted in the report. The position will then be considered again under the Escalation Framework processes.

C&VUHB has reported that hood discussion had taken place around their strategic issues and cultural changes. The provider had expressed the view that the escalation process has helped to maintain the focus of the Health Board on these issues. There will be a further meeting in April 2023.

NJ commented that the RCS Report had been written on the basis of a visit to the HB in March 2022 and the HB had undertaken significant action as a result. WHSSC had written to the HB outlining the areas of concern and the evidence required to provide WHSSC with the necessary assurance. NJ explained that she and Sian Lewis had also met with the Medical Director and Chief Executive of the Health Board and explained the progress that was expected by the next Escalation meeting.

Women & Children
During the winter there had been increased pressure within the paediatric intensive care service. This was anticipated post Covid with a return to children mixing on top of the usual respiratory pressures during the winter months.

AR reminded the Committee that WHSSC continued to attend the Paediatric Intensive Care SitRep meetings. There continues to be high demand for PICU beds.

In response to a query around Paediatric activity levels in C&VUHB, NJ explained that WHSSC had received assurance from the HB that they would be able to deliver the contract for 2022/23, but throughout the year due to pressures of theatre and staffing allocation across other Paediatric surgical disciplines the HB has not been able to deliver the level of planned contract activity. This has remained a focus of the performance meetings with the HB. NJ highlighted that, in conjunction with the JC, WHSSC would be reviewing the contract for next year and the provision for Paediatric Surgery. Outsourcing options remain on the table.

Mental Health & Vulnerable Groups
NJ explained that details around the NWAS and Ty Llidiard Services had been covered within the Mental Health presentation.

Adele Roberts (AR) felt it was important to add to the Mental Health update that WHSSC received a report on 7 November 2022, jointly undertaken by NHS Wales and NHS England, relating to a serious incident, which had led to the death of a patient on 20th April 2022. There were 12 recommendations, which will be considered by the Mental Health and Vulnerable Groups Commissioning Team. The

date of the Inquest has not yet been confirmed. The final report and findings of the inquest will be reported to the Quality and Patient Safety Committee once concluded. An update will be provided to the Joint Committee through the Chair's report.

Intestinal Failure (IF) – Home Parenteral Nutrition
The action on the Intestinal Failure (IF) invoices had been closed and an update has been provided within the report. Some new IF risks will be added onto the CRAF in January 2023 mainly around the financial and contractual arrangements.

4.0 Other Reports Received
Members received reports on the following:

- **Services in Escalation Summary**
  WHSSC currently has 6 services in escalation to report, although this will be reduced to 4 as 2 services are scheduled to come out of escalation. One service has also reduced its level of escalation and there are no new services in escalation. The table at the end of this paper provides a summary of each of those services.
- **CRAF Risk Assurance Framework**
  Members were provided with an updated position regarding the WHSSC CRAF. Members noted the updated Risk Appetite Statement that had recently been approved by the JC.
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
  AR provided a briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period October to December 2022.

It was acknowledged that the structure of the CQC had recently changed and may have had an impact on the structure for producing the reports. However, going forward WHSSC will continue to work closely with the CQC on their action plans and meet with them regularly.

Incident and Concerns report
An update report was noted and received by the Committee for assurance. The Chair asked for the content of the report to be considered with perhaps some additional information added to the next report.

5.0 Items for information:
Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 8 November 2022,
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above.	
Summary of services in Escalation (Appendix 1 attached)	
Matters requiring Committee level consideration and/or approval None	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	21 March 2023 at 13.00hrs

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
September 2020	FACTS	CTUHB	2	• Workforce issue	• Last escalation meeting was held on 14/12/22 • Assurance was provided for the remaining key requirements • The service was formally de-escalated to level two on 16/12/22 Service will continue to be monitored through an improvement plan for further de-escalation (confirmation of clinical leadership and recruitment of remaining psychology posts)	**To be removed from escalation** 

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	3	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 5th December 2022 • Improvement Board established to oversee delivery of an integrated improvement plan • Emergency SOP has been fully implemented • Majority of posts recruited to or start dates agreed. • Improved leadership evident via escalation meetings • Progress against de-escalation action plans, and a favorable report following the latest quality visit provided assurance to support de-escalation of service to Level 3 • Further audit being conducted around the referral processes to enable consideration of further de-escalation.	
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • The service was de- escalated on delivery of the immediate actions required by the GIRFT recommendations (per March update), but remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed at the most recent	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					meeting in October 2022 and, although significant progress towards the GIRFT benchmarks was noted, it was agreed that WHSSC would need to review the final report of the Royal College of Surgeons of England (RCS England) Invited Service Review to be prior to any potential further de-escalation. • This report was received in November 2022 and was subsequently reviewed by the Cardiac Commissioning Team. As a result of the report's urgent recommendations to address patient safety risks, and in view of a small number of new concerns identified by the RCS, WHSSC concluded that further assurance was required further assurance before de-escalation could be taken forward, and the service remains in Level 3 escalation.	
July 2021 (original escalation) April 2022 (escalated from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of a failure to provide the requested GIRFT improvement plan and HEIW report, the service was re-	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
					escalated in April 2022. • The service has since provided both a GIRFT improvement plan and HEIW report (and action plan), and WHSSC has developed de-escalation criteria based on the GIRFT recommendations and action plans. • The de-escalation criteria were discussed at the November 2022 escalation meeting. It was agreed that there was no expectation that the criteria would need to be delivered in full to facilitate de-escalation, but that the service would need to evidence demonstrable progress as a result of targeted actions • A further escalation meeting has been scheduled for April 2023.	
November 2021	Adult burns	SBUHB	3	• 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	• Escalation monitoring meetings held on 12th August, 27th September and 1st December 2022. • The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023. • The capital case remains on target with the planned timeline. • The next escalation monitoring	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 17.01.23	Movement from last month
				concerns the progress of the capital case for the long term solution and sustainability of the interim model.	meeting is arranged for 3rd March 2023.	
February 2022	PETIC	Cardiff University	1	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due to critical quality control issue identified during MHRA inspection. Service slow top address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures. • Failure to provide a business case of sufficient quality in a timely manner for replacement of the scanner	PETIC has taken forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. PETIC has been de-escalated and therefore removed from the table of services in escalation. WHSSC corporate directors agreed to de-escalate PETIC following confirmation on 5th December 2022 that the actions in the escalation action plan had been completed. The service has returned to routine monitoring.	**To be removed from escalation**

WHSSC Joint Committee
16 May 2023
Agenda Item: 4.5.5

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**18 April 2023**

Summary of key matters considered by the Committee and any related decisions made

1.0 MAJOR TRAUMA PRESENTATION – SOUTH WALES TRAUMA NETWORK

Members received an informative presentation from the South Wales Trauma Network Manager, which outlined the background of the South Wales Trauma Network (SWTN) and provided an update following the Peer Review which had been undertaken in March 2022.

The peer review outlined a number of areas of good practice with no immediate risks raised across the South Wales Trauma Network (SWTN) which was extremely positive.

Members noted that, thanks to the commitment of the staff and support networks available to them, the progress on improvement had already started to take shape.

2.0 WELSH KIDNEY NETWORK (WKN)

Members received a report outlining the current Quality Patient Safety (QPS) issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 9 March 2023, and WKN Board meeting on 4 April 2023 and that there were 14 items on the current WKN risk register.

Members were informed that the Annual Renal meeting would be taking place in Newport this year as part of 'Kidney Week'.

3.0 COMMISSIONING TEAM AND NETWORK UPDATES

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points

for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

3.1 Cancer & Blood

Workforce issues within the Neuro Endocrine Tumour Service (NETS) have been addressed with the support of a visiting consultant with NET expertise to oversee the delivery of the service. A full review of the service with stakeholders is planned in the near future with the aim of finding a sustainable solution going forward.

A number of issues have been raised around access to the Extracorporeal Membrane Oxygenation (ECMO) pathway at Guy's and St Thomas. A meeting has taken place with them to discuss the pathway access and prioritisation. Clinical links will be established with services in Wales to review the cases via a Harms Review and data is to be shared with WHSSC regarding numbers accessing the services from Wales.

The findings of this Harm Review will be shared with the committee once completed.

3.2 Neurosciences

There were no changes in risks since the last update and no services were in escalation.

Members noted that the engagement period for the Cochlear Implant and Bone Conduction Hearing Implant Service had now concluded and findings were being presented to Management Group for consideration prior to Joint Committee (JC) in May 2023.

3.3 Cardiac

Within the Cardiac surgery services, there had been significant improvements across all areas in escalation and no new risks had been added to the Risk Register since the last report.

Members noted the improved joint working between CVUHB and SBUHB Cardiac Services. Liverpool Heart and Chest Service had worked with CVUHB and SBUHB to share examples of their initiatives in place around recruitment and retention.

Members noted the Newsletter from the Adult Congenital Heart Disease Team promoting heart health awareness and the work that was ongoing in this area.

3.4 Women & Children

- **Paediatric Surgery**

Members noted the issues in relation to the waiting list and the actions in place to improve the situation following further escalation to Level 3 in February 2023. It was noted that C&VUHB are now engaging and providing weekly update

reports to enable monitoring activity levels in real time and regular Executive led escalation meetings were in place.

Waiting times had decreased to meet the Ministerial waiting time of 104 weeks as at the end of March 2023. However, because this relates to children WHSSC have requested further significant reduction to 52 weeks over the next year and will work with the HB to support them in achieving that.

- **Paediatric Intensive Care Unit (PICU)**

There had been considerable focus on PICU over the last quarter and as a result, weekly SitRep meetings led by Welsh Government (WG) were put in place and have shown that there continued to be increased pressure in PICU services across the UK in relation to recovery from the pandemic. Members were informed that HIW had written to the Cardiff & Vale University Health Board raising a number of concerns. WHSSC had recently received the response which along with the findings from a pressure damage report would be considered to determine the level of escalation attributed to the service.

3.5 Mental Health & Vulnerable Groups

Members noted the following key updates:

- A pre inquest hearing has taken place recently regarding the death of a patient whilst in a Women's Enhanced Medium Secure Unit in West London. The date for the full hearing has not been confirmed to date.
- SBUHB Caswell Medium Secure Adult Mental Health Unit is developing a strategy to reshape the delivery of inpatient care and are currently looking at securing more funding to increase the number of seclusion suites on each ward for patients with a more challenging presentation. Members noted that the repatriation programme was going as hoped and there was an expectation that increased numbers of patients would be admitted to the clinic by the end of May.
- The committee received a detailed summary regarding the Gender Development Service (GIDS) for Children and Young People. Some early discussions have taken place with CVUHB regarding the potential for a regional model linked to the Children's Hospital sometime in the future.

3.6 Intestinal Failure (IF) – Home Parenteral Nutrition

Members noted the report highlighting the contractual and inflation risks which had now been mitigated and reduced or closed providing stability to the service going forward.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation

level. Members noted the five services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 3 from 4 in December 2022,
- Paediatric Surgery C&VUHB had been escalated to level 3 in March2023,
- There had been no changes in escalation levels to the other services.

Members provided positive comments on the new template and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report Appendix 1

4.2 Quality Newsletter

Members received a copy of the Quarterly Newsletter which is also available bilingually. A copy is attached to the report ***Appendix 2***

4.3 QPSC Annual Report 2022-2023

Members received the QPSC Draft Annual Report outlining all activities undertaken by the QPSC over the last year. Members approved the draft report noting that any formatting issues would be resolved prior to submission to JC.

4.4 QPSC Terms of Reference

Members received the Draft Terms of Reference (ToR) to consider the changes to the report. Members supported the approach to undertake a minimal review. Members noted that following the Review into National Commissioning they would be updated further to align with the outcome.

4.5 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 and the provider tab that had been added so that individuals who are outside the organisation can see which provider delivers each service.

4.6 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 January to March 2023 was presented to the committee.

4.7 Incident and Concerns report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. The report presented also included an in-depth review of the cardiac incidents reported. This was following queries raised by members at the last meeting requesting further assurance.

Members noted the content of the report and the additional context provided for each of the incidents.

4.8 Service Improvement and Innovation Days

Members received a report providing an update on the Service Improvement and Innovation Days and similar externally organised events relating to specialised services.

Members noted the content of the report, the summary of activities, aims and key points of learning and sharing. The report demonstrated the positive work that had been achieved and undertaken by clinicians

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 16 March 2023
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation

- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval

- QPSC Annual report 2022-2023
- QPSC Terms of Reference

Matters referred to other Committees

As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	14 June 2023 at 14.00hrs

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: 18/04/2023

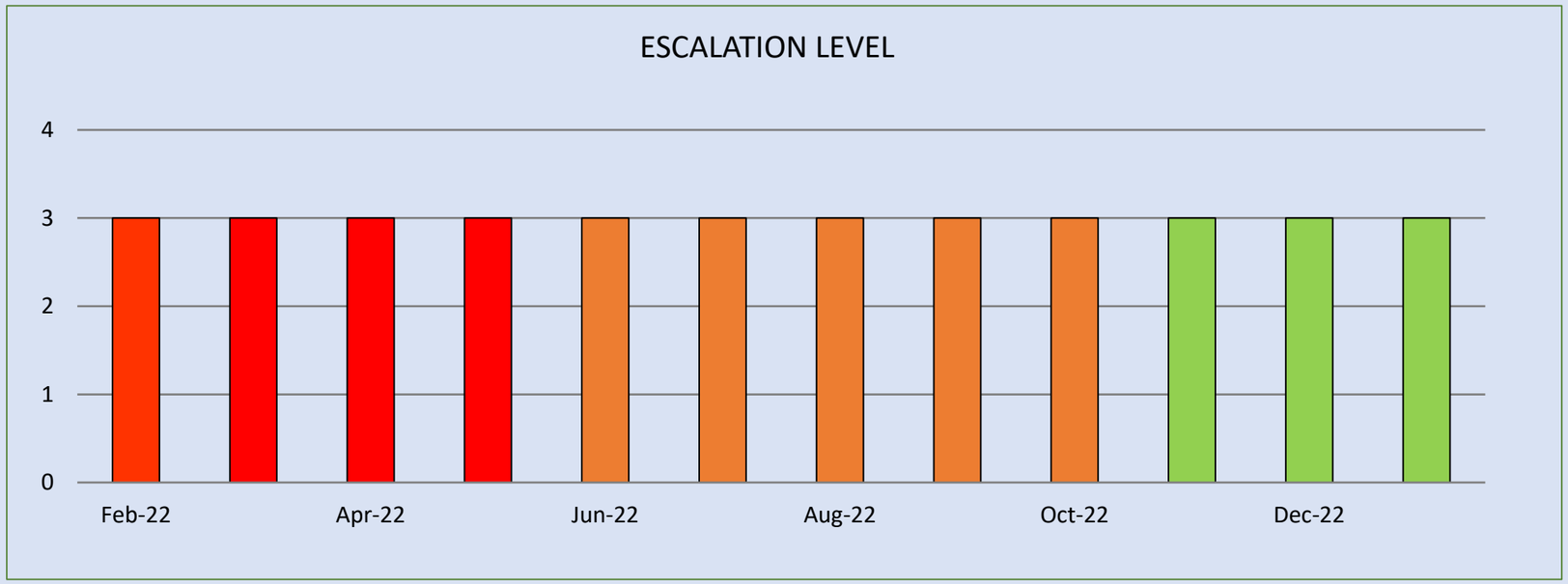
Service in Escalation: Burns

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ March 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	**4**
February 2022 – WHSSC escalation	**3**
August 2022 – WHSSC escalation	**3**
September 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case remains on target with the planned timeline.
The next escalation monitoring meeting is arranged for 3rd March 2023.

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.

Next escalation meeting 03/05/23.

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. Meetings held 27/09/22 and 01/12/22.	MD/ Exec Lead WHSSC		Next meeting 03/05/23
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	
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. Capital case remains on target with the planned timeline. The next escalation monitoring meeting is arranged for 3rd May 2023.	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

Executive Director Lead: Nicola Johnson
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

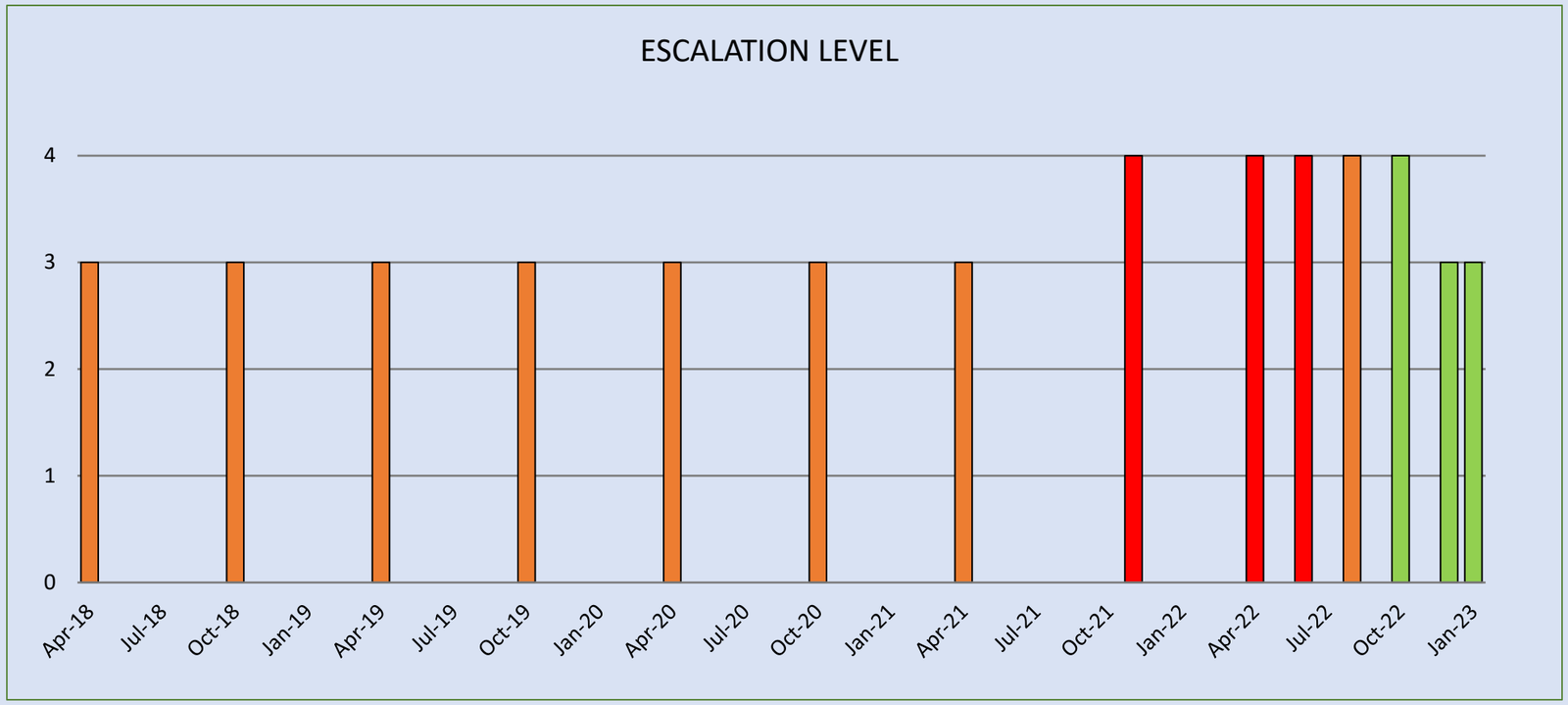
Service in Escalation: Ty Llidiard

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓ January 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3

Rationale for Escalation Status :
De-escalated to level 3.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.

Actions:

Action	Lead	Action Due Date	Completion Date

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.	Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
	Service specification action plan agreed.	Senior Planner		Completed March 22
	Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
	Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
	Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
	Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
	NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
	Reviewed service specification.	Senior Planning Manager		Completed
	Monitor training status of the staff by QAIS.	Shane Mills		Completed
	Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
	Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
	Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	
	Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Ongoing

Issues/Risks:
This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.

July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac

Date of Escalation Meetings: 01/06/22, 20/07/22, 21/11/22, 05/04/23, 27/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/23

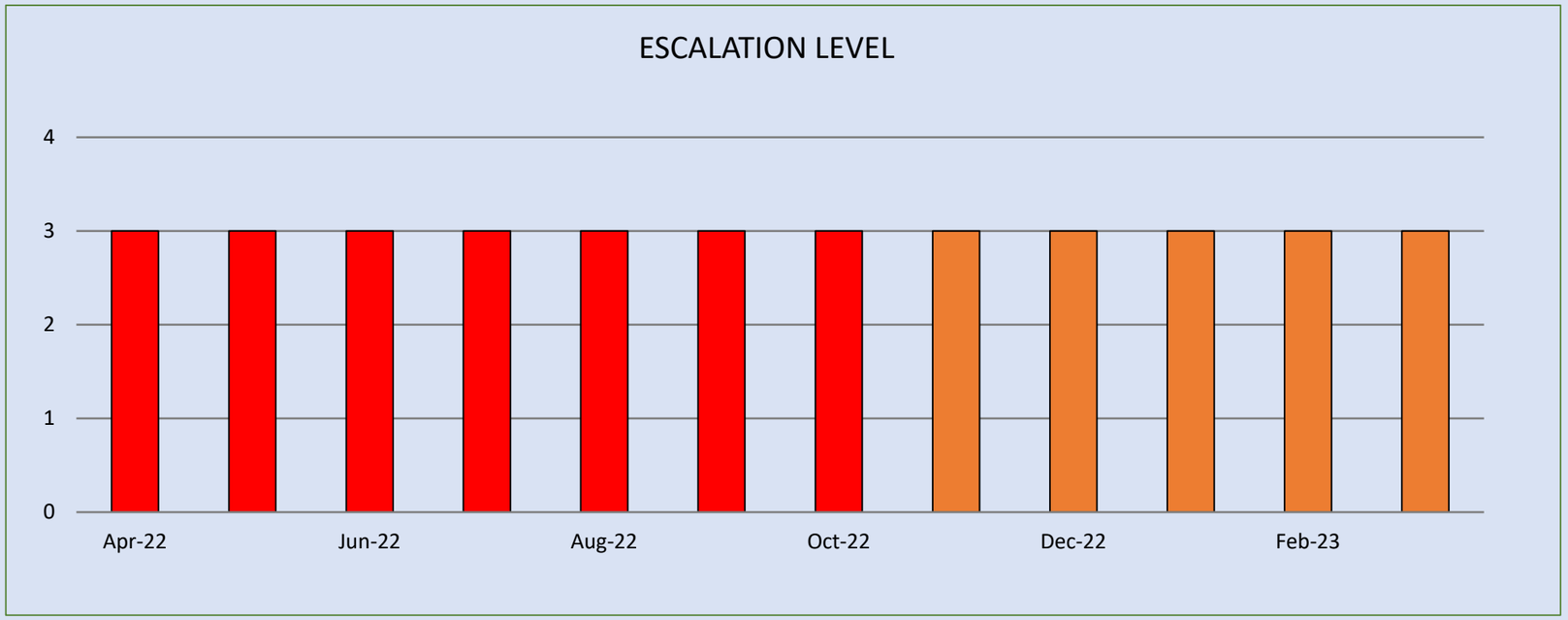
Service in Escalation: Cardiac CVUHB

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ March 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
April 2022– WHSSC escalation	**3**
June 2022– WHSSC escalation	**3**
November 2022– WHSSC escalation	**3**

Rationale for Escalation Status :
Owing to the availability of CVUHB Executive colleagues, there has not been as escalation meeting since November 2022. As such, the Cardiac Surgery service remains in at level 3. Escalation meetings have been scheduled for 5 April and 27 June, at which it is hoped that progress against the GIRFT/HEIW action plan will be evident.

Background Information:

Owing to the failure of Cardiff and Vale University Health Board to…

1. Implement the outcomes of the GIRFT review (June 2021), for which no appropriate SMART action plan has been shared with WHSSC
2. Communicate and address (via a SMART action plan) the additional issues recently identified by HEIW, arising from the concerns with the cardiac surgical service raised by trainees

Actions:

Action	Lead	Action Due Date	Completion Date
Escalate service to Stage 3 of the WHSSC escalation process.	Director of Planning		Completed
Establish regular (every 6 weeks) escalation meetings with CVUHB to oversee escalation process.	Senior Planning Manager		Completed

…there is a risk that people waiting for Cardiac Surgery delivered by Cardiff and Vale University Health Board may receive suboptimal or delayed treatment, and that WHSSC will be unable to effectively monitor.

The following controls have thus been put in place:

- Instituting of regular (every 6 weeks) Stage 3 escalation meetings with Cardiff and Vale University Health Board.
- HEIW report and action plan shared with WHSSC and discussed in escalation meetings.
- Development of SMART action plan to take forward the recommendations of the GIRFT review, shared with WHSSC at escalation meetings to enable the monitoring of progress and identification of any required remedial actions.

WHSSC assurance and confidence level in developments:

Medium – Although progress against the objectives of the action plan is apparent, there has been a noteworthy delay between the last completed and next scheduled escalation meeting, significantly impacting WHSSC's ability to further monitor progress. WHSSC has also experienced a delay in receiving the HEIW report, the provision of which was actioned in the November escalation meeting.

Receive a SMART action plan from the service that addresses the recommendations contained in the GIRFT report.	Senior Planning Manager	In progress - chased 10/06/22	Completed
Receive HEIW report concerning issues with the cardiac surgical service raised by trainees.	Senior Planning Manager		Completed
Monitor implementation of the SMART action plan at escalation meetings.	Senior Planning Manager	In progress	
Development of de-escalation criteria based on recommendations in GIRFT report and action plan.	Associate Medical Director		Completed

Issues/Risks:

June 2022 – Service escalated to Stage 3 of the WHSSC escalation process in April 2022 owing to continuing concerns with engagement; agreed at the 28 June 2022 Cardiac Commissioning Team meeting that the escalation constituted a risk (as opposed to an issue) owing to concern that the failure to implement GIRFT/HEIW recommendations will impact on patients, but that the accompanying narrative should be revised to clarify the precise concerns; escalation meeting held on 01 June 2022, at which an apparently extant action plan was discussed, but not subsequently shared.
July 2022 – Action plan now shared with WHSSC. Second escalation meeting held on 20 July 2022 at which – mindful of the long-term nature of many of the HB's objectives – progress was noted. Agreed that WHSSC would refer to both the GIRFT report and the action plan in order to develop de-escalation criteria in time for the next escalation meeting (September). No change to risk score.
August 2022 – Draft de-escalation criteria shared with Health Board in readiness for discussion at September escalation meeting. No change to risk level.
September 2022 – The de-escalation criteria was discussed with the Health Board in the September escalation meeting. It was agreed in the meeting that the Health Board would provide a formal response in regards to the proposed de-escalation criteria. No change to the risk score.
October 2022 - Health Board had not yet provided formal response to proposed de-escalation criteria. Planned October escalation meeting had been rescheduled to Monday 21 November owing to Health Board availability; Health Board had submitted updated action plan in lieu of meeting. No change to risk score.
November 2022 – Further progress was noted at November escalation meeting; de-escalation criteria discussed – agreed that focus would be on evidencing positive trajectory, assisted by cardiac surgery dashboard; risk score unchanged.
December 2022 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
January 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
February 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.
March 2023 – No escalation meetings since the last CRAF review. Risk level remains unchanged; next meeting scheduled for 5 April 2023.

Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac
Date of Escalation Meetings: 12/07/21, 30/08/21, 21/09/21, 08/11/21, 01/02/22, 13/05/22, 18/07/22, 06/10/22, 16/02/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

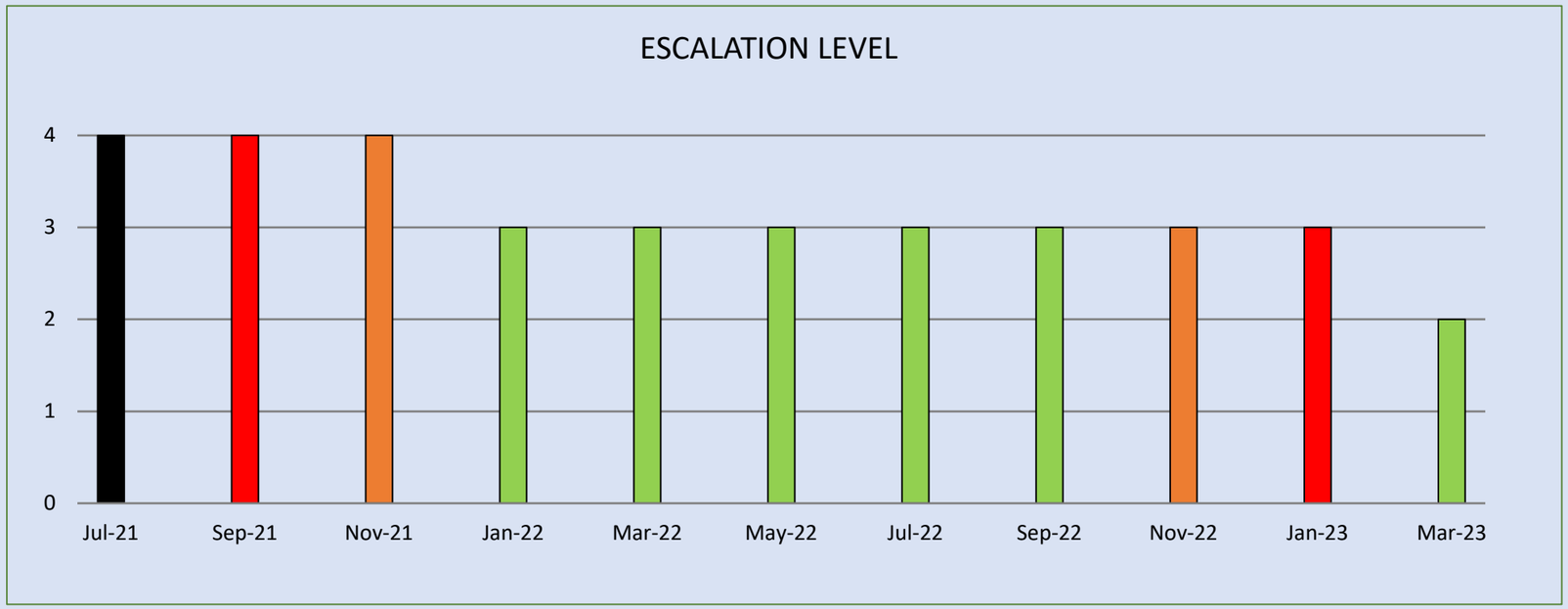
Service in Escalation: Cardiac SBUHB

Current Escalation Level 2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ January 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2021 – WHSSC escalation	**4**
November 2021 – WHSSC escalation	**4**
February 2022 – WHSSC escalation	**3**
July 2022 – WHSSC escalation	**3**
October 2022 – WHSSC escalation	**3**
December 2022 – WHSSC escalation	**3**
March 2023 – WHSSC escalation	**2**

Rationale for Escalation Status :
Reduced to Level 2 owing to significant progress towards the GIRFT benchmarks and the further assurance provided in response to the recommendations of the Royal College of Surgeons of England (RCS England) Invited Service Review report.

Background Information:

There is a risk patients undergoing cardiac surgery in Swansea are at a greater risk of complications as recent evidence from the Getting It Right First Time Review of cardiac services has highlighted a high rate of poor clinical outcomes. As a consequence patients are at risk of harm from practices during surgery and in the post-operative period resulting in long term morbidity issues.

Actions:

Action	Lead	Action Due Date	Completion Date
Service escalated to Stage 4 of the WHSSC Escalation Process.	Director of Planning		Completed
To receive an improvement plan from the service which addresses the clinical outcomes and the 5 process issues highlighted in the report and set out in the GIRFT recommendations by end of July 2021.	Senior Planning Manager		Completed

- Consultant only operating whilst a review of the clinical outcomes takes place
- Mitral Valve surgery to only be undertaken by the 2 consultants with a sub-specialist interest in mitral valve surgery
- Service has established a gold command structure to steer improvement

WHSSC assurance and confidence level in developments:

High – Evident progress GIRFT benchmarks and further assurance provided by the Medical Director in response to the recommendations of the Royal College of Surgeons of England (RCS England) Invited Service Review report have assured WHSSC of the effectiveness of the actions in progress, leading to de-escalation. Service will be monitored via newly convened Risk, Assurance and Recovery meetings pending further de-escalation.

To establish 6 weekly escalation meetings with SBUHB to review progress against the improvement plan.	Senior Planning Manager		Completed
Arrange meeting with SBUHB and C&VUHB to discuss interim arrangements for Aorto-vascular service.	Senior Planning Manager		Completed
WHSSC to write to SBUHB following agreement of interim pathway.	Senior Planning Manager		Completed
Improvement plan to be monitored through the regular escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Ongoing; timelines extended	

Issues/Risks:
March 2022 – Commissioning Team to agree to lower risk score to 3x4=12 at March team meeting as data shows improvement.
June 2022 – Meeting with SBUHB held on 13 May 2022; service continues to show improvement and consideration will be given to de-escalation on provision of six months of data.
July 2022 – Escalation meeting held on 18 July 2022 and analysis of data illustrated further improvements; significant portion of data points now in line with GIRFT benchmarks. Agreed that de-escalation would be further discussed at September meeting, pending submission of Royal College of Surgeons of England (RCS England) Invited Service Review report.
August 2022 – Still awaiting submission of RCS England Invited Service Review Report. No change to risk level.
September 2022 - An escalation meeting is scheduled with SBUHB for the 6 October 2022. It is anticipated that once the RCS England report has been received that the service can be de-escalated. No change to the risk score.
October 2022 – Escalation meeting had noted further progress, but RCS report had still not been received. De-escalation will only be recommended on receipt of report; no change to the risk score. In the event that the report is not submitted, an additional escalation meeting will be convened.
November 2022 – RCS report has been repeatedly chased, but has still not been received. Convening of additional level 3 escalation meeting with Exec-level attendance now in train.
December 2022 – RCS report received and considered by extraordinary meeting of the Cardiac Commissioning Team, which recommended that the service remain in escalation owing to new and continuing concerns. Endorsed by CDGB; escalation letter sent to SBUHB. Risk level to remain unchanged as escalation status remains unchanged.
January 2023 – Escalation meeting planned for February, at which next steps will be discussed.
February 2023 – Escalation meeting in February followed by submission of revised action plan and accompanying letter, which were subsequently considered by the Cardiac Commissioning Team. WHSSC CDG to consider recommendation status imminently. In the event that escalation level is reduced, risk level may be similarly revised.
March 2023 – WHSSC CDGB agreed that the service be de-escalated from level 3 to level 2 of the WHSSC escalation framework and will be monitored via regular Risk, Assurance and Recovery meetings.

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: 18/04/2023

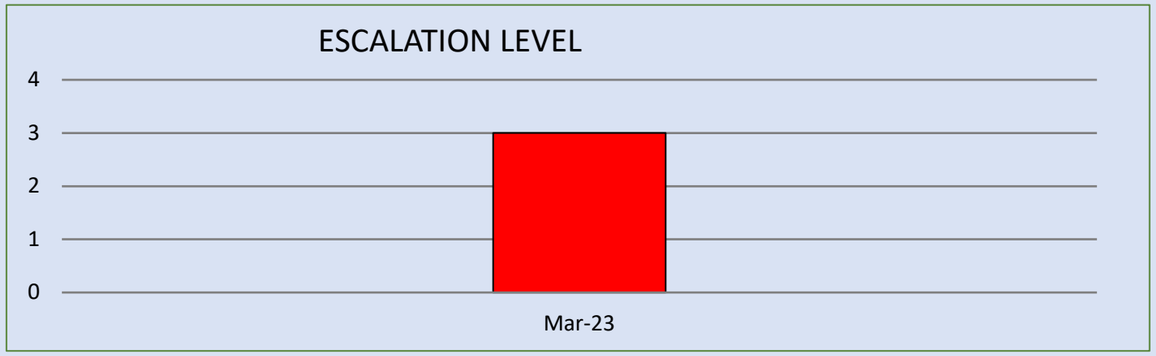
Service in Escalation: Paediatric Surgery

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ March 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	**3**

Rationale for Escalation Status :
The service has moved from escalation Level 1, 'Enhanced Monitoring', straight to Level 3, 'Escalated Measures'.

Background Information:

• Recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The current plan does not deliver contracted volumes
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

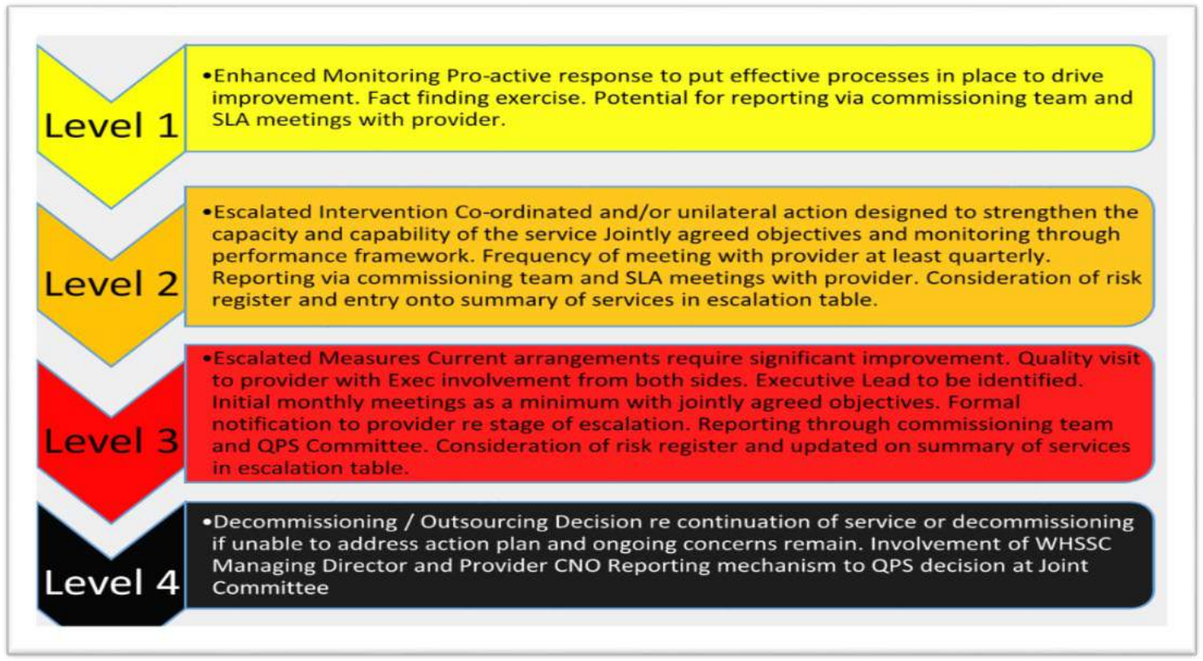
Actions:

Action	Lead	Action Due Date	Completion Date

Issues/Risks:

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

Level of escalation increasing / worsening position

Welsh Health Specialised Services Commissioning NEWSLETTER

3rd Edition, Winter 2022 - 2023

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

NHS Wales Awards 2022

This is the 3rd 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 Newsletter 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 Welsh Health Specialised Services Committee (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.

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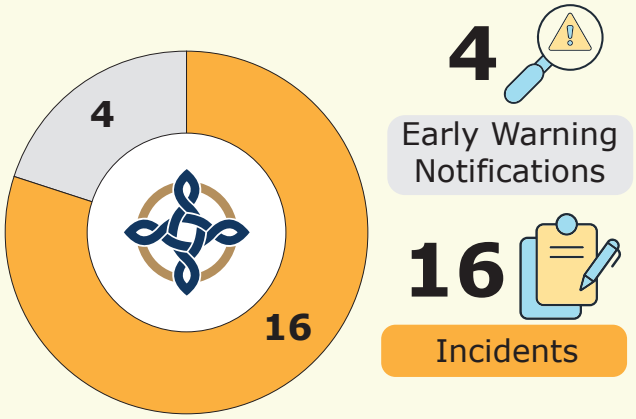
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Contents

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.

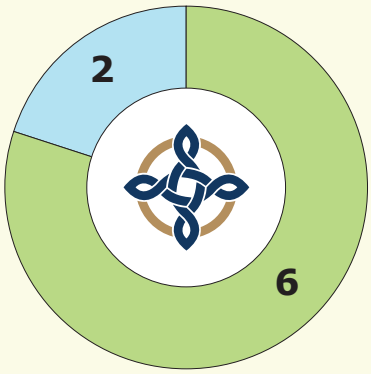
Between the periods of August to December 2022, there were ***16*** Patient Safety Incidents and ***4*** Early Warning Notifications logged.



4 Early Warning Notifications

16 Incidents

Between the periods of August to December 2022, there were ***6*** Patient Safety Incidents and ***2*** Early Warning Notifications closed.



2 Early Warning Notifications

6 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.

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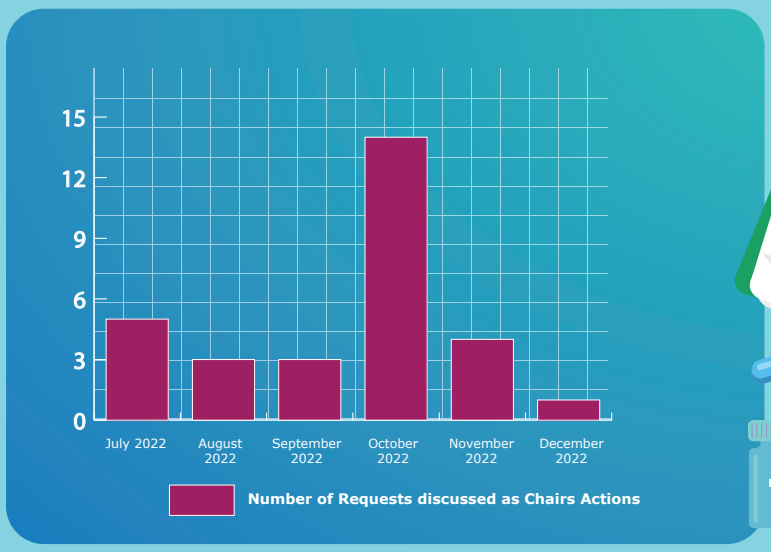
Update from the Patient Care Team IPFR (Individual Patient Funding Request)

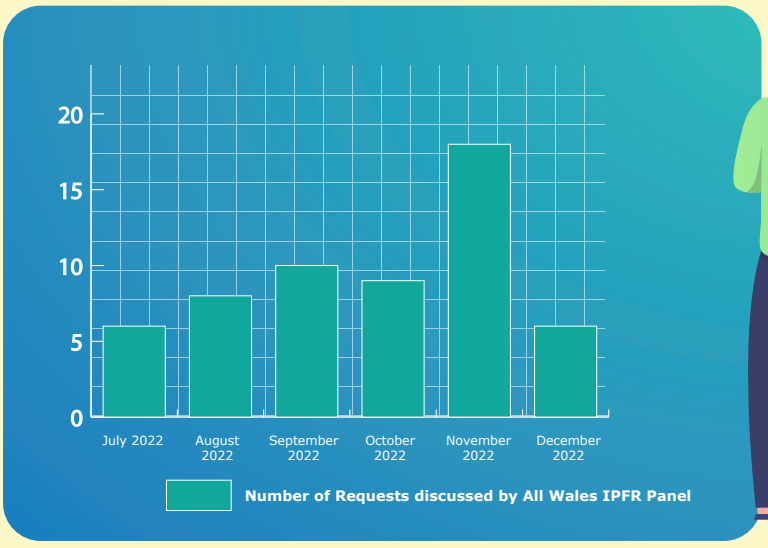
The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarters 2 and 3 2022-23:

Number of Requests discussed as Chairs Actions



Number of Requests discussed by All Wales IPFR Panel



Quality and Patient Safety Development Day

WHSSC held a virtual Quality and Patient Safety Development Day on 26th September 2022. Quality Clinical Colleagues and Independent members from across Welsh Health Boards attended.

The day was a success and featured data systems presentations from NHS England on Specialised Services Quality Programme (SSQD transition project), the data team in WHSSC who presented on MAIR, presentations from the Delivery Unit team on Nationally Reported Incidents and the Delivery Unit's role within these as well as National Quality Metrics Application (NQM App) to support consistent quantitative reporting.

NWSPP presented on the Once for Wales Concerns Management System which also featured updates on CIVICA and the work ongoing producing the platform that will be able to collate and analyse all-Wales data.

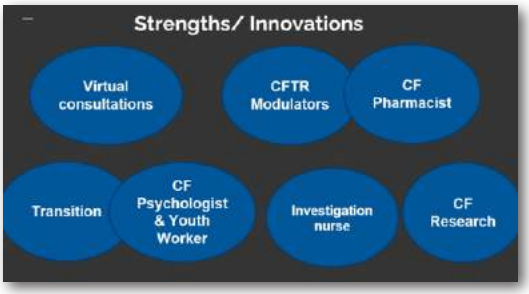
Following evaluation of the day, the following comments were given:

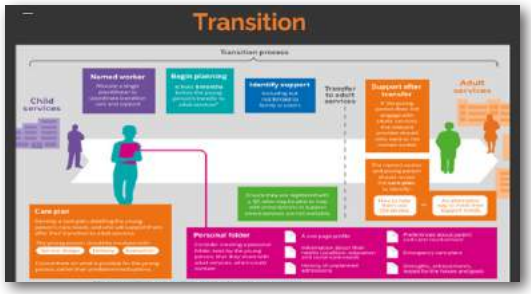
Cystic Fibrosis Service Improvement and Innovation Day

WHSSC held a Cystic Fibrosis Service Improvement and Innovation Day on 11th November 2022 at The Clayton Hotel in Cardiff. The event was attended by 50 people with participants also on Microsoft Teams.

Liverpool Heart and Chest, Alder Hey and Cardiff and Vale Adult and Paediatric teams were in attendance to showcase their excellent presentations and innovative work, with powerful patient stories featured including a patient from Liverpool Heart and Chest who dialled-in via Microsoft Teams to tell his story live!

Slides featured within the Children's Hospital for Wales Presentation:





Slides featured within the All Wales Adult Cystic Fibrosis Centre's Presentation:

Neuro-Endocrine Tumour (NETS) Celebration Event

From left to right: Yolande Mears, Dr Mohid Khan, Angela Hughes, Vicki Dawson-John, Mr Christmas

The NETS celebration took place at the Vale Resort, Cardiff on 13th October 2022. It was well attended by patients, their families, clinicians and stakeholders.

There was a plethora of patient stories that had a huge impact on the audience and it was a wonderful opportunity to network with all who attended in whatever capacity they represented.

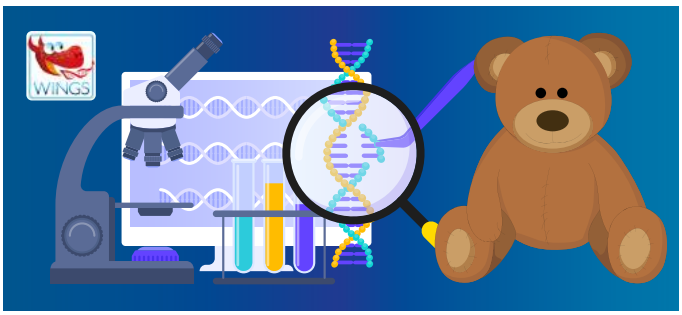
There was a focus on how the service had evolved in order to achieve a Centre of Excellence status. Representatives from this process spoke warmly and with enthusiasm, as to the great efforts made by Dr Mo Khan and his dedicated team to achieve this goal.

Congratulations to all involved!

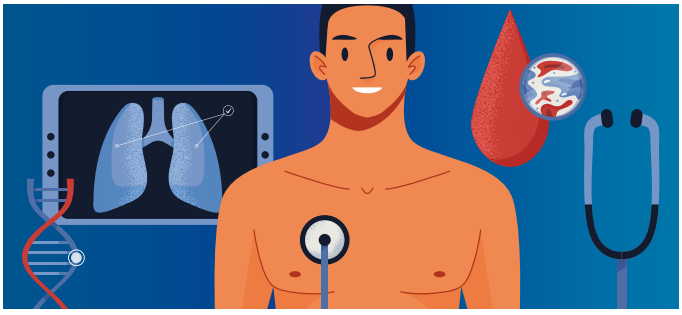
All Wales Medical Genomic Service (AWMGS)

The All Wales Medical Genomic Service (AWMGS) has produced an excellent Quarter 2 Progress Report that highlights excellent work:

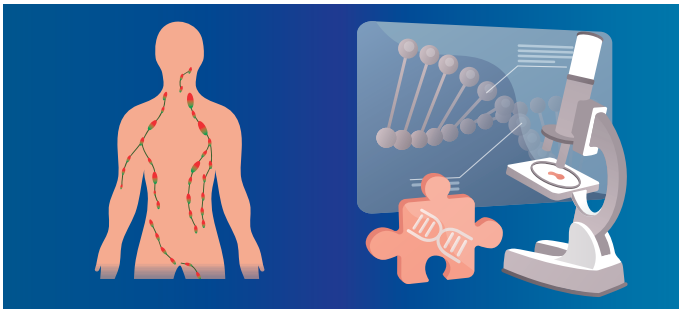
Launch of the PIK3CA Genomic Service for breast cancer in September 2022 which was followed up with an Education Event on 6th October 2022.



An update on the Wales Infants' & Childrens Genome Service (WINGS) that highlights rapid whole genome sequencing testing, diagnosis and patient outcomes.



Secured funding for a pilot to integrate a blood test into the lung cancer diagnostic pathway to accelerate access to personalised cancer treatments.



Development of the Angioimmunoblastic T-cell Lymphoma (AITCL) Service for the DNMT3A, TET2, IDH2 and RHOA genes.

The All Wales Medical Genomic Service (AWMGS) certainly deserve a massive "well-done" on their excellent work and their resulting fantastic news stories!

South Wales Adult Congenital Heart Disease (ACHD) Pilot Wellbeing Group

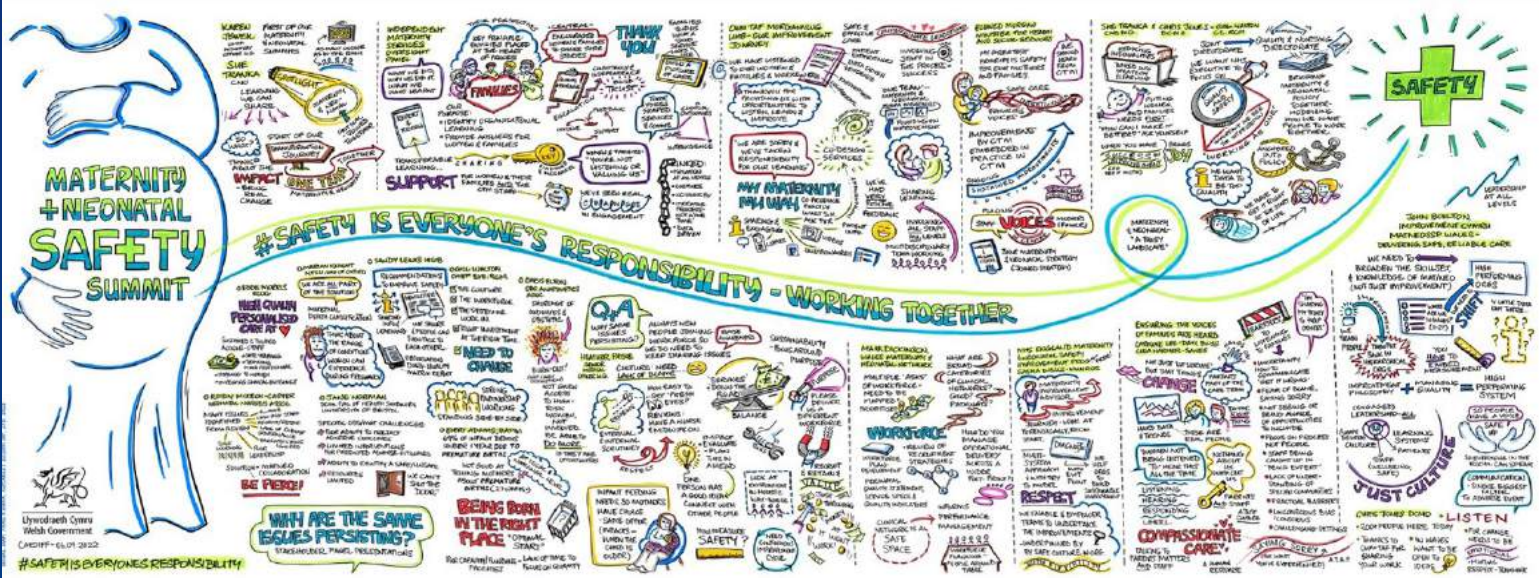
Dr Anna McCulloch and the ACHD Team recently completed a pilot wellbeing project based at the Orchard, Llandough. The project saw 10 patients with ACHD attend with some members also under the supportive care service. Patient feedback was fantastic and saw collaborations with the nursing team and with "Down to Earth" to provide the service. Dr Anna McCulloch and the Team are grateful to the Cardiff and Vale Health Charity for making it possible.

Some of the recommendations for future activity following the pilot were:

- The pilot showed the positive impact a group-based outdoor group can have on the physical and psychological wellbeing of people living with congenital heart disease.
- Patients reported finding peer support to be extremely beneficial.
- The positive outcomes highlighted the need for further group-based activities and for access to peer support.
- The team plan to run a second group, with some original members invited back to participate in a peer mentor training programme.

Maternity and Neonatal Safety Summit

Following on from our last Newsletter piece on the Maternity and Neonatal Safety Summit held on 6th September 2022, the 'Visual Minutes' map has been published that was creatively designed on the day by Scarlet Design.



Click here to be taken to the website which features the interactive 'Visual Minutes' map as well as videos from the day!






Healthcare Financial Management Association (HFMA)

The National Healthcare Finance Awards (HFMA) programme recognises the work of finance teams and individuals from across the UK.

WHSSC colleagues Kendal Smith, Richard Palmer, Dr Kerryn Lutchman-Singh, Karla Williams and some colleagues from outside WHSSC have been looking at access to, and the impact of, WHSSC interventions on our patients.

This cutting edge piece of work was recognised by the Healthcare Financial Management Association (HFMA) and the team were shortlisted for this brand new award and invited to attend the 'Celebrating innovation and excellence in healthcare finance' awards ceremony in London on 8th December 2022.

We are extremely proud to announce that the team won the Addressing Health Inequalities through NHS Finance Action award and we would like to extend our congratulations to all involved; what a fantastic achievement!

WHSSC staff Kendal Smith and Dr Kerryn Lutchman-Singh proudly displaying the award!

NHS Wales Awards 2022

Cardiac Surgical Team: Some of the Cardiac Surgical Team with the NHS Wales Award. Front row (l-r) Cardiac Theatre Scrub staff Chito Fababeir and Victoria Jobson, and Sobaran Sharma, Senior Clinical Fellow, Cardiothoracic Surgery. Back row (l-r) Mark Vernon, Trainee Clinical Perfusionist, Ian Bennett, Senior Clinical Perfusionist, Pankaj Kumar, consultant cardiothoracic surgeon and Deputy Medical Director, Morriston Hospital.

The NHS Wales Awards 2022 saw many excellent innovative projects nominated and Swansea Bay University Health Board were not only shortlisted for the Improving Patient Safety award with their submission 'Impact of implementation of an intra-operative checklist to reduce re-operation for bleeding and blood transfusion' – they went on to successfully win the award!

Quick Round up of Commissioning Teams

Mental Health

5 year Mental health strategy ongoing. Review of current services and further development of these underway.

Women and Chidren's

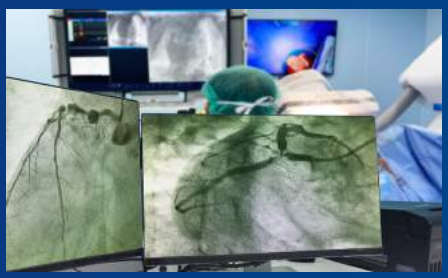
IVF Service Improvement and Innovation Day currently being planned.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic and Inherited Bleeding Disorder Service Improvement and Innovation Days are currenty 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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Recognition of Significant Events and Thank You's

"I was at Ashworth this week with Alison Cannon from NHSE. We went to every unit in the service, also met with Clinical Director and Director of ops. The general consensus from the visit is that the contact they have from the case management team from Wales is second to none. Whilst they have concerns regarding contact from particular areas in England, they feel that the only area they don't need to worry about is Wales. I also saw a number of Welsh patients whilst there and they were also very complimentary about the service you are providing. Just thought I'd share with you all."

Adrian Clarke, Assistant Director of Nursing and Quality, National Collaborative Commissioning Unit (NCCU)

"As you will know we are currently taking forward an engagement process around the WHSSC 10 year strategy. This is a really complicated piece of communications work and key to this has been inclusion on the WHSSC website and links to the Health Boards. It's been a fantastic piece of work and we couldn't have done it without our very own IT guru Laura Holborn. As ever she's stepped up and done a fabulous job and I wanted you to know how great she has been!"

Dr Sian Lewis, Managing Director, WHSSC

"I'm really proud to tell you about another great achievement by one of our WHSSC teams. We have recently been informed that the Quality Team were assessed by CTMUHB Internal Audit and were rated as providing "Substantial Assurance". This is the highest rating possible and means we are doing our core business really well. I think this is probably the 5th team in WHSSC to get substantial assurance in the last year or so, which is something we should all be very proud of! Fantastic work - well done to Adele and the team."

Dr Sian Lewis, Managing Director, WHSSC

Welsh Gender Service

The Welsh Gender Service published their second Newsletter in Summer 2022, scan the QR code below or click this link to access it!

Useful Links

Other useful links:

Welsh Health Specialised Services Committee

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Welsh Health Services Specialised Commissioning

NEWSLETTER

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

whssc.nhs.wales

Winter 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

AGENDA ITEM
3.2.6

QUALITY AND SAFETY COMMITTEE	
END OF YEAR POSITION REPORT 2022/23 – WG IMPROVEMENT GOALS FOR REDUCING HEALTHCARE ASSOCAITED INFECTIONS	
DATE OF MEETING	24/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Bethan Cradle, Lead Infection Prevention and Control Nurse
PRESENTED BY	Greg Dix, Executive Director of Nursing
EXECUTIVE SPONSOR APPROVED	EXECUTIVE DIRECTOR OF NURSING

REPORT PURPOSE	For Noting

ACRONYMS	
IPC	Infection, Prevention & Control

1. PURPOSE

1.1 This report has been prepared to provide the Committee with details of the Health Board's end of year position against the improvement goals for reducing healthcare associated infections set by Welsh Government. National surveillance is mandatory for 5 key surveillance organisms.

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	CTM did not achieve the improvement goals for reducing healthcare associated infections at the end 2022/23. Fewer cases were reported for two of the five surveillance organisms. A significant proportion of the mandatory surveillance organisms reported were community acquired infections. The IPC team do not currently provide a comprehensive service in primary care. Targeted interventions are required in primary care in order to improve patient safety and achieve the reduction expectations. Improvement work was halted in 2022/23 as the Infection Prevention and Control Team were integral to the COVID/ acute respiratory illness preparedness and response plans. Local reduction expectations will be developed for each of the acute sites/care groups based on the improvement goals for reducing healthcare associated infections in 2023/24.
ADVISE	**C Difficile** The reduction expectation for 2022/23 was a rate of 25 per 100,000 population. CTM achieved a rate of 25.34 per 100,000 population. • CTM marginally missed the reduction expectation for 2022/23. • 114 cases were reported which is 26% fewer cases compared to the previous year. • 51% of the total cases were deemed to be healthcare associated. • 30% of the total cases were GP samples. • CTM ended the period with the lowest rate of C.Difficile infection in Wales. **S.aureus bacteraemia** The combined reduction expectation for S.aureus and MRSA for 2022/23 was a rate of 20 per 100,000 population. CTM ended the period with a rate of 32.68 per 100,000 population. MRSA

- An increase in cases was reported compared to the previous year but 75% of the cases were community acquired infections.
- No preventable sources were identified for the bacteraemia.
- CTM ended the year with the lowest rate of MRSA bacteraemia in Wales.

