Quality & Safety Committee

Thu 14 March 2024, 09:45 - 12:30

Virtually via Microsoft Teams

Agenda

09:45 - 09:50
5 min

1. PRELIMINARY MATTERS

1.1. Welcome & Introductions

Information *Carolyn Donoghue, Committee Chair/Independent Member*

1.2. Apologies for Absence

Information *Carolyn Donoghue, Committee Chair/Independent Member*

1.3. Declarations of Interest

Information *Carolyn Donoghue, Committee Chair/Independent Member*

09:50 - 10:10
20 min

2. SHARED LISTENING & LEARNING

2.1. Spotlight Presentation - Acute Oncology Service

Discussion *Dr Ruth Williams, Consultant Chest Physician / Acute Oncology Lead*

Strategic Goal: Improving Care

2.1 Spotlight Presentation AOS v5 QSC 14 March 2024.pdf (17 pages)

10:10 - 10:15
5 min

3. CONSENT AGENDA

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

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

10:15 - 10:20
5 min

4. MAIN AGENDA

4.1. Matters Arising not Considered within the Action Log

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

10:20 - 10:50
30 min

5. SETTING THE SCENE - SERVICE DELIVERY

5.1. Report from the Clinical Executives

Discussion *Clinical Executive Directors*

Strategic Goal: Improving Care, Creating Health, Inspiring People, Sustaining our Future

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

5.1 Clinical Executive Directors Report QSC 14 March 2024.pdf (11 pages)

5.2. Care Group Highlight Reports

Discussion *Care Group Leads*

- Mental Health & Learning Disabilities
- Children & Families
- Unscheduled Care
- Primary Care & Communities
- Diagnostics, Therapies, Pharmacy & Science
- Planned Care

Strategic Goal: Improving Care, Inspiring People, Creating Health, Sustaining our Future

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

5.2a MHLD Highlight Report QSC 14 March 2024.pdf (6 pages)
5.2b Children Families Care Group Highlight Report QSC 14 March 2024.pdf (6 pages)
5.2b Appendix 1 QSE March 2024 - MatNeo Metrics.pdf (14 pages)
5.2c USC Care Group Highlight Report QSC 14 March 2024.pdf (5 pages)
5.2d Primary Care and Communities Care Group Highlight Report QSC 14 March 2024.pdf (7 pages)
5.2e DTPS Highlight Report QSC 14 March 2024.pdf (12 pages)
5.2f Planned Care Highlight Report QSC 14 March 2024.pdf (7 pages)
5.2f Appendix 1 Planned Care- Jan 2024 QSC 14 March 2024.pdf (2 pages)

10:50 - 11:20
30 min

6. GOVERNANCE, RISK AND ASSURANCE

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

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

Strategic Goals: Improving Care

Domains of Quality: Effective

6.1a Organisational Risk Register - March 2024 - QSC.docx (7 pages)
6.1b App 1 - Org RR - March 2024 - QSC.xlsx (7 pages)

6.2. Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity Annual Report

Discussion *Greg Dix, Executive Director of Nursing*

Strategic Goal: Improving Care

Domains of Quality: Safe

6.2 Continuing Healthcare Report QSC 14 March 2024.pdf (13 pages)

11:20 - 11:40
20 min

7. DELIVERING OUR PLAN

7.1. Patient Safety, Quality & Experience Dashboard

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

Strategic Goals: Improving Care

Domains of Quality: Safe

7.1a Patient Safety & Quality Dashboard Report QSC 2024-03-14 Final.pdf (22 pages)
7.1b Appendix Walkround QSC Summary Report-Nov 23 -Feb 24 QSC 14 March 2024 RH Approved.pdf (11 pages)

11:40 - 12:10
30 min

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1. ICTM Annual Report

Discussion *Marc Penny, Director of Improvement & Innovation*

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

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

- 8.1a iCTM QSC Report-March 2024 QSC 14 March 2024.pdf (16 pages)
- 8.1b iCTM Annual Report Q&S Committee-slide deck-Approved v2 QSC 14 March 2024.pdf (14 pages)

8.2. Mental Health Adult Inpatient Improvement Programme

Discussion *Ana Llewellyn, Care Group Nurse Director*

Strategic Goals: Improving Care

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

- 8.2 MH In-patient Improvement QSC 14 March 2024.pdf (7 pages)

8.3. Stroke Services Progress Report

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

Strategic Goals: Improving Care

Domains of Quality: Safe, Effective, Dignified, Timely, Staying Healthy, Staff and Resources

- 8.3a Stroke Progress Report QSC 14 March 2024.docx (14 pages)
- 8.3b QS Stroke Update - DRAFT SOG and SSG Action Plan v2 QSC 14 March 2024.pdf (8 pages)

12:10 - 12:15
5 min

9. CONSENT AGENDA

9.1. FOR APPROVAL

9.1.1. Unconfirmed Minutes of the meeting held on 23 January 2024

Decision *Carolyn Donoghue, Committee Chair/Independent Member*

- 9.1.1 Unconfirmed Minutes Quality and Safety Committee 23 January 2024 QSC 14 March 2024.pdf (21 pages)

9.1.2. Unconfirmed Minutes of the In Committee meeting held on 23 January 2024

Carolyn Donoghue, Committee Chair/Independent Member

- 9.1.2 Unconfirmed Minutes In Committee Quality and Safety Committee 23 January 2024 QSC 14 March 2024.pdf (2 pages)

9.2. FOR NOTING

9.2.1. Action Log

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

- 9.2.1 Action Log QSC 14 March 2024.pdf (7 pages)

9.2.2. Committee Annual Cycle of Business

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

- 9.2.2a Cover Report Committee Annual Cycle of Business QSC 14 March 2024.pdf (3 pages)
- 9.2.2b Quality Safety Committee Cycle of Business QSC 14 March 2024.pdf (4 pages)

9.2.3. Committee Forward Work Programme

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

9.2.3 Quality & Safety Committee Forward Work Programme QSC 14 March 2024.pdf (3 pages)

9.2.4. Healthcare Inspectorate Wales Action Plan Tracker

Information *Greg Dix, Executive Director of Nursing*

Strategic Goals: Improving Care

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

9.2.4a HIW Tracker Inspection Improvement Plans-Feb 24 QSC 14 March 2024.pdf (7 pages)

9.2.5. Clinical Audit Quarterly Report

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Safe

9.2.5 Clinical Audit Quarterly Report QSC 14 March 2024.pdf (8 pages)

9.2.6. Clinical Audit Forward Plan 2024 - 2025

Information *Dom Hurford, Medical Director*

Strategic Goals: Improving Care

Domains of Quality: Effective, Efficient, Safe

9.2.6a Clinical Audit Forward plan QSC 14 March 2024.pdf (4 pages)
9.2.6b Appendix 1 National Clinical Audit Annual Plan CTMUHB 2024 25 QSC 14 March 2024.pdf (12 pages)

9.2.7. Health, Safety & Fire Sub Committee Highlight Reports

Information *Nicola Milligan, Independent Member*

Due to timing of meeting, this Highlight Report will now be received at the May 2024 meeting. There were no matters requiring escalation to the Committee following the meeting held on 4 March 2024.

9.2.8. Radiation Safety Committee Highlight Report

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

Strategic Goals: Improving Care

Domains of Quality: Safe

9.2.8 Highlight Report Radiation Safety Committee QSC 14 March 2024.pdf (3 pages)

9.2.9. Covid 19 Inquiry Preparedness

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

Strategic Goals: Improving Care

Domains of Quality: Effective

9.2.9 C19 Public Inquiry Preparedness Update QSC 14 March 2024.pdf (7 pages)

12:15 - 12:20
5 min

10. CLOSE OUT BUSINESS

10.1. Any Other Business

10.2. Highlight Report to Board - Verbal

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

10.3. How did we do in this meeting - Verbal

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

This provides an opportunity for Board Members to reflect on the meeting and in doing so may find it helpful to consider the following questions:

Is there anything we should do more or less of?

Have we managed our time well and allowed open and balanced discussion?

Have we considered our values and acted in a way that supports embedding our values across CTM? Have we maintained a strategic focus?

Have we received sufficient assurance from a range of sources?

Has our discussion allowed us to better understand the risks that we are managing that may affect the achievement of our strategic goals?

10.4. Identification of Future Spotlights and Thematic Presentations

Discussion *Carolyn Donoghue, Committee Chair/Independent Member*

12:20 - 12:25
5 min

11. PRIVATE/IN COMMITTEE SESSION

The following reports will be received via In Committee session:

- Listening & Learning Story (story relates to the care and treatment provided to a patient with a medical history of Learning Disability plus other medical conditions)
- Maternity & Neonatal Incident Cluster Review
- Review of Health Visiting Services (Bridgend)

12:25 - 12:25
0 min

12. DATE AND TIME OF NEXT MEETING - THURSDAY 16 MAY 2024 AT 9:00AM

(Agenda Item 2.1)	14/03/2024	Quality & Safety Committee	Acute Oncology Services in CTM

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Ruth Williams, Consultant Chest Physician and Acute Oncology Lead
Presented By:	Ruth Williams, Consultant Chest Physician and Acute Oncology Lead
Approving Executive Sponsor:	Dom Hurford, Executive Medical Director
Report Purpose	For Noting
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	N/A
Related Health and Care Standard	Effective Care
Has an EQIA been undertaken?	No – Not required
Are there any Legal Implications /Impact.	No
Are there any resource (capital/Revenue/Workforce Implications / Impact?	No
Link to Strategic Goals	Improving Care

Acute Oncology Services in CTM

Dr Ruth Williams
Respiratory Consultant and AOS Lead

CTM Acute Oncology Service (AOS)

I. Overview of AOS Service
II. RCP Wales 'Cancer at the front door' Report 2023
III. Challenges facing AOS
IV. Examples of interventions from AOS

Cancer Care at the Front Door

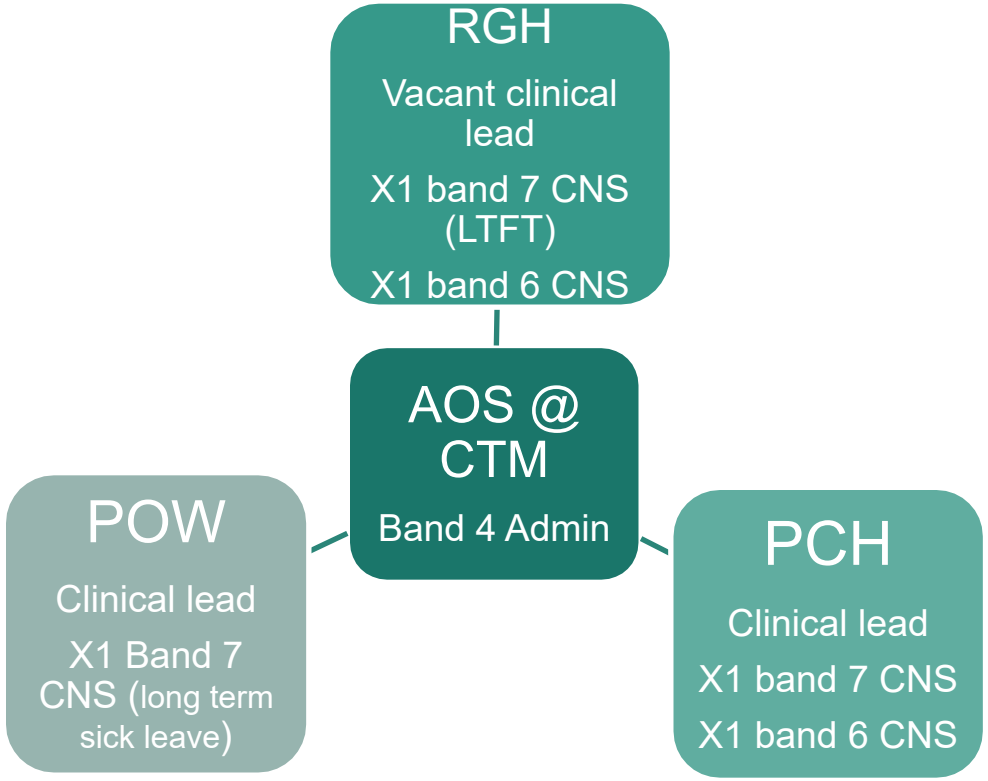
- >1/3rd of Wales cancer cases are diagnosed at an emergency hospital attendance
- 1/5th of acute hospital patients have some sort of cancer related problem
- >1/3rd of cancer related hospital admissions could be avoided or reduced Length of Stay with input from AOS

Cancer care at the front door: the future of acute oncology in Wales | RCP London

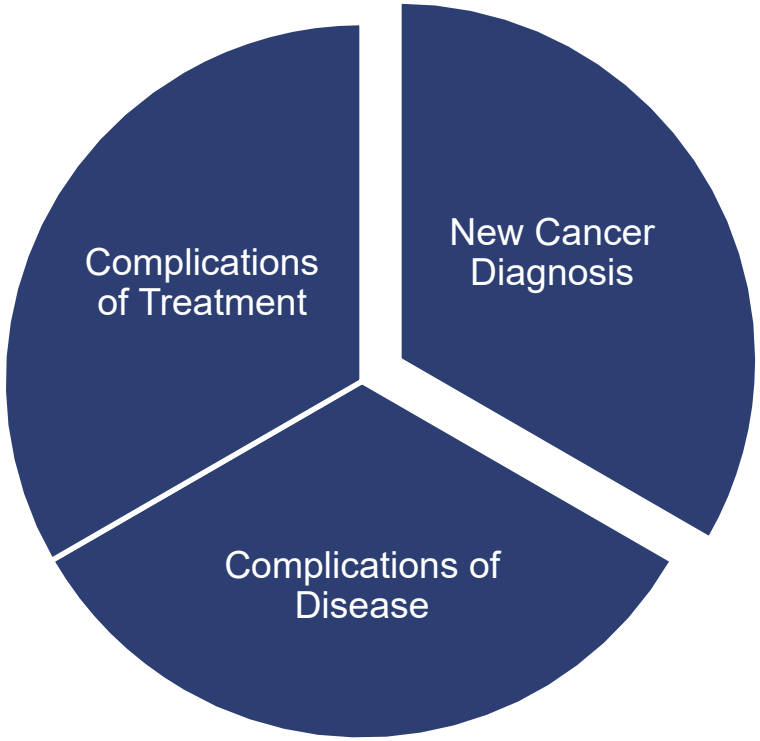
Improving a patient's journey through AOS

- Rapid review and assessment by a specialist team
- Early supported discharge allowing patient to return home with ongoing support
- Signposting to the specialist Multi disciplinary teams (MDTs) to speed up pathway
- Supporting medical teams in the management of complex oncological emergencies
- Support patients and their families during hospital presentations.
- Ambulatory care model to avoid hospital admissions.

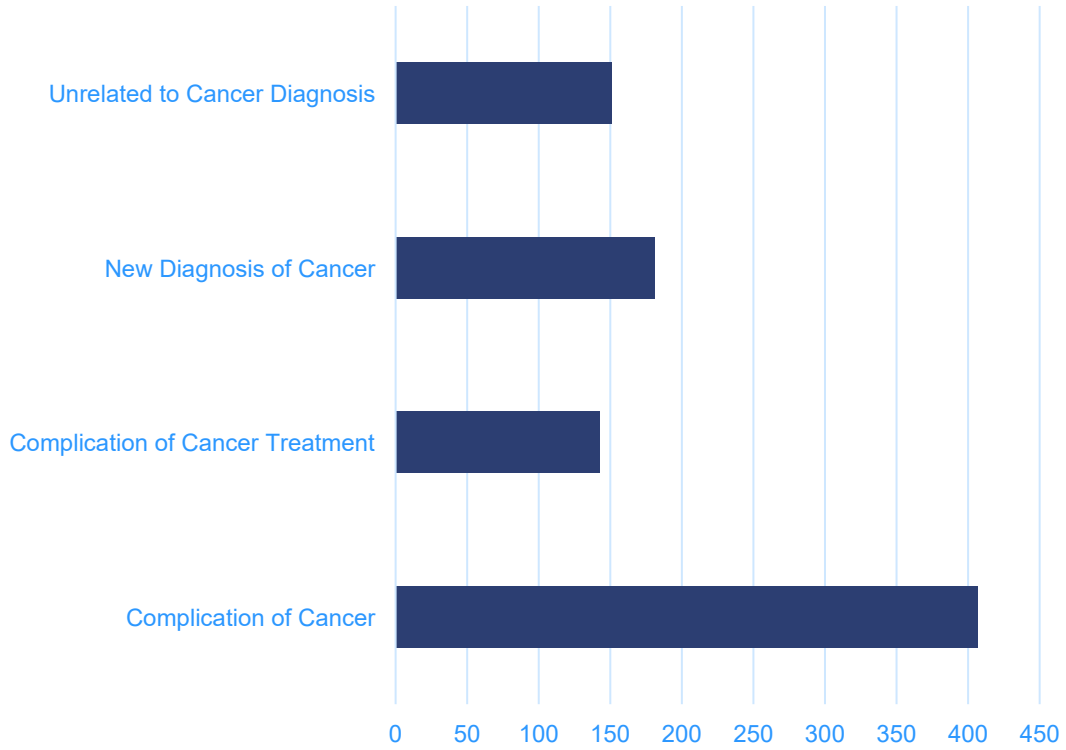
AOS Service at CTM

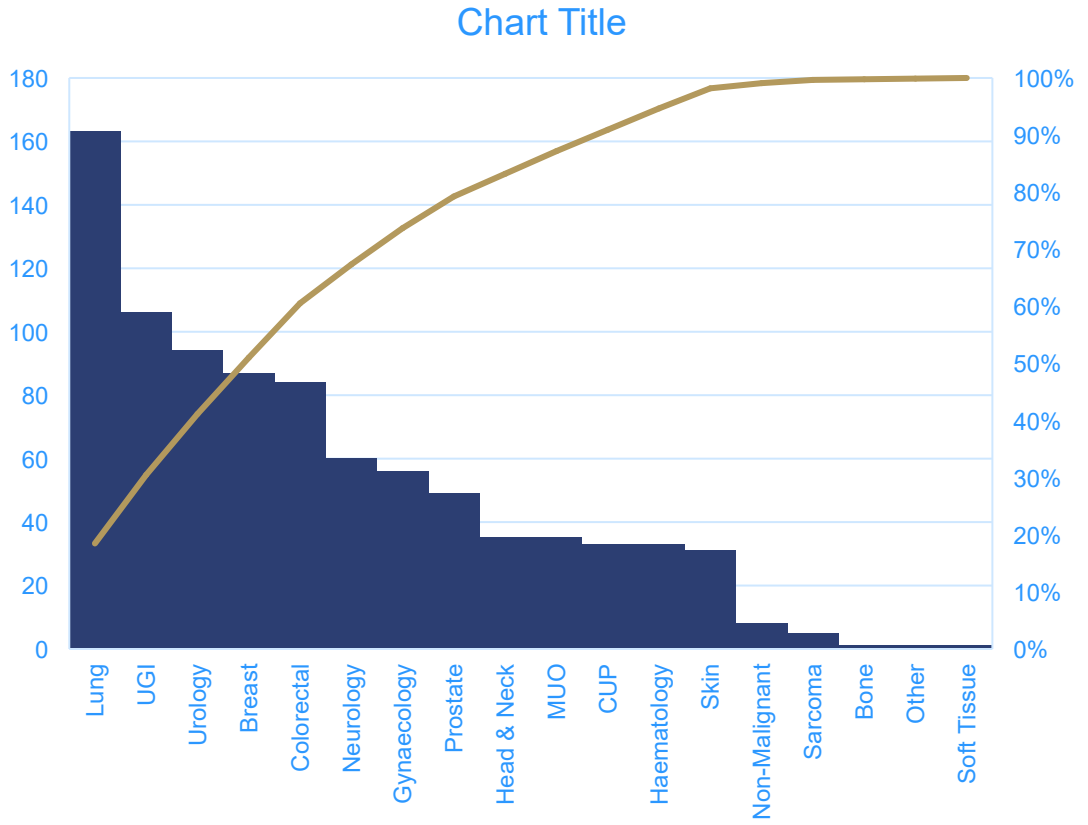


AOS Patients



AOS Service in CTM





Cancer Care at the Front Door: the future of acute oncology in Wales

Royal College of Physicians commissioned report published 2023

Main Recommendations for Health boards

- long-term investment in more specialist staff to ensure cross-cover and a sustainable, resilient service
- a multidisciplinary team approach across primary care, acute medicine, palliative care and oncology
- a focus on reducing health inequalities.
- AOS patients should be screened by an Allied Health Professional (AHP) or appropriately trained AOS team and their AHP needs should be reviewed regularly

Cancer care at the front door: the future of acute oncology in Wales | RCP London

CTM AOS Business Case 2021/22 – SE Wales Service Achievements

Regionally

- Improved regional collaboration
- Provision of an Cancer Unknown Primary MDT and service
- Increased immunotherapy support
- Improved lunchtime MDT at Velindre
- Regional work on digital data capture

Locally

- Improved cross cover (although there is still a gap in POW)
- Soon to see increase in educational offer to staff and improved support to primary care
- AOS having an operational home in CBU.

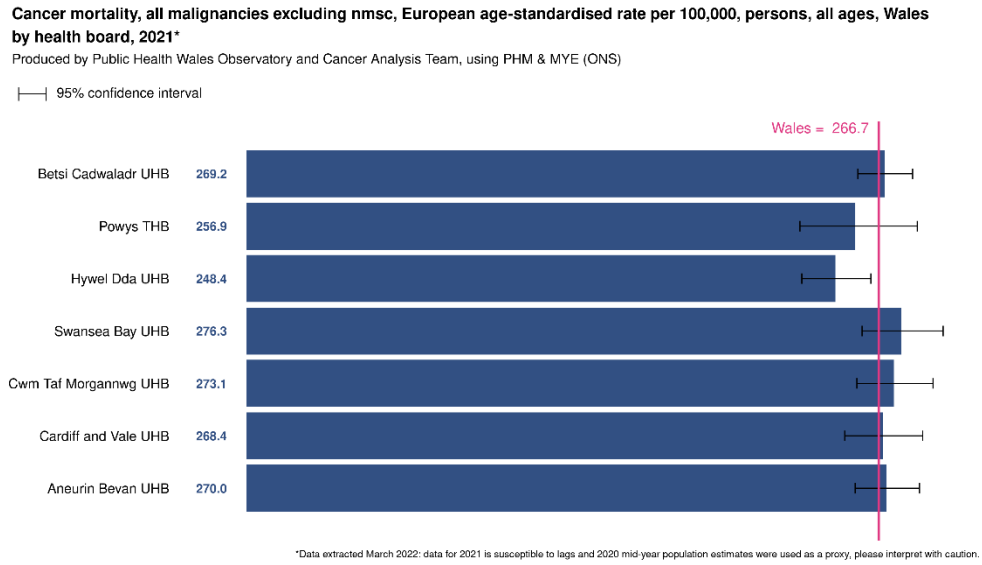
Unmet Challenges

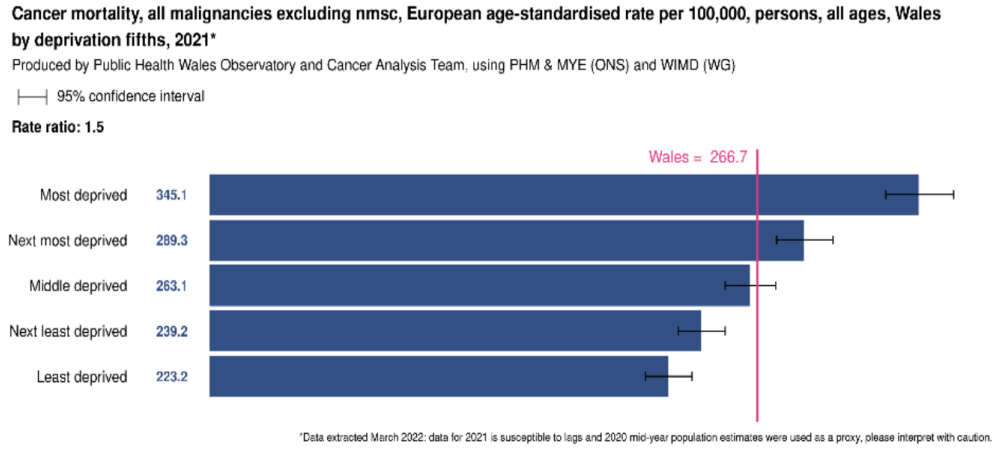
- Funds have been difficult to find!
- The sustainable service in POW – still awaiting Band 6 CNS
- Increased palliative care support
  - Due to the amount originally proposed not being sufficient for a HB wide provision
- No increase in oncologist support
- Likely significant unmet need in AOS population related to AHP's
  - CTM AHP solution – complex due to multiple front door and differing AHP workforce at each site.

Challenge remains around inequalities in health as a result of our population

Challenges Facing CTM

- 3 acute sites with 3 Emergency departments
- 2nd highest cancer mortality in Wales
- High levels of deprivation
- Cost / availability of travel to other sites
- Co-morbid population





Patient Case Story

Patient A

39yr old male presented to A+E Aug 25th 2020

Previous fit + well

Admitted with lethargy, pain and weight loss for several weeks

CT showed probable malignancy – but no clear primary

Complex SHx – single parent for 3 young children

Patient Story

Discharged with biopsy planned

Referral to welfare rights

Palliative care ref

→

6 Ambulatory care reviews

Deteriorating each time

→

Further biopsy / MDT discussions x3

Probable lung cancer

↓

Attendance to AECU

Very poorly

Approaching end of life

Discussions with patient, family and specialist teams

←

Admitted to hospice for end of life care

Died 2 days later

46 days from presentation to death

Benefits from AOS Intervention

- Decreased admissions
- Facilitated early discharge and decreased LOS
- Patient and family support
- Change to palliative care from active investigation in a timely way = improved quality of life

Patient Story 2 – Patient B

Presents to ED with 4/52 hx of worsening left sided abdominal pain.

PMHx – treated AML (stem cell transplant)

→

ED arranged emergency CT – abdominal mass.

Possible sarcoma.

→

Seen by AOS consultant in ED. Findings explained.

Discharged with analgesia and palliative care ref

Referral to sarcoma MDT

→

AOS team in communication with tertiary sarcoma MDT and patient.

Sarcoma team to review patient

↓

AOS review & discussion with patient – unable to travel 3hrs + x2 due pain.

→

Discussed with sarcoma team- AOS facilitated biopsy locally and sample sent to Birmingham for specialist review

→

Sarcoma MDT concluded this was an aggressive relapse of previous AML.

→

Patient reviewed by AOS & referred to local haematology MDT for ongoing care.

Benefits from AOS Interventions

- Support patient and family during complex journey
- Rapid review (same day)
- Early discharge (same day)
- Link with relevant MDTs
- Avoided unnecessary travel / distant hospital appointments

Next Steps

- Work up paper to support increased funding to core acute AHP's alongside upskilling with education and training in AOS
- The oncologist support issue to be formalised via the joint meeting with Velindre
- Help to work with palliative care on increasing that provision to meet demand
- Support with long term development of 7 day service in line with new service specification
- Recruiting to band 6 POW post to ensure sustainable service

Cannot allow inequity of access to services to develop across South Wales, whilst still recognising the differences between our HBs and populations

Agenda Item
5.1

Quality & Safety Committee

Clinical Executive Directors Report

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Greg Padmore-Dix-Executive Director for Nursing and Midwifery • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health
Cyflwynydd yr Adroddiad / Report Presenter	• Greg Padmore-Dix-Executive Director for Nursing and Midwifery • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	• Greg Padmore-Dix-Executive Director for Nursing and Midwifery • Dom Hurford-Executive Medical Director • Lauren Edwards-Executive Director for Therapies and Health Sciences, • Philip Daniels-Executive Director Public Health

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
COSSH	Control of Substances Hazardous to Health Regulations
CTM UHB	Cwm Taf Morgannwg University Health Board
CTM	Cwm Taf Morgannwg
IEN	International Educated Nurses
NMC	Nursing & Midwifery Council
RN/RM	Registered Nurse/Registered Midwife
RSV	Respiratory syncytial virus
MS	Member of Senedd
SEWVN	South East Wales Vascular Network
IR	Interventional Radiology
UKAS	United Kingdom Accreditation Service
CEO	Chief Executive Officer
HCPC	Health and Care Professions Council
AHP	Allied Health Professionals
HCS	Healthcare Scientists
DTPS	Diagnostics Therapy Pharmacy
RCSLT	Royal College of Speech & Language Therapists
SLT	Speech & Language Therapists
HB	Health Board
HEIW	Health Education and Improvement Wales
BBV	Blood Borne Viruses
HMP	His Majesty Prison
AWDPP	All Wales Diabetes Prevention Programme
SPPC	Strategic Programme for Primary Care (SPPC)
WHCs	Welsh Health Circulars

1. Situation /Background

This report presents to the Quality & Safety Committee an overarching update from the four Clinical Executives, this being:

- Greg Padmore-Dix - Nursing & Midwifery
- Dom Hurford-Medical
- Lauren Edwards-Therapies & Health Science
- Philip Daniels-Public Health

The report highlights to the Committee some of the key successes and challenges from across the organisation together with identifying the associated risks as we continue to advance with our commitment to provide high quality patient centred care across the whole of Cwm Taf Morgannwg UHB.

Additional quality-based metrics together with Patient Experience activity continues to be reported to this committee through the Patient Safety, Quality & Patient Experience Dashboard.

Section 1 Nursing & Midwifery

1.1 Launch of Lateral Move Process

In partnership, Workforce and Organisational Development and trade union partners have agreed a scheme to support the Health Board's Attract, Recruit and Retain agenda which has been developed. This scheme will be piloted for Band 5 Nurses and Midwives for 3 months.

This process introduces a more seamless and agile mechanism for doing so, which will benefit both the individual and the organisation by promoting and improving access to a wide range of internal opportunities.

The Scheme will support CTM UHB to retain experienced and valued staff and will also form part of our offer to attract new nurses and midwives to join the organisation. The Scheme will be managed in accordance with equality legislation for all staff who apply for a transfer.

1.2 Recommenced visits by Llais.

The new National independent body Llais has recommenced unannounced visits across the Health board since the Pandemic.
The visits began over the first 2 weeks of February 2024 with a main focus on catering and nutrition with 12 wards being visited across acute and community hospitals.

The initial verbal feedback was very positive with any immediate issues escalated at the time to the ward manager.

We await a formal report following their visits with further details of findings.

1.3 Senior Nurse for Acute Deterioration

Permanent Funding has been successfully approved for the Senior Nurse and the Clinical Lead within the area of Acute Deterioration. These posts have been established within the Planned Care Group and whilst ensuring a focus locally it will also ensure that CTM UHB is influencing.

1.4 International Educated Nurses (IEN) Programme

On completion of the 2023/24 IEN programme, 40 International Nurses have successfully gained registration with the Nursing & Midwifery Council (NMC). A further 11 Healthcare Support Workers (working at CTMUHB), who had previous international registration in nursing, successfully gained registration with NMC registration through the International Adaptation Programme. Overall, there has been an increase of 51 Nursing Registrants within CTMUHB.

1.5 Key Risks / Matters for Escalation

A focused assurance review of RN/RM registration compliance was undertaken across Nursing and Midwifery following some lapsed registrations. Initial findings have identified that the current process requires further strengthening. The Executive Director of Nursing will be writing to all registrants to reinforce the personal responsibility aspects of re-registration.

A joint walk-around of the Unite Health & Safety Representative and Assistant Director of Quality & Safety took place to review the effects of how winter pressures are impacting at a local ward level in the Royal Glamorgan Hospital.
Initial findings related to Boarded Patients, as well as other estate issues.

A joint report is being drafted by the Unite Health & Safety Representative and Assistant Director of Quality & Safety and will be shared with the relevant Care Group Directors.

An increase in acute respiratory infections led to significant challenges across the acute hospital sites in January 2024.
The Infection Prevention and Control Team recommended closure of 10 wards at the Royal Glamorgan Hospital due to a combination of Influenza, RSV and COVID outbreaks. 11 ward closures were also advised at the Princess of Wales hospital due to outbreaks of COVID with Prince Charles hospital being less affected with 3 outbreaks resulting in fewer ward closures.

Section 2 Medical Directorate

This section of the paper provides an overarching update on the achievements and current challenges within the remit of the Medical Directorate.

This section covers the following achievements:

- Heart Failure Service Princess of Wales
- Frailty

Achievements

2.1 Heart Failure Service Princess of Wales

We have had high profile visits to the unit and received lots of praise from Sarah Murphy MS (Bridgend and Porthcawl Constituency) and the Health Minister Eluned Morgan MS.

We are currently developing a heart failure ambulatory Clinic to allow early access to diagnostic and management services, to be treated without the need for an admission.

2.2 Frailty

The Fracture Liaison Service is now being established for CTM. This is a virtual based, nurse led service reviewing all frailty fractures and prescribing bone protection medication. This is a much needed development due to our current low delivery of Bone Health management across CTM, especially PCH & RGH hospitals, in the National Hip Fracture Database.

All three acute sites have now established a front door frailty service. This is excellent for our frail patients, reducing their admissions and more rapidly assessing their needs and treatment.

This section of the report covers the following areas of focus and how the Medical Directorate aim to address them:

- Theatre consistency across CTM
- Vascular services in South Wales

2.3 Theatre consistency across CTM

The Theatre Utilisation Group has set out actions to address the theatre consistency across CTM. There is a need to ensure all theatres start operating promptly and there is a standardised CTM approach to starting times.

Issues affecting this include Job Planning to ensure all teams are on the same time allocations.

2.4 Vascular services in South Wales

Currently, the CTM vascular service is provided by two services – North to the South East Wales Vascular Network (SEWVN) and South (Bridgend are area) to South West Vascular Network. Interventional Radiology (IR) is a fragile service in Wales and SBUHB are imminently unable to prove a service at all. IR is integral to vascular services. This is a South Wales wide issue as the SEWVN is not able to consume all vascular activity for Wales.

We are looking urgently at how Bridgend and the region is managed and how that can be included into SEWVN. This is a national issue and as such managed between the two networks and National leads. We are raising the awareness of this to this Committee and will provide updates as the new service is introduced to manage the need of our population. There will be a verbal update at the Quality and Safety Committee meeting of progress and current position.

Section 3 Therapies and Health Science

This section of the report provides an update from the Therapies and Health Science portfolio.

3.1 Haematology UKAS Inspection, February 8th, 2024

The above inspection took place last month. As a result of the team's hard work, was adverse findings were noted and only three recommendations were issued. This is an excellent result for both the service and the Health Board.

3.2 Seren Award Winner for November

CTM's Mortuary Manager, was delighted to be presented her award by our CEO last month. Nominated by her colleague, for "working in challenging conditions delivering highly skilled, quality and compassionate care to our deceased patients. They are the unseen professionals who are doing an amazing job under the leadership of Yvonne to ensure dignity in death as in life."

3.3 The Health and Care Professions Council (HCPC)

Recognising the importance of developing strong links between CTM and the Health and Care Professions Council, the registering body of a large number of our Allied Health Professions and Health Sciences, it was agreed at a recent introductory meeting, that quarterly meetings will now be held between the HCPC Welsh Professional Liaison Officer and CTM Assistant Director of Therapies and Health Science. These meetings will strengthen relationships between the two organisations and will act as enabler for joint working.

3.4 Big Team Challenge

Allied Health Professionals (AHPs) and Healthcare Scientists (HCS) enrolled in a variety of mixed-profession teams for the Big Team Challenge 2024. Not only does this initiative increase physical activity amongst our workforce, the level of engagement and number of mixed teams across the DTPS Care Group evidences how effective relationships are already forming across professional groups.

3.5 External Visits to Services

Some recent high-profile political visitors to clinical services have enabled teams to raise their profile, share their innovative work, and highlight the impact they have on patient care and outcomes. There was an MS and professional body (RCSLT) visit to the Stroke Ward in Princess of Wales Hospital with a particular focus on the role of the SLT; the Minister for Health and Social Care attended the Lung Health Check mobile scanner (first pilot in Wales); and the Deputy Minister attended the Merthyr PIPYN (supporting children and their families to achieve a healthy weight).

3.6 Keeping Me Well Website

CTMUHB is the first Health Board to link with Cardiff and Vale to share the Keeping Me Well website. The site supports patients with Long Term Conditions. There will be a CTM-specific page but our patients will be able to access a wealth of resources to support their self-management. This development highlights the excellent working relationships between the two HB AHP teams, along with a commitment to share good practice regionally.

3.7 AHP Workforce Planning

AHP Leads have been working with colleagues in the People Directorate to support their workforce planning. The team are the first in the Health Board to adopt the HEIW national workforce planning guidance. The workforce plan will be taken through the Operational Management Board.

Section 4 Public Health

This section of the paper provides an overarching update on the following areas within the remit of Public Health and highlights the achievements, challenges and issues/risks.

4.1 Type 2 Diabetes Prevention

- Funding for 1 and 2 years respectively confirmed for the All Wales Diabetes Prevention Programme (AWDPP) and Strategic Programme for Primary Care (SPPC) funded pre diabetes programmes.

Key issues and challenges:

- Increasing rates of obesity and type 2 diabetes. With approximately 10% of the NHS budget spent on diabetes this raises questions about sustainability of the NHS to meet this expected increase.
- The newly launched obesity tier 1 and 2 service is oversubscribed with a waiting list of more than two years. No funding identified for children's and young people's obesity services.
- No funding identified for remission services (tertiary prevention).
- Current prevention/early intervention funding insufficient to fully meet level of need.

4.2 Stroke Prevention

- Stroke equity audit made recommendations for actions for the CTMUHB. This included the need to focus on secondary prevention of stroke. This was agreed by the SLG.
- Successful bid securing £450k from Value Based Health Care Wales to establish a secondary prevention programme in primary care.

Key issues and challenges:

- Difficulties recruiting to fixed term posts to support the work leading to significant delays in commencing the programme.
- Some issues with permission to access to primary care data systems
- Issues relating to support from Digital Health and Care Wales.

4.3 Weight Management

Key achievement in this work includes:

- Dietetics department have established an adult weight management service with the Tier 2 and 3 service with a capacity to accept 100 patients in the first year. This has been extended to 150 due to the considerable demand for the service.

Key issues and challenges:

- Difficulty in appointing to posts impacting on delivery.
- The weight management programme has a waiting list of approximately 2 years.
- There is no children's weight management service in CTMUHB where we have the highest proportion of children under 5 years old with obesity and overweight in Europe.
- High cost and low availability of key pharmaceuticals.

4.4 Health Protection, including Vaccination and Immunisation

Key achievements in this work area include:

- Delivery of Influenza mop up clinics; planning is currently underway for both an all staff, and school based MMR vaccination catch up programme.
- Planning groups established to consider Hepatitis B and C elimination, and BBV testing and services at HMP Parc and with Probation services.

Key issues and challenges:

- Limited vaccinator resource to manage WHCs and upcoming COVID spring booster campaign.
    - Limited consultant capacity to lead this work (currently out for recruitment)
- Transitional funding from Welsh Government resulted in temporary contracts being extended by the Health Board, with significant impact on staff retention and delivery.
  Funding allocated for 2024-25 is approximately 20% lower that 2022-3 and forms part of the discretionary grant with risks the allocation may be compromised.

5. Key Risks / Matters for Escalation

There are currently no further risks which require escalation to the Quality and Safety Committee as all risks have been highlighted under each section of the report. Assurance is provided that all matters outlined within this report are being addressed through each of the four reporting teams led by the respective Executive Directors.

6. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Creating Health Inspiring People Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below: Growing Well Ageing Well Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd	Whole-systems Perspective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below: Effective Efficient Equitable Person Centred Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Quality of patient care is at the forefront of improvements and decisions made and individual quality impact assessments are completed at the right time by the right team. This report is for information and noting
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Content of this report is applicable to all patients and provides equal access to healthcare with specific EqIAs completed at the right point of time
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Providing high quality, safe care is vital to the reputation of the health board. This report covers items as a broad update for assurance to the committee, however, under the directorship and leadership of the four Clinical Directors responsible for	

	this report everyone strives to protect the health board's reputation.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

7. Recommendation

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

8. Next Steps

The Quality and Safety Committee will continue to receive progress updates together with achievements, new challenges and identified risks through future reporting via this Clinical Executive Directors bi-monthly report.

In addition, as noted in the report some verbal updates to this report will be provided where applicable by the lead Executive Director.

Agenda Item
5.2a

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lloyd Griffiths, Head of Nursing
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CMHT	Community Mental Health Team
CSIW	Care Standards Inspectorate Wales
HIW	Health Inspectorate Wales
HMP	His Majesty's Prison
LA	Local Authority
MHA	Mental Health Act
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident
OPMHS	Older Peoples Mental Health Services
QSRE	Quality Safety Risk and Experience Meeting
RGRP	Right Care Right Person
RGH	Royal Glamorgan Hospital
RCT	Rhondda Cynon Taf
SBUHB	Swansea Bay university Health Board
SSP	Student Streamlining Project
SWP	South Wales Police

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Mental Health and Learning Disabilities Care Group at its meeting on the 14th February 2024.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

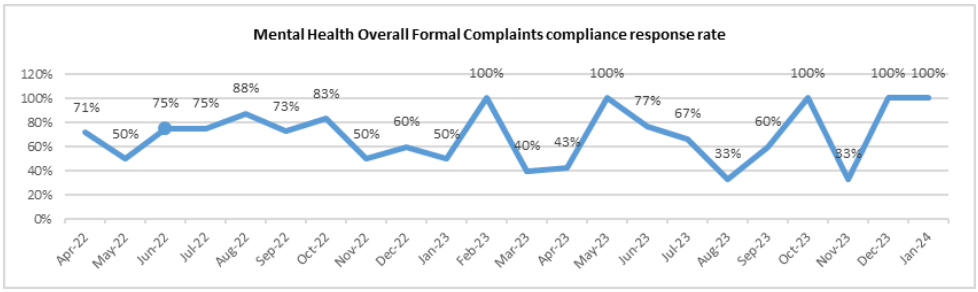
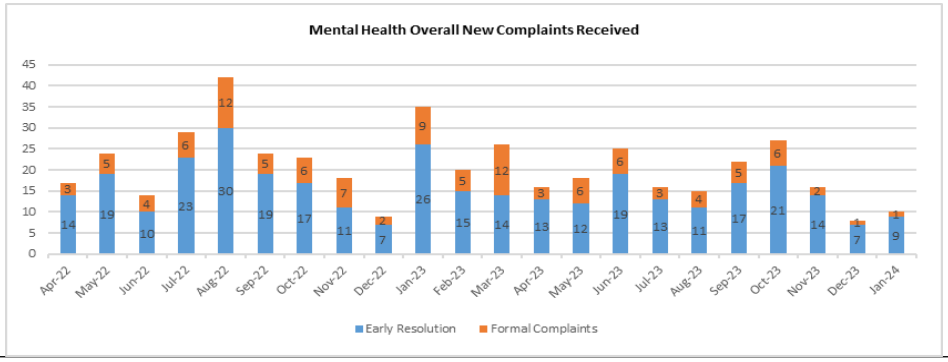
2.2 The Mental Health and Learning Disabilities Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Mental Health and Learning Disabilities Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Mental Health and Learning Disabilities Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

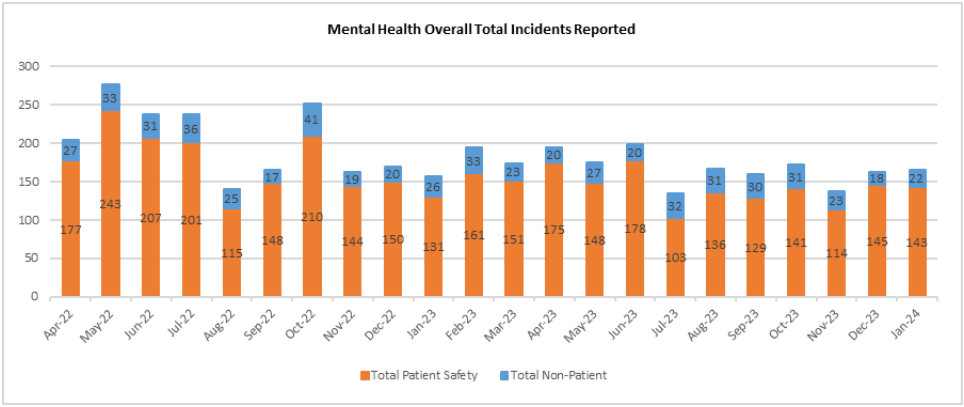
ALERT / ESCALATE	• Registered Nurse vacancies, particularly band 5, remain a significant challenge and a key area of focus, the RGH Mental Health Unit has seen a slight improvement since the last report with 41% of the total band 5 establishment vacant compared to 49% during the last reporting period. Band 5 Vacancies in Ward 14, Princess of Wales (POW) and Angleton clinic remain high with further changes to shifts patterns, bed numbers and operating models being considered by the care group to mitigate this. The recently completed nursing establishment review is being re-worked by the Nurse Director and will be presented to the Care Group Planning, Performance, People and Finance Meeting on 13th March for formal consideration of the recommendations.

ADVISE	• The continued limited availability of Cardio Pulmonary Resuscitation (CPR), manual handling and some other face-to-face training is impacting on mandatory and statutory training compliance and Health Board reputation with HIW. The Care Group is being supported by corporate colleagues who are delivering additional manual handling slots. The Care Group leadership team are working with corporate colleagues to reduce non-attendance. • The Adult Community Directorate note the considerable difficulties that the Mental Health Inreach Team (MHIRT) within HMP Parc have with the transfer of acutely mentally unwell inmates to a more appropriate health setting. The provision of recommendations for transfer and treatment under forensic sections of the MHA, has been an obstacle with seriously unwell inmates remaining in HMP Parc for protracted periods. In response, the Care Group Medical Director is developing a reciprocal arrangement with Caswell Clinic (Regional Medium Secure unit) to provide a "second recommendation" service for HMP Parc. The MHIRT are now reporting weekly on clinical flow issues to the Senior and Lead Nurses. • SWP implemented Phase 1 of Right Care, Right Person (RCRP) on 26/02/24, this involves SWP increasing the threshold for sharing the duty of care with partner agencies for cases where there are Concerns for Welfare. The MHLD care group has organised and chaired HB wide meetings to mitigate the impact of RCRP on the people who use our services and our staff. In conjunction with the Corporate Safeguarding team we have developed and delivered briefings for staff which have been attended by over 250 people. The Head of Nursing for MHLD is the nominated tactical lead for RCRP and is attending daily multiagency briefings where any problems and themes can be discussed and resolved. • HIW, Care Inspectorate Wales (CIW), and Estyn are conducting a joint national review on "How are healthcare, education, and children's services supporting the mental health needs of children and young people in Wales?" The aim of the review is to consider whether children and young people are receiving timely and effective support for their mental health needs. The Child and Adolescent Mental Health Services (CAMHS) directorate have submitted a self-assessment with supporting documentation and are awaiting a start date for the review.

	• SBUHB, who provide CTMUHB's LD services, have advised the care group that HIW and CSIW have recently completed a review of the CTMUHB and RCT LA community LD services. Initial feedback was very positive with no immediate concerns raised on any aspects of service. The staffing team were described as passionate and dedicated and described as working as a cohesive multi-disciplinary team. The reviewers were confident that safe care was being delivered. Full details will be published in the coming weeks. • The Adult Community Directorate note the considerable variation of provision of physical health monitoring for MH service users across the HB. With high levels of physical health related morbidity and mortality, a consistent and effective service for this patient group is seen as a priority. The Directorate will be undertaking a multidisciplinary review of the range of physical health clinics with a view to developing a consistent model.
ASSURE	• Complaint closure compliance is a key priority for the Health Board. Compliance in the MHLD Care Group was 100% in both December and January, however the low volume of formal complaints, only 2 received in this period can lead to the perception of variation in closure compliance performance in the Care Group.  

At the time of compiling this report at the end of December there are 2 open formal complaints (down from 4 in the last reporting period).

- Datix incident reports remain at a consistent level.



- There are 3 open Nationally Reportable Incidents (down from 4 since the last report) all 3 are overdue for completion and assurance has been given by the reviewers that these are progressing.

- All the MHLD wards are now using AMAT. Compliance with ward audits as of the end of February is shown below.

Project overview

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	1	G 97.4%	▼	1
Health and Care Standards	1	G 98.3%	▲	2
Infection Control	4	G 100.0%	▲	2
Medicines Management	2	G 99.0%	▼	0
Patient Safety	13	A 93.8%	▲	8

There are 4 overdue actions in the Patient Safety category which are causing the amber grading, these have been escalated through the Lead Nurses to be addressed.

- The MHLD care group has introduced a multi-disciplinary Medication Scrutiny Meeting. Members of the care group have attended other care groups meetings to learn lessons and ensure a consistent approach across the HB. Themes and trends identified through the panel will be fed up to the CTMUHB Medicines Review Group by the Head of Quality.

- During the MHLD QSRE meeting agreement was reached on the handling of legacy incidents, investigations and complaints to ensure that the operating model and OCP changes will not affect performance and compliance.

INFORM	• There are still 4 beds (out of 20) temporarily decommissioned beds on Ward 14, POW due to a capital project to create a designated CAMHS holding bed. There have been no issues with acuity or demand to date. • During February Half Term our CAMHS Schools In-Reach team ran 3 open access online webinars for parents and carers of young people who experience worries and anxiety. These were published on the HB intranet and social media and were well attended and received.
APPENDICES	**NOT APPLICABLE**

4. Assessment

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

5. Recommendation

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

Agenda Item
5.2b

Quality & Safety Committee

Highlight Report from the Children & Families Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Suzanne Hardacre Director of Midwifery & CYP Nursing • Mohamed Elnasharty Medical Director • Carl Verrecchia, Service Director
Cyflwynydd yr Adroddiad / Report Presenter	Suzanne Hardacre, Director of Midwifery & CYP Nursing
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CMO	Chief Midwifery Officer
CTMUHB	Cwm Taf Morgannwg University Health Board
CYP	Children & Young People
DoM	Director of Midwifery
HCWP	Healthy Child Wales Programme
HIV	Human Immunodeficiency Virus
HIW	Health Inspectorate Wales
HoM	Head of Midwifery
HoN	Head of Nursing
ISH	Integrated Sexual Health

JICPA	Joint Inspectorate Review of Child Protection Arrangements
LW	Labour Ward
OCP 2	Organisational Change Procedure (Phase 2)
PCH	Prince Charles Hospital
PMRT	Perinatal Mortality Review Tool
POW	Princess of Wales Hospital
PSM	Patient Safety Manager
RCM	Royal College of Midwives
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SCBU	Special Care Baby Unit
SEHS	School Entry Hearing Service
SOGS	Schedule of Growing Skills
SRO	Senior Responsible Officer
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WISDOM	Wales Information System for the Dissemination of Obstetric, Gynaecology & Midwifery Material

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Children and Families Care Group at its Quality Safety, Risk and Experience meeting on 8th February 2024.

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

2. Purpose of this Meeting

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

3. Highlight Report

Alert / Escalate	Essential work required to Special Care Baby Unit (SCBU) and the Labour Ward (LW) at Princess of Wales Hospital Bridgend (medical gases, air exchange & electrical upgrades) require services to be decanted elsewhere in order to maintain business continuity. Work likely to take place during summer 2024. Risk based options appraisal developed, working with Chief Operating Officer, Capital Planning and Planned Care colleagues to seek appropriate alternative. Health Inspectorate Wales (HIW) carried out an unannounced inspection of maternity services at Prince Charles Hospital (PCH) on 9th, 10th, 11th January 2024. Draft report received for review. Expected publication date 11th April 2024.

	Health Visitors within the Unite trade union have voted for industrial action (action short of strike) week commencing 26th February. Care Group & Workforce colleagues continue to work closely with trade union representatives and team members to reach a mutually agreeable resolution.
Advise	Care Group nursing and midwifery leadership structure fully implemented from 5th February 2024 following completion of the Organisational Change Process (OCP2). Health Visiting – number of empty caseloads & sickness absence within Bridgend impacting delivery of Health Child Wales Programme (HCWP). Outcome of the Deep dive is awaited. HoN & DoM have met with Employee Well-Being team to develop plans for support. School Entry Hearing Service (SEHS) – Cwm Taf Morgannwg (CTM) remains with Children and Families. Plans being progressed to move arrangements of the programme to audiology services from 1st April 2024. Bespoke wellbeing input for special care baby unit (SCBU) colleagues at Princess of Wales Hospital (PoW) in place. A number of specialist beds have been identified within the community which were provided to children. The beds are not known to the Community Children's Nursing team, work underway to identify source (i.e. old Abertawe Bro Morgannwg (ABMU) / local authority). Trial of elective caesarean section lists within main theatre (POW) have successfully taken place in December. Discussions taking place with Anaesthetic colleagues in February and March. Options for permanent solution being worked through in conjunction with Birthrate+ staffing review
Assure	Modernisation of services within the women's health unit at Princess of Wales Hospital continues. Infertility clinics moved to main outpatient department. The Care Group continues to explore alternative environment for remaining services. Interim senior nurse in post for neonatal services while substantive appointment completes. Rhondda Cynon Taff (RCT) Resilience Programme within Heath Visiting. Monitoring continues to improve data quality, performance and additional contacts. Forecast for term 2 is currently at 75% antenatal contacts (complete) and 80% Schedule of Growing Skills (SOGS). Further contract monitoring meetings in place.

	Service wide Perinatal Loss Forum commenced 26.1.24, monthly meetings to quality assure and finalise Perinatal Mortality Review Tool (PMRT) investigations. HIW unannounced visit to Princess of Wales September 2023. Immediate actions complete. Temperature of medication room still outstanding due to estates work required, work underway within the Care Group to progress. Children & Young People (CYP) Safeguarding Improvement Plan (following the Joint Inspectorate review of child protection arrangements (JICPA) in Bridgend). Same being monitored within Safety & Effectiveness and Safeguarding Operational meetings. Tertiary consultant neonatology sessions have been agreed. The Neonatologist will support CTMUHB with two sessions per week. Commissioning arrangements being finalised. Perinatal workforce strategic planning workshop held on Monday 26th March 2024. Concerns with delays of uploading maternity guidelines into WISDOM now resolved.
Inform	Purposeful leadership visits continue across all services within the Care Group. These are being very well received with constructive feedback provided. CTMUHB met with Welsh Health Specialised Services Committee (WHSSC) on 21st December to discuss neonatal cot configuration, impact and workforce requirements. Terms of reference now received for assurance meetings. Midwife commenced ultrasound training at University of the West of England, supporting development of third trimester midwife led ultrasound service increasing continuity of carer and improved surveillance of small for gestational age babies. Ten midwifery / support worker colleagues supported to attend Royal College of Midwives (RCM) St David's Day Conference in Cardiff on 1st March 2024. Support worker development days being introduced across the Care Group. First day being prepared for maternity support workers, agenda being finalised. Early Years Transformation - Formal written notice has been received from Welsh Government to confirm the closure of early

years transformation programme. There will be no further grant funding.

Patient Safety Manager (PSM) now in place for Children and Families Care Group. Risk & Governance managers now in post within neonatal services at PoW and PCH.

CTM Complex needs/Continuing Care Workshop undertaken on 29th January with Local Authority colleagues in Orbit centre to plan next steps in relation to developing an integrated approach (Awaiting report following event).

Advanced HIV (Human Immunodeficiency Virus) commenced twelve-month secondment within Integrated Sexual Health Service. Work is underway to increase public awareness of HIV and screening uptake following concern that there has been an increasing number of HIV presentation / diagnosis in recent months.

Learning from industrial action - safe services were maintained, no activity required stepping down. Planning in place for end of March due to potential impact.

Risk Register (15 & Over)

Risk No	Risk	Risk Score
5413	Theatre bed in POW – too old for adequate repairs (New bed on order)	16
3008	Injury due to manual handling compliance being low – (currently being re-assessed as manual handling now part of Mandatory and Statutory training for midwives & support workers)	16
2808	Waiting times for performance Neurodevelopmental team	15

Appendices

4. Assessment

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

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

5. Recommendation

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

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

Maternity Metrics:

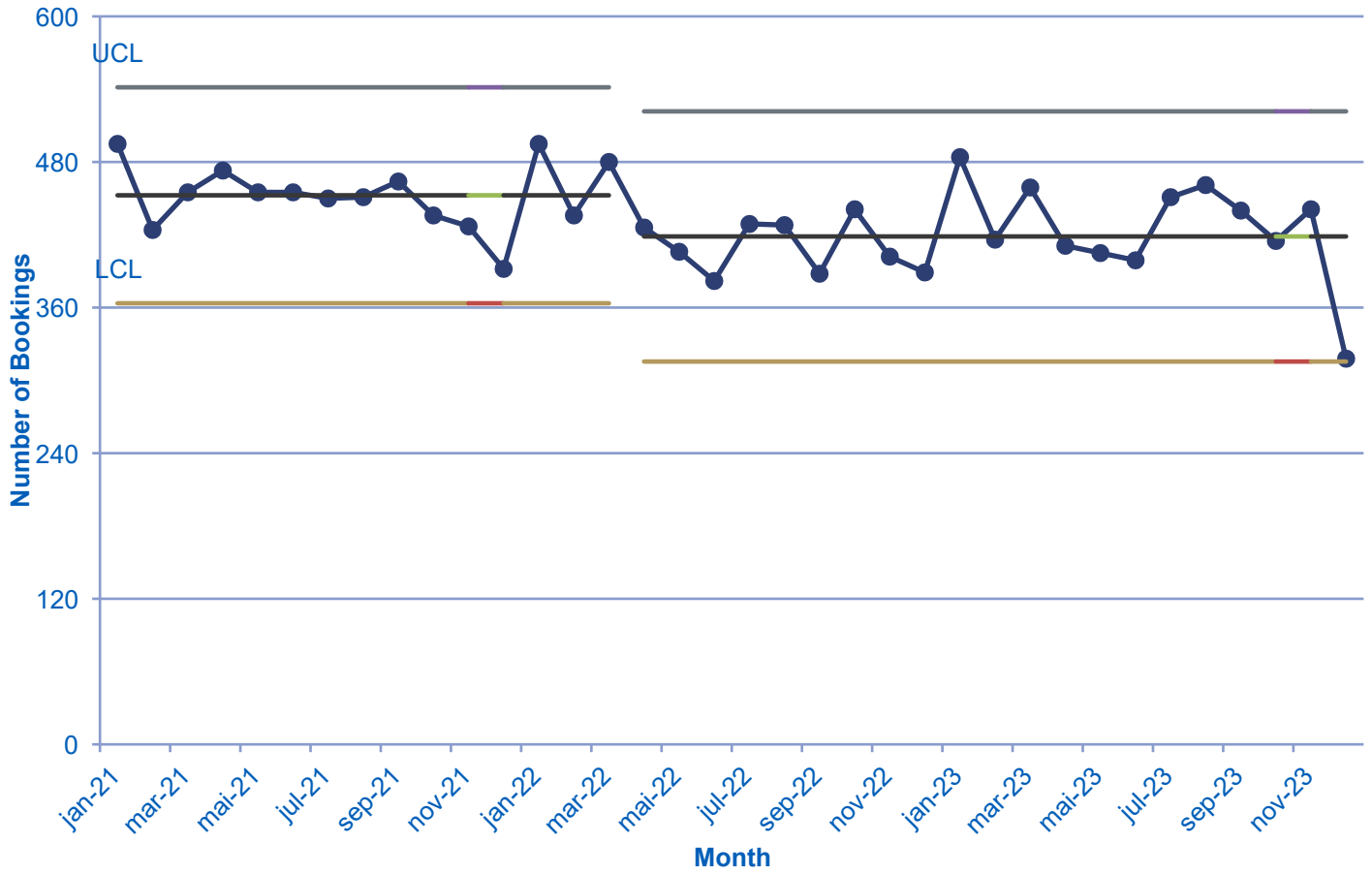
Clinical Dashboard & Quality Improvement Update

February 2024

(Data for December 2020- December 2023 unless otherwise stated)

Elinore Macgillivray, Consultant Midwife for QI and Population Health

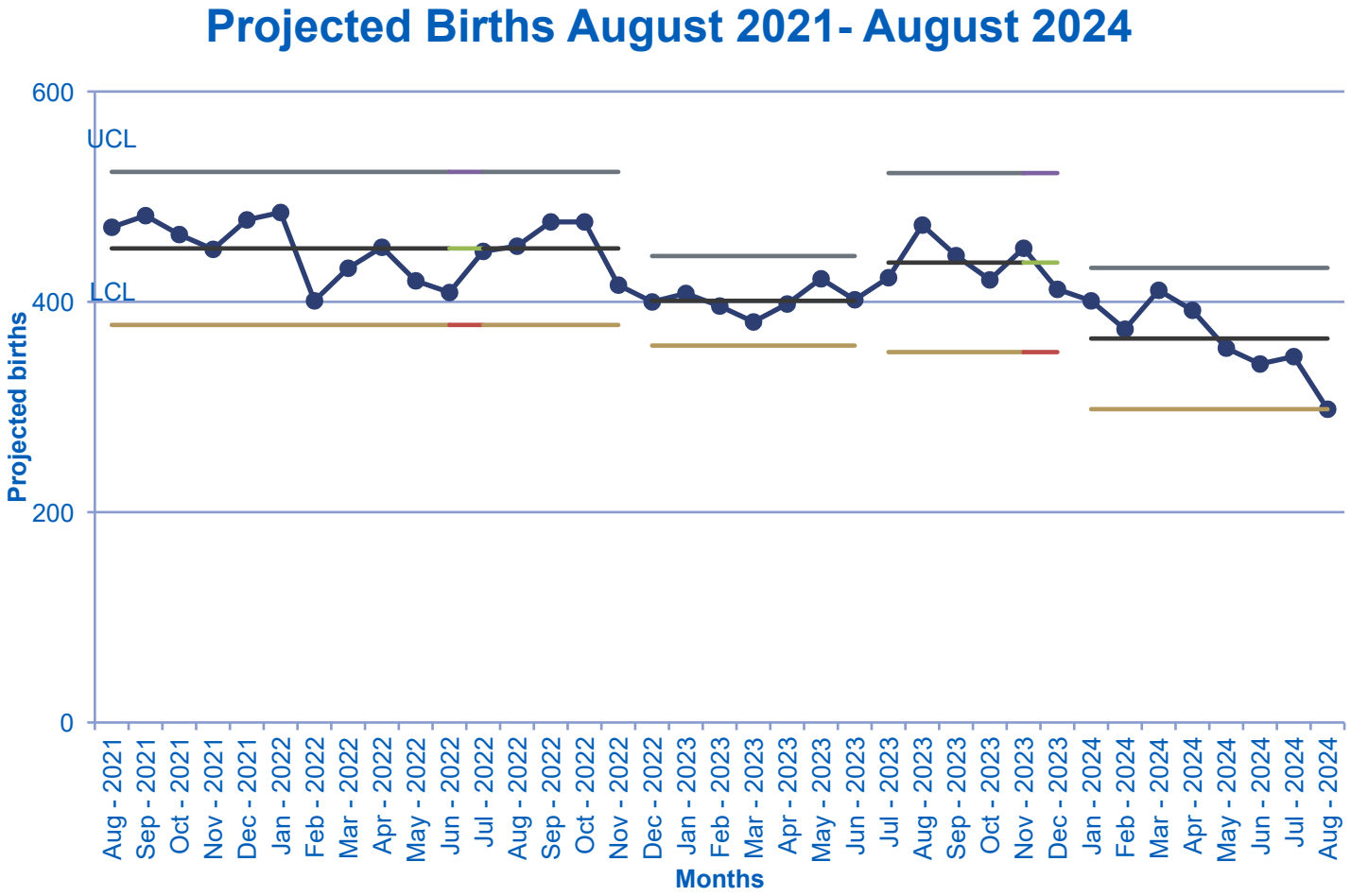
Booking Numbers January 2021- December 2023



The number of monthly bookings decreased significantly in December 2023 to 318. This has been triangulated with other data sources and is correct.

The monthly median number of pregnancy bookings has decreased from 452 to 418 as of April 2022.

Projected Births August 2021- August 2024

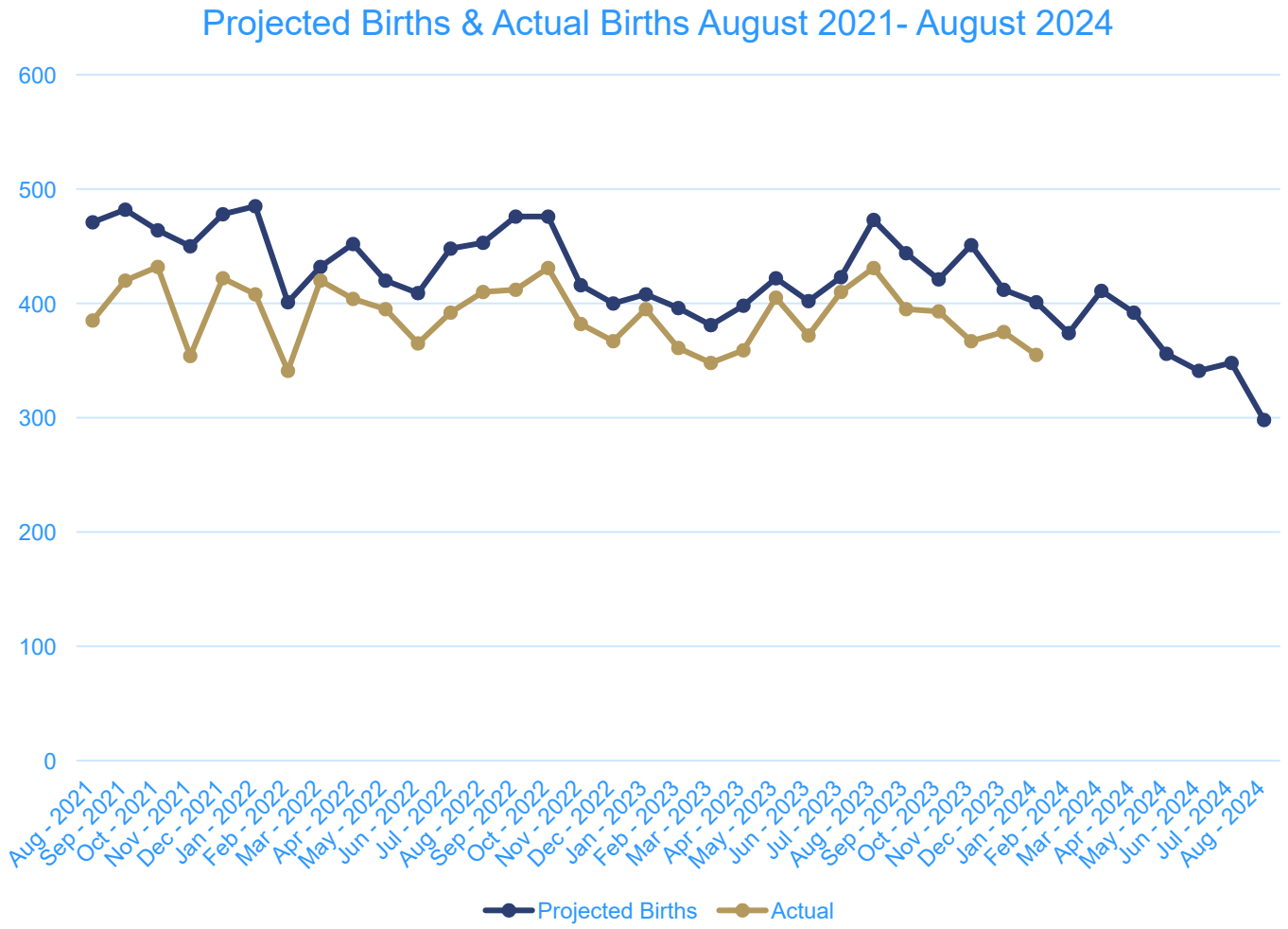


The median number of projected births has decreased from 450 per month in 2021 to 365 per month for February to August 2024 (-19% shift).

This may change as women are booked for maternity care throughout February and March. However, it is unlikely to change significantly, as it is expected that most women who are due to give birth in June, July and August would have already booked with maternity services.

NB. There are always fewer births than bookings as a proportion of women will sadly not reach viability.

Projected Births compared to Actual Birth Numbers



Actual births broadly follow the pattern as projected births.

Each month there are fewer actual births than there are projected births. The median difference is -42 per month.

It is reasonable to assume this pattern will continue. If so, throughout 2024, there will be significantly fewer births in CTM than in previous years.

Digital Self-Referral System

Smoking and Vaping: A Good News Story

A question about smoking/ vaping habits was added to the digital self-referral system at the end of October 2023.

24% of women have told us they smoke or vape.

A further 10% of women said they had given up smoking or vaping in the last 12 months.

The Help Me Quit for Baby team are contacting women prior to booking and are supporting them to successfully quit before their initial booking appointment.

An email is sent from the HMQ support worker to the named midwife to confirm the successful quit:

"*Thank you for referring Ms X to help me quit for baby. I contacted Ms X following digital referral. Ms X engaged well with the service and quit vaping on 28/11/2023. I contacted Ms X today, she confirms she still has not vaped and is a four week quitter. Thanks again for your continued support.*"

Ethnicity: Understanding our Population Needs

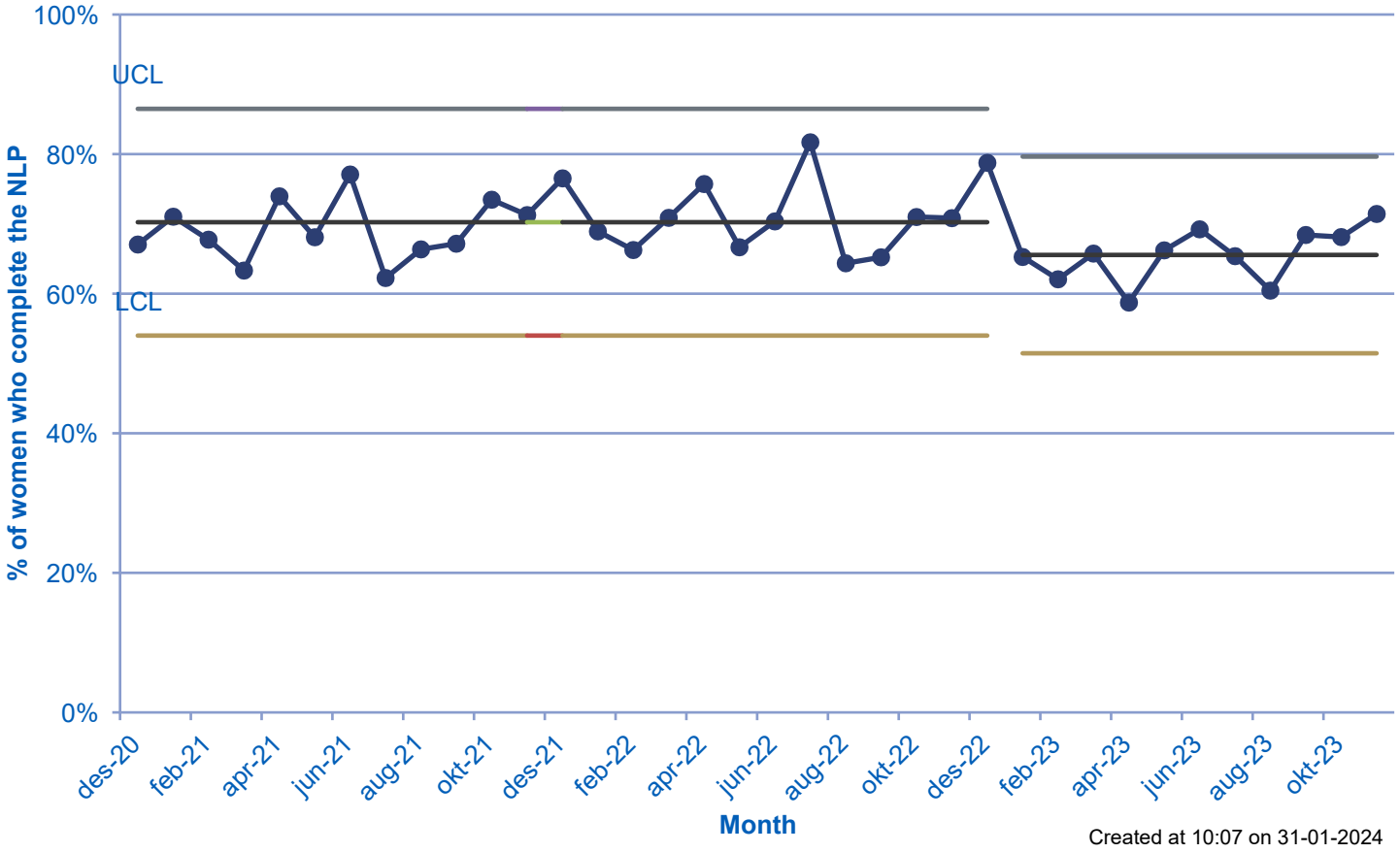
A question regarding women's ethnicity was added to the system in December 2023.

self-reported data shows that 7.6% of women identify with a non-white ethnic group. This represents approximately 30 women per month booking for maternity care that are black or brown.

Additionally, almost 9.3% of women told us they were born outside the UK, in 55 different countries.

These data are helping us to plan and develop a service that meets our population's needs and are informing a paper that will make recommendations about future service provision.

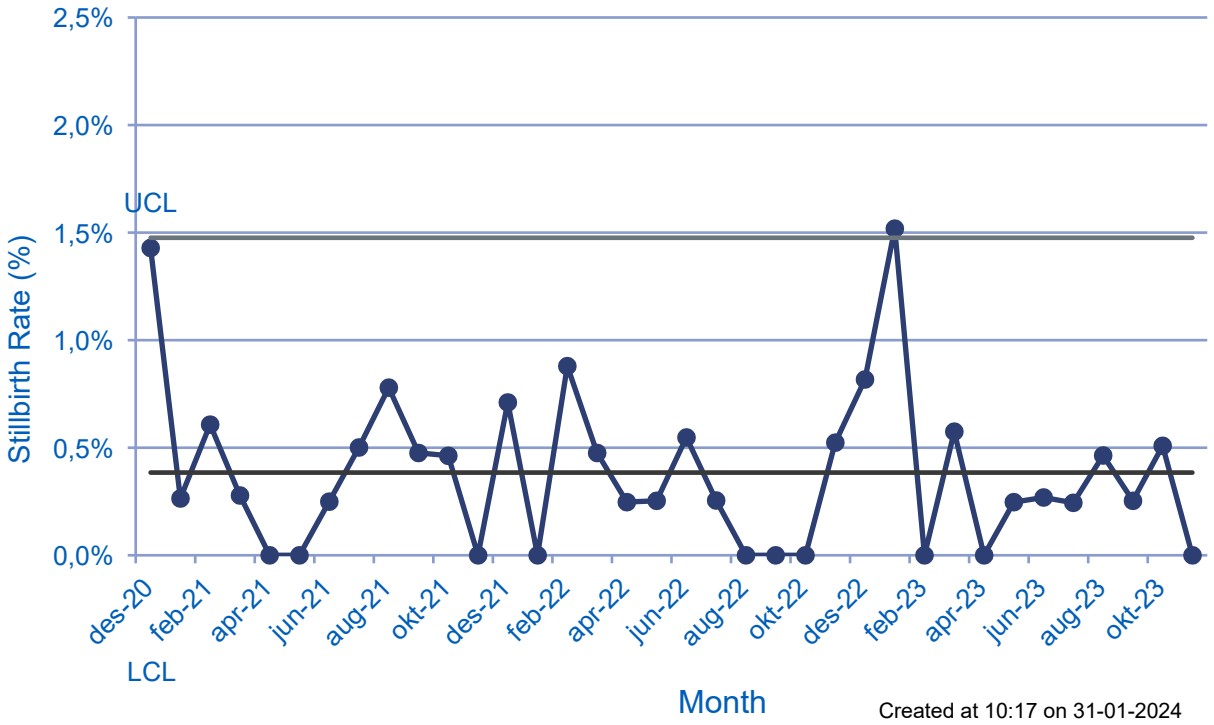
Rate of women completing the All Wales Clinical Pathway for Normal Labour (as a % of those who commenced the pathway)

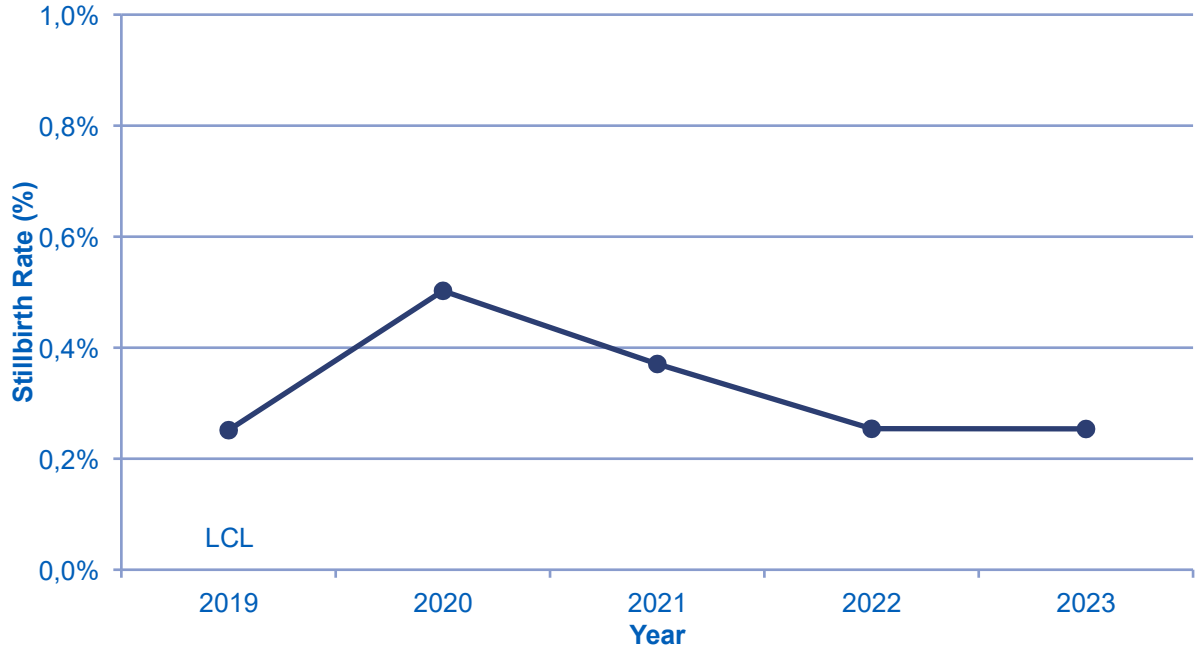


Intervention rates continue to rise, including women birthing on an Obstetric Unit.

In line with this change, the rate of women completing the All Wales Clinical Pathway for Normal Labour (as a % of those who commenced the pathway) is decreasing. The median is now 65%, as compared to the previous rate of 70%.

Stillbirths (Monthly 2020-2023 and Annually 2019-2023)





Stillbirth rates have remained stable. The monthly median rate is 0.38%. There was some concern in early 2023 about the rate in January 2023, which was very slightly outside normal variation. However, the annual rate shows no reason for additional concern or actions.(Data source: Qlik Sense)

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

Neonatal Metrics:

Dashboard & Neonatal Metrics Update

February 2024

(Data for Jan 2022- Jan 2024 unless otherwise stated)

Jodie Hodges
Local Perinatal Safety Champion

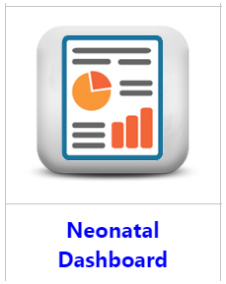
Neonatal Dashboard

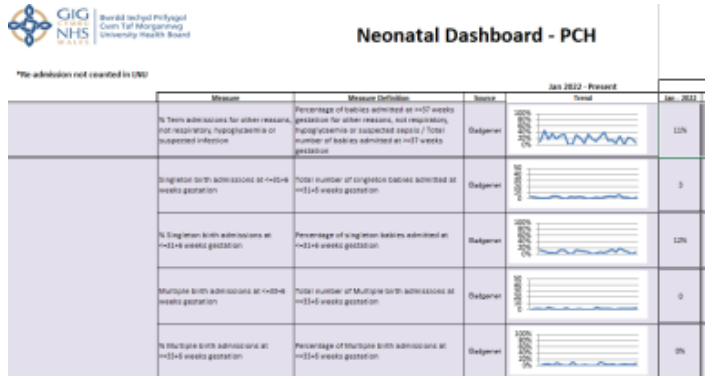
Neonatal Dashboard is now live- as of December 2023

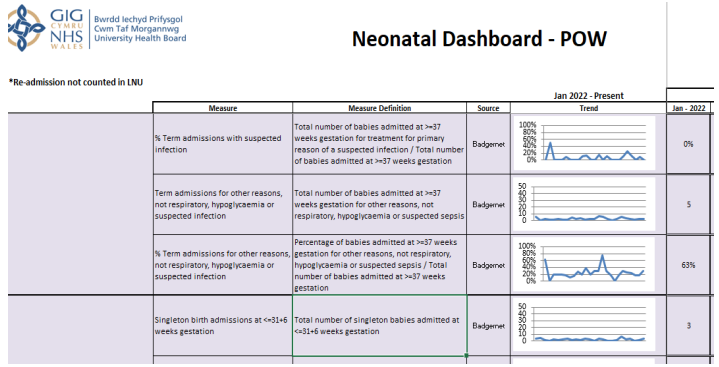
- Dashboard Lunched in December 2024
- Access available to all on SharePoint- http://ctuhb-intranet/dir/Neonatal/default.aspx
- Two tabs currently live

✓ *Clinical Dashboard Metrics*

✓ *Care in the LNU Metrics*







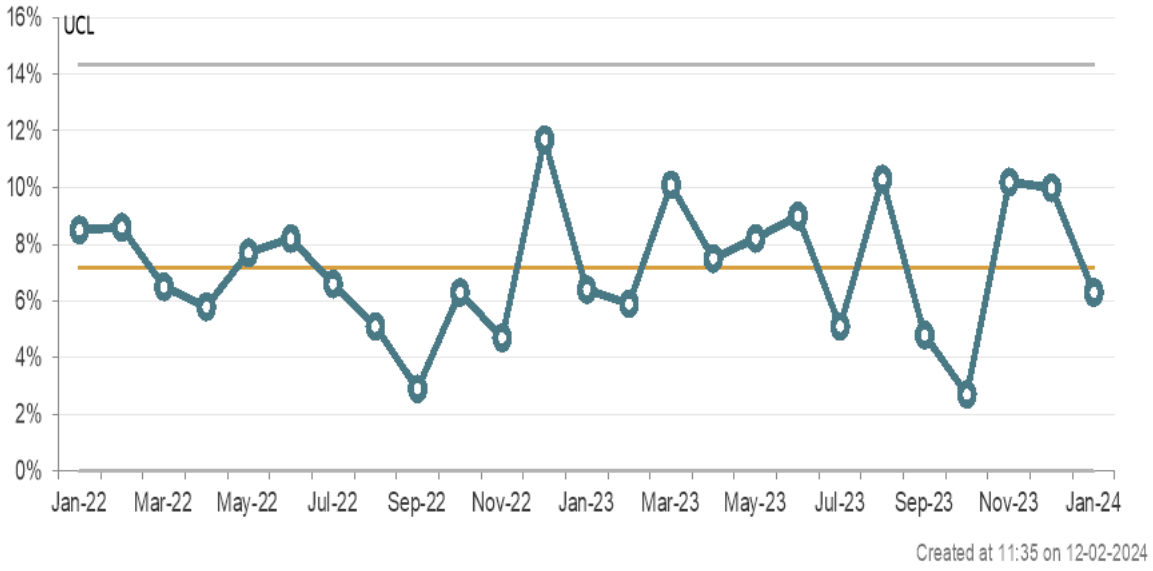
Tabs to be added by 1st April*

- *Neonatal Governance Tab*
- *Staffing Metric tab*

**Tabs require manual input. Relevant data capture forms now approved. Lead Nurse for Service Improvement to distribute to relevant team for completion by 1st March-Dashboard to be updated for 1st April run.*

ATAIN

PCH



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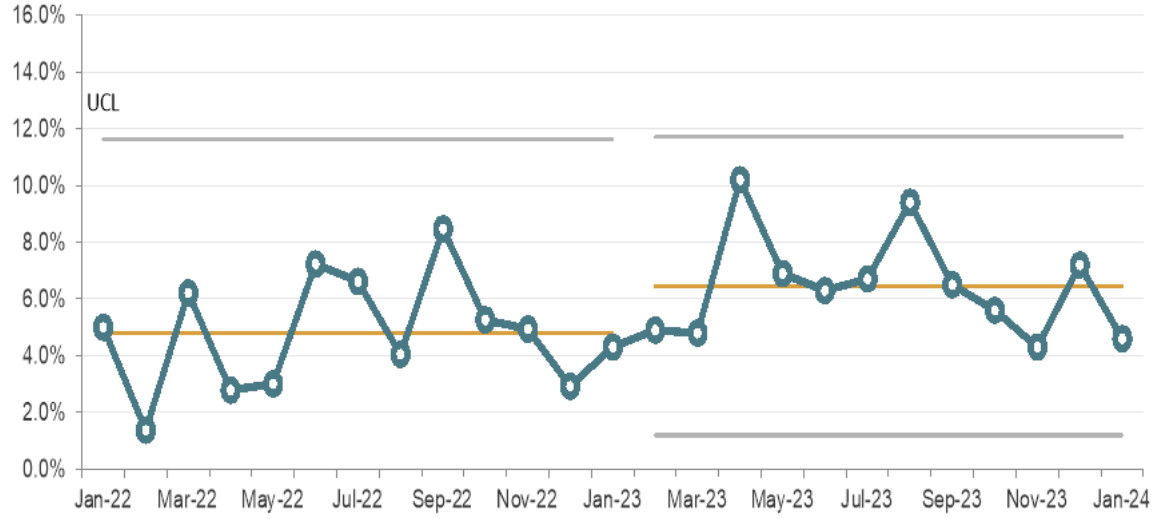
POW



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- Rates fluctuate month to month across the 2 sites.
- Average has remained stable over the last 2 years on the PCH site. Slight increase in the rate on the POW site
- Peaks to around 10% admission periodically
- Further 'deep dive' required to understand why peaks occur. Possibilities include: higher rate of C/S, multiple births, change in medical staff (rotation) etc…

Local Improvement plans:

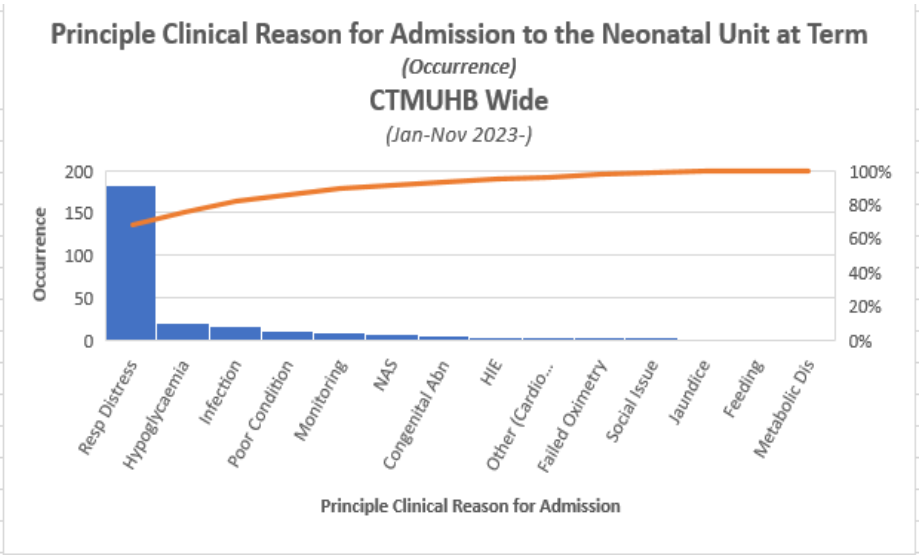
✓ Re-launch of 'Management of Respiratory Distress at Birth Pathway'

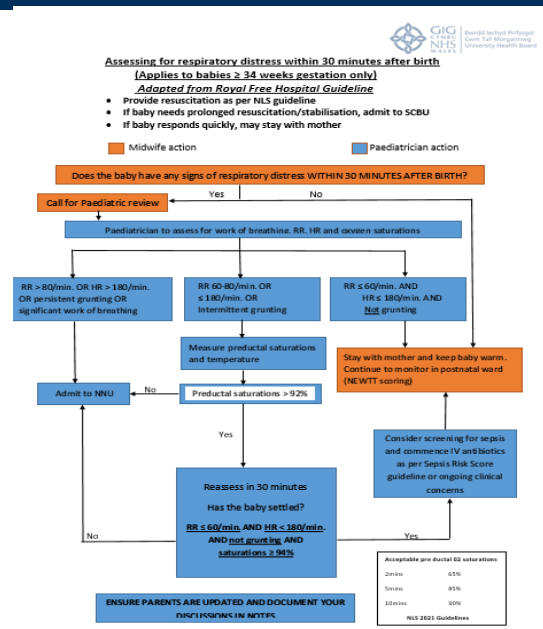
✓ 'Up stream work' looking at the antenatal management of maternal co-morbidities such as (but not limited to) diabetes, obesity, smoking etc.

ATAIN Specific Metrics- Principle Reason for Admission

Respiratory

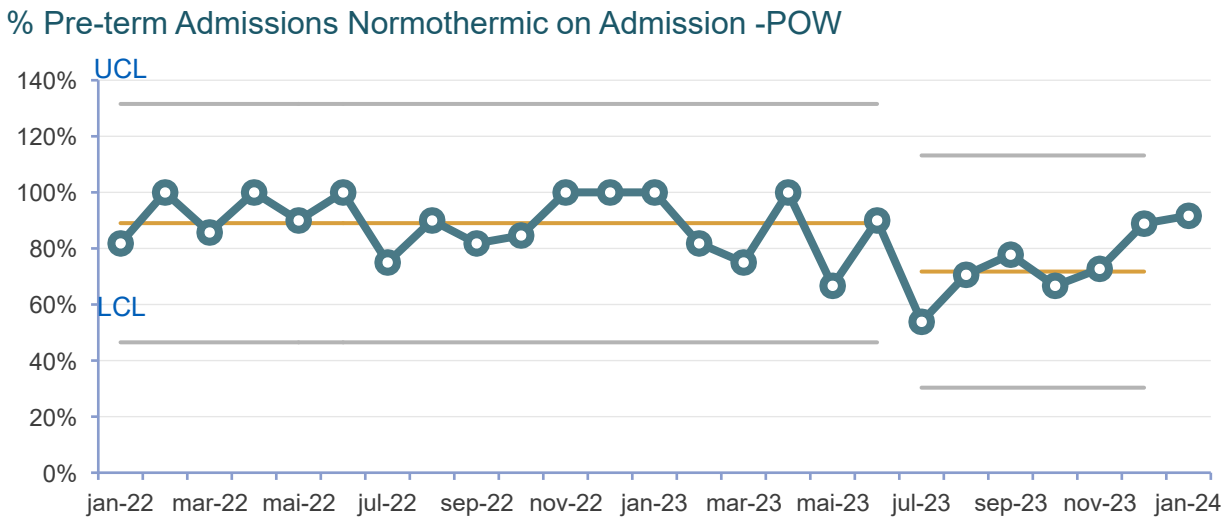
Reason for Admission	Occurrence (Jan-Dec 2023)
Congenital Ab	5
Failed Oximet	3
Feeding	1
HIE	4
Hypoglycaemi	20
Infection	17
Jaundice	2
Metabolic Dis	1
Monitoring	9
NAS	6
Other (Cardio/	4
Poor Conditio	11
Resp Distress	182
Social Issue	3

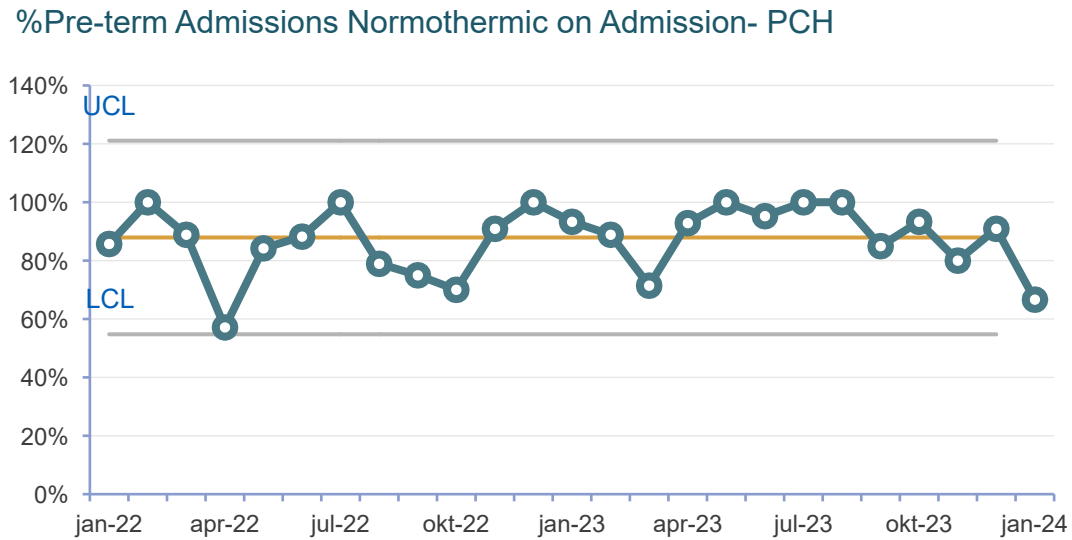




- Management of Respiratory Distress Pathway launched Dec 2023 (soft launch)- plan to relaunch 1st March 2023 that will include support from maternity operational Band 7's
- Further 'upstream work' also required to understand reason for respiratory being the main reason form admissions at term i.e. antenatal management of maternal co-morbidities etc. QI projects to be initiated following completion of 'up stream work'- ST4 doctor supporting with this work.