MSSA

- A 21% increase in cases was reported compared to the previous year.
- 66% of the total cases were community acquired infection based on the date the sample was sent.
- 11% of the total cases had a preventable source and linked to a medical device/surgical site infection.

E.coli bacteraemia

The reduction expectation for E.coli bacteraemia was a rate of 67 per 100,000 population. CTM achieved a rate of 84.92 per 100,000 population.

- Despite not achieving the reduction expectation, 2% fewer cases were reported compared to the previous year.
- 69% of the cases were community acquired infections based on the date the sample was sent.
- 6% of the total cases were deemed to have a preventable source and associated with a urinary catheter.

Klebsiella sp. Bacteraemia

A 10% reduction in Klebsiella sp.bacteraemia was expected in 2022/23 compared to the 2017/18 numbers. CTM achieved a rate of 18.90 per 100,000 population.

- A 5% increase in cases was reported in 2022/23 but CTM ended the year with the lowest rate in Wales.
- 60% of the total cases were community acquired infections based on the sample date.
- 12% of the total cases were deemed to have a preventable source and associated with a urinary catheter.

Pseudomonas aeruginosa bacteraemia

	A 10% reduction in Pseudomonas aeruginosa cases was expected in 2022/23 compared to the 2017/18 numbers. CTM ended the period with a rate of 8.89 per 100,000 population. • A 38% increase in cases was reported compared to the previous year. • 57% of the total cases were community acquired infections based on the sample date. • 10% of the total cases were deemed to have a preventable source and associated with a medical device.
ASSURE	The IPC Team have a planned programme of improvement work for 2023/24 to reduce preventable bacteraemia which includes improving compliance with IPC and ANTT training. IPC huddles are arranged to discuss healthcare associated cases of C.Difficile and preventable bacteraemia but medical engagement must be improved. The learning is shared widely through IPC meetings to inform and influence practice and improve patient safety.
INFORM	A strategic review of the IPC service is planned to determine how an integrated whole system approach for IPC can be achieved/delivered across CTM.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
3.2.7

QUALITY & SAFETY COMMITTEE

REGULATORY REVIEW RECOMMENDATIONS AND PROGRESS UPDATE RELATING TO HEALTHCARE INSPECTORATE WALES (HIW) AND CWM TAF MORGANNWG LIAIS (formally known as the Community Health Council-CHC) VISITS AND REPORTS

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas, Business Manager Patient Care & Safety
Presented by	Greg Dix, Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
HIW	Healthcare Inspectorate Wales
GP	General Practitioner
CMHT	Community Mental Health Team
CIW	Care Inspectorate Wales

ED	Emergency Department
CHC	Community Health Council (since 1st April now Llais-Citizen Voice Body)
AMaT	Audit Management and Tracking

1. SITUATION/BACKGROUND

1.1 This report is based on Healthcare Inspectorate Wales activity and correspondence since the last report for committee in March 2023. Due to the bi-monthly nature of these meetings, this report will cover the 2 month period from the previous report.

An overview table has been included below in 2.1 to provide a 'summarised snapshot' of most recent activity.

All HIW Inspection activity can be accessed via the following link: https://hiw.org.uk/

This report includes updates and key messages from the former Community Health Council (CHC) now Llais, the new Citizen Voice Body.

On the 1st April 2023, CHC's in Wales were abolished and replaced by Llais, the new Citizen Voice Body for Health & Social Care.

Llais, Regional Director has an introductory meeting set up for early May 2023, to meet with the Health Board Chief Executive Paul Mears and the newly appointed UHB Chair Jonathan Morgan to provide an overview of, and introduction to, Llais.

1.2 **Llais – formally the Community Health Council (CHC) Update:** No activity to report for this time frame as no site visits by Llais (CHC) have taken place since the last report.

2.0 HIW activity 17th February-30th April 2023

HIW activity across Cwm Taf Morgannwg University Health Board:

Number of Unannounced	**0**
Number of Announced	**0**
Number of patient/staffs concerns via HIW	**1**
Number of concerns raised through Fieldwork	**0**
Number of HIW & CIW joint Reviews	**1**

2.1 **Unannounced Inspections:**

There has been no (zero) unannounced inspections since the last report to the committee in March 2023.

2.2 **Update following unannounced Inspections:**

Princess of Wales Ward 5 Stroke Ward:

HIW published the final report with the supporting improvement plan on their website as of 28th April 2023:

The report can be found by the following weblink: https://www.hiw.org.uk/sites/default/files/2023-04/20230428POWEN.pdf

2.3 **Update following Announced Inspections**

The final report following the announced inspection to an Independent Contractor GP practice in January 2023 has been published on HIW website as of 25th April 2023 and can be accessed by the following link: https://www.hiw.org.uk/llynfi-surgery on the HIW website.

Community Mental Health Team (CMHT) - Maesteg Hospital

Following the joint CMHT inspection visit by HIW and Care Inspectorate Wales (CIW) which took place with both the Health Board and Bridgend County Council on 13th and 14th December 2022, the final report and supporting improvement plan was published on 16th March 2023 and can be accessed by the following link: Maesteg Community Hospital | Healthcare Inspectorate Wales (hiw.org.uk)

2.4 **Whistle-blower Concern raised via HIW**

Healthcare Inspectorate Wales were contacted by a whistle-blower in relation to concerns over patient safety. HIW strongly encouraged the whistle-blower to contact the health board directly through the whistleblowing policy to raise their concerns directly.

The concerns raised were promptly and fully responded to within the timeframe set by HIW.

2.5 **Local Reviews:**

Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board.

Following the HIW local review of the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within CTM UHB the draft report was received for factual accuracy together with the improvement plan template. The populated improvement plan, supporting documents and a programme of improvement activity was submitted to HIW as a result of the local review. All the recommendations have been aligned to workstreams as part of the Mental Health and Learning Disability in-patient improvement programme and/or other standard workstreams as part of the revised governance arrangements in the new Care Group. As well as the oversight from the workstreams the monitoring of HIW action plans is a standing agenda item on the Care Group Quality Safety Risk and Experience Group

The final report and supporting improvement plan was published by HIW on their website as of 7th March and this can be accessed by the following link: https://www.hiw.org.uk/sites/default/files/2023-03/20230307-CwmTafLocalReview-FINAL-ENGLISH.pdf

2.6 National **Reviews:**

i. ***National Review Patient Flow (Stroke Pathway)***

As part of the National Review work plan of HIW, they decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, HIW elected to focus their review on the stroke pathway. HIW wanted to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. An overarching report of findings from all health boards across Wales will be published by HIW. The health board will not receive an individual feedback report.

It is expected that the report will be published on the HIW website during the Spring 2023

ii. National Review of DNACPR Practices/ Processes

Following the update to the last Quality & Safety meeting regarding the HIW review to examine the use of DNACPR orders across Wales which commenced in January 2023, HIW have written to the health board Chief Executive and Chair to inform them that during the early stages of HIWs scoping and planning, HIW were made aware that plans were already in place for a national thematic review to be carried out by the Mortality Review (MR) Group, co-ordinated by Julie Rix, Patient Safety Manager within the NHS Wales Delivery Unit. Consequently, HIW made a decision to temporarily pause their DNACPR review whilst they take time to understand the full scope of the MR thematic review, to ensure any work undertaken by HIW will be complementary.

HIW informed the health board that they will in time recommence the review, and in doing so will share a Terms of Reference to all stakeholders, outlining their proposed plans for this work. In the meantime, HIW will review all the evidence which was submitted to them following their request in January as part of the initial information request for this review. This information, along with HIWs understanding of the MR thematic review, and the survey responses to date, will help them to refine the scope and future planning of this important piece of work.

HIW thanked the health board and its teams for our contribution and support with their work during its early stages and advised that they will be in touch again in due course.

Child Protection Rapid Review – April 2023

Following the publication of a Child Practice Review in November 2022, the Deputy Minister for Social Services, Julie Morgan MS requested Care Inspectorate Wales (CIW) to lead a rapid review of decision making in relation to child protection.

The overarching objective was to determine to what extent the current structures and processes in Wales ensure children are appropriately placed on, and removed from, the Child Protection Register when sufficient evidence indicates it is safe to do so.

Following receipt of the request from HIW regarding the joint review work with Care Inspectorate Wales and other agencies, a number of documents were provided to HIW in order to support their review, these were submitted in line with the timeframe set by HIW.

Initial verbal feedback has been shared with the Head of Safeguarding with the formal response awaited; it is noted that the survey link which has been shared with relevant staff members working within the field of child protection, such as school nurses, health visitors, midwives, paediatricians, CAMHS staff and safeguarding leads does not close until 5th May 2023.

An overall report on the findings will be prepared and published noting that there will not be individual health board reports published.

Further updates will be provided to future meetings and shared with the Safeguarding Executive Committee and Safeguarding Board.

Audit Management and Tracking system (AMaT)

Further work is being scoped to use the AMaT system to capture the actions arising from HIW activity to allow themes and trends to be identified and allow one dedicated space to capture oversight of HIW actions/ recommendations across the Health Board. Following all HIW inspections, the subsequent improvement plans are being closely monitored on a monthly basis via a centrally held tracker, which is in addition to all HIW inspection activity being included as a standing agenda item on the care groups quality, safety & patient experience governance meetings

3.0 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

For assurance the governance, monitoring, scrutiny and oversight of improvement plans in relation to HIW inspections and all service reviews are maintained without interruption within the new Care Group Model.

4.0 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Subject to the findings and outcomes of the HIW reviews.
Related Health and Care standard(s)	Staff and Resources
	All of the Healthcare Standards Governance, Leadership & Accountability Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.

	Report for information on HIW activity No service or staff impact in direct response from report, this is considered through the improvement action plans Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Subject to the findings and outcomes of the HIW reviews
Link to Strategic Goals	Improving Care

5.0 RECOMMENDATION

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

AGENDA ITEM
3.2.8

QUALITY & SAFETY COMMITTEE

CANCER SERVICES ANNUAL REPORT

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Keryn Jones – Senior Cancer Manager David Williams – SCP improvement Manager Dawn Casey – Macmillan Lead Cancer Nurse Rhian Collins – Macmillan AHP lead for Cancer
Presented by	Dom Hurford, Executive Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
SCP	Suspected Cancer Pathway
CWT	Cancer Waiting Times
PTR	Putting Things Right
HB	Health Board
OPA	Outpatient Appointment
MDT	Multi-Disciplinary Team
HEIW	Health Education and Improvement Wales
CNS	Clinical Nurse Specialist
WCISU	Welsh Cancer Intelligence and Surveillance Unit

1. SITUATION/BACKGROUND

1.1 This report provides an annual update on cancer services across CTMUHB.

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

2.1 Impact of non-compliance with the suspect cancer waiting time measure.

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

3.1 Continued failure to meet the suspected cancer waiting time performance measure.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Additional funding will be required to meet current cancer waiting time performance target
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

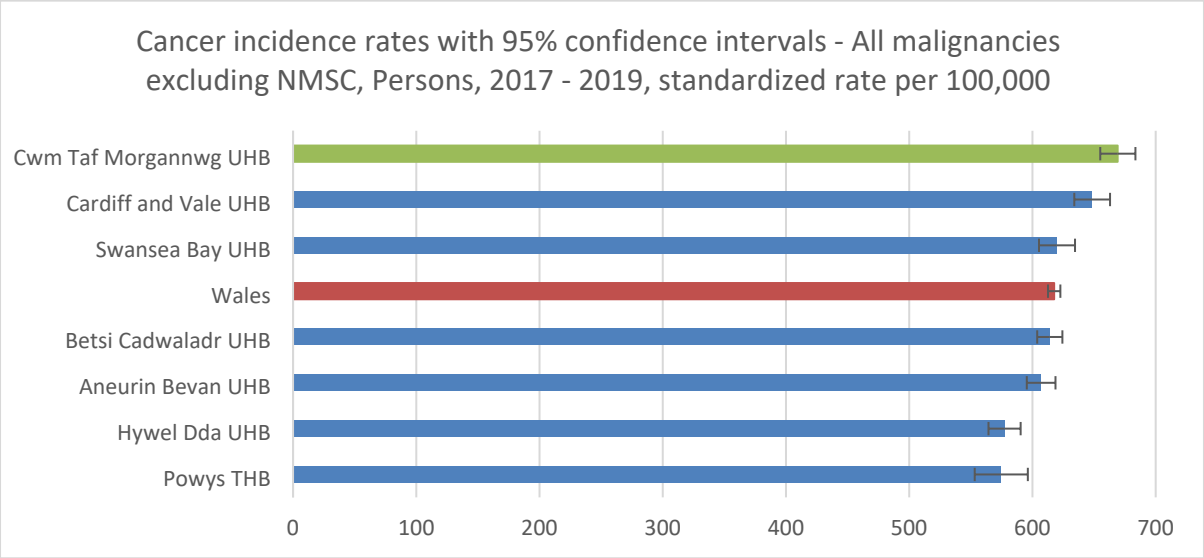
5.1 The Committee are requested to **NOTE** the contents of this report.

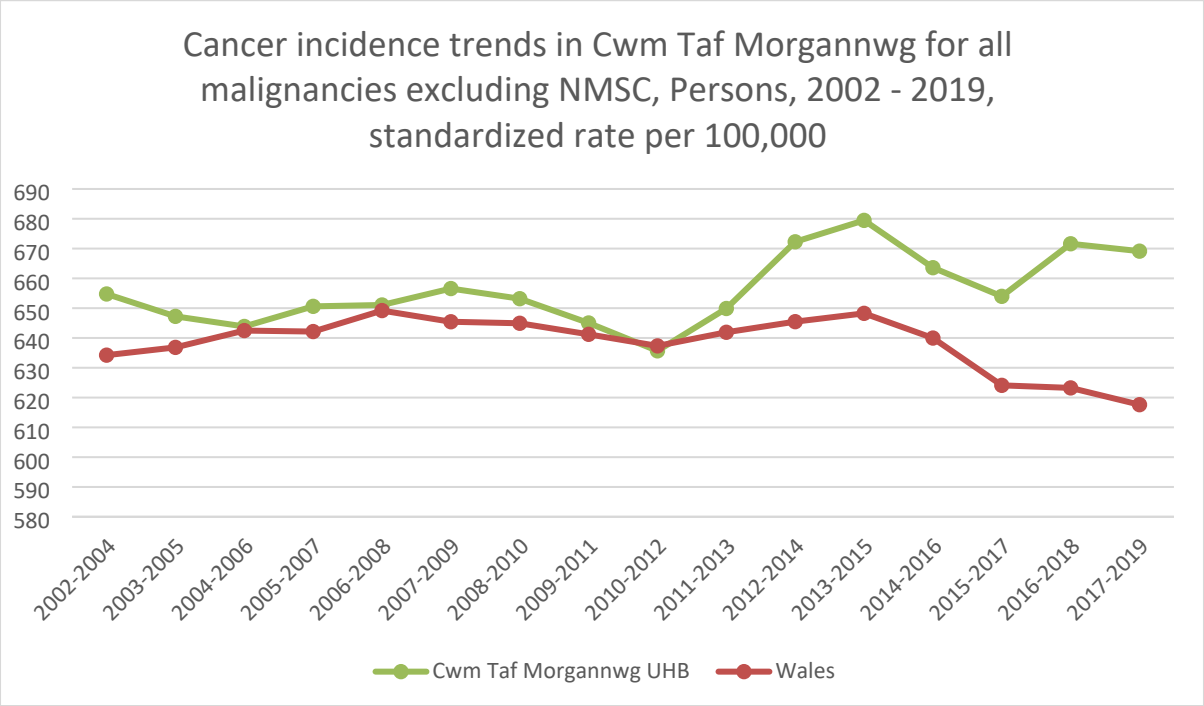
Annual Cancer Report 2022/2023

1.0 Introduction

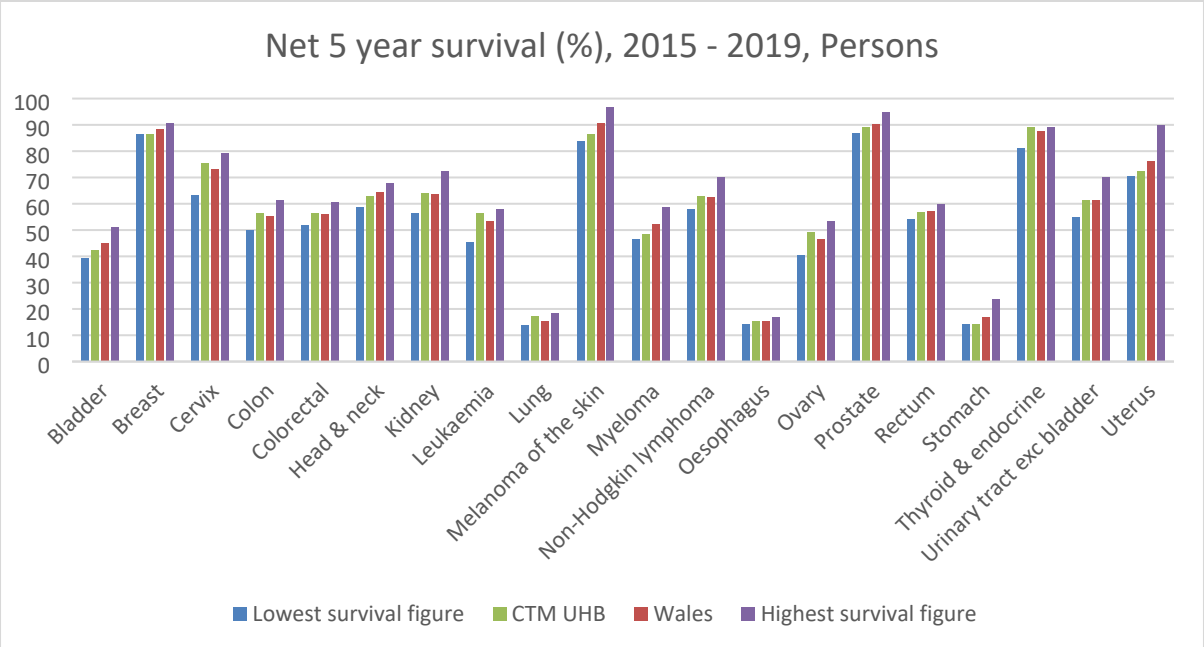
This annual report provides an overview of the challenges faced by our cancer teams, in delivering the National Optimal pathway in this post Covid era and our progress made during this period.

2.0 Cancer landscape across CTMUHB

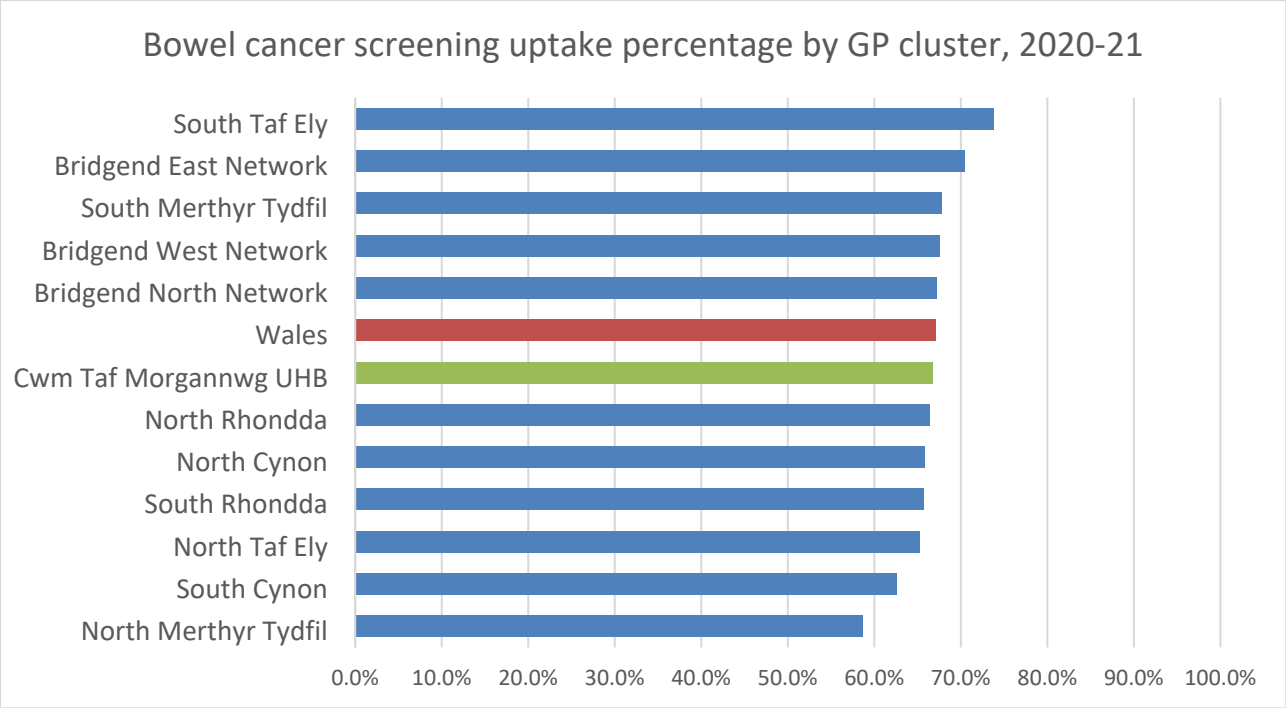




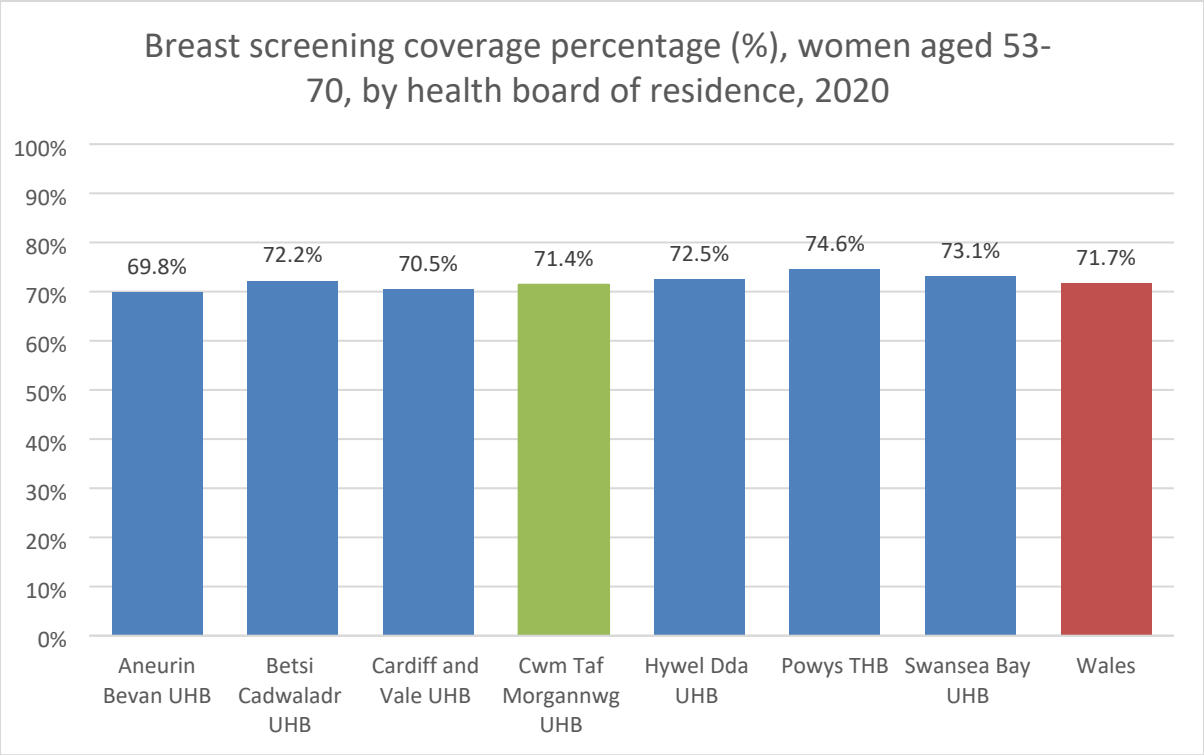
Each year around 3,500 people across CTMUHB are diagnosed with cancer. Cancer incidence has remained at a higher rate in CTMUHB than for Wales, with the rate for Wales decreasing since 2015.



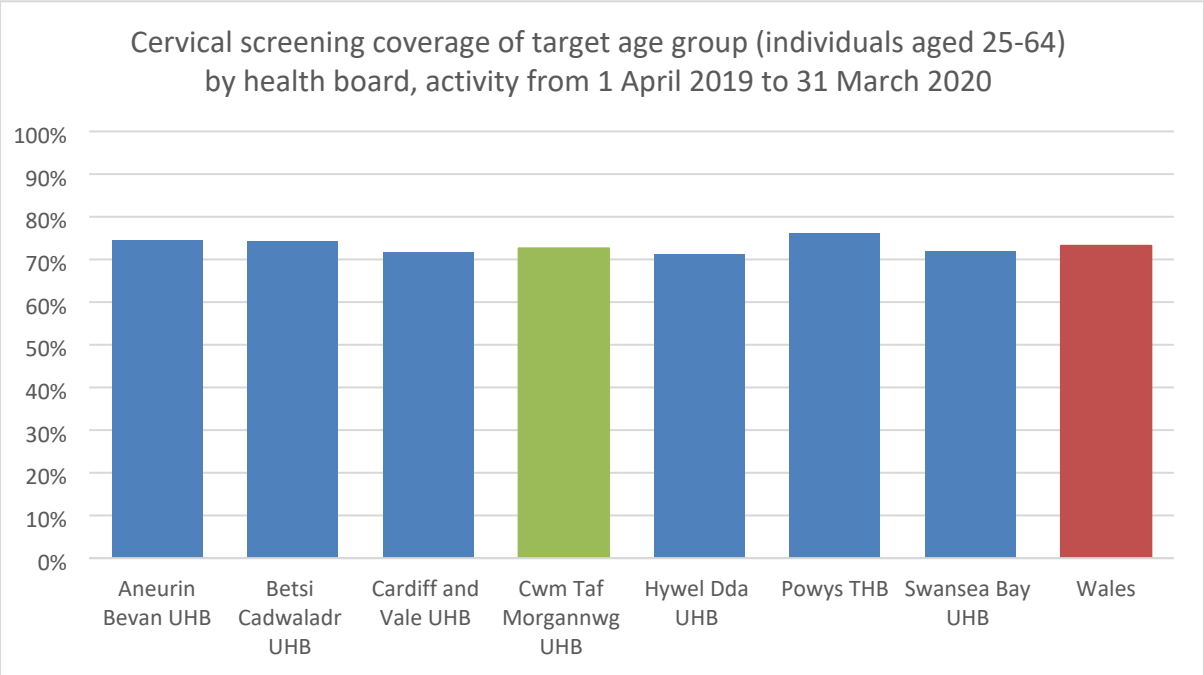
In the latest published cancer survival figures from WCISU one-year and five-year cancer survival increased across Wales for many commonly diagnosed cancer types such as lung and prostate. However, there has been a levelling off and even a decrease in recent years for other cancers such as bladder, anus, larynx and uterine.



Bowel screening threshold has been lowered and expanded to include 55 - 57 year olds in October 22. CTMUHB had 62.1% uptake overall for BSW. Variations of uptake is evident across GP clusters.



The uptake of breast screening across Wales is slowly declining, which is leading to a fall in coverage over recent years. Nevertheless, coverage remains above the 70% standard for nearly all health boards.



The cervical screening coverage across Wales, exceeds 70%. This figure combines the proportion of 25-49 year olds screened in the previous 3.5 years, and the proportion of 50-64 year olds screened in the previous 5.5 years.

3.0 Performance

Whilst now stabilising, cancer services within CTMUHB have been challenged via the ongoing impact and recovery of Covid – 19.

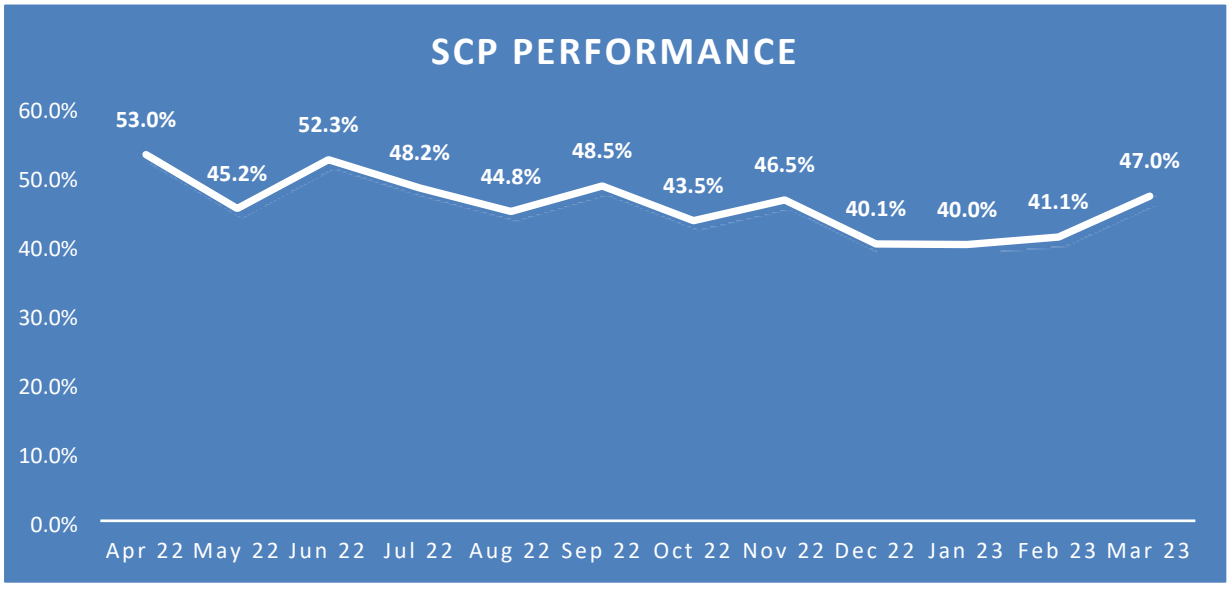
3.1 Referrals

Referral numbers have increased by 6.5% over the last 12-month period compared to the previous 12 months. All main tumour sites except urology have experienced an increase in volumes, although the amount varies between tumour sites. This position is mirrored across Wales.

Tumour Site	Apr 21 - Mar 22	April 22 - Mar 23	Vol Diff	% Diff
Brain	41	22	↓19	↓47
Breast	4632	4853	↑221	↑5
Children	26	20	↓6	↓23
Gynaecology	3990	4413	↑426	↑10
Haematology	410	536	↑126	↑24
H&N	3374	3490	↑116	↑3
Lower GI	5150	5436	↑286	↑5
Lung	1207	1256	↑49	↑4
Other	3839	3584	↓255	↓7
Sarcoma	32	25	↓7	↓22
Skin	4039	4785	↑746	↑15
Upper GI	2380	3229	↑849	↑26
Urology	4332	4118	↓214	↓5

3.2 Cancer Performance

The current CWT target is 75% with the plans to increase it on hold.



**March performance unvalidated*

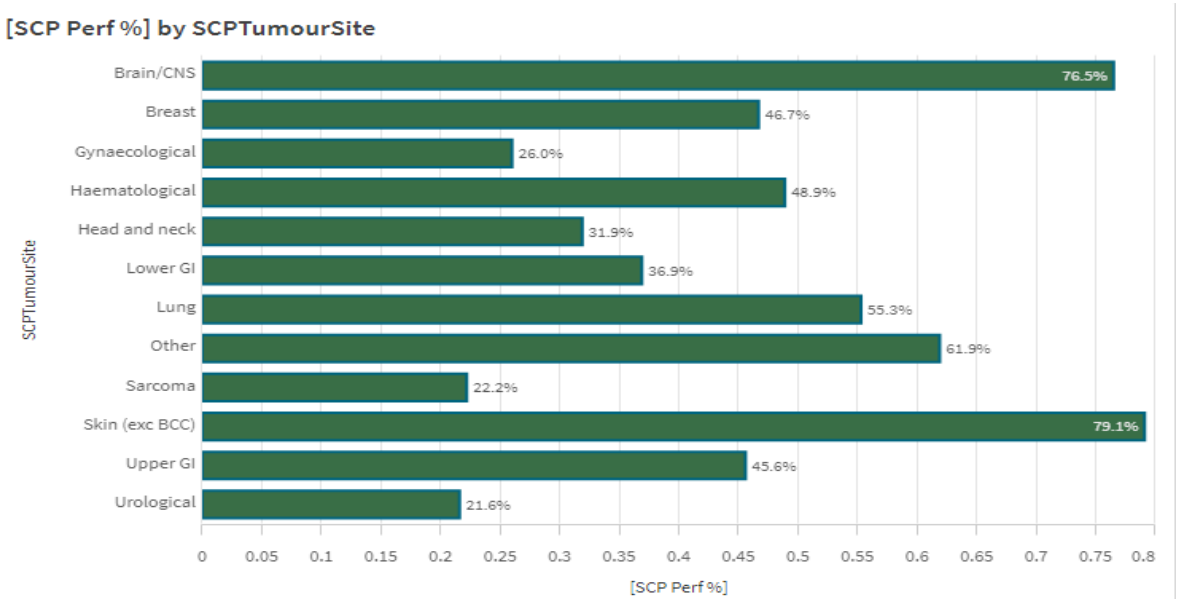
CTMUHB has not achieved the SCP CWT target in any month over the last 12-month period.

In November 2022 concerns surrounding quality and patient experience were raised by the Minister for Health & Social Services in a number of areas within the HB, cancer being one. Subsequently cancer was placed in targeted intervention.

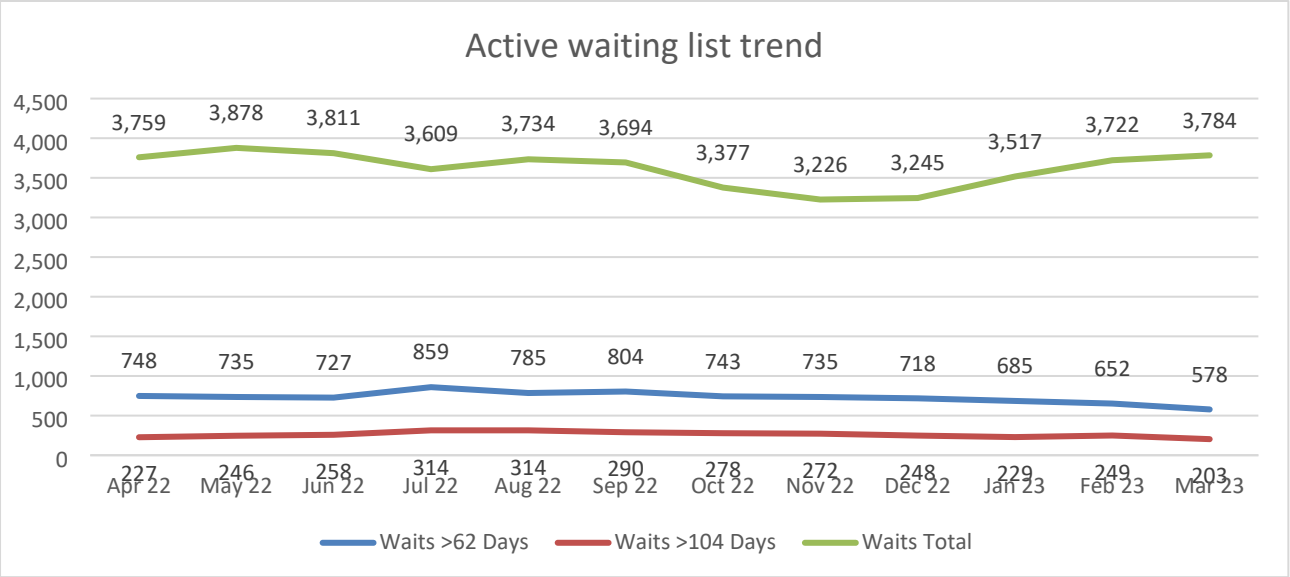
In January 2023, the HB had the worst performance on record.

In comparison to all other acute HB's throughout Wales, CTMUHB consistently has the poorest performance.

Apr 22 - Jan 23	Column1
HB	**SCP Performance**
AB UHB	54.70%
BC UHB	63.80%
CTMUHB UHB	45.80%
CV UHB	56.20%
HD UHB	47.10%
SB UHB	53.10%
All Wales	54.30%



The only tumour site to achieve the SCP CWT target is skin (in 7 out of the 11 months). All other tumour sites have failed to achieve it; although performance varies, as illustrated above.



The total volume of patients on the waiting list, showed a reduction until November 2022. Since then, a monthly increase has been seen.

Backlog clearance has been the priority following the ministerial cancer summit in Sept 2022. As illustrated, this has been achieved.

In comparison to all other acute HB's throughout Wales CTMUHB are ranked 5th in having the highest volume of active patients on the SCP.

The biggest concern and most significant factor in not achieving target, consistently relates to the total number of active patients at 1st OPA and diagnostic stage, accounting for 82% of the entire waiting list.

Bottlenecks specifically at radiology, endoscopy and pathology account for the bulk of the diagnostic challenges.

Fundamental to improving cancer performance is investment in diagnostics and the continuation of backlog clearance.

3.3 Cancer Recovery

Individualised cancer recovery plans have been developed and submitted via the service groups. Immediate operational recovery plans are focusing on the following areas:

- Increasing Straight to Test,
- Embedding the National Optimal Cancer Pathway,
- Reducing outpatient and diagnostic waits,
- Increasing workforce,
- Collaborative working with primary care and regional centres,
- Merging of Multi-Disciplinary Teams,
- Increased engagement and usage of informatics,
- Increased focus on validation and escalation at all pathway stages,
- Ensuring that all cancer activity is prioritised within overall speciality delivery.

4.0 Quality Assurance of Cancer

4.1 Quality Assurance Framework

The quality assurance framework has continued to develop. There has been agreement around frequency of reporting and method of presentation for several outcome measures. The informatics team have developed a dashboard to present the routinely collected measures. This is automatically populated, making the process more efficient.

Work is underway to capture the qualitative elements more effectively. An initial set of data has been collected. Further development is required to refine the data, method of collection and presentation of these.

We have also been able to progress a method of capturing and reviewing patients' deaths whilst waiting for treatment. This data will act as assurance that no patient is coming to serious harm whilst waiting for a diagnosis.

4.2 Cancer Harm reviews

Cancer harm reviews were introduced within CTMUHB in quarter 4 of 2019 as a pilot. As a result of the work that CTMUHB and Betsi Cadwaladr University Health Board (BCUHB) had undertaken, Welsh Government trialled them across Wales, in 2021. Welsh Government have subsequently extended the reporting period from 104 days to 146 days. The CTMUHB standard operating procedure (SOP) has recently been adjusted to reflect this.

As a result of the organisational structure changes, two of the harm review panels are paused and we are moving to a single HB wide panel, supported by a full-time administrator, and nominated individuals at each site. As the new structure embeds these changes will be implemented.

Below is the breakdown of review outcomes since the process started;

Level of harm	No/Low	Moderate	Serious
Total	558	9 (4 potential downgrades)	2

4.3 Ongoing reviews of CTMUHB corporate cancer risk

As described earlier, there has been considerable pressure on cancer services to deliver the suspected cancer pathway and there has been a failure to meet those targets. The overarching risk score for cancer is reviewed regularly and remains at 20.

4.4 National peer review programme

The HB has contributed to the national Radiotherapy peer review as service users.

4.5 Welsh Cancer patient experience survey published

The third Wales Cancer Patient Experience Survey (WCPES), was published this year. Whilst some of the responses are comparable to previous surveys, many questions have been changed. Responses were collected from October 2021 to February 2022, for patients treated between 1st January to 31st December 2020, during the height of the COVID-19 pandemic.

There were 6259 responses across Wales, and over 800 responses from patients in CTMUHB (a response rate of 60.5%). It is worth noting that overall, across Wales there is very little variation in results and this is a testament to how closely the health boards worked together throughout the pandemic to deliver cancer services.

Despite the pandemic, there is very little difference in the overall satisfaction score compared to previous surveys. The overall rating of care for CTMUHB was 8.76 slightly higher than the All-Wales average 8.67.

The HB will be actively involved in the development of a Wales wide action plan, working with the Welsh cancer network. A local action plan is also being produced by the Macmillan Lead Cancer Nurse and Macmillan AHP Lead for Cancer

Areas of focus locally will be;

• Reviewing information and support pathways; ensuring our information is simple, easy to understand and accessible. We are currently working on a Cancer internet site.

• Continuing to work with cancer site teams on the provision of a point of contact, holistic needs assessment and signposting to support services.

• Supporting the Wales Cancer Network and HEIW to review the CTMUHB Nursing and AHP workforce to assess gaps and needs including the appropriate skill mix to support cancer patients.

• Improving secondary care communication with primary care through standardised pathways.

5.0 Workforce

5.1 Macmillan partnership

The Macmillan partnership meetings continue and CTMUHB have been successful in securing the following funding from Macmillan over the last year.

- 1x 8a Cancer clinical psychologist (to be recruited)
- 1 WTE band 7 Secondary breast clinical nurse specialist (recruited)
- 1 WTE band 6 CNS +1 WTE band 4 support workers for haematology (to be recruited)

The HB has been actively involved in working with Macmillan on a project in conjunction with the Coalfields regeneration trust. This project is looking to support people living within the Coalfields areas who are on a cancer pathway.

5.2 Teenage cancer trust partnership

CTMUHB have been working collaboratively with the teenage and young adult unit, and Aneurin Bevan university health board to develop a regional clinical nurse specialist role. A Teenage cancer Trust outreach nurse has been recruited and has already provided improved support for this patient group.

5.3 Tenovus call back service

CTMUHB have been working collaboratively to initiate a clinical nurse specialist call back service for our patients. This service will be provided by experienced CNS (employed by Tenovus cancer care) and offers patients six supportive phone calls. It will provide additional emotional support and reassurance for these patients. Enhancing their experience and providing an additional level of monitoring for patients post treatment or whilst they wait for treatment. The Welsh cancer network will be using this as a pilot of how to offer support to individuals whilst they wait.

5.4 Hepatocellular carcinoma clinical nurse specialist regional posts

Cardiff and the Vale have received funding to provide a Hepatocellular carcinoma CNS service across south Wales. We have worked collaboratively across the region and the posts are now filled.

5.5 Malignancy of unknown origin/cancer of unknown primary (MUO/CUP) CNS

As part of the South East Wales regional business case for acute Oncology service, a CNS has been appointed to support patients with MUO/CUP. We have been working closely with them as they develop the service. Initial feedback is very positive.

5.6 MDT Coordinators and Information Assistants

All existing temporary and fixed term posts have been made substantive, providing job security and assurance to staff.

6.0 Improvement and innovation

Improvement and innovation are crucial in reducing variation across our system and in making strides forward to improve our cancer outcomes. Recently completed and ongoing work streams and projects to support our aims include:

- A business case has been submitted and approved for an additional permanent endoscopy theatre on the existing PCH site. This will assist with training and provide a sustainable solution to current and anticipated future demand. Completion is scheduled for 2024 / 25. Investment is required to increase the establishment to meet the needs of the new unit. Multiple models have been drafted to appoint with agreed establishment in readiness.
- The British Airways site near the Royal Glamorgan Hospital has been procured to provide a regional diagnostic site.
- Tele-dermatology, which is currently live in Princess of Wales is planned to be expanded across CTMUHB.
- Patients previously sent to Cardiff & Vale for Head & Neck free flap procedures have been repatriated to CTMUHB.
- Business Intelligence improvements have been made in line with Cancer Network's specifications. Ongoing Business Intelligence improvements will continue to be made in line with service needs. Additionally, automated data writing has been implemented between the data warehouse and WPAS cancer tracker for diagnostics.
- The CANISC replacement Programme is ongoing with guidance from both the Cancer Informatics Programme SRO and Chief executive of Public Health Wales to implement for all tumour sites by the end of Q2. Breast is the pilot with implementation in May 2023. Necessary changes via DHCW, MDT's and MDT lead job plans are being worked through to facilitate this implementation.
- 'C the Signs' has been live across primary care in CTMUHB since September 2022. The system uses artificial intelligence, mapped with the latest National, regional and local guidelines and research to accelerate the early identification and management of patients at risk of cancer. This 12-month pilot is now entering the evaluation phase.
- The lung health check pilot work (to improve early detection of lung cancer) is progressing and recruitment started. There are detailed discussions ongoing with ICT and INHEALTH; the confirmed service.
- Colorectal cancer strategy 2030 commenced with high degree of agreement across primary, secondary (hospital and specialist services), community and the third sector organisation. Key challenges and priority areas established, with further progress expected following the reconfiguration of services.

- Implemented EBUS service provision for Bridgend residents to access Royal Glamorgan Hospital service within existing capacity.
- Investment in Trans Nasal Endoscopy equipment to provide this diagnostic in an outpatient setting, which releases endoscopy suite capacity for additional procedures.
- Implemented accelerated imaging in March 2023 meaning patients with suspected cancer following endoscopy will have their radiology diagnostics fast tracked.
- Implementing roll out of FIT pathway in line with latest Cancer Network guidance.
- Working on increasing straight to test across a number of pathways.
- Merging the Urology MDTs to increase sustainability and enable clinical learning across CTMUHB.
- The Breast MDT have signed up to the Improvement Cymru improvement programme using Toyota improvement methodologies to improve the first 28 days of their pathway. This work will continue throughout 2023.
- The new Breast Unit opened on the Royal Glamorgan site in February 2023. The medium term intention is to bring Bridgend locality activity into the Unit.
- Introduction of Gynaecology one/two stop. Disestablishment of the SLA with Swansea Bay UHB to increase efficiency and sustainability and provide equity of service across CTMUHB.
- Expansion of the bowel cancer awareness schools programme of the Moondance Cancer Initiative to 8 high schools across Rhondda Cynon Taf. The programme educates children in the sign and symptoms of Bowel Cancer and looks to encourage parents/carers to take part in screening opportunities.
- Partnership working between the Macmillan information and support Service and the HB PALS team to increase awareness of support available to cancer patients and their families.
- Prehabilitation – Prehabilitation service offered to patients in Bridgend with a Colorectal and Upper Gastrointestinal malignancy that require surgery. Prehabilitation steering group established to develop service further to ensure equity across health board and cancer sites.

7.0 Challenges

There are a number of long standing challenges across the HB.

- Achieving the SCP target which is largely attributed to the increased volume of demand and capacity shortfalls in key diagnostic areas,
- Providing a sustainable endoscopy service. Significant changes to process internally are underway along with working collaboratively with the National endoscopy programme. The latter has identified that across the HB there is a shortfall of 6 procedure rooms. A business case has been developed which will provide a 3rd theatre. The workforce model has been approved with recruitment scheduled for Q1. This will facilitate 3 day session working and sustainability. Implementation is planned for 24/25.
- Providing a sustainable pathology and radiology service. Collectively this relates to workforce, capacity and demand with both internal and regional solutions required to resolve. The latter forms part of the Welsh cancer improvement plan.
- Achieving backlog clearance in line with target trajectories.

A significant amount of work has been undertaken with our informatics department to reconfigure trajectories for both backlog clearance and achievement of the SCP target over the next 12 months. These have been approved, submitted and agreed by WG.

AGENDA ITEM
3.2.9

QUALITY & SAFETY COMMITTEE

RADAR COMMITTEE REPORT

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report

Prepared by	Dr Richard Jones, Clinical Lead for Resuscitation and Acute Deterioration Vanessa Jones, Acute Deterioration Lead Bethan Harding, Resuscitation Manager
Presented by	Dr Dom Hurford, Exec Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
RADAR committee	20/03/2023	NOTED

ACRONYMS	
NEWS	National Early Warning Score
RADAR	Recognition of Acute Deterioration and Resuscitation

SITUATION/BACKGROUND

1.1 The purpose of this report is to provide the Quality and Safety Committee with an overview of governance and activity across CTMUHB of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) over 2020-2023.

1.2 The attached annual RADAR report (appendix 1) describes the CTMUHB approach to Acute Deterioration and Resuscitation with reference to:

- The governance infrastructure in place and progress in the Recognising Acute Deterioration and Resuscitation programme.

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

To note the Governance and quality response:

2.1 Structures

2.1.1 The improvement in CTMUHB governance arrangements since 2019 with the formation of the Recognition of Acute Deterioration and Resuscitation Committee (RADAR) and local (previously ILG) RADAR subgroups.

2.1.2 Recognition of the impact and progress made with the Acute Deterioration (AD) programme through the appointment of a Clinical Lead (medical) and an AD Lead (nursing).

2.1.3 The essential role of the Critical Care outreach team and the progress made towards establishing 24/7 service equity on all the acute sites across CTMUHB.

2.2 Acute Deterioration Processes

2.2.1 Updating and embedding NEWS Cymru to have a structured and unified approach across CTMUHB in all clinical areas to allow rapid objective detection of deterioration.

2.2.2 Awareness of our NEWS and Escalation Procedure that provides best practice guidance to health care professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

2.2.3 The introduction of a new Sepsis Screening tool via the Sepsis improvement work plan and the Sepsis Working group

2.2.4 Adoption of the All-Wales Treatment Escalation Plan (TEP) as a response to linked work with mortality reviews, where appropriate escalation and de-escalation have been issues in the identified themes.

2.3 Outcomes and assurances

2.3.1 The establishment of audit and feedback processes to monitor and improve performance e.g., NEWS Cymru compliance audit, analysis of Rapid Response and Cardiac Arrest calls to assess the effectiveness of identification, escalation, and response to acute deterioration within CTMUHB

2.3.2 Standardisation of Rapid Response emergency calls throughout CTMUHB.

2.3.3 Progress with the establishment of 24/7 Critical Care Outreach (CCOT) services on each acute site: - Services are now 24/7 at Royal Glamorgan Hospital (RGH) and Princess of Wales (POW). Prince Charles Hospital (PCH) is currently at 12/7 service which is anticipated to become 24/7 following the induction of newly recruited staff by May 2023.

2.3.4 Establishment of standard operating procedures for CCOT.

2.3.5 Compliance with Welsh Government Sepsis Guidelines 2017.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Structural

3.1.1 The continued work of RADAR and progress with acute deterioration management within the health board posts is at risk as funding for these two key posts (2.1.2) was identified until March 2023. These posts are now at risk in this financial year. Recurrent funding needs to be identified for Acute Deterioration and Resuscitation Medical and Nursing leads.

3.1.2 Critical Care Outreach teams being pulled/redeployed to cover other areas impacting on

- clinical rapid response to the acutely deteriorating patient and severe sepsis.
- education and training for Sepsis+ NEWS Cymru,
- measurement/audit of sepsis compliance.

3.1.3 Lack of dedicated accommodation for training in NEWS, Acute Deterioration, Sepsis, Rapid Response and resuscitation

3.1.4 Ongoing administrative support for local RADAR meetings.

3.1.5 Need to integrate RADAR into new Care Group governance processes.

3.2 Process/Outcome

3.2.1 Pace of progress limited by the current resource for acute deterioration.

3.2.2 Implementation barriers as staff not being able to attend training due to current workplace pressures

3.2.3 Barrier to compliance due to clinical pressures - 80% of suspected sepsis cases are located in our Emergency departments and Admission Units. Pressures in these areas make timely delivery of care and documentation of care a challenge

3.2.4 Need for IT infrastructure support to create a digital NEWS and Sepsis tool

3.2.5 Inability of clinical teams to visualise data collected around compliance. Need for Performance and Informatics resource / time to develop a real-time dashboard for frontline staff, senior clinicians and governance groups.

3.2.6 Need for Communications support to promote implementation, engage all staff groups and to advertise good practice.

3.2.7 Need for AMaT support to digitise Resuscitation Trolley Audits

3.2.8 Clinical pressures continue to impact on attendance at training. The Did not Attend (DNA) rate of all resuscitation training currently is 20%.

3.2.9 Electronic Staff Record (ESR) barriers to matching the revised training matrix to staff resuscitation competencies.

3.2.10 The 'train the trainer' approach has increased demand on training equipment e.g., manikins, and training Defibrillators.

3.2.11 Increased training demand for new areas/changes within the health board e.g., HMP Parc, Powys, Dental boundaries has not been met with an increase in training staff.

3.2.12 Barriers to enrolling in the National Cardiac Arrest Audit which would give us comparable data to benchmark our systems and training with national peers.

4 IMPACT ASSESSMENT

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

5 RECOMMENDATION

5.1 Quality & Safety Committee are asked to:

- **NOTE** the content of this report.
- **RECOGNISE** the role of a RADAR Clinical Lead and an Acute Deterioration Lead to drive improvement in this area.
- **RECOGNISE** the essential role that the Critical Care Outreach teams have in both the response to Acute Deterioration and in delivering education to reduce the impact of Acute Deterioration on the patient and on the Health Board.
- **RECOGNISE** the importance of good quality training in Resuscitation to ensure as good an outcome as is possible following Cardiac Arrest.

RADAR COMMITTEE

Cwm Taf Morgannwg

University Health Board

Annual Report

2022

What will this Annual Report tell you?

Our Annual Report provides you with information about the Recognition of Acute Deterioration and Resuscitation (RADAR) Committee within Cwm Taf Morgannwg University Health Board (CTMUHB), what we do and how we work across the organisation to ensure quality and governance in patient care and safety, and what we plan to do to deliver and continually improve healthcare education, in order to meet changing demands and future challenges.

It provides information about our performance, achievements to date and what we intend to do to build on these.

Contents

Introduction and Background

RADAR Context in Wales.

Health Services in Wales continue to deliver the vision, ambition and approaches that are needed to deliver *'A Healthier Wales'* (1). The demand for services, increasing health and wellbeing inequalities, higher public expectations, the additional challenges due to the impact of COVID-19 on health and social care services, as well as the possibilities that new and emerging medical and digital technologies offer, are set against a backdrop of changing demography, recruitment and resource challenges as healthcare services reset and recover.

Context in CTMUHB

Background

In 2019 CTMUHB received a (Ref 1) Peer Review of Acute Deterioration Services report with a set of recommendations regarding areas for improvement.

The Peer review of Acute Deterioration Services is both a quality assurance and quality improvement programme that assesses the quality of the service being delivered by multi-disciplinary teams and local health boards in Wales. This assessment is set against a framework of local and national guidelines, Patient Safety Alerts and the overall Health and Care Standards for Wales and is underpinned by the principles of Prudent Healthcare.

Sepsis is a specific area of focus of the Acute Deterioration programme.

Also in 2019, the former CTUHB commissioned an external review of Resuscitation Services (Ref 2), where it was noted that governance arrangements regarding the Resuscitation Committee needed to be more robust.

The review team felt that the service should focus more on identifying the organisation's training requirements in relation to the deteriorating patient.

In response to recommendations from both reviews, and practice in other health boards, a new CTMUHB governance infra-structure was created in bringing together resuscitation and acute deterioration (including sepsis) under the consideration of one committee – Recognition of Acute Deterioration and Resuscitation (RADAR) (Ref 3). RADAR reports directly to the Executive Leadership Group, via the Medical Director with links to the Quality & Safety Committee

Two key clinical appointments were made to lead, direct and co-ordinate RADAR activity:

- Medical Clinical Lead x 2 sessions/ week.
- Acute Deterioration Lead Nurse WTE Band 8A. (*key recommendation from Peer Review)

These posts are currently hosted by Clinical Education.

The continued work of RADAR and progress with acute deterioration governance and management within the health board is at risk as current funding for these two key posts is only until March 2023.

2 RADAR Committee

2.1 Policy and Governance

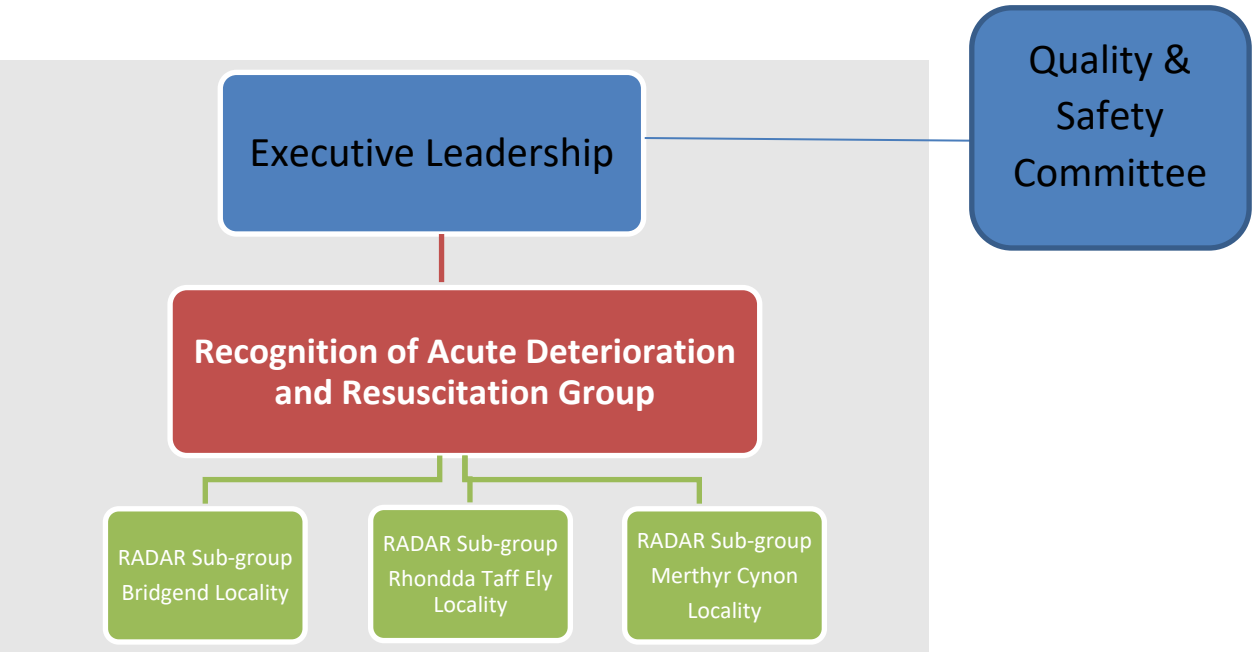
2.2 Quality Improvement – Acute Deterioration Processes including Sepsis

2.3 Education and Training

2.1 Policy and Governance

Organisational governance around resuscitation and acute deterioration has been further developed and aligned. The overarching CTMUHB RADAR Committee (Recognition of Acute Deterioration and Resuscitation) is responsible for the strategic management of all Recognition of Acute Deterioration and Resuscitation related issues within the organisation, supporting the provision of appropriate and effective patient care through implementing operational policies governing the prevention of cardiac arrest and those governing cardiopulmonary resuscitation, practice and training. This approach brought together a number of work streams in order to reduce avoidable mortality and morbidity by improving the function of health board systems that enable early recognition and treatment of deteriorating patients, and cardiopulmonary resuscitation.