Temperature on Admission- Pre-Term Normothermia





Preterm babies who were normothermic on admission (admission temperature between 36.5'c- 37.5'c)

- Aim is for all our pre-term babies to be normothermic on arrival to the NNU.
- Data shows a slight decrease in compliance on the POW site between July- Nov 2023, this is now improving again.

Factors that can influence preterm normothermia:

Transport incubator previously out of use in POW- (broken)- this has now been addressed.

Babies born in the community (unplanned homebirths)who may have been hypothermic on arrival.

Maternity Training Compliance

Merthyr & Cynon **Midwifery Acute** Compliance (inc. ANC)				
	TOTAL LIVE	IN	OUT	%
PROMPT	97	85	12	88%
NLS	97	93	4	96%
BLS	97	93	4	96%
CTG	97	84	13	87%
GAP/GROW	97	77	20	79%
M+S	97	66	31	68%

Bridgend **Midwifery Acute** Compliance (inc ANC)				
	TOTAL LIVE	IN	OUT	%
PROMPT	70	65	5	93%
NLS	70	67	3	96%
BLS	70	67	3	96%
CTG	70	64	6	91%
GAP/GROW	70	60	10	86%
M+S	70	63	7	90%

Obstetric & Anaesthetic staff compliance				
	TOTAL LIVE	IN	OUT	%
PROMPT	80	61	19	76%
CTG	50	42	8	84%
GAP/GROW	50	43	7	86%

Merthyr & Cynon **Midwifery** Compliance (inc. community MCA/HCSW)				
	TOTAL LIVE	IN	OUT	%
PROMPT	44	37	7	84%
Comm PROMPT	44	42	2	95%
NLS	44	42	2	95%
BLS	44	42	2	95%
CTG	38	38	0	100%
GAP/GROW	38	33	5	87%
M+S	44	37	7	84%

Bridgend **Midwifery** Community Compliance (inc. Tirion birth centre and community MCA/HCSW)				
	TOTAL LIVE	IN	OUT	%
PROMPT	34	25	9	74%
Comm PROMPT	34	32	2	94%
NLS	34	32	2	94%
BLS	34	32	2	94%
CTG	24	22	2	92%
GAP/GROW	24	23	1	96%
M+S	34	27	7	79%

Workforce Information (Maternity N&M) (All areas)
Annual Leave, Sickness, Maternity Leave, Vacancies – February 2024

	Maternity Leave		Sickness Absence		Annual Leave		Vacancies	
	Planned vs Actual 13.11.23-4.2.24	**Planned** 5.2.24-3.3.24	**Planned vs Actual** 13.11.23-4.2.24	**Planned** 5.2.24-3.3.24	**Planned vs Actual** 13.11.23-4.2.24	**Planned** 5.2.24-3.3.24	**Planned vs Actual** 13.11.23-4.2.24	**Planned** 5.2.24-3.3.24
PCH	**3.9%**	**3.1%**	**12.5%**	**8.65%**	**17.2%**	**17.66%**	**9.31 wte**	
PoW	**2.76%**	**2.5%**	**6%**	**2.65%**	**16.2%**	**18.6%**	**-**	
Community North	**-**	**-**	**12.1%**	**7.5%**	**13.75%**	**17%**	**-**	
Community Bridgend	**1.85%**	**7.9%**	**10.66%**	**3.42%**	**15.7%**	**17.55%**	**-**	

Agenda Item
5.2c

Quality & Safety Committee

Highlight Report from the Unscheduled Care Group Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	14/03/2023
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Emma James, Unscheduled Care Nurse Director • Alex Brown, Unscheduled care Medical Director • Victoria Healey, Head Of Quality & Patient Safety
Cyflwynydd yr Adroddiad / Report Presenter	Emma James, Unscheduled Care Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Quality & Safety Committee	07/02/2024	

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
POW	Princess of Wales Hospital
Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group

ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic non touch technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute care of the elderly unit
TIA	Transient Ischaemic Attack
MRI	Magnetic resonance imaging
OCP	Operational Change Policy
LTA	Long term Agreement

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Quality, Safety, Risk and Experience meeting on 7th February 2024.

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

2. Purpose of this Meeting

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

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

3. Highlight Report

Alert / Escalate	**Neurology Services** Neurological services are provided by visiting consultants and nurse specialists from Cardiff & Vale University Health Board (C&VUHB) for patients in Rhondda Taff Ely and Merthyr & Cynon, and by Swansea Bay University Health Board (SBUHB) for patients in Bridgend. Due to recent workforce changes affecting the visiting consultants, C&VUHB have notified the operational management team at RGH that two clinics per week (out of three) are to be cancelled from February 2024. There are no confirmed plans to backfill these clinics or clinician identified for these patients to be moved under their care.

	C&VUHB have also notified that two afternoon inpatient ward sessions per week at RGH will not be provided from January 2024 as these are not currently part of the LTA between CTMUHB and C&VUHB. CTMUHB is exploring all opportunities, but in the absence of a CTMUHB delivered neurology service options to provide cover are severely limited.
Advise	Complaints have been transferred to a central quality governance team within the organisation. This has ensured that we maintain equity, consistency and strengthen resilience. USC compliance with the 30 day target has decreased from 100% in December to 85% in January 2023. This is due to a number of historical complaints being closed. Currently there are 17 open complaints and 2 over the 30 day compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This has been closely monitored by the USC Senior Leadership Team which has resulted in a significant improvement. **AMaT** A high- level report has been produced to give an oversight of the outstanding actions on AMaT allowing the Directors to drill down specific areas. The compliance for all areas within the USC care group to highlight areas which require improvement is available on request. Junior doctors strikes are expected to have a significant adverse effect on outpatient activity during the strikes. This will be necessary to continue to provide safe and high quality services through the strikes by consultant, Staff Grade and Associate Specialist (SAS), and nursing/Advanced Health Care Practitioner (AHP) staff. Most nurse specialist clinics have continued, and most medical clinics have been cancelled. Where these are higher risk, as far as possible alternative arrangements are in place (such as providing emergency services for cancer patients). In some areas, some acute clinics will remain cancelled - including TIA clinics. Each clinic has been individually risk assessed and mitigations made where possible. The Escalation Procedure policy has been amended in relation to boarding and pre-emptive transfer and sent out for final comment. This is to provide an operational approach to the effective management of capacity and escalation across all areas

	within CTMUHB. It will set out the standard triggers and expected response from individuals through to Care Group triumvirates. Where local variances are identified, these will be detailed in the appendices and also held by the individual site management/ bed management teams. The procedures are designed to enhance the effectiveness of patient flow and maintain patient safety through the implementation of local actions that support best practice through proactive management of increased emergency pressures
Assure	The Emergency department national survey has received 1113 responses in January 2024 which is a huge improvement from August & September 2023, where only 4 responses were obtained. This is due to the excellent engagement with the staff within CTMUHB to ensure that the information is available to the public to access and leave feedback. The Executive Medical Director and Independent Member for Quality & Patient Safety completed a Walk round at PCH, Ward 3; which is a 24 bedded frailty ward on 11th January 2024. Formal feedback provided to the team, a wonderful team approach and a caring attitude came across instantly from everyone. We are building on this feedback and have established a plan to support the development of the service, notably the Nursing Practitioner roles and the launch of the Acute Frailty model which has commenced this month across the Clinical Decisions Unit. Prince Charles Hospital have developed an Advanced Nurse Practitioner (ANP) role as part of a proof of concept piece of work supporting patient flow at the front door, across ED, Clinical Decisions Unit and GP Assessment Unit. They commenced the role on 22nd January 2024 and there has already been a significant impact to patient care, safety, experience, length of stay and patient flow. Data is being collected in order to quantify the impact and to support future service development.
Inform	To follow on from January's Quality and Safety update in relation to endoscopy delays and harm – the cancer harm review process has been reviewed and is aligned with the existing incident management framework. In reviewing our current process any patient harm is picked up via rapid review process and this review has given assurance that appropriate measures are in place. Of the 734 cases reviewed as part of the cancer harm review process, 2 cases of harm were identified which had already been identified through our usual governance process. Following on from this a briefing paper will be prepared with recommendations that we follow existing governance processes

	in relation to harm review and move away from the cancer harm review process and follow our existing internal arrangements. Following the completion of OCP phase 2, the senior and lead nurses within the USC Group have been aligned to their new portfolios. Oversight of these clinical areas began from January 31st 2024. Successful appointment last month of two Heads of Nursing at PCH and RGH. Last week we appointed two new Lead Nurses for USC at POW and at RGH.
Appendices	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Creating Health
	If more than one applies please list below: Inspiring People and Improving Care
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Leadership
	If more than one applies please list below: Culture
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Person Centred
	If more than one applies please list below: Safe Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reuse
	If more than one applies please list below:

5. Recommendation

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

Agenda Item
5.2d

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lucie Williams, Head of Nursing Primary Care and Communities
Cyflwynydd yr Adroddiad / Report Presenter	Lucie Williams, Head of Nursing Primary Care and Communities
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
ACT	Acute clinical team
AMAT	Audit Management and Tracking System
BD	Twice per day
CDS	Community Dental Service
CNS	Clinical Nurse Specialist
COPD	Chronic obstructive pulmonary disease
CRT	Community resource team
DIC	Death in Custody
DN	District Nursing
GA	General Anaesthetic
GDS	General Dental Services
GP	General Practitioner

HEIW	Health Education Improvement Wales
IT	Information Technology
LMC	Local medical committee
SALT	Speech and Language Therapy
SOP	Standard Operating Procedure
WG	Welsh Government
YBN	Y Bwthyn Newydd
YCC	Ysbyty Cwm Cynon

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Primary Care and Communities Care Group at its meeting on the 29th February 2023.

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

2. Purpose of this Meeting

2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.

2.2 The Primary Community Care Group QSRE Board will:

- Put the needs of patients, carers and the public at the centre of all its business.
- Provide evidence based and timely advice to the Primary Community Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
- Provide assurance to the Primary Community Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
- Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
- Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

Alert / Escalate	**Lymphoedema** – there is currently a backlog of 1,200 patients. There is a plan in place to clear the backlog. Reviews are planned for week of 12th and 19th February across the 3 localities. The team are also contacting the 3,500 patients on the caseload for assurances. A service review is required to ensure there are robust governance processes in place.

	Reduced SALT hours in **CRT** are limiting service delivery due to RIF funding required. **Paediatric General Anaesthetic Lists**. The risk score has been reviewed and increased to 16, due to an agreement made that CDS would use ad hoc theatre lists and become part of the bidding system for vacant GA lists. No lists have been received to date.
Advise	**Parc Prison** – work being undertaken to review current pathways to support patients that present as a self-harm risk. **Transcribing medication within District nursing** – Second phase awaiting GP input regarding SOP agreement. Meeting to be arranged with LMC **YBN** is temporarily relocated from 5th February 2024, for a planned 21 days. To allow required work to be undertaken to improve Water Issues. **DN** teams seeing an increase in BD insulin requests from hospital that are time specific – unable to accept due to patients already on caseload. High levels of sickness and vacancies are affecting care availability for **CRT services** - business case to be submitted. Funding from Welsh government received to support the **Community Nursing specification** and to increase capacity across the DN out of hour's service provision. **Parkinson's service –** review of model being undertaken with support from lead of the service **GDS Dental waiting list** current stands at **13,000** patients. This is increasing month on month. The list requires validation due to multiple names being on list/those that have already found a dentist that need removing. Text messaging service is established and operational from 12th February 2024. **Salaried Dental Service:** significant impact on the management and delivery of services due to work absences. HEIW require assurance that there is appropriate supervision at the Dental training unit. Actions are being implemented to provide necessary educational supervisors cover for next 3 months. **Taff Vale Medical Practice**- The first public consultation event, in respect of the proposal to close two of the practices branch surgeries, was held in Cilfynydd Community Centre on the 16th January 2024. A second public consultation event was held in Ynysybwl Community

	Centre on the 23rd January 2024. The consultation will close on the 8th March. **Spirometry** Funding to implement the Phase one spirometry service for the diagnosis of COPD has been agreed with finance. Ongoing training opportunities for practices who wish to provide the service are being scheduled.
Assure	Llais visit to **Ward 2, YCC** on 02.02.24 – initial feedback was positive in relation to food and fluid charts. Questionnaires left for patients regarding meal times, food choices. Llais visit to Ward D4 on 06.02.24 – initial feedback was positive regarding care provided. Patient Advice Liason Service (Pals) team undertaking weekly visits to speak with patients and relatives **YCC and Ysbyty Cwm Rhondda (YCR)**. **HMP Parc Prison** – has 8 open DIC action plans, all actions are ongoing and will be met within the given timeframes. **Manual Handling and CPR training compliance** lower than average in **District Nursing** due to training availability – plans in place to improve compliance over next 3 months. **ACT** continues to be a 5-day service, funding now in place and recruitment commenced to enable a 7-day service. High levels of sickness in **Palliative Care wards and CNS teams** persists – deployment of staff to support rotas and on call. Review being undertaken across both **Bladder and Bowel** and **Lymphoedema** services in relation to governance measures in place. **HMP Parc**, work undertaken following WG direction with commitment to achieve elimination of Hepatitis B & Hepatitis C by 2030. Review of Optometry governance reporting being undertaken to ensure reporting templates and quality improvements are in line with other contracted professions. **Documentation audit** for primary care specialist nursing services. The team are liaising with the corporate team to develop nursing documentation audit using AMaT.

INFORM

Single point of contact for patients that require **DN service by night**. Review being undertaken to align the day contact numbers also.

Frailty Tool scoring implemented within **DN service**, awaiting further plans for new frailty pathways across CTM.

Bridgend DN teams undertaking a pilot for response times until end of February, with a plan to rollout and audit on AMAT.

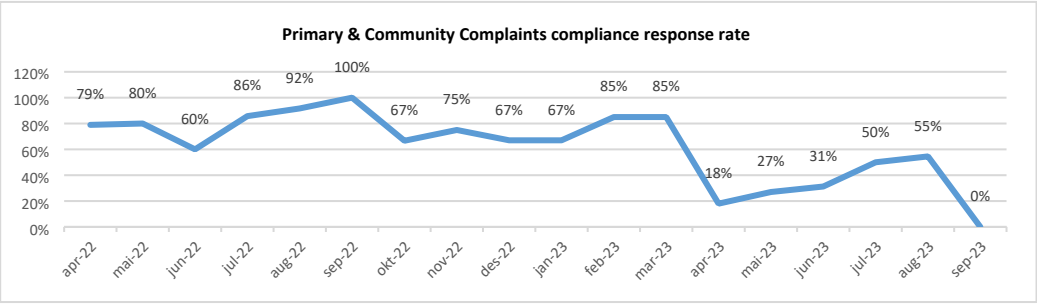
The **Community Integrated wellbeing team** – has merged into the Cluster networks to offer support to individuals with neurological conditions ensuring a more holistic approach to the care provided.

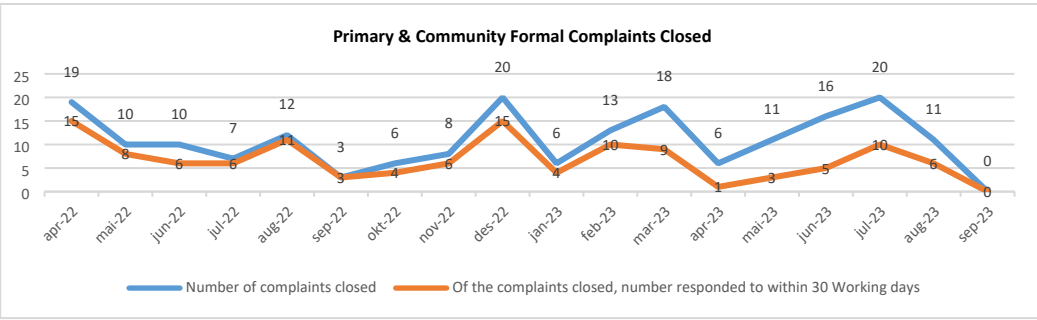
Ward 6, YCC continues to function on agreed operational plan and care for End of Life care patients only and not specialist palliative care.

HMP Parc, introduction of numerous service delivery improvements

- Sexual health screening on admission to prison.
- Kings Fund Pilot on a tool developed to assess the environment to provide effective care for men with Dementia.
- 5 allocated cells being changed to 'Palliative rooms', which will be used to provide end of life care.
- Information leaflet devised to share with all
- All patients to be provided with information for them to be aware of all the Health services available at Parc.

<u>Concerns</u>





	There are 2 open formal complaints and that the small numbers of formal complaints can skew the compliance data. The reduction in the number of complaints is due to the implementation of early resolution at HMP Parc and a change in logging process for Primary Care concerns in line with other HB's Nationally Reportable Incident (NRI) –1 open NRI in relation to Covid. Amat

Project	Number of audits	Current compliance	Improvemen
Health & Safety	1	G 100.0%	
Health and Care Standards	1	G 98.8%	
Infection Control	4	G 95.4%	
Medicines Management	3	G 98.4%	
Patient Safety	12	G 97.1%	

Appendice	Not applicable

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well
	If more than one applies please list below: Growing Well, Living Well, Dying Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Culture and valuing people Learning, improvement and Research Leadership
Dolen i Feysydd Ansawdd	Effective

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below: Efficient Person centred Equitable Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. Recommendation

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

Agenda Item
5.2e

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Lisa Love-Gould- Clinical Director of AHPs
Cyflwynydd yr Adroddiad / Report Presenter	Lisa Love-Gould- Clinical Director of AHPs
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
AHP	Allied Health Professionals
CDs	Controlled Drugs
DI	Designated Individual
DTPS	Diagnostics, Therapies, Pharmacy & Science
HIW	Healthcare Inspectorate Wales
HTA	Human Tissue Authority
IABT	Independent Authorisation of Blood Component Transfu
INR	International Normalised Ratio
ISO	International Organisation for Standardisation
LHP	Llantrisant Health Park
OCP	Organisational Change Policy

OMB	Operational Management Board
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QA	Quality Assurance
RGH	Royal Glamorgan Hospital
RSI	Repetitive Strain Injury
RTT	Referral to Treat Time
SLA	Service Level Agreement
UKAS	United Kingdom Accreditation Service
USC	Urgent Suspected Cancer
WLI	Waiting List Initiative

1. Introduction

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Diagnostics, Therapies, Pharmacy & Science Quality, Safety, Risk & Experience (QSRE) Group up to February 2024.

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	**Radiology-** ID 2713 Backlog of reporting – additional allocated funds have allowed WLI and additional reporting to recommence, as well as outsourcing for routine and some urgent work (USC and some urgent managed in house). Oldest unallocated routine CT now 3 weeks. Oldest routine MR report 16 weeks (specialty specific) USC reports being completed in around 3 days. MRI reporting backlog still remains an issue, but progress is continuing on a weekly basis and is reported through OMB and the integrated performance score card.
Advise	**Pharmacy and Medicines Management –** **Controlled Drugs liquids:** incidents reported on multiple sites of volume discrepancies for Oxycodone. Team are looking into alternate ways of monitoring to ensure easier detection of spillage/wastage vs diversion. This will mean a cost pressure for clinical areas; plan to be developed for next DTPS QRSE.

Consent: incident reported where patient refused treatment with low molecular weight heparin with sub-therapeutic INR (international normalised ratio) admitted with suspected stroke. Stroke then ruled out, so no harm. However, highlighted an issue in the team around knowledge on patients' right to refuse treatment and consent in general. Engaged with learning and development team to ensure training in place for the pharmacy teams.

Storage space: insufficient space in RGH stores to hold adequate volumes of IV fluids. Review of all IV fluid holdings on all sites commissioned, to determine whether sufficient stocks for business as usual and business continuity situations.

Radiology

Civica

Ongoing concerns regarding limited access to patient feedback information. Resolving this would help us use patient feedback to improve the quality of service we strive to provide for our patients and relatives. Discussions will continue with the Central Governance team to try to progress this through 2024.

Nuclear Medicines Risk

Regional problem continues to impede the service we provide for Breast and Urology patients requiring nuclear medicine diagnostics. On-going support from Swansea Bay continues with increased provision through the existing SLA and reduction in the contract provision from Cardiff to rebalance. NHS executive are aware of the regional challenge and are supporting direction of travel while longer term solutions are explored further.
Risk currently being mitigated with this support.

- New US equipment approved pre April which will provide better image quality, will help to mitigate RSI issues,
- MR software upgrades also approved at RGH/PCH which will shorten the sequence scan time and allow us to scan more in the same time.
- Radiology OCP for Snowdrop completed
- LHP - MRI Mobile scanner will be operational from 22/04/24. Planning and implementation meetings underway to deliver this.
- POW HIW Nuclear Medicine inspection scheduled 05/03/24 to 06/03/24.

Pathology

UKAS:
Assessment ended on 8th Feb with the Haematology and Blood Bank remote assessment – this was a really successful assessment with no mandatory findings, a huge achievement given the pressures the services have been under over the last year. Letter confirming completion of inspection received 26.2.24.
Next assessment is scheduled for June 2024 – this will be the 4 year re-assessment, and also against revised ISO 15189:2022 standards. This will be an important assessment for Pathology, a gap analysis has already been undertaken and an action plan is being progressed to ensure compliance with the new standard.

HTA*:*
Update to legal directions – Designated /individual (DI) to undertake a review in terms of capacity planning and contingency storage for CTM Mortuaries, response to be submitted by 24/11/23 in preparation for the Winter period. A review of contingency/escalation plans and related documentation was undertaken, for assurance our current procedures are compliant with HTA standards. Regulatory Update: Action to inform HTA if additional storage is required over the Winter period.

DI updated on UK and Welsh government reforms to death certification which it will introduce from April 2024 resulting in the role of the Medical Examiners service in Wales becoming statutory. This builds on established death review processes providing medical examiners with additional scrutiny of the medical circumstances and cause of death to ensure deaths are appropriately referred to coroners. There are concerns within the pathology directorate that this will further impact on the mortuary and post mortem service demand and system wide capacity to meet this. The position will be observed and concerns in respect of compliance with HTA licence escalated to DI as appropriate.

NB: nuclear Medicine inspection 5-6 March 24, Civica was an action point previously

- **Welsh Government recommendations for community body stores:** Following the Fuller Inquiry and a submission of position by HBs, it was found that body stores which sit outside the mortuaries were not subject to the same level of governance as the mortuaries themselves. WG made a number of recommendations for community body stores. Final discussions in play to conclude the requirements and transfer the service to Pathology in Q1 2024-25.

Assure

Pharmacy and medicines management

HMP Parc: Dedicated HMP Parc Datix Scrutiny Panels will now be set up with Primary Care quality and safety lead.

Controlled Drugs: Recent Internal Audit conducted by NHS Wales Shared Services Partnership (NWSSP) to consider governance and control arrangements of the management of controlled drugs process was undertaken in line with the 2023/24 Internal Audit Plan for Cwm Taf Morgannwg University Health Board

The assurance summary has found that 3 (of 7) areas had 'substantial' assurance and 4 had 'reasonable' assurance. The overall report was 'reasonable': This means some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
The matters that require attention are:

- Reinforcement of some processes in place for the management CDs such as the maintenance of an up to date authorised CD signatory list and safekeeping of Cd order book and register.
- Some CD cabinet keys were a part of a bunch of other keys.
- A system in place to monitor and view the trends regarding the use of CDs across the sites distributed.

Therapies

Patient Experience – CIVICA Therapies PREM Pilot
Now live after 2 years, great data coming through, can also pull off the free type text. Early days as but each profession will get training so they can run their own reports.

Start Date: 2/1/2023 12:00:00 AM End Date: 1/31/2024 11:59:00 PM

		2022	2023	2023	2023	2023	2023	2023	2023	2023	2023	2023	2023	2024	
Question:	Survey	Nov	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Benchmark
3. Was the length of time it took to travel to your appointment today acceptable?	Therapies patient experience survey	-	-	100	-	-	-	75	97	47	40	-	75	81	85
4. Was it easy to find parking?	Therapies patient experience survey	-	-	0	-	-	-	0	86	38	40	-	100	57	85
7. How clean is it?	Therapies patient experience survey	-	-	88	-	-	-	100	90	72	65	-	25	97	85
8. You were listened to?	Therapies patient experience survey	-	-	100	-	-	-	40	100	100	93	-	-	100	85
8. You were given all the information you needed?	Therapies patient experience survey	-	-	85	-	-	-	70	100	100	93	-	-	95	85
8. People were polite to you?	Therapies patient experience survey	-	-	100	-	-	-	70	100	100	100	-	-	95	85
8. You were given enough privacy?	Therapies patient experience survey	-	-	85	-	-	-	100	95	100	93	-	-	92	85
8. You were treated with dignity?	Therapies patient experience survey	-	-	85	-	-	-	100	100	100	100	-	-	94	85
8. People were kind and compassionate to you?	Therapies patient experience survey	-	-	100	-	-	-	100	100	100	100	-	-	96	85

Radiology

Training
PDR compliance - January 70.75%
Core Mandatory Training compliance - 63.12%
Manual Handling – The department currently has one trainer, and have scheduled the 2 days training once a month throughout 2024 – allowing for 6 members of staff to be trained a month. Plans for another trainer, so we can train 12 staff per month. 7 staff trained in January, 6 staff being trained February. Future planning – train more work place assessors to support maintaining our compliance, and audit.
Basic Life Support Training – The in house Radiology RGH trainers started delivering in February and trained 25 staff on site.

Pathology

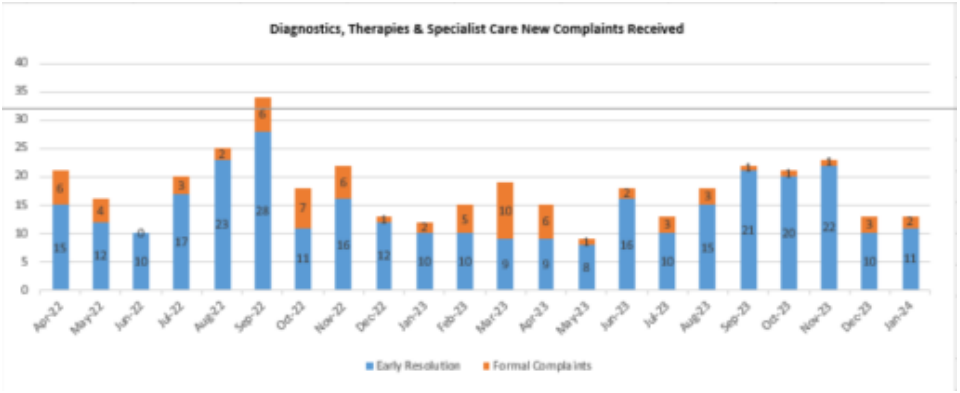
New Policy: Procedure for the Independent Authorisation of Blood Component Transfusion.

This procedure sets out the governance arrangements for Independent Authorisation of Blood Component Transfusion (IABT).
There are currently a small number of Health Care Professionals across CTM that are qualified to carryout authorisation of blood components, however this is not often put into practice due to the lack of robust governance around this process within the Health Board. There is an All Wales Policy that describes governance requirements, however it was felt that the development of a Health Board specific procedure was required to provide a local governance framework to support practice and future training/development of Health Care Professionals in IABT. A working group was set up for policy development, led by Nurse Practitioner at POW, the working group included relevant stake holders to ensure the policy was developed based on a broad spectrum of knowledge. The policy has also been ratified at the Hospital Transfusion Committee and has been taken to OMB under the new process for policy approval as this is a HB wide policy.

Haematology Harm Reviews.
All Haematology harm reviews have now been completed by Clinical Haematology Lead. All have returned as no or low harm.

Inform

DTPS Complaints received and compliance



Data set shows we are **100% compliant** in closing new complaints within 30 days.

DTPS Patient Safety Incidents

Breakdown of open incidents by service (Dec '23 & Jan '24)

Overview: Incident's (December & January)

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
	116	118	145	112	129	130	99	141	110	107	98	73
	97	87	123	98	107	100	81	116	102	87	74	60
No Harm	49	51	53	20	33	34	20	48	26	27	29	25
Low	40	27	54	65	57	53	53	59	56	55	41	29
Moderate	8	9	14	6	16	11	8	7	15	4	3	5
Severe	0	0	2	1	1	2	0	2	5	1	1	1
Death	0	0	0	0	0	0	0	0	0	0	0	0

Incidents	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total Number of Incidents Reported	145	112	129	130	99	141	110	107	98	73	106
Patient Safety	123	98	107	100	81	116	102	87	74	60	88

* No level of harm detail provided in monthly report for January *

Breakdown of open Incidents by Service (Jan)

Service	Number under investigation	
Therapies	22 new in month, 6 remaining Open, 0 in new incident	34 incidents closed in month
Radiology	55 new in month, 19 open, 17 in new incident	11 incidents closed in month
Pathology	15 new in month, 110 open, 5 in new incident	2 closed in month
Medicines	31 new in month, 172 open, 44 in new incident	19 closed in month

Moderate/Severe incidents

5x moderates: downgraded to no harm

1x severe: awaiting further MDT to establish if correct level of harm or requires Nationally Reportable Incident (NRI) reporting

1x death: This has been passed to USC following an incident in ED.

NRIs

NRI detail

ctmuhb.nhs.wales

Total Number of NRIS	New NRIS	Total Number of LRIs	New LRIS
5 (4 overdue)	1 (reported from maternity but radiology element: 47931)	2 (1x pathology, 1x Radiology) 2161 (awaiting	2x IRMERS both closed)

Service	Open number of NRIs	Overdue NRIs	Number scheduled for Panel
Therapies	0	N/A	N/A
Radiology	5	5	1x case 2021 2x case 2022 2x case 2023
Pathology	0	N/A	N/A
Medicines	0	N/A	N/A

New NRI (reported from C&F care group)

47931: Maternal death

No initial breach of duty found within maternity or ITU care on initial review.

- Report is being reviewed externally. Support is being provided to both staff and family.

Update on NRI progress

3x 1st draft of NRI's received (in progress of being reviewed by governance team)
2x investigations in progress

Locally Reportable Incident (LRIs)

Total number for care group: 2

Service	Total Number Overdue
Pathology	1 (awaiting closure : JC awaiting ED to review, ready to close)
17120 (Radiology and unscheduled)	Investigation being completed initially was being completed by unscheduled care

Total number for Care Group

Service	Total Number Overdue
Pathology	1 (awaiting closure : LT to review)
17120 (Radiology and unscheduled)	Investigation being completed (thought was being completed by unscheduled care

Learning From Events Reports (LFER)

1 for Care group

SB&EM reviewing Jan 24

Radiology Incidents

Incidents
Duplicate examination highest in terms of reported incidents. There is a failure to check for previous images and timing issues. Unfortunately, 3 of these incidents were reportable to HIW.

Our investigation and feedback processes are robust, however we are going to add another level of discussion with those involved in radiation incidents (whether they are reportable to HIW or not). This will provide additional feedback of the incident, changes to practice required, and an overview of the reporting and investigation process. Anonymous alerts are distributed across sites for shared learning.

Radiology Risk's

Risk Register
4 >12 Registered Service Risks
2 Risks escalated to Corporate Risk status

Good News

Pharmacy

Sarah Murphy MS (Bridgend) raised the awareness of Heart Failure at a debate session in the Senedd. However, pharmacy element of this service will come to an end when industry funding ceases in March. The rest of the service is funded by value based healthcare, but the pharmacist element was excluded. Discussions continue between Medicines Management and Unscheduled Care to resolve.

	Therapies **Quality Exemplar – Dietetics Oncology** 6 month review of oncology patients requiring specialised dietetic care has shown that 26% had sarcopenia and 81% were medium to high risk of malnutrition, early intervention is essential, clinic model was adapted and moved the caseload from general to a more specialised weekly clinic. Saw 220% improvement on RTT times, went from 4-6 weeks to 9 days. When provided with a choice, nearly all patients opted for a virtual consultation (phone or video call) rather than face to face, only 1 patient opted for in person appointment from the 60 asked. GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board cwmtafmorgannwg.wales Patient Experience – patient centred care I have had a chronic pelvic condition for over ten years. During this time I have been to my GP on many occasion and taken various medication in the pursuit of a resolution. When attending physiotherapy I was always ***made to feel welcomed***, my concerns about my condition were ***listened to carefully*** and were taken seriously. As a consultant myself, I value the advise and guidance of other professionals. During the consultations Vonda demonstrated a ***very high level of technical understanding*** and ***effectively conveyed empathy***. The consultations were professional and thorough and ***my needs were addressed effectively***. My psychological profiles requires me to have a deeper level of understanding than just being instructed. Vonda took time to explain my injury and the reasons for the prescribed stretches and exercises. This more ***holistic approach*** to health care has proved to be very beneficial. For me and in my experience, ***Vonda was the embodiment and personification of professionalism and medical excellence.*** I am now well equipped with the knowledge and experience I require to manage my condition well. ***I genuinely feel that I have received world class medical service***
Appendices	No Appendices

3. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care Creating Health
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well Growing well Ageing well Dying well

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

4. Recommendation

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

Agenda Item
5.2f

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Sharon O'Brien, Nurse Director, Planned Care
Cyflwynydd yr Adroddiad / Report Presenter	Sharon O'Brien, Nurse Director, Planned Care
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Not applicable		

Acronyms / Glossary of Terms	
LATPB	Local Anaesthetic Transperineal Prostate Biopsies
ENT	Ear Nose & Throat
CNS	Clinical Nurse Specialist
PACU	Post Anaesthetic Recovery Unit

1. Introduction

This report had been prepared to provide the Quality & Safety Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience Group at its meeting on 19th February 2024.

2. Purpose of this Meeting

2.1 This report had been prepared to provide the Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience Group at its meeting on 19th February 2024.

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

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

3. Highlight Report

Alert / Escalate

Princess of Wales (POW) Hospital

- While Ward Controlled Access is currently not implemented on inpatient wards at Princess of Wales (POW) Hospital, the CTM UHB Task & Finish (T&F) group initiated corrective actions in their first meeting on November 23. Enhanced care monitoring and risk identification measures have been reinforced during this period, demonstrating an ongoing commitment to patient safety as the group addresses the issues.

Urology

- Remains a key focus of Targeted Intervention for Cancer. The Urology Sustainability Programme has been revised with additional focus on key actions, with weekly review of demand and capacity.
- LATPB machine purchased for service at Royal Glamorgan Hospital (RGH) with NHS Executive capital support.
- Review of medical, nursing and CNS workforce and job plans has commenced to support the ability to enable routine cancer care delivery and reduce waiting lists.

Advise

Corporate Risk Register

- 4 Planned Care risks on the Organisational Risk Register scoring 20:
  - 4491 Demand for Planned Care services exceeds capacity
  - 4071 Failure to meet Cancer targets – some improvements noted but some service improvements linked to diagnostic capacity
  - 4103 Sustainability of a Safe and effective Ophthalmology service - Ophthalmology Harm review funding agreed up until March 2025.

Summary of Incidents (Jan 24)

Incidents	PCH	POW	RGH
Total Number of Incidents Reported	80	100	94

Total Patient Safety	67	85	84
Total Non-Patient	5	9	5
Total Organisational Incidents	8	6	5
Total Number of Incidents Closed this month	92	115	151
Total Number of Open Incidents on Datix Cymru	133	661	419
New Incident	97	255	284
Management review/Make it safe plus	4	34	11
Under Investigation	29	344	108
Awaiting Closure	3	28	16
Number of Nationally Reportable Incidents	0	0	1
Number of Never Events reported	0	0	0
Number of Open Nationally Reportable Incidents	2	5	5

- Prince Charles Hospital (PCH) significantly lower number of open incidents – high number of *New incident* and Incident *Under Investigation* in POW and RGH
- 0 never events
- 8 Nationally Reportable Incidents (NRI) incidents reported for January & December:
    - 2 x avoidable pressure damage 1 x RGH 1 x POW
    - 5 x Ophthalmology - delays in treatment following harm review
    - 1 x max fax referral delay
    - 36 x open NRIs in total for Planned Care

Complaints summary (as of 18th Feb)

Complaints	
Number of Formal complaints received	2
Acknowledgement letter sent within 2 working days	2
Number of Early Resolution received	14
Number of Enquiries received	26
Number of Enquiries received via PALS	23
Complaints Closed	1
Of the complaints closed, number responded to with 30 working days	0
Percentage of closed complaints responded to within 30 working days	0%
Number of complaints final response due this week	2
Of the number due, number closed / closed escalated to redress / withdrawn within 30 working days	1
Percentage of complaints closed within 30 working days where response was due this week	50%
Open Complaints	19

Complaints Overdue - Over 30 Working Days	4
Complaints Overdue - Over 6 Months	0
Number of Reopened complaints	0

Re-commissioned theatre (RGH)

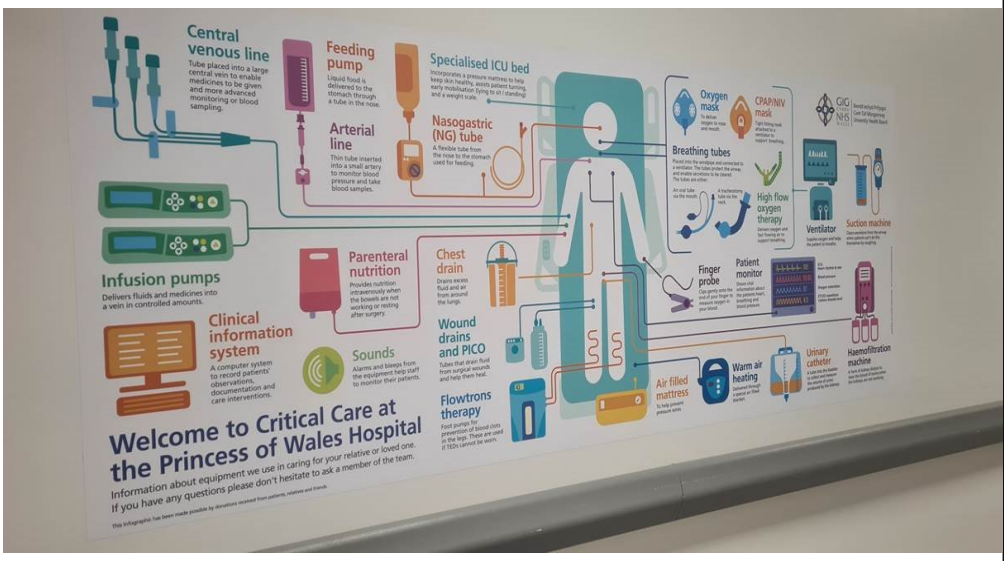
Tirion theatres in RGH on schedule to open in mid-April 2024 to provide dedicated breast surgery, with currently a 3 week delay due to capital works. Weekly group established to deliver the project with full stakeholder engagement. Urgent staffing plan being developed to enable the theatre to open on time.

RGH ward reconfiguration

This will create an enhanced max/fax & complex ENT bay plus a PACU on the same ward. Ensuring staff with the right skill on the ward to care for enhanced/high care level patients

New information boards within Critical Care in PoW and RGH.

This will be placed in PCH once their dedicated Critical Care Unit opens. Currently limited wall space within the temporary ward.



Assure

Llantrisant Health Park (LL.H.P)

Recruitment of 3 x clinical senior and lead appointments into LL.H.P from 1st April 24.

RGH

- New Head of Nursing started end of February
- Robotic surgery commenced for bowel surgery
- No avoidable falls in January

- Significant reduced Bowel Screening Wales (BSW) waiting times from 25 weeks in October to 5 weeks in January

Prince Charles Hospital

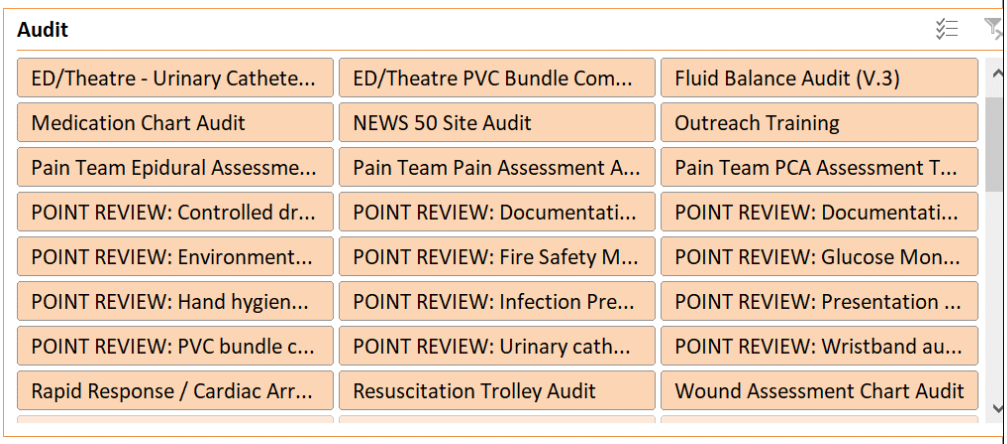
- Improvement in Pressure ulcer assessments and care. No avoidable pressure damage in this quarter.

Inform

Patient Experience feedback – CIVICA (January 2024) (appendix 1)

Monthly Ward Assurance

Percentage of compliance against the ward assurance audits listed below (Jan 2024)



Average of Score

	2024	Avera
	Qtr1	Jan 2 Jan 2
	January	
PCH Anaesthetics Department	N/A	
PCH Critical Care Outreach	N/A	N/
PCH Day Surgical Unit	98.62%	98.7
PCH Endoscopy Unit	97.40%	95.4
PCH ITU	97.39%	94.5
PCH Pre Assessment Clinic	98.23%	96.5
PCH Theatre Department	99.30%	95.1
PCH Ward 05	95.76%	94.0
PCH Ward 06	97.73%	96.3
PCH Ward 07 (formerly ward 3)	92.61%	94.1
PCH Ward 08	95.55%	93.2
PWH Anaesthetics Department	N/A	91.1
PWH Day Surgery Unit	99.01%	96.7
PWH Endoscopy Unit	98.53%	98.1

	PWH ITU	100.00%	97.6
	PWH Theatre Department	100.00%	99.5
	PWH Ward 07	91.75%	90.7
	PWH Ward 08	96.43%	92.9
	PWH Ward 09	94.92%	93.5
	RGH Anaesthetics Department	100.00%	96.3
	RGH Critical Care Outreach	N/A	N/
	RGH Day Surgical Unit	100.00%	100.0
	RGH Endoscopy Unit	100.00%	97.8
	RGH Hummingbird Centre	98.87%	98.9
	RGH ITU/HDU	100.00%	99.6
	RGH Outpatients Department - Main	98.20%	97.9
	RGH Snowdrop Breast Unit	99.03%	97.4
	RGH Theatre Department	97.36%	99.2
	RGH Ward 02	98.74%	94.6
	RGH Ward 03	97.40%	95.4
	RGH Ward 07 ITU	100.00%	96.2
	RGH Ward 08	95.81%	92.4
	RGH Ward 09	87.72%	95.1
	RGH Ward 10	98.31%	96.5
	RGH Ward 15	99.38%	99.4
	PWH Outpatients Department - Main	N/A	N/
	Average	**96.72%**	**95.7**

4. Assessment

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

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient Timely Equitable Person centred Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

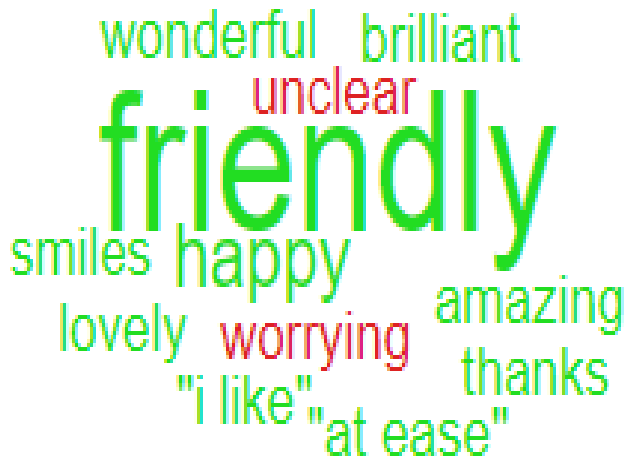
5. Recommendation

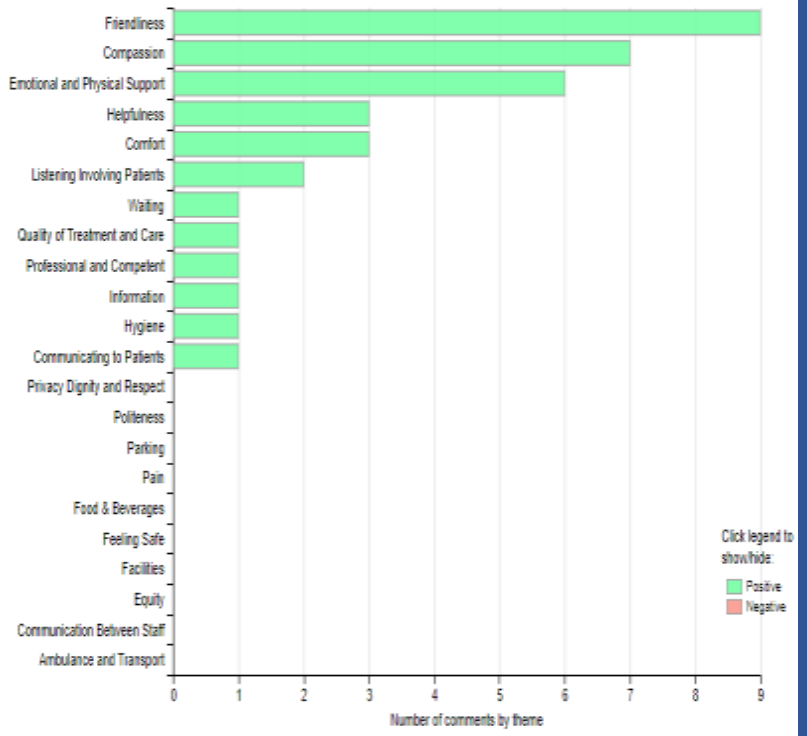
5.1 The Committee is asked to **NOTE** the highlights outlined in section 3 of this report.

Planned Care- Jan 2024

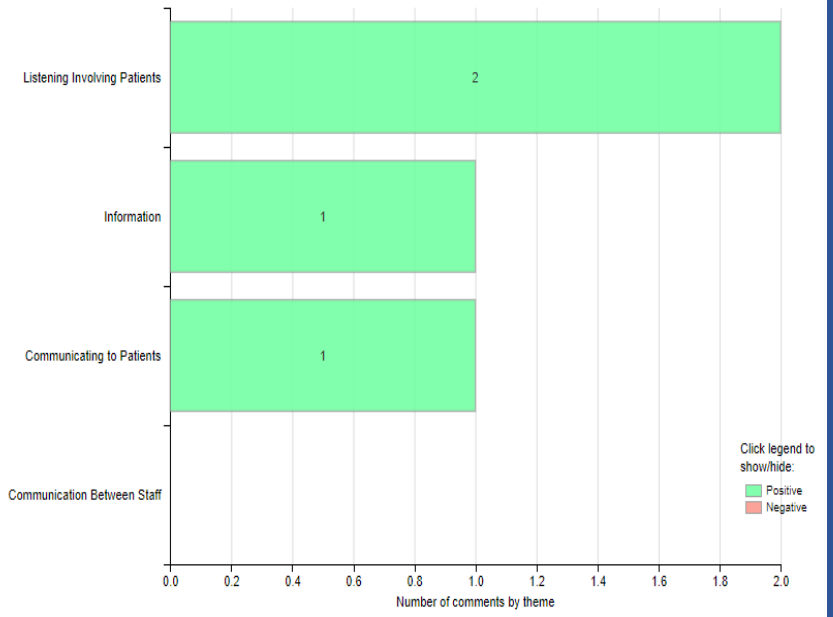
Planned Care themes (all areas- Pansentic)

All used Categories Pos/Neg Count

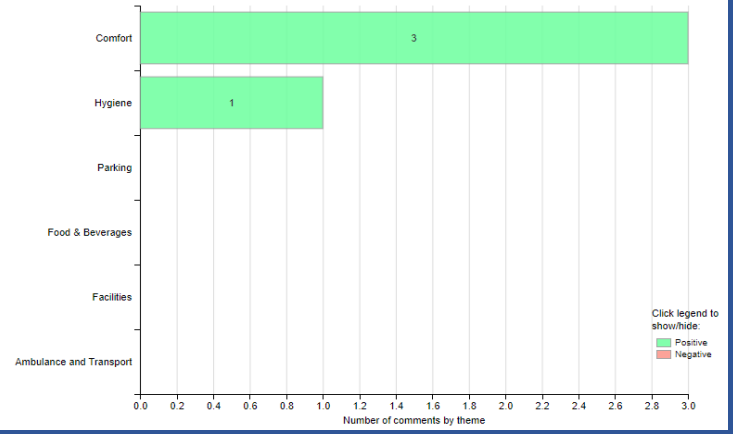




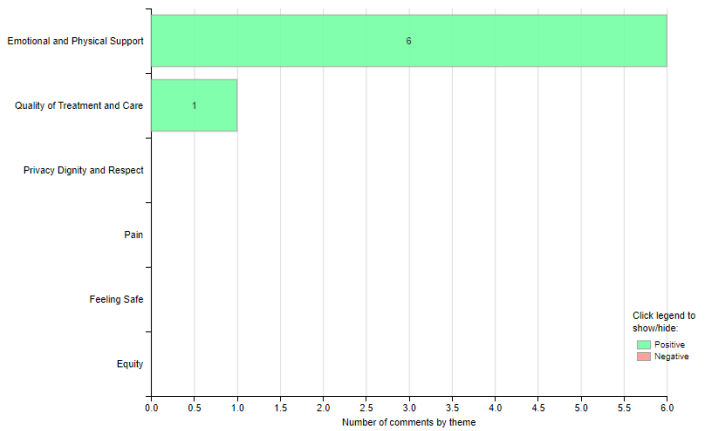
Communication



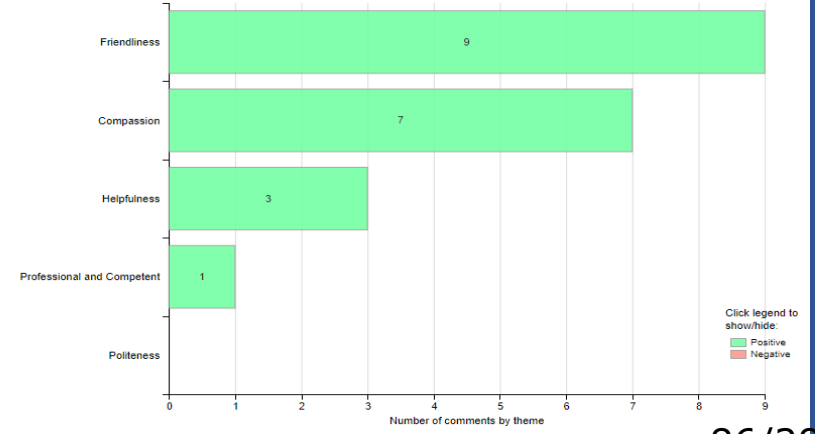
Non- Clinical Service Quality



Clinical Service Quality



Staff Attitude & Capability



		Endoscopy Unit	Trauma & Orthopaedics
Princess of Wales Hospital	Low Scoring Feedback	Nothing needs changing, all staff were brilliant and did their very best.Maybe the only way to improve the whole experience would be if some clever scientist invented a different approach to making you swallow a camera!	The clinician I saw wasn't willing to listen to me and was unclear explaining himself that I had to ask the nurse to summarise when we left the room
	High Scoring Feedback	The kind and friendly staff made an unpleasant procedure bearable.	
Royal Glamorgan Hospital	Low Scoring Feedback		
	High Scoring Feedback		Mum was on ward 3 for almost 2 weeks and staff could not do enough, they spoke to me every visiting time keeping me up to date. They work under extreme pressure with smiles on their faces
Prince Charles Hospital	Low Scoring Feedback	Friendly staff who put me at ease and explained exactly what was happening	
	High Scoring Feedback	Appointment was exactly on time on Thurs afternoon, friendly welcome from [redacted] who took my details and explained the procedure to me.Nursing team reassured me at all times, procedure didn't take long & I was given all relevant results - again by [redacted] who made the whole experience less worrying. Thank you to the team.	

Agenda Item
6.1

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Service, Function and Executive Formal Review	February / March 2024	RISKS REVIEWED
Operational Management Board / Offline via Email	21st February 2024	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	11th March 2024	MANAGEMENT SIGN OFF RECEIVED

Acronyms / Glossary of Terms	
N/A	

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)

Risk Review

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

2.2 The Operational Management Board / Chief Operating Officer approves escalation of Care Group risks to the Organisational Risk Register.

2.3 The Executive Lead approves escalation of central/core function risks to the Organisational Risk Register.

2.4 Risks on the organisational risk register have been updated as indicated in red in Appendix 1.

2.5 Please note that the risk updates are captured at the time the Organisational Risk Register being finalised for submission, which on this occasion was the 1st March 2024. Where review dates have passed and updates were not available these have been followed up and a request to update sent. Reviews received after this date will be reflected in the next iteration.

Training

2.4 Risk training, although not a core training requirement under the statutory and mandatory framework, has been added to the Electronic Staff Record (ESR) to support staff in registering for training and to support ease of reporting. This is managed by the Quality Assurance and Compliance Team. Interest in the course continues with positive uptake.

2.5 The sessions are run by the Assistant Director of Governance & Risk and Heads of Quality and Safety. The session is held virtually via Teams on a monthly basis for a duration of 1 hour and covers the following areas:

- Risk Management Approach

- Practical Approach to Managing Risk
- Risk Assessment and Scoring
- Datix Risk Management Module

2.5 To date **601** members of staff trained to date since training commenced in 2021.

2.6 Focussed sessions to discuss risk have also been undertaken with Care Group Leads and other departments/directorates as required.

2.7 Feedback on the training continues to be positive, please see below:

- 31 attendees have provided formal feedback (using the URL Code for the Evaluation Form, which was introduced in November 2023).
    - 77% (24/31) provided a score of 5/5 in terms of content of the session
    - 20% (6/31) provided a score of 4/5 in terms of content of the session
    - 3% (1/31) provided a score of 3/5 in terms of content of the session

- 100% of the 31 attendees providing formal feedback found that:
    - The session provided the right amount of information.
    - They gained more confidence and knowledge in risk management having attended.
    - They would recommend this training to a colleague.

- None of the 31 attendees considered that changes or improvements were needed to the training content.

- 97% of the 31 attendees providing formal feedback said they felt more confident to escalate a risk through the organisation.

- Some of the recent comments received through evaluation have been included below:

  "Easy to understand and helpful training".

  "Content was informative, trainer was knowledgeable and approachable. Practical help was provided with the Datix risk module".

Board Assurance Framework – Assigned Risks

2.8 The following Strategic / Principal risks are assigned to the Quality & Safety Committee

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Diagnostics, Therapies, Pharmacy & Specialties Care Group

- **Datix ID 5658 – Lack of Dietetic service provision to Princess of Wales Critical Care.** New risk escalated to the Organisational Risk Register in March 2024. Risk score of 16.

Primary Care and Community

- **Datix Risk ID 5417 – Paediatric Dentistry – General Anaesthetic Theatre Lists.** New risk escalated to the Organisational Risk Register in March 2024. Risk score of 16.

3.2 CHANGES TO RISKs

a) Risks where the risk rating INCREASED during the period

Nil as assigned to this Committee.

b) Risks where the risk rating DECREASED during the period

Nil as assigned to this Committee.

Central Function – Corporate Governance

- **Datix Risk ID 4922 - Covid-19 Inquiry Preparedness - Information Management.** Risk score reduced from a 16 to a 12 in March 2024. The system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information, however, it is considered appropriate to reduce the likelihood score from a 4 to a 3 at this stage.

Children and Families Care Group

- **Datix Risk ID 3008 - Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.** Risk score reduced from a 16 to an 8 in March 2024. Children and Families Care Group have reviewed this risk in light of the manual handling training now being mandated sessions. Service wide training is also on track to be completed by September 2025. Risk score therefore reduced in terms of likelihood from a 4 to a 2. The risk will now be managed on the Children and Families local risk register. On this basis the likelihood risk score has been reduced from a 4 to a 2. The rationale for the reduction in consequence score is captured in Appendix 1.

3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Nil as assigned to this Committee.

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

Consequence						
	5			3337 3993 4080	5276	
	4				4906 3131 4908 5404 5579 5658 5417 4152 3133 5254 4907 5646 2713	4491 4071 4103 3826 1133 5590 5640 4632 5462
	3					4732 4691 2808
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

3.5 Matters to Note / Notified emerging risks

- The Assistant Director of Transformation previously identified a new risk for escalation relating to the "Community Brain Injury Service in Bridgend", an update has been received noting that whilst a full replacement service is not in place control measures have been implemented providing risk mitigation and therefore is not considered for escalation to the Organisational Risk Register at this time.

- In January 2024, this report noted that the "Primary Care and Community Care Group have identified a new risk for approval relating to the "Palliative Medicine Staffing Merthyr Cynon", this is expected to be captured in the next iteration of the organisational risk register in March 2024, once agreed by the Operational Management Board". As at time of the March 2024 iteration of the Organisational Risk Register being run this risk is still being assessed and has not yet been escalated to the Organisational Risk Register.

- The January 2024 cover report noted that a new risk (Lack of Dietetic service provision to Princess of Wales Critical Care) was being considered for escalation by the Diagnostics, Therapies, Pharmacy and Specialities Care Group. Members will note that this risk has been escalated in March 2024 under Datix Risk ID a 5658. See section 3.1.

- In January 2024, the Facilities Directorate identified a new risk for approval relating to "Fire doors in staff residential accommodation across organisation are non-compliant to the Regulatory Reform Fire Order 2005". This was expected to be escalated to the organisational risk register in March 2024, once

agreed by the Operational Management Board. Since this update various control measures and mitigating action was taken by facilities and estates teams and the risk assessment reviewed and the score reduced to a moderate level, negating the need for escalation to the Organisational Risk Register.

4. IMPACT ASSESSMENT

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have been subject to QIA.

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

5. Recommendation

5.1 The Committee are asked to:

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

6. Next Steps

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

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
2	5640	Executive Medical Director	Central Support Function - Medical Directorate	Medical Directorate Manager	Sustaining Our Future	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Potential Junior Doctors Industrial Action	**If**...the NHS Wales Junior Doctors take industrial action related to a dispute over pay erosion between 21st-23rd February 2024 and as expected monthly going forward **Then...**there will be significant disruption on clinical services and planned and unscheduled care provision will likely be impacted. **Resulting in...**the quality of the care and services provided to patients and service users being affected in terms of access to services and compliance with performance and delivery objectives. This includes an impact on waiting list times for surgery and outpatients increasing, and patients being unable to access some health care services.	This is a national issue and decisions on any pay increases are out of CTM's control. A decision on strike action has been confirmed for 15th-18th January 2024 and 25th-29th March. There will be no derogation agreed ahead of the proposed strike unless the health board has offered BMA agreed rates to the doctors Consultants/SAS doctors in some cases will be asked and negotiated with to cover gaps in service. National group in place which includes group of senior colleagues who are agreeing process around pay rates for "acting down"	Process to be agreed with BMA for derogation decisions on day of strike with clear info on the information UHB's will have to provide. BMA have stated they will turn these around in 30-60 minutes CTM working group taking place regularly HB can switch pre-existing locum hours around with agreement, however, locums have already cancelled their shifts Planning and preparation with contingency plans for all affected service will be taken. With these measures in place the consequence score will reduce to 3, with a target score of 15. Update March 2024 - Medical Directorate undertaken a review of this risk and no changes made to mitigation or risk score on this review.	Planning, Performance & Finance Committee Quality & Safety Committee People & Culture Committee	20	C4xL5	C3xL5	↔	04.12.2023	20.02.2024	31.03.2024
3	5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Radiopharmaceutical Business Interruption	**IF**: CTMUHB Radiology Department are unable to procure radiopharmaceuticals as per Service Level Agreement with CAV. **THEN** patients will not receive the necessary imaging **RESULTING IN** delayed diagnosis/treatment/intervention and poor outcomes for patients and potential litigation .	Weekly Business Contingency meetings with all Health Boards. WG directive is to share capacity regionally. Clinical stratification of patient priority - USC i.e. imaging at Princess Of Wales. Use of Mag Trace or alternative for SNLB - Breast Services	Update January 2024 Risk reviewed at the end of November 2023. Weekly meeting regionally, engaged with pharmacy Royal Glamorgan Hospital (RGC), dispensing training arranged at RGH with support from Cardiff and Vale clinical scientist, ARSAC license in place, reviewing Delegated Authorised Guideline (DAG) (under radiation protection legislation)for authorising and reporting. USC patients currently being seen in POW as most clinically vulnerable. Will continue to review on a weekly basis. Potential backlog for non USC work. Next review scheduled for mid-January 2024. Update 9th January 2024 - Update 9.1.24: New Service Level Agreement (SLA) required with Swansea Bay, currently in progress. All CTM patients being scanned at Princess of Wales Hospital (POW). Score remains the same, Update March 2024: Risk reviewed on the 19th February 2024 and remains unchanged in terms of mitigation and score as reflected in January 2024. Next review end of March 2024.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	19.2.2024	31.03.2024
4	5276	Director of Digital	Central Support Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety Digital Healthcare Wales interdependencies	Failure to deliver replacement Laboratory Information Management System, LINC Programme, by summer 2025,	**IF:** the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025. **THEN:** operational delivery of pathology services may be severely impacted. **RESULTING IN** potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.	Currently LINC Programme reports progress against timeline to LINC Programme Board and Chief Executive Group. Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	Update January 2024 - This risk was discussed at the LIMS Programme Board on the 9th January 2024. The outcome of the discussion was to retain the risk on the Organisational Risk Register as the risk priority remains high due to reporting issues across all Health Boards. Local build is going well although there are risks in terms of resources. Paper submitted to ELG requesting resource within the department to support the implementation for the next two years. Risk score remains unchanged at present. Update March 2024 - risk to be reviewed a the next LIMS Deployment Programme Board meeting on the 21st March 2024. It is anticipated that the risk score will decrease once Pathology fixed term IT posts are in place.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	04.03.2024	31.03.2024
5	4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update March 2024: Pressure has remained very high across the system over the winter months and the risk scoring remains unaltered. There is daily scrutiny across the organisation and actions being undertaken including the following: • Management focus remains strong within the area of Flow – ensuring that as much as possible, beds are used efficiently; • Within Planned Care, outsourcing has largely stopped, with the UHB now insourcing instead, focusing on increasing theatre capacity and activity and running the system at maximum capacity; • Outpatient activity is now running at pre-Covid rates, ensuring that patients are seen as soon as possible. They are prioritised on the basis of urgency and priority as is appropriate; • Activity within Inpatients and Daycases is increasing month on month; • The Navigation Hub is well embedded now in the screening of nursing homes and hours are increased when the demand is present and resources available. The whole issue of providing timely care to patients remains front and centre of all the work undertaken by the Health Board with resources focused on ensuring that the situation continues to improve, no matter the difficult context. No change to risk score.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	4.3.2024	04.04.2024
6	4071	Chief Operating Officer Planned Care - Care Group	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update January 2024 - Further work undertaken in streaming the Haematuria pathway. Work undertaken with Bowel screening Wales. Next review 5.2.2024. Update March 2024 - no changes to risk update on this occasion and review of risk score has not led to any changes.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	27.2.2024	31.03.2024
7	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 March 2024 A Harm Review Panel set up to monitor and investigate incidents has identified and mitigated risk areas. Glaucoma: • Substantive glaucoma consultant appointments have commenced work in RGH and POW supported by two locum consultants. • Outsourcing of longest waiting referrals is active with harm review panel oversight. • Business Case completed for expansion of Ophthalmic Diagnostic and Treatment Centre community services in Maesteg and YCC. • WGOS4 manual publication promoting discussions on shared care of uncomplicated cases with community optometery. Intravitreal Injection Service: • Prioritised to reduce delays in injections • Harm Review Panel identified administrative changes required to substantially reduce incidents arising Cataract: • Long waiting patients outsourced as part of a South East Wales regional plan to increase cataract surgery capacity. • Additional theatre capacity identified in POW with increased theatre staff and extra surgeon involvement Risk score reviewed and remains unchanged.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2014	27.2.2024	31.03.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
8	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 March 2024 - the Care Group continue with new governance arrangements to give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Performance Group and Stroke Programme board now fully established to focus on the performance and actions for improvement. • Consultant recruitment remains challenged. • On the 18th December the Brainomix AI Software (reporting for CTs and CT angiograms to minimise delays in referral for thrombectomy) was implemented and a report on its early stages was presented at February's Programme Board. It reported that whilst the access to view CT scans was much improved that the current stage of development of the AI was not sufficiently reliable for the reporting of scans. • The South Central Regional Stroke Programme continues in developing options towards a regional solution for stroke services. • Consultant vacancy - discussions are underway to explore opportunities for a Regional approach with Cardiff and Vale to support the Service. • In order to improve the performance of our Stroke service across both PCH and POW a proposal has been developed that would increase the CNS cover up to 24/7. Decision awaited on this. If approved and implemented this should contribute to improving the % of patients admitted to a stroke ward within 4 hours and the number of eligible patients thrombolysed door to needle time of >45mins. • A proposal has been made to expand the remit of the Stroke Data co-ordinator role at PCH to incorporate POW to achieve consistency of process and data collection and robustness across both sites. • The Early Support Discharge Service has been extended to Bridgend to improve equity across the Health Board. • There are challenges to meet demand at the front door at both sites and achieve effective discharge pathways, this is impacting flow across the system, which is an issue in relation to the ring-fencing of Stroke beds, CT scans and conveyancing of self-presenting patients at RGH to PCH. This is not however a CTM only issue as reflected in the National Review of the impact of Flow on Stroke services. An improvement plan is in place to address the national recommendations.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	27.02.2024	31.03.2024
9	5462	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Adult weight management service - Insufficient capacity to meet demand	**If** there is insufficient capacity within the adult weight management service to meet the demand **Then** patients will not be offered timely intervention in line with the All Wales Weight Management Pathway. The current waiting list is over 6 years. **Resulting in** missed opportunity to support activated patients who want support with their weight. Patients will live with over weight or obesity for longer and will be at high risk of a range of obesity related long term conditions such as developing or worsening type 2 diabetes, long term MSK, CVD and some cancers.	People are offered the lowest intervention required in line with the Health Weight Healthy Wales pathways. Those that are waiting are being supported with 'waiting well' signposting. Digital opportunities are being explored to maximise efficiencies within pathways as well as maintaining communication with patients to manage expectations on waiting list times. Existing services, both within the Health Board and with community partners are being maximised and integrated within pathways.	Update January 2024 Last review 15.12.23 next review 11.03.23 Current actions are the monitoring of capacity and demand alongside pathway redesign. Mitigations via provision of an interim offer of a level 2 service have been fully explored. 1300 people remain on the waiting list. There was a 47% response rate to the partial booking letters sent in November. If this trend continues, estimated waiting time will reduce from 6 years to under 3 years. Initial findings from evaluation of pathway redesign (group interventions) will be completed in Quarter 4, from which further capacity mapping will take place. Update March 2024 - no change. risk scheduled for review in March 2024.	Quality & Safety Committee People & Culture Committee Population Health & Partnership Committee	20	C4xL5	8 - (C4xL2)	↔	07.06.2023	15.12.2023	11.03.2024
11	3826 Linked to 4839 and 4841 in Bridgend Linked to 4462	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Emergency Department (ED) Overcrowding	**If:** As a result of exit block due to hospital capacity and process issues patients spend excess amounts of time within the Emergency Department. This is manifested by, but not limited, to significant 12 hour breaches currently in excess of 400 per month. There are also large numbers of patients spending longer than 24hrs and 48hrs within the ED (please see attached information). **Then:** patients are therefore placed in non-clinical areas. **Resulting In:** Failure to deliver Emergency Department Metrics, Poor patient experience, compromising dignity, confidentiality and quality of care. The ability for timely ambulance handover with extensive delays for patients requiring assessment and treatment. Filling assessment spaces compromised the ability to provide timely rapid assessment of majors cases; ambulance arrivals and self presenters. Filling the last resus space compromises the ability to manage an immediate life threatening emergency. Clinicians taking increasing personal risk in management of clinical cases. Environmental issues e.g. limited toilet facilities, limited paediatric space and lack of dedicated space to assess mental health patients. Some of the resulting impact such as limited space has been exacerbated by the impact of the Covid-19 pandemic and the need to ensure appropriate social distancing.	Increased number of nursing staff being rostered over and above establishment. Additional repose mattresses have been purchased with associated equipment. Additional catering and supplies. Incidents generated and attached to this risk. Weekly report highlighting level of above risk being generated. All patients are triaged, assessed and treatment started while waiting to offload. - Escalation of delays to site manager and Director of Operations to support actions to allow ambulance crews to be released. - Rapid test capacity in the POW hot lab has recently increased with a reduction in swab turnaround times. - Expansion of the bed capacity in YS to mitigate against the loss of bed capacity in the care home sector and Maesteg community hospital. - Daily site wide safety meeting to ensure flow and site safety is maintained. - There is now a daily WAST led call (including weekends) with a senior identified leader from the Health Board representing CTM and talking daily through the plans to reduce offload delays across the 3 DGH sites. -Twice weekly meetings with BCBC colleagues to ensure that any delays in discharge are escalated at a senior level to maximise the use of limited care packages/ care home capacity. -Appointment of Clinical Lead and Lead Nurse for Flow appointed Feb 21 - Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. - Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	Update March 2024 - The Unscheduled Care Group Senior Management Team reviewed current ambulatory pathways and the site based clinical teams are in the process of developing an Standard Operating Procedure (SOP) relating to fit2sit. The Care Group also continue to explore the potential to expand ambulatory footprint at the Princess of Wales site. Following the successful bid for WG funding for RGH nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), PCH Ambulatory plans are in place to complete this work by April 24. This will improve patient experience within these departments. This remains an ongoing risk for all 3 sites and is reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With the recent onsite of winter pressures, risk rating to remain at 20.	Quality & Safety Committee Planning & Performance Committee	20	C4xL5	12 (C4xL3)	↔	24.09.2019	27.2.2024	31.03.2024
12	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH).	**If:** the Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department (ED) at the RGH; **Then:** the Health Board will be unable to deliver safe, high quality services for the local population; **Resulting in:** compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update March 2024 - Unscheduled Care Group Senior Management Team risk reviewed, nurse establishment review continues in RGH ED, invest to save paper submitted for RGH ED nursing staff. This forms part of the investment cycle for the financial period 24/25 In the interim the requested staffing level has been achieved via bank and agency and the Care Group hope to reduce and or close this risk in the future months. Risk score remains 20.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	20	C4xL5	12 (C4xL3)	↔	20.02.2014	27.02.2024	31.03.2024
13	5417	Chief Operating Officer	Primary Care and Community Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Paediatric Dentistry - General Anaesthetic (GA) theatre list	**If...** Regular additional GA theatre lists (necessary to meet current and future demand) are not made available to the Community Dental Service team for paediatric GA. **Then...** the number of children waiting list for assessment and treatment will continue to increase beyond 1000 by March 2024. **Resulting in..** 1. children waiting increased times for assessment/treatment who have high levels of dental caries and painful teeth requiring extraction, 2. a further increase in the number of children requiring GA, due to long waits for assessment more children need GA when assessed, conversion rate has jumped form 48% to 80%. Children can only wait 8 wks form assessment to treatment therefore there is a large backlog of assessments due to limited GA lists to provide treatment.	Current theatre lists are run on Monday mornings and Friday afternoons and are likely to be cancelled due to bank holidays. This impacts the running of the service, no additional lists are available when lists are missed. There are currently 800+ patients waiting for appointments, with some already waiting for 17 months. Patients are advised to return to their General Dental Practitioner (GDP) if they experience pain, some children are being prescribed multiple courses of antibiotics to ease dental infections that can only be alleviated by tooth extraction. There is a risk these patients will require the removal of more teeth/more require GA when assessed/children will present as an urgent case in Accident and Emergency if left untreated.	The mitigating action for this risks is the allocation of the Adhoc additional lists by secondary care- if the Care Group can secure these regularly it will improve the output on the list resulting in more patients being assessed and being seen for treatment. The lists do not need to be permanent but regular for a period of time to address the backlog, more children are converting for GA due to the long wait, if the Care Group can get through the backlog and see patients more quickly the conversion rate should decrease and the need for additional lists will reduce. This risk was opened in April 2023, the score has recently increased resulting in escalation to the Organisational Risk Register. The rational for the increase is that the existing theatre lists were not sufficient and additional list to support the backlog and additional referrals has still not been identified. The waiting list is continuing to grow and more children are requiring multiple teeth removing that require a double slot on the GA list which reduces capacity even further/more converting to GA due to extensive waits.	Quality & Safety Committee	16	C4xL4	9 C3xL3	New risk escalated to the organisational risk register in March 2024	20.04.2023	05.03.2024	31.03.2024
14	5658	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Creating Health Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Dietetic service provision to Princess of Wales (POW) Critical Care	**If** there is no dietetic service to POW critical care... **Then** this will impact on the safe and effective provision of nutrition and hydration to critically ill patients... **Resulting in** poorer nutrition provision and increased rated of malnutrition, which in turn lead to increased risk of infection, dependency on mechanical ventilation, poorer patient outcomes, increased length of stay and longer rehabilitation and recovery times following critical care. In addition to increased health utilisation costs, inequity of service provision across CTM critical care units, and non compliance with national standards and guidance as highlighted in critical care peer review.	At present there is no dietetic provision to POW critical care unit due to lack of specialist critical care dietitian on the POW site and lack of funding. Therefore the nutritional needs of critical care patients on the POW site are managed by the critical care Multi Disciplinary Team.	Establish funding for POW critical care dietitian. Meeting with POW Critical Care to discuss risk and mitigations and explore solutions to funding the position as per Guidelines for the Provision of Intensive Care Services (GPIC) Standards. Timeframe March 2024.	Quality & Safety Committee. People & Culture Committee - Workforce aspect	16	C4xL4	8 (C4xL2)	New risk escalated to the organisational risk register in March 2024	19.12.2023	24.01.2024	8.3.2024
16	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	The impact of "Right Care Right Person" approach.	**If:** South Wales Police (SWP) implement Right Care Right Person **Then:** In some circumstances the Health Board will not be able to routinely call upon SWP to assist with people in mental health crisis or with social care issues, for example, missing patients, welfare checks and supervising people who are detained on S136 Mental Health Act. **Resulting in**: Increased risks to our staff and the people who use our services.	Multi-agency planning meetings have been arranged to review policies. This is an emerging picture and one which the Health Board are developing a fuller mitigation against, it is also a picture which has a gradual phased roll out over the next year. Nurse Director for the Care Group will be drafting a report for Operational Management Board later in the month but timelines have not allowed for this at submission to the Organisational Risk Register.	The Health Board will gather and analyse available data to further understand the issues and impact The Health Board will explore options to manage the need in a different way. Risk likelihood assessment: Initial data gathering suggests that the likelihood is more likely to be weekly and not daily. Update March 2024 - Phase 1 of RCRP commenced 26/02/2024. Head of Nursing for MHLD Care Group is tactical lead. Awareness sessions attended by over 250 staff. Health Board wide planning meeting continues to meet. Daily troubleshooting Multi-agency meetings with South Wales Police continue.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3XL4)	↔	08.12.2023	29.02.2024	30.04.2024

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17	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Backlog of Reporting Radiology Examinations	**IF** there is consistent backlog of Radiology reports **THEN** there will a delay in patient diagnosis and treatment, which could lead to poorer patient outcomes **RESULTING IN** deterioration of health and potential death. All radiological examinations should be reported in a timely manner. There is a risk of delay in diagnosis of patient condition and any additional interventions/treatment that may be required following diagnosis due to an excessive backlog and increasing demand in imaging services. There is also a risk of damage to the reputation of the Organisation due to the failure to meet performance targets. The reporting backlog has been compounded by; Reduced effective Radiologist workforce due to retirements, sickness, secondment, maternity leave and limited available Radiologist workforce. RadIS merger which caused problems for outsourcing as prior imaging has not been available as it previously has been. National Cyber attack, computer & RadIS patches which caused two weeks downtime for reporting. Colon CT - All barium enema examinations are now scanned in CT which has increased the specialist reporting significantly with no increase in Radiologist support. Long term inability to recruit Radiologists as there are insufficient numbers trained in the UK. There is also risk of work related stress due to pressure placed on existing Radiologist workforce to meet the demands of the service.	Radiologists performing extra reporting sessions in addition to their normal working hours. Radiographers trained to report accident & emergency images. Up to date job plans for all Radiologists. Datix incident and concerns procedures in place. Data tracked weekly.	Update January 2024 Risk reviewed in November 2023. Risk reduced from 20 to 16 due to additional funding secured, £300,000 non-recurrent until end of March 2024, to be used for outsourcing reports. 250 CT per week, 200 MRI, monitoring to adjust greatest need. 6.5 consultant vacancies still stand, with active recruitment ongoing. Risk score remains under review as likelihood may increase when funding's ends due to sustainability. Risk to be reviewed mid January 2024. Update March 2024 - risk reviewed and there was no change to mitigation, which remains ongoing, and risk score. Next review 18th March 2024.	Quality & Safety Committee Planning Performance & Finance Committee	16	C4xL4	4 C4xL1	↔	08.02.2017	22.02.2024	18.3.2024
18	5579	Executive Director of Public Health Executive Director of Therapies & Health Science	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Lack of Children and Young Persons Weight Management Service	**If** there is no children and young person's weight management service **Then** the Health Board will be unable to support children and young people to manage their overweight and obesity **Resulting in** non-compliance with national standards and pathways, significant risk to patients with increase in childhood obesity rates, obesity related conditions, healthcare costs and no improvement in the health of the most disadvantaged.	Some Level 1 weight management service exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), these programmes are currently fixed term funded until end March 24. There is no level 2 - multicomponent service or level 3 - specialist MDT service. An option appraisal for the introduction of a children and families weight management service has been undertaken.	Update March 2024 - Communication has been sent out to Children and Families and DTPS care groups to clarify the current level 1 service and that there is no current level 2 & 3 offer within CTM. Written information was sent to care groups on 19.2.24 advising that all referrals should be signposted to first line advice. The business case completion is delayed due to operational pressures, a revised target completion date is 1.3.24.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	19.1.2024	29.3.2024
20	4907	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Redress cases efficiently and effectively	**If**: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNB Ophthalmology Redress/Claim cases **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * Regular reports run on all Redress cases, with monitoring by the Head of Legal Services & Legal Services Manager The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update March 2024 - The Legal Services team continue to prioritise other areas of work which have risk of penalties i.e. LFERs and Inquests. An SBAR proposal for a member of the team to undertake some overtime to address extra redress cases has been developed. New invest to save bid has been prepared and is being reviewed. A demand versus capacity versus productivity assessment is being undertaken and will be completed early March. Redistribution of work within the team is being explored.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	29.2.2024	01.04.2024
21	4908	Executive Nurse Director / Deputy Chief Executive	Central Function - Patient, Care and Safety	Assistant Director Quality & Safety	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Failure to manage Legal cases efficiently and effectively	**If:** The Health Board was unable to sustain ongoing funding for the two temporary Legal Services Officers **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from lack of capacity to management cases in a efficient and effective manner, which could result in failure to comply with the WRP procedures resulting in financial penalties	The Health Board are developing an action plan in response to the Welsh Risk Pool review, which includes the reviewing structures and workloads New operating model in respect of quality, safety and governance almost fully implemented. New systems and processes, including escalation, implemented to assist to effectively manage cases. The Assistant Director of Concerns & Claims, Head of Legal Services and Legal Services Manager are all carrying case loads to help mitigate this risk. The team are having to apply an objective triage approach across the portfolio of redress, LFERs and Inquests to support the mitigation of this risk.	Update March 2024 - The Business Intelligence team has produced a report for the Legal Services team and the Care Group teams which provides statement request and progress details. Inquests are now being graded to identify high risk inquests (Red, Amber and Green). Legal Services staff are in the process of reviewing older inquests. Regular meetings continue with Legal and Risk and HMC to ensure open communication in order to manage any issues more efficiently. New process has been developed in line with the Coroners new directions. This has been circulated across the Health Board. Members of Legal Services team now attend Governance meetings to assist with review of statement progress, to provide assistance, identify issues and escalate where necessary.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	29.2.2024	01.04.2024
22	5404	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Post Mortem Backlogs in Mortuary	**IF:** the Coronial service fails to ensure consultant Pathologist capacity to undertake post mortems to meet the increasing demand across the Health Board region. **THEN:** There will be delays in performing and reporting autopsies. **RESULTING IN:** * Mortuary capacity breaches * Inability to store deceased appropriately including long term freezer storage of which the Health Board only has 8 spaces. *deterioration of deceased due to length of stay leading to poor experience for the bereaved and complaints *Failure of the Health Board to provide a quality Bereavement service to the population. * Families not being able to view loved ones due deteriorating condition of the deceased due to prolonged storage *Non-compliance with HTA regulatory requirements and current WG bereavement framework principles *Reputational damage *Reliance on additional contingency storage creating financial risk for the Health Board	Additional contingency storage in place. Weekly situation meetings with Coroner's Office to assess current situation. Short term use of Locum pathologist by service provider commissioned by the Coroner's Office using our current supporting APT resource whilst Pathologist on leave.	Update March 2024 - Maintaining weekly meetings to monitor backlog. Current backlog being maintained at 8 days with the use of additional sessions. Application for Planned Activity Additional Rate (PAAR) to be submitted (funded by the Coroner) to support weekend additional sessions to improve flex to demand increases.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	05.03.2024	02.04.2024
23	3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Mortuary Capacity	**IF:** There is insufficient Mortuary capacity across the Health Board, including bariatric capacity **THEN**: the Health Board will be unable to accommodate any increases in deaths (due to seasonal pressures, pandemics, general increases in service demand), and may exceed capacity in the event of Mortuary closure or refrigeration failure, or funeral directors/undertakers being unable to collect bodies or move bodies between sites due to adverse weather. **RESULTING IN:** bodies not being placed in storage that is in compliance with HTA licencing standards, No capacity for bariatric bodies, leading to HTA reportable incidents, complaints and reputational damage.	Mortuary capacity log is in operation and informs the pathology scorecard for monthly reporting (average, max and min). Business continuity plan is in place to move bodies around the sites to ensure capacity is maintained within the HB. This relies on the Health Boards contracted funeral director to move the bodies in an appropriate and dignified manner. Mortuary staff are trained to complete the mortuary capacity log on a daily basis and to ensure the business continuity plan is executed in the event of likely capacity issues. Nutwell units in use at Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) "Real time" capacity white board installed in both mortuaries so porters/APTs can visualise quickly capacity issues. Private ambulance with a dedicated driver, now in use between sites. 4X4 vehicle so can be used during inclement weather (within reason). Can transport up to 4 deceased per journey, in a dignified manner.	Update March 2024: Daily monitoring of capacity continues. Occupancy appears to be reducing. Risk of further seasonal spike in deaths is still high. Bank Holiday weekend at month end also likely to place additional demand on Mortuary body storage capacity. Further risk by the MES becoming Statutory, increasing it's remit in April. Planned works at the University Hospital of Wales Mortuary places additional risk around regional Mass Fatalities incident(separate risk to be created). Nutwell units still being utilised to manage capacity at Royal Glamorgan Hospital (RGH) which provide an undignified solution to body storage capacity management at RGH site. Dignity in Death Workshop engaging stakeholders in process scheduled for 7th March.	Quality & Safety Committee	16	C4xL4	C4xL2	↔	05.03.2018	05.03.2024	02.04.2024
24	5254	Executive Nurse Director / Deputy Chief Executive	Centre Support Function - Quality Governance - Concerns and Claims	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to manage Redress cases efficiently and effectively in respect of Duty of Candour	**If**: The Health Board is unable to meet the increased work demand in respect of the implementation of Duty of Candour **Then:** the Health Board will not be able to manage cases in a timely manner and will not meet the required targets in respect of Putting Things Right. **Resulting in:** Risk to quality and safety of patient care, resulting from poor management of cases. Financial impact to the Health Board from Redress cases which have been poorly managed and consequently proceed to claim.	Controls are in place and include: * New incident framework developed * Engagement with the All Wales Duty of Candour Network to discuss implementation of the Duty * Reports run on predicted case numbers * Request to the All Wales Duty of Candour Network that an impact assessment is undertaken	Update March 2024 - The Legal Services team continue to prioritise other areas of work which have risk of penalties i.e. LFERs and Inquests. A SBAR proposal for a member of the team to undertake some overtime to address extra redress cases has been developed. New invest to save bid has been prepared and is being reviewed. A demand versus capacity versus productivity assessment is being undertaken and will be completed early March.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	29.02.2024	01.04.2024

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1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
26	3133	~~Chief Operating Officer~~ Executive Director of Nursing / Deputy Chief Executive	~~Central Support Function -Facilities~~ Patient Care and Safety	~~Governance and compliance manager, Facilities~~ Head of Clinical Education	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Poor compliance with Medical Gas Safety Training .	**If:** Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. **Then:** Staff are not being trained in safe storage and flow of cylinders (e.g. oxygen). **Resulting In:** Failure to adequately and safely obtain and continue flow of cylinders (e.g. oxygen), potentially causing harm to patients.	PSN041 Patient Safety Notice and local safety alert disseminated to all staff. Posters developed and displayed in areas to encourage attendance. New staff trained at induction. TNA has been undertaken. Refresher training is undertaken, however current attendance levels by clinical staff for Medical Gas Safety training is poor, hence the current risk score. Medical Gas Cylinder Policy developed with training section completed by Medical Device Trainer, referencing the mandatory requirement for training by all users. Completed To make it a key requirement that staff can be released to attend training to re-enforce safety and operating guidelines of medical gas cylinders. Completed. Medical Device Trainer has put in place a B4 role who is undertaking a rolling programme for Medical Gas Training, with two sessions, twice a month, at each ILG every month. However, although training has been undertaken for Porters and graduate nurses, nursing staff currently in post are still not attending and attendance continues to be poor due to current circumstances with Covid-19 and due to not being able to be released for the 2 hours of training. Medical Device Trainer and Assistant Director of Facilities to request again for the Executive Director of Nursing Midwifery and Patient Care to review nursing attendance and make the necessary arrangements to allow nursing staff to attend training and also to look at the possibility of introducing a 'training day' that will allow nursing staff to be released to attend those courses that are struggling with attendance levels. Meeting held and COO has requested for Facilities to work on a monthly Medical Device Training Compliance report template that can be presented to both COO and ILG Director leads to inform current compliance position and actions to improve attendance and compliance for all courses including Medical Gas Training. Medical Device Trainer has stated that the current report template needs to be reconfigured to account for the change of wards and Directorates for the new ILG structure and to deal with the pandemic, this will take time to complete, hence the change in action implementation date to account for this.	Update March 2024 - New module of training and education related to medical gases has been introduced in collaboration with Learning & Development and All Wales ESR Team to improve compliance and flexibility for all relevant staff to undertake training. Risk score to remain unchanged until training embedded.	Quality & Safety Committee. People & Culture Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	04.03.2024	30.04.2024
27	4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Back log for Imaging in all modalities / areas and reduced capacity	**If:** there is a backlog of imaging and reduced capacity **Then:** waiting lists will continue to increase. **Resulting in** delay and diagnosis and treatment. Due to the Covid-19 outbreak, all routine imaging has stopped and there is reduced capacity for imaging of USC sand Urgent patients.	Due to the Covid-19 outbreak, all routine imaging was curtailed in line with recommendation for the lockdown periods, resulting in reduced capacity for imaging of Urgent Suspected Cancer (USC) and Urgent patients. It is likely to take many months or even years to get back to a pre-Covid state without additional planned care recovery financial support. However, the Welsh Government (WG) target is to return within the 8-week standard for all patients by March 2024. Cancer waits have been prioritised and are now being undertaken within around 2 weeks with the exception of CT scans which are still around 4 weeks at present.	Updated January 2024. Risk reviewed 22.11.2023. Non obstetric Ultrasound 7050 pts - 98 week wait - in-house Waiting List Initiatives (WLI), evenings and weekends MRI 2693 PTS - 50 week wait (main cohort of patients at 20 weeks) ongoing validation and planning for booking more complex cases e.g. arthrograms and General Anaesthetic paediatric lists. CT 2174 pts - 52weeks - active validation and cross site booking in progress Active review of compliance with Referral To Treatment (RTT) booking guidelines and streamlining. Next review scheduled for 15.1.2024. Update March 2024 -MRI van to be sited at CDC from April 2024.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	19.2.2024	18.03.2024
30	4906	Executive Nurse Director / Deputy Chief Executive	Central Support Function - Quality Governance (Concerns & Claims)	Assistant Director of Concerns and Claims	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to provide evidence of learning from events (Incidents and Complaints)	**If:** The Health Board is unable to produce evidence of learning from events. **Then:** the Health Board will be unable to recoup any costs from Welsh Risk Pool for personal injury or clinical negligence claims made against the Health Board. **Resulting in**: Risk to quality and patient safety with potential for further claims as learning and improvement will not have taken place. Financial impact to the Health Board	Controls are in place and include: * Monitored and reported through the weekly Executive Quality & Safety meeting. * Regular engagement and meetings with the Executive team to assist in gathering of learning. Improvement plan implemented by WRP with monthly targets to submit the backlog. * Learning From Event Report (LFER) Standard Operating Procedure devised and disseminated * LFER 'How to Guide' devised and disseminated * Ad-hoc training available on request. * Internal targeted monitoring in place.	Update February 2024: LFER status is regularly monitored in: Weekly Patient Safety, Complaints and Legal Services data meeting, Weekly Executive Patient Safety Meeting and Quality & Safety Committee. New systems and processes have been in place for some time in respect of the management of LFERs. However, benefits from improvements are now coming to fruition, with LFERs being managed in a more efficient way. If non-engagement, more timely escalation is proving successful. A deadline for the end of January 2024 has been set by WRP to submit and have approved all LFERs triggered before 1st September 2023. All deferred LFERs were submitted within timeframes, therefore 53 submitted. We have received a penalty on 1 of the cases. WRP have indicated that penalties will be applied to LFERs which are not submitted within timeframes, this remains a risk area for the health board with 16 LFERs overdue. These will be submitted, with a risk of these being Red or Amber deferred. LFER SBAR developed in readiness for Q&S Committee.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	29.02.2024	01.04.2024
33	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 Care of The Elderly (CoTE) service and no specialist advice available	Update January 2024: Senior Management Team reviewed, following clarity of ask from Executive Team. Unscheduled Care Group will hold responsibility for Consultant orthogeriatrician to be working with the wider Care of the Elderly Team on each site. Awaiting disestablishment of posts in planned care in order to fund. Risk rating remains at 16. New review date 28/02/24. Update March 2024 - Previous update remains, Orthogeriatrician service model is being reviewed in CTM as part of the trauma and orthopaedic reconfiguration of service. SMT reviewed and has requested that this risk is transferred to planned care Directors for management. SMT again reviewed Awaiting disestablishment of posts in planned care in order to fund. This forms part of the investment cycle for the financial period 24/25.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	27.02.2024	31.03.2024
34	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to recruit sufficient medical and dental staff	**If:** the CTMUHB fails to recruit sufficient medical and dental staff. **Then:** the CTMUHB's ability to provide high quality care may be reduced. **Resulting in:** a reliance on agency staff, disrupting the continuity of care for patients and potentially effecting team communication. This may effect patient safety and patient experience. It also can impact on staff wellbeing and staff experience.	• Associate Medical Director for workforce appointed July 2020 • Recruitment strategy for CTMUHB being drafted • Establishment of medical workforce productivity programme • Work to understand workforce establishment vs need • Development of 'medical bank' • Developing and supporting other roles including physicians' associates, ANPs -Improving induction and development of new doctors	Update March 2024 - led by the Change Hub Programme Team, in collaboration with the Care Group leads and Chief Operating Officer, the Medical Workforce Productivity Programme (MWPP) has now been reformed to focus its efforts on workforce performance across the health board. There are now two accountability groups that meet monthly (Performance and Escalation Group & Workforce Framework Group) - these feed in to the MWPP, Value and Efficiency, and then Transformation Board. No change to risk score.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	04.03.2024	31.05.2024
35	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.	Update March 2024 - Realignment of budgets completed - 3.5 wte AHP going currently out to advert. Once successfully recruited into, the capacity available within the team will meet the demand. Further discussion and investment to address backlog of patients will be required.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	22.2.2024	28.3.2024

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
36	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Fire Enforcement Notice - POW Theatres.	**IF:** The Health Board fails to meet fire standards required in this area. **Then:** the safety of patients, staff, contractors/visitors etc. and the protection of the buildings could be compromised. **Resulting in:** potential harm, risk of fire. Possible further enforcement in the form of prosecution.	Storage room obtained on ward 16 to store theatre equipment to ensure evacuation corridor is kept free for evacuation. Staff training on lift evacuation. Closed storage cupboards purchased for safe storage of equipment. "safe" areas identified with Senior Fire officer for storage of equipment in corridors. Weekly meetings to discuss and plan building work necessary to meet requirements of the enforcement notice. Enforcement notice has been extended to December 2023. A meeting has been arranged with FRS in November with plans with a view to gaining a further extension. Need to plan for drop in theatres to mitigate work commencing	Update January 2024 - A request was made to South Wales Fire & Rescue Service (SWF&RS) to extend the Fire Enforcement Notice by a period of 2 years to enable the remedial scheme to be implemented. SWF&RS have initially agreed an extension of 12 months, with the agreement the Health Board could apply for a further extension if necessary. The current Notice is now due to expire on 1st January 2025. There is documentation on this available on request from the Assistant Director of Health, Safety & Fire. Update March 2024 - status of the Fire Enforcement Notice remains as outlined in January 2024. Business Case is in development for Welsh Government Funding and is due to be submitted by October 2024.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	05.3.2024	06.05.2024
39	3337 Linked to RTE Risk 4813 and M&C 4817. Also linked to 4804.	Chief Operating Officer Director of Primary Care and Mental Health Services	Central Support Function: Digital & Data Mental Health Care Group	Lead Infrastructure Architect Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Creating Health	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Use of Welsh Community Care Information System (WCCIS) in Mental Health Services	**If:** Mental Health Services do not have a single integrated clinical information system that captures all patients details. **Then:** Clinical staff may make a decision based on limited patient information available that could cause harm. **Resulting In**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace.	Control measures updated September 2023. 1. A PID has been developed which outlines the processes, resources and timelines sought - this to be discussed in September Programme Board. 2. The Business Case to be refreshed on the back of the PID once approved. It will need to identify additional staff resource required to progress the disaggregation process to bring all CTMUHB staff who currently use WCCIS via local authority over to CTMUHB WCCIS platform. Requires Programme Board approval. 3. Business case to be progressed following Board approval. 4. A new MHLD Care Group risk will be developed relating to the operational mitigations required in the interim to support safe communication and this will be held by the High Quality Clinical Record group, part of the Inpatient Improvement Programme	Update March 2024 - There is still no confirmation of national replacement system as yet. The Health Board and Care Group are exploring alternative interim digital systems and there are 2 events in March to look at the suitability of the PARSI and RIO systems. The mitigation and risk score remains unchanged.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	05.03.2024	31.07.2024
40	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	New Mental Health Unit	**IF**: Mental health inpatient environments fall short of the expected design and standards. **Then**: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. **Resulting in**: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation – Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 – 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	Update March 2024 - Still Awaiting a feasibility review on Mental Health inpatient space that will support the mitigation for this risk. Care Group Director engaging with the Capital Team on progressing this at present. No change to risk score at this stage.	Quality & Safety Committee	15	15 (C3xL5)	6 (C3xL2)	↔	15.06.2021	29.02.2024	01.07.2024

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
4922	Director of Corporate Governance Interim - Executive Director of Nursing	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management	IF: The Health Board doesn't prepare appropriately for the Covid-19 Inquiry THEN: the organisation will not be able to respond to any requests for info RESULTING IN: poor outcomes in relation to lessons learnt; supporting staff-wellbeing and reputational issues.	The Covid-19 Inquiry Working Group are monitoring a number or preparedness risks such as: - Retention and Storage of information, emails and communication - Capturing reflections of key decision makers prior to any departure from the Health Board - Organisational Member. The Health Board has a Covid-19 Inquiry CTM Preparedness Plan which is monitored via the Covid-19 Inquiry Working Group. The Board and Quality & Safety Committee received a detailed update on the preparedness progress at their respective meetings in March 2022 and September 2022. The Assistant Director of Governance & Risk is the first point of contact for any Inquiry contact and the Executive Director of Nursing is the Interim Senior Responsible Officer (SRO).	Update March 2024 - Covid-19 Inquiry Project manager has been working with the Head of Information in the digital team to explore automation options to support the archiving and cataloguing of information. It is important to note that the archiving will be a hybrid approach. While the automation will undoubtedly save time – it will extract properties data from files within a specified folder, this can then be manipulated to speed up the coding as well as the capture of this data, there is still a need for manual elements such as description and identifying keywords. There is also a need to be able to capture Adhoc files and data. A form/workflow has been designed that will incorporate these elements also to support the archiving process.	Quality & Safety Committee	12 (Risk score reduced from a 16 in March 2024)	8 (C4xL2)	The system for the timeline is now in place and population of information linked to the repository has commenced. The resource implications are significant and therefore it will take some time for the Health Board to map and archive all information, however, it is considered appropriate to reduce the likelihood score from a 4 to a 3 at this stage.
3008	Chief Operating Officer	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Risk of injury due unavailability of opportunities to train and maintain compliance with Manual handling training.	**If:** There is a lack of manual handling training there is the risk of potential injury to a member of staff or injury to the patient. **Then:** There are a number of clinicians who have not had the opportunity to meet the requirements for manual handling training. **Resulting In:** Potential harm being caused to both staff and patients.	1. Staff are aware of the risks associated with manual handling. 2. All staff have been informed to consider the ergonomics of the environment that this activity is being undertaken. 3.Appropriate equipment is available in the clinical areas or on request from the MH team e.g. pat slides, slide sheets, hoists. 4. Manual Handling risk assessments are incorporated into the admission bundles 5. The training group are planning training for clinical staff with the manual handling department - current position that this can not be supported 6. Ask other HB`s their MH requirements SBUHB online training package to be shared. 7. Directorate will Seek out any opportunities for online updating to support current practice 8. 2 registered nurses to undertake train the trainer and initially cascade to community midwifery staff, commencing Sept 2022. 9. Staff member identified to action monthly module B training to facilitate improvement in knowledge and skills- agreed 11.10.22 10. In agreement with MH team 2 midwives to undertaken 5 day TTT course for manual handling in July. Meeting arranged with MH team to arrange bespoke 3 hour course for all midwives to be implemented 2023/2024 for 100% compliance in 12 months.	Update January 2024 - Bespoke Manual Handling training was commenced in Sept 2023. The plan is that the agreed sections of the All Wales Manual Handling Passport will be completed by all staff over a 2 year period. Year 1 (Part1) – Mod A, B, part of C Year 2 (Part 2) - Mod C, D and E (with agreed exceptions) With regards to compliance, the majority of staff are already rostered to attend Part 1 between Sept 23 – July 24. A follow up email was sent to line managers and roster managers before Christmas reminding them to book on any staff who had not already been rostered. With regards to Part 2, when the training dates for next academic year are released, the roster managers will roster all of there staff on to training for the entire year so that we can see the compliance trajectory and chase up rebooking staff in an efficient manner should they not attend training for any reason. Update March 2024 - on target to achieve compliance with part one of course, therefore risk score in terms of likelihood reduced.	Health, Safety & Fire Sub Committee of the Quality & Safety Committee	6 (Risk score reduced from a 16 in March 2024)	2 (C2xL1)	Children and Families Care Group have reviewed this risk in light of the manual handling training now being mandated sessions. Service wide training is also on track to be completed by September 2025. Risk score therefore reduced in terms of likelihood from a 4 to a 2. The risk will now be managed on the Children and Families local risk register. The rationale for the reduction in consequence as well as likelihood is as follows. It is anticipated that with training and awareness sessions 3-4 hours this year and 4 hours next year, clinicians will minimise their risk of a manual handling injury and where one could not be avoided e.g. back strain leaning over a birthing pool, the impact is minimised through training i.e. changing the position more regularly reduces the potential amount of back strain.