It is chaired by the AMD for Quality and Effectiveness on behalf of the Medical Director with a Medical Consultant appointed as the Clinical Lead. There is a Lead post for Acute Deterioration which commenced in January 2021 to develop and embed a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the identification, escalation and response to the acutely unwell patient.
The internal structure of the subgroups of RADAR will be further re-aligned over 2023 with the establishment of the new CTMUHB organisational structure.



2.1.1 **Supporting services**

Resuscitation service

The Resuscitation Service for CTMUHB has a significant focus on providing training to ensure health care professionals are competent and up-to-date with the relevant life support skills for their roles. A training and resuscitation equipment service is also provided to Powys Training Health Board, General Practices and Dentists among other SLAs. This service is also a Resuscitation Council Accredited Training Centre for Level 4 Life support training.

Critical Care Outreach Service

In order to provide a 24-hr response to acute deterioration the Critical Care Outreach teams have been expanded.

Current Outreach establishment

- Princess of Wales Hospital 7WTE (2 x band 7,5 x band 6)24/7
- Royal Glamorgan Hospital 7WTE (6 x band 7,1 x band 6)24/7
- Prince Charles Hospital 7WTE (1x band 7, 6x band 6) 12/7* (*plus Friday/Saturday nights to go 24/7 May 2023

The expansion of the teams allow a critical care outreach presence at all rapid response calls. The establishment of 7 WTE per site allows for a vital teaching role to be included, which supports the provision of training on acute deterioration, NEWS, sepsis and acute kidney injury (AKI). Due to increased demand for both clinical workload and education, bids have been submitted to expand the teams to 8WTE on each site.

The service continues to face challenges where outreach staff are called back to cover gaps in ITU, emergency departments and areas of high acuity. Strategic direction and leadership are required for this team and service and moving forward could be provided by the acute deterioration lead post.

2.4 **Quality Improvement – Acute Deterioration Processes**

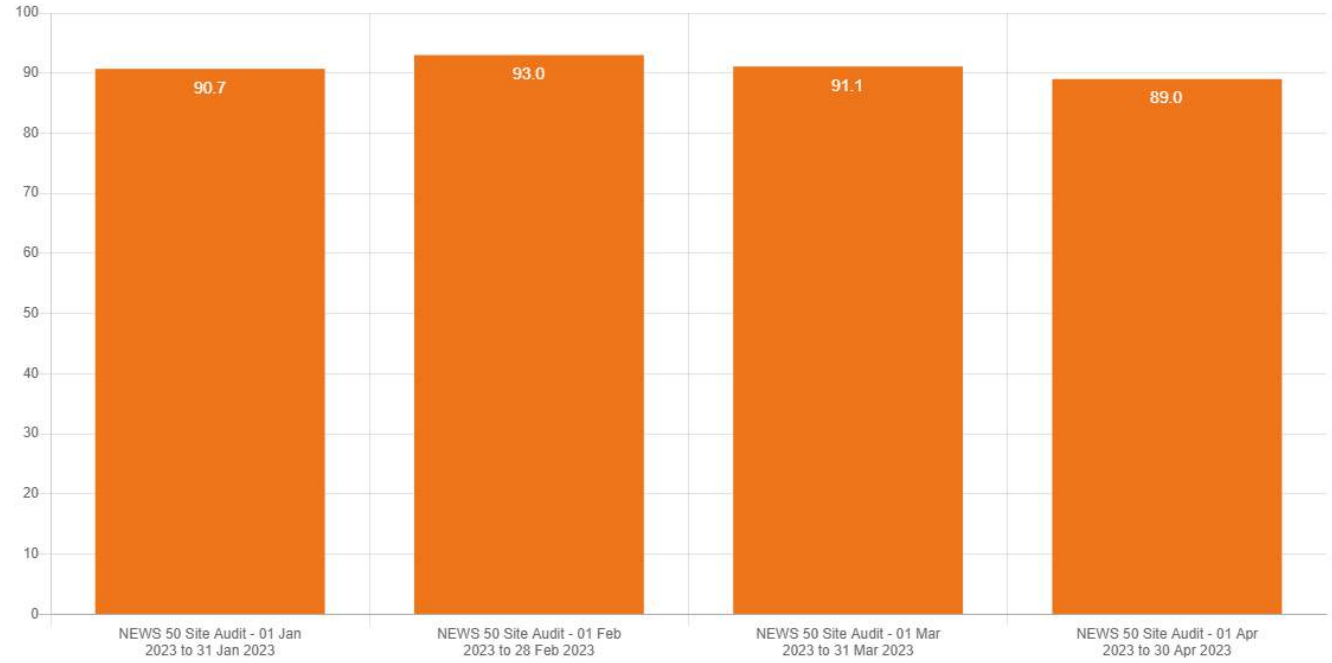
2.2.1 NEWS Guidance

The focus of work is to have a structured and unified approach across Cwm Taf Morgannwg University Health board (CTMUHB) in the areas set out in the Welsh Government (WG) Task and Finish group report on provision of critical care outreach services in Wales Ref and compliance with Welsh Government Sepsis (2017) guidelines (ref 5) including the use of the National Early Warning Score (*NEWS*) in all clinical areas to allow rapid objective detection of deterioration.

As a direct result of the work led by the Clinical Lead and the Acute deterioration lead posts, NEWS charts have been updated in alignment with NEWS2 principles and rolled out as 'NEWS Cymru' charts (ref 7) standardised across all acute and community hospitals in CTMUHB. Specific education and training to support the standardisation has been provided to all staff and incorporated into existing training programmes e.g., Health care support worker induction training and our resuscitation training programmes.

In order to provide assurance within the health board that the NEWS charts are completed accurately and appropriately escalated an audit pro forma has been developed based upon NICE CG50. Data is entered monthly onto the Audit Management and Tracking (AMaT) system. Results are disseminated to all ward managers, senior and head of nursing for review. Any compliance issues are also discussed within the ILG Recognition of Acute Deterioration and Resuscitation RADAR meetings. NEWS audits are used to provide evidence of learning in Learning from events reports (LFER).

Fig 1. CTMUHB NEWS audits Jan23-April 23



2.2.2 NEWS and Escalation Procedure

This clinical procedure has been produced to provide Cwm Taf Morgannwg University Health Board (CTMUHB) best practice guidance to health care professionals in determining and identifying patients within our care who are at risk of becoming unwell or presenting with abnormal physiological status.

The procedure specifically provides a framework through which doctors, registered nurses, healthcare assistants and allied healthcare professionals are informed of their responsibilities in relation to: -

- the minimum standards for monitoring patient's physiological observations
- recording and communicating the results of the monitoring of such physiological observations
- the minimum actions and referral route that must be taken in accordance with the NEWS scoring system

2.2.3 Sepsis Screening Tool

Sepsis

Sepsis is a complication of infection in which a *dysregulated host response is associated with organ dysfunction and increased risk of death.* It is estimated that there are in the region of 500 'suspected sepsis' admissions per year in CTMUHB, with a mortality of about 7%.

Early recognition and response to Sepsis improves outcome.

Sepsis is one of the leading causes of Acute Deterioration and therefore our response to the Acutely Deteriorating patient has Sepsis at its core. Our response to Sepsis is built upon the response to all forms of Acute deterioration i.e., recognition, escalation and timely response by appropriately trained clinicians.

The entry criteria for recognising "Sepsis" are the Suspicion of infection PLUS a NEWS score of 3 or more. This should lead to a patient being screened for sepsis using a *sepsis-screening tool.*

**A note on tools*

Screening tools are used to help clinicians make a judgement on a likely diagnosis at the bedside in a timely manner. Waiting many hours for microbiological confirmation is obviously not an option. There are several tools used for screening a patient for Sepsis. They have varied sensitivities and specificities and no individual tool is ideal. Tools that are too sensitive over-estimate the likelihood of sepsis and lead to many people being over-treated with antibiotics and fluids. This in itself is harmful but added to this is the risk that treating a non-septic patient as septic leads to the true diagnosis being missed e.g.: heart failure, pancreatitis etc. Tools that are too specific under-estimate the likelihood of sepsis leading to patients not receiving essential, early antibiotics. Tools that are overly complicated are difficult for staff to follow and are not practical in most clinical situations as presenting cases seldom conform to rigid protocols.

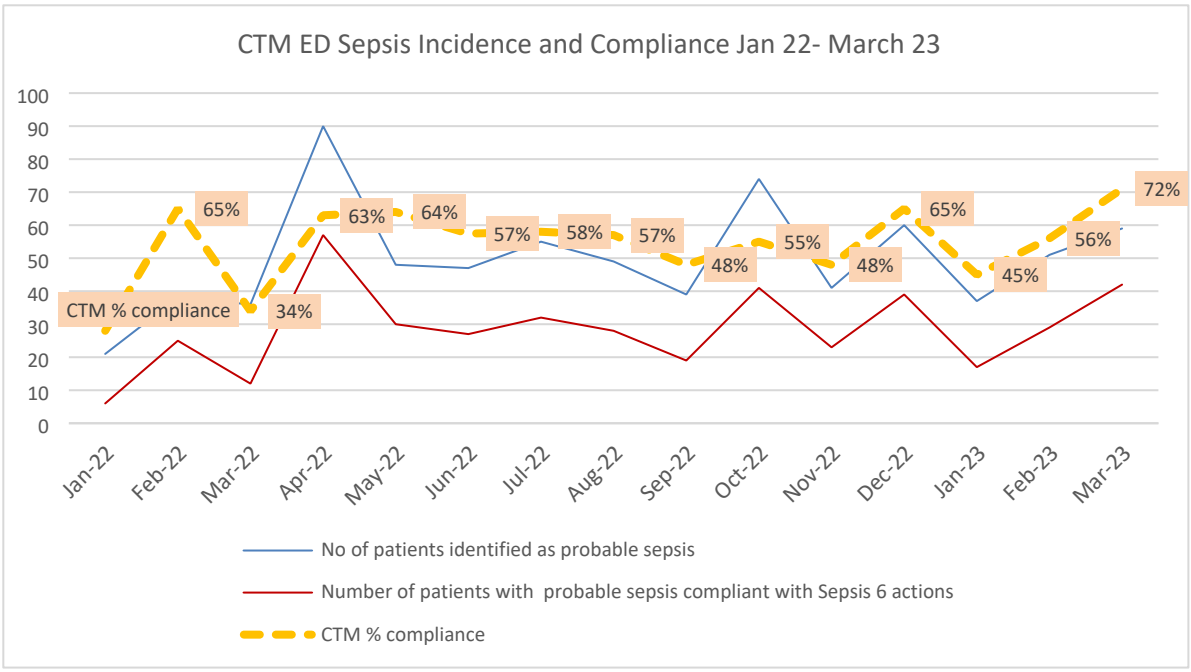
Sepsis is one of the main causes of acute deterioration and if not identified and treated in a timely manner can lead to multi-organ failure, admission to Intensive Care and death.

In CTMUHB historically there were several sepsis screening tools in use. To ensure consistency in the identification of sepsis within the hospital setting a new sepsis tool was developed using a collaborative approach between pharmacy, medical and nursing leads and using the NICE guidelines and the new guidance from the Academy of Medical Royal Colleges. We introduced it into our Emergency Departments (where we see 75% of Sepsis presentations.) Over the course of the year through a great effort in education we have rolled it out to the rest of our hospitals. The new sepsis tool focuses on risk stratifying patients into categories to ensure those at most risk receive timely care. (Ref 4)

To support the timely administration of antibiotics, the first line antibiotics for use within Emergency departments was standardised and a QR code attached to the tool which links to the Antibiotic guidance. This has helped to reduce the time to prescription and administration of antibiotics in the patient with probable sepsis.

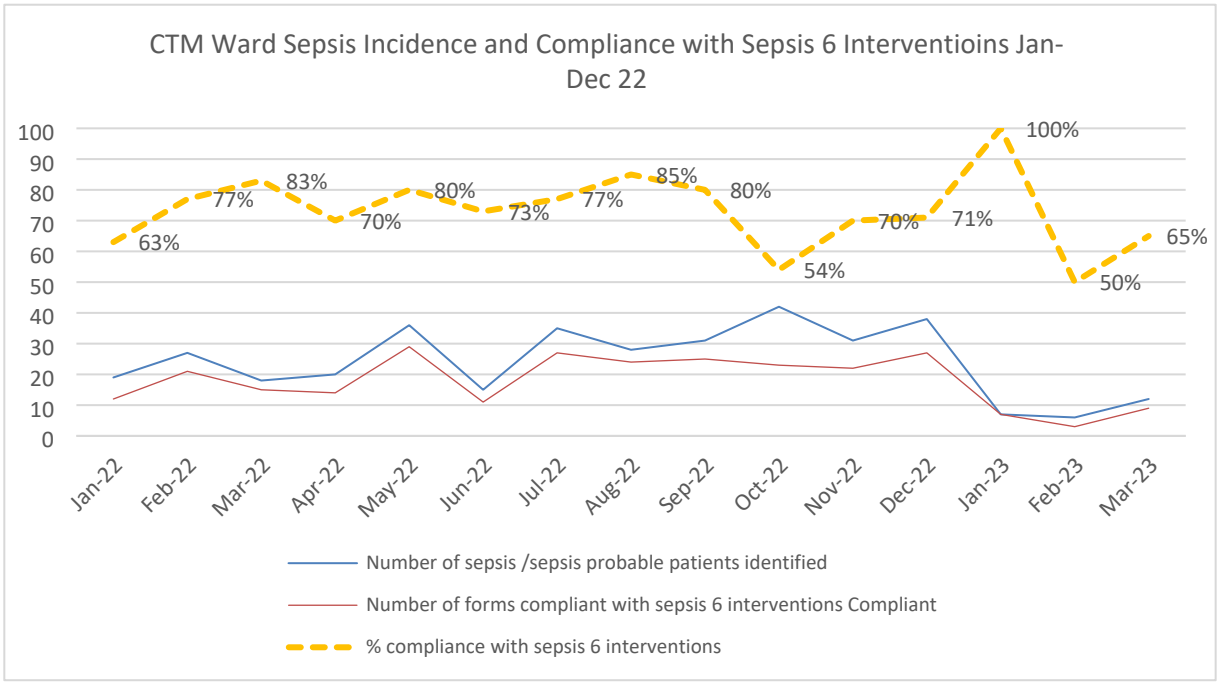
The sepsis tool was trialled within the three Emergency departments for a period of three months. Initial results indicated an increase in the use of screening from 7 screening forms to 90 forms per month and an increase in compliance from 34% to 63% with timely treatment.

CTM Emergency Department Sepsis Incidence and Compliance



Following on from the intial trial in ED the sepsis screening tool has been introduced into *all wards* within RGH/PCH/PoWH. Ongoing work continues on providing meaningful data from all sites

CTM Ward Sepsis Incidence and Compliance



2.2.4 Acute Kidney Injury (AKI)

The National Confidential Enquiry into Patient Outcomes and Death report (NCPOD) in 2009 demonstrated poor management of acute kidney injury (AKI) throughout the UK. In the UK up to 100,000 deaths each year in hospital is associated with acute kidney injury. Up to 30% could be prevented with the right care and treatment. NICE recognises this, and

identified only 50% of cases with AKI documented as cause of death received satisfactory or good care (NCEPOD 2009).

In order to improve the management of AKI within CTMUHB an AKI steering group was developed and an AKI sticker bundle was drafted which prompts actions for Medical/nursing staff when patient has an AKI. The AKI steering group reports into RADAR.

The AKI sticker bundle has been introduced into the acute medical wards within RGH, and the care of the elderly wards (COTE) wards in POWH. To measure sticker compliance an audit has been developed on AMaT to ensure that AKI alerts are being managed appropriately and in a timely manner and to identify areas of low compliance to make improvements. Ongoing roll out will take place within all sites in 2023.

2.2.5 Fluid Balance

Fluid balance is an essential tool in determining hydration status. Accuracy in recording fluid intake and output is vital to the overall management of certain patient groups and facilitates the assessment and evaluation of the patient's condition. In addition, accurate fluid balance is an essential component in the prevention and management of an AKI.

In order to improve compliance with recording of a patient's fluid balance status a whole site audit within Royal Glamorgan Hospital and within the Care of the elderly (COTE) wards at POWH were conducted. The results of the audit identified areas for improvement. Ongoing work is being done with the Health Care Support Worker (HCSW) team to develop a fluid balance training session Registered nursing staff are educated via the CCOT within the acutely unwell study days and on the ward teaching. To underpin fluid balance training a procedural document has been written.

The purpose of the procedure is to raise staff awareness by providing a clear set of standards in managing optimal hydration and effective fluid balance. The aim is to guarantee that health care staff apply a consistent and safe approach to maintaining assessing and recording of individual patient's fluid balance. The intention is to create a set method for recording a detailed and accurate fluid balance by establishing effective standards and management for optimal hydration while supporting staff to determine an appropriate and timely rationale for starting and stopping a fluid balance.

To provide assurance on compliance a monthly fluid balance audit is conducted within RGH site which will be introduced to all sites within 2023.

2.2.6 Burden of Acute Illness

Knowledge of how many acutely unwell we have in our acute hospitals in any one period of time is vital to plan provision of services for Acute Deterioration.
We conducted an audit to assess the burden of acute illness within each secondary care hospital over a 24-hour period and to review the escalation process in order to provide assurance around the management of acute deterioration on each site. (Ref 4)

We looked at these parameters:
The number of NEWS charts in each clinical area
The number of patients scoring NEWS ≥6 in each area
The number of patients who scored ≥6 – 8 who were escalated in line with policy
The number of patients scoring ≥9 in each area who were escalated as per clinical policy

We undertook a separate review into:
The number of rapid responses calls in previous 24 hours
The number of admissions to Critical Care in previous 24 hours
The number and location of cardiac arrest calls in previous 24 hours

2.2.7. Resuscitation and Clinical Skills

The resuscitation service for CTMUHB currently has 12 members. This consists of 1 resuscitation manager, 3 resuscitation practitioners, 3 resuscitation training officers, 3 Clinical skills officers and 2 administrators. Currently there are 6 members of the team who are actively training, however, 3 of these have additional managerial responsibilities within the UHB. In addition to this they provide a service to Powys Health Board, GPs, Dentals and other SLAs.

Throughout 2021-22, there was a focus on standardisation of Resuscitation Standards in CTMUHB. This included a complete review of the CTMUHB resuscitation policy, and a renewed resuscitation training compliance matrix for the organisation.

Additionally, the resuscitation equipment was standardised across the health board, with a major change to equipment taking place in Princess of Wales Hospital with the rollout of new resuscitation trolleys across what was then the Bridgend locality group.

The standardisation of equipment, along with the rollout of the Rapid Response Calls, has not only improved patient safety, but has also rationalised equipment with a significant reduction in equipment utilised.

During 2021-22 the Royal Glamorgan Hospital and Prince Charles Hospital, received 40 new defibrillators along with the relevant training of staff to ensure competence and safe use.

The service also provided support and training for staff to roll-out a new standard operating procedure in Ty Llidiard, as part of the response to a Welsh Government investigation into a recent incident. This included working closely with Welsh Health Specialised Services (WHSSC) Committee and Welsh Ambulance Service NHS Trust (WAST) to create a hybrid 2222/999 response to emergency calls.

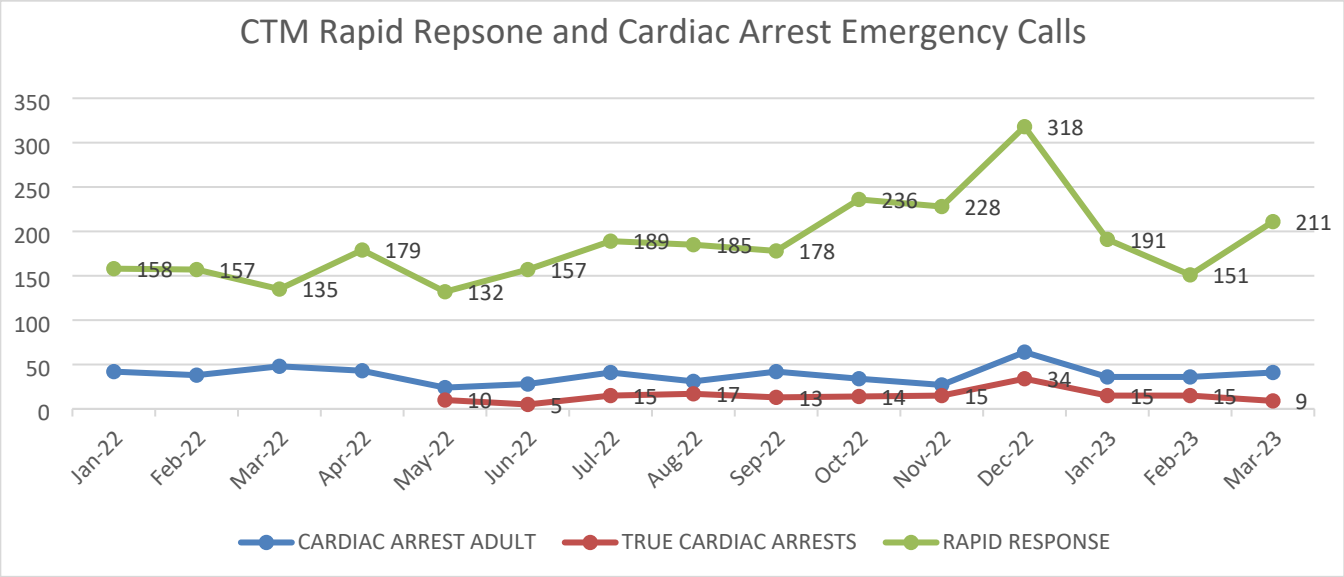
2.2.8 Rapid Response Systems

Clinically significant deterioration of patients admitted to general wards is a recognized complication of hospital care. Rapid Response Systems aim to reduce the number of avoidable adverse events. Over the last 2 years in CTMUHB we have standardised our Rapid Response Call to a NEWS of 9 or over. Rapid arrival at the bedside of the appropriate team has led to patients being seen earlier in their deterioration. Access to Critical Care is enhanced, ward-based treatments are maximised and decisions on further management e.g.: end of life decisions are clarified.

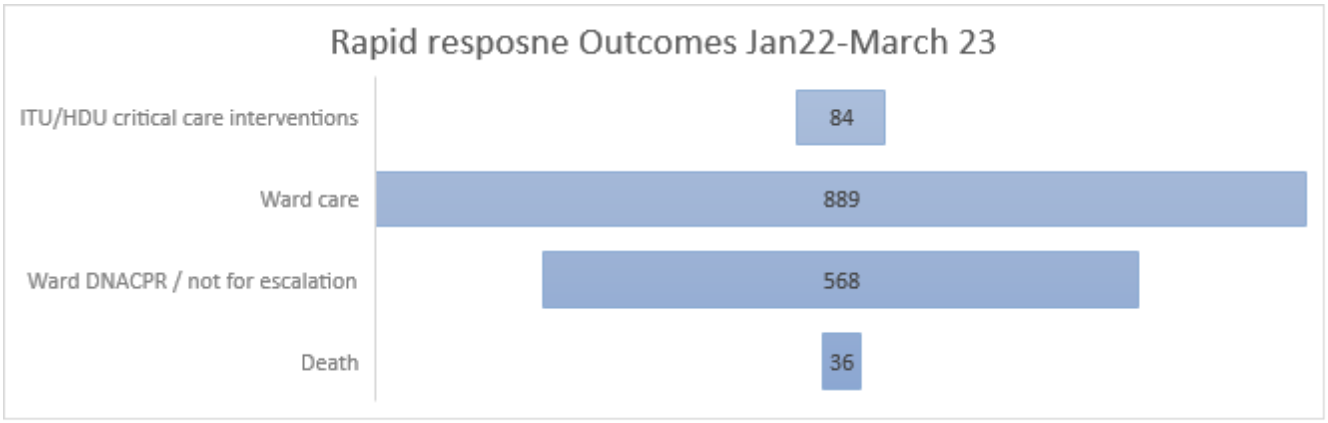
Metrics	Method of data collection	Rationale	How we will do this
Hospitals should measure and track cardiac arrests in regular ward patients	Measure all cardiac arrests occurring within the ward environment	Rates of cardiac arrests on general wards can be seen as an indicator of an organisations ability to appropriately identify and manage patients who deteriorate	We compile a monthly list from switchboard of 2222 calls and input onto AMAT, differentiating which are for Cardiac Arrest and which are for Rapid response
Hospitals should measure predictable cardiac arrests in general ward patients	Cardiac arrest occurring in hospitalised ward patients who met the hospital's escalation threshold at least 30mins prior to and within 24 hr of the cardiac arrest.	IHCA associated with a mortality risk of 80% historic data show that there are preceding derangements in patient observations for up to 8 hours prior to the CA. This forms the basis for escalation criteria for the RRS.	From the RR/CA audit form we have a record of monthly Cardiac arrests that had a NEWS> 6 in the 24hrs prior to arrest.
Hospitals should measure timeliness of their response to ward patient deterioration	measure hospitalised patients who received evaluation by staff with critical care skills or advanced skills within the pre specified time	To assess whether the response of the RRS is timely	There is a box on the audit form that is Y/N for a timely response. Rather than having specific response times in there it may be a judgement call of the auditor whether there was a timely response or not
Hospitals should evaluate timeliness of critical care interventions	Proportion of hospitalised ward patients who receive critical care within 6 hrs of an escalation criteria breach	To measure the facilitation or provision of critical care within 6 hrs. Respiratory support invasive/non invasive Vasopressors/ inotropes	In the rapid response box, we record Critical Care intervention and a Time (which could mean transfer to ITU or intervention on the ward or t/f to theatre etc)

		Invasive monitoring	
Patients that exhibit warning signs should receive a timely documentation of goals of care	Proportion of hospitalised ward patients who had goals of care discussions either in place or newly documented by a clinical provider within 24hrs of first breaching the escalation criteria	Delays of care at either end of palliation-invasive spectrum are associated with avoidable morbidity. The deteriorating patient's best interest can only be served if a treatment plan communicating the goals of care is developed and implemented at this time.	This is recorded in the DNACPR/Not for escalation box.
Hospitals should provide means by which patients and family members can activate the rapid response team			This is under discussion.
Hospital should consider measuring the frequency of RRT activations by patients and family members			This would be easy to measure if and when we proceed with family member activation.
Hospitals should evaluate safety culture in relation to deteriorating patients and their care	The hospital uses a survey tool regularly to evaluate hospital staff perceptions of safety culture in relation to the Rapid response systems	RRS organisation wide patient focused systems to be developed to prevent potentially avoidable deaths and serious adverse events as cardiac arrests. Culture and attitudes of an	The regular Staff feedback form on Outreach records this.

	Adapt existing tool.	organisation affect patient outcomes	
Hospitals should measure the length of stay on general wards of all patients with breach of escalation criteria	Measure total length of stay for ward patients who breach escalation criteria differentiated form those patients with timely documented goals of care. Should include ITU LOS	RRS operates under the premise that early identification of patients experiencing clinical deterioration leads to early intervention and better clinical outcomes.	A NEWS of 9 is a rapid response call. Further administrative support needed to ascertain this data.
Hospitals should measure ICU length of stay of patients transferred to ITU following breach of local escalation criteria.	Measure the length of stay for patients admitted to ITU from the ward within 24hrs of triggering deterioration. Patients admitted with delayed initiation of critical care should be differentiated from those with prompt escalation of care.	Value in healthcare is defined as the health outcomes achieved relative to their financial cost. The cost of emergency ITU admissions from general wards unknown	This is deliverable if and when as above, administrative support is forthcoming.



Graph illustrates the total number on monthly Rapid response calls, Cardiac Arrest calls and true Cardiac Arrest calls within PCH/RGH/POWH January –December 2022 * Feb and march data to be checked against switchboard



Rapid Response outcomes for RGH/POW/PCH sites Jan 22-March 2023

2.2.9 Treatment Escalation Plans (TEPs)

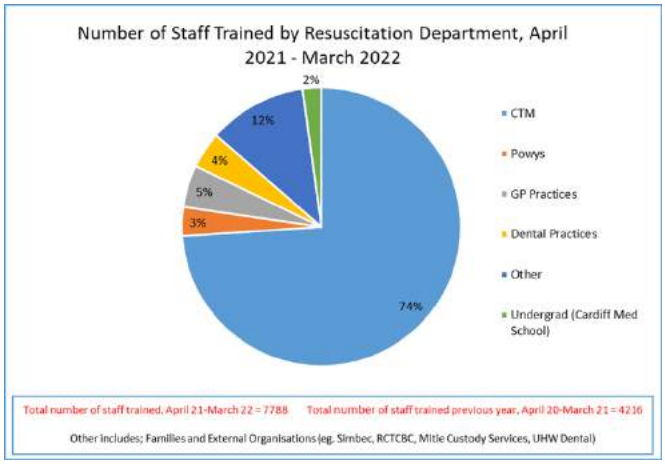
A TEP form is a way of the healthcare team recording a patient's individual care plan should they deteriorate in an emergency, focusing on which treatments may or may not be most helpful to them. The information recorded on the TEP form helps to guide healthcare professionals in an emergency, as to which treatments would or would not help an individual patient.

A TEP encourages a patient and their team to discuss certain aspects of treatment in advance, promoting careful planning. A TEP ensures that a patient does not receive treatments that they wouldn't want.

In CTMUHB we have adapted and adopted the All-Wales TEP template and are committed to rolling this out for all new acute admissions. (Ref 6)

DNACPR *Sharing and Involving- A Clinical Policy For Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults in Wales.*

This policy was updated in April 2022 and recommends a biennial audit into documentation of the DNACPR discussion using the DNACPR forms. Our most recent audit is available on request along with an action plan. The audit is being repeated in May 2023. (Ref 7)



2.3 Education and Training

2.3.1 Resuscitation training

The Resuscitation Service continues to deliver mandatory life support training from Level 1-3 (graph 1 and 2), for CTMUHB, Powys HB and all local GP's and Dentists. The department is also a leading National provider in the delivery of Level 4 Advanced Resuscitation Courses, for Adults, Paediatrics, Newborns and Trauma. These courses are delivered on an income generation basis, with internal and external faculty engagement required to deliver. The number of staff trained is outlined below

Staff trained, April 2021 to March 2022 Level of training numbers

Vaccination Teams across the UHB have been supported with training to enable them meet the urgent demand throughout the Covid-19 pandemic. Upskilling training was also delivered to 44 ITU staff and 52 Paediatric staff with level 3 Paediatric Immediate Life Support (PILs) in response to the Respiratory Syncytial Virus (RSV) risk.

Over the past year, the Resuscitation Team worked collaboratively with the Practice Development Nurses and Midwives (PDN & PDM) to deliver 'Train the Trainer' (TTT) 'in house' training programmes for Level 2 Basic Life Support, increasing flexibility and opportunity to offer further training places and therefore increasing compliance. This in turn releases time for the Resuscitation Practitioners and Training Officers to focus on the delivery of Level 3 training, organising and facilitating debriefing sessions following arrest calls, investigating and preparing evidence for Rapid Reviews and scrutiny panels, attending 2222 calls, cardiac arrest audits, and Datix queries. Through this activity areas for improvement are identified and training needs incorporated into future training programmes. E.g., redesign of the cardiac arrest audit form. The revised audit enables identification of areas needing improvement in training and provides a trail of decision making.

In order to meet service demand and provide the UHB with the most appropriate training, alternative training packages have been considered beneficial. Following investigation into the prevalence of sick patients and cardiac arrests in our Community Hospitals, it has been agreed to offer qualified nursing staff a bespoke package, which includes Basic Life Support, Sepsis and AKI, among other things. This package is being designed in conjunction with the UHB's Critical Care Outreach Teams. This will replace the previous training of ILS, which is more suitable for acute sites. This has enabled the service to increase the number of

participants on each course and collaboration between Resus and CCOT has increased training delivery capacity.

Additionally, training for other allied health professionals has been reviewed, identifying appropriate level of training for the role being undertaken e.g., level 2 rather than level 3, as they are either looking after "well patients" in outpatient departments or in an area covered by CCOT/2222 calls and where the patient should be accompanied by a nurse i.e., Radiology. In response to changes to the Resuscitation Council UK Guidance regarding the suitability of Paediatric ILS up to the age of 18, we have changed training requirements for staff working within Ty Llidiard to reflect this.

The changes to CTMUHB training compliance standards to more appropriate requirements for each health care role and the promotion of Train the Trainer packages are intended to enable increases in compliance for Resuscitation training (for training matrix please see ref 11).

2.3.2 Critical Care Outreach Service

The Critical Care Outreach Teams (CCOT) deliver acute deterioration training within the secondary sites. NEWS training is also provided by the health care support worker programme and the resuscitation practitioners during Immediate Life Support and Advanced Life Support.

To complement the Immediate Life Support (ILS) course provided by the resuscitation team, the Acute Life-Threatening Events-Recognition and Treatment (ALERT) course has been introduced across CTMUHB for all registered nursing staff. This ensures a unified approach to education to manage an acutely unwell patient within a ward environment. The plan for 22-23 is to extend the provision of the course and develop a multi-professional faculty to facilitate, this would provide best learning environment for the candidates on the course.

Title	Sites	Frequency	Staffing and hours
Acutely unwell study day	All	Monthly	X6 staff total 36hrs
ALERT	All	Monthly	X6 staff total 36hrs
NEWS		Weekly	12 hrs. monthly
Sepsis		weekly	12 hrs. monthly
AKI		Weekly	12 hrs. monthly
Newly Registered Nursing Induction Programme (NRNIP)	All	Bi-annually	6 hrs. annually
Student Nursing Programme	All	Bi annually	18hrs annually
CTM Tracheostomy training	All	Monthly	6hrs monthly

2.4 National Work

The focus of RADAR since it commenced in 2021 has been on establishing fit for purpose ways of working across CTMUHB. It has noted activity ongoing at a National Level and has

been working to identify what would be appropriate to engage with further. This is an area of focus and further development over 2023-24.

2.4.1.1 Work within UK

Resuscitation Council UK. (RCUK)
CTMUHB adheres to the RCUK's guidelines for protocols and training of staff. The RCUK are a collaboration of research councils working effectively to enhance the overall impact and effectiveness of resuscitation research, training and innovation activities in the delivery of the government's objectives for science and innovation.

The National Cardiac Arrest Audit (NCAA)
The NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrest in the UK in order to inform practice and policy. The vast majority of organisations in the UK are enrolled in the audit but no LHB in Wales is. A paper was submitted to the RADAR committee in 2021 which agreed that CTMUHB should participate in the NCAA. We are working with the Welsh Resuscitation Forum on taking this forward.

Academy of Medical Royal Colleges (AoMRC)
A recent paper from the AoMRC (Ref 9) led healthcare organisations across the UK to review their approach to Sepsis screening. In summary, the paper acknowledges there is a balance to be found between early antibiotic administration and the danger of over-use of antibiotics and that priority is given to sicker patients based on NEWS scoring. Decision to treat should come from early review by a senior clinical decision maker.
Both at an LHB and a Wales level we are engaged in addressing the paper.

2.4. 2 Work within Wales:

The predecessor to Improvement Cymru, 1000Lives+, had several national workstreams focussed on Acute Deterioration pulled together via the Rapid Response to Acute Illness learning set (RRRAILS).
CTMUHB worked closely with RRAILS and led the way in updating and standardising our approach to NEWS, sepsis and AKI.

After a 4-year hiatus, Improvement Cymru, at the behest of Welsh Government, is attempting to set up a National Acute Deterioration Faculty: an expert panel that will review the current evidence and make recommendations to LHBs in Wales.
The Clinical lead for RADAR and Lead for Acute Deterioration are key members of this expert panel and expect CTMUHB to be at the forefront of any changes.

Up until last year Welsh Government required all LHBs to submit monthly data on Sepsis incidence and compliance. It is expected that Welsh Government will resume a requirement for data when the Acute Deterioration Faculty advises it what data is meaningful to collect.

Our Lead for Acute Deterioration is the Chair of the Welsh Outreach Forum, a part of the UK National Outreach Forum. Regular meetings occur where peers share service innovations and discuss future collaboration.

The Sepsis in Wales group has recently been set up to bring all LHBs together to update and standardise our approach to Sepsis screening following the publication of the Academy of Medical Royal College's Sepsis paper. The group is chaired by our Clinical lead for RADAR.

Welsh Advanced and Future Care Planning Group:
In the vast majority of clinical interactions, the response to Acute Deterioration is good. Often, where the response is less good, the problem lies in issues around appropriateness

of escalation. Too often, patients in the last few hours of a natural and anticipated death are subjected to investigations and interventions that are futile and distressing for them and their families.
We receive regular reports from the Mortality Review process which illustrate these issues. Thoughtful, early advanced care planning aims to reduce these issues.
In CTMUHB our work to roll out Treatment Escalation Plans is key to ensuring good, prudent and dignified care to all our patients.

Reference for papers All available on request

1 CTUHB Peer review report:	2 Resuscitation Services review
3 RADAR TOR	4 WG critical care report
5. CTM Sepsis Screening Tool	6. Burden of Acute Illness Audit
7. TEP policy/form/patient information leaflet	8. DNACPR audit and Policy
9. AoMRC Statement on Antibiotics In sepsis	10. International Society for rapid response systems Metrics
11. Cardiopulmonary policy and Resuscitation Training matrix	

AGENDA ITEM
5.1

QUALITY & SAFETY COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	24th May 2023
FOI Status	Public
If closed please indicate reason	Not Applicable – Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive
Report purpose	FOR REVIEW & APPROVAL

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

Committee/Group/Individuals	Date	Outcome
Service, Function and Executive Formal Review	April / May 2023	RISKS REVIEWED
Operational Management Board – Phase 1 Risks Scoring 20 and above	19th April 2023	RISKS REVIEWED
Executive Leadership Group	15th May 2023	REVIEWED AND MANAGEMENT SIGN OFF RECEIVED

ACRONYMS	

1. SITUATION/BACKGROUND

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

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

2.1 At the Operational Management Board meeting on the 19th April 2023, a targeted review of risks scoring 20 and above (escalated to the Organisational Risk Register) was undertaken and Care Group Director Teams were tasked with specific review actions. Improvement in terms of mitigation, moderated scoring and timeframes will hopefully be evident over the next few reporting periods.

2.2 The Care Group Highlight Reports received a the Operational Management Board will now include a specific risk update in terms of 'new, closed, de-escalated' risks for the Organisational Risk Register.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. **378** members of staff trained to date. There are targeted in person sessions with Primary Care Teams scheduled during May 2023.

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

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **Principal / Strategic Risks (Board Assurance Framework)**
The organisational risks captured in Appendix 1 are aligned to the Principal/Strategic Risks reported to the Board via the Board Assurance Framework Report. These risks as assigned to the Quality & Assurance Committee are:

- Risk No. 1 – Sufficient capacity to meet emergency and elective demand. Risk score of 20.
- Risk No. 2 – Ability to deliver improvements which transform care and ehance outcomes. Risk score of 16.

3.2 **Organisational Risks (Score of 15 and above)**

3.2.1 **NEW RISKS**
Nil this period.

3.2.2 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period
Digital and Data

- Datix ID 4671 - Lack of a resilient and performant Digital Network Infrastructure and Assets. Risk increased from a 15 to a 16.

b) Risks where the risk rating DECREASED during the period
Patient Care & Safety – Central Function

- Datix ID 4908 – Failure to Manage Legal cases efficiently and effectively. Risk de-escalated from a 16 to a 12 in March 2023. Further assurance was sought from Board Members and therefore further rationale has been captured to support de-escalation.

Medical Directorate – Central Function

- Datix ID 5214 – Critical Care Medical Cover. Risk score reduced from a 20 to a 12. Risk was robustly reviewed by the Medical Director this period where risks 4590 and 4798 were amalgamated.

Diagnostics, Therapies & Health Sciences

- Datix ID 4920 - Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales. Risk score reduced from a 15 to a 12.

Children and Families Care Group

- Datix ID 5014 - Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital. Risk score reduced from a 16 to a 12. This risk update was captured post ELG meeting on the 15th May 2023.

Digital & Data

- Risk ID 4887 - Retrieval and filing of case notes in the POW Medical Records Library. Risk score reduced from a 20 to a 15.

Rationale for changes captured in Appendix 1.

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

All Care Groups

- Datix ID 4253 - Ligature Points - Inpatient Services. Risk closure placed on hold in March 2023 as further assurance was required in terms of the completion or Capital and Estates actions. This has been received and is captured in Appendix 1. Risk Closed.

Medical Directorate – Central Function and Diagnostics, Therapies and Specialties

- Datix ID 4590 – Critical Care Pharmacist Resource. Risk Closed.

- Datix ID 4798 - Unsafe therapy staffing levels for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital. Risk Closed.

Unscheduled Care Group

- Datix ID 4512 - Care of patients with mental health needs on the acute wards. Risk Closed.

Diagnostics, Therapies and Specialties Care Group

- Datix ID 5323 - Fluoroscopy Room has become Obsolete. Risk Closed.

Rationale for closure captured in Appendix 1.

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

Consequence						
	5			3337 4772 3993 4887	4080 3826 5276	
	4				4458 4148 4337 4743 4906 4679 3131 4152 3585 3133 1133 4479 5254 5036	4491 4632 4071 4103 4907 4922 5267
	3					4691 4732 5207 2808 4217
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

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

Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to:

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

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to the new system supplier will be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review the new system suppliers revised delivery plan. There has been several meetings between Health Boards, LINC Programme and Commercial Providers. At a meeting held on the 13th December it was agreed by NHS that deployment would be sequential and in the original running order. Health Board configuration meeting scheduled with Commercial supplier for 10th January 2023. Update May 2023 - Concerns around viability of proposed implementation plans have been widely discussed and escalated. The next LINC Programme Board is scheduled for the 9th May 2023 where further discussions will take place.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	5.5.2023	31.5.2023
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 enquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Establish a Timeline for CTMUHB - the timeline will have a few elements and uses and will continue to evolve as information is archived. This Timeline does not include the Health Board Information as this requires the archiving of documents in order to populate it. Archiving Information against the Timeline is yet to commence as the current Covid-19 Information Manager resigned from the role and left the Health Board at the end of August. Recruitment for a successor to the role was unsuccessful and therefore the pace of progress in developing the Health Boards Timeline and gathering key documentation centrally is being significantly impacted which could be detrimental to the Health Board being able to efficiently and effectively respond to requests from the Inquiry. The AD for Governance & Risk is exploring other options for resourcing this role including project management support. Following a briefing meeting with Legal Counsel it was clear that the Health Boards focus should be on the timeline and documentary evidence at this stage which has heightened the risk in terms of the resource afforded to the preparedness for the inquiry. Legal Counsel advised the Health Board to pause the introduction of the All Wales Reflection document at this stage of the Inquiry. At the Covid-19 Pandemic Inquiry Working Group on the 11th October the likelihood of this risk was increased from a 4 to a 5 based on the above risk factors. Update May 2023 - The Health Board has successfully appointed to the Covid-19 Information Manager position with a planned commencement date of the 30th May 2023. The likelihood of this risk will be revisited once the new post holder has commenced and has undertaken an initial assessment of the Health Boards preparedness.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	23.11.2021	28.4.2023	30.06.2023
4491	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	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.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
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 April 2023 - New Service Level Agreement signed with Tenovus Cancer Care, for a telephone call back system to provide additional support to patients. It is a service to support the patients who are waiting/improve the patient experience. There is no additional mitigation that has been added this month. Next review 31.5.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.04.2023	31.05.2023
4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	In terms of recruitment the following actions are underway over the next 6-12 months: • Meeting with Executive Director for People held on 24.11.2022 to discuss Medical Workforce (MWF) recruitment (including PAs, Specialist's) • Liaising with Care Group Medical Directors regarding their Care Group workforce planning and strategy • Once the Health Board identifies the gaps from the Medical Workforce Productivity Programme group on the establishment work stream it can then target specific areas with either Consultant, Specialist, MG cover • A report is also being prepared on British Association of Physicians of Indian Origin (BAPIO) for international recruitment. These are risks that will continue due to the National workforce availability. The Health Board will need to tackle these issues in a variety of ways – there is no one solution. The approaches include –recruitment, job planning (compliance and standardisation), establishment, new ways of working (MDT and expanding alternative roles), ADH spend and national rate cards, sickness rates, all of these impact on the workforce and are part of the programme. As the Health Board now has a planned stepwise programme it is dealing with the matter with more clarity and direction.	Quality & Safety Committee People & Culture Committee	20	C5 x L4	15 (C5xL3)	↔	01.08.2013	09.03.2023	30.04.2023
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Sustainability of a safe and effective Ophthalmology service	**IF**: The Health Board fails to sustain a safe and effective ophthalmology service. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in:** Sustainability of a safe and effective Ophthalmology service	Measure and ODTC DU reviews nationally. . Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTC's, weekend clinics). . On going monitoring in place with regards RTT impact of Ophthalmology. . In line with other services, to meet the RTT requirement services are being outsourced - maintaining this level of performance will be challenging going forward. . Additional funding for follow up appointments provided and significant outsourcing undertaken (6,500 cases) with harm review piloting to assess all potential harms. . Additional services to be provided in Community settings through ODTC (January 2020 start date). . Intravitreal injection room x2 established with nurse injectors trained. Follow up appointments not booked being closely monitored and outsourcing enactioned. Regular updates re follow up appointments not booked being monitored by Management Board / Q&SR (patient safety issues) and Finance, Performance and Workforce Committee (performance issues). Reviewing UHB Action Plan in light of more recent WAO follow up review of progress. Primary and Secondary Care working Groups in place. Ophthalmology Planned care recovery group established overseeing a number of service developments: WLI clinics, outsourcing of Cataract patients, development of an ODTC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	Update December 2022 - There has been a significant decrease in >104 week stage 1 waiting list subsequent to additional weekend activity. At the beginning of November 2022 we were reporting 1869 RTT cases >104 weeks, The Health Board has carried out 66 additional sessions, primarily addressing cataracts and General Ophthalmology. Scheme extended into January. Consequent to this piece of work, all stage 1 cataract conversions will be sent to C&V during February and March for assessment and procedure. C&V are providing capacity for 500 stage 4 patients, CTM currently have 228 stage 4 conversions >104 weeks and this number will increase whilst we continue with the weekend activity. Validation work is being carried out in tandem with the booking of weekend work and RTT rules. Progress has been made with the regional programme, an Option Appraisal presentation has been circulated to all HB's to include 6 delivery models for local preference ranking. All options are being explored and evaluated against a set of agreed criteria. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	23.12.2022	30.1.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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 May 2023 - The CTM Stroke Strategy Group has agreed an integrated action plan with a number of short, medium and long term actions, some of which have resource implications. Progress is being made in a number of areas: - SOP and patient pathway developed for stroke patients presenting at RGH - WAST agreement to advise patients on acute stroke site locations - Ring-fencing of stroke beds ongoing • Continued CTM-wide stroke consultant rota • Ongoing regional developments with CAVUHB continue. CTM consultant in post as Clinical Lead for Stroke for the South Central Wales Stroke Delivery Network. Developments underway to capture patient outcomes and experience data. • Prescribing nurse and specialist pharmacist have been identified to support the initiation of the AF and BP project in Primary Care. Work is progressing on implementation. A primary care nurse will work locally with those at risk to raise awareness of the signs and symptoms of stroke. - Radiographer approved CTAs now operating on all 3 acute sites, reducing delays in thrombectomy - Implementing CT perfusion (CTP) scanning to extend the window of thrombolysis and thrombectomy - Development of new stroke thrombolysis and thrombectomy pathway underway in response to new stroke guidelines, published in April 2023 - WHSSC commissioned thrombectomy service hours extended from 08:00-00:00 from 2nd May 2023. Awaiting confirmation of date for 24/7 service - Discussions between CTM, Stroke Association and Public Health Wales resulted in agreement to run FAST campaign in Wales from 27th April 2023 - Social media campaign funded by CTM Public Health for local FAST campaign	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	05.07.2021	11.05.2023	11.06.2023
4743	Chief Operating Officer	All Care Groups	Deputy COO (Acute Services)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure of appropriate security measures / Safety Fencing	**If:** there is a failure in security measures. **Then:** there is an increased likelihood of patients having unrestricted and inappropriate access on the site. **Resulting In:** absconding events and possible harm to the patient or members of the public	The risk of absconding, and self harm/ suicidal ideation for Mental Health and CAMHS patients is risk assessed on admission and reviewed regularly thereafter. Works programme to review and renew physical barriers such as door locks and restricted window access to limit unauthorised ingress and egress from Mental Health and CAMHS units are in situ. High risk patients are escorted when outside the units Absconding patient policy in place Some fencing is in place in the areas concerned, however, it is aged and fails to provide an adequate barrier.	Funding Bid for approx. £385K has been submitted by Estates Update April 2022: The Car Park Security Fencing in the Bridgend Locality is now largely complete with minor 'snagging issues' to close off. Door systems in Ty Llidiard CAMHS have been upgraded to include an alarm system on the Mag-lock doors. If the Mag-lock does not engage within a set time frame, then an alarm will sound. Multi storey Car Park at Princess of Wales Hospital has had anti-climb security fencing fitted. This was a WG Capital scheme and is awaiting final project sign-off to complete the works. The only outstanding area is the stairwell which will require more detailed technical design work to identify a solution. That work has commenced and once complete the works can be tendered. This will require further funding in 22/23 Capital & Estates Update September 2022 - solution to the fencing of the stairwells has been found and funding uplift approved in August ACMG. This work should commence in the early autumn completing within the financial year. Update October 2022 - Deputy COO Acute Services to review this risk from a pan Health Board perspective and identify actions per Care Group as appropriate. Timescale 31.12.2022.	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	05.07.2021	1.11.2022	31.12.2022
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:** Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Continue to implement actions identified in the control measures. Action plans are in the process of being reviewed so a timescale will follow once the review has been undertaken by the lead. Update September 2022 – Risk reviewed by Nurse Director for Unscheduled Care, risk to be closed owing to multiple changes to structures and reporting systems since original risk was opened. Risks to be reviewed and understood against new frame work outlined by the Six Goals Board local governance, quality and safety feedback mechanisms and unscheduled care quality and performance reporting mechanisms. Risk will be closed once the detail has been agreed and new risk superseding this current risk. Update 3.11.2022 - mitigations to improve flow and discharge at POW now being addressed through workstreams 2, 3 and 4 of the UEC 6 goals programme, with rapid focus on reducing lost bed days due to discharge delays, formal launch of D2RA model and pathways Dec 22, along with launch of e-whiteboards/discharge referral forms. Update 25/04/23 - review of this risk performed by the USC SMT improvement plans in place as part of 6 goals improvement programme however this programme is not yet in implementation stage. Targeted improvement trajectories in place for USC group relating to 4hour ambulance delays and patients waiting over 12hours within the department which will improve overcrowding. This remains an ongoing risk for all three ED's and will be reviewed regularly as implementation of targeted improvement takes place. New review date 30/07/23	Quality & Safety Committee	20	C5 x L4	15 (C5xL3)	↔	24.09.2019	25.04.2023	30.07.2023
4907	Executive Director of Nursing	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager	Update April 2023- New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager now in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation.	Quality & Safety Committee	20	C4xL5	8 (C4xL2)	↔	02.11.2021	28.04.2023	30.06.2023
5267 (Capturing risks 4106 and 4157 which are now closed)	Executive Director of Nursing & Quality	Centre Support Function - Patient Care & Safety - Nursing	Deputy Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	There is a risk to the delivery of quality patient care due to difficulty recruiting & retaining sufficient numbers of nurses	**IF:** the Health Board fails to recruit and retain a sufficient number of registered nurses and midwives due to a national shortage & Health Care Support workers (HCSW's) **Then:** The Health Board's ability to provide high quality care may be impacted as there would be an overreliance on bank and agency staff. **Resulting in:** The potential for disruption to the continuity and of patient care and risk of suboptimum team communication due Potential to impact on patient safety and staff wellbeing. Financial implications of continue high use of agency cover (includes registered nurses and HCSW's) Please note - this risk is an amalgamation of two previous risks i.e., 4106 and 4157, these have been closed with a narrative to state this combined new risk has been created.	Proactive engagement with HEIW Scheduled, continuous recruitment activity overseen by WOD. Overseas RN project continues. • Close work with university partners to maximise routes into nursing • Retire and return strategy to maintain skills and expertise • Dependency and acuity audits completed at least once in 24 hrs on all ward areas covered by Section 25B of the Nurse Staffing Act; this has now been rolled out to all wards within CTMUHB. • Reporting compliance with the Nurse Staffing Levels (Wales) Act regularly to Board • Regular review by Birth Rate Plus, overseen by maternity Improvement Board • Implementation of the Quality & Patient Safety Governance Framework including triangulating and reporting related to themes and trends • Targeted approach to areas of specific concern reported via finance, workforce and performance committee The HCSW agency shift requests will follow the same type of forms and sign off from December 2022. Nurse Roster Policy now approved, ratified and implemented in December 2023. This includes KPIs which will allow monitoring of effective roster management. Automated nursing agency invoicing system implemented within the Health Board by the Bank office team - rosters must be locked down daily to enable the system to work- provides more rigor to roster management at ward/ department level.	NURSE ROSTERING Nursing Productivity Group actions are progressing well through this forum. Registered Nurse Off contract agency in hours and out of hours forms have been in place for two months – there has been a noticeable reduction in usage and thus spend on off contract Registered Nurses. Workforce and finance teams are working together to provide joint metrics and monitoring of agency usage and cost progress monitored via Nursing Productivity group who report into the Value & Effectiveness portfolio group. SAFER CARE Roll out continues on all sites. ENHANCED SUPERVISION Corporate nursing team are due to undertake focused work on areas who have a high number of HCSW agency requests to understand the demand in terms of whether HCSW's are required to support the supervision of an individual or group of patients, whether the requests are related to the increase acuity or due to high sickness/vacancy rates and/ or poor fill rate from bank HCSW requests. The risk score for this risk has been increased to 20 in January 2023 due to the fact that severe operational pressures in the clinical areas, including the opening of several different areas of unfunded beds and frequent "boarding" of additional patients on some wards mean the frequency of the likelihood which was scoring 4 ((Frequency: At least weekly) is now scored at 5 (Frequency: At least daily). This score will be reviewed in March 2023 Update 11/05/2023: The Health Board are linking into National Retention Work-stream and contributed to drafting the National Framework. In line with NHS Wales the Health Board have implemented Exit Questionnaires and supporting interviews, where appropriate. Undertaking "Coffee mornings" for spouses of CTM UHB employees to undertake an assessment of eligibility to apply for the registered nurse adaptation process. The Corporate Nursing team working with People Services on focussed aspects of recruitment and retention. The Corporate Nursing team is collaborating with the University of South Wales, in relation to International recruitment of Student Nurses to their undergraduate programmes. Undertaking Mobile Recruitment Fairs to support student streamlining. School Career Fairs – to attract younger people into the profession and also promoting the Apprenticeship Scheme.	Quality & Safety Committee	20	C4xL5	C4xL3	↔	25.10.2022 (It should be noted that although the new reframed risk opened in October 2022 the previous iterations of this risk - Datix ID 4106 and 4157 were opened on the 01.06.2015 and 01.01.2016 respectively)	11.5.2023	11.06.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3131	Chief Operating Officer	Diagnostics, Therapies 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.	Long Term Mortuary Capacity Plan. (5 year lease of additional capacity based at PCH has been approved by Executive leadership team in November 2022. Additional unit delivered and preparation and equipping underway to go live by the end of January.) Ongoing discussions with the Coroner have resulted in a 1 year reprieve of post mortems by CTM staff but continuing use of Mortuary space at PCH for external Medical examiners to use from January 2023. SLA being drawn up. Plan to implement electronic white boards for mortuaries in 2023-24. April 2023 - DTS Care Group have advised that they have consciously reduced the risk as the Health Board is past the winter peak where we anticipated major issues and the 5 year rental on the new unit providing an additional 85 spaces at PCH site mitigates and reduces the risk. The Health Board continues to have the Nutwell units as additional (rather than being used as daily capacity as they were prior to January 2023) should there be a surge. The Care Group are comfortable that this risk may be dynamic but consider there is strong mitigating action in place that has been well supported and recognised by the executive team. Should the situation deteriorate the Care Group will make sure they review and amend and escalate as appropriate.	Quality & Safety Committee	16	C4xL4	C3xL2	↔	05.03.2018	23.3.2023	31.5.2023
5036 Link to RTE 5155	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Service Director - Diagnostics, Therapies and Specialties Care Group	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm & Statutory Duty / Legislation	Pathology services unable to meet current workload demands.	IF: Pathology services cannot meet current service demands. THEN: - there will be service failure - there will be continued delays in reporting of Cellular Pathology results - failure to provide OOH services required for acute care - inadequate support and accommodation for Clinical Haematology cancer patients - increased turnaround times for provision of results including timely autopsies - increased pressure on existing staff - inadequate training provision throughout - inability to repatriate services from Bridgend. RESULTING IN: 1. Failure to meet cancer targets and national cancer standards 2. Anxiety for patients waiting for delayed results 3. Unsuspected cancer cases being missed in the backlog potentially leading to patient harm. 4. Delays in the reporting of critical results and issue of blood products OOH leading to patient harm 5. failure to meet the standards required for provision of autopsy reports for the ME service 6. Clinical incidents due to errors and poor training. 7. Poor compliance with legislation and UKAS standards (that are mandated by the HB and Welsh Government). 8. Reputational damage and adverse publicity for the HB. 9. Continued inequity of services provided to CTM patient population. 10. Suboptimal care for Haematology cancer patients	1. Triaging of patient samples (into urgent & routine) as they arrive into Cellular Pathology. 2. Outsourcing of routine Cellular Pathology backlog to an external laboratory (LDPATH) 3. Expansion of Cellular Pathology into POCT training room. 4. Capital bids being progressed for ageing equipment. 5. All Wales LINC programme for implementation of Pathology LIMS and downstream systems. 6. Use of locums throughout all departments. 7. Advertisement and recruitment for vacant posts 8. Use of overtime to cover OOH services. 9. Business case to increase capacity of CNS support for Clinical Haematology patients. A Cellular Pathology Recovery Plan paper has been submitted to the Executive team for review - end of May 2022	Blood Bank Capacity Plan Due date 1.12.2022 Demand & capacity review Due Date 31.07.2023 Workforce redesign Due date 31.07.2023 Dedicated Pathology IT resource Due Date 31.7.2023 Accommodation review Due Date 31.07.2023 Novation of Equipment to the Managed Service Contract Due date 3.7.2023 Update April 2023 - Risk score reduced to 16 to reflect current position, this is dependent upon ongoing review and continued investment from the HB.we have consciously reduced the risk to 16 as we have had funding to year end to continue the outsourcing and there is a tentative commitment for a significant amount to continue the outsourcing through 2023-24 which we are comfortable that it allows us to reduce the risk on that basis. We will keep this under review and should the situation change we will update the risk register and adjust the risk assessment appropriately.	Quality & Safety Committee	16	C4 x L4	6 (C3xL2)	↔	02.03.2022	23.3.2023	31.05.2023
5254	Executive Director of Nursing.	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 April 2023: New operating model in respect of quality, safety and governance almost fully implemented. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full Duty of Candour implementation. Local impact assessments across Wales are almost complete, which will form the basis for the National Impact Assessment.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	27.04.2023	30.06.2023
4479	Executive Director of Nursing & Midwifery	Central Support Function - Infection, Prevention and Control	Deputy Lead Infection Prevention Control Nurse & Decontamination Officer,	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	No Centralised decontamination facility in Princess of Wales Hospital (POWH)	**If:** there is no centralised decontamination facility in POWH **Then:** there are a number of areas undertaking their own decontamination via automated/manual systems. **Resulting In:** possible mismanagement of the decontamination processes/near misses/increased risk of infection/litigation risks and non compliance with national guidance/best practice documents. The hospital site is at risk of losing their JAG accreditation in Endoscopy if plans to centralise decontamination is not progressed. There is no dirty - clean flow for procedure room 2 in endoscopy. There is some decontamination equipment in HSDU that needs replacement. The decontamination equipment in Urology is at the end of it's life and there are regular service disruptions due to failed weekly water testing results.	Monthly audits undertaken in all decontamination facilities in POWH by the lead endoscopy decontamination officer and results shared at local decontamination meetings. AP(D)support available on site. Monthly 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.	Centralised Decontamination Facility at POWH - 02/08/21 - SOC approved by WG and design team appointed. Project team group and working group to be set up - Timeframe 30.09.2021. Each area that decontaminates scopes/intra cavity probes(outside CSSD)has developed SOPs detailing the decontamination process. Evidence of SOPs to be shared at decontamination meeting in POWH. Lead IPCN to ask Operational Lead for Decontamination to action. Update 3.5.2023 - Update 03.05.23 business case still being developed due to delays in tender returns and analysis. However scheme being subject to strategic review in light of consideration of the benefits of a regional solution	Quality & Safety Committee	16	C4xL4	2 C1xL1	↔	30.12.2020	3.5.2023	3.7.2023
1133	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site. September 2022 Review by Nurse Director for Unscheduled Care: Currently 6.3 wte ANPs in post with 3 new trainees commencing. Advert for locum Consultant in progress Ad-hoc locum for middle grade to cover for absences and planned leave	ED sustainable workforce plan developed and being implemented (May 2021). Reviewed no change as at 7th September 2021. Reviewed 21.09.2021 - remains working progress. Update September 2022 - Nurse Director Review 7/9/22: Unscheduled care group to review immediate workforce resource across all three acute sites by end of October 2022. Actions to then be decided in terms of immediate measures for distribution of staff, governance lines to be agreed (nursing, AHP and Medical) and immediate plan for winter months to be agreed and acted upon. Medium term and substantive plans for workforce requirements and innovations to be worked through as part of six goals board and advanced practice board.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4 x L4	12 (C4xL3)	↔	20.02.2014	12.10.2022	07.03.2023
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Due to capacity issues to deal with Covid-19 staff not attending medical gas safety training and courses being rescheduled.	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update April 2023: Action: Use reporting template to monitor attendance. Complete. Action: Med Device Trainer to review with another UHB what can be delivered via e-learning to support some elements of this subject. Timescale: 31/05/2023. Medical Device Training is in constant communication with clinical leads to create and adapt solutions to increase Medical Gas Training compliance across the UHB. As of Dec 22 the current Medical Gas training details for CTMUHB are as follows: Total Staff Requiring Training - 2287, Staff Trained - 168, Compliance Percentage - 7.34%, Untrained Staff - 2119. No significant increase in compliance. Attendance still poor for this subject matter, Med Device Trainer reviewing with another UHB what can be delivered via e-learning to support some elements of this subject, such as refresher training, however attendance would be required for initial training (WG 21/02/2023). The current risk rating will remain unchanged until Medical Gas Training Compliance increases significantly. As this remains at high risk, a review will be completed in 3 months. Review Date: 31/05/2023	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	30.3.2023	31.05.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
3585	Chief Operating Officer.	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Princess of Wales Emergency Department Hygiene Facilities	**If:** the toilet and shower facilities are not increased within the Emergency Department. **Then:** at times of increased exit block the facilities are insufficient for the needs of the patients in the department. **Resulting In:** Poor patient experience, complaints and further concerns raised from the Community Health Council have repeatedly flagged this issue on visits to the department.	There are additional toilet facilities in the radiology department that mobile patients can be directed to however staff do whatever they can within the constraints that they have. Additional facilities being explored as part of departmental capital works.	Additional facilities being explored as part of departmental capital works. There is a capital plan for improvement works in ED. The improvements will be – 1. NIV cubicle, 2. Creation of a second patient toilet, 3. Improvement to HDU area, 4. Relocation of Plaster Room, 5. Creation of 2 paediatric bays with adjoining paediatric waiting room, 6. Redesign of waiting room and reception desk. Prior to the Covid pandemic, improvements 2-6 were planned, but the creation of an NIV cubicle has taken priority. The plans are in the process of being signed off for all areas but there is no confirmed start date yet. There was / is potential for delays in sourcing materials by contractors and we need to consider the need to keep contractors as safe as possible from any Covid contact. Patient numbers are now increasing daily but we are restricting visitors and relatives attending with patients (unless required as carers etc). We have also developed a remote waiting room for patients who can safely wait in their cars. This will help to mitigate the footfall in the department when the capital work commences. Update February 2023 - Commencement of capital works in ED which will include a second, disabled access patient toilet. This will be situated within the main department and will be accessible for within the clinical area.	Quality & Safety Committee	16	C4 x L4	1	↔	31.05.2019	06.02.2023	30.04.2023
4148	Executive Director of Nursing & Midwifery	Central Support Function - Quality Governance (Quality & Patient Safety)	Assistant Director Quality, Safety & Safeguarding	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Non-compliance with Deprivation of Liberty Safeguards (DoLS)legislation and resulting authorisation breaches	**If:** the Health Board fails to adequately resource the DoLS Team to address the backlog of authorisations and adequately manage a timely and effective response to new authorisations. **Then:** the Health Board will be unlawfully depriving patients of their liberties and failing to comply with the DoLs legislation **Resulting in**: the rights, legal protection and best interests of patients who lack capacity potentially being compromised. Potential reputational damage and financial loss as a result of any challenge by the ombudsman or litigation.	During February 2023 review of this risk the control measures have been revisited and streamlined. - Hybrid approach to the management of authorisations which includes the ability to offer a virtual format if necessary, although face to face is the preferred mechanism. - An action plan will be overseen by the Deputy Head of Safeguarding to monitor the management of the backlog. - Welsh Government have agreed to a change of use of current 22/23 funding to appoint an agency to clear the current backlog. This agency includes Best Interest Assessors and section 12 Doctors to undertake assessments. - The current backlog is reviewed regularly to ensure that urgent authorisations are prioritised. - A further part time and full time Best Interest assessor were appointed in December 2022, their induction is now complete and they are fully integrated into the DoLS team.	The Health Board has received confirmation that the Welsh Government will be offering funding to address backlogs in authorisations, to provide training in the MCA and prepare the implementation of the Liberty Protection Safeguards. This will be offered in three stages. CTMUHB have already succeeded in securing a £123,000, this has been used to extend the Best Interest Assessor and the Practice Facilitator roles. There will also be a three day Best Interest Assessor post going out to audit in May 22. It is anticipated that the Health Board will need to apply for further funding throughout the year to address any backlog and plan to implement the LPS. - The implementation of the change in legislation with regards the Liberty Protection Safeguards will improve the Health Boards compliance however the date of implementation is still awaited. The Code of Practice is currently out for consultation. - The DoLs Team are meeting with leads within the Locality Groups to work with CSGs to progress the action plan in order to enhance the awareness of the MCA, the risks associated with DoLs authorisations and timely review required and reporting compliance. This work has commenced within YCC and YCR. There are plans to extend this work throughout CTMUHB. Update April 2023 - The Government have announced that LPS will not be progressed during this Parliament. However, Welsh Government are committed to strengthening DoLS and continuing to raise awareness of the Mental Capacity Amendment Act 2019. Therefore, further funding is available to CTMUHB to help reduce the DoLS backlog and provide training and awareness for MCA. A proposal has been submitted to retain the additional Best Interest Assessors and Mental Capacity act Practitioners. In addition, to utilise funding to appoint an agency to clear the current backlog of DoLS, this will include the use of s12 Doctors. Should funding be approved, the backlog of DoLS will be cleared within approximately two months. It has been confirmed that this funding is recurrent, which will allow CTMUHB to sustain a model that continues to complete DoLS in line with statutory guidance.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	01/10/2014	20.04.2023	20.06.2024
4152	Chief Operating Officer	Diagnostics, Therapies 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. Update April 2023 - PCR funding bid for 2 biochemists - FITT testing - new vetting criteria	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	17.04.2023	15.05.2023
4458	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	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update – UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) - rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4906	Executive Director of Nursing	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 April 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 and assisting Clinical Service Groups with improvements and learning from events. This transition came into place in April 2023. Training and a buddy system has been implemented to support this transition. 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. Better LFER reports are available per care group to allow for better oversight by the Care Group triumvirate. WRP are no longer accepting incomplete LFERs and therefore this will drive better and more timely completion of LFERs. Quality assurance procedure now in place to ensure learning is of the required standard. Increasing the approval rate. The approval rate is being monitored via the Executive Patient Safety meeting.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	27.4.2023	27.06.2023
4679	Executive Director for People (Executive Lead for Occupational Health)	Central Support Function - Occupational Health	Head of Service - Employee Health Wellbeing Service (Occupational Health)	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Absence of a TB vaccination programme for staff	**If:** the Health Board is not providing TB vaccination to staff **Then**: Staff and patients are at risk of contracting TB **Resulting in**: Failure to comply with the Department of Health and Social Care guidance and lack of confidence in the service	The 'fitness letter' issued by Occupational Health to the appointing line manager following an employee health clearance highlights vaccination status. Screening for latent TB for new entrants and offering T spot testing to assess positive or negative.	Update for May 2023 - A new process has been mapped which needs to be ratified with the Occupational Health Dr provision, Specialist Respiratory Nurse Team and Pharmacy before training and implementation of TB screening can take place. A meeting is being arranged to progress.	Quality & Safety Committee People & Culture Committee	16	C4xL4	8 C4xL2	↔	09.06.2021	21.04.2023	30.06.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
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.	Seeking confirmation that non-recurrent funding is made permanent for fixed term posts - timeframe 31.3.2022. Consideration required for further investment in the service to allow us to meet the demands on the service and reach the Welsh Government target of 80% of assessments being seen within 26 weeks. This will also reduce the need for WLI every year. Further investment in the service following D&C review - Timeframe - 31.03.2022. September 2022 Update – it was agreed at the August PCR Board meeting that funding would be made available to support an additional Consultant, uplift to for a member of the Pharmacy staff, the appointment of an Administrative Assistant and a Health Care Support Worker. In addition, Welsh Government has announced that there will be funding for ND services across Wales over the next few years. The funding will be allocated to Regional Partnership Boards for distribution in-line with Regional Integration Fund aligned to the six national models of care with emphasis on taking a whole system approach with education, social care, health and 3rd sector working to deliver new models of care. October 2022: Risk remains unchanged however, review underway with Clinicians. Next review 31.12.2022. Next review scheduled for 1.3.2023 regarding mitigating action - Consideration required for further investment in service. April 2023 - Improvement in waiting times with no children waiting >104 weeks. additional funding agreed through regional partnership board so the service model is being referred.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	25.04.2023	31.05.2023
3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2021. Need to plan for drop in theatres to mitigate work commencing	Need building work to be undertaken to ensure safety. Operating theatres will need to close for this to occur. Fire enforcement notice has been extended to December 2023 by South Wales Fire and Rescue Service, work is ongoing with the construction supply chain partner to complete detailed design, obtain planning permission, a costed programme and submit a business case to Welsh Government by Spring 2022. Progress has been made in identifying a preferred short term decant option for theatres which has a high level costing attached. Paper drafted for ELG consideration prior to further WG discussions to enable the commencement of detailed design work and a business case submission to secure WG funding. WG have requested an options review be urgently undertaken on this as the preferred decant option is indicatively costed at £50M. The ILG are confirming availability for a management review of alternative options for delivery prior to a stakeholder session. Post this a report will need to be prepared for and discussed with WG to determine the way forward in terms of business case processes and timings. Update September 2022 from Capital & Estates - initial meeting with WG indicated that further work required to follow up on alternative options to the 6 theatre modular build so follow up WG meeting being arranged for late October / early November. Supply Chain partner reengaged to undertake more detailed engineering and design works. Update November 2022 - Risk remains unchanged as the options work is ongoing and meeting with WG is likely to be at the end of November with an outcome to the options review being discussed at that meeting. It is expected that this meeting will confirm the preferred way forward. Updated Dec 22 - WG and SWFRS meetings deferred until January due to potential crossover of enabling and decant options with the planned procurement of the BA site in Llantrisant. Clinical engagement and option appraisal session planned for the 11th January to confirm preferred options for provision of decant theatres to support the main works taking place. Mobile theatres (revised design) have been visited and are being reconsidered as an option.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	3.5.2023	3.7.2023
4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of orthogeriatrician as NICE guidance and KPI1 NHFD	IF: If we do not have this specialist service THEN: our patients will receive suboptimal care than others in the UK and across Wales with potential for non achievement of KPIs set by the Welsh Government, increased length of stay, increased complications such as delirium and pressure ulcers and increased mortality. RESULTING IN: The inability to achieve good outcomes and care appropriately for our patients has a detrimental effect on staff wellbeing too.	The already stretched on call medical team are contacted for ad hoc advice. There is no COTE service and no specialist advice available	Recommendation: Employ a frailty team at each site to care for this complex group of patients. This may have cost benefits such as reduced length of stay, reduced complications and reduced complaints. Timeframe: 31.01.2022 Update June 2022: Funding for Consultant Orthogeriatrician identified and two COTE elderly posts in place. Update September 2022 - COTE and Orthogeriatrician service model being finalised for PCH. Timescale within next 3 months.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	30.06.2021	07.09.2022	03.10.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then:** If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update April 2023: SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/05/2023. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023- beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed. Review Date: 31/05/2023	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	13.04.2023	31.05.2023
3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	1. Process in place for clinical teams to access information via local authority and health board teams. 2. Clinical teams will only use historical information as part of their current risk assessment and if this is not available they will judge the risk accordingly. 3. WCCIS Programme Board establishment for CTM will be finalised by the 30th June 2021, Merthyr and Cynon CGS Lead will Chair this group. The Chair of this group will report to the Senior Responsible Officer. The Task and Finish Groups established and aligned to this Programme board. 4. Local Authority have recently developed reports for Mental Health which identifies practitioner caseloads, admissions and discharges and care plan for compliance. 5. Deployment order in place for all existing WCCIS mental health staff users 6. Community Drug and Alcohol Team in Bridgend have now moved over to WCCIS, early implementation learning continues to take place. 7. WCCIS Regional Working Group now has a representative from the Health Board to maintain pace of delivery for WCCIS mental health rollout. 8.CTM have set up a Project Board in partnership to prepare for implementation of WCCIS 9. Project manager has been recruited. This role is leading on the development and implementation plan. 10. Business Case identifying additional ICT resource to progress the disaggregation process developed and awaiting approval. Workforce capacity impacts on programme deliverables. Patient Safety Controls: • CSG's have undertaken initial review and rationalised staff access to all information systems to understand the presenting need for access. • CSG's have introduced mechanisms to monitor and control access to FACE/WCCIS/W Drive to ensure prudent access to patient information. • Each clinical team has at least one staff member with resources and training to access information in line with agreed permissions to ensure ease of access to available information from all systems. • RTE lead nurse will lead pan CTM MDT working group to develop consistent approach to clinical record keeping and monitor ongoing IG process/ workstreams (Meeting date in November to be confirmed).	1. A Business Case has been developed which identifies additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. Business Case pending approval. 2. Director of Digital, CTMUHB undertaking a review to understand if WCCIS remains the best solution to progress for CTMUHB in general and for Mental Health specifically. WCCIS "go-live" at ABUHB in August 2022. Lessons learnt group is attended by CTUHB Project Manager. 3. Options Appraisal completed with plans to present to the ELG on the 7th November 2022 with a view to progress to full Business Case. A service improvement and learning team is being established and the role of this team will be to develop robust oversight and mitigations in relation to record keeping until such time and integrated system is available. Update April 2023 - Use of Welsh Community Care Information System (WCCIS) in Mental Health Services : The HB has committed to rollout of v5 within 2023/24. The Director of Digital will be the SRO, working closely with the Service Director as digital and operation have to be aligned on the implementation process. The Programme Board is due to convene May 2023.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	28.04.2023	31.05.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer Director of Primary Care and Mental Health Services Rhondda Taf Ely Locality	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. A scoping document case to be prepared and submitted to Welsh Government -COMPLETE scoping Document submitted and agreement to commence a Strategic Outline Business Case received. 3. Develop a strategic outline business case. Timescale March 22 currently scoping the configuration of a future focused mental health unit - paused due to pandemic 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5.work paused due to pandemic. Resource to be identified to progress business case process 6. A Quality Improvement Programme in relation to inpatient care is being developed and a workstream in relation to therapeutic environments is being established with the aim of optimising the patient experience. Inaugural workshop to take place early 2023. 7. Recruitment has taken place for Assistant Director of Strategic Transformation and this role will lead a range of strategic programmes including recommencing a new capital business case for a new Mental Health Unit. COMPLETE Update April 2023: A Quality Improvement Programme in relation to inpatient care is being developed and a work stream in relation to Safe and Therapeutic Environments has been established with the aim of optimising the patient experience. Inaugural workshop is scheduled to take place on the 26th April. Estates escalation review undertaken in all 4 CSG areas. Estates strategic review in development which will align with RPM capital funding. RTE and Bridgend have significant opportunities for rationalizing and improving estate.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	25.04.2023	01.06.2023
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update April 2023 - No changes made bar next review date as cost of living crisis still relevant.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	13.04.2023	30.06.2023
4217	Executive Director of Nursing & Midwifery Infection Control	Central Support Function - Infection, Prevention and Control	Lead Infection, Prevention and Control Nurse	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	No IPC resource for primary care	**If** there is no dedicated IPC resource for primary care. **Then:** the IPC team is unable to provide an integrated whole system approach for infection prevention and control. **Resulting In:** non compliance with the reduction expectations set by WG. A significant proportion of gram negative bacteraemia, S.aureus bacteraemia and C.Difficile infections are classified as community acquired infections.	Liaise with specialist services in primary care e.g.. bowel and bladder service IPC team investigate all preventable community acquired S.aureus and gram negative bacteraemia and share any learning with the IPC huddles arranged in primary care to look at community acquired. Update August 2021: the IPC team is working collaboratively with the bowel and bladder service to investigate all preventable urinary catheter associated bacteraemia. Any learning points/ actions is being shared with community teams. Work in progress to start/reintroduce RCAs/IPC huddles for community acquired C.Difficile cases.	Update 11/05/23 - IPC Nurse Consultant, HARP Team has not commenced honorary contract with CTM as yet. Meeting arranged between Lead IPC Nurse and Nurse Consultant end May 2023. Deputy Executive Director of Nursing to undertake strategic review of IPC service.	Quality & Safety Committee	15	C3xL5	6 C3xL2	↔	16/07/2020	11.05.2023	11.7.2023
4721	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Shift of the boundary for attendances at the ED.	IF: the current boundary change to redirect emergency cases from the lower Cynon Valley to the Royal Glamorgan Hospital is not reviewed: THEN: patients will continue to be admitted to a hospital further from their home RESULTING IN: increased pressure on the medical teams to manage an increased patient cohort, lack on continuity of care with follow up arrangements closer to home	Boundary change currently subject to review to understand the impact across CTM.	Boundary change currently subject to review to understand the impact across CTM. Update April 2022 - Meeting to be convened between M&C and RTE clinicians to agree way forward. For discussion at Execs 25th April. Review 30.06.2022. No change to mitigation or risk score. Update September 2022 - Following review of this risk scoring by the COO the consequence score has been reassessed as a 3. This risk remains under constant review.	Quality & Safety Committee	15	C3xL5	12 (C3xL4)	↔	28/06/2021	11.10.2022	30.11.2022
4887	Director for Digital	Central Support - Digital & Data Function	Medical Records Manager	Improving Care	Service / Business Interruption	Retrieval and filing of case notes in the POW Medical Records Library	IF: The Medical Records Filing library at Princess of Wales is full to capacity making it very difficult for staff to retrieve and or file case notes. THEN: Risk of unable to manoeuvre mobile racking, therefore unable to access case notes Risk of fire as case notes close to source of ignition Risk of Fire Service or HSE closing access department Very High risk of upper limb injury Risk of notes falling from height causing injury (some case notes are in excess 8.3kg) Risk of Fire Service or HSE closing access to department RESULTING IN: If we could not retrieve any case notes, Consultants would be unable to make clinical decisions impacting on patient care. If the whole library was affected, this would impact 100 of thousands of patients care. Admissions/Outpatients would have to be cancelled staff refusing to continue to work in unsafe environment. Multiple and serious injuries to staff, possibly death.	(The case notes are very tightly packed on shelves. Mobile racking is failing due to age, lack of maintenance, and weight Case notes are being stored inappropriately on floors under desks, and insecurely at height. The working environment is congested, with no dedicated storage space for large ladders. Significant force is required to retrieve each file (123.N - this is 3 times higher than what is considered to be high force).) Broken Racking at Bridgend Offsite Stores - Repairs have been carried out with damaged racking in Bridgend North Rd Offsite stores. Temporary use of container deployed on site. Broken Racking at POW - On each occasion the racking has failed, the engineer has been able to repair it (£500 + VAT) but it continues to fail. Please see progress notes for more information. Access to this specific racking is permitted to Supervisors only, who only access it once a day. The Filing Library is closed to non-Medical Records staff, aside from the Porters who require access for emergency OOH admissions. Task and Finish group establish to address the above risks. Capacity has been identified at Glanrhyd and noticed served to SBUHB to vacate. It is hoped that we will be able to relocate notes to this area in mid-July, which will address the immediate H&S issues. Currently waiting for procurement process to be completed.	Update May 2023 – Relocation of case notes has taken place, these notes are now in storage at Glanrhyd hospital site. This has helped the situation in medical records Bridgend but still does not allow for sustainable growth of notes into the future. In response to this the destruction of notes embargo due to the infect blood enquiry has now come to an end and a piece of work is needed to understand the resource needed to scope and undertake destruction of suitable notes to future support the storage risk around patient notes. Based on this latest mitigation position the likelihood score has been reduced to a 3.	Digital & Data Committee & Quality & Safety Committee	15 ↓ 20	C5xL3	10 C5xL2	↔	27.10.2021	3.5.2023	3.6.2023

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
4908	Executive Director of Nursing	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in**: Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads The Health Board are reviewing the Covid funding in respect of the recruitment Covid19 specific Redress Handlers. Meetings with Care Groups to be established in respect of complaint responses to ensure legal aspects have been reviewed and validated.	The Health Board have developed an action plan in response to Welsh Risk Pool review, which is in the process of being delivered. Recommendation from the review are being monitored by the Audit & Risk Committee. All actions due to be completed by the end of March 2023. Update September 2022 - Benchmarking exercise completed, which demonstrates low staffing to workload capacity with counterparts across Wales. Invest to save bid has been drafted with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review and workshop is being held in Sept 2022 to review skill mix in the claims handling team. Update October 2022 - Invest to save bid has been completed and submitted for consideration, with a hope to recruit 2 Redress Handlers. In addition opportunities are being explored to realign resources from the changes to quality and safety within the Operating Model review. A workshop has been held with the Legal Services team to review ways of working moving forward into the new operating model. Update December 2022: - Invest to save bid was unsuccessful, therefore alternative funding options being explored. Some limited capacity will be realised in the new operating model for quality, safety and governance. CTM commissioned Legal and Risk to provide assistance and direction on the historic redress cases, however L&R have no capacity to take these over. Therefore, will have to be dealt with in turn, as part of the backlog.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	8 (C4xL2)	Invest to save bid was unsuccessful, therefore alternative funding options being explored. The new operating model is now at implementation phase with any vacancies being advertised. Once in post, there will be some extra capacity. An action plan to prioritise older cases has been developed. Extra capacity will be used to focus on the backlog in readiness for the implementation of Duty of Candour. Risk score has been reduced as a result of the above mitigation. At the Q&S Committee on the 16th March, members considered it premature to de-escalate this risk score as the action plan has not been completed. This has been deferred back to the risk owner for consideration on the 17.3.2023. Further rationale for de-escalation added as follows: Update April 2023: New operating model in respect of quality, safety and governance almost fully implemented. Legal Services Manager now in post. 1 claims handler post is due out to advert. Slippage monies due to vacant posts have been used for short term para legal agency to assist with the Redress backlog, in readiness for full DoC
5214 (Capturing risks 4590 and 4798 which are now closed)	Executive Medical Director / Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Medical Cover	**If**: Critical Care workforce issues across Medical, Therapies and Pharmacy teams. Requirements for standards set out in national GPICS documents - Critical Care provision. Unable to sustain 3x level III units across CTM due to these workforce issues. Need to provide a sustainable model to drive quality of care for patients. Mitigate the impact of Critical Care changes on other specialties. Agreement for new outline mode 2x Level III and 1x Tier 1 unit. **Then**: Critical Care Leadership group established to drive programme with pan-CTM CC group representing all sites to support CC Leadership. Colleague awareness that need them all as well as expanding the MDT workforce, including delivering care in new ways. Options appraisal with robust business case to support the clinical needed changes to the current model. Workforce integral to business case. Agreed funding in place and recruitment of Middle Grade tier currently happening at POW. **Resulting in**: Workforce in Critical Care integral to planning and model development. 2 year interim model to enable broader CTM plans with long term model to be determined. Recruitment process to change to sell the new model approach to fill funded gaps. PMO to support the model planning and implementation. Clear timeline of activity for CC Leadership to deliver stages of programme.	Daily management of the rota. Use of agency to cover gaps. CTM internal cover (limited options). Development of CTM strategy for Critical Care. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. 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.	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12. The risk of workforce establishment (and all the factor related to that) have been incorporated into the Medical Workforce Productivity Group. This group is chaired by the Medical Director who is responsible for this risk. The MPWG reports monthly and is overseen and accountable to the Value and Effectiveness Committee and the Transformation Board. As such it is under close scrutiny on a continual basis. By this process any areas of increased risk will be highlighted rapidly and addressed.	Quality & Safety Committee People & Culture Committee	12 (C4xL3) reduced from a risk score of 20	8 (C4xL2)	Update 12.4.2023 - 3 Critical Care related risks (4590, 4798 and 5214) combined. RR score reflected to overall score of 12.
4920	Executive Director of Therapies & Health Sciences	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Capacity within the ED/ Medical/ Rehabilitation and Orthopaedic Inpatient Occupational Therapy Service within Princess of Wales	**If:** clinical capacity remains significantly reduced due to staff sickness and vacancies **Then:** clinical service delivery will be negatively compromised. **Resulting in:** increased length of stay, potential clinical incidents, poor clinical outcomes for patients, and increase in complaints. It will impact on staff wellbeing within the team and increase incidence of staff sickness.	Regular team meetings to support prioritisation and wellbeing. Updating AHP lead in Bridgend ILG on potential impact.	Recruitment of locum. Additional hours offered, resulting in part- time staff working additional hours. Redeployment of staff according to clinical priority, utilising a therapies version of daily "safe to start" with AHP Clinical Director, where staffing is monitored daily Update September 2022 - Last review 30.8.22 next rv 31.10.22. No change to mitigations, recruitment in progress, and improvement in staffing is expected by November. Update October 2022 - No change to mitigations, recruitment still in progress. Update 28.12.2022 - two vacancies are anticipated to be recruited to March 2023 following the return of maternity leave and retire and return employee. Ongoing discussion with staff member temporarily re deployed due to Long COVID regarding returning to substantive post. Review 31.3.2023 Update February 2023 - No change for this period, next planned review is due 31.3.2023. Update April 2023: risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.	Quality & Safety Committee	12 (C3xL4) reduced from a risk score of 15	12 (C3xL4) Target score is being revised hence the risk has not been closed.	As a result of the following update the risk likelihood has been reduced. risk deescalated to a score of 12 (consequence score of 3, and a probability score of 4), as new staff are being recruited and staff are returning from maternity leave and sickness absence.

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
5014	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of Obstetric & Gynaecology patients in the ED at the Royal Glamorgan Hospital	**If** patients present at the ED at the RGH with obstetric and gynaecology related issues there is a risk that there could be delays in treatment and transferred required to hospitals with obstetric and gynaecology services. **Then** they will need to be transferred to a site with the appropriate services **Resulting In** a delay in the provision of appropriate care and treatment and this could lead to in-utero death, neonatal injury or disability, death of a pregnant lady due to blood loss and a loss of reproductive ability.	Pathways in place and subject to regular review. WAST is aware of the patient pathway and the need for O&G patients to go straight to PCH. Patients self presenting at the RGH ED would be prioritised for transfer to PHC Emergency cases would receive immediate general surgical care from non O&G specialists	Update May 2023: Children and Families Care Group have reviewed this risk and advised that any incidents are investigated and learning used to update SOPs e.g. The obstetric SOP is frequently reviewed to incorporate learning and improvements. There is a meeting on the 25th May to meet and review Gynae and Obs pathways between the Care Group and ED in RGH . The Care Group have revisited the scoring for this risk and determined that the liklihood should be reduced to possible. It is possible hat it could happen and when it does the consequence could be major.	Quality & Safety Committee	12 (C4xL3) reduced from a risk score of 16.	C4 x L2	As a result of the Children and Families Care Group review and current mitigation the liklihood of this risk occurring has been re-assessed and reduced. Therefore this risk is de-escalated from the Organisational Risk Register.

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
4253	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Ligature Points - Inpatient Services	**IF:** the Health Board fails to minimise ligature points as far as possible across identified sites. **Then:** the risk of patients using their surroundings as ligature points is increased. **Resulting In:** Potential harm to patients which could result in severe disability or death.	**Bridgend Locality:** The anti-ligature works has not yet been completed and signed off. There are snagging issues on ward 14 and remedial decoration. On PICU the bathrooms have not been started. All works have been chased by Senior Nurse to project lead for updates on completion. Actions identified for escalation if no update received regarding completion dates. The risk score remains unchanged at present. o Increased Staff observations in areas where risks have been identified. o Any areas of the unit not being occupied by patients are to be kept locked to minimise risks o The use of safe and supportive observations o Risk assessment process for patients and environment is in situ o Some ant-ligature work has been completed in some bedrooms which are used for patients assessed as being at higher risk.	**Bridgend Locality:** o action plan developed with support from the head of nursing within the ILG. o Heath Board has approved additional staffing by night and to fund the outstanding capital anti ligature works. guidance issued to all staff on the implementation of local procedural guidelines. o Use of therapeutic activities to keep patients occupied Update 25.5.2022 - Major Works complete and official handover undertaken on the 25th May 2022 with contractor. Risk scoring reduced from a 20 to a 15. The Target Score has not been met as there are still works to complete internally with Estates. Bridgend 28.10.22 All anti-ligature works in PICU, Ward 14, Angleton have been completed and areas handed over subject to completion of a few outstanding snags by the contractors. Work is awaiting final sign-off. Review end of December 2022 with a review of revisiting the risk score. Update May 2023 - From a capital perspective they have undertaken all the required anti ligature works to which this original risk referred and these have all been signed off by estates.	Quality & Safety Committee Health, Safety & Fire Committee	Jan-23	Risk Closed 13.1.2023 - Health Board Capital works department have signed off all of the schemes connected to the anti ligature work. On Hold in closure section. This will not be removed from the Organisational Risk Register whilst sufficient assurance is sought to the satisfaction of the Audit & Risk Committee. Confirmation received that the capital works have been completed. Consideration at the Audit & Risk Committee in April 2023. **May 2023 -** to close as confirmation of works completed received.
4590	Executive Medical Director	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Critical Care Pharmacist Resource	**If:** additional resource is not identified to increase the critical care clinical pharmacy service **Then:** there is a risk that insufficient support can be provided to meet national standards and there would be lack of capacity to support future surges in demand, such as Covid. **Resulting In:** an increasing risk to patient safety, increased workload for critical care nursing and medical staff and lack of appropriate support for digital developments such as e-prescribing	SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Meetings to discuss potential funding arranged with ACT leads. INCLUDED in the Reconfiguration Group work for sustainable model. New Chief Pharmacist aware o f issue and forming part of their evaluation of Pharmacy model across CTM. SBAR included in Medicines management and advised to include in ACT directorate IMTPs. Baseline level of service (0.2wte) pharmacist time per site. A small pool of CC trained pharmacists are providing clinical services to acute wards which would be impacted if they are redeployed to support ITU, resulting in risk to patient safety and flow on acute wards.	June 21: Current situation included in planning review of CTMUHB ICU services Aim is to secure funding for 1WTE 8a specialist pharmacist for each critical care in RGH, POW and PCH and also supporting technician resources Update November 2021 as reported to the Quality & Safety Committee: Discussions are ongoing with ILGs so that pharmacy resource costs are included in any new business cases e.g. PACU and progress can be made to meeting the standards. Update February 2022: Discussion are ongoing with ILG's and submission for funding was made in Medicines Management in IMTP Feb 2022. Update August 2022 - Currently 40% gap in staff in post vs standards (1.5 wte) across all acute sites. Funding agreed for RGH and staff recruited into post. Currently non-recurrent. Funding request submitted within IMTP. UPDATE DECEMBER 22 - new Reconfiguration Group to address all workforce shortfall issues (inc Pharmacy), also part of new CP plans	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalat5ion section of the Organisational Risk Register/
4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Diagnostics, Therapies and Specialties Care Group	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 16-9-21 Continuing with therapy business case as actions below. No other updates	Discussions with all 3 critical care units regarding repurposing of funds to develop SLT posts. Nursing leaders aware and case being taken to next Operational Management Board. Three separate organisational critical care risks for workforce (medical, therapies, pharmacy) on Risk Register. Single combined risk has been drafted.	Quality & Safety Committee	May-23	Risk Closed as amalgamated into Datix Risk ID 5214 - captured in the de-escalat5ion section of the Organisational Risk Register/
4512	Chief Operating Officer	Unscheduled Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Care of patients with mental health needs on the acute wards.	**If:** there is a consistent number of patients with mental health needs who are being cared for on the acute wards without RMN support or there are delays in discharge an appropriate EMI setting; **Then:** patients who have been sectioned and / or are under medication review may remain on wards where specialist mental health therapy and input is not possible; **Resulting in:** incidents of staff and patients assaults may occur; poor patient experience; increased supervision needed.	MHL team contacted for each patient who required support; 1:1 patient supervision where required; Ward manager and senior nurse undertake regular patient reviews; Regular meetings with the mental health CSG in place. , number of working groups established and working well.	Regular meetings with the mental health CSG in place, number of working groups established and working well. No change to mitigation or risk score. Update September 2022 - update requested from the Deputy COO - Primary Care, Community and Mental Health. Update October 2022 - Deputy COO - Primary Care, Community and Mental Health and Interim Clinical Service Group Manager, Mental Health are reviewing this risk and consider that the risk score will be reduced in the next update of the Organisational Risk Register. Timeframe assigned: 31.12.2022.	Quality & Safety Committee	May-23	Update 24th April 2023, risk has been reviewed and updated, no longer a site risk and individual risk assessments are completed on patients should there be delays, this will capture the impact and actions for the patient therefore progressed to closure.

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
5323	Chief Operating Officer	Diagnostics, Therapies and Specialties Care Group	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fluoroscopy Room has become Obsolete	IF room 3 in POW is not replaced THEN there will be situations where there is no interventional Radiology service at POW (during maintenance and potential break down of Room 6) RESULTING IN having to transfer very unwell patients to other hospitals, pressure on staff and services at other sites to accommodate. Overall poorer patient experience and potentially outcomes.	Utilising Room 6 to its full capacity Some Barium lists being performed at RGH when possible	Completion of SON to support replacement of Room3 - Timeframe 27.1.2023 30.1.23 RGH has list every other Friday SON submitted, initial agreement to fund new room Welsh Government funding received in 22/23 to procure new equipment - currently in storage. Detailed design work completed for new room and works out to tender. Works expected to be undertaken over the summer and completed by autumn	Quality & Safety Committee	May-23	Updated April 2023 - SON submitted and has been approved and is progressing. initial agreement to fund new room 17.4.23 Patients continuing to transfer to RGH - Equipment purchased, awaiting building works at POW. Target score met.

AGENDA ITEM
5.2

QUALITY & SAFETY COMMITTEE

HEALTHCARE INSPECTORATE WALES ACTION PLAN TRACKER - PROTOTYPE

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas Business Manager Patient Care & Safety Group
Presented by	Greg Padmore-Dix Executive Director of Nursing
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
HIW	Healthcare Inspectorate Wales
AMaT	Audit Management and Tracking
ILGs	Integrated Localities Group (s)
CTM	Cwm Taf Morgannwg

1. SITUATION/BACKGROUND

1.1
As Cwm Taf Morgannwg University Health Board is an NHS organisation Healthcare Inspectorate Wales regularly inspect all the sites and services by either announced or unannounced inspections, HIW also regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

Following every HIW inspection a report of their findings is developed and where applicable an improvement plan detailing the findings by HIW and the agreed CTM improvement action(s), together with identifying the responsible office and timeframe for the actions to be completed is progressed and once finalised and approved by CTM and accepted by HIW is published on HIW website.

One of the recommendations from the structured Assessment 2018 R6 not closed relates to the action that 'the audit recommendation tracker should be expanded to include the recommendations of other external agencies e.g. Healthcare Inspectorate Wales and the Delivery Unit'.

Currently the central team provide an overview report to each Quality & Safety Committee on a bi-monthly basis reporting on HIW activity for the timeframe in between each meeting.

Responsibility for ensuring all actions have been appropriately completed and continuous monitoring for compliance has previously sat within the former ILGs (now Care Groups following the changes within the organisational change plan).

In line with the organisational changes and the Care Group model, the ownership and accountability for each HIW improvement plan will sit with the Care Groups and the Clinical Service Groups reporting to the Quality Safety and Patient Experience group of each of the relevant Care Group.

Oversight and continuous monthly review for assurance to the Executive Directors, Quality & Safety Committee and Board will sit within the central team, who have developed a tracker document to monitor all open and live HIW inspection improvement plans until the implementation of AMaT has been completed to allow for continuous monitoring of all the HIW improvement plans following each inspection.

The tracker will be sent to each of the responsible Care Group leads at the end of each month for an update on actions and whether these are closed, or where these have passed the timeframe, an update on the mitigating

reasons why not completed and a new timeframe for completion will be requested.

Whilst the further work is being scoped within AMaT to capture the actions arising from HIW activity allowing for the themes and trends to be identified and allow one dedicated space to capture oversight of HIW actions/ recommendations across the Health Board, all HIW inspection improvement plans are being closely monitored on a monthly basis via a centrally held tracker, which is in addition to all HIW inspection activity being included as a standing agenda item on the Care Groups Quality, Safety & Patient Experience Governance meetings as well as a monthly oversight at the Executive Director led Patient Safety meetings.

The development and implementation work of AMAT continues with the Programme Manager for AMaT in order to make a number of changes to the fields currently in the inspection module of AMaT to allow sufficient management and the ability to monitor progress against recommendations arising from HIW inspections.

The inspection module within AMaT is not restricted to HIW inspections and can include all types of inspections, internal and external audit plans, visits and accreditation with work to date having been jointly undertaken with the Business Manager Patient Care & Safety and the Corporate Governance Business Manager as well as the Assistant Director of Governance and Risk to, where possible, make changes to some of the fields within the inspection module to ensure it is compatible with the requirements of CTM UHB for recording, managing and the continuous monitoring of all Improvement plans following a HIW Inspection.

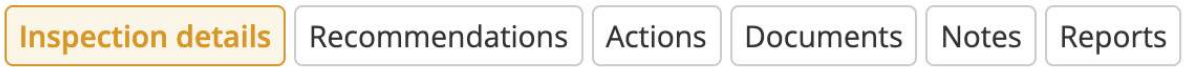
AMaT is used by several health boards across Wales and there are only a small number of changes that can be made to make the module health specific due to the All Wales use of the module.

Some changes and improvements to the fields in AMaT have already been made to date and following an overview session of the inspection module which was delivered to the Executive Nurse Huddle meeting on 12th April 2023 there was agreement from all to proceed with this module for assurance and monitoring of HIW Inspections.

The overview of the module demonstrated the functionality for the Care Groups to have overall accountability and assurance of the actions for their care group areas.

Dashboards **Your Inspections** **Inspection Actions**

Section to Update Inspections:



Updating and approving actions

Do you have overdue actions?

- Click on the on the top right corner of each AMaT page to see your To Do List and links to overdue items.

Action Status - When an action is added it is set to 'In progress', it can then have the following status.

- Go to the 'Actions' tab in the inspection.
- Click on 'Manage' for the actions you wish to update or approve.
- Choose 'View & Edit' from the menu.

If updating the action, add comments of completion and upload evidence, then change the **STATUS**.

approving the action, read the comments and view the uploaded evidence, then change the **STATUS**.

In the module you are able to reject an action and if this happens the originator of the action will receive a notification and be able to update the action once again

Below is a table of the status available, against each of these status the system allows a report to be produced:

Rejected (To be resubmitted)

Fully complete (Approved)

AMaT has the ability to produce a range of reports which includes but not exhaustive:

- Inspections – a report detailing all the inspection details for the inspections detailed in 'Your Inspections' section of the dashboard
- Inspection report – a report detailing all the information recorded within an inspection
- Actions – a report detailing all the actions
- Recommendations- A report detailing all the recommendations for an inspection

AMaT has the functionality to provide a weekly email notification to each user who has due or overdue items in AMaT, each user will automatically receive the email at 8am each Monday morning. These actions will also be available to access through their To Do List on AMaT.

The AMaT system will automatically send a notification email when:

- A New inspection recommendation is added
- New Inspections actions are added
- An action has been updated
- Action status update
- Action rejected
- New inspection note is made

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

2.1 Note the ongoing work to implement the AMaT system and the transition from the audit tracker over to the Inspections module within AMaT

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

3.1 No matters for escalation

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

5.1 The Quality & Safety Committee is asked to **note** the work completed to date and to support the progress to implement all HIW Inspections within the AMaT Inspection Module

(Agenda Item 6.1)	24.5.2023	Quality and Safety Committee	Maternity and Neonatal Metrics

Report Details:	
FOI Status:	Please select: Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Suzanne Hardacre Director of Midwifery and Nursing Children and Families Care Group
Presented By:	Suzanne Hardacre Director of Midwifery and Nursing Children and Families Care Group
Approving Executive Sponsor:	Greg Dix Executive Nurse Director
Report Purpose	Please Select: For Noting
Engagement undertaken to date:	Not applicable

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Outlined within the presentation
Related Health and Care Standard	Safe Care Individualised Care Governance Leadership and Accountability Timely Care
Has an EQIA been undertaken?	No – Not a policy or guideline
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Sustaining Our Future Inspiring People Improving Care Creating Health

Maternity & Neonatal Improvement Programme – Transition into Health Board Arrangements & Oversight

No.	Milestone	RCOG rec	Completion date	Owner	Current status	Supporting comments. Please provide details on status rating	Risk to delivery identified?
1	Long-term strategy - Staff and public consultation and finalise	7.67	31 December 2022	SH	completed	11/1/23: With Comms dept. being prepared for launch; tbc by DOM	
2	Maternity/NN priorities included in CTM long-term strategy	7.67	31st March 2023	SH	on-track		Dependent on CTM long-term strategy development
3	Re-run Culture Survey	7.56	31st March 2023	SH	delayed	Both Maternity and Neonatal	
4	QI plan implementation (joint Maternity/Neonatal)		31 March 2023	SH/EM	on-track	16/1/23: considerable progress including QI training; Mat/Neo collaboration and PERIprem	
5	Maternity dashboard go-live	7.63	30 September 2022	EM	completed	16/1/23: Maternity dashboard go-live Nov 22; with training support for staff;	
6	Joint Maternity and Neonatal dashboard	7.63	30 March 2023	EM/ROD	on-track	16/1/23: development of a tab for NN dashboard on Maternity dashboard	
7	Audit to be undertaken in 6 months time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level (CEPOD)	7.3	31st March 2023	ME	closed - see change below 22/11/22	16/23: Closed due to change in iterations based on Welsh Gov./IMSOP advice and ensuring delivery is according to Wales and UK wide expectations; see milestone below	
8	Revised - Audit to be undertaken in 6 months time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level (CEPOD) - tbc on 18hrs	7.3	30 June 2023	ME	complete d	16/1/23: all women presented in A&E to be seen within 12hrs by a consultant. This target is the ambition for HBs across Wales and UK. It is not achievable within the current workforce model. However, a strategic workforce plan is being developed, inclusive of both Maternity and Neonatal in the new CTM governance structure. CTM HB is currently compliant with the 18 hours window. To date no safety incidents have been raised. ***Action:*** *HB keep this under continuous review; MD presented to QSE 24.1.23 and NMS 19.1.23*	

Focus on Neonatal improvement programme:

- **Total 56 NN deep dive recommendations which include 14 escalations and 5 immediate**
- **All 19 immediate** actions completed
- **10** of the 19 **Medium term** actions completed
- **9** of the 16 **short-term** actions completed
- **1** of the 2 **long-term** actions completed
- Overall **17 remaining actions** to be completed
- BAU checks on **embedding improvements** to be completed

Tables demonstrating by timescale and workstreams completed/remaining actions:

Timescale	Total no.	Actions completed	Remaining actions
Immediate	19	19	0
Medium	19	10	9
Short-term	16	9	7
Long-term	2	1	1
Total	56	39	17

Progress at 24.4.23

- Handover from Programme Manager to Director of Midwifery and Clinical Improvement Lead for Neonates on 31.3.2023.
- Of 17 actions to be completed – 4 prepared for assurance and checking w/c 24.4.23, further 4 due (2 weeks).
- BAU testing evidence in practice – essential for sustainability.
- Transitional care pilot in progress at POW. Benchmarking exercise completed
- Clinical elements of Mat Neo Dashboard complete – awaiting final updates from Informatic colleagues.
- Several Perinatal collaborative QI projects underway – evidence of 'Bright Spots' nationally recognised within Mat Neo SSP.
- Neonatal IPAFF Challenge session held with SRO on 19.4.23.
- Care Group MatNeo Improvement Board in place (last meeting 24.4.23).
- Mat Neo Safety Board Oversight (28.3.23, next meeting 22.5.23).
- Meeting DoM & DU to agree Targeted Intervention Requirements
  - Evidence (QLM, QWFE, SEC) to be sent to DU in May
  - DU / Maternity and Neonatal Network site visit with showcase events by clinical colleagues at PCH on 5th June.

Maternity & Neonatal Improvement Programme – Wash up plan – remaining actions from RCOG recommendations on closure of the Programme.

Things to know: QI (training sessions held and projects identified) and Maternity and Neonatal dashboard development on-track; Medical Mandatory & Statutory Training uptake to be improved; Transitional care pilot to commence 17th April 2023

Milestone	Due	Progress
Long-term strategy (vision for next 3 years)	Mar 2023	Staff and public consultation finalised; Comms dept. for launch
Re-run Culture Survey – Maternity and Neonatal	Mar 2023	
Quality Improvement (QI) – Maternity and Neonatal	Mar 2023	Several QI training sessions held; with further 'adhoc' as required; Medics to increase uptake; Neonatal first QI MDT meeting to be held 2.3.23; also All Wales PERIprem launched to be inclusive of NNAP/MDT approach
Transitional care	Mar 2023	Being scoped; presentation to Maternity and Neonatal safety board 19.1.23; MDT meeting to be held 27.2.23; 3 month pilot to commence at POW on 17.4.23; Visit to Plymouth TC service 17.3.23
Joint Maternity and Neonatal dashboard	Mar 2023	NN tab being developed for inclusion onto the Maternity dashboard live (Nov 22); *note: Neonatal dashboard developed*
Audit to be undertaken in 6 months time to assess the average and range of time taken for emergency admissions to be reviewed at consultant level (CEPOD)	closed	Closed: change in iterations based on Welsh Gov./IMSOP advice; MD presented update to QSE 24.1.23; adhere to existing protocols 18hr window – fully compliant and no safety incidents

Neonatal Engagement

- Formal process of collecting prems data via civica
- Psychology support on the neonatal unit
- Family integrated care QI project.
- How we engage Social media posts (Facebook, Twitter),Engagement Forum (monthly)Awareness days, Face to face meet ups, Patient Stories, Sharing our progress and outcomes (You said, we did)
- Bliss peer supporters in progress
- Feedback metods,Collect compliments via social media,Thank you cards,PALS,Concerns.
- BFI Stage 3
- Grow brain training

Neonatal Safe and Effective Care

- Neonatal Pharmacist
- Governance nurse for neonatal services, robust governance review process.
- QI training
- Representation at all Wales NN network governance forums
- Forward audit plan
- Clinical improvement lead
- Perinatal Mat/Neo safety Champion for UHB.
- Progress of dashboard
- Peri-Prem Cymru
- Rotation of medical and nursing staff to tertiary centres.
- Robust reporting governance structure

QUALITY OF LEADERSHIP AND MANAGEMENT - NEONATAL

- Staff engagement
- Perinatal approach further maturing collaborative working (Mat Neo safety support perinatal lead/periprem. Joint metrics.
- How the leadership team are using data to drive service
- Workforce planning (Whssc, BPAM NOV 22, Mat-Neo safety support programme.
- Robust reporting structure.
- More visible leadership- Medical /Nursing
  - Establishment of senior leadership roles
  - Leaders have effective joint working relationships and
  - Evidence of High Trust.
- Proposed plan for addition roles within the service post project management office.
- Out of hours senior manager on call
- IMTP

Proposed Assessment Revisited: 15.8.2022	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care			Y		
Quality of Women's and Family Experience			Y		
Quality of Leadership and Management			Y		
Joint Maternity & Neonatal Working			Y		

Proposed Assessment 19/04/2023	Basic Level	Early Progress	Results	Maturity	Exemplar
Safe and Effective Care			Y		
Quality of Women's and Family Experience			Y		
Quality of Leadership and Management			Y		
Joint Maternity & Neonatal Working				Y	

- IPAAF Assessment 15.8.22 showed all domains to be in early results.
- IPAAF Assessment 19.4.23 showed all domains clearly within results with maturity for collaborative working with maternity.
- Evidence within QWFE of moving to maturity. Service asked to review self-assessment profile due to significant progress within this domain.

Background

Cwm Taf Morgannwg University Health Board has a history of successful collaborative working between Maternity and Neonatal Services and now works as one Perinatal Service.

External investigations and scrutiny have promoted the need for cross service multi-disciplinary team working across our Maternity and Neonatal Services.

Examples include:

ATAIN reviews

IUT Pathway (development and ratification)/Exception reportable birth discussions

Collaboration when undertaking NRI's

MDT handover each morning on labour ward

IUT Pathway

Development and Ratification Process- Collaborative Working

Ratification of the CTMUHB IUT Pathway. Aim to provide our birthing people and babies with the best care possible when experiencing threatened preterm labour.

- Work lead by Consultant Neonatologist and Intrapartum Lead
- Multiple MDT meetings held with representation from Maternity and Neonatal services to ensure effective collaborative working
- MDT approach throughout with consideration from each service valued by both parties
- The pathway has now been ratified and is the best it could possibly be because of the success of cross service collaboration

Exception Reportable Births- Case Discussion

If you have fewer than 6 sections feel free to delete

All exception reportable births (Singleton <32 weeks , Twins <34 weeks, BW <1500kg) discussed as a joint MDT to attain in the birth in our units was avoidable or unavoidable- (similar to ATTAIN).

- Joint MDT review with maternity and neonatal representation at each meeting
- Maternity and Neonatal services working as one 'perinatal team' when reviewing care and concluding if the birth in our unit was avoidable or unavoidable
- Any identified learning shared across maternity and neonatal services
- IUT dashboard developed to record cases, collate identified learning and visualise themes and trends in care

Exception Reportable Births- Dashboard

All exception reportable birth data collated onto IUT dashboard- one for each site (PCH/POW)

- Metrics used to identify themes in care for continued learning and improvement
- Metrics used or quality Improvement
- Identified learning collated and shared
- Data presented on various platforms for learning, quality improvement, assurance.
- Dashboard accessible by Maternity and Neonatal teams

Lessons learned

- Delay in final ratification of IUT Pathway- this was because of effective collaboration and time taken by each service to ensure the final pathway was the best it could possibly be.
- Effective collaboration can only improve patient care and outcomes.
- Development of the IUT Pathway and Exception Reportable Birth case discussion has set a president for future collaboration and the progression of the Cwm Taf Morgannwg 'Perinatal Service'.

Further information

Dr Amit Kandhari (Consultant Neonatologist)
Mr Mohammed Elnashar ty (Clinical Director)
Dawn Aspre (Intrapartum Lead POW)
Leanne Richards (Lead Neonatal Nurse for Improvement)

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

Neonatal Data

Current Format, how are we now using data?

- Work is underway to integrate neonatal metrics in to the Maternity dashboard- meeting 9th of February.
- Data capture forms completed.
- Additional tabs will be added with the neonatal data, including clinical and workforce metrics
- Combined dashboard will be available to all staff on SharePoint and utilised for quality, safety and improvement purposes

•Triangulate with Prems data

Collaboration through our improvement journey

In 2020, CTM also requested an external review of neonatal services. The neonatal services 'Deep Dive' review, resulted in 25 'escalations' for improvement. Joint working between maternity and neonatal colleagues was strengthened as a result.

For sustainably of the improvements made, Maternity and Neonatal Services recognised the need for presenting joint metrics.

Moving forward – developing the Neonatal dashboard

As a part of sustainability arrangements, neonatal services have monitored key metrics and identified areas for improvement on an ongoing basis. The dashboard was developed containing:

- clinical measures
- public health measures
- Governance data
- Commissioning/staffing numbers

All of the above is presented as time series data, refreshed monthly. Data is currently manually sourced from badgernet/mits/e roster every month

Creating a combined Maternity and Neonatal dashboard

Neonatal metrics were being reported regularly, with data extracted from various sources, including staff rosters and Badgernet. The data were being presented alongside maternity dashboard metrics for an overview of the whole service.

Work has been completed to develop the key neonatal metrics required for a thorough view of the service.

Support is being provided by IT colleagues to create additional tabs on the maternity dashboard that will include the neonatal data to create a combined MatNeo dashboard.

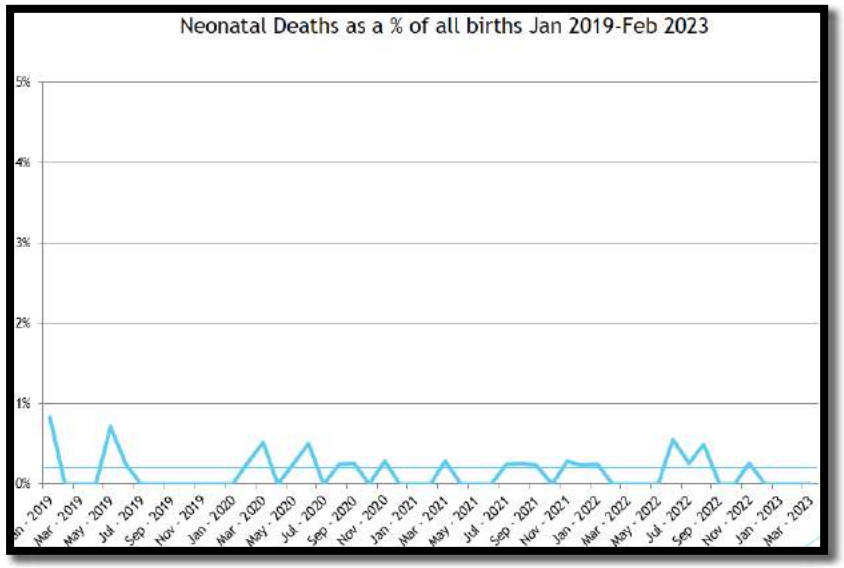
Model for Improvement

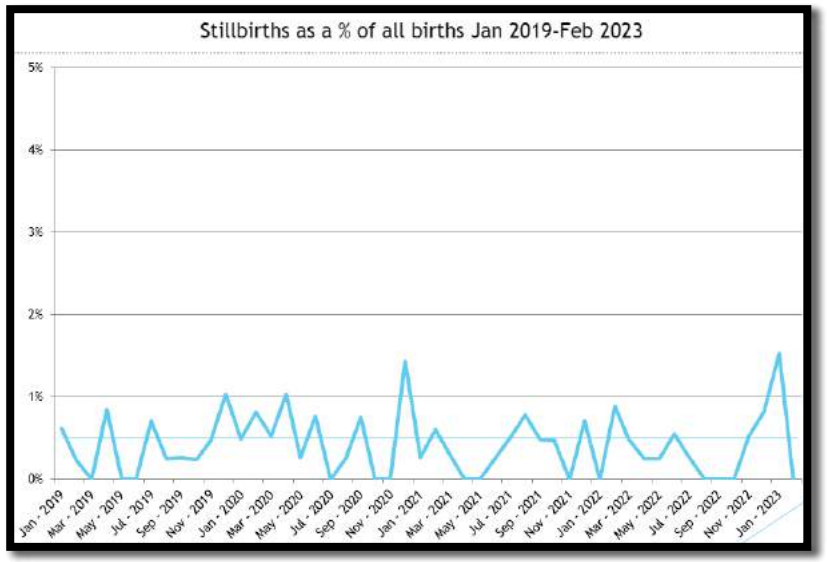
Quality Improvement

- Perinatal approach to improvement
- Mat neo safety support programme
- Peri-Prem Cymru
- Thermoregulation
- ROP
- ATTAIN
- IUT
- Family integrated care
- Golden drops.
- Streamlined pathway for staff to be supported in QI projects.