	A	B	C	D	E	F	G	H	I	J	K
1	Datix ID	Strategic Risk owner	Strategic Objective	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Month Closed on Org RR	Closure Rationale
2	Nil										

.2Agenda Item
6.2

Quality & Safety Committee

Continuing Health Care

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Sian Lewis, Lead Nurse Continuing Health Care • Mark Abraham, Head of Commissioning MHLD
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director Primary Care Communities MHLD
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
MHLD QSRE Group	06/12/2023	Bi monthly report throughout 2023
PCC QSRE Group		

Acronyms / Glossary of Terms	
CHC	Continuing Health Care
CIW	Care Inspectorate Wales
D2RA	Discharge to Recover and Assess
ESR	Electronic Staff Record
FNC	Funded Nursing care
HEIW	Health Education Improvement Wales
MAOG	Multiagency operational group
NCCU	National Collaborative Commissioning Unit

PREMS	Patient reported experience measures
PROMS	Patient reported outcome measures
SUI	Serious Untoward Incident
MHLD	Mental Health Learning Disabilities
QSRE	Quality Safety Risk & Experience
MAOG	Multi-Agency Operational Group
LA	Local Authority
CIW	Care Inspectorate Wales
EMI	Elderly Mentally Infirm
RCT	Rhondda Cynon Taf
MDT	Multi-disciplinary team
CTM UHB	Cwm Taf Morgannwg University Health Board
NCCU	National Collaborative Commissioning Unit
CSSIW	Care Social Services Inspectorate Wales

1. Situation /Background

1.1 The purpose of this report is to provide members with an update on quality, safety, risk and experience issues in Continuing Health Care services provided across Cwm Taf Morgannwg University Health Board.

1.2 This an annual report reflects the QSRE issues for the period of December 2022 to December 2023 following on from its previous report to the Quality & Safety Committee on 24th January 2023. For the purpose of this report, the scope of Continuing Health Care (CHC) is inclusive of packages of care commissioned by the Health Board for individuals who are eligible for Continuing Health Care, Funded Nursing Care (FNC), S117 Aftercare and other joint health and social care packages.

1.3 CHC is provided across a range of settings including in hospitals, care homes and domiciliary care at home.

1.4 Continuing Health Care services are delivered and monitored through the following areas, Adult, Children and Mental Health (MH) and Learning Disabilities (LD).

1.5 Adult and Children are responsible to the Primary Care and Communities Care Group and MHLD through the MHLD Care Group. Each service group has its respective QSRE meetings held every 2 months to report, discuss and seek assurance on matters relating to CHC in these areas.

1.6 Each Care Group has a monthly cycle of Clinical Placement Panels whereby individual packages are scrutinised, approved and financed.

1.7 Additionally Clinical Placement Panels monitor the Quality and Safety of care package reviews, which are completed 3 months after inception and annually thereafter. More focused reviews are completed in response to changes in individual needs or risk.

1.8 There is a regional approach to responding to concerns within the Care Homes and Domiciliary care providers in CTM UHB in line with the national guidance on managing 'Escalating Concerns', known locally as the Multi Agency Operational Group (MAOG). This is a collaboration between Local Authorities (LA), the Health Board, Safeguarding and Care Inspectorate Wales (CIW) established to review the governance of the providers operating in the region.

1.9 The National Policy on Patient Safety Incident Reporting & Management 2023 set out specific guidance for the Incident reporting, Investigation and Management of incidents in commissioned care. du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

2. Specific Matters for Consideration

2.1 Internal Quality Assurance

2.1.1 Financial report

December 2022				
Care Group	**2022/23 Forecast of Current Packages £**	**Number of Current Packages**	**D & D**	**New Packages**
CYP	139,700	3	1	0
Primary Care & Community	13,347,452	201	184	163
Mental Health & LD	35,943,734	573	163	211
Grand Total	**49,430,885**	**777**	**348**	**374**

December 2023				
Care Group	**2023/24 Forecast of Current Packages £**	**Number of Current Packages**	**D & D**	**New Packages**
CYP	271,403	3	1	1
Primary Care & Community	14,465,615	205	187	181
Mental Health & LD	42,248,535	615	228	257
Grand Total	**56,985,553**	**823**	**416**	**439**

These figures demonstrate growth in both the numbers and the financial element of CHC in year. The clinical teams work hard to contain the cost, negotiating with the care sector and ensure that the care provision meets the assessed need and care plan of individuals.

The transformation of LD inpatient services under the Improving care Improving Lives report 2020 supports reducing the number of patients in specialist LD hospitals. The alternative community provision is challenging in terms of both capacity and cost. The cost of a complex care home bed is routinely more expensive than that of a hospital bed. Through the Regional Partnership Board Capital program LD accommodation and support services has been

prioritised and there is a mapping exercise due to publish recommendations for a future LD accommodation strategy to be developed.

There will be an additional number of individuals who receive their care through core services only, such as our palliative care patients receiving end of life care.

2023/24 saw providers request a substantial inflammatory uplift to meet the challenges of the independent sectors rising costs of care to include the minimum wage increases and staff retention.

There is an expectation that 2024/25 will have a similar trend with the added pressures of social services care allocations and further increases to the national wage.

2.1.2 Review Compliance

Under the CHC Framework 2021 there is a requirement to review all commissioned health care packages at 3 months after the package commences and annually thereafter. There is currently a 78% compliance in undertaking reviews.

Compliance has been influenced by the redirection of resources. Significant CHC Team resources were required to support the successful closure of a large EMI Nursing Home in RCT.

Additionally, the MHLD Care Group completed an equality impact assessment which supported a decision to undertake more frequent reviews of higher risk packages of care. This is intended to support patients transferring to least restrictive and less costly accommodation and support models of care.

Individual Case Mangers receive monthly supervision which prioritises the reviews. Those packages out of compliance with Commissioning reviews continue to receive clinical reviews by the MDT.

2.1.3 Compliments and Concerns

There have been 2 formal complaints this year, both related to the CHC process and eligibility outcomes. Neither complaint was upheld by the Health Board, although one was referred to the Local Authority as it related to 'Fairer Charging' responsibilities applied by them.

There have been 45 compliments received throughout the report period. Themes include; feedback on training, MDT support with complex cases, families experience and student placements.

The CHC process can be a very emotive experience and process for patients and families involved. The Team are keen to develop an appropriate set of PREMS and PROMS which to determine effect outcomes within the service. The Team are working with Patient Experience Team to identify suitable measures for commissioned care. Suitable measures to be implemented within 6 months of the report.

2.1.4 Incident Management in Commissioned Care

One new Locally Reported Incident in the report period which related to the unexpected death of a patient in Care Home. The incident remains open to Safeguarding pending outcome of the Police investigation. Wider care homes reviews were undertaken and no concerns identified for remaining patients at the home.

Two incidents closed in the report period;

One relating to patient assault in Independent Hospital where CTM patient was the perpetrator. Incident subject Safeguarding process in Gwent, subsequently closed subject to criminal prosecution. The Independent Hospital shared leaning through Safeguarding process and the remaining CTM patients at the hospital were reviewed without concern. Incident was opened and closed as Nationally Reportable Incident.

The second related to a CTM patient who died unexpectedly in independent hospital. Cause of death not determined by Post-mortem and Inquest pending. This Locally Reported Incident closed by the Health Board as no harm identified after initial investigation. However, the Health Board will monitor the outcome of the inquest and reopen for further investigation if necessary.

The publication of the national policy for Patient Safety Incident Reporting and Management 2023 includes a specific section on Health Boards responsibilities for commissioned care. Work is underway (final draft circulated for comments in January 2024) to ensure the revised Incident Management Toolkit for CTM UHB includes how incidents in commissioned care are investigated. In doing so the opportunities for learning will be sought through a whole systems

approach to incident management and discharging in part its responsibilities under the Duty of Quality 2023.

2.1.5 Appeals & Disputes

In the reporting period there have been 16 Appeals instigated by families. 10 cases have been resolved with only 1 case requiring an independent review panel consideration. The 6 remaining appeals are being progressed within the nationally agreed timescales of 6-months.

In the reporting period there have been 22 interagency disputes between Health Board and Local Authority. 10 resolved informally, 4 required Level 1 Formal resolution and 6 did not progress. 2 disputes remain under action.

2.1.6 Retrospective Claims

A Retrospective claim, enables individuals and or their legal representative to receive an independent review into their eligibility for CHC and free NHS care, we currently have 27 cases with 16 pending cases, waiting legal and financial authority to pursue.
14 cases were reviewed during 2023, of which only 10 cases identified partial or full eligibility receiving a level of reimbursement. We have seen a steady increase of requests through 2023, resulting in an increased workload. There is a strict timeframe of 6 months to consider all cases, we currently have 12 breaches in this area, mainly due to the delay in accessing care home notes. In an aim to address these breaches some additional resources have been diverted from the nurse assessor team to focus on completing case chronologies, to address current breaches and limit others reaching these deadlines.

Due to the retrospective nature of the claim, they can often have a negative impact on the financial forecasting for CHC.

2.2 External Quality Assurance

2.2.1 Escalation Concerns & Closures

One Independent Hospital and Three Care Homes within CTM UHB have been subject to 'Escalating Concerns' process in the report period. Two Nursing Homes; both resumed routine monitoring, however, the second made a decision to close at a later date. One LD

Residential setting resumed routine monitoring. One hospital resumed routine monitoring.

The EMI Nursing Home which closed was providing care for 36 CTM residents. Working in collaboration with RCT Local Authority, the provider, residents and families all 36 were successfully relocated to alternative care home provision with only a small number requiring out of area placements.

A further 3 Independent Hospitals and three Care Homes out of area with CTM patients were subject to enhanced monitoring. Two Care Homes resumed routine monitoring; one remains under escalating concerns subject to interagency monitoring arrangements. However, the 3 hospitals resulted in closure with 3 CTM patients requiring transfer to alternative Independent provision.

2.2.4 National CHC Workstream

The NHS Executive has commissioned the NCCU to undertake a review of the costliest CHC packages commissioned by Welsh Health Boards in Wales. This review commenced in October 2023 and to date the NCCU have reviewed 55 CTM MHLD Commissioned care packages. The reviews have identified potential opportunities for £271k savings with £138k realised by CTM commissioners by the end of January 2024.

Additional capacity from the NCCU was critical in identifying saving opportunities. It is important to note that the NCCU reviews are limited to reviewing records available at the time. Not all recommendations are agreed by the CTM MDT and some of the recommendations overlapped with existing CTM plans for patient progression.

A thematic review of the national learning is underway by NCCU and will be presented to the Values and Sustainability Board in NHS Executive. Initial feedback provided by NCCU identifies that the multiple record systems used by Health Boards is challenging and leads to poor business intelligence in CHC.

2.3 Hospital and Care Home Capacity

The total Nursing Care Home beds in CTM is circa of 900 beds.

The demands on EMI Nursing provision in CTM has been challenging over the report period. The Care Home closure in the RCT has been

somewhat offset with additional beds opening in the Bridgend and RCT.

The current EMI nursing bed provision in the CTM area is around 270 beds.

It is important to note that a substantial 56 bed EMI Nursing provision in Powys has been embargoed to new admissions under escalating concerns throughout the report period further impacting on EMI Nursing capacity.

The current General Nursing Provision in the CTM area is 630 beds.

The last 2 years has seen a reduction of approximately 90 general nursing bed across CTM, 40 lost due to closure, the remaining 60 changed category, providing additional residential or EMI nursing. Inability to recruit appropriate registered nurses, staff costs and CSSIW regulations have been identified issues in their decision making.

More specialist Nursing Care Home provision is available through an Independent provider within CTM and the demands of this type of provision for complex and comorbid conditions for Adults and older adults is increasing.

The beds above do not include a wider variety of Specialist residential and supported living services for MHLD. Demand on specialist LD provision is increasing due to the transformation of inpatient care and younger complex children transitioning into adulthood. This area is recognised and identified as an area of priority for the Regional Planning Board.

Secure inpatients service for females is currently limited to one site in Wales which is located in CTM region. However out of the 7 females requiring secure inpatient care 3 are within Wales and 4 in England.

2.4 Quality Improvement

2.4.1 Discharge to Recover and Assess

In 2023 saw the launch of the Discharge to Recover and Assess (D2RA) pilot for those with complex need (pathway 3). CTM UHB and Bridgend County Borough Council (BCBC) jointly commissioned 6 general nursing beds in Bridgend over a 6-month period. This provided lots of opportunity for joint working with the home. The

nurse assessors visited the home on a twice a week basis, to review and assess individual patients with a weekly multi-agency virtual board round. The majority of individuals admitted to these beds were assessed and rehomed in a suitable home or remained in a permanent bed in the home, with a small number of individuals returning home with a package of care.

2.4.2 Whole System Review

As a CHC Team considerable effort has allocated to reviewing the processes and systems to support the governance arrangements for CHC. The current processes and systems are dependent on human resources and this is complicated further by multiple electronic systems used.

The lack of automation and volume of duplication required across multiple systems results in human errors and in efficient processes.

2.4.3 Continuing Health Care Training

Under the CHC framework 2021 the CHC Team have developed training materials and dedicated roles and responsibilities for delivering training across the Health Board.

In 2023 over 450 employees were in receipt of face-to-face training.

2.5 Quality Planning and Improvement

2.5.1 Domiciliary Care Contract

Under the direction of the Commercial Contracting, Commissioning and Effectiveness work stream, we have worked closely with procurement to establish contract and service specification for Domically care to be implemented from 1st April 2024. Currently Domiciliary care commissioned on a spot purchase basis and the development of the contract and service specification will sustainability and financial governance of such packages.

2.5.2 Sustainability of CHC training

A future training plan will include ESR module and support from HEIW is being explored to develop National Training programme for Continuing Health Care.

2.5.3 Standard Operating Procedure-Joint Commissioning S117 Aftercare

CTM UHB and the three Local Authorities in the region have consolidated an agreed position for discharging their responsibilities when jointly commissioning S117 Aftercare services. The procedure will be rolled out to colleagues across MHLD services with additional awareness sessions on the revised funding application document which is intended to support outcome-based commissioning.

2.6 Quality Improvement and People's Experience

2.6.1 D2RA Discharge to Recover and Assess.

Patients admitted and families were complementary of the process. Accepting the need for long term care is challenging and as a result a number of residents remain in the care homes.

2.6.2 Court of Protection

The prevalence of Court of Protection applications in commissioned care remains proportionately high is a small service area as patients and their representatives object/appeal to receiving the packages of care determined by Health and Social Care professionals. Significant resources require allocation at short notice which impact on the wider CHC team capacity.

2.6.3 Service User Engagement

CHC Team have made contact with Improvement Cymru to review the appropriate PROMS and PREMS available to support outcome measurement in CHC.

3 Key Risks / Matters for Escalation

3.1 Multiple records systems for CHC leading to inefficient processes.
3.2 Capacity within commissioned care as demand rises.
3.3 Financial risk associated with steady increase retrospective claims.
3.4 Care Home capacity and thresholds for complexity changing as demands increase.
3.5 LD inpatient transformation resulting in high-cost models of care in community.
3.6 Current financial forecast is over budget in context of further uplift challenges next financial year.

4 Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM /Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM /Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Data to Knowledge
	If more than one applies please list below: Whole System Perspective
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe
	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	Yes - Reduce
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5 Recommendation

5.1 Note the findings of this report.

Agenda Item
7.1

Quality & Safety Committee

PATIENT SAFETY & QUALITY DASHBOARD

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.l.jenkins-forrester@wales.nhs.uk
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director of Quality & Safety
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

This presentation of the Patient Safety & Quality Dashboard to Committee provides data from 01.01.24 to 29.02.24 taken from systems on 05.03.24, unless otherwise specified.

This report contains the Patient Experience overview as appendix 1.

Key areas to note in this reporting period are:

- Number of Complaints managed via PTR (formal) has increased.
- Compliance with the 30 working day target for responding to complaints has been maintained at above 85% for January and February 2024.
- Increase in number of new PSOW referrals being received.
- The Nationally Reportable Incidents submitted has decreased in January and February 2024.
- Comparison data of reporters view on level of harm and severity post investigation included in the report.
- Slight increase in the number of medication incidents reported.
- The number of incidents reported relating to patient falls increased slightly during the period.
- 4,801 survey response received, with satisfaction score remaining above 80%.
- Learning From Events Report included as an appendix from (Page 16 onwards).

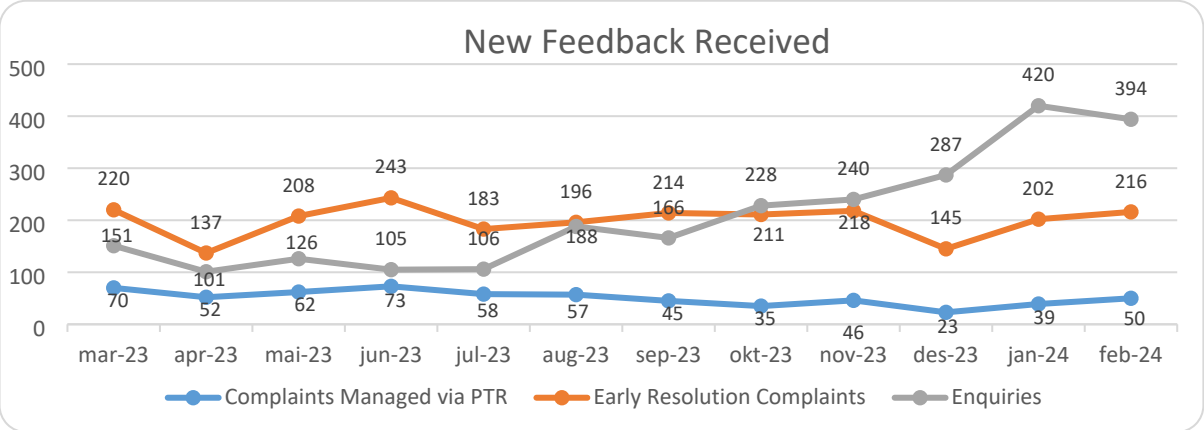
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

Complaints

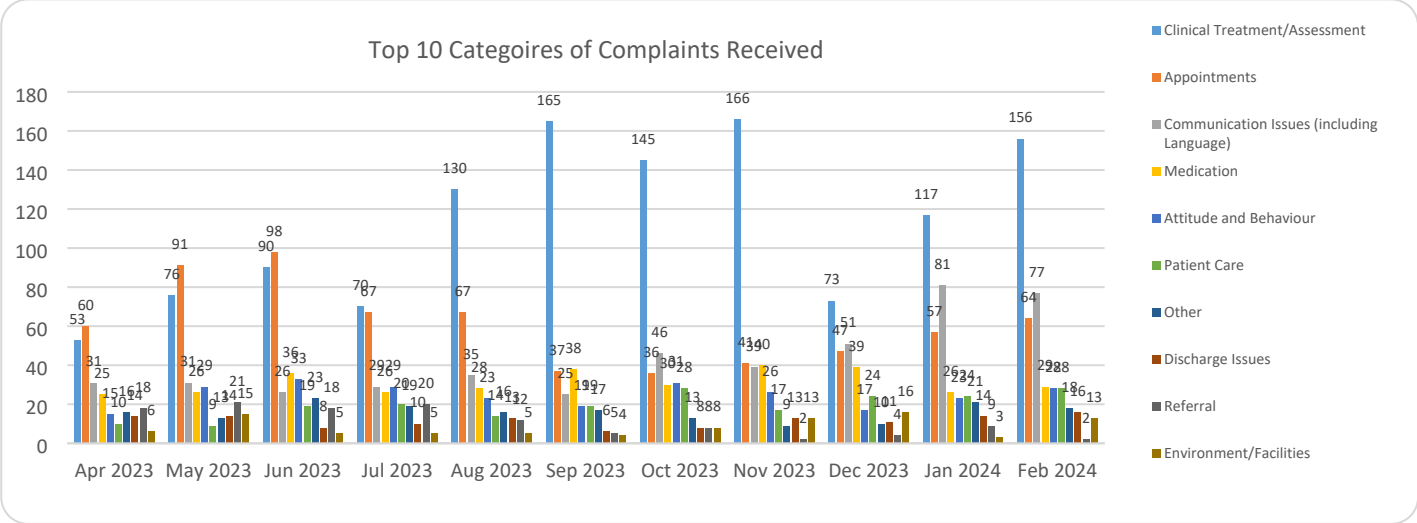
New Complaints Received

Between the 01.01.24 and 29.02.24 the Health Board received a total of 507 complaints. Of these, 89 were categorised as formal and managed under the Putting Things Right Regulations (PTR). This represents an increase in the number of formal complaints highlighted in the last report to Committee, however this is consistent with the 'seasonal'



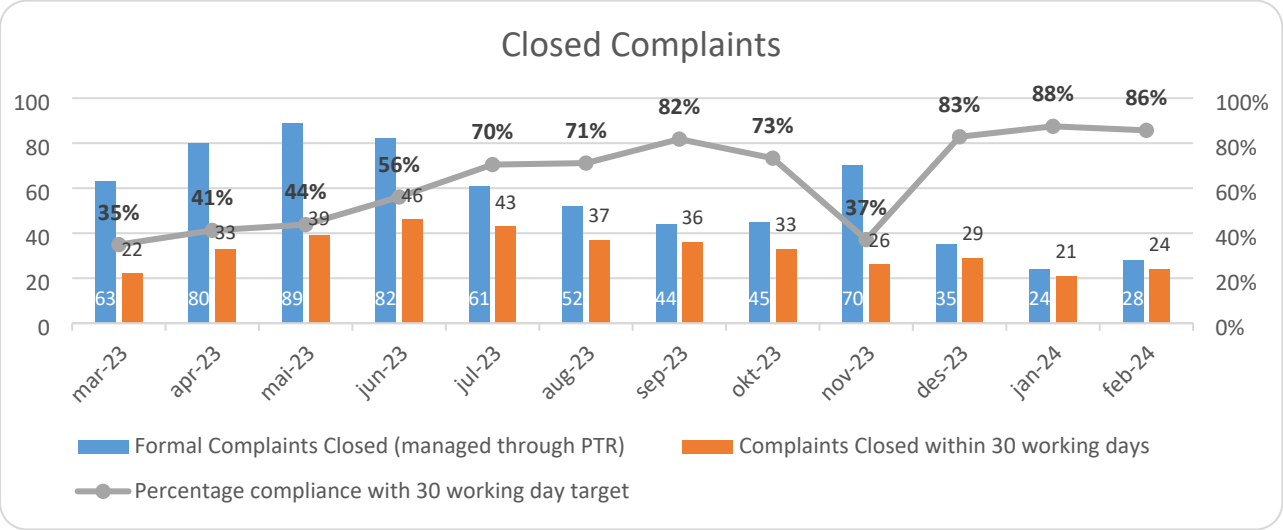
trends from previous years. The increase in the number of enquiries being recorded is reflective of robust reporting of interactions within the prison service. The trend in relation to the management of feedback being received is reflected in the chart below.

For <u>all complaints</u> received in January and February 2024, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (273), Communication Issues (158) and Appointments (121).



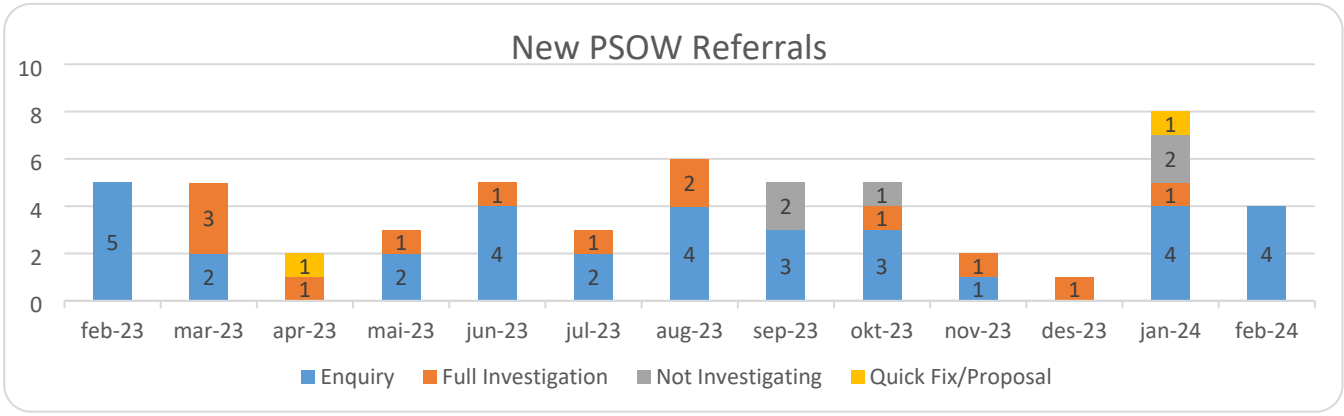
<u>Closed Complaints</u>

Within the period of 01.01.24 to 29.02.24, the Health Board closed a total of 52 formal complaints (managed through PTR). The previous report to Committee highlighted that during November 23, focused work was undertaken to address the number of historic cases open (those over 30 working days) and provide a final response to patients or their families. As a result of this focussed work compliance with the 30 working day target decreased to 37%. Compliance has returned to 83% during December 2023 and has been maintained at above 85% for January and February 2024. As at 01.03.24, the Health Board had 69 open formal complaints. Of these, 15 complaints were open over 30 working days.



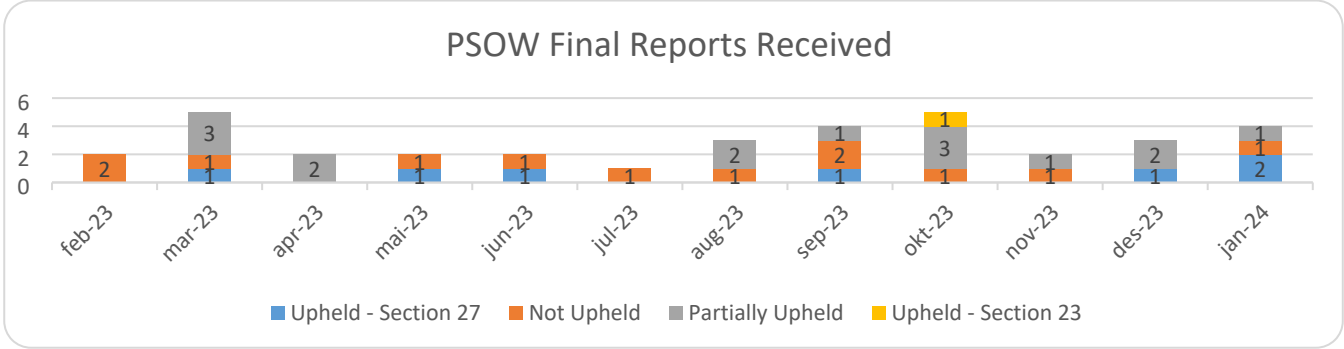
Public Services Ombudsman for Wales

The Health Board received notification of 12 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.01.24 and 29.02.24. Of the 12 referrals, 8 were received as enquires, 1 as a full investigation, 2 as not investigating and 1 as an enquiry.



It should be noted that due to a change in notifications from the PSOW and updates to the Datix Cymru system, the Health Board is now able to accurately record those referrals where the PSOW decides not to investigate.

During the same period, the PSOW issued 4 final reports to the Health Board, 2 were upheld, 1 was partially upheld and 1 was not upheld. No final reports were received in February 2024.



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

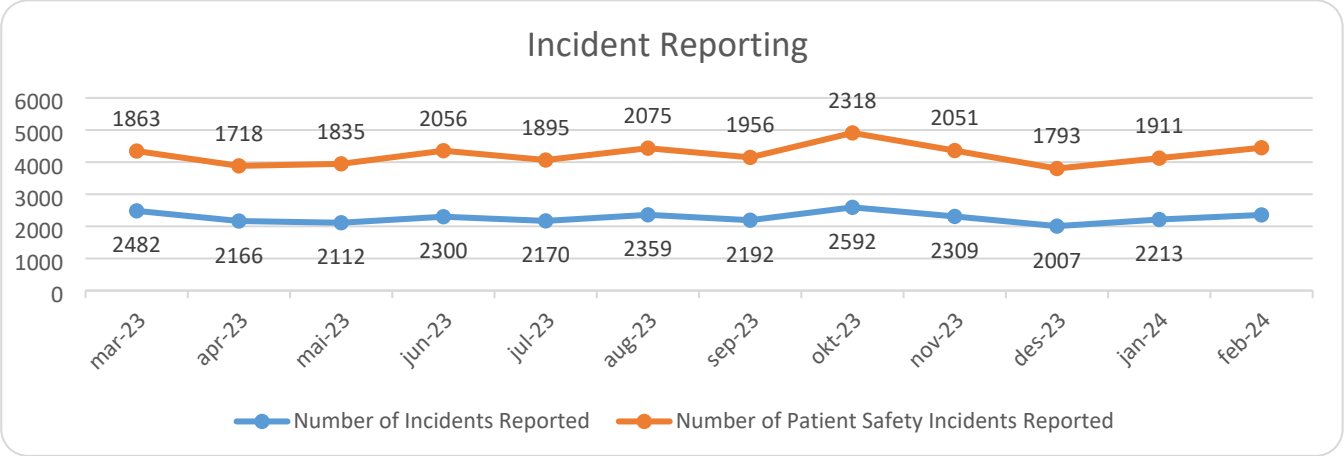
		Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Total
Diagnostics, Therapies and Specialist Care	Not Upheld	0	0	0	0	1	0	0	0	0	0	1
	Upheld	0	1	0	0	0	0	0	0	0	0	1
	Total	0	1	0	0	1	0	0	0	0	0	2
Community	Partially Upheld	0	0	0	0	0	0	0	1	0	0	1
	Total	0	0	0	0	0	0	0	1	0	0	1
Families and Children	Partially Upheld	1	0	0	0	0	0	0	0	2	0	3
	Total	1	0	0	0	0	0	0	0	2	0	3
Mental Health	Not Upheld	0	0	0	0	0	1	0	0	0	0	1
	Total	0	0	0	0	0	1	0	0	0	0	1
Planned Care	Partially Upheld	0	0	1	0	1	1	0	0	0	0	3
	Not Upheld	0	0	0	0	0	0	1	0	0	0	1
	Upheld	0	0	0	0	0	1	0	0	0	0	1
	Total	0	0	1	0	1	2	1	0	0	0	5
Primary Care	Not Upheld	0	1	0	0	0	0	0	1	0	1	3
	Partially Upheld	0	0	0	0	0	0	1	0	0	0	1
	Total	0	1	0	0	0	0	1	1	0	1	4
Unscheduled Care	Not Upheld	0	0	0	1	0	1	0	0	0	0	2
	Partially Upheld	1	0	0	0	1	0	2	0	0	1	5
	Upheld	0	0	1	0	0	0	1	0	0	2	4
	Total	1	0	1	1	1	1	3	0	0	3	11

As at 01.03.24, the Health Board currently has 48 Open PSOW cases, of these 25 are awaiting a response from the PSOW to instigate any further action required. Compliance has been submitted and confirmation of closure is awaited on 11 of the 48 cases. 10 are at final report stage with actions being implemented by the Care Groups.

2.2 Patient Safety Incidents

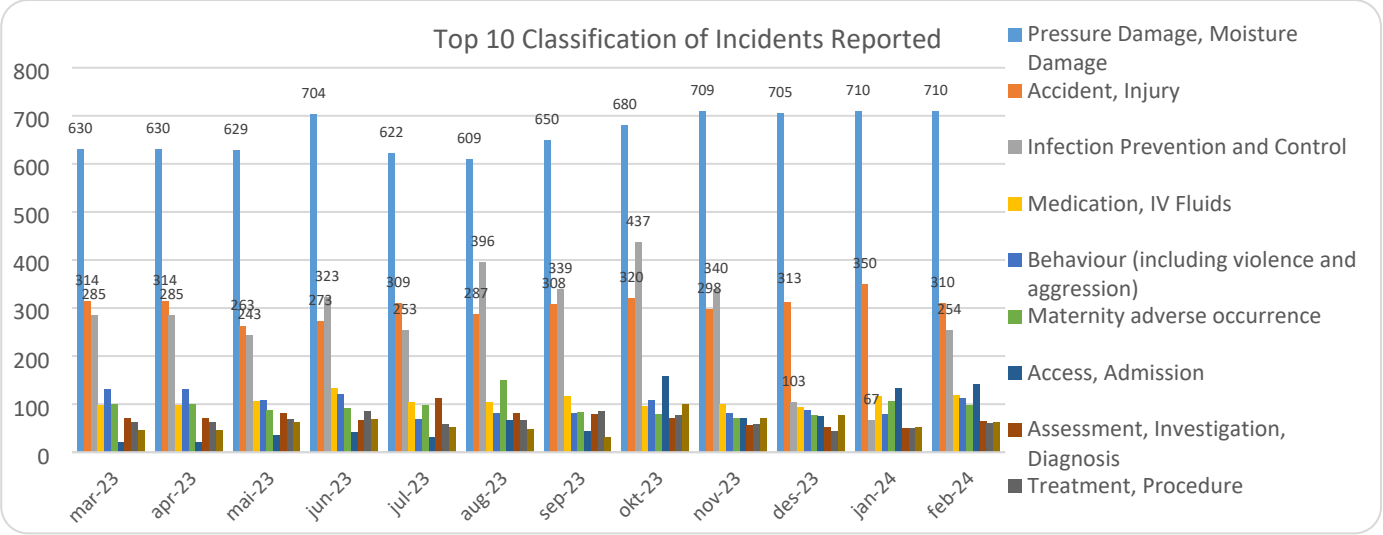
Total Patient Safety Incidents

A total of 4,569 incidents were reported between 01.01.24 and 29.02.24, this represents an increase of 253 when compared with the previous 2 months (4,316).



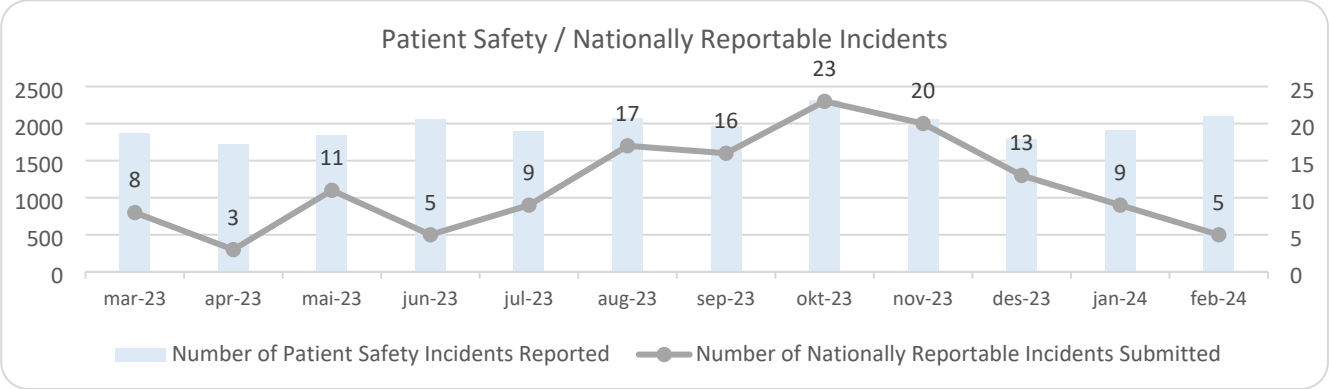
Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has remained relatively consistent. Of the 4,569 incidents reported, 88% (4,003) were reported as the patient affected.

The top 3 types of incidents reported for January and February 2024, linked to a patient affected are: Pressure Damage /Moisture Lesion (1,414), Accident, Injury (611) and Infection, Prevention & Control (443).



<u>Nationally Reportable Incidents</u>

Between 01.01.24 and 29.02.24, 14 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



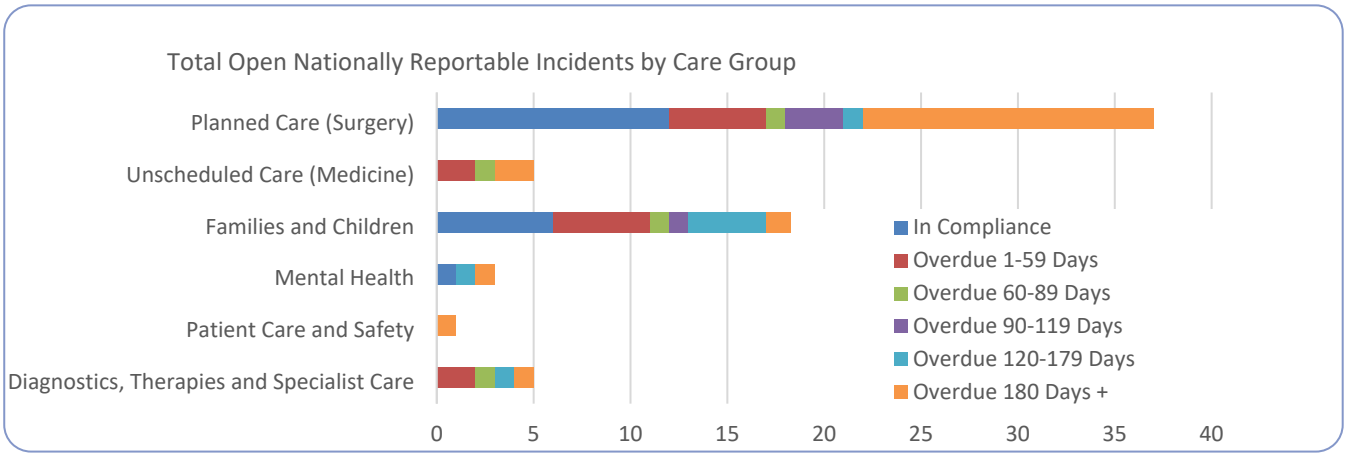
As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive (formerly known as the "Delivery Unit"). This is reflected in the increase in both January 2023 (12) and May 2023 (12) which are linked to the submission of legacy ambulance delays and notification of Ophthalmology incidents, following completion of the harm review process that occurred prior to the reporting period and pressure damage deemed avoidable following review at scrutiny panel.

The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Total
Access, Admission	0	0	0	1	0	0	1	1	1	2	0	6
Accident, Injury	0	0	0	0	0	0	0	0	0	0	1	1
Assessment, Investigation, Diagnosis	0	1	1	2	1	3	0	5	3	0	0	16
Equipment, Devices	0	1	0	0	0	0	0	0	0	0	0	1
Infection Prevention and Control	0	0	0	0	6	10	13	5	1	0	0	35
Infrastructure (including staffing, facilities, environment)	0	0	0	0	0	0	0	1	0	0	0	1
Maternity adverse occurrence	0	2	0	1	4	0	0	0	1	2	1	11
Medication, IV Fluids	1	0	0	1	0	0	1	0	0	0	0	3
Patient/service user death	0	3	1	0	1	0	0	0	0	1	0	6
Pressure Damage, Moisture Damage	1	5	3	2	5	2	7	8	5	3	3	44
Transfer, Discharge	0	0	0	0	0	0	0	0	0	1	0	1
Treatment, Procedure	1	0	0	2	0	1	1	0	2	0	0	7
Total	3	12	5	9	17	16	23	20	13	9	5	132

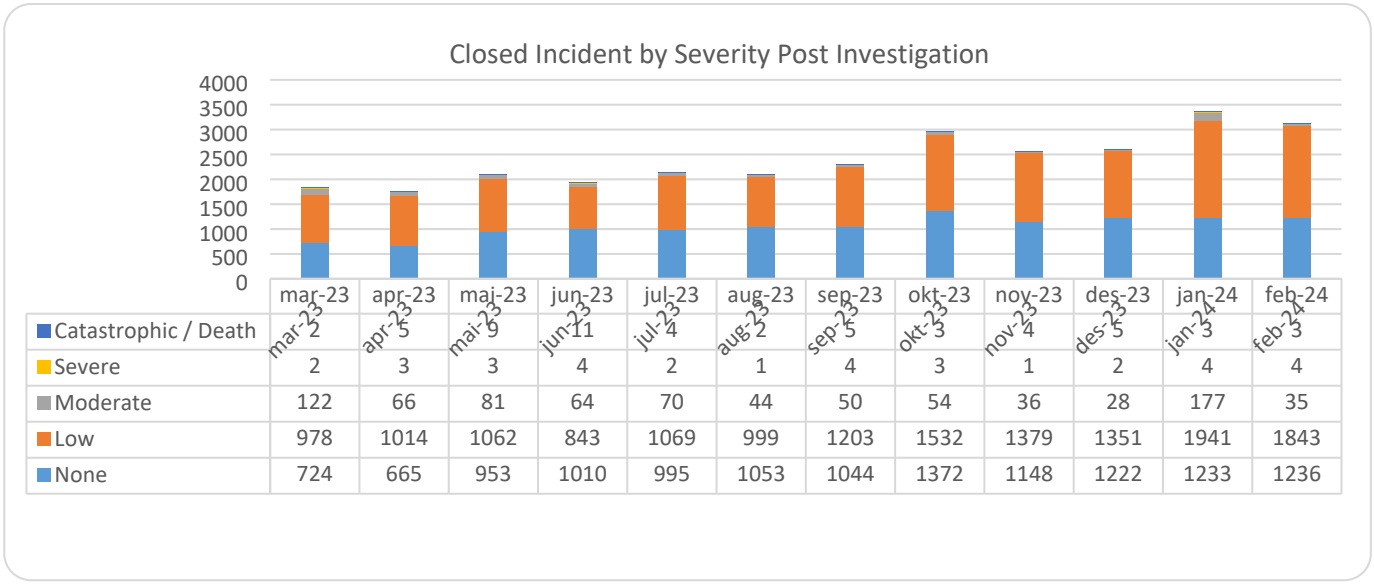
As at the 01.03.24 the Health Board currently has 72 open Nationally Reportable Incidents, of which 53 are overdue the timescale for completion. A trajectory plan is in place to ensure investigations are concluded and an outcome provided patients and their families. An

overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Closed Patient Safety Incidents

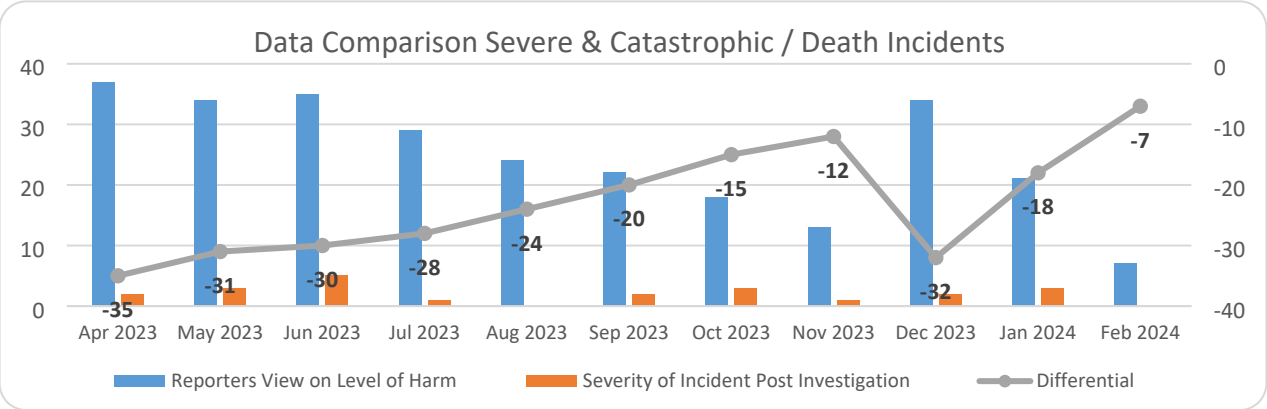
Between the 01.01.24 and 29.02.24 a total of 6,479 patient safety incidents were closed. Of the 6,479 patient safety incidents closed, 14 were closed with severity post investigation of severe harm (8) or catastrophic/ death (6). The 12 month trend is reflected in the table below.



	mar-23	apr-23	maj-23	jun-23	jul-23	aug-23	sep-23	okt-23	nov-23	des-23	jan-24	feb-24
Catastrophic / Death	2	5	9	11	4	2	5	3	4	5	3	3
Severe	2	3	3	4	2	1	4	3	1	2	4	4
Moderate	122	66	81	64	70	44	50	54	36	28	177	35
Low	978	1014	1062	843	1069	999	1203	1532	1379	1351	1941	1843
None	724	665	953	1010	995	1053	1044	1372	1148	1222	1233	1236

Work continues to be undertaken to ensure that a severity of moderate, severe or catastrophic / death recorded on conclusion of an investigation accurately reflects where it can be determined that an incident has been directly caused or attributable to an intervention (action/inaction) by the Health Board. In addition, mechanisms to support a comparison of reporter's view of level of harm and the severity recorded post investigation have been established.

The level of harm attributed to an incident is reviewed and recorded at 3 stages within the incident management process, reporter view on Level of harm, level of harm following management review and severity determined post investigation. Trend information providing a comparison between the reporters view on level of harm and severity of incident post investigation is provided below:



Duty of Candour

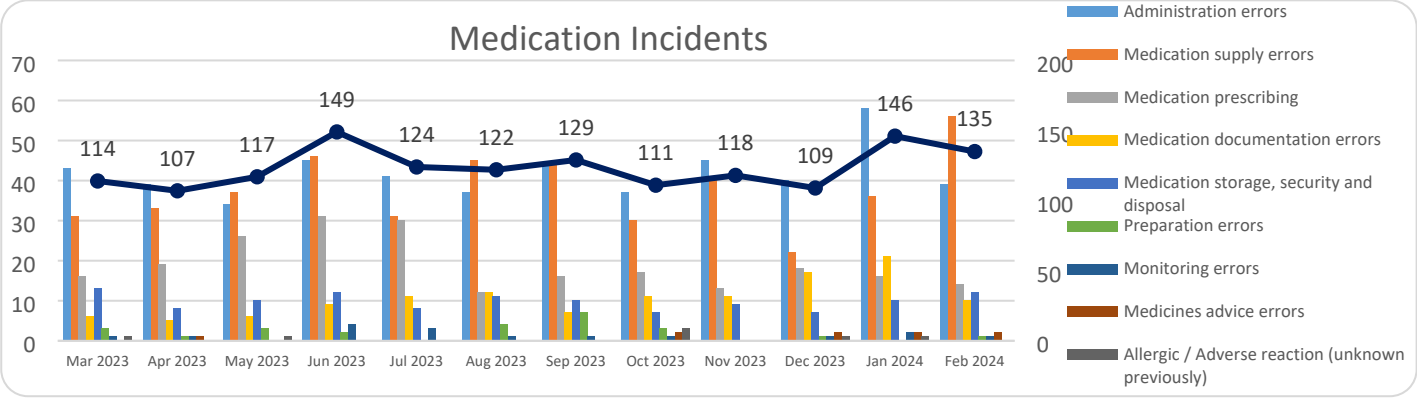
The Duty of Candour regulations where implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. To support the implementation of the Duty of Candour processes, dashboards have been developed to provide 'live' data at a glance along with the introduction of weekly data validation audits.

Number of Incidents	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024
Where Duty of Candour Triggered	4	7	9	13	12	13	15	12	6	15	25
Where In-person notification completed	4	5	6	10	11	11	15	11	6	14	21
Where letter of notification sent	3	4	5	10	8	11	10	8	5	9	8

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

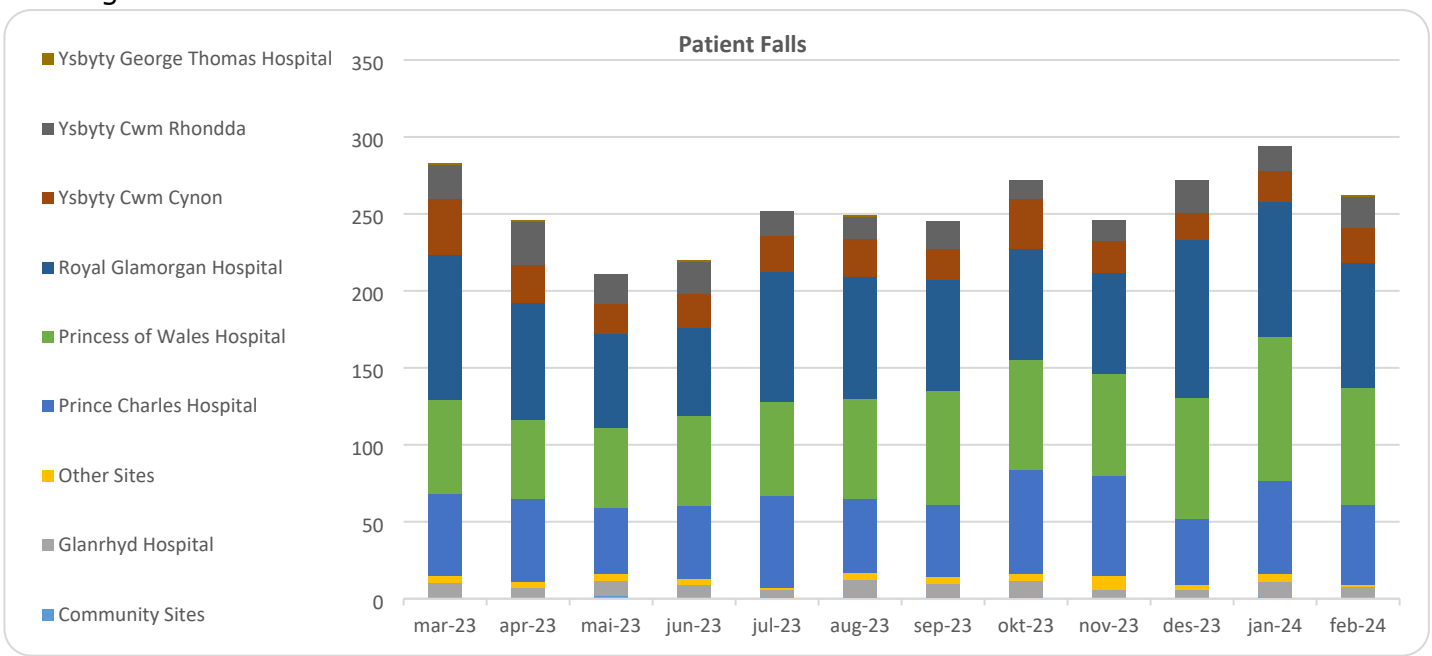
A total of 281 medication incidents were reported as occurring between 01.01.24 and 29.02.24. This is an increase of 54 when compared with the previous 2-month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (97), supply errors (92), and medication documentation errors (31).



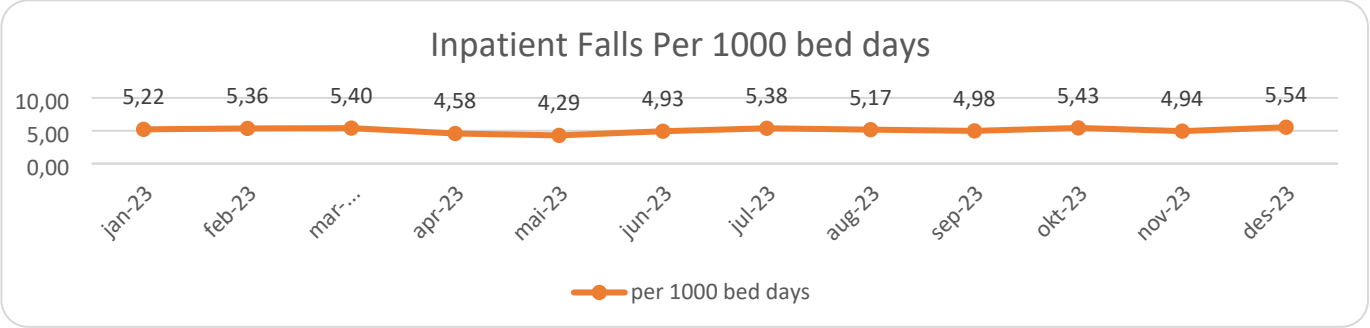
89% of the medication incidents were reported as resulting in no (131) or low (120) harm, with the remaining reported as resulting in moderate harm (28) and severe (2) harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 556 falls, where the person affected was a patient, were reported during January and February 2024. This represents a slight increase of 39 compared with previous months. Of the falls incidents within the time period, 90% were reported as no (145) or low (353) harm. The remaining incidents were reported as moderate (54) and severe (2) harm. No incidents relating to patient falls were reported as resulting in death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



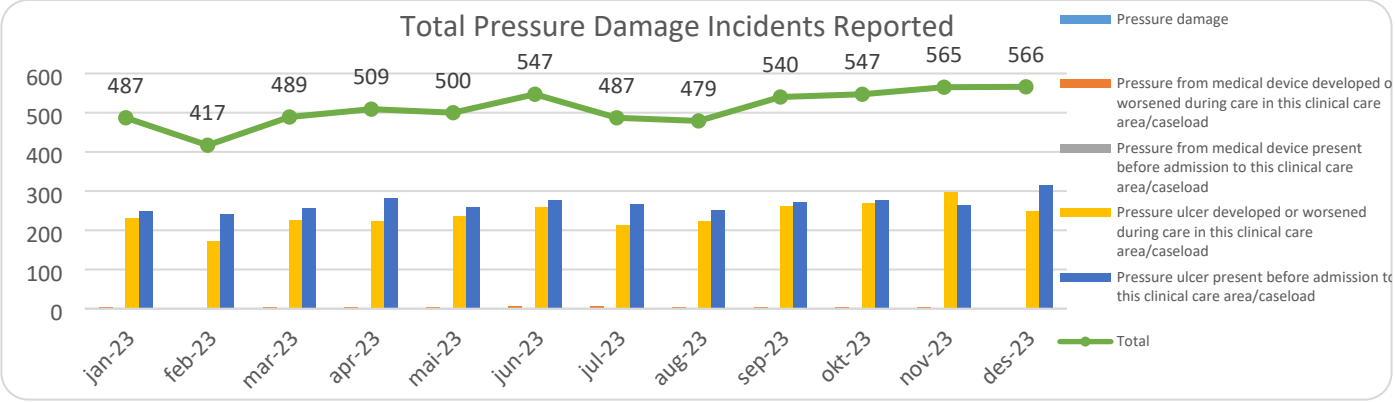
During the time period, the highest number of inpatient falls occurred on Ward 15 (19), Ward 18 (19) and Ward 10 (18) at Princess of Wales Hospital.



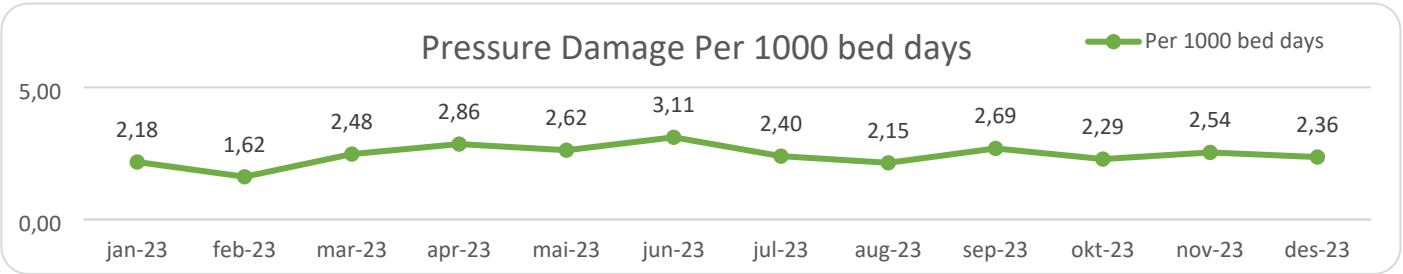
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.3.3 Pressure Damage

Between the 01.01.24 and 29.02.24, a total of 1,150 pressure damage incidents were reported, of which 536 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (614) were reported as being present before admission to this clinical care area/caseload.



Of the 536, identified as developing or worsening during current caseload, 212 were identified as occurring within the community. This represents a decrease of 36 when compared with the previous two months.



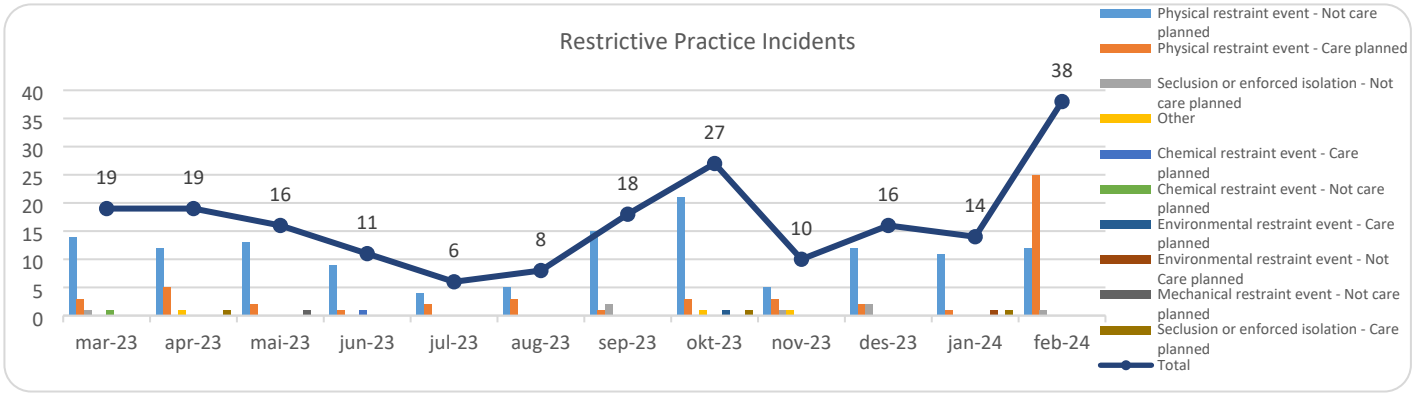
The pressure damage improvement programme continues to progress with a particular focus on grading of pressure damage and completion of required documentation.

2.3.4 Mental Health Metrics

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

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

Restrictive Practices

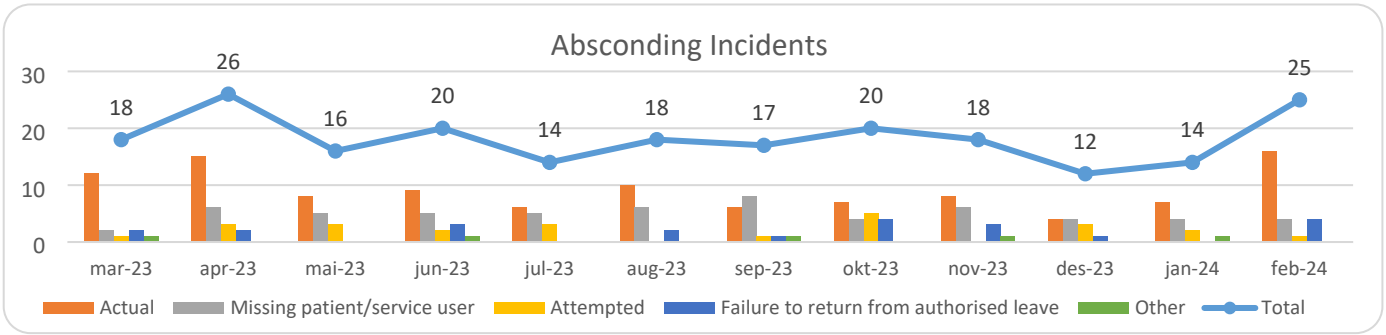


Between 01.09.23 and 31.10.23, a total of 52 incidents relating to using Restrictive Practices were reported within Mental Health. This is an increase of 26 incidents when compared to the previous two months.

Of the 26 incidents, 27 were reported as care planned and 25 were reported as not care planned. The highest number of incidents were reported as occurring on the Psychiatric Intensive Care Unit at Princess of Wales Hospital (17) and Seren Ward, Ty Llidiard (14). The 14 incidents reported at Ty Llidiard relate to the same patient and accounts for the increase in incidents for the two month period.

Absconding incidents

During January and February 2024, a total of 39 Absconding incidents were reported, a decrease of 7 when compared with the previous 2-month period. 23 were recorded as actual absconding, with the remaining recorded as missing patient / service user (8), failure to return from authorised leave (4), attempted (3), and other (1). The highest number of incidents were reported as occurring in Emergency Care at Royal Glamorgan Hospital (8).



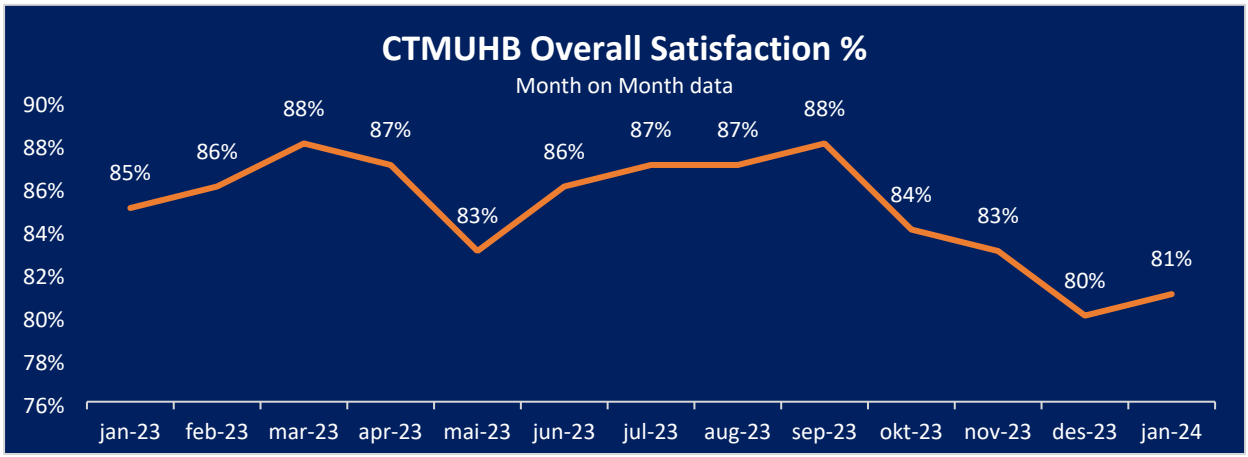
2.4 Patient Experience

2.4.1 Surveys

The Health Board currently has 28 surveys active, of which 10 are set up for text messaging to patients to gather feedback. These surveys are operational for the following services:

- Emergency department
- Heart failure
- Endoscopy
- Gynaecolgy and Sexual Health
- WISE,
- Maternity
- Lymphedema

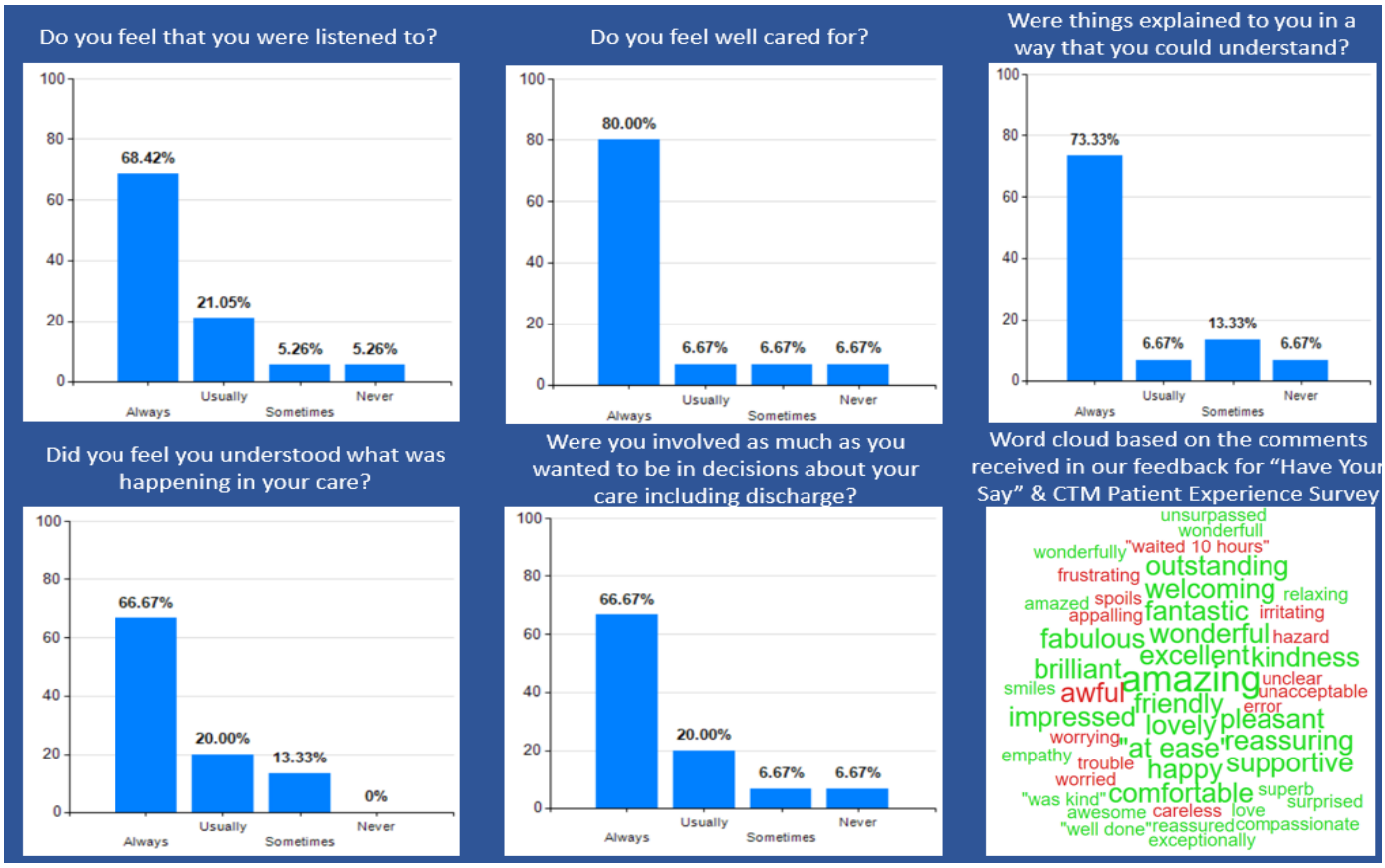
Between November 2023 and January 2024 a total 23,855 text messages were sent out to Patients. From these, 4,801 responses were received. From January 2023 the satisfaction score has remained above 80%. The trend is reflected in the chart below.



Posters are placed around hospital sites displaying QR codes, inviting patients to share their recent experiences of using the Health Board's services. Red boxes are also distributed across the three District General Hospital sites for feedback to be left. This will be extended to other sites.

2.4.2 Have Your Say

Between November 2023 and January 2024 the Health Board received 258 completed Have Your Say Cards. The information included these cards is depicted in the graphic below.



3. Key Risks / Matters for Escalation

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

- The transition to the new operating model poses a challenge in relation to the extraction and presentation of data. Work continues to align the Datix Cymru System to the Care Group Structure and ensure up-to-date information is accessible across the Health Board on a range of metrics.
- Maintaining compliance with the 30 working days' complaints response rate.
- Trajectory plan for reduction of Nationally Reportable Incidents.

4. Assessment

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

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

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

	Activity where performance falls short of the Health Board's quality & safety performance measures may result in impact to the trust and confidence in the Health Boards processes.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

Members of the Quality & Safety Committee are asked to:

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

6. Next Steps

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

Quality & Safety Committee

Appendix - Learning from Events Reports

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Stephanie Muir Assistant Director of Concerns & Claims
Cyflwynydd yr Adroddiad / Report Presenter	Nigel Downes, Assistant Director Quality & Safety
Noddwr Gweithredol yr Adroddiad /	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Report Executive Sponsor	

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
LFERs	Learning from Events Reports
SLA	Safety Learning Adviser
SBUHB	Swansea Bay University Health Board
WRP	Welsh Risk Pool

1. Situation /Background

1.1 On 1*st* September 2023, new timescales for the submission of Learning from Events Reports, were implemented by the Welsh Risk Pool.

1.2 Cases with qualifying liability/decision to settle or make admissions (trigger date) admitted/made **BEFORE** 1*st* September 2023, have 60 working days to submit the LFER to the WRP from the trigger date and 6 months from the date of deferral to ensure that all learning is approved if the case is deferred.

1.3 Cases with qualifying liability/decision to settle or make admissions (trigger date) **AFTER** 1*st* September 2023, have 4 calendar months to submit the LFER to the WRP from the trigger date and 12 months from the trigger date to ensure that all learning is approved if the case is deferred.

1.4 WRP noted that any LFER which was deferred **BEFORE** 1*st* September 2023 has an absolute deadline of January 31*st* 2023, for the case to be **APPROVED.**

2. Specific Matters for Consideration

2.1 The Health Board had 90 LFERs which were deferred, of which, 53 were deferred more than 6 months.

2.2 Workshops were established between Legal Services and Heads of Quality & Safety, whereby LFERs were reviewed, actioned and escalated where necessary.

2.3 In addition, the Legal Services team established regular meetings with the WRP Principal Safety & Learning Advisor for reconciliation of data and feedback and advice on the more complex LFERs.

2.4 The Health Board successfully submitted **all LFERs** which were deferred for **more than 6 months within the timescales required**.

2.5 The team have achieved milestones and progress was made towards our ultimate objective of the submission of all deferred LFERs. The success achieved is a testament to our teamwork and collaboration.

2.6 In the pursuit of effective management of the long standing deferred LFERs, the implementation of structured processes and collaborative initiatives played a pivotal role in driving success. We established regular meetings between the Legal Services team, the Heads of Quality and Safety and the Business Intelligence team.

2.7 Key to the success of these meetings has been the availability of good data, underpinned by regular data reconciliation and validation processes undertaken by the Legal Services team, linking with Welsh Risk Pool. By ensuring that our data is both comprehensive and up to date, we will be able to identify trends, patterns, and emerging issues.

2.8 Moreover, these meetings have been complemented by the provision of well-crafted reports. Drawing upon the data at our disposal, these reports offer a comprehensive overview our LFERs, highlighting key trends, areas of concern, and opportunities for improvement. By presenting information in a clear and accessible manner, we have empowered our stakeholders to make informed decisions and prioritise actions based on evidence-based assessments

2.9 Crucially, the collaborative nature of these meetings has facilitated open dialogue and knowledge sharing among participants. By bringing together experts from various domains, we have fostered a multidisciplinary approach to LFER management, enriching our understanding of complex issues and enhancing our capacity to develop targeted interventions. Through constructive discourse and exchange of ideas, we have leveraged the collective intelligence of our team to drive innovation and drive positive change.

2.10 As a result of these efforts, our LFER management processes have been strengthened immeasurably, with greater transparency, accountability, and efficiency pervading every aspect of our operations. By harnessing the power of collaboration, supported by good data and robust reporting, we have laid a solid foundation for sustained success in managing and mitigating risk effectively. Looking ahead, we remain committed to fostering a culture of continuous improvement, where collaboration and data-driven decision-making remain central tenets of our approach to LFER management.

2.11 Current Position
Deferred LFERs

29 Deferred LFERs			
Due Date	**No**	**Submitted**	**Not Submitted**
Prior to September 2023	1	Evidence submitted not sufficient working with SLA and SBUHB to progress. (penalty received)	
January 2024	5	2	3 Overdue and escalated
February 2024	0	NA	NA
March 2024	3	1	2
April 2024	1	0	1
May 2024	5	2	3
June 2024	0	NA	NA
July 2024	14	1	13

There are currently 29 deferred LFERs (most of these are recently deferred from the panels in November, December 2023 and January 2024

There is a 6 month deadline of resubmitting evidence to WRP.

6 have already been submitted to WRP and are awaiting to go to panel.

4 are overdue and have been escalated to the clinical leads (note 1 of the overdue is the outstanding LFER with SBUHB)

Current position Outstanding Triggered LFERs

37 LFERs have triggered and are outstanding		
Due Date	**No**	**Status**
November 2023	1	Overdue and escalated
December 2023	1	Overdue and escalated
January 2024	4	Overdue and escalated
February 2024	7	Overdue and escalated
March 2024	8	Work ongoing
April 2024	7	Work ongoing
May 2024	3	Work ongoing
June 2024	6	Work ongoing

There are 13 LFERs which have triggered and are overdue the 4 month deadline for submission. These are being discussed on a weekly basis prioritised and escalated as required.

3. Key Risks / Matters for Escalation

3.1 There is one deferred matter which sits between Cwm Taf Morgannwg University Health Board and Swansea Bay University Health Board. Collaboration has extended beyond our health board and we have been working with colleagues to move this case forward in readiness for closure. We received confirmation on 28th February 2024 that we will receive a £2,500 penalty for that case.

3.2 It should be noted that whilst considerable collaborative work has been undertaken to realise the achievements, LFER submission within deadlines required remains challenging.

3.3 As outlined above there are 16 LFERs in total that are currently overdue. Meetings are undertaken weekly to move these LFERs forward, coupled with escalation to clinical leads and directors where necessary.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered	If no, please include rationale below:
Cydraddoldeb	Yes: ☐	No: ☒

Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 The process for the management of deferred LFERs has continued and is now the process used for the management of all LFERs. It is recommended that this approach continues.

6. Next Steps

6.1 Continue the regular monitoring and effective management of LFERs.

Agenda Item
7.1 appendix

Quality & Safety Committee

Executive Director & Independent Member Quality & Patient Safety Walkrounds November 2023-February 2024

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Allison Thomas Business Manager, Patient Care & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Greg Padmore-Dix Executive Director of Nursing, Midwifery & Patient Care/Deputy Chief Executive
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
MDT	Multi-Disciplinary Team

RGH	Royal Glamorgan Hospital
PCH	Prince Charles Hospital
POW	Princess of Wales
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
SSNAP	Sentinel Stroke National Audit Programme
AHP	Allied Health Professionals
YCR	Ysbyty Cwm Rhondda
ABUHB	Aneurin Bevan University Health Board
HASU	Hyper Acute Stroke Unit
NHS	National Health Service
CNS	Clinical Nurse Specialist
ANP	Advanced Nurse Practitioner
CT	Computerised tomography (CT Scan)
USC	Unscheduled Care
HCA	Health Care Assistant
RCT	Rhondda Cynon Taff
SAS	Speciality & Associate Specialist

1. Situation /Background

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

1.2 The walkrounds are anticipated to last no more than 1.5 hours and to minimise ward and staff disruption whilst providing an opportunity to enhance the patient safety culture by connecting senior leaders, clinical staff, support staff patients and carers. These Walkrounds facilitate an opportunity to come together typically in a patient care setting to openly discuss patient safety, best practice, concerns, issues and determine actions for improvement in a continued and sustained manner. One of the objectives is to increase visibility of the senior Executive team and Independent members across the whole of CTM UHB, and to provide an opportunity to celebrate success stories as well as identify patient safety related issues.

1.3 At the natural end of each walkround immediate verbal feedback is discussed with the supporting clinical team, and during this time any required actions are agreed together with agreeing who is the responsible lead for each action and a defined time scale for completion of the actions. Any urgent matters are immediately escalated by the site/area/ward lead to the Care Group triumvirate as a matter of priority.

1.4 Continuous monitoring and reporting on the actions identified during the Walkrounds are expected to be managed and monitored through the Care Group Quality, Safety and Patient Experience group meetings for assurance and improvements and for wider sharing across the organisation to support the spread of improvement and excellence.

2. Specific Matters for Consideration

The table below details the walkrounds completed for the period November 2023-February 2024

During the months of November – January a few walkrounds were cancelled which was due to availability, winter pressures and infection control issues however, where possible the Executive Director continues to undertake the planned Walkround with any cancelled walkrounds being rearranged at a more suitable date.

Date of Walkround	Site/Area/Location	Executive Director and Independent Member 'Buddy Team'
21st November	POW Day Surgery	Sally May & Mel Jehu
30th November	RGH Ward 12	Paul Mears & Lynda Thomas
5th December	PCH Stroke Ward	Lauren Edwards & Ian Wells
6th December	POW Ophthalmology Day Surgery	Linda Prosser
14th December	YCC Ward 4	Paul Mears & Lynda Thomas
2024 11th January	PCH Ward 3	Dom Hurford & Dilys Jouvenat
8th February	PCH Theatres	Gethin Hughes & Nicola Milligan
20th February	RGH Ward 15	Greg Dix & Patsy Roseblade

2.1 Below is a summary of feedback and comments noted during some of the above Quality & Patient Safety Walkrounds:

Areas of Good Practice noted during the Walkround to Ward 12 in RGH include:

- Great commitment by staff to provide good quality care
- Excellent ward receptionist who knew everybody and everything and was determined to have the best run ward
- Good organisation of space including an area for staff to leave belongings

Area of Concern noted during the walkround include:

It was noted that there were no safety risks however,

- The ward was noticeably busy and that the 'boarding' bed was a permanent fixture

Areas of Good Practice noted during the Walkround to the Stroke Ward in PCH include:

- Evidence of strong MDT working
- All members of the team valued
- Safe to Start x2 daily is an opportunity to discuss demands/pressures on stroke beds
- MDT conversations during daily Board Round, using e-Whiteboard
- Nursing posts on the ward are popular, retention of nursing colleagues is good
- Goal planning, meetings involving patient, family and MDT
- Significant improvement in bringing stroke patients over from RGH
- Expansion of CNS cover until 18:30

Areas of Concern noted during the Walkround include:

- Lack of 7 day working for Clinical Staff (medical, nursing, AHPs) impacts on Patient Care and SSNAP performance
- Lack of nearby rehab/therapy space for AHPs
- Delays in transfer of care to ABUHB and YCR results in rehab requirements on the ward not staffed or equipped for this
- Staffing for HASU bay required to come out of general ward establishment – can be challenging
- Ring-fencing stroke and thrombolysis beds can be challenging due to general acute pressures
- Therapy Nurse (B3) is supposed to be available to support rehab but acuity/pressures on ward means they are usually required to support general care on the ward
- Different approaches of NHS staff and Social Care staff is challenging
- Stroke Ward part of Band 6 rotation
- Challenges with recruiting/retaining therapy posts

Key issues and notable practice include:

- Committed and passionate clinical teams
- No digital patient records
- Exploring options for CNS/ANP staffing model
- High-quality interactions with patients witnessed
- Good quality patient and carer information boards

- Plans to explore CNS permissions to request CT scans
- Warm welcome from the team who were knowledgeable and committed in their leadership

Actions agreed include:

- Continue to progress with plans for CNS/AHP recruitment which is led by the Deputy Clinical Service Group Manager and Lead Nurse for USC with an agreed timeframe of February 2024
- A visit to YCR Stroke Rehab to be coordinated and led by the Executive Director of Therapies & Health Science within the timeframe of February 2024
- Continue with ongoing progression of Stroke Improvement plan which is led by the USC leadership team with a timeframe of February 2024

Areas of Good Practice noted during the Walkround to Ward 3 in PCH include:

- Wonderful team approach and caring attitude came across instantly from everyone on the ward
- Assuring to see that the HCA Co-ordinator was engaged in ensuring there are themed activities for the seasons during the year, during this walkround we were aware of recent Halloween and Christmas activities
- Overall aim on the ward is to mobilise all patients to the activities room however, for those patients who were unable mobilise to the activities room, bedside activities were in place, so all patients are engaged in activities
- The 'Bus Stop' was noted and seen as a wonderful concept
- Fidget board is fantastic as are all the adaption and decoration in the room.
- Whole team giving time, effort and resources above and beyond (and their families too).
- Establishing the activities room
- Making patients feel cared for and attention to the non-clinical aspects that matter so much
- Dementia focussed care and adapting the ward to reduce anxiety

The walkround team were also made aware of plans to expand the excellent care and services already delivered on this ward.

Areas of Concern noted during the Walkround include:

- Unable to expand the ward remit outside of Merthyr /RCT patients due to Social working imitations
- Not always able to offer same level of care (to such a very high standard) when illness (ward and staff) and absences.

The Walkround team noted there are limited resources however, following discussion further improvements were noted, this includes the 'What the Ward Needs' as:

1) Dedicated therapist
2) Pharmacy time increased
3) Weekend Physiotherapy cover as sets patients back 2 days every week with no weekend cover

Staff on the ward feel strongly for the need to expand specialist staffing to include the following key roles/posts in order to further enhance and provide a complete and even further improved and rounded service of care which would have a significant impact on length of stay times include:

1) Mental Health nurse
2) Tissue Viability nurse
3) Continence nurse

It was also noted that consideration for increased designated pharmacy time would further support the work of the pharmacist by enabling a consistent approach to bone health needs, as currently this is not manageable for all patients. With expansion of designated pharmacy time this would enable more dedicated time and allow for bone health needs to be assessed for all patients.

Fracture Liaison Service. This service can be managed for large number of patients through this improved model however, in order to fully deliver this service, the team require additional dedicated roles, a dedicated Nurse Practitioner would be an excellent starting point for this service.

It was noted that a need to be re-designated this ward as an acute medical ward is required and would change the designation and nursing requirements as historically this ward was a surgical ward pre-COVID however, it then became a COVID ward with its designate remaining as a surgical ward.

Two new SAS doctors to join the team to expand reviews and service.

Key issues and notable practice include:

- Team are understandable very proud of the ward and service they deliver-this was clearly evidenced by the walkround team
- Friendly positive atmosphere
- Everyone wanting the absolute best care for the patients
- Limited in delivery of ambition by resources and workforce limitations
- No end to ideas of improving care
- Need to establish a plan to support the development of the service - notably the Nurse Practitioner roles
- Support for the Acute Frailty model which is being introduced at the front door

Other discussion and comments include:

- The Ward need to put themselves up for awards for all they are doing
- The Walkround team acknowledged that is was a real privilege to see all they are doing for CTM patients and have asked how this model can be spread further across CTMUHB

The walkround team were highly impressed by the staff, commitment, dignity and care of services being provided to the patients on this ward and offered their sincere thanks to all who gave their valuable time to talk with the Executive Medical Director & Independent Member.

Areas of Good Practice noted during the Walkround to Theatres in PCH include:

- Many areas of good practice noted and discussed in relation to best and more efficient use of theatre space and the expansion of the services to support theatres.
- Evidence of good team working at senior level with the theatre manager, lead nurse and head of nursing

Areas of Concern noted during the walkround include:

- Concerns with regards to timing and commencement of theatre lists on time
- Concerns were noted with regards to communication issues within the theatre teams.
- Whilst there has been progress, the senior team and theatre staff are working through some legacy issues which continue to need addressing to ensure the commitment in the retention of staff, ensuring that their health & well-being is looked after as well as to avoid adverse impact on patient care and experience.

Key issues and notable practice include:

- Collaboration and engagement with teams in the service to ensure changes are worked through together
- Whilst the walkabout was supported by three senior members of staff, it was not possible to meet with theatre staff on this occasion, thus triangulation of observations and feedback was not fully achieved.

Actions agreed include:

- Theatre leadership team to detail concerns to executive team regarding the concerns in relation to theatre start times.
- Theatre leadership teams to provide a brief to the executive team in relation to on-going communication challenges between staff members.

Areas of Good Practice noted during the Walkround to the Ward 15 in RGH include:

- The Ward environment was noted to be clean, tidy and with no clutter
- Low levels of Falls and Pressure Ulcers
- The Ward Manager has built up an inexperienced team of RN's to competent Orthopaedic Nurses over the last 6 months

Areas of Concern noted during the Walkround include:

- Staffing levels are challenging especially when beds are used for escalation
- The mix of elective orthopaedics and acute trauma is challenging due to the acuity of patients and the IP&C risk to the arthroplasty patients

Actions agreed include:

- Review of staffing levels by the senior nursing team to ensure surge patients have adequate staffing to cover

Overall, the Executive Directors and Independent Members have thanked the ward staff and offered their sincere thanks to all staff, patients, carers and family members who have given their valuable time to talk with the walkround team during all of these very valuable walkrounds.

Work continues to coordinate ongoing walkrounds across the health board which includes Primary Care and Community with the inclusion of new Independent Members who have been appointed since the end of the term for some of our former Independent Members for whom thanks and appreciation is given for all their support and contributions to these

Executive Director and Independent Member Quality & Patient Safety Walkrounds.

3. Key Risks / Matters for Escalation

3.1 No key risks or matters to escalate noted within this Executive Director & Independent Member Quality & Safety report.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This report is prepared and intended for information to the committee to note the feedback and findings from assurance walkrounds
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This report is prepared and intended for information to the committee to note the feedback and findings from assurance walkrounds
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

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

Agenda Item
8.1

Quality & Safety Committee

iCTM Annual Report

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Marc Penny – Director of Improvement & Innovation
Cyflwynydd yr Adroddiad / Report Presenter	Marc Penny – Director of Improvement & Innovation
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Executive Leadership Group	20/11/2023	Noted
Improving Care Board	18/10/2023	Endorsed

ACRONYMS	
AgorIP	WG Funded Innovation and Patent Advise service
CTMUHB	Cwm Taf Morgannwg University Health Board
DHCW	Digital Health and Care Wales
HEI	Higher Education Institutes
IC	Improvement Cymru
ICB	Improving Care Board
iCTM	Improvement and Innovation Cwm Taf Morgannwg
IHI	Institute of Health Improvement
LSH	Life Science Hub
NWSSP	National Wales Shared Services Partnership
OMB	Operational Management Board
PMO	Programme Management Office
QI	Quality Improvement
SBRI	Small Business Research Initiative
SU	Swansea University
TI	Targeted Interventions
USW	University South Wales
VBHC	Value Based Health Care
WVHC	Welsh Value in Health Centre

1. SITUATION/BACKGROUND

1.1 In 2021 CTMUHB implemented a new Directorate iCTM to ensure a robust Improvement, Innovation, Value Based Healthcare and Change function existed to support and facilitate service and quality enhancement and enable it to build the change capability needed to meet its strategic objectives and future vision.

1.2 During 2021/2022 the team focused on understanding the needs of the organisation and in March 2023 the iCTM team set out its 3 year business plan, with the iCTM directorate building capacity for change across the organisation, co-ordinating improvement and innovation activity and engagement with staff, patients, communities & partners in driving the adoption and spread of the most impactful improvement and innovation options, all underpinned by the principles of Prudent and Value Based Healthcare and co-creation. Appendix 1

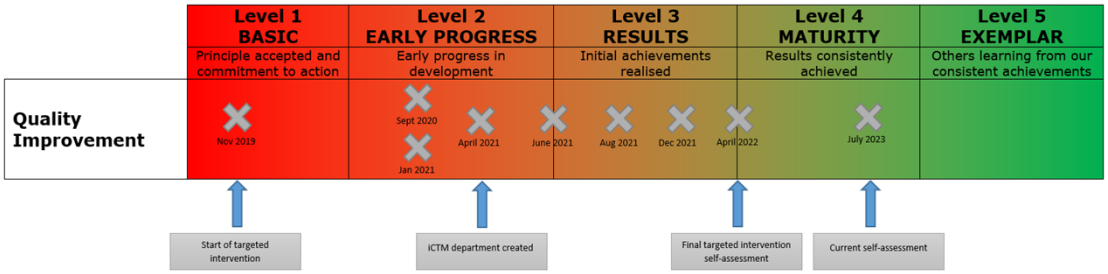
1.3 This report provides an update on progress made against the 3 year business plan and celebrates successes.

We envision Cwm Taf Morgannwg University Health Board as an organisation with mature change capabilities across its services and corporate functions, reaching out through our partners and communities.

"This vision reflects a whole systems approach to health and care, where a commitment to improvement, innovation and change is embedded at all levels of the organisation built on a philosophy of Prudent and Value Based Healthcare."

Success will be demonstrated by growing workforce capability for change and engendering a culture that welcomes it; laying the foundations for delivery of CTM 2030: Our Health, Our Future and supporting our Population Health aims.