Data and Performance Working Group

- Ensure that essential data is collected accurately
- Highlight good practice through data collection and disseminate to the neonatal team
- Identify areas for improvement
- Share the highlight report with clinical teams, managers and service leads so that data informs decision making and QI projects
- Engage the junior team and colleagues in QI projects
- Bench mark against similar units and national standards
- Share successful projects throughout the network

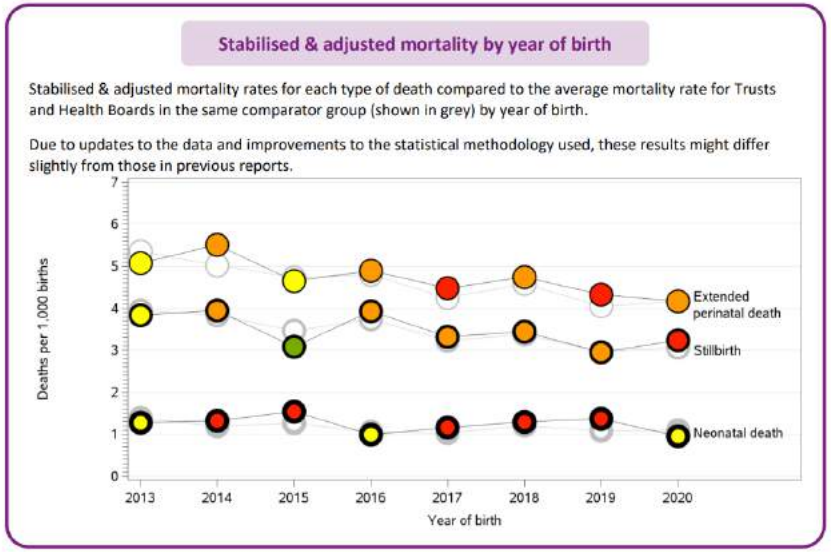




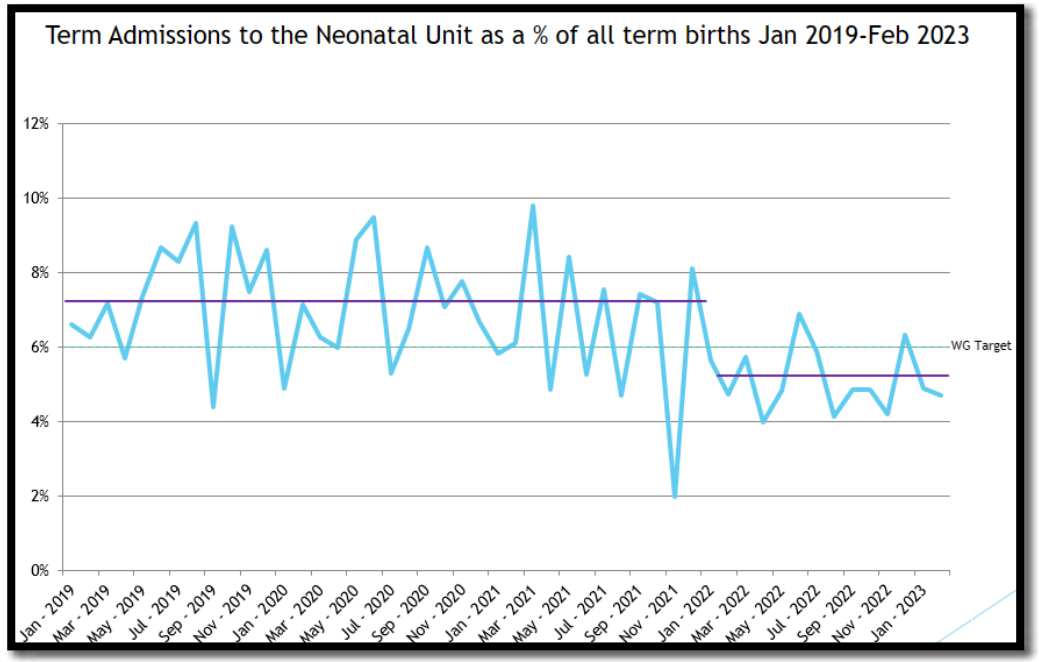
Stillbirth & Neonatal Death rates stable over time.

MBRRACE Data for 2020 cases
Reduction in extended perinatal death.

Local and National QI initiatives in place



MBRRACE 2021

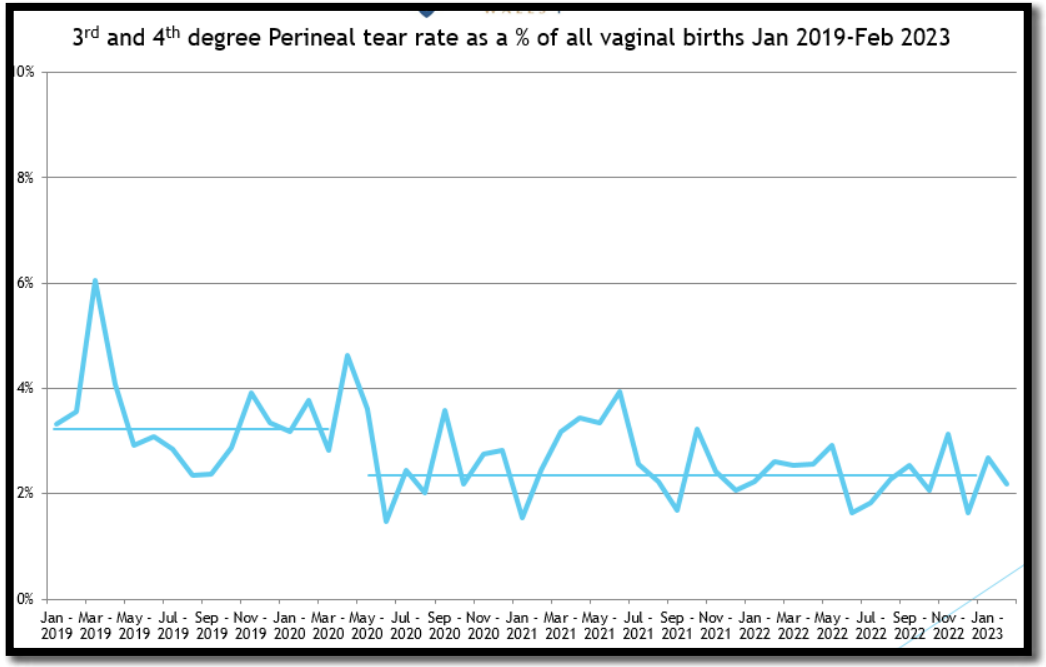


Term Admissions to Neonatal Unit

7.5%. Median re-set Jan 2022 as 6 points below the median line, now 5.1%. ATAIN QI group continues to review and support best practice

3rd & 4th Degree Tear Rate

No change in median for 3 years. Not an outlier.



Maternity & Neo Data, Performance & Quality Improvement - ATAIN

What Went Well..

- 7.5%. Median re-set Jan 2022 as 6 points below the median line, now 5.1%. ATAIN QI group continues to review and support best practice.
- Metrics remain stable no exceptions to report.
- There were no babies born outside of gestational criteria in CTM 100% of shifts maintained BPAM standards.

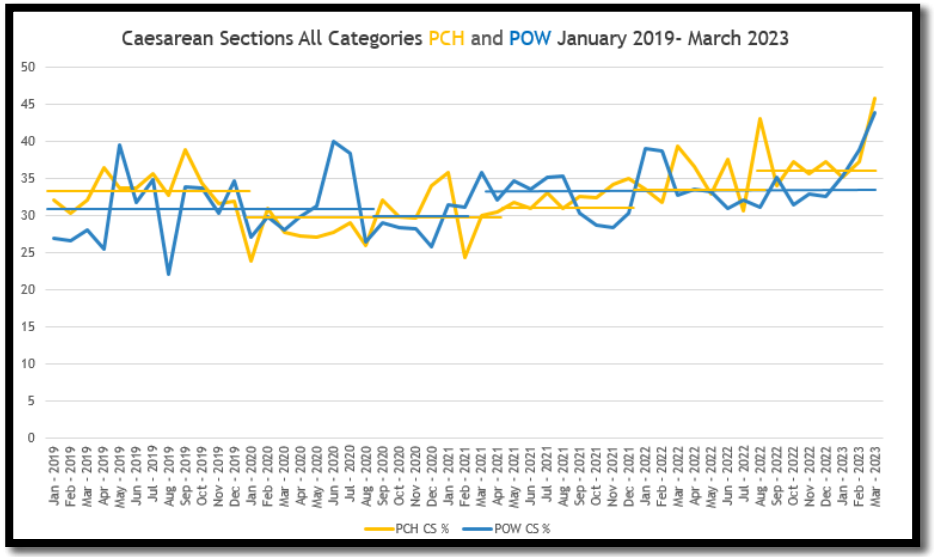
What needs to improve..

- Respiratory distress remains the most common reason for admission of term babies
- Receiving Breast milk on discharge remain low however this is a consistent metric. Repatriated infants have often made this change before admission to CTM.
- Staff unavailable for work in NN units in CTM remains high (POW)
- Watch closely the infants temperature on admission as there is an increase of admission temperatures above 37.5

Actions for Improvement..

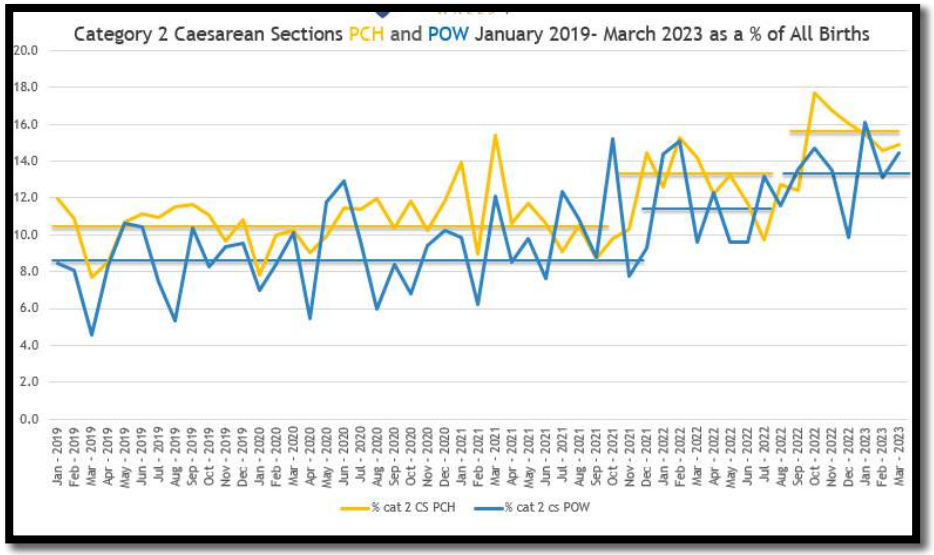
- On going projects on breast feeding – golden drops, to further improve breast feeding a longer term QI project has commenced.
- Thermoregulation project in first stages – Getting to understand the problem '5 whys' establishing a team.
- Perinatal Quality improvement team has been established to support the delivery of Peri-prem Cymru. Local celebration/launch TBC
- Make safe for staffing in place at POW- across site cover from PCH
- EM to support QI presentation to the Paediatric medical team.

Maternity & Neo Data, Performance & Quality Improvement – Signals for Improvement



Cat 2 CS (RCOG): Maternal or fetal compromise which is not immediately life-threatening. Birth should be achieved within 75 minutes of the decision. This is where there appears to be the most significant rise in CS

Numbers fluctuate more as they are smaller numbers
PCH 1st 12 points 10.2% median. 6 points above median in dec 2021- May 22. Median reset: 13.7%. Now 15.9%.
POW 1st 12 points median 8.4%. 6 points above median in Dec 21- May 22 Median reset 11.7%. . Aug 22- Jan 23 13.2%



Category 2 Caesarean Sections

- Deeper dive into category 2 caesarean sections, including women's experience of receiving information and being supported to make decisions
- Share with multi-professional team at Governance meeting
- Audit with a specific focus on decision making for category 2 CS
- Use QI tools to understand the current processes (5 Whys, Fishbone etc.)
- Use findings from above to develop programme of QI, using QI methodology including SMART aim

Normal Labour Pathway

- Understand current processes, using QI tools to identify areas for improvement
- Undertake quality improvement programme based on findings

Maternity only Clinical Incidents by level of harm
March 2023 data
Families and Children's care group
(Maternity) data

Note: The Health Board have recently transitioned from an Integrated Locality Model into a Care Group operating model and are also realigning the quality governance structure to support the new operating model. Therefore, reporting going forward will be aligned to the new Care Group model.

Table below demonstrates total no. of incidents reported related to patient safety:

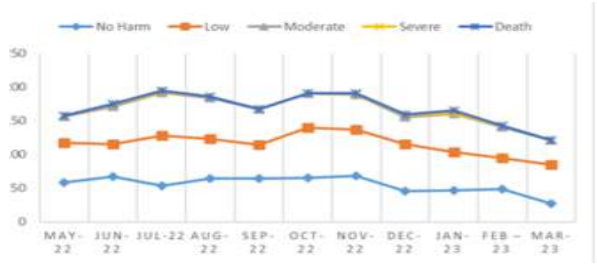
Incident level - harm	May - 22	June-22	July -22	Aug - 22	Sept - 22	Oct-22	Nov-22	Dec-22	Jan - 23	Feb – 23	March - 23
No Harm	58	67	54	64	64	65	68	46	47	49	27
Low	59	48	74	59	50	75	69	69	57	46	58
Moderate	39	56	64	61	53	51	52	40	56	46	36
Severe	1	3	1	2	0	0	1	3	1	2	0
Death	0	1	2	0	0	0	1	1	4	0	0

Table below demonstrated no. of serious incidents:

Incidents	MAY -22	June-22	Jul-22	Aug-22	Sept-22	Oct -22	Nov-22	Dec -22	Jan 23	Feb - 23	Marc - 23
No. of serious incidents outstanding	21	15	15	7	7	7	7	7	7	8	9

Table below demonstrated no. of open/concluded inquests:

Inquests	May Apr-22	June 22	Jul -22	Aug -22	Sep 22	Oct -22	Nov-22	Dec -22	Jan -23	Feb - 23	Mar 23
Total no. of open inquests	8	8	8	9	9	10	11	11	11	12	12
Total no. inquests concluded	0	0	0	0	0	0	0	0	0	0	0



- As there appears to be a drop in the number of incidents reported for the month of March– this is being cross referenced to ensure reporting is continuing.

Number of Maternity incidents closed across the care group by month

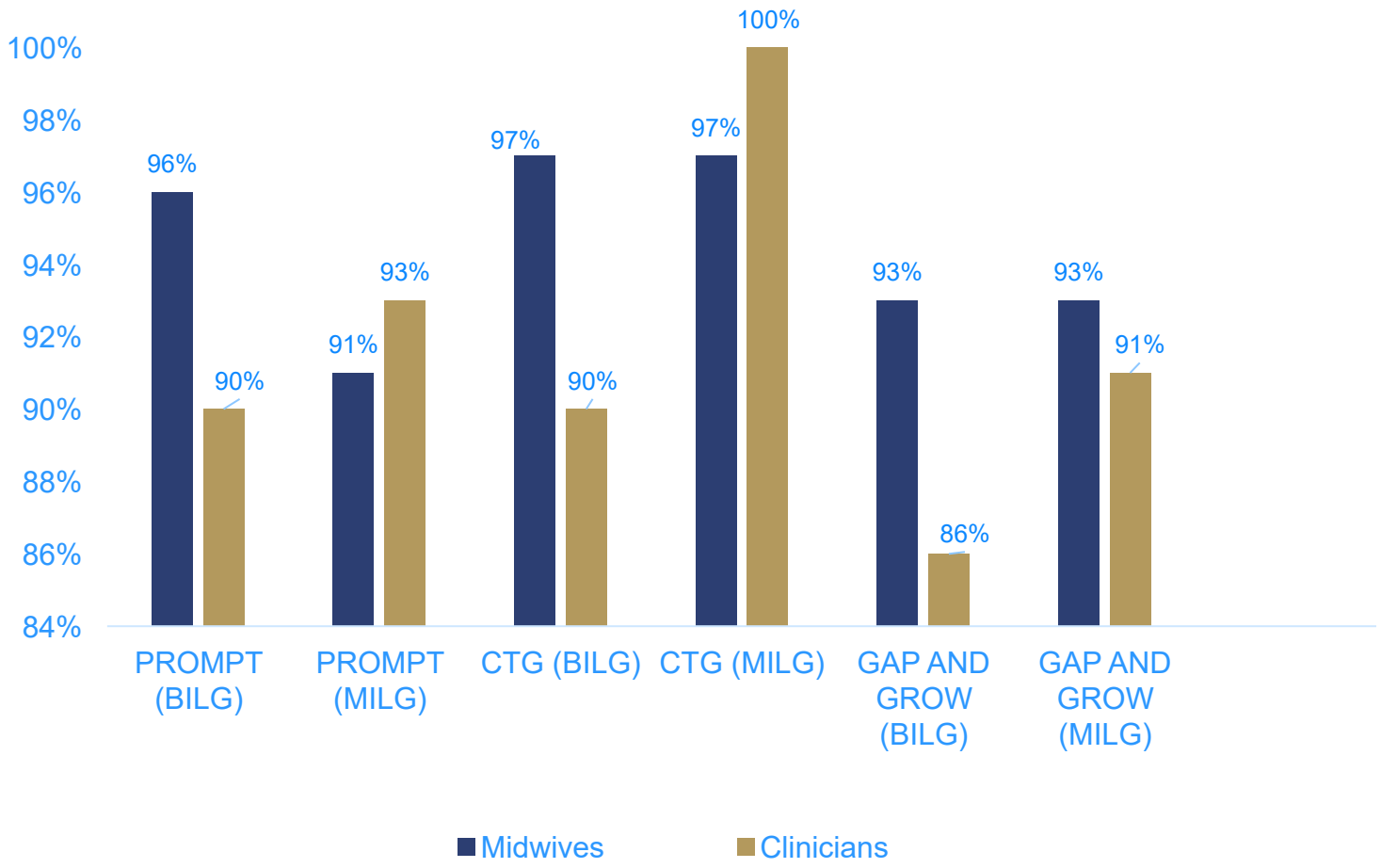
October	November	December	January	February	March
151	132	137	171	139	201

Neonatal Incidents April 2022 to March 2023

Both Sites	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	
Total Number of incidents	17	29	27	22	8	18	29	26	23	26	18	40	283
Cat/Death	1	0	0	1	0	0	0	0	0	0	0	0	2
Severe	0	0	0	2	0	0	0	0	0	0	0	0	2
Mod	5	5	1	3	0	1	2	1	1	1	1	3	24
Low	3	8	13	10	4	3	3	7	7	11	6	19	94
None	8	16	13	6	4	14	24	18	15	14	11	18	161
Closed	14	28	25	20	7	14	26	23	17	20	8	17	219
Under Invest	3	1	2	2	1	4	3	3	6	6	10	13	54
Awaiting Closure	0	0	0	0	0	0	0	0	0	0	0	1	

Neonatal Incidents Level of Harm

Both Units									
Date	Total Number of Incidents	Cat/Death	Severe	Mod	Low	None	Awaiting Closure	Overdue	Closed
Apr 22	17	1	0	5	3	8	0	3	14
May 22	29	0	0	5	8	16	0	1	28
Jun 22	27	0	0	1	13	13	0	2	25
Jul 22	22	1	2	3	10	6	0	2	20
Aug 22	8	0	0	0	4	4	0	1	7
Sep 22	18	0	0	1	3	14	0	4	14
Oct 22	29	0	0	2	3	24	0	3	26
Nov 22	26	0	0	1	7	18	0	3	23
Dec 22	23	0	0	1	7	15	0	6	17
Jan 22	26	0	0	1	11	14	0	6	20
Feb 22	18	0	0	1	6	11	0	10	8
Mar 22	40	0	0	3	19	18	1	13	17
	283	2	2	24	94	161	1	54	219



Note: MILG - *Important to note workforce numbers increased this month due to returns from sick therefore staff training had improved but does not reflect in the %.*

PROMPT- DNA due to rostering issues – Roster Managers notified to ensure avoidance of future roster issues.

CTG (Bridgend) Only 2 staff non compliant)

Compliance is reviewed/monitored on a monthly basis, staff who are not complaint are contacted by the training team to ensure their compliance. If still not compliant, this is escalated to the Care Group medical director to ensure all the staff are compliant. Rota is adjusted to allow the medical staff to complete any required training.

Maternity Patient Reported Experience Measure (PREM) 2022

Introduction

The Maternity Patient Reported Experience Measure (PREM) was designed and introduced in September 2021. A number of questions are utilised in order to seek experience data across all areas of the maternity service journey. In order to collect longitudinal feedback throughout the maternity journey, the PREM comprises four questionnaires.

Questions generally align with the Care Quality Commission (CQC) Maternity Survey, recognised as a validated tool with which to gather objective experience data around women and pregnant people's experience of their maternity care.

The PREM system is programmed to automatically distribute text message links to service user mobile phones at different trigger points throughout pregnancy and early parenthood. These are distributed via the Civica system and linked with Health Board Maternity Information Systems (MITS and WPAS). Upon completion of a questionnaire, experience data is collated within the Civica system.

Where comparable, Cwm Taf Morgannwg UHB PREM data has been benchmarked against data from the most recent CQC Maternity Survey (2022).

During 2022, there were **4668** births across Cwm Taf Morgannwg UHB and there were **2356** completed questionnaires across all four phases of the PREM. Overall, more than 82% of women said they were 'likely' or 'extremely likely' to recommend maternity services.

Responses

This report considers the responses across all four PREM questionnaires from 1st January 2022 to 31st December 2022:

- **Phase 1** - following anomaly ultrasound scan around 20 weeks gestation = **451**
- **Phase 2** - around 37 week's gestation = **487**
- **Phase 3** - 14 days following live-birth = **1018**
- **Phase 4** - 12 weeks following live-birth = **400**

Antenatal Care

- Women reported that when first finding out they were pregnant, they mostly contacted their GP (57.11%) or midwife (38.44%). Direct access to a midwife at CTM is currently lower when compared to the CQC Survey (63%) which reflects the need for service re-design to increase direct access to a midwife by ten completed weeks of pregnancy (Welsh Government, 2019). *These data reflect clinical dashboard information, work is underway to improve the % of women having their initial*

pregnancy booking by 10 completed weeks. A community quality improvement project is underway to establish a simple and easy-to-use digital self-referral system.

- Over 80% of women reported that completing the booking process was easy. Women indicated that most midwives and health care professionals providing care had introduced themselves and they were mostly given enough time to ask questions and discuss their pregnancy in a meaningful way. In addition, most women indicated that they were happy with their plan of care for pregnancy, having seen their midwife or obstetrician as much as they had wanted to and being able to access help or support via their community midwife if they needed this.

- Information was easy to understand and they felt comfortable to ask questions. Although some women reported not being given enough information, the majority of women indicated that they could recall having discussions with their midwife around important issues including their mental health, the importance of monitoring their baby's movements, their emotional well-being, diet, smoking, medication, domestic abuse, vaccinations, folic acid and Vitamin D (86-99%).

- Women gave responses about their questions or concerns being always listened to during check-ups with their midwife (74%) or obstetrician (64%), and this appears to be an area which sits lower than the CQC survey (80%). *In response, the service are working with the Public Service Ombudsman for training for clinicians around communication and active listening, and supporting staff in managing informal concerns, and training sessions have been commissioned via the Birth Rights organisation relating to women's rights during pregnancy and childbirth. The service are currently scoping training relating to professional responsibilities in partnership with the General Medical Council and Nursing & Midwifery Council (NMC).*

- Around 36% of women indicated that they had been offered antenatal classes (provided by CTMUHB), of which around 10% had completed antenatal classes. *There is work underway to prioritise Solihull Antenatal Education training to community midwives in partnership with the Early Years Transformation work stream with the aim of increasing the number of women being offered and receiving valuable antenatal education to support information provision and supporting positive parent-infant relationships.*

- One of the most significant areas where the service have heard from women (within the PREM) and more widely is around continuity of care and building a trusting relationship with their midwife/caregivers. Currently 28% of women receiving care at CTMUHB indicated that they had always received continuity of care via their named community midwife which is lower than the CQC Survey (37%). *Focussed work is ongoing around optimising continuity of care wherever possible including developing*

a set of community midwifery standards and engaging with the Welsh Government national Birth Rate Plus review to ensure the midwifery establishment is supported and enabled to provide continuity of care.

Intrapartum Care

- Generally, women indicated that their concerns were fully responded to if they had contacted a CTMUHB maternity setting relating to an urgent concern (85%), in addition to feeling that their concerns had been fully addressed if they had attended in relation to this urgent concern (83%).

- Women had generally received enough information from their midwife or doctor to help them decide where to have their baby (60%), and sits more favourably than the CQC survey (52%). CTMUHB offers all 4 settings for place of birth; home, along-side midwifery-led unit (AMU), freestanding midwife-led unit (FMU) and obstetric unit (Welsh Government, 2019). 47% of women indicated that they had been offered a choice of birth setting. This sits less favourably than the CQC survey at 71%. *A quality improvement project is ongoing to support information around discussing and offering choice and birth planning.*

- During labour and birth, women indicated that they were given enough time to ask questions or discuss their wishes and concerns. Most midwives and health care professionals providing care during labour and birth had introduced themselves, were aware of the woman's medical history and had offered women the pain relief they felt that they had wanted. Additionally, a high number of women (81%) indicated that they (and their birth partner or companion) had not been left alone at a time when it had worried them which is higher than the CQC survey (74%).

- Women generally felt that their caregiver had respected their birth plans and preferences, had supported them to make choices which were right for them and had given information and explanations that they could understand during this time. The majority of women indicated that they had confidence and trust in the staff caring for them during labour and birth (84%), which sits higher than the CQC survey (78%).

- 64% of women said they had felt fully involved in the decision to proceed with induction of labour, which sits less favourably than the CQC survey (83%). Women did generally feel supported with information and discussion around induction of labour (65%) which is higher than the CQC survey (55%). *A quality improvement project is ongoing around induction of labour and supporting informed decision making.*

Postnatal Care

- Most women felt that their infant feeding decisions were always respected and women had mostly received enough information and discussion to support them in preparing to feed their baby. Additionally, women mostly felt that they had received active support and encouragement with feeding their baby. All areas sit more favourably in CTMUHB than in the CQC survey. 75% of women indicate that they had met their own personal feeding goals (for example, breastfeeding for as long as they had wanted to). *The service is engaged with a number of quality improvement projects around parent-infant relationships, giving early colostrum and infant feeding education.*

- Overwhelmingly, women indicated that the maternity wards and settings in which they received care were very clean. 46% of women indicated that their discharge from hospital had been delayed, predominantly relating to awaiting take home medication and neonatal examination. *Quality improvement work is ongoing in partnership with the maternity pharmacy lead and supporting newly qualified midwives to undertake the neonatal examination.*

- Women overwhelmingly felt that they were happy with the plan for their community postnatal care and felt they had seen a midwife as often as they had wanted or needed to (91%) which sits much more favourably than the CQC survey (62%). Women reported that their midwife had discussed both their physical, emotional and psychological wellbeing with them during the postnatal period. Women generally felt that they had been able to discuss and seek about any aspect of their pregnancy, birth and postnatal care.

Communication, Interaction with staff and Birth Partners

- 35% of women indicated that their partner (and other people close to them) could be involved in their maternity stay as much as they had wanted to be, which sits lower than the CQC survey (41%). *In response, the service are revising and updating the current maternity visiting arrangements in line with current Public Health and infection, prevention and control (IPC) advice.*

- The majority of women report always being treated with kindness and understanding in early pregnancy (75%), during the whole antenatal period (77%) and during labour and birth (84%), and each stage sits more favourably than the CQC survey (71%).

- The majority of women report always being treated with dignity and respect during the antenatal period (85%) and during labour and birth (89%), each stage sitting comparably, or more favourable than the CQC survey (85%).

AGENDA ITEM
6.2

QUALITY AND SAFETY COMMITTEE

TY LLIDIARD TIER 4 CAMHS INPATIENT UNIT REPORT

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lloyd Griffiths, Head of Nursing for CAMHS
Presented by	Lauren Edwards, Director of Therapies and Health Science
Report purpose	FOR NOTING

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

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
PALS	Patient Advice and Liaison Service
TL	Ty Llidiard Tier 4 CAMHS Inpatient Unit
YP	Young People/Person
HoN	Head of Nursing for CAMHS
iCTM	Improvement and Innovation CTM (Cwm Taf Morgannwg)
LSU	Low Secure Unit
NG	Nasogastric
PMVA	Prevention and Management of Violence and Aggression

PICU	Psychiatric Intensive Care Unit
WHSSC	Welsh Health Specialised Services Committee
NCCU	National Collaborative Commissioning Unit, part of WHSSC
HIW	Healthcare Inspectorate Wales
QAIS	Quality Assurance and Improvement Service
QI	Quality Improvement
SI	Serious Incident
NRI	Nationally Reportable Incident
LRI	Locally Reportable Incident

1. SITUATION/BACKGROUND

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

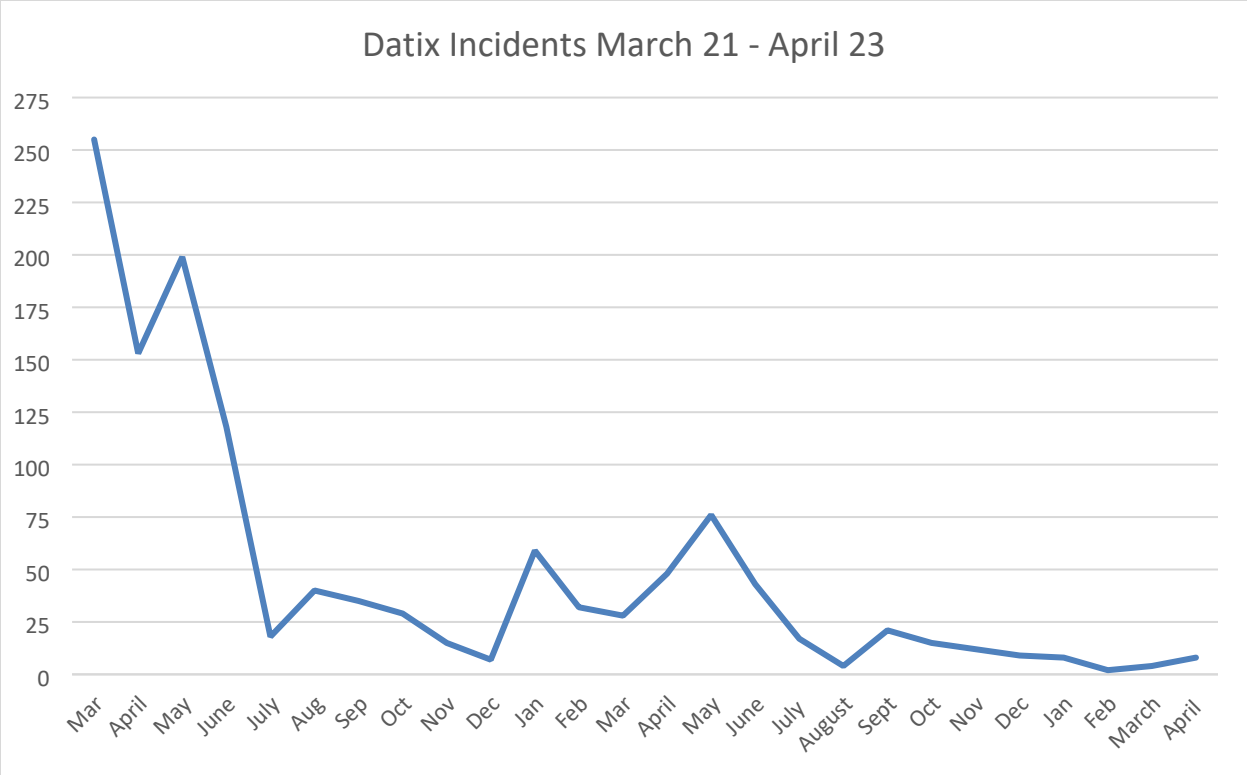
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 TL is in enhanced monitoring arrangements with WHSSC. The focus of the monitoring relates to concerns regarding the service specification and culture/leadership. Positive feedback continues to be received from WHSSC regarding the visibility and oversight of improvements at TL, as well as the reporting standards and progress being made and sustained. TL was de-escalated to Level 3 monitoring by WHSSC in December 2022 and conversations regarding further de-escalation are ongoing.

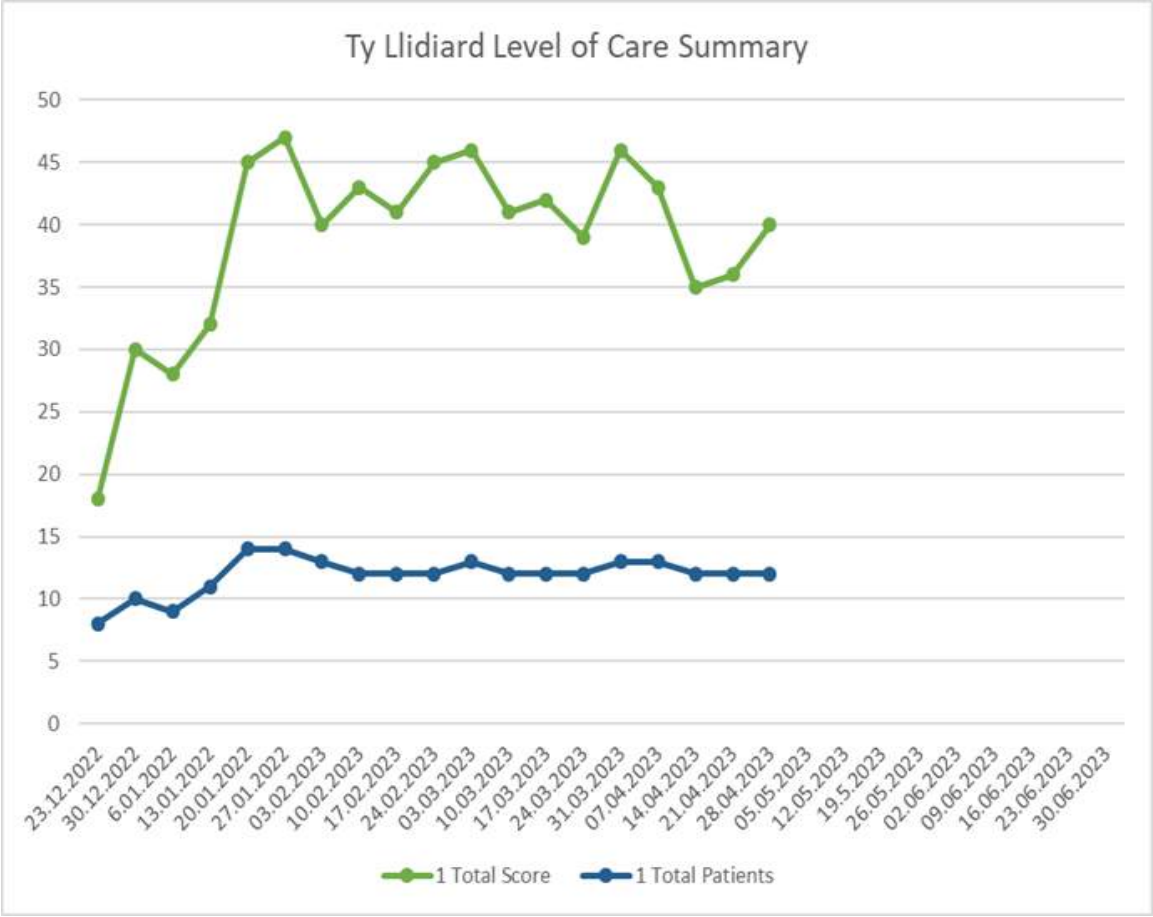
3. Quality Assurance

3.1 Patient Safety Incidents (Feb-April 2023)

There were 15 incidents reported during this period (3 in February, 4 in March and 8 in April), compared to 108 in the same period in 2022. All incidents classified as low or no harm.



The acuity and occupancy levels are demonstrated by the graph below which is a summary of the *Level of Care* results. Level of Care is a rating scale recommended by NCCU, which TL and NWAS are using 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. It is also important to point out that these high levels of acuity and occupancy are at a time when the ward has also been managing the ongoing building work.

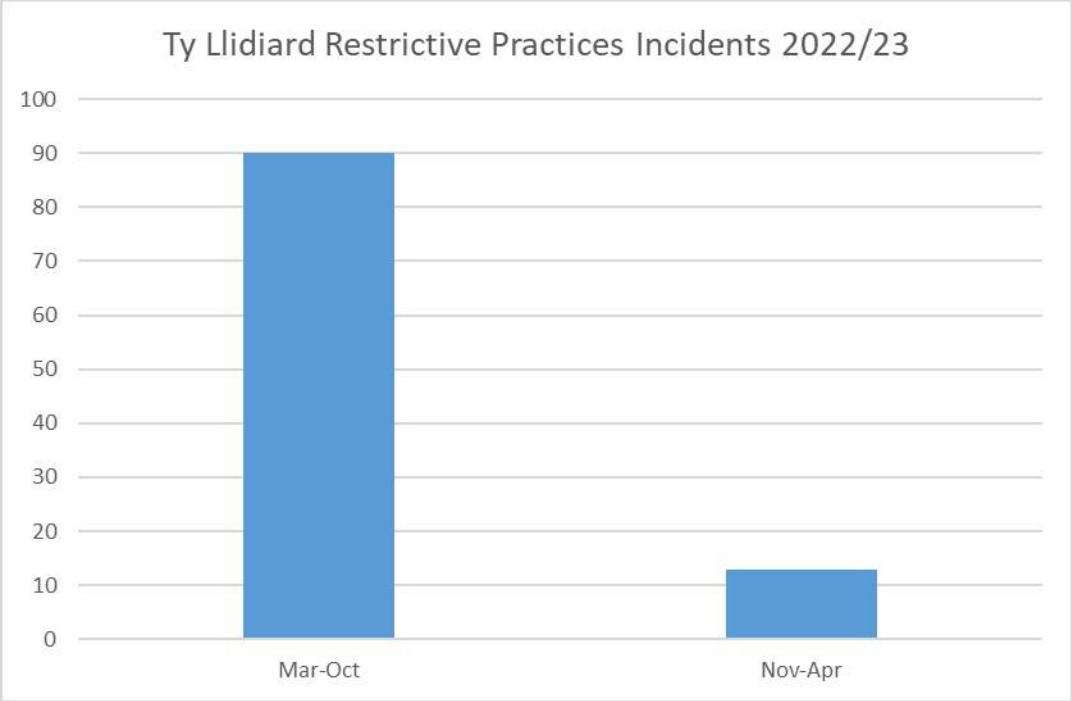


3.2 Reducing Restrictive Practices

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

In the past 6 months, there have been 13 Datix incidents involving restrictive practices. This is a significant decrease compared to 90 incidents in the previous 6 months and historical levels that were also much higher.

This has been achieved through changes in clinical practice, supported by an MDT who are committed to reflect, learn and improve the quality of care and support provided to YP.



3.3 Patient Stories and Case Studies

The Ty Llidiard team have started to use patient stories and case studies to show their progress and to demonstrate how they support individuals with complex needs with care and compassion in a more calm and confident manner. Reporting improvements in this way allows the team to evidence improved experience and outcomes for patients and families.

There were no incidents involving absconding from TL (actual or attempted).

There are no incidents which are overdue in terms of investigation or closure.

3.4 Complaints

There was one formal complaint during this period from a parent concerned that their child had been detained under the MHA. This complaint has now been resolved.

3.5 Compliments

Understanding the experiences of our 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									

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.

In February we received the compliment below from a member of our therapy team who moved on to a new position in CAMHS. It has been shared with permission and is included as an example of the improvements in culture and MDT working.

Hi all,

Thought I would leave some feedback in terms of the nursing staff whom I feel have really helped me during my short time here. The nursing staff (nurses, HCAs and the kitchen staff whom are all based on the wards) have all gone above and beyond in supporting, guiding and shown me so much kindness. Even if this was a short bittersweet time – they took time to answer all my questions I had, gave me advice, made me laugh, and helped me settle back into working on the wards after working in the community with so much support. Nothing was ever too much for them, they always checked in how I was and so much more and I am really grateful for all this. It meant a lot. They are all awesome ☺

3.6 Current open SIs (NRI or LRI)

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

3.7 **Ombudsman complaints**

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

3.8 **Claims/redress cases**

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

4. People's Experience/co-production

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

4.2 Pet therapy is one of the suggestions that came out of these meetings and we continue be visited by our Alpacas and therapy dog, Cody. Following another suggestion later this month we have arranged a visit from a reptile expert who will be bringing snakes and lizards for the YP to handle.

4.3 As part of the capital works programme that has been going on since New Year we have had to partition off the area where the new ward office will be whilst the building work is completed. The YP have taken the opportunity to decorate this area. This has led to a request for a more permanent area of the ward which they would like to be able to draw on a personalise, therefore using slippage from the capital scheme we will be creating a permanent Graffiti Wall next to the new ward office.

5. Visual Identity

5.1 The second phase of our new coproduced logo and 4Cs philosophy, Caring, Compassionate, Calm and Confident, has been installed in staff and patient areas and has been positively received by YP, families, staff and visitors. This phase was funded through CTM charitable funds

Dining Room Corridor

MDT Meeting Room

Ward Entrance

5.2 The third and fourth (final) stages will be completed soon and will see a large external sign installed and the new ward office wrapped in 4Cs themed graphics.

6. Quality Improvement

6.1 Our quality improvement group is well established and meets 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.

7. Improvement Board

7.1 A monthly 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.

7.2 Monthly escalation meetings continue with colleagues from WHSSC, in addition to regular meetings between the CTMUHB and WHSSC executive leads for TL. Significant improvements have been made to the reporting format for the escalation meetings, resulting in ongoing

positive feedback from WHSSC and de-escalation from level 4 to level 3 in December 2022.

8. Staff Experience

8.1 During our staff engagement events we received feedback on the importance of saying "thank you" to colleagues and the pride people now feel about working in TL. As a thank you to ALL colleagues for their work on the improvements made and as a welcome gift to new starters, we have produced a pack of branded items, including a tote bag, water bottle, pen and notepad. These were presented at an informal Thank You event held in April and have been extremely well received.

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

9.1 TL remains in Level 3 escalation with WHSSC. Although WHSSC remain assured by the progress being made, the scale and nature of changes required continue to require sustained support and focus within CTMUHB.

9.2 As part of the improvement work within TL, changes to the layout of the unit have been suggested by the National Collaborative Commissioning Unit (NCCU). The senior leadership team have met with the Director of

Quality and Mental Health/Learning Disabilities from the NCCU to explore what such changes could look like.

9.3 Phase 1 is near completion. Phase 2 has been designed and costed at circa £700k. A SON has been completed and submitted. Phase 2 mainly consists of the creation of an Extra Care Area and Disability Discrimination Act friendly bedroom, ensuring Ty Llidiard meets the WHSSC service specification.

10. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below: Dignified care Effective Care Individual Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required as no changes to service provision articulated
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Estates work suggested by WHSSC/QAIS will be associated with significant capital requirements
Link to Strategic Goals	Improving Care

11. RECOMMENDATION

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

AGENDA ITEM
6.3

QUALITY & SAFETY COMMITTEE

A FOCUS ON MENTAL HEALTH HIW INSPECTIONS

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Ana Llewellyn, Nurse Director
Presented by	Ana Llewellyn, Nurse Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS USED IN PAPER AND APPENDIX	
BLS	Basic Life Support
CIW	Care Inspectorate Wales
CMHT	Community Mental Health Team
HIW	Health Inspectorate Wales
ILG	Integrated Locality Group
ILS	Immediate Life Support
MHLD	Mental Health and Learning Disabilities
PMVA	Prevention and Management of Violence and Aggression
QSRE	Quality Safety Risk and Experience Meeting
RTE	Rhondda Taff Ely

1. SITUATION/BACKGROUND

1.1 This report provides committee members with an overview of recent and legacy HIW inspections of mental health services in the Health Board.

1.2 There are two main inspections applicable to mental health services:

- *Mental Health Service Inspections* – these are usually unannounced and consider the Health and Care Standards 2015 and compliance with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards.
- *Joint CIW and HIW Inspections of Community Mental Health Services* – these are usually planned and consider how services Meet the Health and Care Standards 2015 and Social Services and Well-being Act (Wales) 2014 and how they comply with the Mental Health Act 1983 and Mental Capacity Act 2005. These inspections usually require multi-agency services to submit evidence in advance of a planned visit by inspectors.

1.3 In addition to these routine inspections HIW does also undertake national thematic reviews and bespoke inspections of services of concern.

1.4 This report will update the Committee on updates, to the three recent inspections and the legacy HIW action plans, provided to the Mental Health Quality Safety Risk and Experience Board on 12th April 2023.

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

2.1 HIW Discharge Review

2.2 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.

2.3 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.

2.4 In June 2022 HIW identified a number of significant patient safety concerns relating to discharge governance, communication arrangements between teams (including the issue of the lack of a single electronic record), significant limitations in the involvement of patients and carers risk management and discharge arrangements.

2.5 This immediate assurance action plan was initially monitored by the Mental Health Head of Nursing based in Merthyr Cynon ILG and also within RTE ILG, due to the concerns being centred on discharge practices in Royal Glamorgan Hospital. From September 2023 the monitoring arrangements transferred to the MHLD Care Group and this immediate assurance action plan has continued to be monitored by the MHLD QSRE.

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

Completed Actions	Number of actions due for completion by next QSRE (May)	Number of actions with later timescales	Number of actions with slipped timescales
43	0	0	10

2.7 The areas of slippage are in 4 main areas:

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

2.8 As part of their review of discharge arrangements HIW identified concerns relating to the discharge of two patients who subsequently died. Independent reviews have been commissioned of these cases with investigating officers identified from outside the Health Board.

2.9 The other areas of slippage are being addressed through the Mental Health In-patient Improvement Programme priorities and will be discussed later in this report.

2.10 The immediate assurance action plan owner will provide revised timescales for the remaining 10 actions and will update on these at the next MHLD QSRE meeting.

2.11 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)

2.12 HIW asked the Health Board to submit an improvement plan by 7th April 2023. At the time of writing the Health Board is yet to have confirmation from HIW that this improvement plan has been approved.

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

Completed Actions	Number of actions due for completion by next QSRE (May)	Number of actions with later timescales	Number of actions with slipped timescales
1	1	38	0

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

2.15 HIW undertook a three day unannounced Mental Health Service Inspection 14 -16 November 2022 and identified a number of immediate concerns. The Health Board was required to submit an immediate assurance action plan to address a number of concerns related to record keeping, ward environments, mandatory and statutory training and routine ward checks.

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

Completed Actions	Number of actions due for completion by next QSRE (May)	Number of actions with later timescales	Number of actions with slipped timescales
26	0	1	4

2.17 All of the remaining actions relate to training. The national mental health outcome measure trained had an original completion date of end of July and this is unchanged. However 4 other areas of training had earlier completion dates that have subsequently been revised. All of these training requirements relate to face-to-face training where there is limited training availability. In addition the service has to balance the release of staff for training with the requirement to maintain safe staffing levels.

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

- Dysphagia training – 14th July
- PMVA – 11th July
- ILS and BLS – 31st May
- Evacuation – 31st May

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

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

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

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

Completed Actions	Number of actions due for completion by next QSRE (May)	Number of actions with later timescales	Number of actions with slipped timescales
22	8	2	1

2.23 The action that has been delayed is the development of a Standard Operating Procedure for staff personal alarms. This should have been completed and presented at the March QSRE meeting. It has a revised timescale and will be presented to the May QSRE meeting with the other 8 actions that are due for completion for that meeting.

2.24 **HIW and CIW Community Mental Health Team Review: Maesteg CMHT**

2.25 HIW and CIW completed an inspection of Maesteg Community Mental Health Team in December 2022. They provided verbal feedback on 14th December 2022. In both the verbal feedback and in the final report the team were commended for their staff and service user engagement; high quality care planning, risk management and physical health monitoring; and cohesive team working and partnership between the Health Board and the Local Authority. This positive practice has been shared across the Health Board in a learning event.

2.26 There were no immediate assurances required.

2.27 The final report was published on 16th March 2023: 20230316MaestegHospitalCMHT-Full-EN.pdf (hiw.org.uk)

2.28 HIW and CIW identified 7 areas for improvement for the Health Board and Local Authority. These have been further divided into 23 sub-actions. The table below provides an overview of progress against those actions:

Completed Actions	Number of actions due for completion by next QSRE (May)	Number of actions with later timescales	Number of actions with slipped timescales
13	6	4	0

2.29 **Legacy Mental Health HIW action plans**

2.30 Prior to the implementation of the new operating model in September 2022 RTE ILG reviewed all mental health HIW inspection action plans dating back to 2016 and found that there were a number of actions that had not been completed.

Date of Inspection		Number of Recommendations	Updated status as of Feb 2023		
			Completed	Partially completed	Not complete
11/07/2016	RGH	27	26	0	1
22/01/2018	RGH adult inpatient	25	23	1	1
08/07/2019	RGH	44	39	1	3

2.31 This review of open actions was handed over to the new MHLD care group and has continued to be monitored by the care group QSRE. As of 1st February 2023 five legacy recommendations incomplete, with 2 other recommendations partially complete.

2.32 These seven recommendations (some of them repeated in each inspection from 2016 onwards) relate to the lack of a single electronic record, mandatory and statutory training and medical and nurse staffing levels.

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

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

2.35 A Quality, Safety, Risk and Experience governance framework led by the Nurse Director is in place to ensure proactive oversight of issues previously outlined in this paper. The QRSE Board has a standing agenda item for external oversight, which includes HIW inspections. The recent and legacy HIW action plans are on the agenda for every meeting and are actively monitored via this board.

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

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

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

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

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

2.40 ***Statutory and Mandatory Training:*** A Pan CTM review of ESR competencies has been undertaken, with support from the Learning and Development team. A working excel document will be used for all wards as an interim assurance measure for reporting and maintaining compliance. This will enable the development of robust trajectories. Trajectories are in place for PMVA training with a plan to achieve 85% compliance by July. Trajectories are nearing completion for WARRN training. There are however significant challenges with corporately provided resuscitation and manual handling training. There are limitations in the availability of face to face training.

2.41 ***Policies:*** A care group policies group has been convened and has completed a scoping exercise of all MH specific policies. An outline policy improvement plan was reported to the QSRE in April 2023 and is progressing the prioritisation of policies for updating. The Health Board arrangements for ratification and management of clinical and operational policies is being reviewed by the Executive Medical Director and the Assistant Director of Corporate Governance.

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

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

2.44 The Executive Director of Therapies and Health Sciences has recently been identified as the executive lead for the In-patient Improvement Programme.

2.45 A further in-person in-patient improvement workshop was held on 26th April. Workstream leads were given the opportunity to share their improvement driver diagrams and to seek further support and improvement ideas from attendees. These ideas will be further developed and will form an aggregated improvement plan for in-patient services.

2.46 The Assistant Director of Mental Health in the Performance and Assurance arm of the NHS Wales Executive (formerly known as The Delivery Unit) attended the workshop as an observer.

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

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

3.2 The availability of some face to face training is also escalated to committee as this will continue to impact on mandatory and statutory training compliance.

4. IMPACT ASSESSMENT –

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The quality and safety of care for people in receipt of mental health services is central to this report.
Related Health and Care standard(s)	Choose an item.
	If more than one Healthcare Standard applies please list below: Safe Care Individual Care Timely Care Governance, Leadership and Accountability Dignified Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)

	No new, changed or withdrawn policies or services outlined
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	There are resource implications for the additional workforce proposed to underpin the internal oversight of mental health services. New posts are funded from recurrent the Mental Health Service Improvement Fund,
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

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

AGENDA ITEM
6.4

QUALITY & SAFETY COMMITTEE

PATIENT SAFETY & QUALITY DASHBOARD

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Presented by	Nigel Downes, Assistant Director of Quality & Safety
Approving Executive Sponsor	Executive Director of Nursing, Midwifery & People Services Executive Medical Director
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Discussions with key individuals in corporate services and within directorates and localities Joint working with Performance and Planning team	Various dates	Choose an item.

ACRONYMS	
NEWS	National Early Warning Score
HMR	Hospital Mortality Review

1. SITUATION/BACKGROUND

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.03.23 to 30.04.23 taken from systems as on 02.05.23, 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. Implementation of a robust triage process with a focus on early resolution along with the embedding of the PALS at Princess of Wales.
- Compliance with the 30 working day target for responding to complaints decreased to below 50% during March and April 2023. A plan is in place to address the number of complaints open over 30 working days while maintaining the focus on the complaints due.
- Reduction in the number of Public Service Ombudsman for Wales referrals received.
- The number of compliments recorded on the Datix Cymru system has continued to decrease from November 2022. Work is being undertaken to explore options for engaging with staff to ensure robust recording of compliments received.
- The number of patient safety incidents reported has increased during March and April 2023. The inclusion of closed incident information reflects the actual harm following investigation. 0.43% were recorded in March and April 2023 with an outcome of severe or catastrophic / death.
- Patient falls and Pressure Damage Incidents have remained relatively consistent with previous months.
- Number of absconding incidents increased in last 2 months.
- Addition of Medical Examiner Referral information enables a wider and more accurate picture of mortality within the Health Board to be reflected.

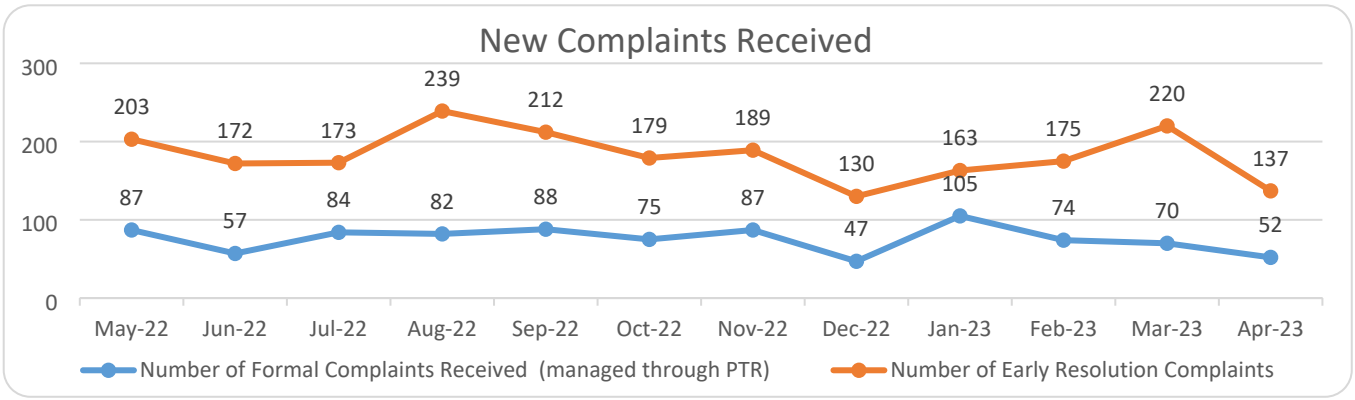
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Patient / Service User Feedback

Complaints

New Complaints Received

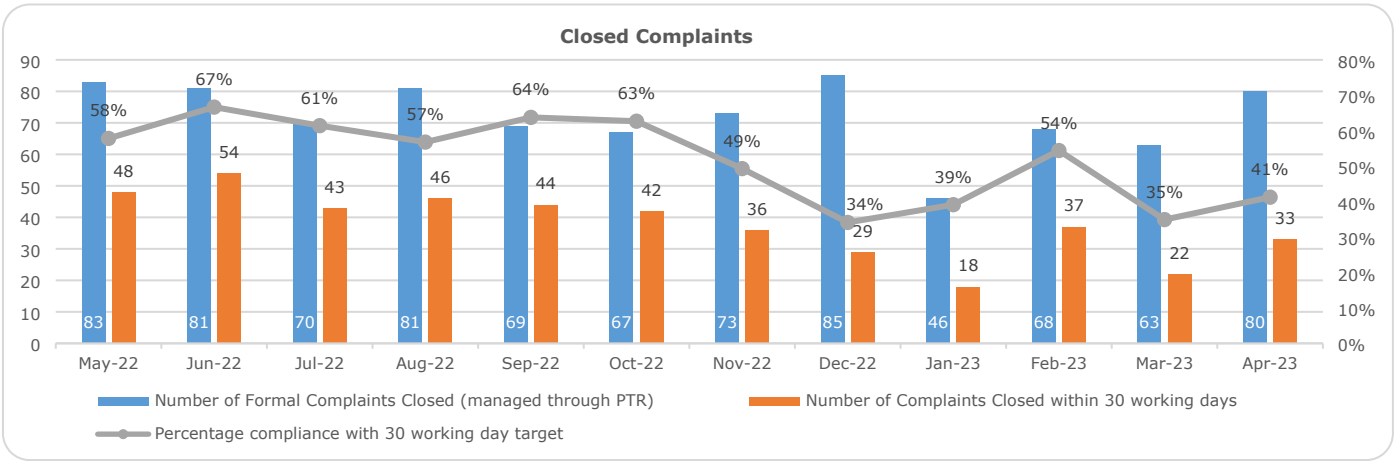
Between the 01.03.23 and 30.04.23 the Health Board received a total of 479 complaints. Of these, 122 were categorised as formal and managed under the Putting Things Right Regulations. The chart below highlights a steady increase in the number of complaints received between December 2022 and March 2023, however this trend has reversed in April 2023 with a significant decrease compared to the previous month.



For all complaints received in March and April 2023, the top 2 types of complaints received remain consistent with previous months, with the addition of medication as top theme. These relate to Clinical Treatment / Assessment (121), Appointments (120) and Medication (50).

Closed Complaints

Within the period of 01.03.23 to 30.04.23.23, the Health Board closed a total of 143 formal complaints (managed under the Putting Things Right Regulations). Compliance with the 30 working day target has decreased and remains below 50% for March and April 2023.



A review of the systems and processes for the management of complaints has been undertaken which has included the standardisation of procedures and templates to ensure a consistent approach is adopted across the Health Board. A robust triage process has been implemented with the aim of an increase in early resolution correlating with a decrease in formal complaints giving a better outcome for our patients and their families which directly impact on and further improve compliance with the 30 working day response rate. In addition a clear process for escalation has been established supported by weekly case review meetings to monitor compliance with Putting Things Right timescales.

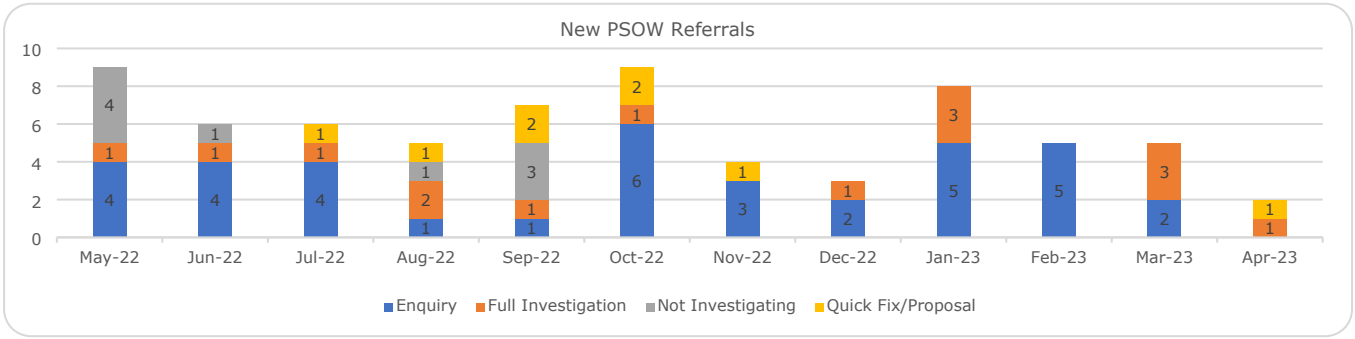
Patient Advisory Liaison Service (PALS)

The role of the PALS officers is now embedded within the Princess of Wales Hospital with two staff in post supporting patients, families and carers proactively in resolving or escalating any queries /issues raised through visibility on the wards, telephone or email at point of contact.

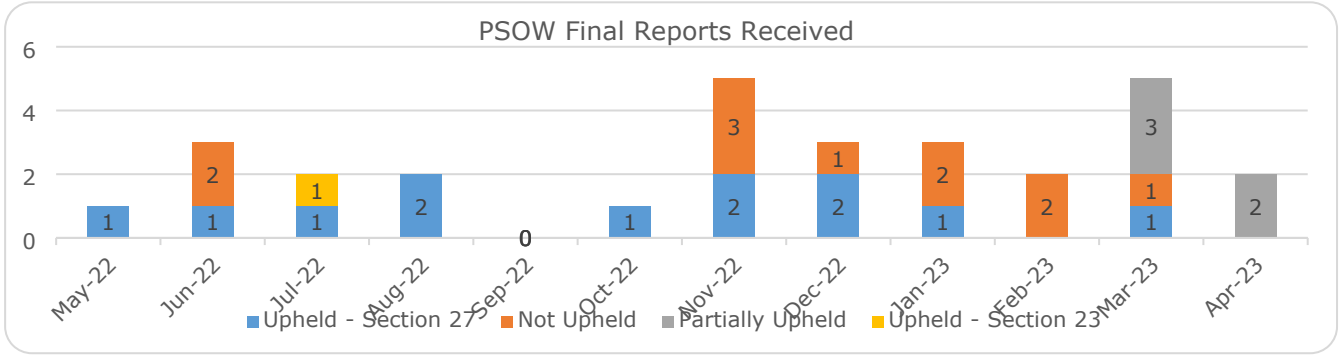
The Health Board is looking to advertise two roles in Prince Charles Hospital next and once recruited will look to extend into Royal Glamorgan Hospital and a part time community based role to ensure there is access to this service across the whole of CTM, promoting engagement with our communities to enable them to drive service improvement.