1.4 In 2019 CTMUHB entered Targeted Interventions for a number of areas including Quality Improvement, with WG setting maturity assessment criteria for progression. Over the last 3 years the HB has moved from a basic level of QI to Maturity/Exemplar status. Appendix 2.



2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING

2.1 The following sections highlight progress made against the iCTM business plans, key areas for celebration and focus for the next 12 months

2.2 During 22/23 the iCTM Innovation Team secured £100k capital funding from WG Economy team to enable the fit out and purchase of technology for an innovation and improvement collaboration space at The Hub in Llantrisant. The iCTM team moved into this space in October 2022 with the space used as a collision and collaboration space for the HB, academia, 3rd sector and industry.

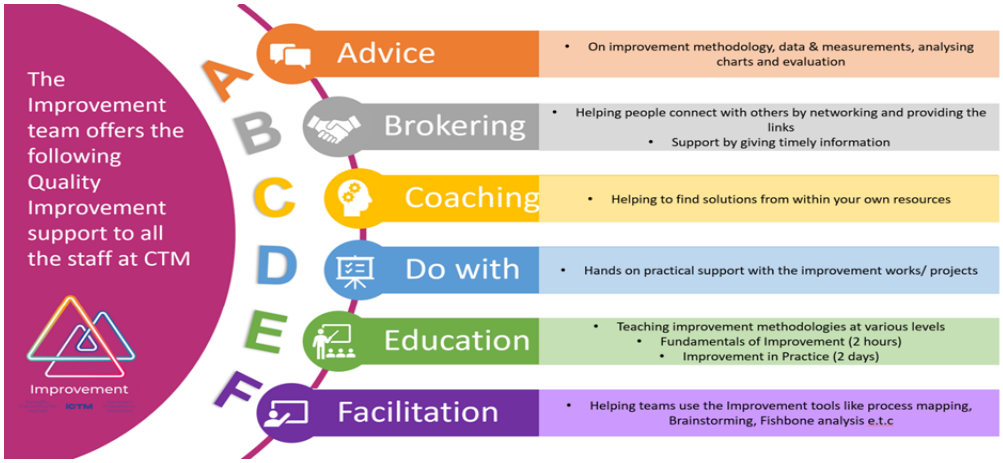
2.3 QI Vision

'Working together with our people, patients and partners to understand areas for quality improvement and developing the capability, capacity and delivery mechanisms across the whole health system to deliver improved outcomes for our patients and improved working practices for our people aligned to our Health Board Values and the principles of Prudent and Value Based Health Care.'

2.4 QI 2025 Outcome Aims – Progress Update

2.4.1 All teams within CTMUHB have access to and pull on Quality Improvement support resulting in a measurable increase in capacity and capability to improve services

- Help and guidance available to all teams through a redesigned SharePoint site and training resources
- A cross-organisational, multidisciplinary team has been created to provide support, prioritise and allocate resource using the "ABCDEF model"



- Improvement work is alignment with organisational strategic goals through OMB, ICB and Strategy Groups
- QI business partner assigned to each care group to coordinate support
- Improvement stories and tools are shared via articles in all staff newsletter, presentation at staff Q&A sessions, Twitter & Facebook and attendance at local team events

2.4.2 We have a mature ideation process in place where all our people know how to and actively engage in the identification of problems and forming solutions

- Successful implementation of staff ideation system and scheme SimplyDo with idea & solution challenges aligned to organisation need / CTM 2030
- SimplyDo challenges this year;
  - Improving day-to-day work (to identify efficient ways of working)
  - Owning your own health (to support wellbeing in work)
  - Healthy Planet, Health People (to support environmental sustainability)
  - Health and Care Standards (to support patient safety concerns raised in the audit)

2.4.3 Improvement form part of all our peoples roles and they see it as core to their day to day work

- Created a multi-layered strategy that utilises the training and enthusiasm that exists in our staff working in partnership with IC
- Teams prioritised as needing support are the focus of the two-day project-based Improvement in Practise course, which is offered monthly. This year the following teams have participated:
  - Maternity
  - Neonates
  - Therapies
  - CAMHs
- Unique to CTM, a MDT Improvement Faculty created, frontline MDT resource of QI champions, provide two sessions of support every week to QI in the organisation enabling them to provide hands on support and mentoring in their areas of CTM
- Wales "Safe Care Collaborative" includes six teams supported by iCTM take part in monthly coaching and national improvement events
  - Acute Deterioration (RADAR)
    - Reduction in number of rapid responses/arrests where a ceiling of treatment discussion is had during a rapid response call/arrest. Positive patient and relative feedback from use of Treatment Escalation Plan and good communication.
  - Paediatrics Diabetics
    - To increase the number of children and young people achieving a HBA1C of less than 48 mmol/mol within 12 months of diagnosis of type 1 DM by 20% by March 2024.
  - Falls
    - Improvements from this falls project will impact on patients, their families, ward staff, the health board and wider society. By reducing falls we expect to have an impact on individuals' function, length of stay and discharge destination which has significant financial benefits to both the health board and society as a whole. We expect staff morale to be impacted by the positive changes and through reduction in the increased workload associated with falls.
  - Pressure Damage
    - Reduction in the number of avoidable community acquired pressure ulcers
  - Community Midwifery
    - Improved access to maternity services is expected to have a positive impact on the safety and experience of maternity services. This should enable women to receive safer pregnancy messages as early on as possible to optimise the health of pregnant women.
  - Navigation Hub
    - The reduction in inappropriate admissions to acute sites will allow faster treatment for patients requiring acute care and greater bed capacity for inpatients, whilst providing residents requiring medical intervention to receive this within their usual home.

2.4.4 A community of practice for improvement where our people collaborate on improvement

- Implemented CTM QI community of practise, presently has more than 30 'QI Champions'.
- SimplyDo collaboration platform provides a space to highlight and share good improvement ideas
- First annual CTM Improvement Celebration event held, bringing together teams from across CTM to share learning, celebrate success and build improvement connections for future collaboration

2.5 QI 2022 / 2023 in Numbers

2.5.1 SimplyDo CTMUHB Staff Ideas Platform

	Strategic Goals (SG)	Activities/Highlights	Impact	Current
1	Improve the **quantity** of engagement, enabling efficiency savings, demand reduction and better health outcomes	Filming of SimplyDo Bright Ideas demo	Total active users	918
		SimplyDo incentives confirmed - £375 Just Eat Vouchers	Average monthly active users	11%
		Over 140 Ideas Submitted on SimplyDo!	Conversion of ideas created to submitted	72%
2	Improve the **quality** of engagement, enabling efficiency savings, demand reduction and better health outcomes	Rebuilt the monthly progress group	Completed strategic challenges	3
		Staff idea management training session delivered	Ideas implemented in project boards / redirected	79.8%
		Estimated idea benefit analysis completed	ROI of ideas per year (i.e. cashable / non-cashable saving)	4,524 hours* / £286,000*
3	Raise **awareness** of the improvement and innovation process amongst staff, supporting culture change	Realignment discussions around how we continue to evolve idea management to increase engagement and transparency	Average post submission poll response	8.8

Contribute towards to the 4 key strategic goals of the **CTM 2030 Strategy**:

- **Creating Health:** Explore new ways to work smarter and deliver better health outcomes
- **Improving Care:** Push boundaries of the care we can provide with a focus on better patient and staff experience
- **Inspiring People:** Empower staff and patients by improving the levers and mechanisms required to achieve the art of the impossible
- **Sustaining Our Future:** Find more sustainable and environmentally restorative practices can improve outcome for current and future generations

2.5.2 Training Numbers April 2022 – July 2023:

- 220 people trained as part of their normal professional development in Fundamentals of Improvement
- Additional 63 Fundamental of Improvement sessions run
- 150 attended 2 day Improvement in Practice

2.5.3 Multiple team events supported

- Mental Health and Learning Disabilities, People & OD, Midwifery and Neonates, Finance, Podiatry, Critical Care, Haematology, Breast Cancer & Histopathology

2.6 QI Key Achievements for Celebration

- Significant improvement in the assessment of CTM in relation to Quality Improvement maturity moving from a WG assessment of Basic to now Mature with some elements of Exemplar achieved
- Value-Based Healthcare project launched in Partnership with Welsh Wound Innovation Centre to address Community Acquired Pressure Ulcers alongside a safety collaborative with district nurse teams
- Falls Reduction Collaborative in Adult Mental Health launched
- Significant progress made via our 6 improvement projects as part of the all Wales Safe Care Collaborative
- IV Fluid Programme, addressing a critical safety issue by ensuring safer use of fluid replacement, rolled out across CTM after successful pilot with potential for national implementation.

- Success of our capacity building approach demonstrated at our first QI showcase event where 21 improvement projects were demonstrated to members of the Executive and Board and over 60 guests
- At-a Loss grief workshops and cafés launched across communities in CTM to support bereavement in support of CTM 2030
- Endoscopic Retrograde Cholangiopancreatography (ERCP) improvement work where waste and patient safety / quality issues have been identified and improvement interventions implemented
- Launched in collaborative with Patient Safety Team Ward Accreditation – releasing time to care, improving safety and reducing waste. iCTM are offering hands on support and training following visits to support them in addressing any issues found and advancing their accreditation.
- Implementation of '5 minute improvements' – a quick and easy tool for teams to use to find improvement solutions to day to day problems or challenges on our wards.
- Process mapping support provided to teams across the organisation (including radiology, haematology, neurodevelopment, paediatrics, ophthalmology, the nurse bank) to aid in service redesign and identification or efficiencies. A training package to further support this work in development.
- Now over 1,000 members of CTM staff actively engaged with the staff ideas and improvement platform SimplyDO with over 140 improvement suggestions made

Innovation

2.7 Innovation Vision

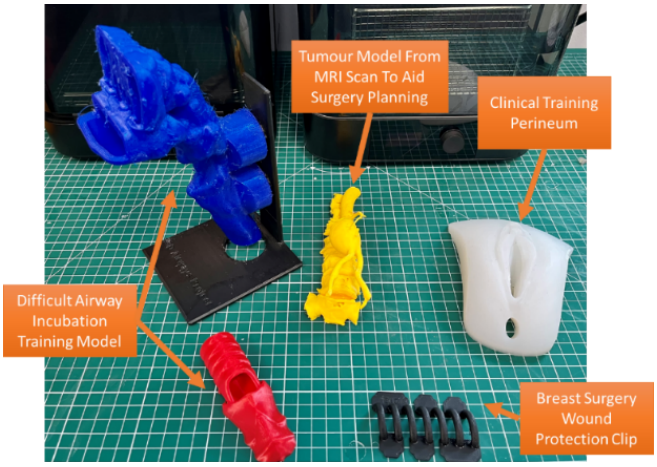
'Working with partners in Local Authorities, Third Sector, Industry and Academia to build and enable a culture of innovation via engaged and motivated people. Encompassing systematic activity, which supports continuous improvement in quality, financial prudence and operational performance; helping deliver strategic change and improved population health outcomes. Enabling rapid digital innovation prototyping and application of new technology to old problems. Acting as host for the Regional Partnership Board Regional Innovation Coordination Hub (RIC Hub).'

**the Innovation team is made up of 2 x wte, however after secondments and other funding by external organisation / RIC that leaves just 0.6 x wte delivering direct innovation services into CTMUHB*

2.8 Innovation 2025 Outcome Aims – Progress Update

2.8.1 *We will have in place an 'ideas pipeline' for both Academic and industrial partners to provide a greater understanding of our current challenges to develop and build new approaches and novel solutions*

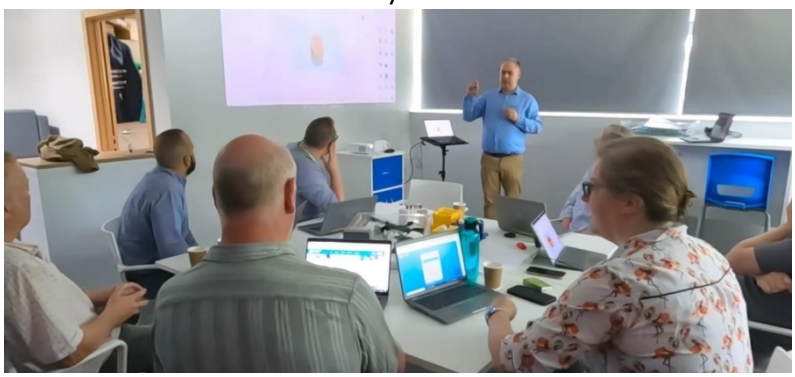
- Using SimplyDo staff ideas platform to encourage innovation ideas
- Bright Ideas challenge to allow staff members who have ideas to submit for review and provision of access to the SimplyDo ideas platform to USW academic staff to enabling their input into ideation and solutions
- Difficult to incubate 3d printed training airway developed with the Difficult Airway Society to improve training and clinical safety
- Working with Clinical Education & USW developed a new clinical training device for perineum suturing to improve training and clinical safety



2.8.2 A community of practice for innovation where our people collaborate on innovative change.

- Engaged with multiple partners and stakeholders to develop the HB capability around:
  - Environmental sustainability
  - 3D Rapid Prototyping supporting clinical and educational problem solving
  - Arts & Health innovation research
  - National RIC Practitioners development programme
  - Health & Housing UKRI funding secured
  - Intensive Learning Academy for Digital Innovation

- Developed innovation networks with our academic partners and neighbouring HB's including:
  - Health Technology Wales Stakeholder Group
  - AgorIP NHS steering group
  - SBRI programme review board
  - All Wales Executive Innovation Leads group
- Held a number of Innovation Events for HB colleagues to encourage and nurture innovation including:
  - Cwm Taf People First Viva Fest
  - Digital Skills Festival for young people, Techniquest Discovery Centre, Cardiff Bay with CTM Dental colleagues
  - 3D print simulation show and tell, USW
  - Bevan Commission Planned Care innovation projects showcase event
  - Circular Economy Innovation Communities celebration event
  - Women in Innovation Showcase event
  - Arts and Health Community of Practice



2.8.3 *We will have a culture which takes new evidence based approaches, and explores other disciplines for ideas, through 'Innovation labs' specifically around rapid physical and digital prototyping*

- Developed with USW a short 3d design and prototyping course aimed at healthcare professionals
- Worked with HB colleagues who have submitted innovation ideas via SimplyDo to turn into reality through prototyping and product development
- Development and patent of breast wound protection clip driven by identified clinical problem
- Partnership between CTMUHB, CVUHB, NWSSP, WVHC and USW to look at recycling of the 22,000 inflatable support boots prescribed every year

2.9 Innovation 2022 / 2023 in Numbers

2.9.1 Funding:

- Successful Moondance Innovation funding for 2 CTM projects totalling £215k grant funding (new resource and equipment)
- £22k UK Research & Innovation funding for phase 1 housing innovation work (off-set HB existing spend). Additional £15k Registered Social Landlords funding to support RIC funded healthy housing innovation manager role
- £33k DHCW NDR funding in collaboration with ICT (new spend)
- £5k funding from Cardiff Met University for a general Innovation fund within CTMUHB (new spend)

2.9.2 11 x members of CTMUHB staff attending the Wales intensive Learning Academy MSc in Digital Transformation

2.10 **Innovation Key Achievements for Celebration**

- Development of a maker space and start of a network including the ORIEL3D portal for NHS and HEI staff to share images, designs safely and securely
- First Patent secured for over 10 years from an idea suggested by a member of staff turned into a prototype and about to be tested in a formal R&D project – breast wound protection clip
- UHB's anchor institution plan with partners including 3rd Sector, Public Health Wales, Transport for Wales, HEI's, NWSSP and the WVHC
- Sustainability including exploring operating theatre Recycling of plastic packaging into 3D printer filaments, Cardboard Recycling with ELITE Paper Solutions, into commercial viable products including horse bedding for South Wales Police (the latter shortlisted for NHS Wales Award)

2.11 **Regional Innovation Hub**

2.11.1 As key part of the local and regional innovation ecosystem we will be supporting the missions outlined by Welsh Government in its recent published Wales Innovates strategy. The underlying message of the strategy is that innovation is not an end in itself, but that developing a culture of innovation is. With such a culture, innovation becomes a tool to enrich our education, our economy, our health and wellbeing, and our environment.

2.11.2 A key driver of 'Wales Innovates' is to enable Welsh organisations, businesses and universities to form consortia, to compete more effectively for UK and international research and innovation funding. With a recent successful bid to Innovate UK we have led a multi- partnership group to explore new ways to support the drive to make homes more energy efficient with the additional impact on health and wellbeing, delivering against one of our priority areas.

2.11.3 Our refreshed Year 4 and 5 activity plan sets out a continuation of the work to date and builds on the new areas of priority given the focus on identifying and promoting high-value innovation and improvement activity, while meeting the 4 key design principles set out in 'A Healthier Wales'. The annual RIC hub report is attached to Appendix 4

2.12 Value Based Healthcare Vision

'Working collaboratively across the Health Board and partners to develop a strategy and plan to deploy Value Based Healthcare across the whole health system; embedding its philosophy and methodology into our day to day operations and work. Acting as an advocate and critical friend for the embedding of VBHC and ensuring alignment of activities and projects to be an enabler to the Health Boards Population Health strategy with a focus on patient outcomes.'

2.13 Value Based Healthcare 2025 Outcome Aims – Progress Update

2.13.1 Our workforce is educated, motivated & embedding our vision as a golden thread through the planning, delivery & evaluation of a whole system approach delivering improved patient outcomes.

- Regularly promote and encourage uptake of VBHC training and education opportunities across CTM
- Supported 25 staff to complete the Sustainability Wales training with Centre for Sustainability
- Attended four staff development days to introduce the principles of VBHC, 150 staff covered

2.13.2 A digitally integrated system collating, analysing & utilising PROMS, PREMS, clinical & workforce experience measures, informing VBHC decision making, care & improvements.

- Patient Reported Outcome Measures (PROMs) collected across heart failure projects (medication optimisation, cardiac rehab), Lymphoedema, Mobile Respiratory Bus via the DrDr platform
- Patient Reported Experience Measures (PREMs) collected across 52 surveys via the Civica Platform
- Clinical Reported Outcome Measures (CROMs) collected in heart failure (launched Nov 22)
- Workforce Reported Experience Measures (WREMs) developed and piloted for roll out in 2023/24
- Family Reported Experience Measures (FREMs) developed and being piloted in Paeds and Heart Failure Palliative Care

2.13.3 Actively measure cost & outcome data to prioritise areas and implement high value interventions that align to our population needs, reducing unwarranted variation low value activity.

- Reality mapping and costing profiles completed for heart failure pathways and alcohol liaison support pathways at all sites
- Review of inappropriate echo's for heart failure diagnosis and testing of system to actively monitor outcome, costs and utilisation of assays for procurement / contracts
- Implementation of VBHC measures across VBHC projects
- Developed with NWSSP a VBHC procurement and contracting trial with Roche

2.14 Value Based Healthcare 2022 / 2023 in Numbers

2.14.1 £2.79m annual investment in VBHC including:

- £648k for heart failure pathway projects
- £421k for new 24/7 Alcohol Liaison Service
- £328k for Lymphoedema and Cellulitis improvements
- £234k for AF and Hypertension enhancements
- £85k for community acquired wound management improvements
- £81k for diabetic podiatry implementation
- £58k for UroGynae implementation

2.14.2 Education:

- 19 CTM staff attended the Intensive Learning Academy Executive Education course in VBHC
- 2 members of staff involved in doctoral research into VBHC

2.14.3 Data collection:

- 2877 PROMS
- 4899 PREMs
- 201 CROMs

2.14.4 Projects and Involvement:

- 250 CTMUHB staff involved in VBHC projects
- 27 VBHC projects initiated, 17 directly funded
- 86,723 Patients impacted on by VBHC projects – (Full year figure)

2.14.5 31 new WTE staff, 5.37 WTE additional hours into roles – 52,210 additional hours of work enabled

2.15 Value Based Healthcare Key Achievements for Celebration

2.15.1 6 VBHC supported projects have won awards 2022/23 – Heart Failure Diagnostics, Remote Monitoring Heart Failure Digital App, Frailty, MyMobility T&O, Lymphoedema, Mobile Respiratory Bus

2.15.2 CTMUHB VBHC implementation and progress has been recognised as good practice from the wider VBHC community; advice and guidance sought and provided to other NHS organisations in Wales, UK and Industry on successful approaches.

Change Hub

2.16 Change Hub Vision

'Working in partnership across CTMUHB and with other regional and national organisations, the Change Hub provides a structured, patient focussed and collaborative approach in the prioritisation, development and delivery of organisational critical programmes and projects which underpin CTM's strategic objectives. As a centre of excellence the Change Hub provides a vehicle for sustainably embedding Project Management and Change across the organisation.'

2.17 Change Hub 2025 Outcome Aims – Progress Update

2.17.1 We will have a community of change practice supporting us to be a learning organisation where our capability to implement successful change increases based on best practice and learning.

- Established and launched in September 2022 in partnership with University of South Wales Commercial Services Ltd (USWCS), engagement has been very strong with a clear commitment towards continuous professional development
- A range of short training courses, webinars and accredited training have been sourced through our academic partner USW
- Our partners USW, are providing CTMUHB staff access to a range of significantly subsidised accredited and free short-courses with a range of learning opportunities for staff and providing significant cost savings to CTMUHB

2.17.2 CTM has a critical mass of skilled and knowledgeable change staff across all disciplines able to provide the level of support the organisation needs.

- Over 350 members of CTM Change Community of Practice and growing on a monthly basis
- Development of training modules and individual and group coaching/training across the organisation to develop Change capacity and capability

2.17.3 Have the structures and resources to support the delivery of high priority cross organisational change programmes & projects to a consistent, high quality & cost effective approach.

- The Change Hub/PMO has a small flexible multi-disciplinary group of both permanent and fixed term roles augmented with operations based support
- Recruitment of specialist contractors (Patient Centred Contact business case) where specific capabilities are required
- Developed a consistent "house approach" to Change and Project and Programme Management and a standardised suite of materials which are available to the whole organisation

2.18 Change Hub 2022 / 2023 in Numbers

- 350+ members of staff now members of the Change Community of Practice
- Accredited courses undertaken by CTM staff (as of June 2023):
  - 11 x Prince2 (Project Management)
  - 4 x MSP (Managing Successful Programmes)
  - 1 Change Management

- 7 x Level 7 Coaching & Mentoring
- Non-accredited courses undertaken by CTM staff (as of June 2023)
- Coaching Skills x 19
- Benefits Realisation x 135
- Data visualisation x 13
- Other x 10

- 6 Goals: Improved A&E performance of 70% for 4 hour waits; reduction of WAST over 4 hour handovers; reduced WAST lost hours at all DGH's and reduced length of stay by 0.9 days
- Attend Anywhere - 4,900 AA consultations held since April 22
- SOS/PIFU - 8 services live to date
- Consultant Connect - 100% of GP Practices have access
- WPRS - 16 specialities live

2.19 **Change Hub Key Achievements for Celebration**

- Successful development and implementation of the CTM Transformation Portfolio. Five strategic pillars which are directly aligned with the CTM 2030 strategic objectives form the key tenants of the structure
- 6 Goals – Implementation of : the navigation hub, Discharge to Recover then Assess pathways, Electronic White boards; supported discharge notification form and electronic transfer of care; securing capital funding for medical Same Day Emergency Care in PCH; standardisation of data across Health and Social Care to manage and report on flow and discharge
- Successful delivery and closure of the COVID19 Vaccination programme
- Decommissioning of Ysbyty Seren

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

3.1 None – report is for noting and providing an update to the Q&S Committee

4. IMPACT ASSESSMENT

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below: Creating Health Sustaining our Future Inspiring People
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Not Applicable
	If more than one applies please list below: Broadly links across all strategic areas
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:

Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Learning, Improvement & Research
	If more than one applies please list below: Culture and Valuing People
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Equitable and Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

5. RECOMMENDATION

5.1 The Quality & Safety Committee are asked to **NOTE** the contents of this report and the progress and delivery of improvement and innovation within CTMUHB.

APPENDICES (AVAILABLE ON REQUEST)

Appendix 1 – iCTM Business Plan 2022 – 2025

Appendix 2 – Targeted Interventions Assessment Criteria

Appendix 3 – iCTM Innovation and RIC Hub events

Appendix 4 – RIC Hub Annual Report

iCTM Annual Report Overview

We envision Cwm Taf Morgannwg University Health Board as an organisation with mature change capabilities across its services and corporate functions, reaching out through our partners and communities.

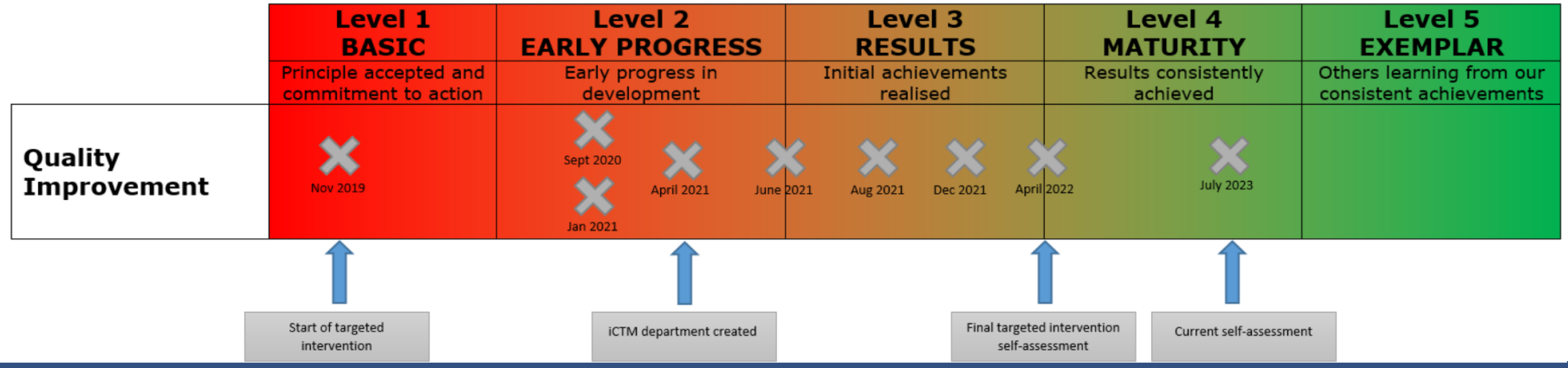
“This vision reflects a whole systems approach to health and care, where a commitment to improvement, innovation and change is embedded at all levels of the organisation built on a philosophy of Prudent and Value Based Healthcare.”

Success will be demonstrated by growing workforce capability for change and engendering a culture that welcomes it; laying the foundations for delivery of CTM 2030: Our Health, Our Future and supporting our Population Health aims.

Quality and Safety Committee March 2024

Background

- 2019 CTMUHB entered Targeted Interventions for a number of areas including Quality Improvement
- 2021 CTMUHB implemented a new Directorate iCTM to ensure a robust Improvement, Innovation, Value Based Healthcare and Change
- 2021/2022 team focused on understanding the needs of the organisation and in March 2023 the iCTM team set out its 3 year business plan
- Presentation and associated report provides an update on the iCTM 3 year business plan and celebrates successes
- 2022 iCTM secured £100k capital funding from WG Economy team to enable the fit out and purchase of technology for an innovation and improvement collaboration space at 'The Hub' in Llantrisant
- Over the last 3 years the HB has moved from a basic level of Quality Improvement to Maturity/Exemplar status (as assessed by WG maturity assessment criteria)



Quality Improvement

'Working together with our people, patients and partners to understand areas for quality improvement and developing the capability, capacity and delivery mechanisms across the whole health system to deliver improved outcomes for our patients and improved working practices for our people aligned to our Health Board Values and the principles of Prudent and Value Based Health Care.'

Quality Improvement Progress

- Help and guidance available to all teams through a redesigned SharePoint site and training resources
- Cross-organisational, multidisciplinary team has been created to provide support to operational areas
- Wales "Safe Care Collaborative" includes six teams supported by iCTM take part in monthly coaching and national improvement events
- Implemented CTM QI community of practise, presently has more than 30 'QI Champions'

Training Numbers April 2022 – July 2023:

- 220 people trained as part of their normal professional development in Fundamentals of Improvement
  - Additional 63 Fundamental of Improvement sessions run
  - 150 attended 2 day Improvement in Practice

2025 OUTCOME AIMS

- All teams within CTMUHB have access to and pull on Quality Improvement support resulting in a measurable increase in capacity and capability to improve services
- We have a mature ideation process in place where all our people know how to and actively engage in identification of problems and forming solutions
- Improvement form part of all our peoples roles and they see it as core to their day to day work
- A community of practice for improvement where our people collaborate on improvement

Engaging With Our People - SimplyDo Staff Ideas

- Successful implementation of staff ideation system and scheme SimplyDo with idea & solution challenges aligned to organisation need / CTM 2030

- SimplyDo challenges;
  - Improving day-to-day work (to identify efficient ways of working)
  - Owning your own health (to support wellbeing in work)
  - Healthy Planet, Health People (to support environmental sustainability)
  - Health and Care Standards (to support patient safety concerns raised in the audit)
  - Winter Pressures
  - Bright Ideas

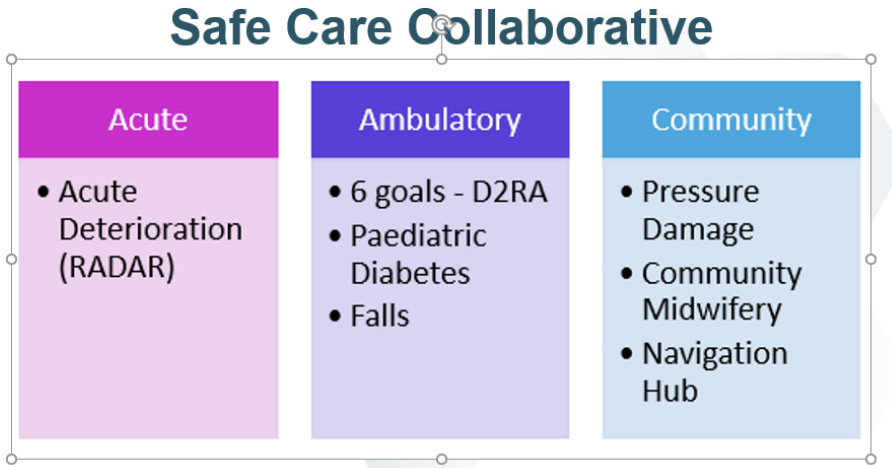
	Strategic Goals (SG)	Activities/Highlights	Impact	Current
1	Improve the **quantity** of engagement, enabling efficiency savings, demand reduction and better health outcomes	Filming of SimplyDo Bright Ideas demo	Total active users	918
		SimplyDo incentives confirmed - £375 Just Eat Vouchers	Average monthly active users	11%
		Over 140 Ideas Submitted on SimplyDo!	Conversion of ideas created to submitted	72%
2	Improve the **quality** of engagement, enabling efficiency savings, demand reduction and better health outcomes	Rebuilt the monthly progress group	Completed strategic challenges	3
		Staff idea management training session delivered	Ideas implemented in project boards / redirected	79.8%
		Estimated idea benefit analysis completed	ROI of ideas per year (i.e. cashable / non-cashable saving)	4,524 hours* / £286,000*
3	Raise **awareness** of the improvement and innovation process amongst staff, supporting culture change	Realignment discussions around how we continue to evolve idea management to increase engagement and transparency	Average post submission poll response	8.8

Contribute towards to the 4 key strategic goals of the **CTM 2030 Strategy**:

- **Creating Health:** Explore new ways to work smarter and deliver better health outcomes
- **Improving Care:** Push boundaries of the care we can provide with a focus on better patient and staff experience
- **Inspiring People:** Empower staff and patients by improving the levers and mechanisms required to achieve the art of the impossible
- **Sustaining Our Future:** Find more sustainable and environmentally restorative practices can improve outcome for current and future generations

Focusing On Patient Safety – Safe Care Collaborative

- An Older Peoples and Mental Health Falls Collaborative
- A partnership with the Welsh Wound Innovation Centre to improve management of Community Acquire Pressure Ulcers
- Participation in the national '*Safer Care Collaborative'* - a partnership with Improvement Cymru and the Institute for Healthcare Improvement



Ongoing Improvement Projects

Care Group	Topic
Planned Care	Call 4 Concern
	200 Minutes Back
	Ward Accreditation
	RGH Ward Storage
	Hysteroscopy
	Podiatry in-reach
	AHP Palliative Care
	Cardiac arrests
	Interstitial Lung Disease
	Opthalmology GIRFT
	Early mobility
	ERCP Review
Women, Children and Families	Gynaecology Theatre
	Peadiatric Surgey
	Looked After Children
	Menopause Management
	Paediatric SLT
	Maternity QI Capacity Breast Cancer Pathway
Unscheduled Care	Navigation Hub OPTIMISE

Dx, Therapies and Pharmacy	Peadiatric Prescribing
	Medicines waste reduction
	Inhalers Waste
	Single use drugchart
	Clinical Engineering process improvement
	Antibiotic Prescribing
	End-of-Life care Y Bwthyn
	Adverse Drug Events
PC and Communities	Occupational Therapy in PC
	VNHC Pressure Damage
	At-a-loss bereavement
	YCC Pressure Ulcer Project
MH & LD	Falls Older Peoples Collab
	Neurodevelopmental Services
	Mental Health Pharmacy

Quality Improvement Celebration

- Successful implementation of staff ideation system and scheme SimplyDo with idea & solution challenges aligned to organisation need / CTM 2030
- Value-Based Healthcare project launched in Partnership with Welsh Wound Innovation Centre to address Community Acquired Pressure Ulcers alongside a safety collaborative with district nurse teams
- Falls reduction collaborative with Adult Mental Health inpatient teams
- IV Fluid Programme, addressing a critical safety issue by ensuring safer use of fluid replacement, rolled out across CTM after successful pilot with potential for national implementation.
- Success of our capacity building approach demonstrated at our first QI showcase event where 21 improvement projects were demonstrated to members of the Executive and Board and over 60 guests
- At-a Loss grief workshops and cafés launched across communities in CTM to support bereavement in support of CTM 2030

Innovation

'Working with partners in Local Authorities, Third Sector, Industry and Academia to build and enable a culture of innovation via engaged and motivated people. Encompassing systematic activity, which supports continuous improvement in quality, financial prudence and operational performance; helping deliver strategic change and improved population health outcomes. Enabling rapid digital innovation prototyping and application of new technology to old problems. Acting as host for the Regional Partnership Board Regional Innovation Coordination Hub (RIC Hub).'

Innovation Improvement Progress

- Difficult to incubate 3d printed training airway developed with the Difficult Airway Society to improve training and clinical safety
- Developed a new clinical training device for perineum suturing to improve training and clinical safety
- Development and patent of breast wound protection clip driven by identified clinical problem
- Partnership between CTMUHB, CVUHB, NWSSP, WVHC and USW to look at recycling of the 22,000 inflatable support boots prescribed every year
- 11 x members of CTMUHB staff attending the Wales intensive Learning Academy MSc in Digital Transformation

Funding:

- Successful Moondance Innovation funding for 2 CTM projects totalling £215k grant funding (new resource and equipment)
- £22k UK Research & Innovation funding for phase 1 housing innovation work (off-set HB existing spend). Additional £15k Registered Social Landlords funding to support RIC funded healthy housing innovation manager role
- £33k DHCW NDR funding in collaboration with ICT (new spend)
- £5k funding from Cardiff Met University for a general Innovation fund within CTMUHB (new spend)

2025 OUTCOME AIMS

- We will have in place an 'ideas pipeline' for both Academic and industrial partners to provide a greater understanding of our current challenges to develop and build new approaches and novel digital solutions
- A community of practice for innovation where our people collaborate on innovative change
- We will have a culture which takes new evidence-based approaches, and explores other disciplines for ideas, through 'Innovation labs' specifically around rapid physical and digital prototyping

Innovation Celebration

- Very successful Ministerial visit by Vaughan Gething Economy Minister
- Development of a maker space and start of a network including the ORIEL3D portal for NHS and HEI staff to share images, designs safely and securely
- First Patent secured for over 10 years from an idea suggested by a member of staff turned into a prototype and about to be tested in a formal R&D project – breast wound protection clip
- UHB's anchor institution plan with partners including 3rd Sector, Public Health Wales, Transport for Wales, HEI's, NWSSP and the WVHC
- Sustainability including exploring operating theatre Recycling of plastic packaging into 3D printer filaments, Cardboard Recycling with ELITE Paper Solutions, into commercial viable products including horse bedding for South Wales Police (the latter shortlisted for NHS Wales Award)

Value Based Healthcare

'Working collaboratively across the Health Board and partners to develop a strategy and plan to deploy Value Based Healthcare across the whole health system; embedding its philosophy and methodology into our day to day operations and work. Acting as an advocate and critical friend for the embedding of VBHC and ensuring alignment of activities and projects to be an enabler to the Health Boards Population Health strategy with a focus on patient outcomes.'

Value Based Healthcare Progress

- Promote uptake of VBHC training and education opportunities:
  - 19 staff attended Intensive Learning Academy Executive VBHC course
  - 2 members of staff involved in doctoral research into VBHC
  - Supported 25 staff to complete Sustainability Wales training
- New PREMS and PROMS collection platform procured:
  - 2877 PROMS, 4899 PREMs and 201 CROMs
- Projects and Involvement:
  - 250 CTMUHB staff involved in VBHC projects
  - 27 VBHC projects initiated, 17 directly funded
  - 86,723 Patients impacted on by VBHC projects – (Full year figure)
- Developed with NWSSP a VBHC procurement and contracting trial with Roche
- Resources
  - 31 new WTE staff, 5.37 WTE additional hours into roles – 52,210 additional hours of work enabled

2025 OUTCOME AIMS

- Our workforce is educated, motivated & embedding our vision as a golden thread through the planning, delivery & evaluation of a whole system approach delivering improved patient outcomes
- A digitally integrated system collating, analysing & utilising PROMS, PREMS, clinical & workforce experience measures, informing VBHC decision making, care & improvements
- Actively measure cost & outcome data to prioritise areas and implement high value interventions that align to our population needs, reducing unwarranted variation low value activity

Value Based Healthcare Celebration

- 6 VBHC supported projects have won awards 2022/23 – Heart Failure Diagnostics, Remote Monitoring Heart Failure Digital App, Frailty, MyMobility T&O, Lymphoedema, Mobile Respiratory Bus
- CTMUHB VBHC implementation and progress has been recognised as good practice from the wider VBHC community; advice and guidance sought and provided to other NHS organisations in Wales, UK and Industry on successful approaches
- Implementation of PROMS (Patient Reported Outcome Measures) for the HB
- £2.79m annual investment in VBHC

Agenda Item
8.2

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Ana Llewellyn, Nurse Director
Cyflwynydd yr Adroddiad / Report Presenter	Ana Llewellyn, Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science
Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Mental Health In-patient Improvement Board	27/02/2024	

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

1. Situation /Background

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

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

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

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

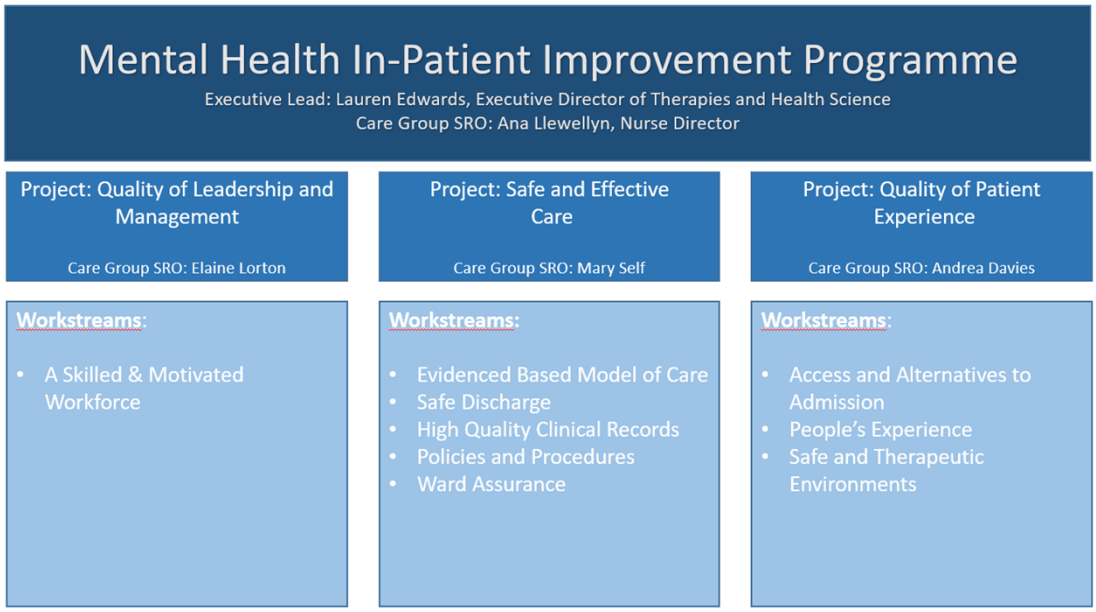
1.5 The discharge review was published on 7th March and includes a further 40 recommendations: Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board (hiw.org.uk)

2. Specific Matters for Consideration

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

2.2 A Mental Health Inpatient Improvement Programme was developed with a number of work streams. The HIW actions and the four improvement themes referenced above were aligned to these work streams.

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



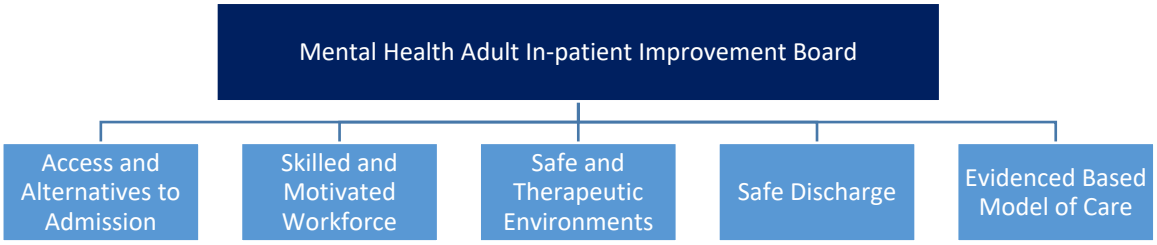
2.4 As part of HIW's Local Review process a further improvement plan was required to be submitted to HIW three months and eighteen months after acceptance of the initial improvement plan.

2.5 The Health Board submitted an updated improvement plan with associated evidence to HIW on 30th November as requested, detailing that 32 out of the 40 recommendations had been ratified as completed by the Improvement Board, which is chaired by the Executive Director of Therapies and Health Science. To date, HIW have not provided a response to this submission.

2.6 At last Quality and Safety Committee members were advised that the Improvement Programme intended to pause and refresh the programme during January, partly due to the level of progress to date and partly due to the impact of organisational change on workstream leads.

2.7 Because many of the workstreams in the programme had relevance across the care group and did not relate solely to in-patient improvement the programme workstreams were revised to include only those that required a specific in-patient focus and for the other workstreams to move to reporting via the Care Group's routine QSRE governance arrangements. It was proposed that the leads for routine QSRE sub-groups, such as Policies and Procedures; People's Experience and High Quality Clinical Records would report to the In-patient Improvement Board for any actions specifically related to the in-patient improvement plan.

2.8 The revised in-patient improvement programme is as follows:



2.9 Due to changes to organisational structures the Care Group has seen several leadership changes and as such new workstream leads have been appointed to some of the workstreams. Workstream leads are currently engaged in handover and workstream re-design.

2.10 The refresh of the CTM Improvement Programme also coincided with a first national workshop on 1st February to develop the national Mental Health Safety Programme, which will focus on a national Mental Health In-patient Improvement Programme. A further national workshop is planned for 3rd March and it is anticipated that further detail on the work programme will be available to Health Boards after this. The Health Board improvement programme will further evolve to include any additional workstreams that may be required.

2.11 The Improvement Board formally met on 27th February and approved the revised improvement programme structure and re-design.

2.12 The remaining 8 recommendations were also reviewed, including those with planned later timescales for completion.

Rec. No	Requirement	Timescale	Update
2	WARRN training to 85%	31/1/24	Currently at 86% - ratified as **Approved**
8	Other training to 85%: • Care and Treatment Planning (CTP) • Information Governance (IG) • Prevention and Management of Violence and Aggression (PMVA)	31/1/24	• CTP – 66%. Staff booked on training and trajectory to 85% by April. Training model being reviewed to build sustainability. • IG – 87% • PMVA – 86%
15	Most of the actions for this recommendation complete but there is outstanding action for a	31/3/24	This policy has been developed and is being progressed through

	Section 140 Policy to be developed.		consultation and ratification process.
19	Clinical Record System	End 2024 but have agreed to update HIW after 31/1/24	The Health Board is currently exploring the procurement of mental health information systems and is meeting with providers and users of those information systems. Update will be provided to HIW by 8th March.
27	Crisis Assessment Suite Prince Charles Hospital	No formal date in the plan but have agreed to update HIW after 31/1/24	Improvement Board noted that the interim arrangements are to be in place for the next 18 months while estates work is ongoing at the hospital. The Board agreed to **Approve** virtually by 8th March pending the evidence submission.
31	Demand and capacity review of Mental Health Therapies	31/3/24	In progress and will be completed by next Improvement Board in April
36	Policies and Procedures	1/6/24	A further 6 policies have been ratified. A full update with trajectory will be provided to HIW by 8th March.
38	This recommendation relates to the ability for social worker partners to be able to access datix.	31/1/24	A Standard Operating Procedure has been developed and all 3 local authorities are being consulted. Agreement at Improvement Board to **Approve** virtually by 8th March

2.13 Committee members will note that the Improvement Board determined that it would submit an updated improvement plan to HIW by 8th March, even though this has not been formally requested by HIW. This is because the Health Board has committed to providing a number of updates when the improvement plan was submitted on 30th November. The next formal meeting of the Improvement Board will be on 23rd April 2024 so the update

to HIW will be formally approved virtually by the Nurse Director and the Executive Director of Therapies and Health Science.

2.14 Subject to virtual approval on 8th March the submission to HIW will detail completed recommendations as follows:

Recommendations	Number completed and approved by Improvement Board	Number with planned later timescales	Number with slipped timescales
40	**35**	**4**	**1**

3. Key Risks / Matters for Escalation

3.1 Committee members are asked to note the slippage on completing one of the recommendations in full.

4. Assessment

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

Environmental /Sustainability Impact (5Rs)	

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service provision
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: No change to service provision
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	There are public and stakeholder concerns about the quality and safety of in-patient mental health services	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Improving mental health services is dependent on people – there are challenges to recruitment and retention in in-patient mental health services.	

5. Recommendation

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

6. Next Steps

6.1 The Adult Mental Health Inpatient Improvement Board, chaired by the Executive Director of Therapies and Health Science next meets formally on 23rd April 2024 and will review progress and evidence against the HIW recommendations.

Agenda Item
8.3

Quality & Safety Committee

Stroke Services Progress Report

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	• Kevin Duff, Head of Strategic Planning and Commissioning • Sarah Follows, Unscheduled Care Group – Service Director • Sian Bingham, Interim Clinical Group Service Manager
Cyflwynydd yr Adroddiad / Report Presenter	Alex Brown, Care Group Medical Director - USC
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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

1. Situation /Background

1.1 The Quality and Safety Committee receives quarterly progress reports on stroke services in CTMUHB which outline a number of short, medium and long term measures being taken by the health board to further improve the quality of care in CTMUHB's stroke services.