Public Services Ombudsman for Wales

The Health Board received notification of 7 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.03.23 and 30.04.23. This represents a continuation of the overall decrease from November 2022. Of the 7 referrals, 4 were received as full investigations, 2 as enquiries and 1 as a quick fix/early settlement proposal.



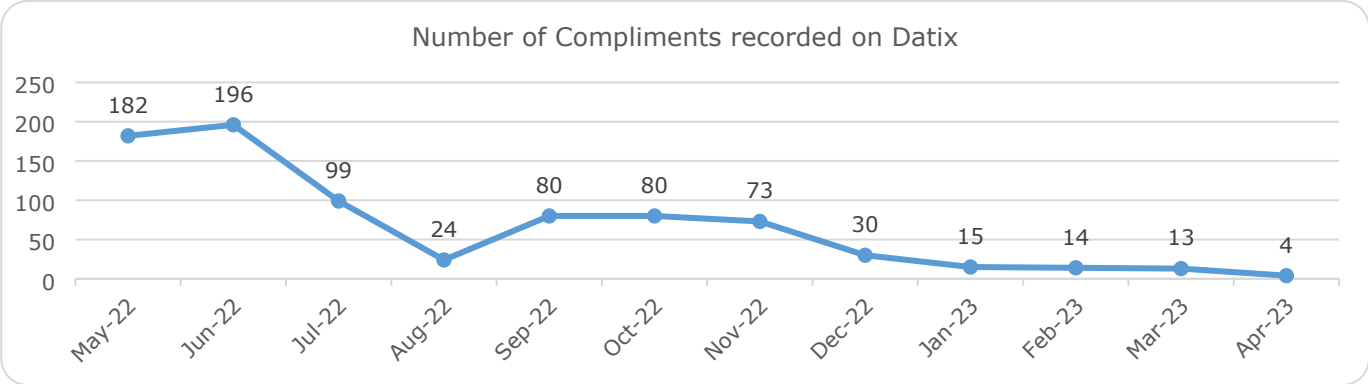
During the same period, the PSOW issued 7 final reports to the Health Board. Of these, 1 was not upheld, 1 was upheld and 5 partially upheld. The upheld reports relate to services provided by Unscheduled Care (4) Primary Care & Community (1) and Families & Children (1).



The Health Board currently has 52 Open PSOW cases, of these 24 are awaiting a response from the PSOW to instigate any further action required. 12 are at final report stage with actions being implemented by the Care Groups.

Compliments

Whilst compliments are received across the Health Board via a number of mechanisms the number of compliments recorded on Datix Cymru has continued to decrease over the 12 month period between 01.06.22 and 30.04.23, this is reflected in the chart below. A total of 17 compliments were recorded during March and April 2023. This is not reflective of the number of compliments received but linked to accurate recording on Datix Cymru.



Work is ongoing to review mechanisms and systems to ensure a robust process is established to capture, record and report information relating to the compliments received.

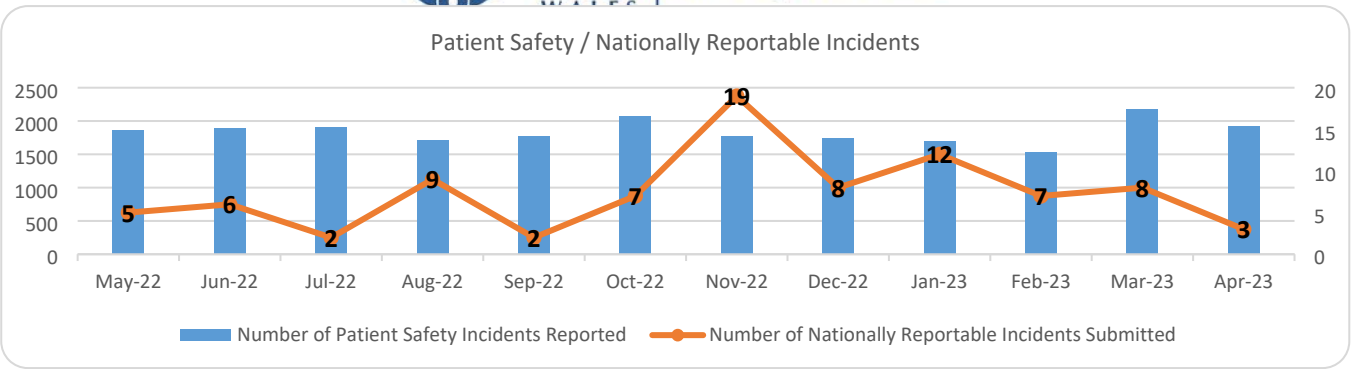
2.2 Patient Safety Incidents

Total Patient Safety Incidents

A total of 4648 incidents were reported between 01.03.23 and 30.04.23, this represents an increase of 911 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 increased in March and April 2023. Of the 4648 incidents reported, 89% (4125) were reported as the patient affected. The top 3 types of incidents reported for March and April 2023, linked to a patient affected are Pressure Damage /Moisture Lesion (1286), Infection, Prevention & Control (744) and Accident, Injury (651)

Nationally Reportable Incidents

Between 01.03.23 and 30.04.23, 11 nationally reportable incidents were submitted to the NHS delivery unit. No never events were identified in this period. The ratio of Nationally Reportable Incidents to the overall number of patient incidents is demonstrated in the chart below.



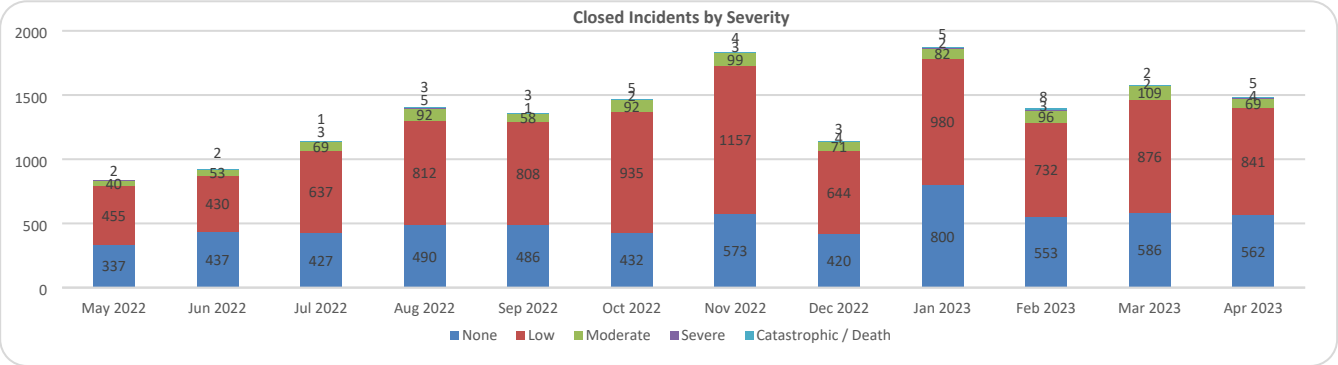
As highlighted in previous reports to Committee it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the Delivery Unit. This is reflected in the increase in both November and January as a result of the submission of legacy ambulance delays and notification of Ophthalmology incidents following completion of the harm review process that occurred prior to the reporting period.

The type of Nationally Reportable Incident notifications submitted in March & April 2023 is highlighted in the table below:

	Mar 2023	Apr-23	Total
Access, Admission	1	0	14
Accident, Injury	0	0	3
Assessment, Investigation, Diagnosis	1	0	5
Maternity adverse occurrence	1	0	6
Medication, IV Fluids	0	1	2
Patient/service user death	1	0	4
Pressure Damage, Moisture Damage	2	1	11
Safeguarding	0	0	3
Transfer, Discharge	0	0	7
Treatment, Procedure	2	1	9
Total	8	3	64

<u>Closed Patient Safety Incidents</u>

Between the 01.03.23 and 30.04.23 a total of 3120 patient safety incidents were closed. Of these incidents 64 were closed without a severity post investigation being a recorded. In April 2023, changes to the Datix Cymru System were introduced to ensure incidents are not able to be closed without a severity being recorded. In addition an audit programme of closed incidents is being introduced to ensure all required fields are being completed on closure. Of the 3056 where a severity was recorded, 0.43% (13) were closed with severity post investigation of severe harm (7) or catastrophic/ death (7). The 12 month trend is reflected in the table below.

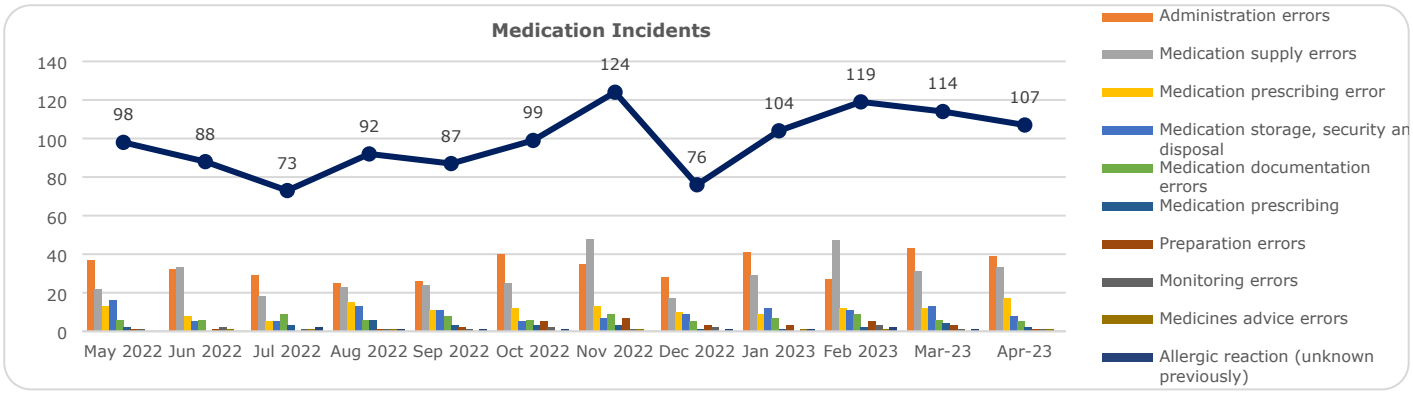


Future reports to Quality & Safety Committee will include information to demonstrate compliance with Duty of Candour Requirements.

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

A total of 221 medication incidents were reported as occurring between 01.03.23 and 30.04.23. This is consistent with the previous 2 month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (82) Medication supply errors (64) and Medication prescribing (29).

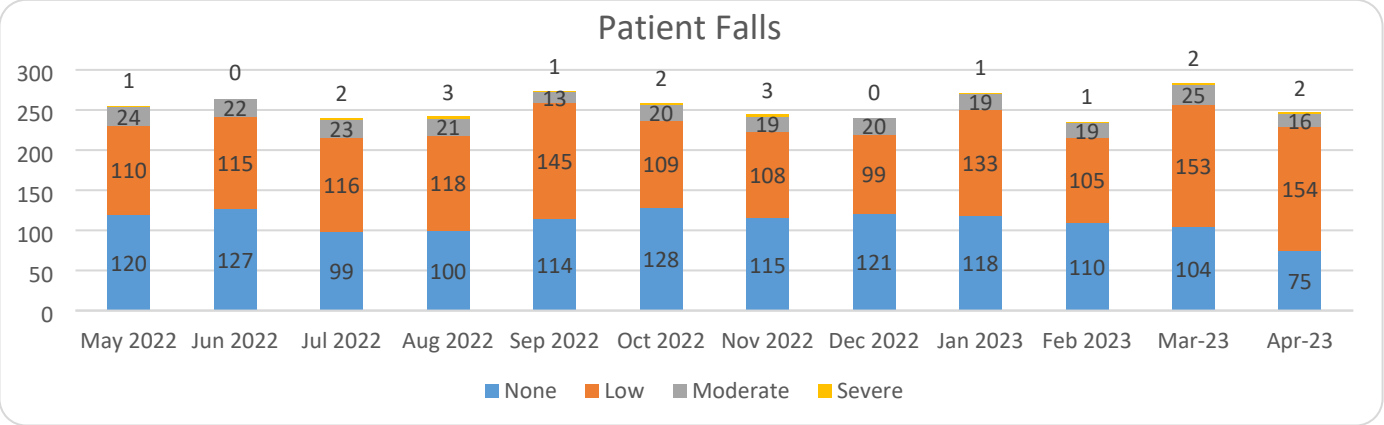


88% of the medication incidents were reported as resulting in no (76) or low (100) harm, with the remaining reported as resulting in moderate harm (22) and severe (3) harm. It should be noted that the introduction of a specific Community Pharmacy form has impacted on the data quality for medication incidents as a number of fields are not included for completion, including the harm field. Therefore, for the 3 months identified above, the harm was not recorded for 20 incidents.

2.3.2 Patient Falls Incidents

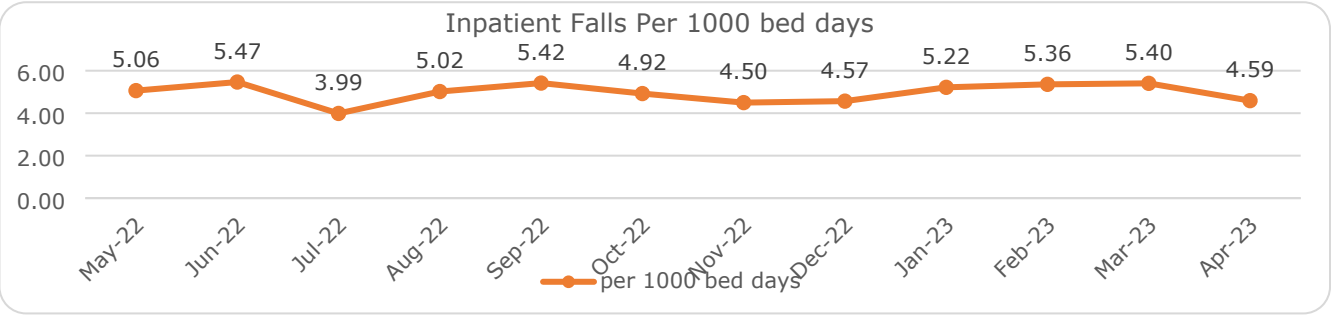
A total number of 531 falls, where the person affected was a patient, were reported during March and April 2023. This represents an increase of 25 in the number of falls reported in comparison to the previous 2 month period. Of the falls incidents within the time period, 92% were reported as no (179) or low (307) harm. The remaining

incidents were reported as moderate (41) and severe (4) harm. No incidents relating to patient falls were reported as resulting in death.



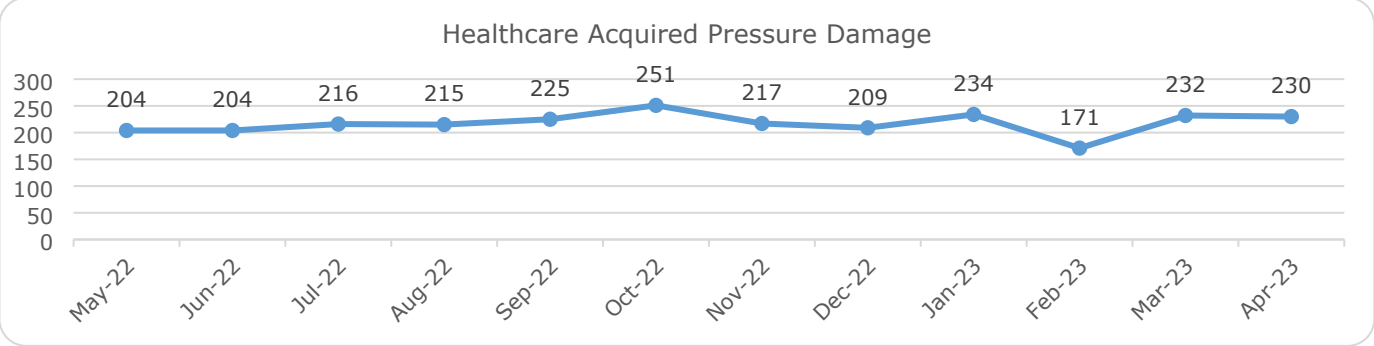
During the time period, the highest number of inpatient falls occurred on Ward 1 at Ysbyty Cwm Cynon (20), Ward B2 at Ysbyty Cwm Rhondda (20), and Ward 15 at Princess of Wales Hospital (18).

Work continues to develop and refine safety metrics for areas such as inpatient falls and pressure damage incidents per 1000 beds.



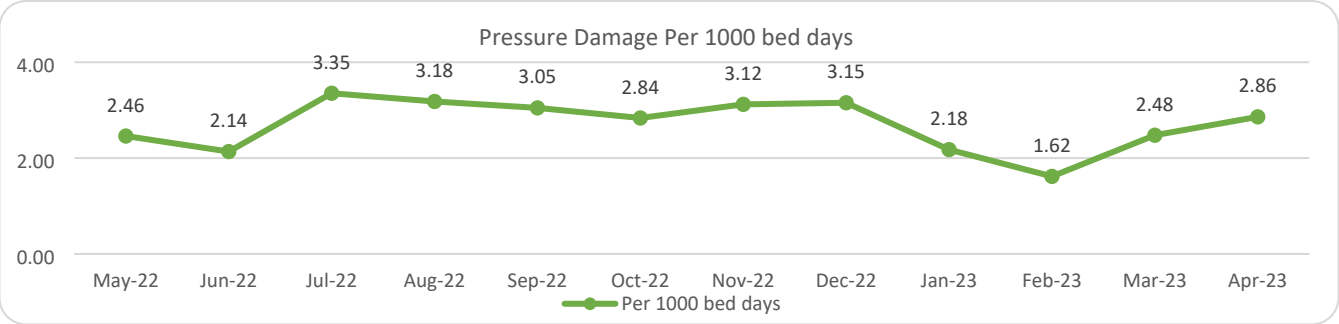
2.3.3 Pressure Damage

Between the 01.03.23 and 30.04.23, a total of 1,001 pressure damage incidents were reported, of which 466 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (535) were reported as being present before admission to this clinical care area/caseload.



Of the 462, 282 were identified as being hospital acquired and 180 as community acquired. This demonstrates a continued decrease of community acquired pressure ulcers identified in the previous 2 months.

The locations with the highest reported hospital acquired pressure damage incidents were reported within the Emergency Department (34), Acute Medical Unit (17), and Ward 8 at Princess of Wales Hospital (7). There were 16 hospital acquired grade 3 pressure damage incidents reported during March (9) and April (7). There were 3 hospital acquired Grade 4 incidents reported during the 2 month period.

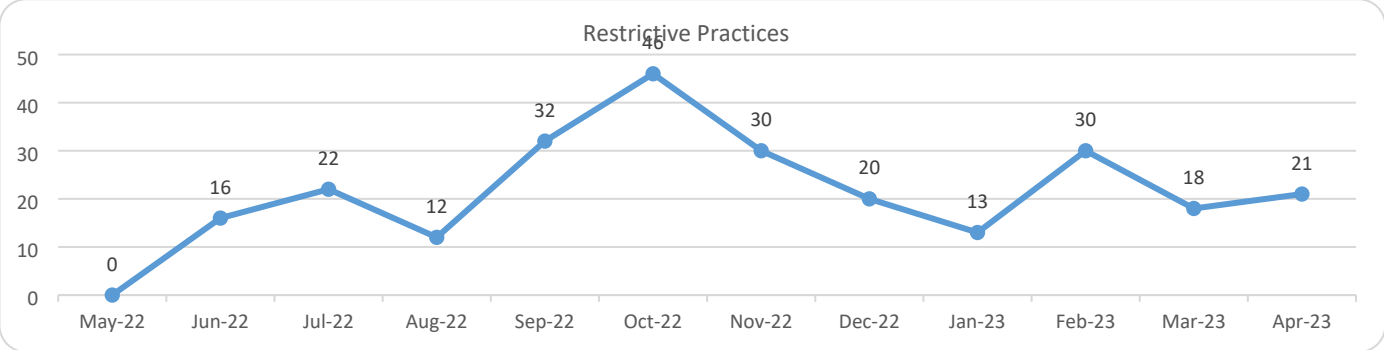


2.3.4 Mental Health Metrics

Number of 136 Assessments in police cells

The number of 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

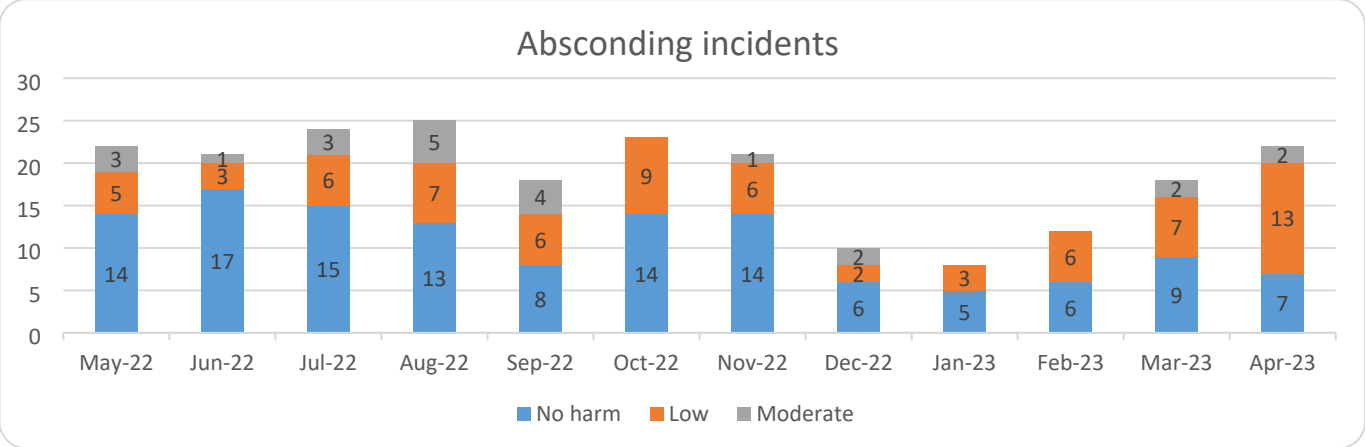


Between 01.03.23 and 30.04.23, a total of 39 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 11 incidents when compared to the previous two months. Of the 39 incidents, 74% (29) were reported as not care planned, 23% (9) were reported as care planned and 3% (1) as other. Of the 39 incidents, 92% were reported as no (21) or Low (16) harm. The remaining incidents were reported as moderate (2) occurring on the Psychiatric Intensive Care

Unit at the Royal Glamorgan Hospital and severe harm (1) at Coity Clinic (PICU) at the Princess of Wales Hospital.

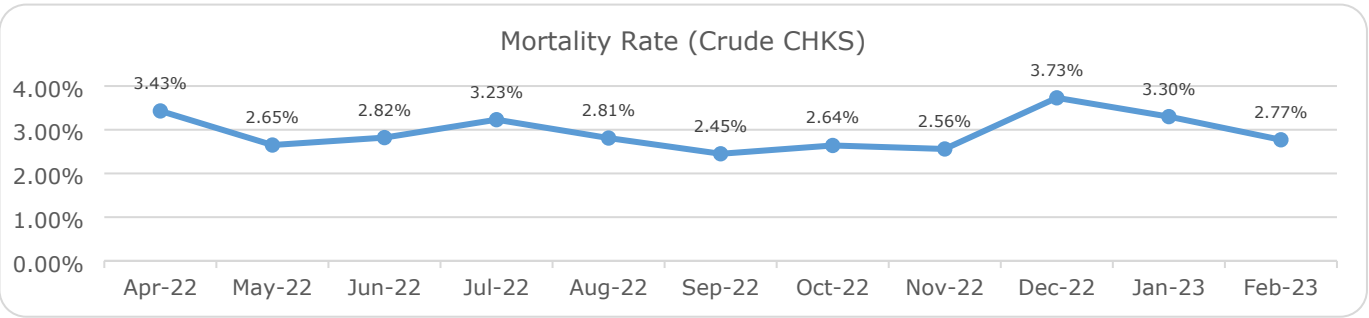
Absconding incidents

During March and April 2023, a total of 44 Absconding incidents were reported, an increase of 24 when compared with the previous 2 month period. 27 were recorded as actual absconding, with the remaining recorded as missing patient / service user (8) attempted (4), failure to return from authorised leave (4) and other (1).



82% of the absconding incidents reported in the time period (01.03.23 to 30.04.23) were recorded as No (16) or Low (20) harm, with the remaining incidents reported as moderate harm occurring in the Emergency Care Department and Ward 9 at Prince Charles Hospital, Emergency Department, Acute Mental Health Admissions Unit and Psychiatric Intensive Care Unit at the Royal Glamorgan Hospital.

2.3.5 Mortality Rate



As highlighted in the chart above, there has been a decrease in the crude mortality rate since December 2022. At the time of preparing the report, the information was not available for March and April 2023. It should be noted that the crude mortality rate is an in-month figure extracted from Welsh Patient Administration System (WPAS) based on the number of patients who have an outcome recorded as deceased. The figure is not adjusted for population, co-morbidities or expected deaths i.e. palliative care.

Work is currently ongoing to develop and implement a data validation process for mortality information and address the disassociation between CHKS and WPAS. A scoping exercise has been undertaken which has established that mortality data is collected in a number of different locations across the Health Board and in differing formats. The work being undertaken will establish a standardised format for the recording of information and ensure data can be collated in a consistent format, with the aim of presenting a more accurate picture of mortality within the Health Board. This will include data captured in Datix Cymru relating to medical examiner referrals and provide the ability to drill down with a greater degree of accuracy.

Medical Examiner Referrals

The table below outlines the number of deaths for 2022-23, the number where an initial review has been undertaken (either by the Medical Examiner or UMR), and the number and percentage outstanding.

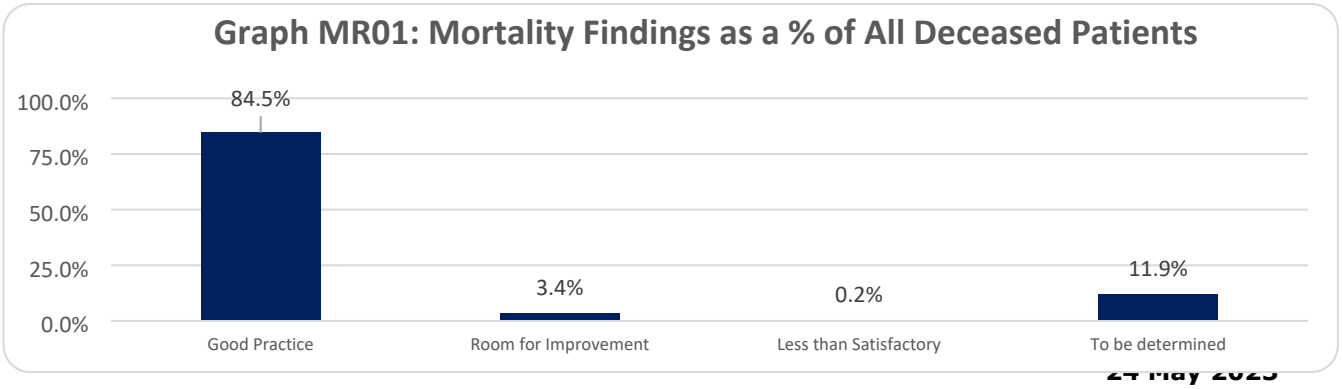
	Total Deaths	Number Reviewed	Number Outstanding
CTMUHB	3250	3183 (98%)	67 (2%)

The table below shows the number of cases referred by ME for 2022-23, cases identified for Hospital Mortality Review, the number where the review has been completed and the number and percentage outstanding.

	Total Deaths	Total Referrals	Number of HMR Required	Number Complete	Number Outstanding	Stage 3 Required
CTMUHB	3250	1401 (43%)	606 (43% of referrals (19% of all deaths)	307 (51%)	299 (49%)	18 (0.6%)

Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. However, due to a focus on completing the outstanding backlog of Hospital Acquired Covid cases, of which the Mortality Review Team has been responsible for the completion of Wave 1 & 3, this has impacted on the number of 2022-23 deaths that can be reviewed, meaning a backlog of current cases requiring HMR has accrued.

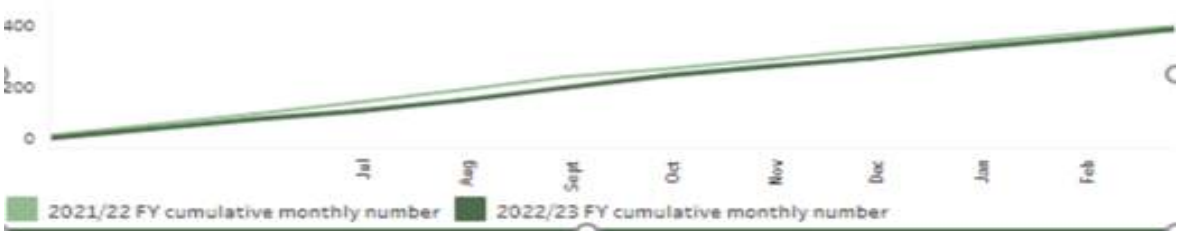
The graph below highlights Mortality Findings for 2022-23.



Further detailed information in relation to medical examiner referrals will be included in future reports.

2.3.6 Infection Prevention & Control (IPC)

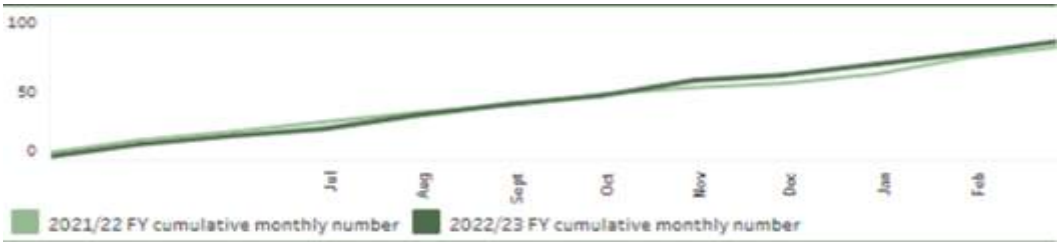
Clostridium Difficile



Whilst CTM marginally missed the reduction expectation for 2022/23 with a rate of 25.34 per 100, 000 population, it currently has the lowest rate in Wales. Key notes to highlight are:

- 26% fewer cases reported in 2022/23 compared to the previous year
- 51% of the cases are healthcare associated infections
- 30% of the total samples were sent from primary care
- The RCA process needs to be strengthened to maximise opportunities for learning and sharing best practice

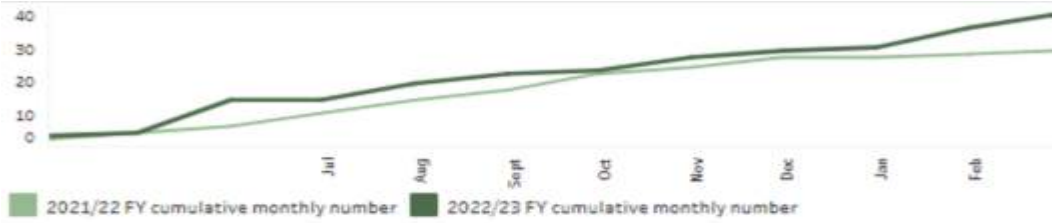
MRSA bacteraemia



CTM reported an increase in MRSA bacteraemia compared to last year and did not meet the reduction expectation for 2022/23. It should be noted that CTM has the lowest rate of MRSA bacteraemia in Wales. Additional points to note include:

- No cases have been reported in the last 6 months
- 75% of the cases reported are community acquired infections.
- No cases associated with a medical device/deemed to be a preventable infection.

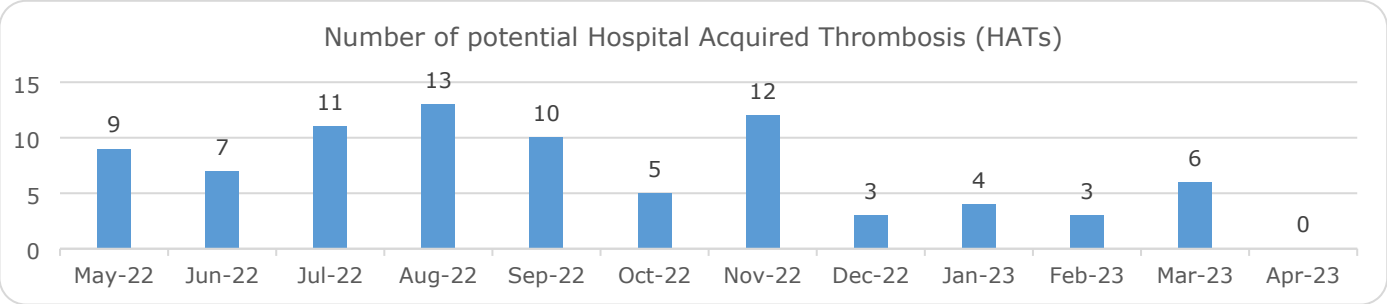
MSSA bacteraemia



CTM did not meet the reduction expectation for 2022/23 and there was a 21% increase in cases reported. 66% of the cases are community acquired infections. 11% of the total cases were deemed to be preventable following investigation by the IPC team and linked to an IV line or post operative surgical site infection._Improvement work is planned for 2023/24 to improve device management and compliance with ANTT practice/IPC Training.

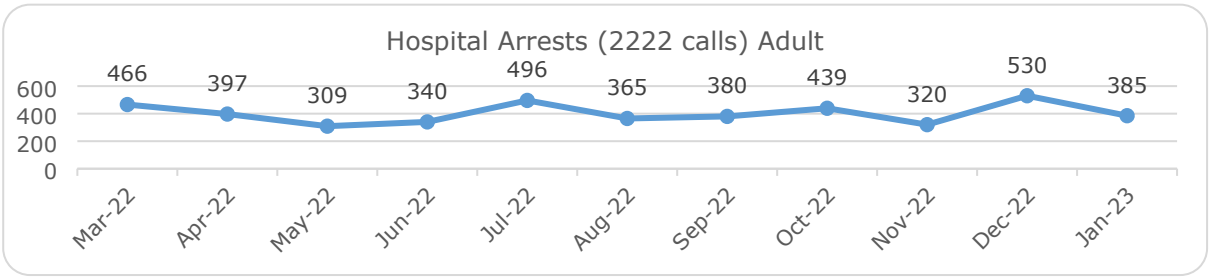
2.3.7 Hospital Acquired Thrombosis (HAT)

There were 9 potential HATs identified for February and March 2023 compared to 7 for the previous 2 month period. Work is required to determine the scope and accuracy of the data on a Health Board wide basis. It is also important to remind Committee that this measure is prior to the investigation of each case to identify if a HAT occurred or not. The ambition is to provide information that shows potential versus actual HATs.



2.3.8 Hospital Cardiac Arrests and NEWS Training

Hospital Cardiac Arrest Calls (222)



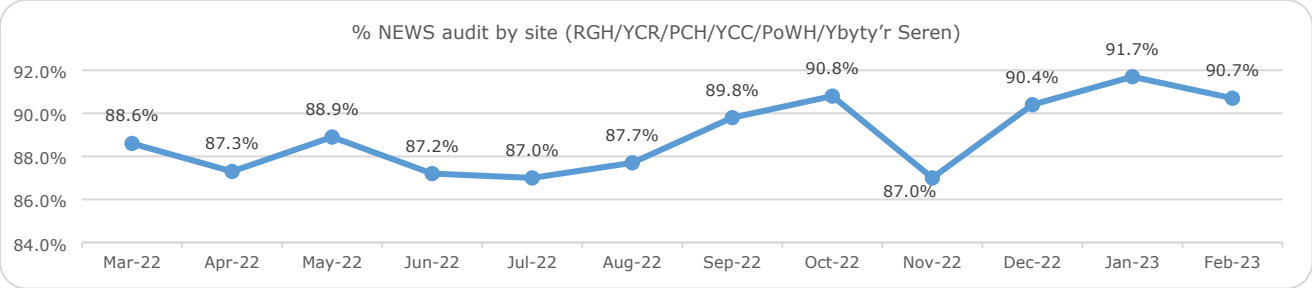
The number of calls taken rose significantly to 530 during December 2022 but decreased to a level consistent with the previous months. Up to date Health Board information was not available at the time of preparing the report. A reliable mechanism for the collation of this information is currently being established.

Hospital Cardiac Arrest Calls will remain an important metric for inclusion in this report, as the objective is for cardiac arrests only to occur in the Emergency Department. Strengthening our pre-arrest reviews and monitoring acute deterioration, as well as improving on our DNACPR processes, NEWS scoring, and training strategy, are integral to success in this area.

NEWS Audit

Following a dip during November 2022, compliance with NEWS has increased to above 90% from December 2022 onwards. Information was not available for March and April at time of preparing the report.

Recognising Acute Deterioration and Resuscitation (RADAR) group will be expanding metrics to ensure there is a constant review of activities in relation to NEWS.



2.3.9 Community Metrics

A number of metrics (summarised in the table below) are measured in relation to Community Services including District Nursing treatments which has steadily increased over the 12 month period. Following a steady increase, average length of stay decreased during April 2023 in Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda, whilst remaining relatively consistent with previous months on other Health Board sites. Further work is required to refine and validate this data.

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb – 23	Mar – 23
District Nurse treatments	34298	36231	35265	35376	36155	35404	36739	36333	34494	35937		
Referral to At Home Services (All Referrals)	90	120	122	129	123	128	119	125	138	125	145	182
Ysbyty'r Seren (ALOS)	55	63	0*	0*	0*	0*	0*	0*	0*	0*	0*	0*
*Princess of Wales Hospital, Ward 21 (ALOS)	-	-	16	22	47	22	39	48	33	21	21	20
Ysbyty Cwm Cynon (ALOS)	61	63	49	51	64	64	57	56	72	80	74	50
Ysbyty Cwm Rhondda (ALOS)	67	70	56	67	55	62	80	68	73	72	79	62
Palliative Medicine, Bridgend (ALOS)	19	14	20	9	10	24	19	23	18	15	18	11
Palliative Medicine, Pontypridd/RGH (ALOS)	4	19	12	7	8	8	11	7	6	10	7	9
Palliative Medicine, YCC (ALOS)	16	13	32	16	36	4	25	28	24	25	18	23

2.4 Patient Safety Solutions

There has been **no** new patient safety alert or notices issued since the last Quality & Safety Committee meeting.

Current Compliance
In total, there is **1 alert** and **0 notices** in which the Health Board are reporting non-compliance.

Non–compliance for alert **PSA008 Nasogastric tube** misplacement status is an ongoing issue which is currently being reviewed on an All Wales Level.
An all Wales Training package for NG Tube insertion is being established. The Delivery Unit have advised that the first national meeting took place in September 2022. The Health Board currently provides face to face training for nurses and F1 & F2 doctors. The assessment following the receipt of training is required to be strengthened. Face to face training was not provided during the pandemic, however confirmation has been received to state this has recently been re-established.

2.5 Patient Experience Initiatives

2.5.1 Carers
Welsh Government issued a directive in 2021, which requires Health Boards to have a process in place to support unpaid carers when the person they care for, are discharged from hospital. A patient information leaflet has been published to ensure that carers have information to help navigate the patient's journey and to offer sign posting to available support through health care/third sector. CTM Carers Steering group is working in collaboration with third sector colleagues, such as Local Council's and the Regional Integrated Fund to explore and develop a further strategic action plan to support the unpaid carer's, using the information from the carer's hackathon (this was held via the Regional Partnership Board with representatives from third sector/health and carers to understand what their needs were) and the population needs assessment.

Funding from Welsh Assembly from 22/23 to support carers short breaks has also been distributed via the Regional Integrated Fund.

2.5.2 Chaplaincy Support
As part of the implementation of the Under 16 baby loss pathway and in partnership with the Clinical Bereavement lead three foetal collective cremation funeral services at Coychurch, Glyntaf and Llwydcoed Crematorium have been held. This initiative is supported by charitable donations from the local Funeral directors, Supermarkets and National Charity "Aching Arms" to ensure the experience is as individual as possible. All were well attended by parents and there has been positive feedback. CTM is the only Health Board in Wales to facilitate such an initiative to support families.

We continue to raise awareness of the role of the Chaplain's department with a focus upon spirituality through delivering teaching sessions to support staff to gain an understanding of their own and others personal spirituality that may impact on their own wellbeing and enable them to recognise spiritual distress in patients and colleagues, signposting them to support as necessary. Specific Training has been

delivered to nurses and doctors in Prince Charles Hospital Neonatal Unit and a group of Doctor's from across the HB.

An extension of this training to support student nurses and midwives training has been delivered to student nurse and midwives as part of their induction programmes. This is to support them to gain the knowledge, skills and competencies relating to spirituality care. This cohort are the first students to come through having had competencies of spiritual care as part of their degree course. Further work to evaluate these competencies and exploring how the department can support the students to embed these skills into daily practice is now taking place.

There are two pilot projects underway at the Princess of Wales hospital. One is to facilitate students to meet and shadow a chaplain and the other to support inpatient wards to write competencies to enable the implementation of spiritual care champions, which is hoped will be rolled out across the Health Board in the future.

2.5.3 Bereavement

Bereavement Clinical Lead continues to be instrumental in changing the pathway and process for pregnancy loss and support families and staff alike.

The PATH02 (pathology 02) form for pregnancy loss has been revised and feedback from families and staff is positive. This change means that the Health Board has a more transparent and patient centred approach to pregnancy loss and families feel more informed of their options of disposal of pregnancy remains. Information booklets have been created and printed and are available for patients and staff.

Training and development of bereavement services continued this month, with training delivered to 45 International educated nurses as well as a band 6 development programme. Feedback was positive and more sessions are planned for the future.

An excellent HTA (Human Tissue Act) inspection was undertaken with a special mention regarding the pregnancy loss changes that bereavement have put in place.

2.5.4 Patient Feedback Volunteers

Patient Feedback volunteers are instrumental in supporting completion of the All Wales Survey/Have Your Say surveys at Princess of Wales and Prince Charles Hospital Sites. The patient feedback volunteers visit weekly and contact the Heads of Nursing and Senior Nurses to agree which areas or wards to target for feedback. Collecting service user feedback is just one role of the volunteering service and forms an essential element, while other projects are undertaken this will remain a core function of the service with an increase in interest from other volunteers to participate.

2.6 Duty of Quality / Quality Impact Assessment (QIA)

Work is underway involving both corporate teams and the change team in establishing a standardised approach to QIAs as well as the implementation of the Duty of Quality's 6 quality dimensions and 5 associated enablers across the organisation's reporting

processes. In seeking to achieve a substantive position for this financial year the corporate nursing and patient safety team led by the Deputy Executive Director of Nursing is preparing to host a summit in quarter 2 of 2023 attending to the implementation across finance, education, operations, quality governance, clinical care, communications and commissioned services.

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

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

- Maintenance of robust quality governance arrangements during the transition to a centralised function has remained paramount. The implementation of OCP in relation to Quality and Governance arrangements is nearly complete, with final vacancies in the recruitment process taking place.
- 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. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This report outlines key areas of quality across the Health Board.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	This report applies to all Health and Care Standards.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	• Report for information for Health Board patient safety & patient experience activity • No service or staff impact in direct response from this report, this is considered through improvement work and other reports • Report not requesting proposal for any changes to services or staff
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The requirements to deliver safe, high quality care impact on resources including workforce. The new operating model will support delivery of safe, high quality care.
Link to Strategic Goals	Improving Care

RECOMMENDATION

Members of the Quality & Safety Committee are asked to:

4.1 **NOTE** the content of the report

4.2 **DISCUSS** the content of the report and flag areas (if not already identified) where further assurance is required

4.3 **NOTE** the risks identified

4.4 **SUPPORT** the direction of travel in developing a wider reach of quality reporting and locality based assurance reports

Appendix 1

People's Experience Activity Report (December 2022 – January 2023)

Patient centred care remains the focus of service delivery and improvement across the Health Board and the Patient Experience Team continue to engage with patients, families and carers alike to enable their voices to be heard within this.

This is undertaken through a variety of methods and in terms of receiving first hand qualitative data from patients, the Health Board utilises Civica – patient feedback system. The system continues to be embedded across services with more bespoke surveys being created as further departments come on board. The project team is currently working with the three acute ED departments to create a survey that meets the needs of the service. The SMS texting system requires improved IT infrastructure to enable activation of this service throughout CTM UHB.

Patient feedback received February 2023.

The nurses are very helpful and the food is very good.

My wife has terminal cancer and was brought in to control her pain medication. The ambiance was perfect for my wife. There was a calmness about the place and the staff were very welcoming and attentive. The nurses couldn't do enough for us. It is such a pleasant place. Well done for providing such a facility.

Liaison with family members began in an extremely open and warm hearted way. After months and months have worn on, this now seems to be at a premium and communications are somehow cooler, and the family feel held at arm's length with our very real grief around our relative's condition overlooked. We feel like inconvenient numbers rather than humans, with communication policies being inaccessible and no opportunity for meetings with the family and the key staff after the initial three months.

I want to thank all of the staff at the EPU for their service during such a difficult time. I was offered telephone support after attending A&E with vaginal bleeding. When the bleeding became worse I attended EPU who gave me an ultrasound. There was no heart beat. The staff were incredibly sensitive and understanding at such an awful time for me. I was treated with dignity, respect and was given time. Everything was explained to me in a sensitive way and I am truly grateful.

All staff have very helpful and informative. Would be helpful is there was a shelf in the shower for belongings. Students were brilliant.

Many services manage to have lunch and keep the service running, I do not understand how you need to closed the department for staff to have a lunch break while an eight-month pregnant patient is told to go for a walk. Terrible.

Carers

The Carer's co-ordinator continues to engage with carer's, patients, families and staff alike to raise awareness of the unpaid carer and the need to ensure their voice is heard within the discharge planning process to enable signposting where needed. The weekly information carer stands in the 3 acute hospitals continue to identify and support unpaid carers in a hospital setting. Posters have been displayed throughout the hospital, information booklets provided to emergency departments, discharge liaison services, outpatients departments and the acute wards.

Chaplaincy

Significant Spiritual and pastoral care provided (December 22- end Jan23)

- 663 Patients
- 204 Relatives/carer's
- 364 Staff

The Bereavement and Loss Workshop was presented to CTMUHB 2030 Leaders and the response from community leaders was overwhelmingly positive, which has resulted in subsequent offers for venues to hold more workshops and 'At a loss Cafes' across the Health Board have been provided.

The annual memorial service, in collaboration with County Bereavement services, was held at Llwydcoed Crematorium and live streamed for those who could not and/or felt unable to attend. Carol services resumed at RGH, YGT and YCR and were very well attended, patients and families were pleased these had resumed. Comments below were provided by those attending POW service:

It was a lovely time together singing carols and sharing some of the Christmas readings from the New Testament. At the end one of the hospital volunteers asked to sing a Christmas song "It's the most Wonderful Time of the Year" and one of the patients from Angelton who had previously been a member of a male voice choir joined in with her.

Most people stayed for tea/ coffee and mince pies / biscuits. The hot drinks were especially welcome as it was very cold and as one of the patients with dementia remarked loudly "it's freezing in here!"

It was a joy to catch up with a patient from Caswell who chaplaincy had regular contact with prior to the HB transfer in 2019 and who now has accompanied leave from the ward. He hopes to be able to come to some of the Thursday morning services that are held in the chapel.

Volunteers

Meet and Greet Volunteers

The meet and greet volunteer role provides a wayfinding service for those attending our sites across CTM UHB. The following provides an overview of this service across the organisation.

- The meet and greet service at the Princess of Wales & Royal Glamorgan Hospitals was reintroduced several months ago providing wayfinding, signposting and information. In addition, the volunteers encourage feedback from service users by handing out or supporting the completion of the "Have Your Say" cards.
- In December 2022 recruitment for new volunteers was re-opened and promoted via our local community volunteer centres and the volunteer service intranet and internet sites, which included additional volunteers for YCC, DSHP and RGH.
- Since 2020, our vaccination centre volunteers have supported the work stream across the Health Board and have been invaluable to the delivery of services, during the busiest times with over 120 volunteers supporting with meet and greet, wayfinding and signposting.

Wellness Improvement Service (WISE) Volunteers

The Wellness Improvement Service was officially launched on 5th September 2022. During December and January wellness sessions have continued to take place with volunteers supporting wellness coaches and participants.

Pets as Therapy Volunteers

The Pets as Therapy service is a positive and a welcomed form of alternative therapy, which benefits patients, service users and staff. The volunteer service has been working jointly with the Cariad Pet Therapy Organisation to explore expanding their services more widely across CTMUHB.

To date we currently have the following volunteers and therapy pets at clinical sites which include:

- Palliative Care Unit (RGH) and Dementia wards (RGH)
- Y Palliative Care Unit (POW)

- CAMHS, Ty Llidaird (POW)

Cariad Pet Therapy has been instrumental in supporting CTM UHB with this initiative and have recently won an ITV Wales Wellness award. The Pet Therapy project was presented to the Quality and Safety Committee on the 24th January 2023, which was warmly received and hugely supported, the volunteer service has been invited back to the Quality and Safety Committee at a later date in 2023 to provide a presentation on volunteering from a broader aspect.

Arts, Crafts, Good to Grow and Volunteer Drivers

The Arts and Crafts Group are keen to continue their workshops and plans will be made during 2023 with the aim to make items to donate to our wards and departments, with planned themes. Some of our arts and crafts volunteers also support other projects including WISE, meet & greet and digital support volunteers. To date we have 2 volunteer drivers supporting with transporting participants to Y Bwythyn Newydd to enable them to get involved with the good to grow project which is also supported by volunteers under the guidance of the Occupational Therapist, with a volunteer driver handbook being developed and currently awaiting approval.

Veterans

Work continues to highlight the Armed Forces Covenant and how this affects the service we offer veterans/serving/territorial personnel who have associated medical conditions as a result of their time in service.
The ESR system has been updated to reflect a training package that staff can access to highlight the responsibilities of the NHS organisation.
The exploration of WPAS systems on an all Wales basis is still being undertaken to review how links can be inputted into the system to track patient referrals that can be expedited under the Armed Forces Covenant.

Bereavement

The Clinical Bereavement Lead continues to liaise with staff, third party stakeholders, patients to embed the Once for Wales Care of the Bereaved Framework across the Health Board. This involves a number of facets which are detailed below:

- The Care After Death policy and bereavement checklist has been updated.
- A new Pregnancy Loss under 16 weeks policy has been produced. This policy means that patients who experience pregnancy loss are supported and the procedure they encounter is sensitive and appropriate for their circumstances. A newly created Pregnancy loss

under 16 weeks information booklet produced has also been written to accompany this policy.

- Delivery of bereavement training to bereavement link nurses within clinical areas on pregnancy loss and care after death has commenced.
- Set up regular forums with contracted funeral directors within CTM UHB to share wider vision for bereavement services across the Health Board.

PALS service

The Head of People's Experience and the PALS team in POW are updating processes & procedures to ensure maximising engagement with patients/families/carers and staff. As the service has recently transferred into the People's Experience portfolio this will support the planned expansion of the service across the Health Board enabling visible 'front of house' service supporting people's experience and feedback to support service improvements and shared learning. The Care to Share clinics have been reinstated across the wards in PoW to gain real time patient feedback.

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

11/04/2023

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

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

11/04/2023

Notices as at: 11/04/2023												
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	Non-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	Non-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	Non-compliant	Compliant	Non-compliant	Non-Compliant	Compliant	Compliant	Non-Compliant	Compliant	Non-compliant

Agenda Item 6.4.1	24/05/2023	Quality and Safety Committee	ED Spotlight: A review of Pressure Ulcers and Falls

FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Richard Hughes, Deputy Executive Director of Nursing
Presented By:	Becky Gammon, Assistant Director of Nursing
Approving Executive Sponsor:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Report Purpose	Please Select: For Discussion For Noting
Engagement undertaken to date:	Across care group, sites and within corporate teams.

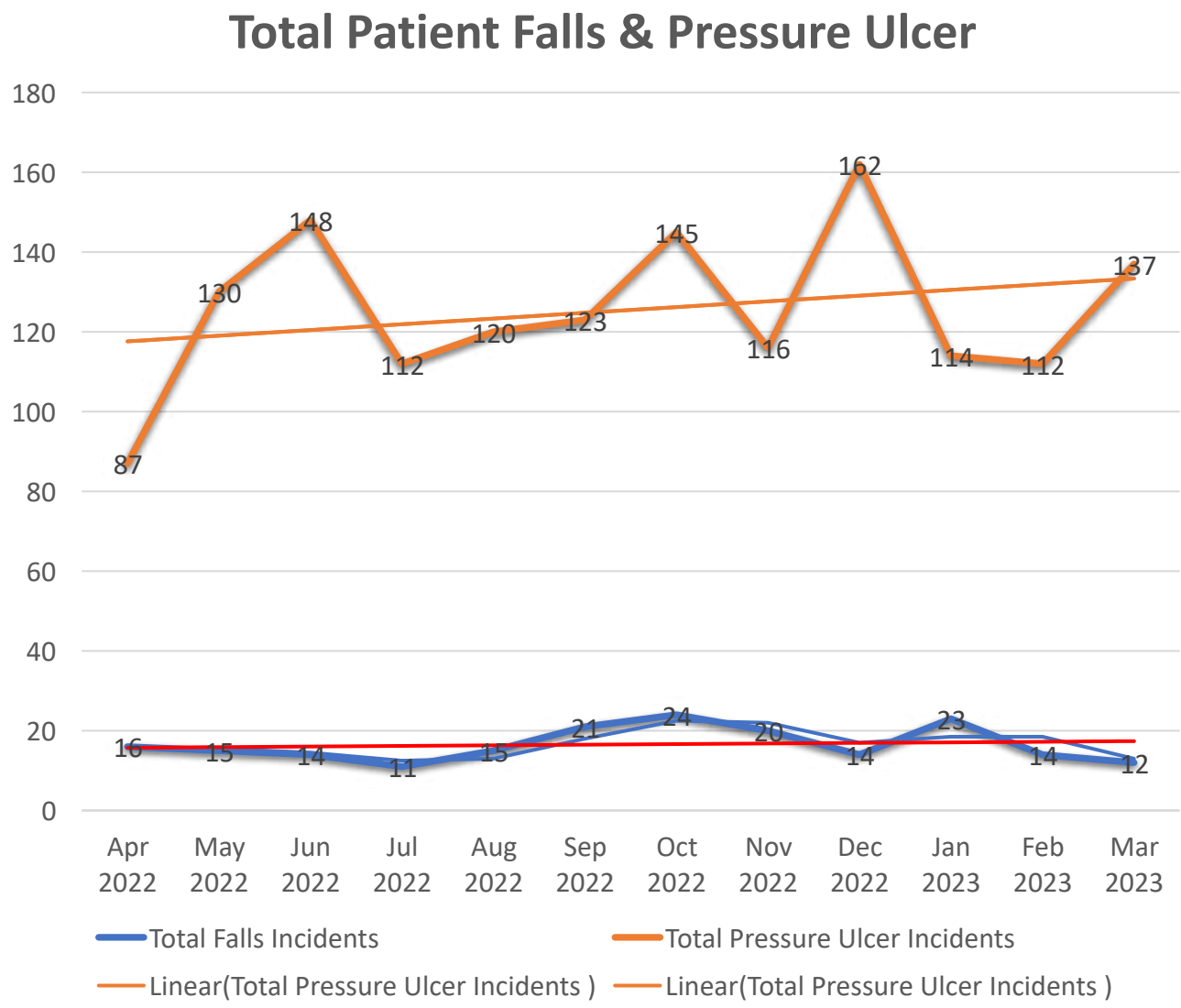
Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Impact will rest with output and associated reporting structures described in presentation.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	No, this is a review of facts and exciting arrangements.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Inspiring People Improving Care

ED Spotlight Presentation

A Review of falls and pressure ulcers

Overview

- Increasing trend of the total number of pressure sores recorded in the Emergency Department (ED) both community and hospital-acquired.
- Recording data points representing irregularity month on month with numbers on the whole sustained above 112.
- The total number of falls remains linear with no statistically significant trends.



Falls

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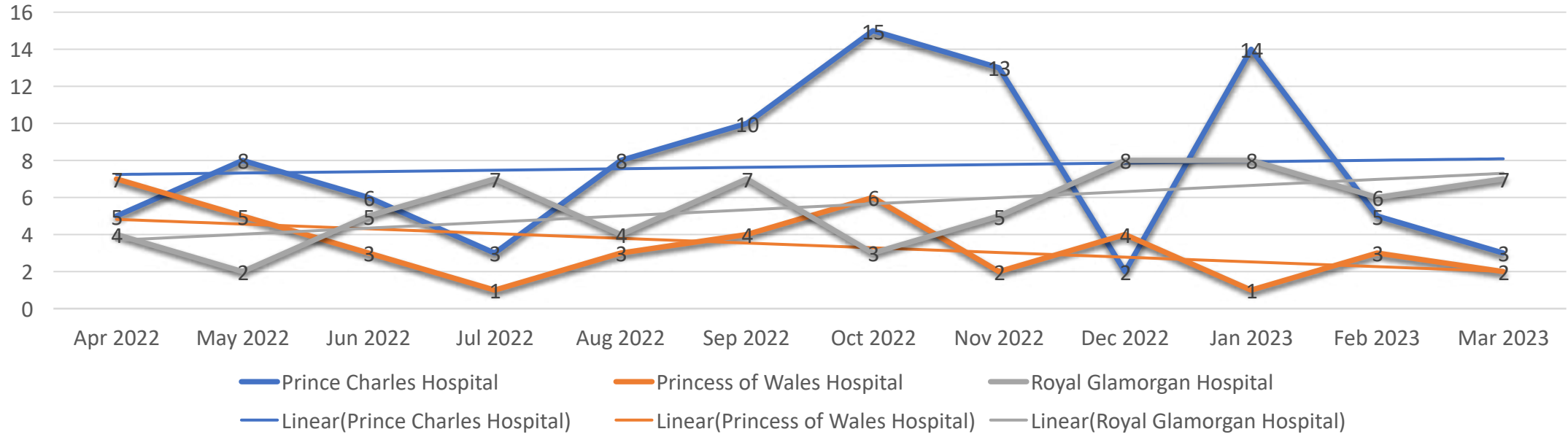
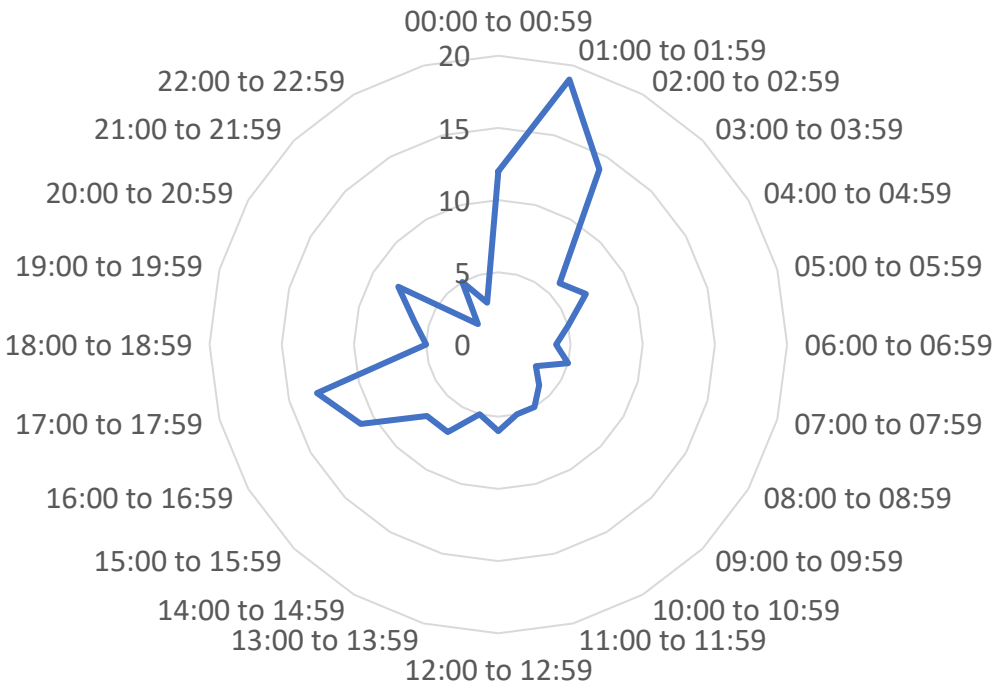
Number of Patient Falls Incidents By Hospital Site

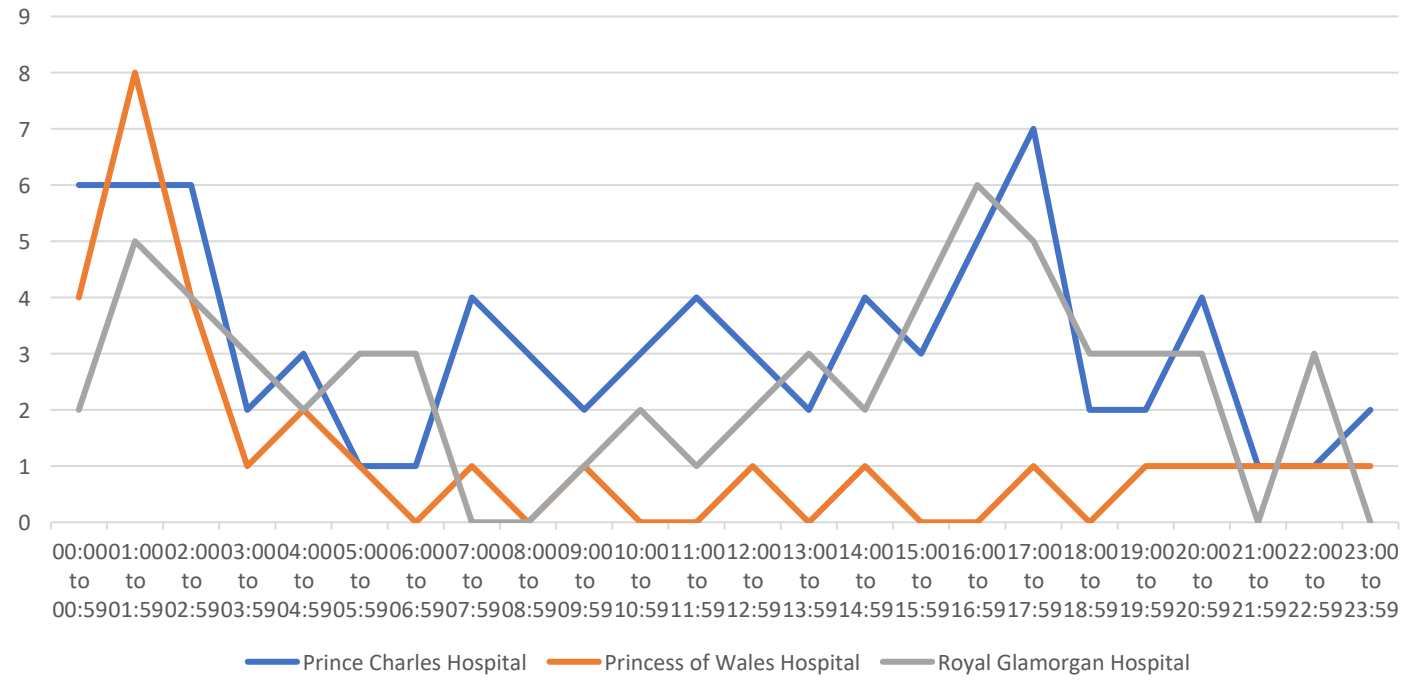


- The chart above describes falls of all types (no harm, low harm, moderate harm, and severe harm) by hospital sites within the ‘ED’ footprint.
- Prince Charles Hospital demonstrates a higher proportion of falls in 6 months out of 12 with The Royal Glamorgan Hospital reporting slightly fewer but more than The Princess of Wales Hospital ED.
- While the Princess of Wales Hospital demonstrates a downward trend in the total number of falls reported, Prince Charles and the Royal Glamorgan Hospitals demonstrate an upward trend in reporting.

Time of Falls Incidents

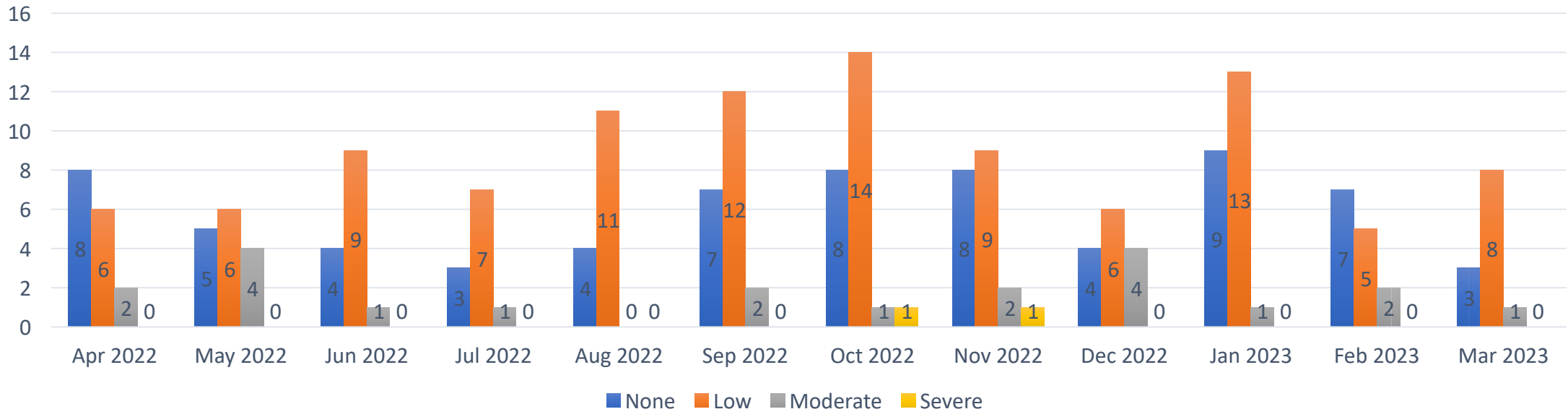


Time Band within which Falls Incident Occurred



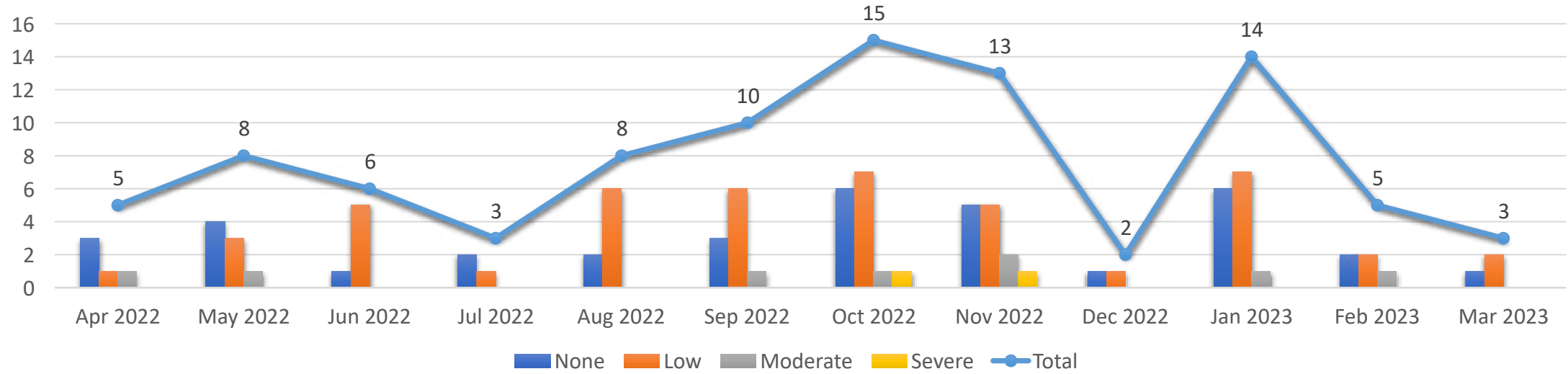
- Whilst the two charts demonstrate variation across the three sites as to the relationship between reported falls and time of the day, there is a clear alignment between all three demonstrating higher numbers between the hours of midnight and 3 am.
- There is a second peak for all three sites between the hours of 4 pm and 6 pm, particularly on the Royal Glamorgan and Prince Charles Hospital sites.

Severity of Incidents Across Emergency Departments



- This chart demonstrates the recorded fall incidents across the 12-month period broken down by the level of harm associated with falling.
- The majority of falls are associated with low and then no harm as an outcome of the incident.
- There is not enough information to demonstrate causation at the organisational level, however, the months of August, September, October and January are all aligned with the reported operational narrative provided at the time in relation to significant patient flow issues, ward boarding and ambulance delays.

Prince Charles Hospital



- The number of fall incidents being reported is higher in low and no harm as the outcome.
- The number of falls being reported is a driver for the overall reported numbers for CTM as a whole.
- The number of fall incidents represented is directly correlating with the length of stay in the extended areas of the department (GP assessment), with some patient stays in ED lasting 96 – 120 hours.
- The available capacity and therefore number of patients within the ED compared to the other two sites may increase the potential for increasing incidents of falling.
- Whilst the number of data points will not yet support a positive response, additional work has been started on clinical assessment for the need for onward admission to the next bed to accommodate frailty and risk of falling as a priority issue.
- The above and improved compliance with falling risk assessments is aligned with improving numbers across February and March.

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University Health Board

How are the team at Prince Charles Hospital responding?

A newly implemented approach to the assessment and scrutiny of falling-related incidents has recognised the positive intervention at the clinical level:

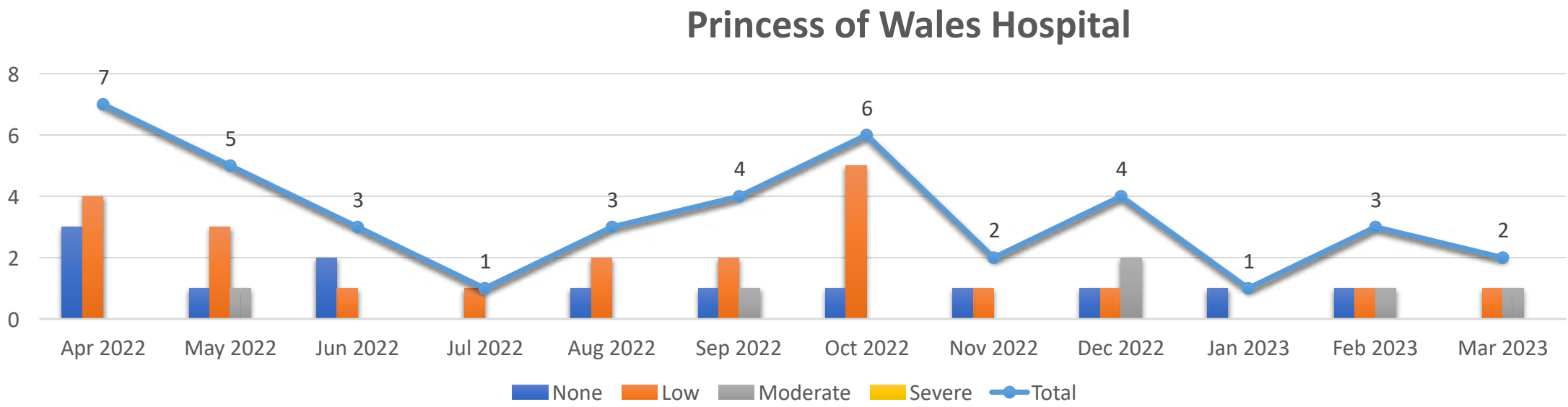
- Improved compliance with at-risk-of-falling risk assessments.
- Improving and considered approaches to appropriate placement and prioritisation for ward placement where admission is required.

With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

The two defined peaks in incidents reported have been recognised by the team. Whilst the initial intelligence points towards the movement of the workforce to attend to transfers as well as nocturnal toileting demands, there will be further work and ongoing surveillance of the data to understand potential measures to flatten the peak and mitigate the understood causes.

Recent recruitment strategies have realised an overall reduction in agencies to support vacancies. This has resulted in elevations of consistency and earlier intervention.

Work has begun, however, is required on an ongoing basis as to the geography of the department and what is determined within the ED footprint versus what is required as additional surge space as a result of capacity issues within the hospital. This is important to further understand the data of falls being reported in the ED versus ward or outpatient areas.



- The number being reported for this site are relatively consistent and low in number consisting of low and no harm incidents in the majority.
- The data is also demonstrative of the work being carried out by the clinical and operational team in prioritising ward transfer for those at risk of harm from falling as well as appropriate placement whilst in ED.
- There is also the recognition of long ambulance waits, it is not clear if this impacts the falls data, but with improving ambulance flow in the last three months, there has been a reduction in falls, not an increase.

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How are the team at Princess of Wales Hospital responding?

Whilst very early in the journey, the team were eager for the organisation to recognise the beginning of a new fragility model across the emergency floor. With a section of the acute medical unit being dedicated as a frailty unit, there is now improved flow and early identification of frailty and associated risks (falling). This is proving to be a positive edition which has also seen AMU vacancies reduce by 40%. More to follow in the near future!

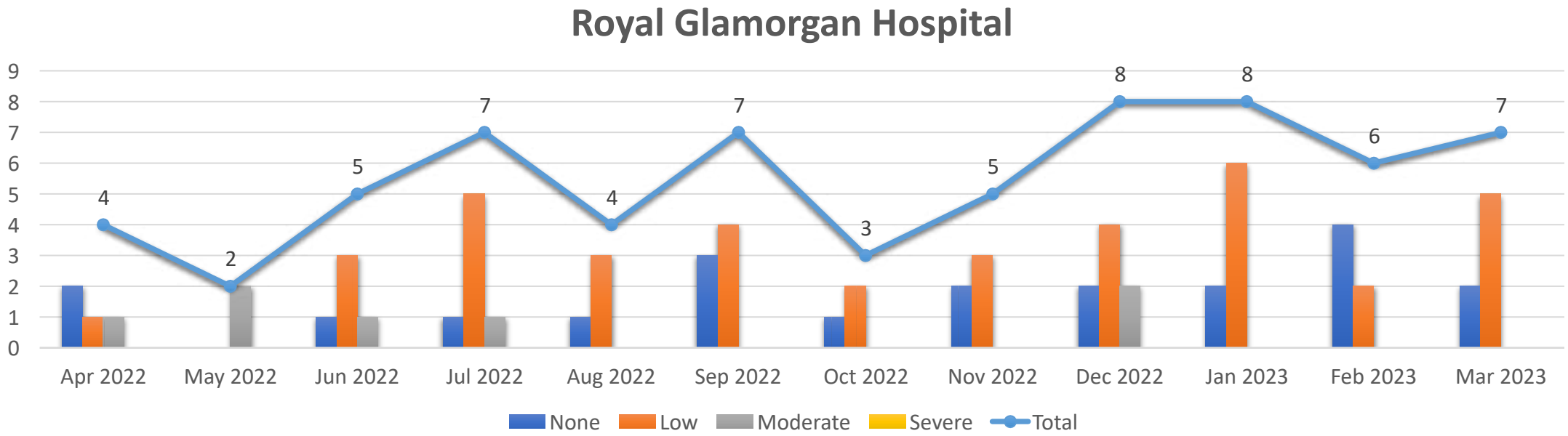
The senior team have reported improving quality and compliance in the assessment of risk in falling as well as an associated improvement in the awareness and documented assessments and actions plans for the treatment of recognised delirium.

With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

As part of the work to improve on the quality of assessments and appropriate resource. There has also been a noticeable improvement in the compliance and quality of enhanced supervision needs assessments,

A newly implemented approach resulting in positive interventions at clinical level:

- Improved compliance with at-risk-of-falling risk assessments.
- Improving and considered approaches to appropriate placement and prioritisation for ward placement where admission is required.



- The number being reported for this site are relatively consistent and low in number consisting of low and no harm incidents in the majority.
- The data is also demonstrative of the work being carried out by the clinical and operational team in what is the smallest ED environment within the organisation.
- There appears to be no suggested trend with the numbers of falls being reported below 8, month on month.

With the established Unscheduled Care Group, the Head of Nursing, clinician colleagues and senior nursing team are committed to working in partnership with our other two sites in order to strengthen and extend the capacity to learn and share from incidents with a greater emphasis on prevention.

As part of the work to improve the quality of assessments and appropriate resources. There has also been a noticeable improvement in the compliance and quality of enhanced supervision needs assessments.

With overall incidents recorded being lower, the team will be looking at the series of moderate-level harm incidents of falling over the course of April, May, June and July to determine if there is a common causation. This will be shared at the first harm-free care board.

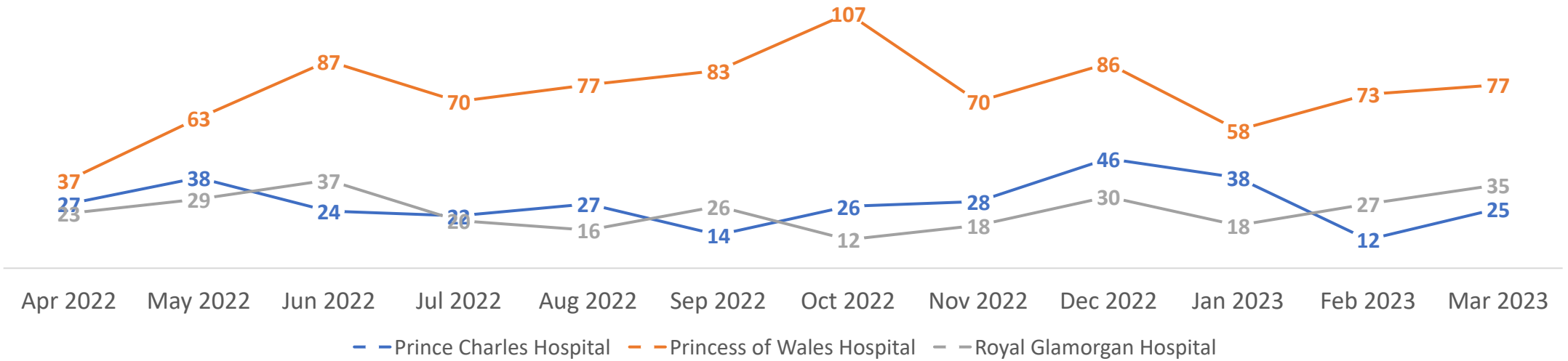
How are the team at the Royal Glamorgan Hospital responding?

The care group leadership team are in the process of transforming current site-based processes of falls incident analysis to accommodate the sharing of information across multiple areas, care groups and associated/relevant organisations (WAST). Royal Glamorgan team members will be active with other colleagues across the care group in structuring this over the next few months.

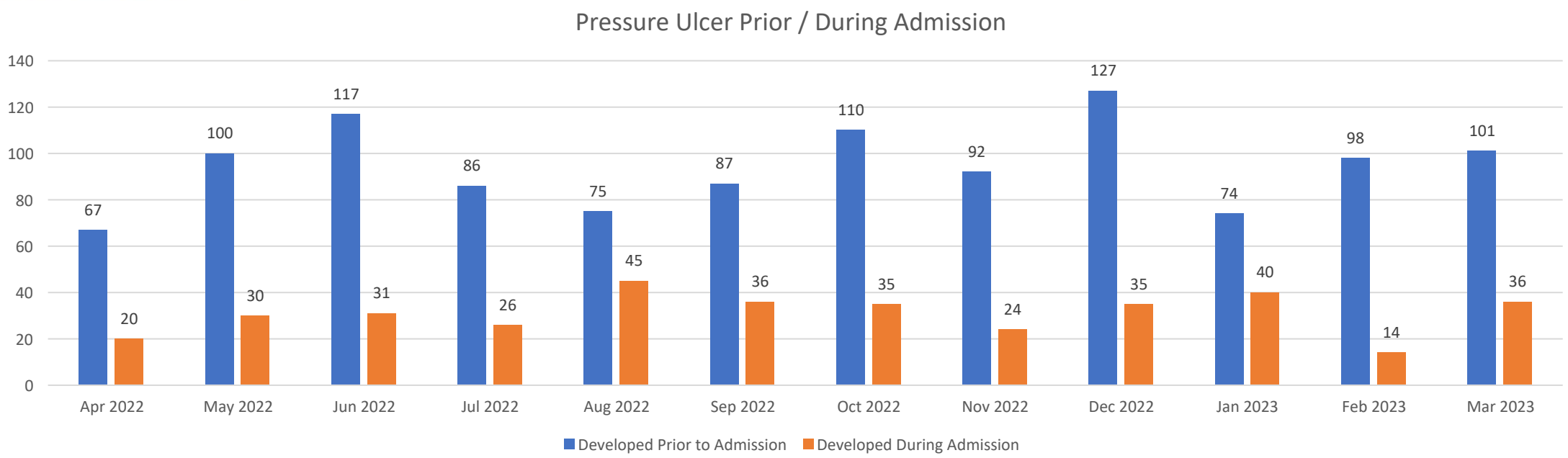
Pressure Ulcers

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

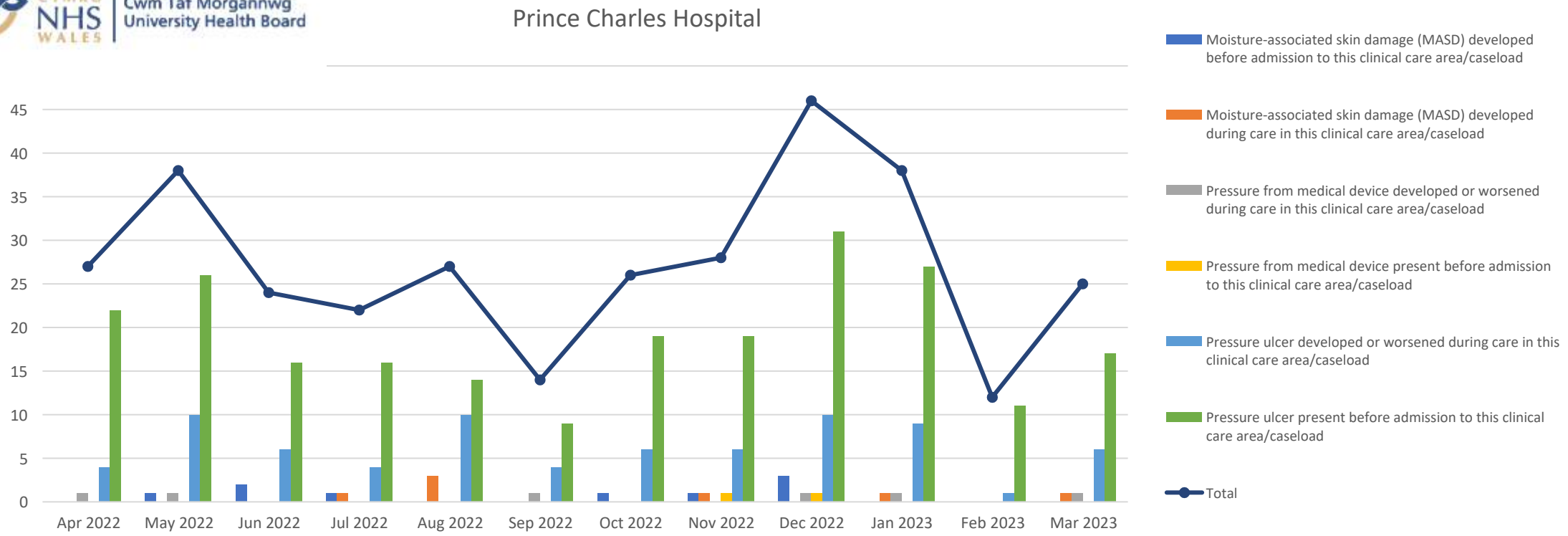
NUMBER OF PRESSURE ULCER INCIDENTS BY HOSPITAL SITE



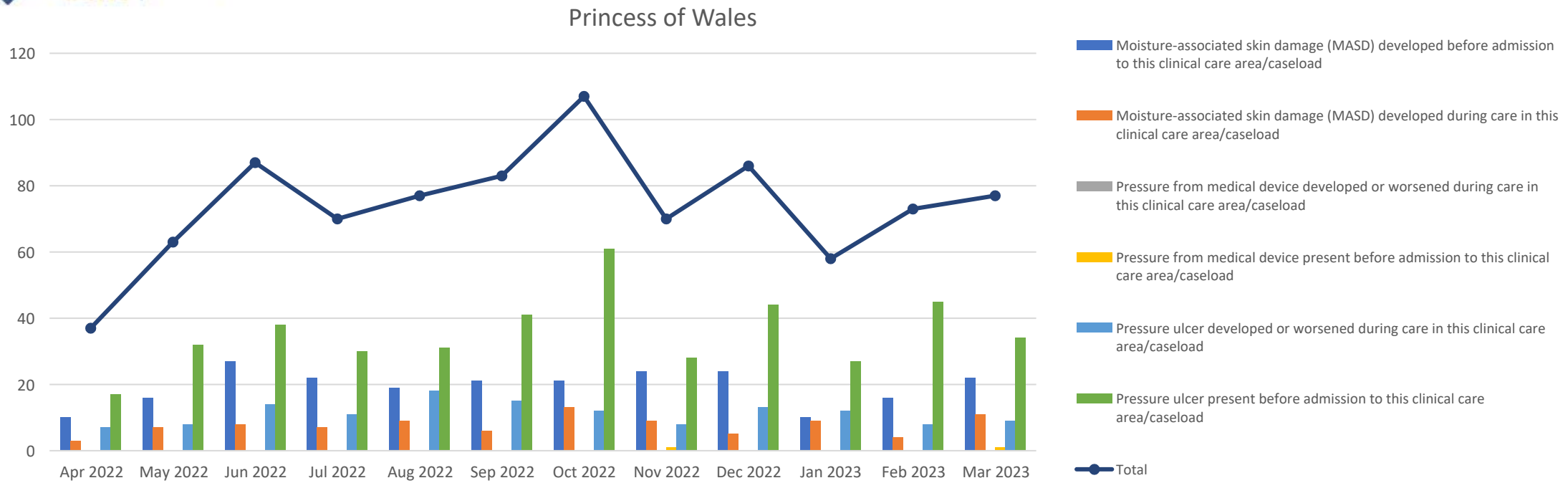
- The table above details the number of **all** pressure ulcers (community and hospital-acquired) reported in our three EDs over a 12-month period.
- Whilst the Royal Glamorgan and Prince Charles sites remain consistent with slight elevations across winter 2022/23, the Princess of Wales site sits as an outlier, demonstrating a significantly higher number of reported incidents.



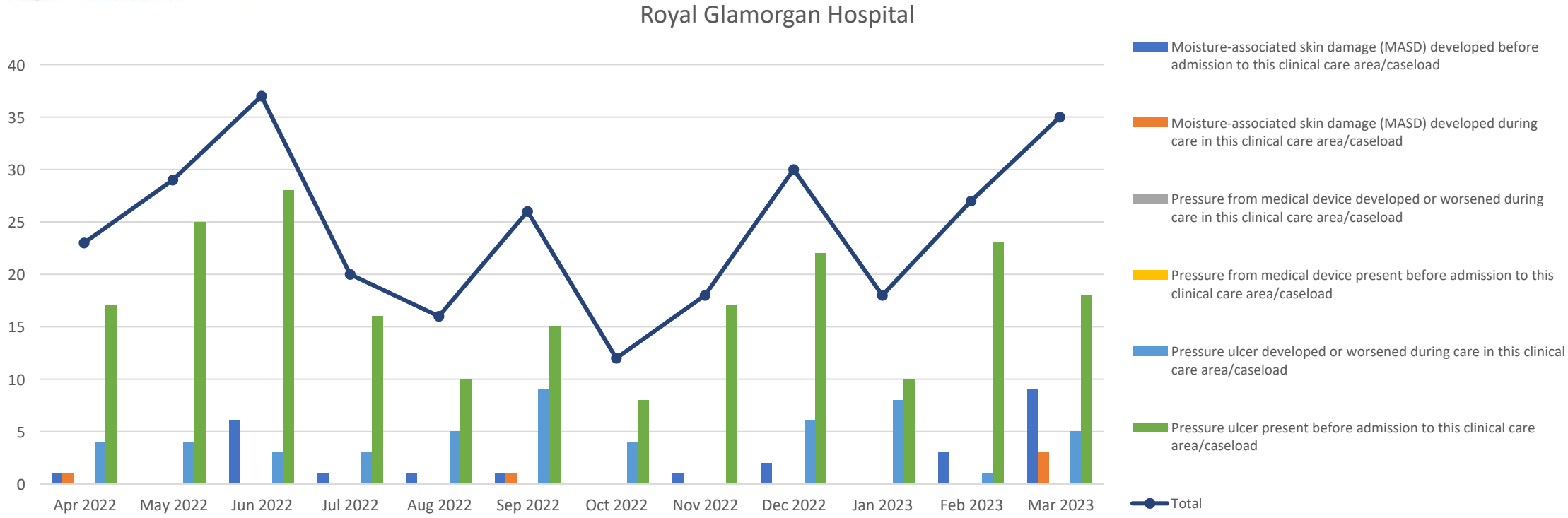
- The table above details the total number of pressure ulcers broken down by prior admission and during admission, reported in our three EDs over a 12-month period.
- The data demonstrates a clear distinction between pressure damage being captured as a community in origin versus damage which may have been acquired as a result of a lapse in hospital-based care.
- There is no statistical significance to determine any correlation to seasonal or other associated relationships.



- The table above details the pressure ulcers, broken down into the described categories for the ED at our Prince Charles site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage.

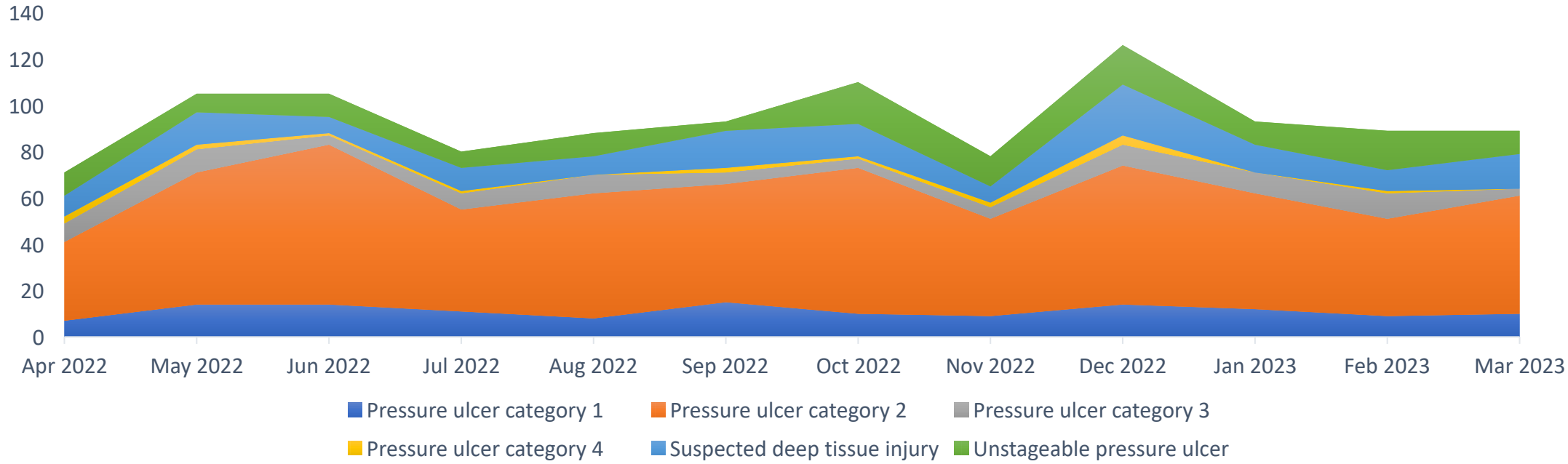


- The table above details the pressure ulcers, broken down into the described categories for the ED at our Princess of Wales site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED, but it also demonstrated double the number of Prince Charles and the Royal Glamorgan Hospitals.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports. The total number reported is again, double that of the two other sites.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage.



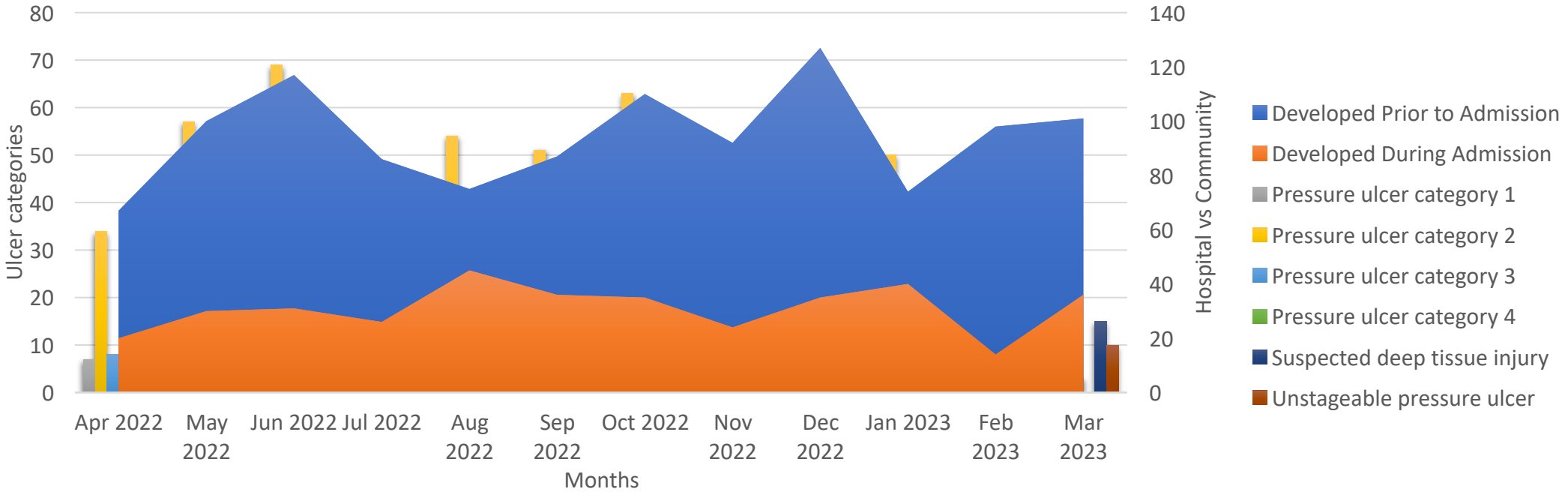
- The table above details the pressure ulcers, broken down into the described categories for the ED at our Royal Glamorgan site.
- The data suggests a higher proportion of pressure damage as being acquired prior to presenting to ED by a significant margin.
- Whilst lower in numbers, care-associated pressure damage does have a correlation to operational capacity issues, supported by operational situation reporting data and WAST operational reports.
- The recorded data demonstrated very minimal device-related skin damage and small levels of moisture-associated damage but does demonstrate higher levels when compared to the two other sites.

Pressure Ulcers by category



- The table above details the pressure ulcers, broken down into their associated categories.
- The data suggests category 2 pressure damage as the primary classification across all months.
- There are clear correlations between elevated numbers of suspected deep tissue injuries with increased numbers of category 3, 4 and unstageable injuries.
- There is an association between the demonstrated peaks in the aforementioned with operational data demonstrating significant patient flow concerns and extended ambulance delays with associated community delays.

Pressure Ulcer Category vs Hospital & Community Acquired



- The table above details the pressure ulcers, broken down into their associated categories against overall pre/during admission numbers.
- Here the data is suggesting a mirroring of category 2 and damaged classified as ‘prior to admission’.
- There is also an identifiable pattern of category 1 and suspected deep tissue injury with an injury sustained ‘during admission’ i.e. in ED.
- There appears to be a disassociation between category 3 and 4 pressure ulcers with the other elements described above.

So, what now?

When cross-referencing the harm data with operational situation reports, the data is suggestive of some correlation between the numbers of hospital-acquired injuries and increased length of stay within the ED footprint across all three sites, with particular reference to Prince Charles Hospital. This is likely due to the capacity profile and therefore higher numbers of extended bed waits in ED.

There is already work underway between CTM and WAST as to the potential use of 'repose' mattresses for those identified at significant risk of harm who are experiencing delays in being handed over. This is being piloted in SBUHB, however, is in the early stages with some anxiety as to the symptom and not the cause being addressed.

Whilst migrating from the ILG structure to the care group arrangement, additional work is needed to facilitate the holistic review of the relationship between pressure injury identified within the acute environment which may have originated within the community setting. This includes detailed work on the potential for harm with extended delays for ambulances.

It has yet to be established as to the reason for higher levels of reported harm when comparing the Bridgend region to that covered by Royal Glamorgan and Prince Charles sites.

As previously mentioned, the team at the Princess of Wales site are at the beginning of a new fragility model across the emergency floor. With a section of the acute medical unit being dedicated as a frailty unit, there is now improved flow and early identification of frailty and associated risks (pressure damage). This is proving to be a positive in the early stages, particularly in improving flow out of ED.

How does this translate?

January 23 to May 23
Care groups realigning the governance agenda out of the ILG structure

May 23 to June 23
Modelling to establish reporting mechanism and associated performance indicators to the Improving Care Board

May 2023
Implementation of Duty of Candour Act and Quality Principles as part of new arrangements

June 2023
Focused analysis with support form corporate team as to relationship of reporting between three acute sites.

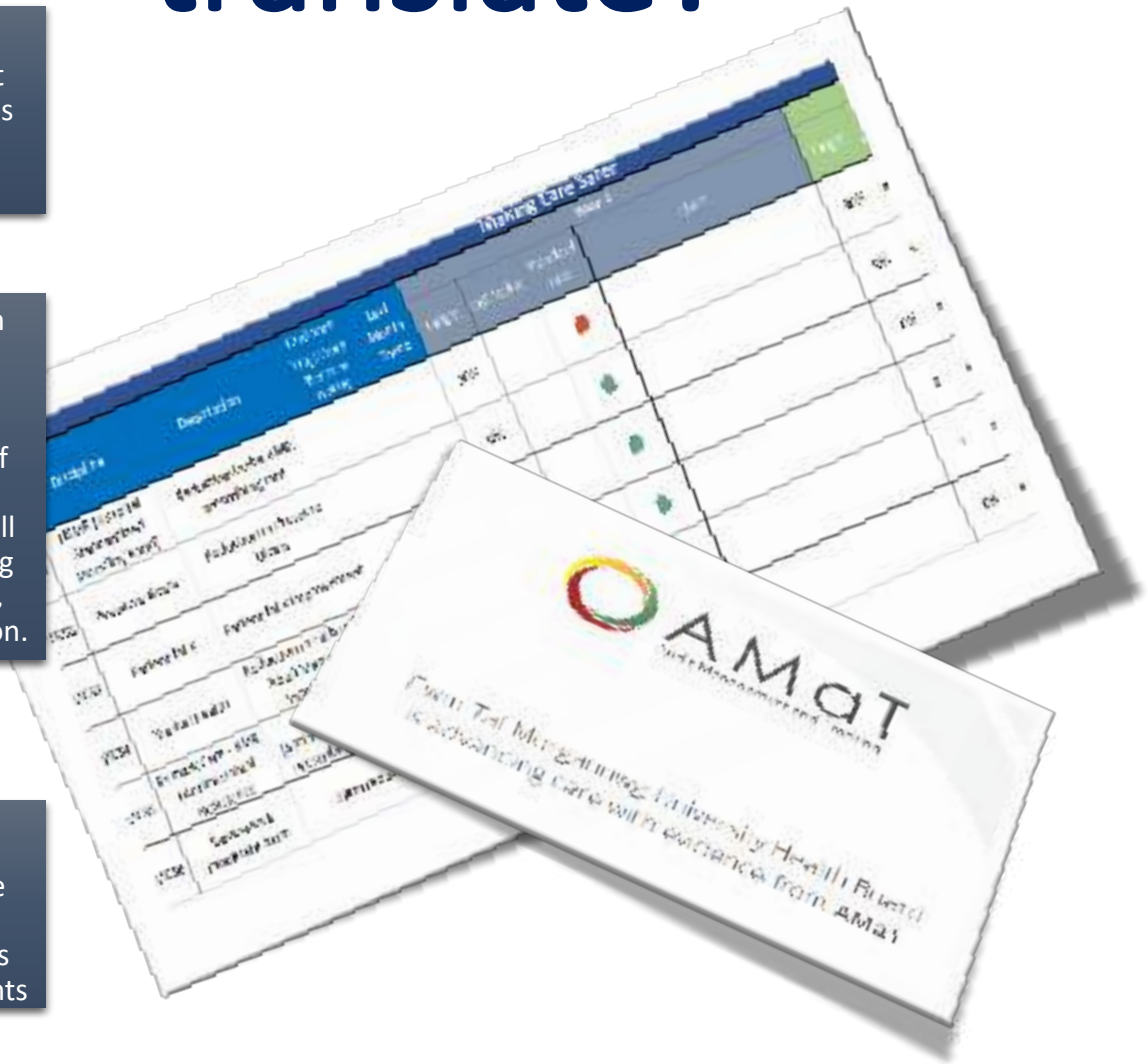
June to August 23
Unscheduled and Community Care groups (with WAST) to carry out focused piece of work on joint surveillance and shared learning

July 2023
Launch of the 'Harm Free Care Board, chaired by Deputy Nurse Director for strategic oversight of learning and intervention across all care groups regarding falls, pressure sores, hydration and nutrition.

May to July 23
Evaluate and describe relationship to the interventions described with stakeholder groups such as iCTM, the pressure ulcer collaborative and wound care innovation.

February to August 23
All care groups reporting on agreed Standardised data sets as to the Quality KPIs complimented by consistent audit cycle

August 23
Triangulation of all governance arrangements to the broader regulatory Learning from Events Reporting requirements



Recommendation:	**The Board or Committee are asked to:**
Harm Free Care Board (in development) to report in September 2023 on the progress of work and update on reporting structure (operational).	• *Consider the narrative against the provided data.* • *Note the future work and prospective governance arrangements at operational levels.* • *Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.*

Agenda Item 6.4.2	24/05/2023	Quality and Safety Committee	Learning and actions following a death in Maesteg Hospital

FOI Status:	Open (Public)
If closed please indicate reason:	Not applicable
Prepared By:	Richard Hughes, Deputy Executive Director of Nursing
Presented By:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Approving Executive Sponsor:	Greg Dix, Executive Director of Nursing & Deputy Chief Executive
Report Purpose	Please Select: For Discussion For Noting
Engagement undertaken to date:	Across care group, sites and within corporate teams.

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	Impact will rest with output and associated reporting structures described in presentation.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	No, this is a review of facts and exciting arrangements.
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Please Select: Inspiring People Improving Care

Lessons Learned

Learning and actions following a death in Maesteg Hospital

Assessment

The RCA made a number of recommendations following the investigation which were subsequently evidenced as completed:

1. Local feedback to relevant staff
2. Shared learning across the CTMUHB
3. Environmental risk assessment training, including roles and legal responsibilities for all staff
4. Staff to use electronic referrals for work requested for estates, and for those who hold managerial responsibility to initiate them and escalate as required.
5. Development of a strategy to support ongoing documentation training and audit, mandatory training to be reviewed and considered regarding upskilling of risk assessments and risk analysis.
6. Audit of documentation to ensure that CTMUHB documents are in use.
7. Staff who undertake Datix investigation to be supported by relevant training, and a consideration of peer review to provide an environment around shared learning and to support good practice.
8. Regular clinical supervision to be incorporated, or maintained.
9. Mandatory safeguarding training compliance to be audited.
10. There are two dementia champions within the ward staff, this process continues, to support staff in effective care planning.
11. All staff to be aware of their role in escalating concerns, and to be aware of the policies that underpin this.
12. Regular team meetings to continue, with agendas and minutes to ensure that relevant information is shared with all members of the ward team who may not be present and that these are available for scrutiny if required.
13. Information booklet containing information about Llynfi ward for patients and families, on admission.

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

Additional elements to consider (Recommendations)

Awareness and oversight of the Deprivation of Liberty Safeguards have improved in recent months with partnership working between our safeguarding professionals, clinicians and the DoLS practitioner team.

Welsh Government have now confirmed substantive (recurrent) funding to maintain the current oversight (leadership team) for DoLS within CTM and enable substantive recruitment to the necessary posts.

Using the learning from the incident, the Unscheduled Care Group is currently reviewing the estate across our three acute sites to ensure where required, wards are furnished with the appropriate equipment to control access in and out of the ward environment where it is necessary and proportionate to do so.

As the organisation transition out of the previous ILG structure to the newly established care groups, it is recognised of the significance in the changes to team leadership described in the RCA. The care group Directors, supported by corporate teams are ensuring staff are supported to report and escalate concerns where required to do so.

Care group Nurse Directors and Corporate Nursing leaders are in the process of developing a central database for audit and compliance to improve the oversight and availability of information and associated learning (AMaT).

Care group and site based leadership teams are collaboratively engaging with the corporate teams in the formation of operational reporting structures on quality and patient safety metrics whilst also developing and triangulating the opportunities to share learning and ensure robust governance. This work is coexisting in the development of the Harm Free Care Board and Improving Care Board.

Both the Deputy Executive Director of Nursing and Assistant Director for Quality Governance are overseeing the implementation of the Duty of Candour and Quality Act in CTM. Progress is being made with Candour processes fully operational and monitored by our central teams. Work is underway in the preparation for the implementation of the 6 quality dimensions (STEEEP) and 5 enablers in our quality and patient safety reporting mechanisms from ward to board.

Recommendation:	**The Board or Committee are asked to:**
To consider the actions directly associated with the RCA as evidenced and closed with lessons learned now being considered across the organisation as described in the presentation.	• *Consider the narrative outlined in the presentation.* • *Note the future work and prospective governance arrangements at operational levels.* • *Consider whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.*

AGENDA ITEM
6.4.3

QUALITY & SAFETY COMMITTEE

EXECUTIVE DIRECTOR & INDEPENDENT MEMBER QUALITY PATIENT SAFETY WALKROUNDS JANUARY – APRIL 2023

Date of meeting	24/05/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Allison Thomas, Business Manager Patient Care & Safety Group
Presented by	Greg Padmore-Dix, Executive Nurse Director
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

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

ACRONYMS	
HoN	Head of Nursing
YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
PCH	Prince Charles Hospital
ITU	Intensive Care Unit

PDN	Practice Development Nurse
TU's	Trade Unions
IPC	Infection Prevention & Control
DTOC	Delayed transfer of care
HDU	High Dependency Unit
CCU	Critical Care Unit
CTM	Cwm Taf Morgannwg
PACU	Post Anaesthetic Care Unit
SLT	Speech & Language Therapy
MDT	Multi-Disciplinary Team
MPEC	Multi Professional Education Centre
MD	Medical Director
COO	Chief Operating Officer
AMaT	Audit Management and Tracking

1. SITUATION/BACKGROUND

1.1 Executive Director and Independent Member Quality & Patient Safety Walkrounds take place across the whole of the organisation to gain assurance of the quality of care delivered to our patients and staff together with providing an opportunity for visibility of the Executive Directors and the Independent Members

1.2 The framework for the Executive Director & Independent Member Quality & Patient Safety Walkrounds has recently been updated to reflect organisational changes and an enhanced set of prompt questions

1.3 As a Health Board, we aim to ensure that quality and patient safety is firmly at the heart of everything we do, with a culture that enables the active involvement of the population who receive care along with those who provide it, across every area of our organisation, in quality and patient safety, with a focus on learning and improvement.

1.4 The Executive Director and Independent Member Quality Patient Safety Walkrounds are focused on listening to patients, relatives, carers, staff and stakeholders, all of whom have a strong interest in ensuring the Health Board is optimally positioned to provide high quality, safe and effective care to the right person and at the right time. Engagement in the walkrounds is seen from every area of the organisation and are an integral part of our overall quality, improvement and safety process

1.5 The Executive Director and Independent Member Quality & Patient Safety Walkrounds also focus on engaging with staff and understanding the patient safety and staff safety issues faced by front line staff together with including a clear focus and engagement on staff health and well-being

1.6 The outcome/findings and key themes to be considered from the Walkrounds will provide assurance to the Care Groups and support the sharing and wider learning across the Health Board demonstrating that CTM UHB Values and Behaviours are being embedded across the health board

1.7 At the end of the walkround the Executive Director & Independent Member provide immediate verbal feedback to the clinical/management team who support the Walkround, this includes sharing of excellence as well as where required, agreeing any actions for improvement, the actions are agreed along with a timescale and responsible lead person. The walkrounds are reported to the Quality, Safety, Risk and Patient Experience meeting of the relevant Care Group and all subsequent ongoing monitoring of the agreed action plan is through this group.

1.8 The Patient Care & Safety team Business Manager liaises with the Care Groups for the coordination of the walkrounds across all areas of the Health Board, including Primary Care, Out of Hours and Community.

1.9 The following table captures the outcomes from the seven Walkrounds that have been completed between January to April 2023.

1.10 Details of the completed walkrounds for the period January-April 2023 are detailed in Table 1 below:

Table 1

Date of Walkround	Site/Area/Location	Executive Director and Independent Member 'Buddy Team'
31/01/23	PCH – ITU PCH – Theatre	Gethin Hughes & Nicola Milligan
01/02/23	POW-ITU	Linda Prosser & James Hehir
01/03/23	RGH-ITU & HDU	Lauren Edwards & Ian Wells
07/03/23	PCH - ED	Dom Hurford & Dilys Jouvenat
15/03/23	POW-AMU	Paul Mears & Lynda Thomas
04/04/23	YCR-Ward 2	Gethin Hughes & Nicola Milligan
27/04/23	TyLlidiard	Stuart Morris & Jayne Sadgrove **No summary feedback received due to the date of walkround*

The following section details the feedback received from the six completed walkrounds for the timeframe January-April 2023:

1.11 **Feedback:**

<u>PCH ITU and Theatres</u>

Positive Feedback:

- Area calm and welcoming.

- Improvements made to relatives waiting area.
- Use of substantive staff to improve the nursing roster.
- Practice Development nurse supporting development needs of staff.
- Equipment purchased to support patient communication.

Areas for improvement/Risk:

- Fire safety risk highlighted, there is work underway to address risk.
- Limited rehabilitation space, staff initiatives informing resolutions.

POW ITU
Positive Feedback:

- Good team morale.
- Excellent IPC outcomes.

Areas for improvement/Risk:

- Small Unit which creates recognised sustainability risks.
- No patient shower facility.
- Diagnostic delays and DTOCs due to site pressures.
- Very high dependency on agency and locum.
- Lack of progression opportunities for Registered Nurses (Band 5), which impacts on retention of staff.

RGH ITU & HDU

Positive Feedback:

- Digital clinical records working well.
- Effective wellbeing interventions for staff in place.
- Patient and family wellbeing support in place (bereavement clinic; coffee mornings)
- National and international research activity undertaken.
- Effective and responsive critical care outreach team.
- Clinical education programme in place.
- Recruitment and retention: clarity on CCU model for CTM will reduce uncertainty.
- PACU (post-anesthetic care unit).

Areas for improvement/Risk:

- Ongoing issue of pseudomonas in 1x sink in HDU.
- Medical workforce challenges, eg recruitment; covering on call; sickness.
- No Speech and Language Therapist input to support trachea management.
- DTOC average 5 days (national guidance suggests 4 hours).

PCH ED

Positive Feedback:

- Safe to Start meetings attended by multi-disciplinary teams.
- Very supportive culture. Dedicated staff. Team have a "can do" attitude.
- HIW actions being delivered upon.
- PCH ED practices are being used elsewhere to improve services.
- Paediatric Area welcoming for children, staff ensure children are cared for compassionately.

Areas for improvement/Risk:

- Lack of storage area for additional beds and equipment, currently stored in public corridor.
- ED Demand and Capacity – since opening of the Grange Hospital has impacted on patient numbers attending ED.
- Lack of patient flow through ED/hospital – impacts length of stay in ED for medical and surgical patients. Increases workload of Nursing team within ED.
- Paediatric Mental Health concerns – CAHMs required daily.
- Medical staffing issues – sickness and recruitment.

POW AMU

Positive Feedback:

- Swipe card (Security access) to AMU; for safeguarding as young persons on the ward (16-18yrs).
- Staffing board up to date at entrance to the ward.
- E-whiteboards in use. MDT ward rounds including AHPs/nurses and all grades of doctors.
- Positive feedback on electronic nursing care record.
- Learning board in staff room with focus on key risks, e.g. falls/pressure ulcers as well as thank you cards/compliments shared.
- Positive changes in the physical environment including creating trolley cubicles with enhanced privacy for patients.
- Good leadership from ward manager and senior nurse with clear understanding of the needs of patients/staff.
- Deputy Ward Managers lead various governance areas to ensure all staff updated on key developments with governance meetings to review incidents etc.
- Strong leadership from consultant in acute medicine who is part of the Wales-wide work on Safe Care Collaborative. Structured support and supervision for junior doctors.

Areas for improvement/Risk:

- E-whiteboard more training required to maximise efficiency.
- Governance meetings infrequent – due to workforce pressures.
- Staff room in need of updating/improvement.
- Prolonged length of stay challenge due to issues of flow within the hospital.
- Physical environment challenging in some areas.
- Large bathroom on ward is being converted to a staff office. Have been waiting for completion, therefore plan for relatives' room not able to progress.
- Cluttered environment due to lack of storage facilities.
- Suboptimal communication noted between medical and radiology teams. Plans in place to resolve.
- E-requesting of radiology procedures need to be enhanced to prevent delays in requests/reports, which has impact on flow.
- Suitable Staff wellbeing room for debrief/timeout required.
- Further training required for staff on e-whiteboards and capacity for digital training.

YCR Ward B2

Positive Feedback:

- Patient wellbeing activities observed e.g. making Easter bonnets.
- Calm inviting area (with Easter bunting).
- Patients appeared well cared for.
- Senior nurse was very informative during the visit with clear knowledge of the area had a passion for the patients and their outcomes.

Area of Concern/Risks:

- Cleanliness of main stairway cause for concern.
- Remains of social distancing "sticky labels" noted on some chairs in the corridor.
- There was a general feel of being unkempt.
- Limited visiting in place at time of walkaround. A more open visiting approach, especially at mealtimes, may assist patients with their nutritional needs.

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

2.1 All round positive feedback has been received from all staff involved in the walkrounds including appreciation of the process, value and receiving the assurance that each walkround provides and concludes with

2.2 Actions from the feedback/summary reports are to be taken forward by the agreed responsible person and monitored for completeness through the Quality, Safety and Experience Group

2.3 Further development of the walkround schedule is in progress together with development of a live dashboard of key metrics and information which will be provided to the walkround team in advance of the walkround, in addition further development of an electronic feedback summary template which will be available for use on iPADs in an electronic format is ongoing which will allow for real time feedback, as well as work continuing with the AMaT team in order to triangulate information with the ward assurance audits and concerns for assurance.

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

3.1 Acknowledge the feedback information collated from each walkround for this timeframe and receive assurance that the action plans are monitored through each Care Group.

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
	Staff & Resources Staying Healthy Safe Care Individual Care Timely Care Effective Care

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to **NOTE** this report

AGENDA ITEM
6.5a

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE PLANNED CARE QUALITY, SAFETY, RISK & EXPERIENCE (QSRE) MEETING	
DATE OF MEETING	24th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	Noting

ACRONYMS	
FUNB	Follow Up Outpatients Not Booked

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Planned Care Quality, Safety, Risk & Experience Group at its meeting on 18th April 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	Duty of Candor process will require increased reporting for cohort of FUNB Ophthalmology patients.
ADVISE	• Director of Nursing and Director of Operations for Planned Care in post from 3rd April 2023. • Royal Glamorgan Hospital (RGH) elective Orthopaedic model now delivering care for 24 patients (from 15 beds) to reduce waiting lists. Workforce review required to support increased beds. • RGH Surgical Assessment Unit (SAU) still not in operation due to surge / bed pressures • PACU at RGH is operational and has increased its bed base • Prince Charles Hospital (PCH) Elective capacity review required to increase planned care bed base. • PCH Pre Assessment-implementation of a 1 STOP clinic 6th March 2023. This will improve patient experience and time to surgery **Single Cancer Pathway – Highlight Report** Weekly performance meetings have been reinstated for all Tumour sites and support services. A template has been developed to ensure that there is standardised reporting. This enables the Cancer Business Unit (CBU) to develop a weekly highlight report. • 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 started in PCH & RGH 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 for next 12 months and Ophthalmology outsourcing until end March 2023 to clear 104 week waits has commenced.

ASSURE	• Ongoing work to validate and update complete Planned Care Risk Register in progress as part of Governance re-structure • Theatre Improvement programmes continue across all 3 acute sites to support standardised processes and workforce across CTM • Clinical Service Group monthly Operational Assurance and Business Meetings commenced. • Clinical Service Group weekly performance meetings within Planned Care have commenced. • Consistent weekly process commenced to provide assurance re DoC sign off by Care Group Directors • PoW Weekly harm review panels taking place for Ophthalmology FUNB cohort of patients. Additional sub-speciality harm review panels are running on an ad-hoc basis with specialist clinician input for glaucoma/diabetic retinopathy patients. • Monthly Ward Assurance audit reports via AMaT fully embedded and presented at Planned Care QSR&E Committee (Appendix 1)
INFORM	• Oesophageal High resolution Manometry / pH monitoring Service commencing in CTM HB. This is the gold standard for diagnosis and treatment of patients with reflux and other oesophageal common benign conditions. Training for nursing workforce on the Manometry investigation started mid April 2023 • Hot gallbladder list service will commence on 15 May 2023.
APPENDICES	Choose an item.

Appendix 1 – Ward Assurance (April 2023) Planned Care Group

	Documentation	Controlled Drug	environmental	HH & BBE	Uniform	Glucose	PVC	Catheter	IP&C	wristband
PCH Day Surgical Unit	100%	100%	97%	100%	100%	100%	95%	100%	100%	100%
PCH Endoscopy Unit		93%	100%	-	100%	-	100%	-		100%
PCH Theatre Department				88%	100%					89%
PCH Ward 05	73%	87%	91%	100%	100%	100%	100%	100%	74%	95%
PCH Ward 06	95%	100%	94%	90%	100%	80%	91%	95%	90%	91%
PCH Ward 07 (formerly ward 3)	76%	97%	88%	100%	100%	100%	93%	96%	87%	100%
PCH Ward 08	88%	-	97%	95%	100%	-	97%	92%	97%	100%
PWH Day Surgical Ward				100%	88%	-	96%	-		100%
PWH Endoscopy Unit		97%	83%	100%	100%	100%	100%		86%	100%
PWH Theatre Department				-	-	-	-	-		-
PWH Ward 07	-	-	-	-	-	-	-	-		-
PWH Ward 08	90%	97%	97%	100%	100%	100%	71%	67%	100%	100%
PWH Ward 09	92%	93%	91%	100%	100%	100%	100%	100%	100%	100%
RGH Day Surgical Unit	-	-	-	-	-	-	-	-		-
RGH Endoscopy Unit		-	-	-	-	-		-		-
RGH Theatre Department	-			100%	100%	-	-	67%		100%
RGH Ward 02	-	100%	94%	85%	100%	100%	97%	100%	92%	100%
RGH Ward 03	87%	97%	85%	95%	100%	100%	100%	83%	95%	100%
RGH Ward 08	90%	91%	88%	85%	100%	100%	88%	94%	89%	100%
RGH Ward 09	83%	93%	91%	100%	100%	100%	98%	96%	89%	100%
RGH Ward 10	91%	100%	97%	100%	100%	100%	96%	95%	95%	100%
RGH Ward 15	96%	100%	100%	100%	100%	100%	100%	100%	97%	100%

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

AGENDA ITEM
6.5b

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE UNSCHEDULED CARE GROUP	
DATE OF MEETING	24th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma James, Unscheduled Care Nurse Director Alex Brown, Unscheduled Care Medical Director & Victoria Healey, Head of Quality & Patient Safety
PRESENTED BY	Alex Brown, Unscheduled Care Medical Director
EXECUTIVE SPONSOR APPROVED	Greg Dix Executive Nurse Director

REPORT PURPOSE	Noting

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
ED	Emergency Department
HIW	Healthcare Inspectorate Wales
PCH	Prince Charles Hospital
POW	Princess of Wales
RGH	Royal Glamorgan Hospital
DoN	Director of Nursing for Unscheduled Care

YCR	Ysbyty Cwm Rhondda
YCC	Ysbyty Cwm Cynon
MIU	Minor Injury's Unit
OCP	Organisational Change Policy
USC	Unscheduled Care Group
PTR	Putting Things Right

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 16th March 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	**Minor Injury Unit at Ysbyty Cwm Rhondda** From the 1st April 2023, the MIU at YCR has become a walk-in service following the cessation of telephone triage services provided by 111. Patients are now able to present directly to the MIU and will be booked and triaged by a designated triage nurse. Initial feedback is very positive with attendances reaching the maximum numbers on most days. The change to the operating model will be captured via Patient Reported Experience Measure's (PREM's) via CIVICA which is the health boards service user feedback system, the feedback received will be reviewed in 6-8weeks to assess impact.

ADVISE	Duty of candour (DoC) was implemented on 1st April 2023, the guidance outlines that DoC will trigger if unexpected or unintended harm that is moderate and above is suffered or may be suffered following a provision of healthcare. Since implementation an average of 30-40 moderate harm and above incidents have been reported via the Once for Wales system for unscheduled care however significant work has been undertaken to triage these incidents. A series of DoC training sessions have been undertaken via the patient safety teams with nursing and medical staff to ensure the correct levels of harm are being reported. This education and training will continue until the DoC has been embedded into daily practice. 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 5 remain outstanding however more will now move over to the Six Goals Programme to progress. Complaints have been transferred to a central quality governance team within the organisation. This will ensure we maintain equity, consistency and strengthen resilience. USC compliance with the 30 target has increased from 57% in February to 60% in March. The USC leadership team has now been established and have provided a commitment to support, improve trajectories and have put a mechanism in place to escalate when clinicians and nurses are unable to achieve 30 day compliance. This will be closely monitored by the USC Senior Leadership Team with a significant improvement trajectory expected. **Stroke Quality Improvement Measures – February 2023** Prince Charles Hospital achieved a **'B' rating** (first time since pre-Covid) for Oct-Dec 2022 in the Sentinel Stroke National

Audit Programme (SSNAP)**,** which is a significant achievement given current pressures.

Overall improvements across the four quality improvement measures, these include **17%** admitted to stroke unit within 4hrs (3.3% in January), **14%** thrombolysed within 45mins (0% in January). **53%** of patients who were diagnosed with a stroke received a CT scan within 1hour compared to 48% in January and the stroke specialist assessed **66%** within 24hrs compared to 56%.

STROKE TASK AND FINISH GROUP

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

Healthcare Education and Improvement Wales Visit to Prince Charles Hospital

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

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

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

USC risks rated over 20 are highlighted as below for noting, regular updates are received at the Quality, Safety, Risk and Experience meeting.

	4632 - Provision of an effective and comprehensive stroke service across CTM encompassing prevention, early intervention, acute care and rehabilitation. Update provided in March 2023, mitigating actions are reflected in the organisational risk register, please refer to the organisational risk register for further information. **3826 –** Emergency Department (ED) Overcrowding, update 24th April 2023 by the USC Senior Management Team, improvement plans in place as part of the 6 goals improvement programme however, this programme is not yet in its implementation stage. Targeted improvement trajectories are in place for USC group relating to 4 hour ambulance delays and patients waiting over 12 hours within the department which will improve overcrowding. This remains an ongoing risk for all three ED's and will be reviewed regularly as implementation of targeted improvement takes place. New review date 30th July 2023. **4512-** Care of patients with mental health needs on the acute wards. Update 24th April 2023, risk has been reviewed and updated, no longer a site risk and individual risk assessments are completed on patients should there be delays, this will capture the impact and actions for the patient therefore progressed to closure.
ASSURE	**Welsh Ambulance Services NHS Trust (WAST) Immediate Release Review** Significant improvement in the compliance against immediate releases for both red priority and all priority calls. Recent WAST Chief Executive Officer Briefing highlighted the improvements over the last 10 weeks with the average number of immediate release declines reduced from 11 (4 red) per week to 0.7 (0.4 red) per week. 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 carried out in ED RGH. The environmental audit score was 55%, the hand hygiene score was 82%, compliance with Bare Below Elbow (BBE) was 100% and Personal Protection Equipment (PPE) use 81%. IPC audits

	for POW ED, staff achieved excellent hand hygiene and BBE scores – 100%, PPE 67% and environmental score 69%. IPC audits for ED in PCH. The environmental audit score is 58%, Hand hygiene 78%, BBE 93% and PPE 17%. Senior Nurse and IPC leads have made arrangements to meet estates and facilities colleagues to address the issues identified. Nursing issues were also identified, USC Nurse Director and IPC working collaboratively to develop an improvement plan.
INFORM	**POW ED Capital Works** Programme approximately four weeks behind schedule due to subcontractor issues. Handover date now set at 12th May 2023. **Medical Outlier Patients** Across CTM, there is a 'core' of medical wards and medical inpatients which the medical teams look after. The actual number of patients in hospital under these teams is now consistently higher, leading to short staffing and reliance on locum staffing. In the short term, the Care of The Elderly (COTE) team in RGH are needing to reduce their consultant ward rounds to once weekly for the most well patients. These patients will remain under regular review with the junior doctors, with consultant board rounds and consultant review if there is any clinical deterioration. In response to this, the Unscheduled Care team is writing a proposal for the medical workforce, which aims to: • Increase and diversify the medical workforce • Improve access to training and development • Significantly reduce the agency overspend This workforce proposal aims to be ready for escalation for approval (or otherwise) within a month. Immediate release request Standard operating procedure, has been drafted and circulated for comments to the wider USC team Pre-Emptive Patient transfer and boarding standard operating procedure, has been drafted and circulated for comments to the wider USC team.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
6.5

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE MENTAL HEALTH AND LEARNING DISABILITIES CARE GROUP	
DATE OF MEETING	24th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ana Llewellyn, Nurse Director, Primary Community and Mental Health Care Groups
PRESENTED BY	Ana Llewellyn, Nurse Director, Primary Community and Mental Health Care Groups
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Director of Nursing

REPORT PURPOSE	NOTING

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

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its meeting on 12th April 2023.

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

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

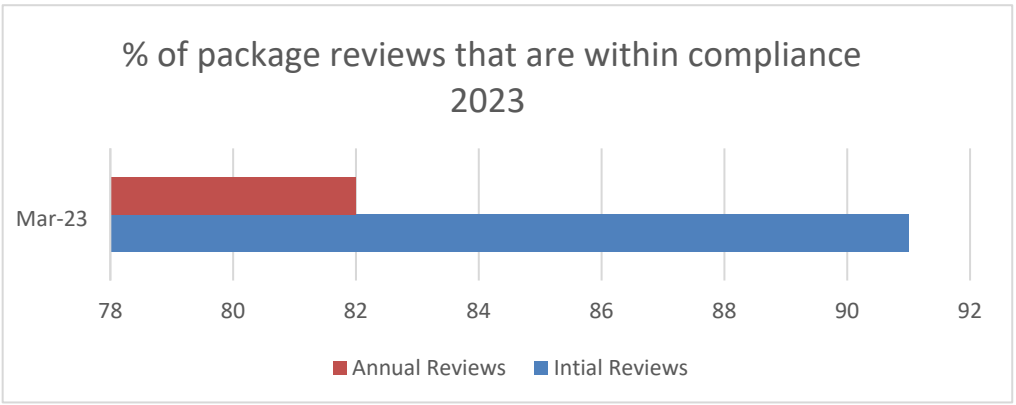
2. HIGHLIGHT REPORT

ALERT / ESCALATE	• Committee is advised of progress towards a **Single Clinical Record System** (Datix Risk Register ID 3337). The Executive Team and Board have supported the progression toward implementation of WCCIS and an Implementation Board will convene in May, chaired by the Director of Digital. • The **limited availability of CPR and some other face-to-face training** that is outside of the control of the care group is impacting on mandatory and statutory training compliance.

ADVISE	• **New Issues Related to MHLD Commissioned Services:**
	  ○ Cwm Gelli Lodge Nursing Care Home in Gwent became subject to enhanced monitoring from 3rd April 2023. CTM commissions 4 beds at the site which was reviewed last on 31st March 2023. Safeguarding Strategy meeting has been held.
	  ○ Gellineudd Locked Rehabilitation Hospital notice of closure received 5th April 2023. Pending closure 1st May 2023. CTM UHB currently commission 1 female bed and discharge planning underway prior to closure with an Adult Nursing Home placement identified.
	
	• There are emerging issues in relation to the process of Section 136 assessments at Princess of Wales Hospital and these issues centre around the local agreements between the police force and the Health Board. The local management team are working in partnership with the police and have developed an escalation process to address some of the misunderstandings that have been evident recently.
	
	• The **Ward Assurance** working group has identified an initial core of specialist MH audits and is working on a further shortlist for AMaT inclusion. CTP, CTO and MHA admin audits have been agreed and will go live within the next 4 weeks. AMaT roll out and training across all mental health sites is on track.
	
	• A Pan CTM review of ESR competencies has been undertaken, with support from the Learning and Development Team. A working excel document will be used for all wards as an interim assurance measure for reporting and maintaining compliance to mitigate some of the challenges identified through this work.
	
	• The medium term solution for **Crisis Assessment Facilities at PCH** as part of the ongoing estates improvement at PCH has now been resolved. The Mental Health Team commenced using the new facility on 3rd April.

ASSURE

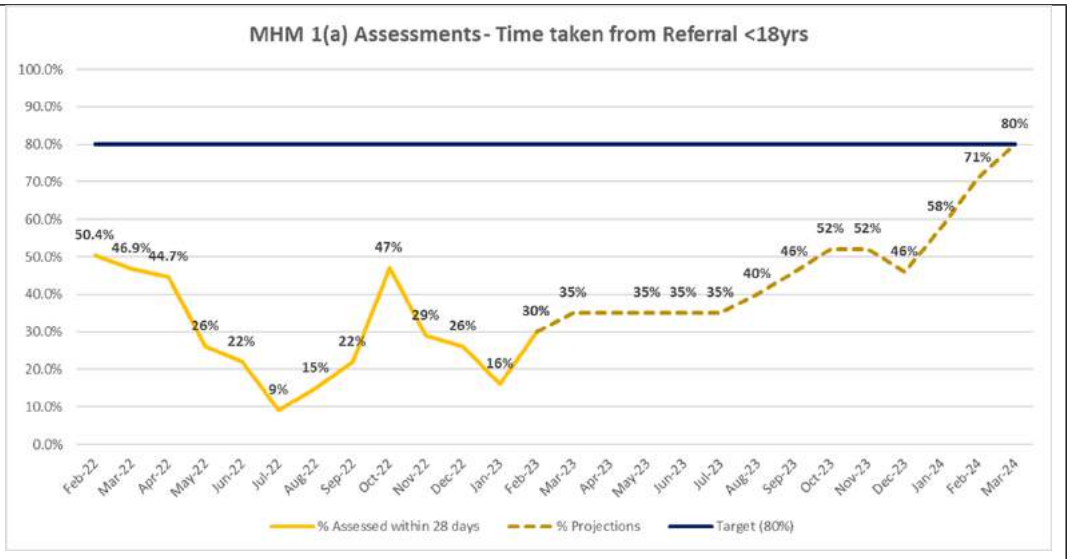
- **Commissioning Reviews.**
  - Reviews are undertaken by Commissioning Case Managers at 3-month post placement and annually thereafter.

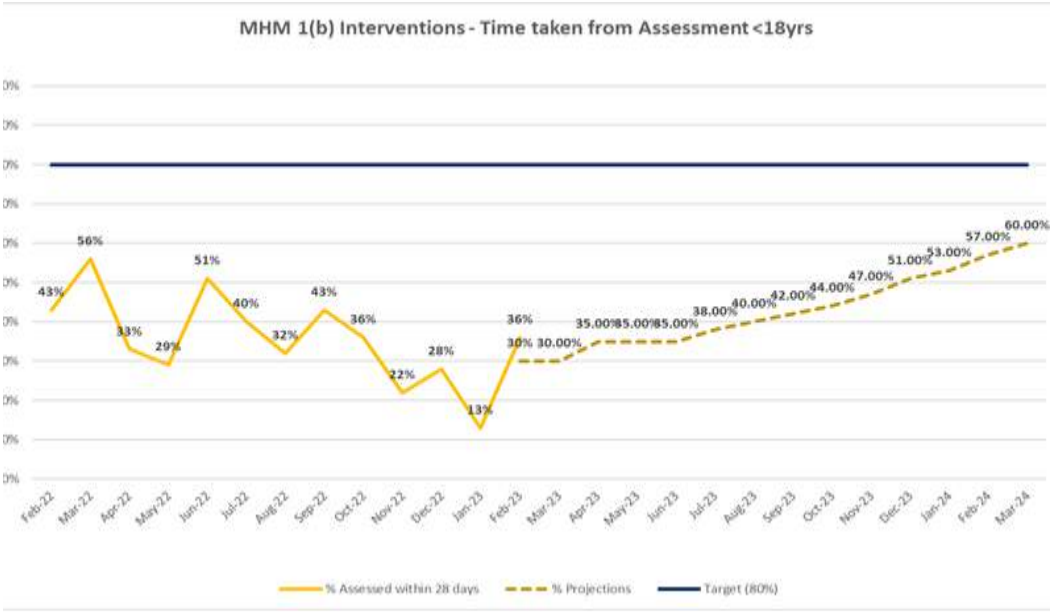


  - Compliance with annual reviews is affected by the need to respond to urgent changes in need and concerns over quality raised through statutory processes.

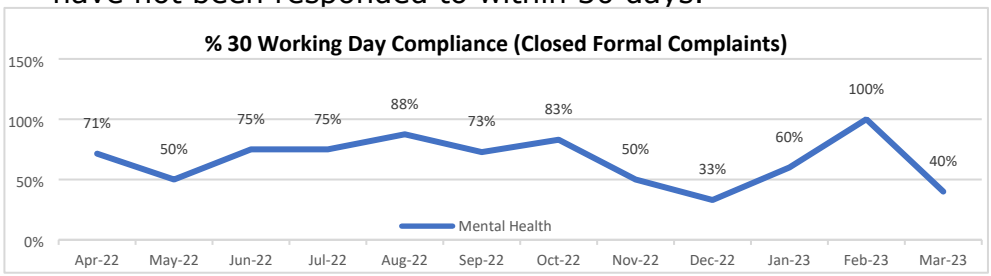
- A **Quality Improvement Programme** has been developed for the care group with four main priorities: in-patient services, older adult in-patient falls (as part of the national IHI / Improvement Cymru Safe Care Collaborative), Ty Llidiard Improvement and Reducing Restrictive Practice. An in-person workshop was held on 26th April and was well attended. The DU were also invited and the Assistant Director for Mental Health in Wales attended in an observational capacity.

- The Deputy COO has oversight of a full recovery plan for **Mental Health Measure Performance** with trajectories for improvement for CAMHS:





Significant validation process work and the planning of additional sessions for care and treatment planning has been taking place and **Part 2 Mental Health Measure CAMHS** performance has improved from 37.4% December 2022 to 85.6% in January 2023. This improvement has been sustained during February and March with performance falling just short of the 90% target.

	• **Complaint Closure Compliance** is a key priority for the Health Board. Compliance in the MHLD Care Group is currently at 40%. The low volume of formal complaints can artificially skew the reporting and as of 23 April 2023 there are 7 formal complaints that have not been responded to within 30 days.  • There are 6 open **Nationally Reportable Incidents** with 4 of those overdue for completion. These cases are complex and are being actively managed. The data from the central governance team reports that there are 12 open **Locally Reportable Incidents.** There is further work to validate this figure and monitor the progress against these LRIs.
INFORM	• The **repatriation of Community CAMHS to Swansea Bay UHB** was completed as planned and all services transferred at the end of March 2023. • The Delivery Unit are currently undertaking a **Review of Memory Assessment Services, a Review of Psychology Services and a Review of Older Adult Crisis Services** as part of a wider national review programme. Any recommendations will be monitored via the Care Group QSRE meeting. • The **Perinatal Service** was subject to a Royal College of Psychiatry peer review during April. The formal response is awaited. • **RCN Nurse of the Year Awards** – Three nominations shortlisted with Learning Disability Acute Liaison Nurses shortlisted further to finalists – Award Ceremony scheduled for June 2023. • A 16 hour 'soft roll out' of the **111#2 direct access to mental health advice and triage** commenced on 4 April in anticipation of 24 hour service from 1 May.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
6.5d

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE CHILDREN & FAMILIES CARE GROUP	
DATE OF MEETING	24th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	SUZANNE HARDACRE Director of Midwifery & Nursing CATHERINE ROBERTS Service Director MOHAMED ELNASHARTY Medical Director
PRESENTED BY	Suzanne Hardacre – Director of Midwifery & Nursing, Children & Families Care Group
EXECUTIVE SPONSOR APPROVED	GREG DIX – EXECUTIVE NURSE DIRECTOR

REPORT PURPOSE	Noting

ACRONYMS	
C&F	Children and Families
CHC	Continuing Health Care
CTMUHB	Cwm Taf Morgannwg University Health Board
CYP	Children and Young People
DU	Delivery Unit
ESR	Electronic Staff Record

HCWP	Healthy Child Wales Programme
HRH	Her Royal Highness
IPAAF	Integrated Performance, Assessment and Assurance Framework
IP&C	Infection Prevention & Control
MRSA	Methicillin Resistant Staphylococcus Aureus
PCH	Prince Charles Hospital
PDR	Personal Development Review
POW	Princess of Wales
PREM	Patient Reported Experience Measures
QFE	Quality of Families Experience
QSPE	Quality, Safety and Patient Experience
RCN	Royal College of Nursing
RCM	Royal College of Midwives
RGH	Royal Glamorgan Hospital
SBAR	Situation, Background, Assessment, Recommendation
SCPHN	Specialist Community Public Health Nursing
SEHS	School Entry Hearing Service
SRO	Senior Responsible Officer
TI	Targeted Intervention
USS	Ultrasound Scan

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children & Families Care Group Quality and Safety Committee at its meeting on 13th April 2023.

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

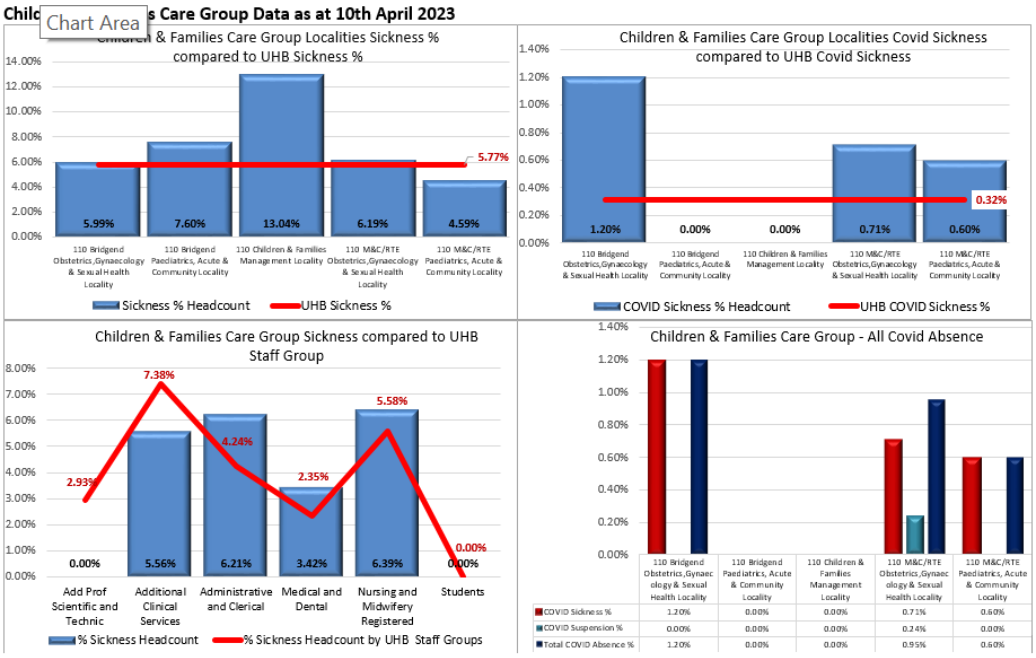
1.3 The Committee is requested to **NOTE** the report.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Delivery Unit (DU) & Maternity & Neonatal Network planned visit to maternity services at Prince Charles Hospital on 5th June 2023 as part of Targeted Intervention De-Escalation Framework. Meetings with the DU underway, the Care Group are aligning evidence for submission to the DU in advance. Maternity and Neonatal Improvement Programme transferred to Health Board on 31.3.23. Oversight, progress and assurance provided as per the Maternity and Neonatal Escalation Framework (V7 April 2023 – Appendix A). Integrated Performance, Assessment & Assurance Framework (IPAAF) Challenge session on 19th April 2023 with Senior Responsible Officer (SRO). Service self-assessment and SRO assessment demonstrates Neonatal services are firmly in RESULTS with evidence of emerging maturity within Quality of Family Experience (QFE). School Entry Hearing Scheme (SEHS): the service has not received an agreed date from colleagues in Audiology. They have advised that they are unable to accept any additional activity without agreed funding. In terms of over 52 week waits for diagnostics, there could be potential harm for children in this cohort. Discussed within Operational Management Board (OMB) to advise on next steps and transfer to Diagnostics and Therapies Care Group.
ADVISE	The C&F Care Group are working with Diagnostics Colleagues who are addressing some sonography staffing challenges. The current shortages could have a significant impact on C&F obstetric and gynaecology services. Challenges with Ultrasound Scan (USS) provision within maternity are being experienced across Wales. Discussed at Heads of Midwifery Advisory Group 20th April 2023.

	Infection control colleagues identified an issue with an obstetric theatre trolley and the "soft" padding is being replaced. Unannounced baby abduction drill held at Prince Charles Maternity Unit on 2.3.23. Saturday Development Healthy Child Wales Programme (HCWP) Assessment Clinics: Introduction of a Saturday 'pop up' clinic to address outstanding continence assessments for Children and Young People (CYP) over 5yrs has been completed – evaluation in progress. Women's Hub at Royal Glamorgan Hospital (RGH) - Proposed opening date 2nd May 2023. SBAR escalated within Care Group – Health Care Support Workers (HCSW's) without Breaks in Continuing Health Care (CHC) packages. Discussions being held with Workforce.
ASSURE	Staffing Issues continue across Specialist Community Public Health Nursing (SCPHN) services, Neonates at Princess of Wales (POW) and acute Paediatrics at Prince Charles Hospital (PCH). Recruitment underway. A review of SCPHN practitioners working practices is underway across the Health Board. Repeat Maternity Culture Survey planned for May 2023, ambition for further surveys to become 'one perinatal' survey later in the year. Annual Patient Reported Experience Measures for Maternity (PREM) 2022 completed. PREM data used to inform continuous improvement through triangulation with clinical outcomes. Personal Development Review (PDR) compliance @50% - work progressing with managers to provide support in uploading reviews to the Electronic Staff Record (ESR). Additional safeguarding training in place, Safeguarding lead nurse attending C&F QSPE meetings to provide regular updates.

INFORM



Children's Ward at PCH has recruited their first paediatric nurse for neurodiversity.

Royal College of Midwives (RCM) UK and Her Royal Highness The Princess Royal visited maternity and neonatal

2 midwives are finalists in national Royal College of Midwives (RCM) Awards on 19th May in London

3 midwives are finalists at Royal College of Nursing (RCN) Nurse of the Year Awards Wales in June.

CTMUHB Midwife appointed lead for PeriPrem Cymru (Perinatal Optimisation).

Quality improvement project in school nursing for the development of E-consent to support the school immunisation programme

All areas reviewing AMaT dashboard to ensure audits and areas are aligned to the Care Group.

International Day of the Midwife (IDM) on 5.5.23 and International Day of the Nurse (IDN) on 12.5.23 celebrations

	St John's immunisation incident – investigation and all actions complete.
APPENDICES	**YES - (Please Include Appendix Title in Box Below)Appendix A – Maternity and Neonatal Assurance & Escalation Framework Version 7.0 April 2023.**

MATERNITY & NEONATES ASSURANCE, RISK & ESCALATION FRAMEWORK

APRIL 2023 2022 V7.0

CHILDREN & FAMILIES CARE GROUP

The following structure outlines the "Floor to Board" Escalation, with two way communication which also flow from Board to Floor. The Framework aligns to a 'Four' Lines of Defence Model and has been updated to reflect The Duty of Quality Statutory Guidance and Quality Standards (Welsh Government 2023).

4th Line of Defence
Independent challenge to the levels of assurance provided by the service operations and oversight functions
Assure & Monitor

Welsh Government

- **Joint Executive Team (JET)** Monthly
- **Quarterly Delivery Boards**
- **Integrated Quality & Performance Delivery (IQPD)** Monthly

External Independent Reviews (HIW, Internal and External Audit) etc.

Cwm Taf Morgannwg UHB Quality & Safety Committee

Board Level Assurance & Scrutiny
Frequency Bi-Monthly

Maternity & Neonatal Safety Board (MNSB)

Independent Member Representative attends

Board Level Assurance & Scrutiny

Frequency: Bi-monthly

3rd Line of Defence
Further oversight functions who can also set direction
Monitor Performance Activity
Assurance & Scrutiny

External Stakeholder

Engagement

Collaboration

Externality of Clinical Case Reviews

Sharing Best Practice

National Guideline Development

Welsh Government

Maternity Neonatal Safety Support Programme

Maternity & Neonatal Network

Improvement Cymru

Digital Healthcare Wales

Children & Families Care Group

Quality, Safety & Patient Experience Committee

Frequency: Bi-Monthly

Children & Families Care Group

Concerns Meeting -Maternity, Neonatal & ISH

Concerns Meeting – Children & Young People

Frequency: Monthly

Children & Families Care Group

Maternity & Neonatal Programme Board

Frequency: Monthly

2nd Line of Defence
Care Group oversight functions who set direction, monitor performance and activity

Assurance & Scrutiny

1st Line of Defence

Quality Safety & Patient Experience Committee (formerly Service Wide Assurance Group SWAG)
(Maternity, Neonatal, Gynae & ISH)
Frequency: Monthly

Service ('Floor') Level Operational Activity Quality &Performance monitored on a day-to-day basis

Business as Usual Activity

Teams and Processes

Self-Assurance & creating a culture that supports psychological safety for colleagues

Service Level (e.g. Ward, Tiers) Meetings

Week 1 – Workforce & Education,
Week 2 – Safety & Effectiveness
Week 3 - Experience & Engagement (WESEE)
Week 4 - Professional Governance

Multi Professional Forums
Antenatal Labour & Postnatal Ward Forums, MDT Risk, MDT Clinical audit,
MDT Clinical Governance
Frequency: Monthly

Service User Engagement Groups (e.g. My Maternity, My Way, Birth Partner Group, Breast Feeding Group)
Frequency: Monthly

Neonatal Clinical Improvement Group

Frequency: Bi-Weekly

Assurance and Closure Panel
Frequency: Monthly

Staff Engagement & Communication

Unit / ward meetings

Clinical Supervision, Caring for You Engagement Sessions

Senior Multi-Disciplinary Teams

Eg Rapid Review
Frequency: Weekly

Multi-Disciplinary Teams
Eg Risk, DATIX
Frequency: Weekly

Points to Note / Reference Documentation
Terms of Reference for all service meetings are available upon request and are located in the Maternity "Fileshare". All Meetings have minutes and action logs. Exception Reports inform Service and Care Group QSPE meetings. Should risks or concerns be identified then the process adopted will be in accordance with the relevant Health Board Policies and Procedures. This Framework is underpinned by CTM Quality Strategy (2022-2025) and Quality and Patient Safety Governance Framework which defines responsibilities at service level through to the Executive Level.

DRAFT

AGENDA ITEM
6.5e

QUALITY & SAFETY COMMITTEE	
HIGHLIGHT REPORT FROM THE DIAGNOSTICS, THERAPIES, PHARMACY AND SPECIALTIES QUALITY, SAFETY, RISK & EXPERIENCE (QSRE) MEETING	
DATE OF MEETING	24 May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carl Verrecchia, Care Group Service Director, Diagnostics, Therapies, Pharmacy & Specialities
PRESENTED BY	Greg Dix, Executive Nurse Director
EXECUTIVE SPONSOR APPROVED	Greg Dix, Executive Nurse Director
REPORT PURPOSE	Noting

ACRONYMS	
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. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Specialties Quality, Safety, Risk & Experience Group through April 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	• No new alerts

ADVISE	<u>Pharmacy and Medicines Management</u>
	• The Medicines Management Quality and Safety Committee have approved the following policies and procedures:
	  ○ Terms of reference (return)
	  ○ Alert distribution process (return)
	  ○ Stock shortages procedure (return)
	• The CTM Use of Medicines Policy is under development. A scoping exercise has been completed to determine what we have, what needs updating and what needs to be included. Work will now proceed to completing the Medicines Policy, which will then be forwarded for approval/ratification.
	• Work is underway to ensure appropriate monitoring of patients prescribed biological therapies and received via Homecare Services, as a recent local audit identified non-compliance with national standards.
	• Staffing resources still approximately 50% less than national standards; invest to save to address this nearing approval
	
	<u>Therapies</u>
	• Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation), remains a high risk on the organisational risk register.
	  Incidents relating to patients accessing the stroke pathway rose significantly throughout April. Weekly multi-disciplinary stroke task and finish group meetings are enabling the development of a Standard Operating

	Procedure (SOP) to address the delays in accessing specialist stroke intervention. <u>Radiology</u> • Planned care recovery proposal to significantly reduce waiting times for non obstetric ultrasound has been approved and will commence through May to help our patients have quicker access to diagnostics and ongoing treatment. • Internal audit will be revisiting the radiology departments as a follow up through June / July 2023. Pathology • Some further high risks identified that are being worked through in terms of mitigating actions around blood bank cover issues at PCH, LIMS support, and PM backlogs linked to HM coroner and Medical Examiner (ME) service. • Very positive HTA report received following on from inspection, fuller detail included in Chief Operating Officers (COO) report.
ASSURE	<u>Pharmacy and medicines management</u> • An action tracker has been developed and is being sent out weekly to monitor progress with applications for controlled drugs licences to ensure compliance with the Misuse of Drugs Act. The licences required for compliance have been identified, information and support provided to the teams applying for licences, and the tracker put in place to ensure this progresses in a timely fashion. • Lack of pharmacy support to maternity identified in previous Q&S reports has been rectified: a clinical pharmacist and pharmacy technician resource has been identified and assigned. The PCH Head of Pharmacy seeks to further strengthen this team in the future. <u>Radiology</u> • Radiology Quality Assurance framework has now been ratified, no further updates from HIW and Learning From Events Reports (LFERs) ongoing. • The Repetitive Strain Injury (RSI) RIDDORs and impact on waiting times (in process of adding this to RR and scoring). This is linked to Sonographers and the repetitive nature of Obstetric scanning.

INFORM	Pharmacy and medicines management • Regional Quality Assurance inspection of RGH aseptic unit due 12th and 13th June. • Multiple complaints with Sciensus– escalated to WMHC (inc delayed deliveries, incorrect patient registration) Therapies • The Verbal abuse to staff mentioned in the April report is continuing. Exploring support for a HB comms campaign with our local communities, explaining the impact (ABUHB were running a campaign that included statistics on how staff are leaving the profession due to this, and the impact on communities if staff continue to leave). • Therapies have noted a trend in incidents related to newly qualified staff who trained during the COVID-19 lockdown. The breadth of multi-disciplinary working was reduced during this time, and the impact is now being seen. As a result, clinical supervision has been increased. • An Allied Health Professionals team in Bridgend were finalists at the UK-wide Advancing Healthcare Awards for their multi-disciplinary approach to managing swallowing, nutrition and medication in elderly care home residents. The project showcased how an integrated AHP team can promote positive patient experience, improve clinical outcomes, reduce costs and contribute to a greener environment. • CTM have appointed the first Consultant Podiatrist post in NHS Wales. The post holder provides strategic and clinical leadership on expert practice for the management of foot and ankle care. His specialist skills are of huge benefit to patients. **Pathology Services** • GP electronic test requesting **(GPTR):** there has been a drive to increase uptake in Primary care led by the Biochemistry service, we have finally implemented in Morlais Medical Practice which is one of the largest practices in the Merthyr area. This has now boosted compliance to 93% uptake making us the leading HB in Wales at the last report. This has a significant positive impact on patient safety in terms of accuracy of data into

	Pathology systems, and also improved laboratory workflows. • Notable reduction in concerns and incidents being reported around the Cell Path backlogs. • **Complaints compliance in DTPS for April is currently as follows:** **Therapies** – 50% (6 complaints in total 3 were resolved with early resolution 20 3 out of compliance) **Radiology** – 0% (8 complaints in total with 6 being resolved early so 2 out of compliance) **Pathology** – 100% (1 complaint) **Medicines Management** – 100% no complaints received Overall compliance with 30 days in April is 67% • **Patient Safety Incidents with moderate or severe harm in month (April)** **Therapies** – 1 moderate **Radiology** – 0 **Pathology** – 12 moderate and 2 severe **Medicines management** – 2 moderate and 1 severe Further work will be done in DTPS on management of complaints and improving the quality of responses and compliance within 30 days during May.
APPENDICES	**NOT APPLICABLE**

AGENDA ITEM
6.6

QUALITY & SAFETY COMMITTEE

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

Date of meeting	24 May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Lucy Timlin, Head of Business Support
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Executive Director of Operations
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Planned Care and Unscheduled Care Boards	Various	SUPPORTED

ACRONYMS	
HIW	Healthcare Inspectorate Wales
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POWH	Princess of Wales Hospital
YCC	Ysbyty Cwm Cynon
MIU	Minor Injuries Unit

SDEC	Same Day Emergency Care
ED	Emergency Department
WAST	Welsh Ambulance Service Trust

1. SITUATION / BACKGROUND

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

The areas include:

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

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

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

2.1 Diagnostics including LINC

The situation with the highest scoring risks is as follows:

- **Mortuary Capacity** – to address issues around insufficient capacity, the new unit based at PCH has been in use since mid-January, reducing the risk to a score of 16. Further review following comments from the last Quality & Safety Committee it was agreed that the risk score would remain with mitigations in place. Mortuary capacity is reported daily through Flow meetings. There is currently a backlog in post mortems, and the Pathology team is working through discussions and solutions with HM Coroner.

- Difficulty in meeting **workload demands** within Pathology services persist, and action has been taken in the following areas:

- The outsourcing of cellular pathology remains in place for 2023-2024. Initial Trial of breast cancer pathology outsourcing has been successful, adding further resilience into cancer diagnostics

- The Cellular Pathology vacant medical posts have now progressed to advert with the Department considering dates in June 2023 for panel – some potential candidates have been identified.

For the **LINC process**, concerns are being maintained around ability to deliver the programme and regular meetings are being held to update on risks and timelines.

Committee members will be pleased to hear that measures have been taken to mitigate against harm caused by sonographer gaps in Radiology where there are currently five colleagues unable to scan due to Repetitive Strain Injury. All are being managed through Occupational Health and are in work helping but are unable to scan patients.

Two Locums are in place at present and staff have been moved around to balance non obstetric USS with the absolute need for obstetric support. There is an advert out to cover vacancy and it is anticipated that the HB may be able to pick up fixed term staff as part of the Planned Care Recovery proposals.

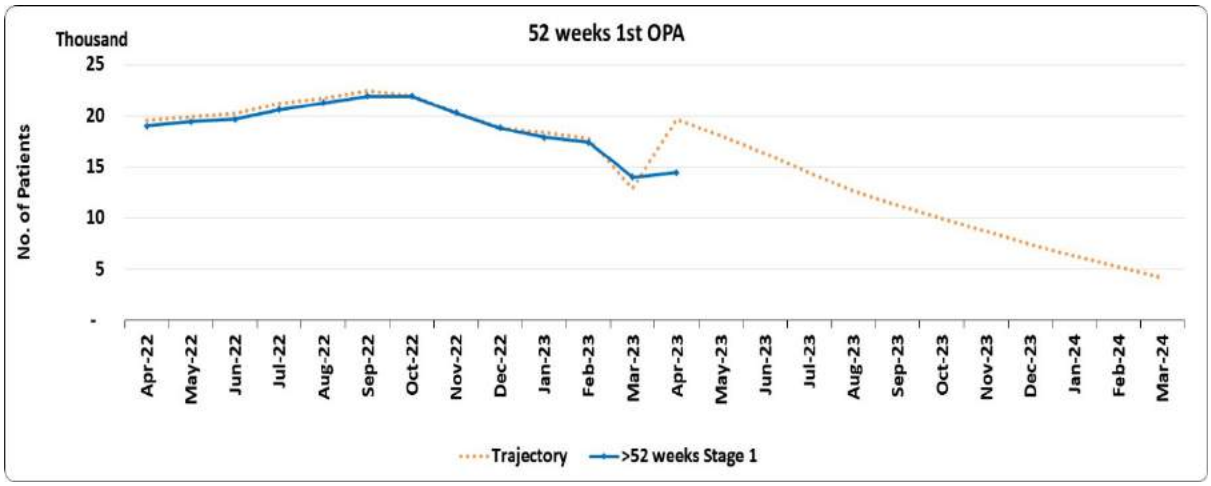
2.2 Planned Care – Waiting Times

Performance on Waiting Times remains an area of significant management focus. Key matters of interest to committee members include:

- **Over 156 week Position** – this continues to improve, with planned clearance of the stage 1 position. The improvement in position is demonstrated below (as at 09 May 2023):

Stage 1	50
Stage 2	166
Stage 3	114
Stage 5	1518
TOTAL	1848 (- 566 Q4 2022 – 2023

- **New Outpatients** – the >52week position is outlined below. The position remains static in April as a consequence of reduced working days and the pending planned care recovery schemes to be agreed and commence.



Key points that will interest committee members are:

- it is anticipated that the length of wait will continue to reduce across all specialties, with patients being seen for first outpatients within two years within all specialties with challenges recognised in ENT, Urology, Ophthalmology and Dermatology;

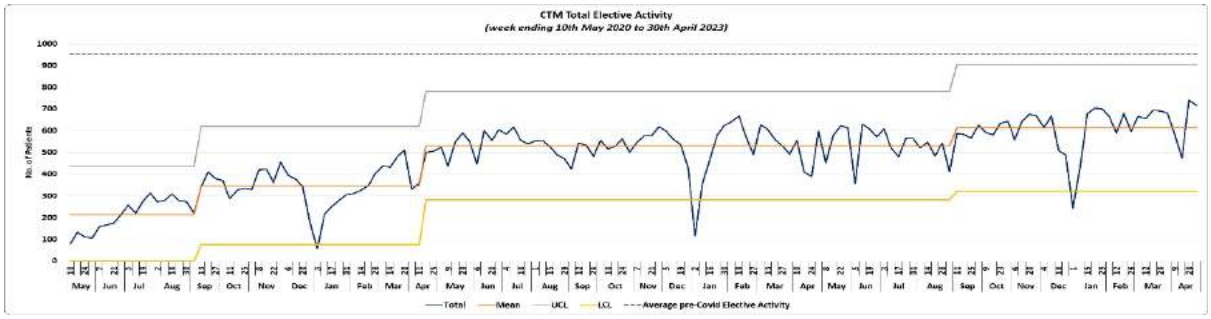
- In each of these four specialties there are actions being taken to increase capacity including extra clinics and theatre sessions in Ophthalmology, Urology and ENT, the recruitment of Locum Consultants and additional Pharmacy and Primary Care resource in Dermatology;

- Improvement programmes are in place to realise efficiencies in outpatient departments.

- **Stage 4 – Treatments**

  - Additional theatre capacity continues to be realised with the support of an insourcing company. With an upward trend of performance being achieved;

  - Additional weekend working is being scoped across all sites.



Risks

- PCR bids have been submitted, with an outcome awaited – the improvement target for June is reliant on the schemes and an early decision is needed.

- Availability of 'elective bed capacity' – currently POW has nine beds identified for elective care, although plans to reinstate the DSU have progressed. There are plans for additional capacity with Ward 16 and Bridgend Clinic.

- The PCH DSU is now fully operational with the additional support from insourcing theatre team. There are no ring-fenced inpatient beds due to ongoing unscheduled care pressures, which continues to impact on productivity and efficiencies through DSU. In mitigation, plans for four inpatient beds are being confirmed.

2.3 Cancer Services

SCP target 75%	*May*	*Jun*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Apr **
Total Treated	*298*	*271*	*303*	*291*	*279*	*316*	*310*	*249*	*289*	*241*	*304*	*307*
Total Treated in Target	*134*	*135*	*145*	*134*	*129*	*139*	*145*	*97*	*110*	*99*	*149*	*160*
Total Breached	*164*	*136*	*158*	*157*	*150*	*177*	*165*	*152*	*179*	*142*	*155*	*147*
Performance %	*45.2*	*49.8*	*47.9*	*46.0*	*46.2*	*44.0*	*46.8*	*39.0*	*38.1*	*41.1*	*49.0*	*52.1*
Retrospective performance %	*44.9*	*52.3*	*48.5*	*45.9*	*47.2*	*43.3*	*47.8*	*40.3*	*40.0*	*41.3*		

* = unvalidated position

Cancer performance remains subject to the highest level of concern and escalation at all levels internally. Weekly cancer assurance meetings continue, attended by all specialty leads and chaired by the Planned Care Director and a highlight report is provided weekly to the COO. Key issues include:

- New backlog clearance and performance trajectories have been approved and submitted for the next 12 months;

- Performance in March was achieved in line with agreed trajectory (target 48% - CTM performance 49%), and has showed a sustained improvement for the last three months;

- Predicted April performance is 52.1% but currently is an unvalidated position;

- The biggest concern and the significant factor for not achieving targets continues to relate to the total number of active patients waiting at first outpatient (35%) and diagnostic stage (45%) of their pathway. This accounts for 80% of all active patients on the suspected cancer pathway, but is an improvement of 2% from last month.

- Variation in waiting times and volumes across sites, which are multifactorial collectively with diagnostic delays in radiology, endoscopy and pathology, and delays at tertiary sites for treatment are also significant contributors to under achievement.

The focus on treating the longest waiting patients and reducing backlog continues across Care Groups.

2.4 Unscheduled Care

Committee members will be interested to hear of broad progress around the improvements in patient services across the Group:

- **Emergency Pressures Escalation Procedure** – a review has been completed and will be presented at the Operational Management Board Meeting this month, aimed at the prompt care of patients in EDs;

- A new pan CTM **'Safe 2 Start'** (S2S) template has been drafted and will be launched across the three acute sites. This will have a really beneficial impact upon patient safety;

- Work has been completed to refine the **Boarding and Pre-emptive Transfer Policy** to provide assurance and to ensure Health & Safety safety standards are being met. This is also supported through the Emergency Pressures Escalation plan. The Bed Management and Flow Subgroup, part of the Six Goals Programme, has now been re-launched to support this;

- A cycle of **improvement work** has commenced to deliver a reduction in ambulance handover times for our patients;

- On 2 May, a **Zero Tolerance to Ambulance Handovers > 4 hours Policy** was launched at RGH, with a plan to roll out across POW and PCH. The response has been very positive by our teams and there has been a significant improvement not just in handover > 4 hours but also overall total hours lost;

- The Care Group has established a **fortnightly partnership meeting with WAST** and Site based leadership teams to further improve

integrated pathway development, communication and seasonal planning;

- **Critical Care Re-configuration** – a CTM Critical Care Re-configuration Programme Board has been established to progress the development of the new Critical Care model. Membership includes key stakeholders across the system and professional groups, including WAST colleagues and an outline timeline for the key milestones has been proposed for ratification at the next Board meeting. Standard monthly communication will be circulated to stakeholders following Board meetings and a Communication Strategy will be developed;

- The **Navigation Hub** – was launched in December 2022, demonstrating positive results in terms of reduced conveyances following a WAST contact. Further work is ongoing to engage with colleagues from WAST at a local and national level around utilisation of this service prior to conveyance. This work remains ongoing with bi-weekly meetings in partnership with WAST.

2.5 Children & Families

Progress on a broad range of issues is included in the full report elsewhere but committee members will be pleased to her about the following:

- The **Maternity and Neonatal Improvement Programme** ended on 31 March 2023, and all the planned changes have been embedded. The Maternity & Neontal Improvement Board will be developed into a Care Group Improvement Board so that the momentum of improvement will continue with the sharing of good practice, team support and robust monitoring of impact;

- In Gynaecology, a **Theatre Efficiency Quality Improvement Project** is underway and changes have been made. In addition five day case theatre sessions per week were identified and allocated to gynaecology. This capacity has enabled the treatment of 225 women, 131 of whom had been experiencing the longest waits (>156 weeks). With this progress there should be no women waiting gynaecology day case surgery over 156 weeks by the end of June;

- In **Paediatric Neurodevelopment**, there were no waits over 104 weeks by the end of March within the Health Board provided services;

- The **Womens' Hub in RGH** (yet to be formally opened) is supporting its first patients this week.

2.6 Primary Care & Community

- The development of the **Navigation Hub** continues with a range of services all aimed at signposting individuals to appropriate primary care and community services, as well as directly supporting patients and avoiding unnecessary hospital admission. Call handling for not only GP OOHs but District Nursing and Urgent and Emergency Dental access providing triage and booking of appointments; new pathways with WAST such as PTAS where GPs directly pull off appropriate cases from the WAST stack; advice and triage for Care Homes and other professionals working in community (including WAST crews), and emergency supply of palliative care medicines.

- **General Practice Sustainability** – increased demand and workforce pressures is having a negative impact on GP sustainability widely. To mitigate this, regular assessment of the GP escalation toolkit takes place and direct contact where escalation levels are high. Repeat of the desktop exercise to identify those practices at risk and where this is the case proactive engagement is made to work through an action plan. Four out of the 11 identified last quarter have now been de-escalated from red to amber/green.

- **Improvement programmes** – focusing on remodelling of the community hospitals and the community teams continues to progress;

- Primary Care have been successful in appointing two **special care dentists** and their focus will be to reduce the long waiting list, however this can only be achieved through support from Planned Care with additional general anaesthetic theatre sessions.

2.7 Mental Health

Issues in Mental Health include:

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

- A medium term solution for Crisis Assessment Facilities at PCH has now been resolved as part of the ongoing estates improvement. The Mental Health Team started using the new facility on 3 April;

- A **Quality Improvement Programme** has been developed for the Care Group with four main priorities: in-patient services, older adult in-patient falls Ty Llidiard Improvement and Reducing Restrictive Practice.

An in-person workshop was held on 26 April and was well attended. The DU were also invited and the Assistant Director for Mental Health in Wales attended in an observational capacity.

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

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

- Planned Care Recovery;
- Cancer Services and the imperative to improve performance in all areas;
- The activity in and challenge for the Emergency Departments across the Health Board.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The paper considers a number of key quality, safety and patient experience issues
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet completed.
Legal implications / impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential legal impact.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Any matter which results in patient harm (for example delayed follow up) has a potential financial impact.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

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

AGENDA ITEM
6.7

QUALITY & SAFETY COMMITTEE

LEARNING FROM EVENTS REPORTS

Date of meeting	24th May 2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Stephanie Muir, Assistant Director of Concerns & Claims
Presented by	Stephanie Muir, Assistant Director of Concerns & Claims
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR DISCUSSION / REVIEW

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

ACRONYMS	
LFERs	Learning from Events Reports
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 Welsh Risk Pool Committee relaxed this deadline during the pandemic period.

1.4 The Welsh Risk Pool Committee reinstated this deadline with effect from 1st November 2021.

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 Despite actions being undertaken in respect of improving compliance with the submission of LFERs, the Health Board has recently received a £25,000 penalty for the 8 LFERs that had been deferred for longer than 12 months. Monies have been recharged to the relevant service areas.

2.2 The Claims Team have developed and implemented an LFER Recovery Plan to reduce the historic LFER cases, with an anticipated completion of all historic cases by 31st December 2023.

2.3 This LFER Recovery Plan, with trajectory, is monitored weekly at the Executive Patient Safety meeting.

2.4 The Assistant Director of Concerns & Claims holds regular meetings with WRP to discuss and monitor the progress of LFERs.

2.5 As at 30th April there are a total of 64 deferred LFERs which are categorised as follows:

0 cases deferred for more than 12 months
17 cases deferred for more than 10 months
10 cases deferred between 8-10 months
12 cases deferred between 6-8 months
25 cases deferred less than 5 months

There are a further 37 cases, which have been newly triggered prior to 1st April 2023.

Between 1st April and 30th April 2023 there have been a further 10 LFERs which have triggered.

2.6 The recent revision of the Quality Governance Delivery model, proposed new arrangements for quality, safety and governance provided an opportunity to revisit how LFERs are managed within CTM UHB. These changes in the management of LFERs were established on 1st April 2023.

2.7 The new arrangements provide an opportunity to realign the LFER process with the patient safety team, with the process being managed by Patient Safety & Improvement Managers. This move will provide enhanced support to the clinical service groups.

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 Welsh Risk Pool imposing financial penalties.

3.2 The Health Board needs to move to a position whereby learning is recorded/captured in a centralised way at point of incident/complaint/claim.

3.3 Actions taken:

- Reports/dashboards developed for the newly formed care groups.
- LFER facilitation moved to patient safety improvement managers.
- Escalation process for missed deadlines formulated.
- Training and buddy system implemented for the Patient Safety Improvement Managers.
- "LFER how to guide" developed and shared.
- Learning Framework developed.
- Shared Learning Event undertaken.
- Learning Repository developed to capture learning.
- Training undertaken on Datix, highlighting the need to complete actions and upload evidence of actions.

Actions in progress:

- Ensure accountability for learning is clear in the new Care Group set up.
- Early notification being developed that would give Care Groups early notification that learning is required ie. at breach of duty.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	There are quality and safety implications. If learning from events does not occur, improvement actions and preventable measure will not be put in place and therefore incidents/complaints can reoccur.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required for this report.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Resource will be required to take forward this work.
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Note** progress made.
- **Support** actions taken and in progress.

AGENDA ITEM
6.8

QUALITY & SAFETY COMMITTEE

CTM ALLIED HEALTH PROFESSIONALS & HEALTHCARE SCIENCE DELIVERY PLAN

Date of meeting	(24/05/2023)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Melanie Barker, Assistant Director of Therapies and Health Science
Presented by	Lauren Edwards, Executive Director of Therapies and Health Science
Approving Executive Sponsor	Executive Director of Therapies & Health Sciences
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Executive Leadership Group	(15/05/23)	NOTED

ACRONYMS	
AHP	Allied Health Professional
CTM	Cwm Taf Morgannwg University Health Board
DoTHS	Director of Therapies and Health Science
HCS	Healthcare Science
USW	University of South Wales

1. SITUATION/BACKGROUND

1.1 AHPs represent 13 individual professions, who individually and collectively work to empower people of all ages to manage their own wellbeing and prevent or reduce the impact of psychological and physical ill health and disability.

1.2 HCS professions represent a diverse group of over 50 disciplines, acting within each area of the Health Service. From good health to poor health; from self-management, presentation, assessment, diagnosis, treatment to recovery – healthcare scientists play an important role for patients in each of these phases.

1.3 In 2019, Welsh Government launched both the ***Allied Health Professions Framework for Wales -Looking Forward Together*** *a*nd the ***Healthcare Science in NHS Wales - Looking Forward Framework****.* Both Frameworks set out the vision and direction of travel for the AHP and HCS professions in Wales. They outline a series of actions to be implemented by Health Services in the short, medium and long term in order to improve the quality of life for people in Wales through enabling NHS Wales to be safer, more sustainable, and provide increased value in the future.

1.4 The ***All-Wales DoTHS Peer Group***, having professional accountability for both AHP and HCS, have identified 5 key priorities for delivery in 2023-24. These priorities are:

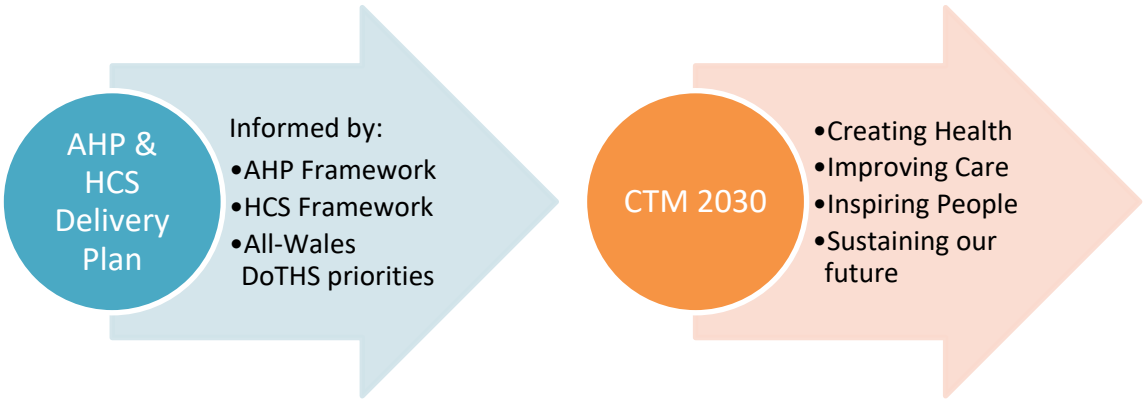
- Implementation of AHP Framework
- Implementation of HCS Framework
- Support Implementation of WG strategic programmes
- Support the Development of a Digital Strategy for AHP and HCS in Wales
- Support the NHS Wales Decarbonisation Strategy.

1.5 As an enabler to the delivery of each of the identified national priorities for AHP and HCS, a local delivery plan is being developed within CTM. This is being done through engagement with AHP and HCS colleagues, as well as other stakeholders. To date, workshops have been held, including with USW facilitation, to understand key local challenges and priorities for the next three years.

1.6 The Chief Scientific Adviser and Chief Allied Health Professions Adviser from Welsh Government both attended a session to provide an overview of the national picture and priorities.

1.7 Discussions around the AHP and HCS Delivery Plan have been structured around the four goals of CTM2030 Our Health, Our Future. This has ensured that the focus has been on identifying the ways in which these professions will contribute to the delivery of our

organisational strategy, taking into account the priorities and challenges for these professions. One aim of the AHP and HCS Delivery Plan is for these clinicians to feel engaged and clear on the ways in which their work is contributing to the achievement of our ambitions for CTM.



1.8 During the engagement events, CTM colleagues have identified priorities that can be categorised under 6 headings:

QUALITY & SAFETY	- PROMs & PREMs - STEEEP - Quality Management System - Capture & cascade of learning - Professional regulation	**IMPROVING CARE**
ACCESSIBILITY & RESPONSIVENESS	- Service transformation - New models of care - Early intervention - Population health	**IMPROVING CARE** **CREATING HEALTH**
WORKFORCE	- Wellbeing & culture - Recruitment & retention - ACPs, consultants - New roles, top of licence - Multi-professional HCSWs - Comms re: our roles & impact - Support workforce: career pathway; multi-professional roles - Leadership	**INSPIRING PEOPLE**
SUSTAINABILITY	- See on symptoms (SOS) - Patient-initiated follow-up (PIFU) - Virtual working - Products and equipment	**SUSTAINING OUR FUTURE**
DIGITAL & DATA	- Demand and capacity modelling - Digital patient contact options - Self-help resources - Keeping Me Well (Webpage Development) - Skills	**SUSTAINING OUR FUTURE**
RESEARCH AND DEVELOPMENT	- Knowledge & skills - Clinical Academics - HEI partners - Effective & efficient interventions	**IMPROVING CARE**

1.9 All of the above priorities align with the national direction of travel and the CTM AHP and HCS Delivery Plan will reflect clarity on the roles that they play in delivering the organisational strategy, CTM 2030.

1.10 The launch of the Delivery Plan is scheduled to take place on the 5th July 2023, in the Lecture Theatre - Princess of Wales Hospital. Attendance is anticipated from a wide-range of stakeholders.

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

2.1 The purpose of the report is to inform the Quality and Safety Committee on the development of a dedicated CTM AHP and HCS Delivery Plan which will support the delivery of the identified actions of the AHP and HCS WG frameworks, National DoTHS priorities, CTM2030 goals, and the identified local priorities areas for CTM AHP and HCS. The launch is planned for 5th July 2023.

2.2 To inform the Committee of CTM AHP and HCS identified areas of priority for focus within the Delivery Plan. These have emerged through engagement sessions with CTM AHP and HCS.

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

3.1 There is a risk that lack of consistent, reliable data to support AHP and HCS service delivery will impact monitoring and reporting identified key actions.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	An effective Delivery Plan will enable delivery of high quality, innovative patient care, including development of new roles and models of care required to achieve the ambitions of CTM 2030
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Staff & Resources Safe Care Timely Care

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required at this stage
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 To **endorse** the focus of CTM AHP and HCS Delivery Plan priorities to deliver the National AHP and HCS Frameworks, national DoTHS priorities, and the ambitions within CTM 2030.

5.2 To agree the planned launch of the Delivery Plan on July 5th 2023.