1.2 The purpose of this report is to provide an update on progress of the development and performance of stroke services in CTM UHB to February 2024.

2. Specific Matters for Consideration

2.1 Investment of £500,000 was received in 2023/24, however, Regional Integration Funding for the existing Early Supported Discharge team ceased from September 2023, resulting in additionality of £130,000. This investment has enabled expansion of the ESD across the Bridgend area but it has not been possible to allocate the volume of resource required to fully mobilise our ambitions for stroke service developments.

2.2 Service developments continue but progress remains limited by the availability of further investment and wider acute service pressures.

South Central Wales Regional Stroke Network Programme

2.3 Welsh Government's Quality Statement for Stroke emphasises the importance of collaborative work to address all aspects of the stroke care pathway. To address challenges faced by our current services, Cardiff and Vale and Cwm Taf Morgannwg University Health Boards, along with key stakeholders, established the South-Central Wales Stroke Delivery Network. A governance and programme structure is in place as well as a small programme team but there is currently a vacancy for a clinical lead.

2.4 During the regional summit across CAV and CTM Health Boards that was held on 10th October 2023, two potential options for the development of regional integrated stroke services were presented. To ensure every possible opportunity had been considered before a full options appraisal can be undertaken, it was agreed that additional options needed to be explored.

2.5 It was evident that further pre-engagement with the clinical teams was needed, which would include in-depth scoping of each of the options to fully understand the benefits, risks and issues associated such as patient travel times, finance, estates and workforce. Work would also be undertaken to map out the end to end pathways, based on the national optimal pathways and proposed service specifications. In addition the two HBs will complete a baseline service mapping assessment of the current services provided and associated activity, which will give a detailed understanding of the benefits or implications to the proposed service change options.

2.6 At the Programme Board meeting held on 20th February, it was agreed that the original timelines were too ambitious considering the scale of work that needs to be undertaken, therefore a revised draft high level programme plan was presented, with the aim of developing a more detailed and realistic Programme plan.

2.7 To ensure we have a clear and consistent approach to external and internal communications and engagement with all of our stakeholders, which will support the collaborative production of a clinical model, a draft Communications and Engagement Framework has been developed and shared with the stakeholders for comment. Phase one involved the completion of a patient experience survey, inviting all stroke patients from the past year and a staff survey designed for clinicians working in stroke care. Analysis of the surveys has been undertaken and a draft Phase 1 Engagement Report has been shared with key stakeholders.

CTM UHB Strategic and Operational Development of Stroke Services

2.8 The Stroke Programme Board involves key stakeholders from across the acute and rehabilitation stroke pathways to enable the further development of the stroke action plan and the operationalisation of quality and safety improvements. The Programme Board is supported by a Stroke Operational Group, which is able to undertake more granular analysis of the acute stroke pathway and identify opportunities for improvement in its day-to-day running.

2.9 The recent recruitment of directorate managers in the Unscheduled Care Group and forthcoming interviews for a Clinical Director for Stroke Services will provide senior leadership and a singular focus for stroke services across CTM UHB. The Directorate Managers will come into post at the end of March 2024 and interviews for the CD role are being held in the first week of March.

2.12 The above improvements to the operational governance and scrutiny of acute and rehabilitation stroke services in CTM UHB has enabled the Stroke Strategy Group to return to its originally-intended strategic oversight and co-ordination role, meeting on a 6 monthly basis. The Stroke Strategy Group continues to keep oversight of the development of stroke services across the whole pathway from prevention and early intervention, through to life after stroke. It ensures an appropriate fit between the development of stroke services in CTM UHB and the emerging regional model across CAV and CTM Health Boards.

Service developments and improvements

2.13 A number of service developments have been made through the Stroke Programme Board and Stroke Operational Group:

- The USC Care Group Stroke Programme Board and Stroke Operational Group governance arrangements continue to embed. There is a focus on analysis of the data and updating the programme of improvement actions to feed into the Programme Board (**see separate attached appendix**).

- A proposal for a model for CNS cover 24/7 across PCH and POW has been developed. If funding is identified, the extension of the service would maximise opportunities for thrombectomy referral/transfers and the impact would be monitored including via the key Stroke Quality Improvement Measures.

- A rolling advert for the Stroke Consultant vacancy has been in place. In addition discussions with Cardiff and Vale regarding a regional solution are underway particularly in relation to a solution to mitigate the risk to maintaining the CTM 1 in 4 Stroke Rota for 24/7 Thrombectomy.

- Since the last report, the Brainomix AI software reporting for CTs and CT angiograms was implemented on 18th December. The aim of the software is to minimise delays in referral for thrombectomy. Initial reports from the Stroke Consultants is that the new software has significantly improved access to scans for out of hours but that the AI needs further development to improve its level of accuracy so that it can achieve the required levels of clinical efficiencies.

- The Early Supported Discharge service has been extended to Bridgend, resulting in Health Board wide access for CTM patients. Progress will be monitored and reported through the Stroke structure.

- CTM has contributed to the national review of Stroke Self Presenters and the outputs from this are awaited.

Quality Improvement Measure performance

2.14 The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides an overview of performance against 6 national Quality Improvement Measures (QIMs) which are part of the suite of improvement measures in the SSNAP:

- direct admission to an acute stroke unit within 4 hours
- thrombolysis with a door to needle time within 45 minutes [1]
- CT scan within 1 hour
- assessment by a stroke consultant within 24 hours
- Patients assessed by one of OT, PT, SALT within 24 hours
- Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team

2.15 The latest performance report against the four QIMs is attached at **Appendix 1**. Performance remains low against some key indicators, and sadly this is a picture that is replicated across Wales.

[1] Drug Treatment known as Thrombolysis is used as soon as possible following the stroke to dissolve the blood clot.

Organisational Risk Register

2.16 Demand, capacity and performance challenges across the stroke pathway are recognised as a risk in the CTMUHB Organisational Risk Register. The risk is included at **Appendix 2.**

3. Key Risks / Matters for Escalation

3.1 The intended impact of the short, medium and long term actions, along with the regional and national stroke programmes, is to improve the quality, safety and experience of care for patients, their families and our workforce. CTM has ambitions to achieve a SSNAP rating of 'A', and so work continues to make improvements within current resource and to explore opportunities for additional investment and how this would be most effectively utilised.

3.2 There are a number of key risks to highlight and escalate:

- Resilience in the CNS workforce at PCH and POW impacts on the key stroke Quality Improvement Measures and directly on the quality and experience of our patients. A Business Case has been developed outlining the resources required to achieve a 24/7 service and the anticipated impact of this.

- Inpatient therapies (SLT, Physio, OT and Dietetics) resource is below national recommendations. Issues with patient flow, impacting on patients moving in a timely manner from admission to acute and on to a rehab environment, also results in a reduction in the amount of rehabilitation that stroke patients receive.

- Challenges in recruitment of a Stroke Consultant impacts on the key Stroke Quality Improvement Measures and the provision of a 24/7 Thrombectomy Rota. A rolling advert has been out for more than 6 months. In order to mitigate the risk, discussions are ongoing with Cardiff and Vale UHB to seek a regional solution.

- There is an inconsistency in the process of SSNAP data collection across both acute stroke admitting hospital sites (affecting data quality) as POWH does not have a dedicated Stroke Data Co-ordinator role. This impacts on data quality. A business case has been developed for resource to support POWH.

- The lack of a 7 day clinical model. There is concern regarding clinical capacity to ensure service resilience and improved outcomes for patients regardless of the day or time of their admission.

- Regional development discussions are progressing with significant clinical engagement, but there is no confirmed WG funding for any potential developments.

- There are challenges to meet demand at the front door at both stroke admitting sites (POWH and PCH) and to achieve effective discharge pathways. This impacts flow across the system which is an issue in relation to the ring-fencing of stroke beds, CT scans and timely conveyance of self-presenting patients at RGH to PCH. This is not however a CTM-only issue as reflected in the National Review of the Impact of Flow on Stroke Services. An improvement plan is in place to address the national recommendations.

- In order for the national stroke care ambitions to be achieved, local services are required to deliver effective and efficient acute care and rehabilitation post-72 hours. Whilst some investment was identified for 2023/24, it has not been possible to identify the volume of resource required to mobilise all of our ambitions.

- Insufficient stroke rehabilitation bed capacity in YCR affects flow from ward 10 in PCH.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Ageing Well If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)*	A Healthier Wales If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Whole-systems Perspective If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Safe If more than one applies please list below: • Effective Care • Dignified Care • Timely Care

	• Staying Healthy • Staff and resources
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: Significant challenges delivering a consistent high-quality stroke pathway across CTM.	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: EIA to be undertaken as part of further work if required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	SSNAP data is reported nationally and is below the standards at which we strive to perform	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)	
	Service improvements required to meet the QIM standards that we aspire to is associated with significant additional resource that it has not been possible to identify.	

5. Recommendation

5.1 The Quality and Safety Committee are asked to:

- Note the ongoing significant challenges faced across CTM stroke services and across Wales, reflected in the QIM performance data
- Note that the identification of some additional resource to support stroke service developments has been utilised to expand the ESD service. It has not been possible to identify the large-scale funding required to deliver improvement across all 4 QIMs.

- Note the identified need for investment in front door stroke services (i.e. CNS to achieve 24/7 model and equity for patient access in and out of hours).

- Note the developments made in some aspects of the stroke pathway And the updated action plan.

- Note the focused work on the stroke pathway undertaken through the revised operational governance structures.

- Note the regional and national work being undertaken to develop high quality prevention, identification and treatment for stroke. WG financial support for these developments has not been confirmed.

6. Next Steps

6.1 Next Steps being taken through the stroke planning and operational structure:

- Ongoing targeted focus on stroke pathway service developments and quality improvement by Stroke Operational Group, Programme Board and Stroke Strategy Group.

- Ongoing active engagement with regional and national stroke programme.

- The Health Board is awaiting the report from the All Wales Review of self-presenters in stroke by the NHS Wales Executive Delivery Unit to identify any actions that need to be incorporated into the CTM UHB Stroke Action Plan.

Appendix 1

Quality Improvement Measures across PCH and POWH

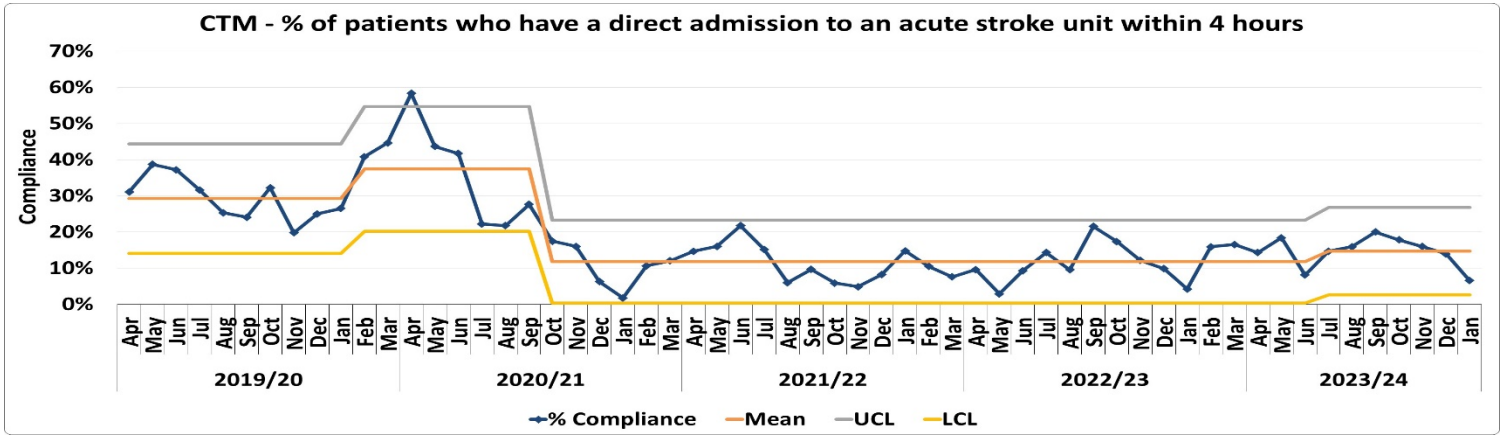
The CTMUHB Integrated Performance Dashboard is published on a monthly basis and provides the Health Board with an overview of 6 national Quality Improvement Measures (QIMs), which are part of the suite of improvement measures in the SSNAP:

- Direct admission to an acute stroke unit within 4 hours
- Thrombolysis with a door to needle time within 45 minutes
- CT scan within 1 hour
- Assessment by a stroke consultant within 24 hours
- Patients assessed by one of OT, PT, SALT within 24 hours
- Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team

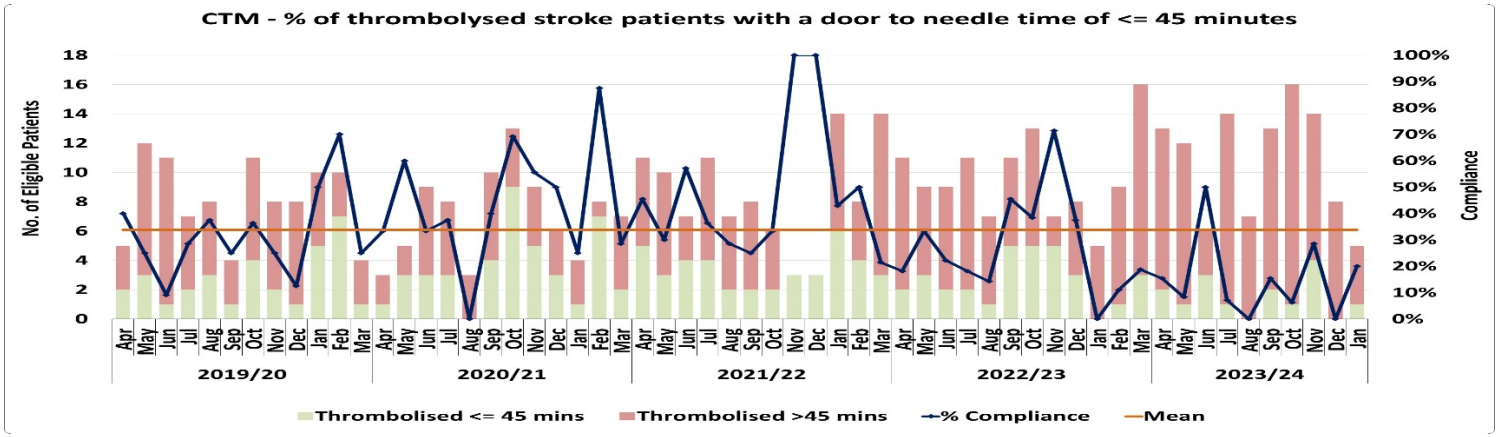
Overall, patient flow challenges on both the POWH and PCH sites have had a direct impact upon the ability to admit people to a stroke ward within 4 hours. In addition, increased length of stay for stroke patients at the POWH site is linked to challenges regarding flow.

Challenges in meeting the target for assessment by a stroke consultant within 24 hours reflects the current 5 day working model of the stroke team. Challenges remain with numbers of stroke patients continuing to present at the Royal Glamorgan Hospital, leading to delays in accessing the stroke pathway at PCH.

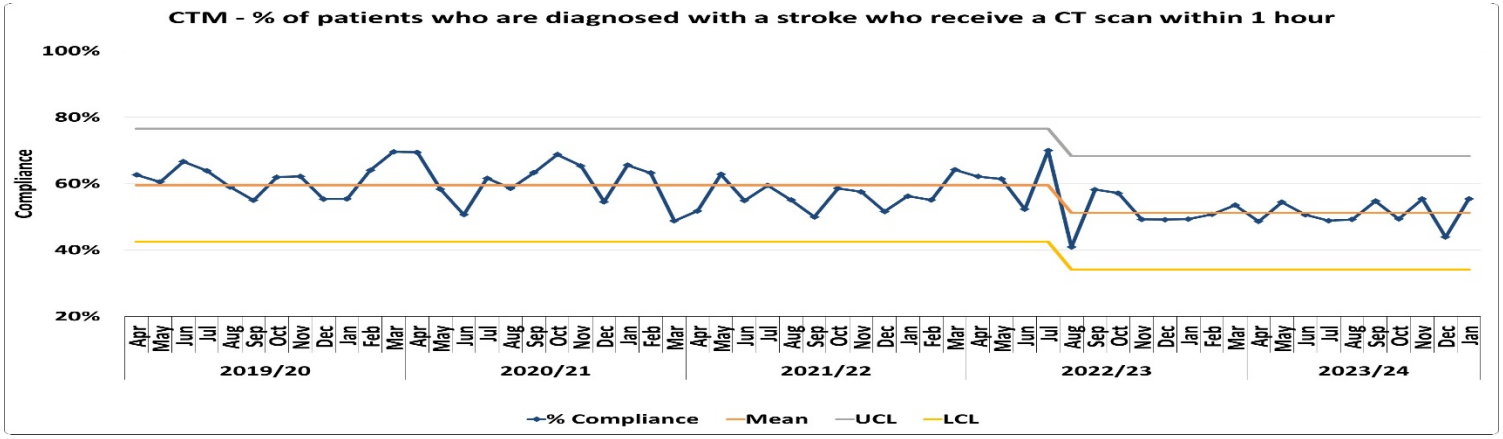
% compliance with direct admission to an acute stroke unit within 4 hours



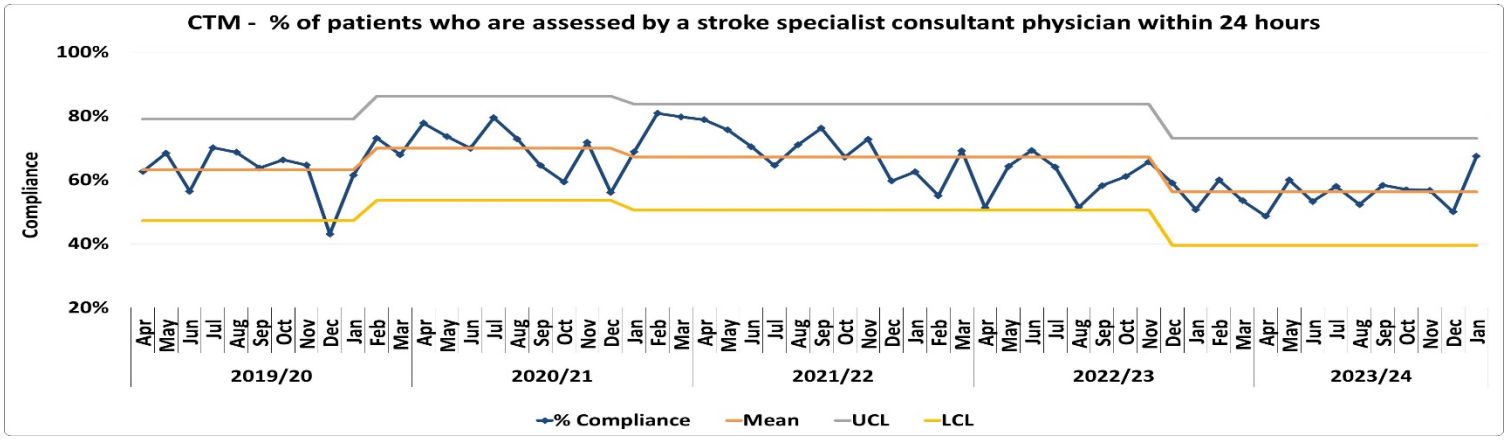
% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes



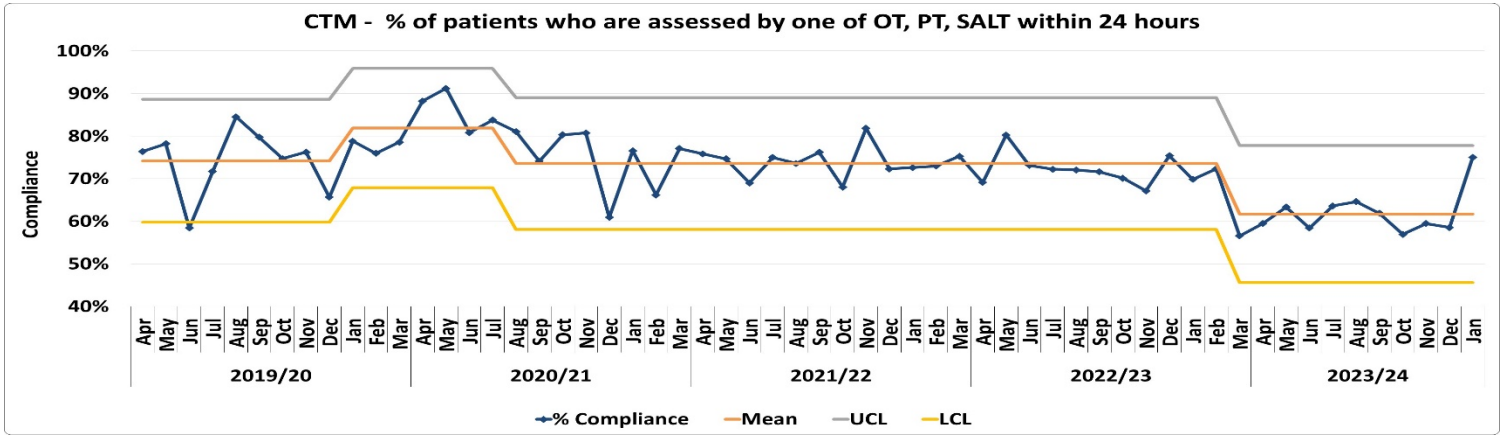
% compliance of patients diagnosed with stroke received a CT scan within 1 hour



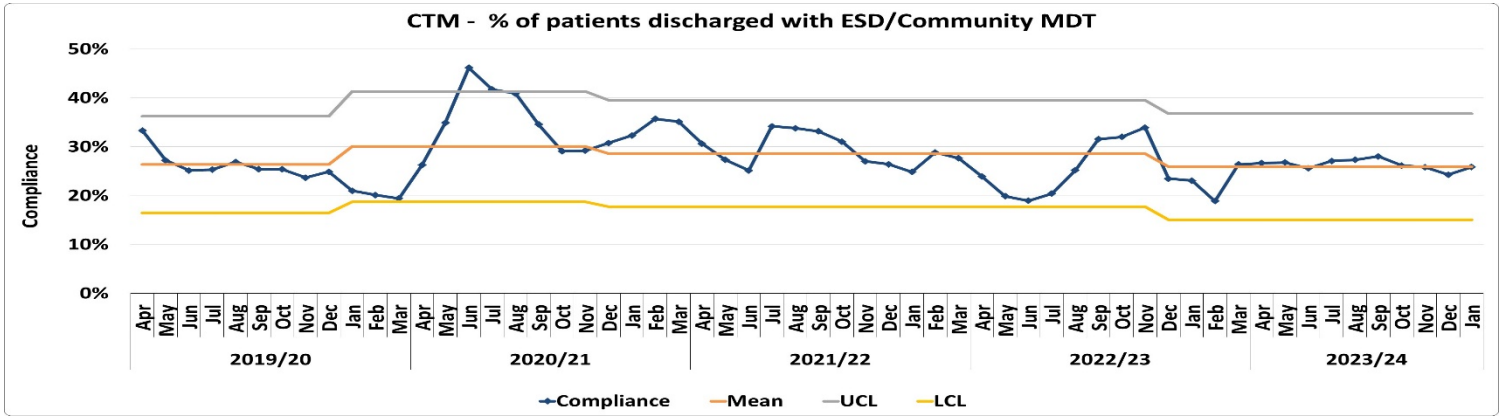
% compliance assessed by a stroke consultant within 24 hours



% of patients assessed by one of OT, PT, SALT within 24 hours



Discharge Standards - % of applicable patients discharged with ESD/Community Therapy Multidisciplinary Team



Appendix 2

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.	January 2024 update new governance arrangements will give a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Group established 1st meeting held in September 2023 with a focus on the performance and actions for improvement. • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Brainomix implementation continues led by Stroke Consultant. • The USC SMT have had further engagement with colleagues from CAV in developing options towards a regional solution for stroke services. These would involve significant service change and potential for investment – options will follow a regional piece of work. • Directorate teams exploring feasibility of developing further stroke ANP roles. • Review undertaken of the historical action plan aligned to the stroke strategy group where many of these actions have been closed. Risk Remains 20, C4 C5 Review date 28/02/2024. From approved risk register for January (March risk register to be approved at time of writing)

Stroke Operational Group Action Plan

Indicator	Actions	Dependencies	Lead	Timescale	Updates	completion indicator	
% compliance with direct admission to an acute stroke unit within 4 hours							
	To increase the Stroke Nursing capacity and resilience to provide 24/7 cover	Funding	CSG Manager	mar-24	Proposal to be presented		
	To ensure Ring-fenced Stroke beds on both sites -	Improved flow	Head of Patient Flow		SOP collaboration with patient flow team and Senior Nursing team around patient flow. Beds ring-fenced however demand due to flow a risk.		
	Updated FAST campaign plans to be clarified		tbc				
	Staff recognition of stroke symptoms on presentation of patient across hospital sites		ED Senior Nurses		Red flag Training for receptionists		achieved - to be moved to monitoring template
	Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients	Current roles filled	Lead Nurse USC	Nov 2023 - Apr 2024	Changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service agreed. To be implemented when CNS provision is backfilled.		
% of thrombolysed stroke patients with a door to needle time of <=45m	To continue exploring options to fill the vacant Stroke Consultant role @PCH	Applicant uptake	CSG Manager/tbc		Rolling advert for post live. Regional discussions underway		
	To increase the Stroke Nursing capacity and resilience to provide 24/7 cover	Funding	CSG Manager	mar-24	Proposal presented. Awaiting decision.		
	Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients	Current roles filled	Lead Nurse USC	Nov 23 - Apr 24	Changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service agreed. To be implemented when CNS provision is backfilled.		
% of patients who are diagnosed with a stroke who receive a CT scan witin 1 hour	Increase Stroke Consultant to reduce reliance on Everlight	Applicant uptake	CSG Manager/tbc		Rolling advert for post live. Regional discussions underway		
	To implement, rollout and review Brainomix		Stroke Clinical Lead		implemented 18th December 2023 Quality Assurance Group established. Initial feedback provided.		achieved - to be moved to monitoring
	To ensure all CNSs have access to training to request the CT upon admission	Funding			Explore training opportunities for PCH CNS to achieve status to request CT. POW CNS implementation to be explored.		POWH has shared their policy for requesting radiology and requirements needed.
	To increase the Stroke Nursing capacity and resilience to provide 24/7 cover	Funding			Proposal presented and awaiting decision.		
	Explore changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service	Current roles filled	Lead Nurse USC	Nov 23 - Apr 24	Changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service agreed. To be implemented when CNS provision is backfilled.		
	Implement Biotronics 3D		Stroke Clinical Lead				
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Extend Consultant service to 7 days - Increase Stroke Consultant numbers	Applicants	Stroke Clinical Lead				

% of patients who are assessed by one of OT, PT, SALT within 24 hours	Extend therapies service to 7 days	Funding	Head of SLT		Stroke Investment paper submitted to HB Quality & Safety Committee January 2023 included therapy staffing requirements	
% of applicable patients discharged with ESD/Community Therapy MDT	Extend ESD service pan CTM	Applicants	Head of SLT		Expansion across to bridgend currently in process following HB investment. Referral criteria/pathway being established	
Underpinning To achieve robust reporting and processes to ensure consistency across CTM	To explore options to establish a Stroke co-ordinator role/function pan CTM	Funding	CSG Manager		Proposal to be presented	

ACTIONS	% compliance with direct admission to an acute stroke unit within 4 hours	% of thrombolysed stroke patients with a door to needle time of <=45m	% of patients who are diagnosed with a stroke who receive a CT scan witin 1 hour	% of patients who are assessed by a stroke specialist consultant physician within 24 hours	% of patients who are assessed by one of OT, PT, SALT within 24 hours
To increase the Stroke Nursing capacity and resilience to provide 24/7 cover					
To ensure Ring-fenced Stroke beds on both sites					
Updated FAST campaign plans to be clarified					
Staff recognition of stroke symptoms on presentation of patient across hospital sites					
Improve CNS hours to capture more patients presenting within time window and identify eligible thrombectomy patients					
To continue exploring options to fill the vacant Stroke Consultant role @PCH					
To implement and rollout and review Brainomix					
To ensure all CNSs have access to training to request the CT upon admission					
Explore changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service					
Implement Biotronics 3D					
Extend Consultant service to 7 days - Increase Stroke Consultant numbers					
Extend therapies service to 7 days					
Extend ESD service pan CTM					
Underpinning					
To achieve robust reporting and processes to ensure consistency across CTM					

% of applicable patients discharged with ESD/Community Therapy MDT

Stroke Operational Group Actions Monitoring

Indicator	Actions	Dependencies	Lead	completion date	Review/Monitoring Actions	Monitoring Actions (for ongoing monitoring)
% compliance with direct admission to an acute stroke unit within 4 hours	Ring-fence Stroke beds - SOP collaboration with EA and Senior Nursing team around patient flow		EA	sep-23	Maintain ring-fenced beds on both sites	Continue to monitor on a monthly basis
	Staff recognition of stroke symptoms on presentation of patient across hospital sites			okt-23	Red flag Training for receptionists	Embed training as part of induction with all new reception staff upon appointment and embed refresher training into PDR if appropriate. Continue to Monitor Quarterly
	Explore changes to CNS rotas at PCH to extend coverage as an interim measure to achieving a 7 day service	roster provision authorisation	LMB	1 month	Discussions with Senior Nursing team and CNS underway	
% of thrombolysed stroke patients with a door to needle time of <=45m						
% of patients who are diagnosed with a stroke who receive a CT scan witin 1 hour						
% of patients who are assessed by a stroke specialist consultant physician within 24 hours						
% of patients who are assessed by one of OT, PT, SALT within 24 hours						
% of applicable patients discharged with ESD/Community Therapy MDT						
Underpinning To achieve robust reporting and processes to ensure consistency across CTM						

Stroke Strategy Group Action Plan

Actions	Dependencies	Lead	Timescale	Updates	completion indicator
Review current pathway for Orthoptics and explore potential for unification of service across CTMUHB	Funding	Assisstant Head of Orthoptics	mar-24	Orthoptic stroke services continue to have different pathways across the HB and there is still a lack of unification.The new NICE guidelines 2023 recommends that people in hospital following a stroke should all be offered a specialist orthoptist assessment as soon as possible. As inpatient or urgent outpatient if discharged The CTM Head Orthoptist post still remains vacant and has not been advertised.It is not possible for Orthoptists to go to the ward currently due to a fully committed small workforce of 8 staff covering paediatric (including visual processing and visual function clinics), adult ocular motility, glaucoma and botox clinics. Plan to review options and go out to advert	
Optimisation of medication and compliance for patients on Primary Care Atrial Fibrillation (AF) and Hypertension Registers. Case Detection of patients with AF and Hypertension.	Primary Care	Health and Wellness Porgamme Manager	mar-24	CTM UHB Value Based Health Care Business case successful as part of Regional Business Case. Work progressing on implementation. This action has moved to an ongoing monitoring phase so the review date moves accordingly	

Updated FAST campaign plans to be clarified	PHW	tbc			
Work with Cardiff and Vale UHB to explore potential for regional working and regional enhanced stroke unit	CaV UHB / National Stroke Programme Board	Regional Stroke Programme Manager	Q1 2025/26	At the recent Programme Board meeting held on 20th February, it was agreed that the original timelines were too ambitious considering the work that needs to be undertaken, therefore a revised draft high level programme plan was presented, with the aim of developing a more detailed programme plan	

Stroke Operational Programme Board

Actions	Dependencies	Lead	Timescale	Updates	completion indicator
Develop stroke community rehabilitation model	Funding	Head of SALT	mai-24	Extension of ESD complete across Bridgend area, serving POWH. Further development of community model to feed into regional planning process	
Development of community hospital stroke rehabilitation model.	Primary Care, Mental Health and Communities Care Group	Assistant Director PC & Communities	jul-24	Community Bed remodelling programme underway, feed into SPB.	
Track progress against HIW Action Plan.	Six Goals Programme	USC Care Group Director	mar-24	Monitoring of plan ongoing	

Agenda Item Number: 9.1.1

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality and Safety Committee 23 January 2024 held via Microsoft Teams

Members Present:

Carolyn Donoghue	Independent Member (Committee Chair)
Kath Palmer	Independent Member (Vice Chair)
Dilys Jouvenat	Independent Member
Nicola Milligan	Independent Member
Patsy Roseblade	Independent Member

In Attendance:

Dom Hurford	Executive Medical Director
Lauren Edwards	Executive Director of Therapies & Health Science
Gethin Hughes	Chief Operating Officer
Greg Dix	Executive Director of Nursing
Richard Hughes	Deputy Director of Nursing
Philip Daniels	Executive Director of Public Health
Gareth Watts	Director of Corporate Governance & Board Secretary
Emma James	Care Group Nurse Director
Sarah Fox	Head of Midwifery & Gynaecology
Nigel Downes	Assistant Director of Quality & Safety (In part)
Sallie Davies	Deputy Medical Director
Lisa Love-Gould	Clinical Director, Allied Health Professionals
Sharon O Brien	Care Group Nurse Director
Ana Llewellyn	Care Group Nurse Director
Becky Gammon	Assistant Director of Nursing & Peoples Experience
Alex Brown	Unscheduled Care, Care Group Medical Director
Owen Weeks	Unscheduled Care, Care Group Medical Director
Chris Beadle	Assistant Director of Health, Safety & Fire
Richard Jones	Clinical Lead for Resuscitation & Acute Deterioration (In part)
Vanessa Jones	Acute Deterioration Lead (In part)
Adam Cooke-Young	Clinical Practitioner
Jodie Hodges	Midwife
Gwenan Roberts	Committee Secretary, Emergency Ambulance Services Committee (In part)
Stephen Harrhy	Chief Ambulance Services Commissioner (In part)
Emma Walters	Head of Corporate Governance & Board Business

Agenda Item

1. PRELIMINARY MATTERS

1.1 Welcome & Introduction

The Committee Chair welcomed everyone to the meeting, 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. Members noted that the meeting would be recorded to aid the Committee Secretariat in ensuring the accuracy of scrutiny related discussions and decisions made during the meeting. Members noted that the recording would be destroyed once the minutes had been confirmed as accurate. Members confirmed they were happy to proceed.

1.2 Apologies for Absence

Apologies have been received from:

- Helen Lentle, Independent Member
- Hywel Daniel, Executive Director for People
- Julie Denley, Deputy Chief Operating Officer
- Mary Self, Care Group Medical Director
- Mohamed Elnasharty, Care Group Medical Director
- Stephen Sarasin, Care Group Medical Director
- Suzanne Hardacre, Director of Midwifery & Nursing
- Cally Hamblyn, Assistant Director of Governance & Risk
- Gaynor Jones, Staff Side Representative

1.3 Declarations of Interest

The Committee Chair declared that she was Chair of the Welsh Wound Innovation Centre which was referenced within a report on today's agenda. G Dix also declared that he was a Board Member of the Welsh Wound Innovation Centre.

2. SHARED LISTENING AND LEARNING

2.1 Listening & Learning Story

A Cooke-Young shared a presentation which related to a patient's journey within the Care of the Elderly Service. The Committee Chair extended her thanks to A Cooke-Young for sharing the story.

G Hughes also welcomed the presentation which was a powerful description of the experiences of many of the older patients who are admitted to the Health Board. He advised that 241 of these patients were sat in beds within the Health Board at the current time, with the longest waiting patient being 609 days awaiting discharge. G Hughes advised that the presentation highlighted the harm and deconditioning these patients experienced during the last period of their lives which was unacceptable. G Hughes advised that he felt that this presentation needed to be shared with Local Authority colleagues to highlight the experiences of patients in the last days of their lives.

D Hurford extended his thanks to A Cooke-Young for sharing the story, which was one of many stories of equal sadness and added that staff were daily caring for patients who were sat in hospital beds waiting for packages of care to be put into place. D Hurford advised that the system was doing harm to patients, particularly at the back door and advised that a piece of work was being undertaken at Princess of Wales Hospital in relation to the Acute Frailty Model at the front door, which would also be launched at Prince Charles Hospital in the coming days, and should help to address the issues highlighted.

O Weeks welcomed the story which unfortunately highlighted a very common occurrence and advised that as soon as a frail elderly patient was admitted to a ward, they become at high risk of hospital acquired infections and deconditioning. O Weeks sought clarity as to the latest position regarding the introduction of Trusted Assessor status and whether the introduction of Trusted Assessors would help to address the issues identified, acknowledging the issues being experienced in the delays in undertaking social care assessments.

E James advised that work had been undertaken in relation to Electronic Transfer of Care which formed part of the Discharge to Recovery and Assessment and added that two Trusted Assessors were being put into place on each site, with their role being to support nursing colleagues with the completion of assessment forms in the correct way to limit the number of queries being raised resulting in delays. Members noted that some of these posts should be in place at the end of January 2024.

P Daniels welcomed the presentation which he had found to be powerful and advised that he too felt this presentation needed to be

shared with the Leaders of the Local Authorities and the CTMUHB Chief Executive Officer for further discussion.

P Roseblade advised that sadly the issues highlighted within the presentation were all too familiar and added that these issues had been in place for a number of years with very little improvement being seen, which needed to be recognized. P Roseblade added that the only way in which she could see these issues being resolved was to have a joint discussion with Local Authority Leaders and Welsh Government, with Welsh Government being the only organisation who were empowered to make the changes that were necessary.

The Committee Chair agreed that this presentation needed to be shared more widely and advised that Committee Members and attendees would all need to look at ways in which they could influence an improvement in the position moving forwards.

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

2.2 Spotlight Presentation - Sepsis

R Jones and V Jones shared a presentation and highlighted the key matters for Members' attention.

The Committee Chair extended her thanks to R Jones and V Jones for sharing the presentation and advised that the Committee were keen and committed to regularly monitoring Sepsis as an area of focus moving forwards. She would be interested to hear what the rationale was as to why the Welsh Government no longer requested information on this area.

R Hughes welcomed the presentation and the work being undertaken by the Team which was demonstrating a positive output and sought clarity as to whether consideration needed to be given to using digital observations to flag patients who might be at risk of sepsis as well as the digitalization of sepsis screening elements. R Jones advised that this was an area that the Team had been considering for some time and advised that there would be a resource requirement attached to this. R Jones added that whilst he was supportive of digital identification and escalation, he felt that it was important to not take away the Clinicians at the bedside and advised that the presence of a senior clinical decision maker was highly important. R Jones recognized that consideration would need to be given to the digital future moving forwards and extended his thanks to V Jones,

Members of the RADAR Committee and Outreach Teams who had led the education and training element of this within the Health Board.

D Hurford extended his thanks to the Team in relation to the work undertaken to date in relation to education and training which had resulted in positive progress being made in improving sepsis compliance.

A Brown advised of the need to maintain an element of caution when issuing paperwork and flowcharts, given that when focus is placed on sepsis this may lead to losing sight of other potential medical conditions which could cause similar symptoms and present in similar ways. A Brown sought clarity as to some of the causes as to why sepsis was being missed by clinical staff and whether it related to lack of resources or to staff dealing with multiple issues. R Jones advised that causes included systemic issues, staff awareness issues and staff having to deal with a number of issues at any one time. In relation to systemic issues, Members noted that the Team were constantly trying to find a tool that was the most sensitive and specific. In relation to staff awareness issues, this could be addressed through training and education. In relation to the third element, Members noted that there was evidence in place which highlighted that identification and escalation of sepsis was not as robust during surges in demand.

N Milligan extended her thanks to the Team for presenting the update and recognized the significant amount of work being undertaken. N Milligan added that concerns had been raised previously at this Committee in relation to sepsis compliance and added that it was evident from the Mortality Reviews that one of the themes being identified related to delays in commencing sepsis treatment and advised that she fully supported a re-focus on Sepsis within the Committee.

In response to a question raised by K Palmer as to whether there were any trends and whether sepsis impacted on elderly people more than younger people, R Jones confirmed that it mostly affected older and vulnerable patients who had co-existing medical problems which made them immuno-suppressed. In relation to trends, R Jones advised that there was not enough data available at present to determine whether there were any trends and added that the Team were constantly reviewing data to determine whether performance was improving.

The Committee Chair welcomed the presentation and extended her thanks to R Jones and V Jones for the work being undertaken in this area and advised that the Committee would continue to maintain focus in this area.

Resolution: The presentation was **NOTED.**

3. CONSENT AGENDA

The Committee Chair reminded Members that the consent agenda items had been moved to the end of the agenda and noted that there were no items that Members wished to move to the main agenda for discussion.

4. MAIN AGENDA

4.1 Matters Arising not considered on the Action Log

There were no matters arising.

5. SETTING THE SCENE – SERVICE DELIVERY

5.1 Report from the Clinical Executives

The Clinical Executives presented the report and highlighted the key matters for Members attention. The Committee Chair advised that comments had been received in relation to the content of the report following the last meeting and added that further comments would be welcomed from Members if they wished to share them.

P Roseblade made reference to section 1.3 which related to the successful pilot of the ward accreditation programme and sought clarity as to whether there was any evidence of a reduction in harm in relation to falls and pressure damage as this was not yet evident in the reported figures. P Roseblade added that if evidence was in place, at what point should Members expect to see a reduction in the figures reported. G Dix advised that whilst there had been a reduction in harm events being reported, this was not directly attributed to the accreditation programme, and advised that Members should start to see an improvement as work progresses in relation to falls reduction and pressure reduction.

P Roseblade made reference to the update included within the report regarding Estates issues within the Special Care Baby Unit at Princess

of Wales Hospital. P Roseblade advised that the report stated that this was the biggest Estates issue within the Health Board and sought clarity regarding this statement as it was her understanding that the biggest Estates issue was within Theatres and related to Fire Safety. G Dix advised that the Estates issues within the Special Care Baby Unit were particularly concerning as there were issues relating to the electrical infrastructure and confirmed that Estates issues within Theatres also remained an area of concern.

P Roseblade made reference to section 3.1 within the report which related to leadership development for professional leads and sought clarity as to whether this cohort of staff were able to undertake training sessions within their contracts or whether training needed to be undertaken during their own time, or within clinical time. L Edwards advised that whilst Allied Health Professional and Healthcare Science staff did not have protected ring-fenced time within their contracts in the same way as other professionals, the Health Board valued and supported its staff to undertake their Continued Professional Development within their contracted hours.

K Palmer welcomed the report which she had found to be helpful and informative and advised that she would welcome an update at a future meeting in relation to the ward accreditation programme, to include the timescales for roll out and what the programme consisted of.

K Palmer welcomed the update provided in relation to the Healthcare Pathways programme and advised that she would welcome a further update on this at a future meeting. D Hurford advised that an event was being planned regarding this programme and added that he would be happy to extend an invitation to Quality & Safety Committee members to this event so that they can gain a better understanding of the programme.

K Palmer advised that she looked forward to receiving future updates on the Palliative Care Service and Mortality data and added that she was supportive of the work being undertaken in relation to weight management services, particularly the work being undertaken on prevention. K Palmer also noted the issues highlighted within the report by the Executive Director of Public Health in relation to recruitment process approval and delays.

The Committee Chair noted the update included within the report in relation to the deep dive being undertaken regarding Endoscopic

Retrograde Cholangio-Pancreatography which may need to be presented to Quality & Safety Committee if any issues are identified and noted the exceptional performance that had been reported in relation to Organ Donation which needed to be celebrated.

Resolution: The report was **NOTED.**

Action: Update on the ward accreditation programme to be presented to a future meeting to include an update on timescales for roll out and content of programme

5.2 Care Group Highlight Reports

5.2a <u>Planned Care Care Group</u>

S O Brien presented the report and highlighted the matters contained within the alert/escalate section.

The Committee Chair welcomed the report and recognised the innovation being undertaken within the Team to do things differently. The Committee Chair also welcomed the positive changes being made within Ophthalmology.

In response to a question raised by P Roseblade as to whether the Ward Controlled Access issue on inpatient wards had now been resolved, G Hughes advised that J Denley, Deputy Chief Operating Officer was leading a piece of work to review access across all hospital environments and advised that an outcome report was due imminently regarding the actions required. G Hughes agreed to provide a further update by email to Committee Members outside the meeting.

Resolution: The report was **NOTED.**

Action: Update to be shared with Members by email in relation to the review being undertaken into ward-controlled access issues

5.2b <u>Primary & Community Care Group</u>

A Llewellyn presented the report and highlighted the matters contained within the alert/escalate section. The Committee Chair advised that she was pleased to see the positive progress that had been made in relation to recruitment which had been an area of concern for Committee Members.

Resolution: The report was **NOTED.**

5.2c **Children & Families Care Group**

S Fox presented the report and highlighted the matters contained within the alert/escalate section. The Committee Chair advised that Committee Members did not underestimate the challenges associated with the decant of the Special Care Baby Unit which would be a difficult task to plan.

In response to a question raised by N Milligan as to whether Health Visiting issues were specific to Bridgend only, S Fox advised that whilst there were challenges across the service, there were particular issues being felt within the Bridgend area and added that she would be happy to present the findings of the deep dive being undertaken to a future of meeting of the Committee which would identify the learning that has been obtained.

Resolution: The report was **NOTED.**

Action: Deep Dive to be presented to a future meeting outlining the outcome of the review into Health Visiting issues experienced in the Bridgend area.

5.2d **Mental Health & Learning Disability Care Group**

A Llewellyn presented the report and highlighted the matters contained within the alert/escalate section. The Committee Chair recognised the significant amount of work undertaken over the last year to improve services.

G Hughes made reference to the risk that had been added to the Organisational Risk Register in relation to Right Care Right Person which had a risk score of 20. A Llewellyn advised that this was a police initiative that had been initially developed in Northumberland and added that the Police Service would stop engaging with activity that was not part of their core business, which could leave the Health Board at serious risk of harm, serious risk to life and criminal activity. Members noted that the Team were currently working through the assessment and impact of this, with the initial assessment being presented to the next Operational Management Board, given the impact this would have across the whole Health Board.

N Milligan made reference to the number of registered nurse vacancies within the service and sought clarity as to whether this was related to a recruitment issue or a retention issue, and if it related to retention, was there any learning to be gained from the staff that were leaving. A Llewellyn advised that both recruitment and retention was an issue. In relation to retention, Members noted that it had been identified via an anonymous concern that had been submitted that newly registered nurses were finding inpatient environments challenging alongside there being no significant leadership available within these areas. In relation to recruitment, the reputation of inpatient environments significantly impacted the ability to recruit, with many registered nurses opting to work in less challenging environments, for example, community settings. Members noted that the Team had developed a plan which should hopefully address the issues being experienced and noted that the Team were also undertaking some work on leadership and culture and development opportunities for staff.

D Jouvenat made reference to statutory and mandatory training compliance and advised that it had been reported to the Health, Safety & Fire Sub Committee that whilst manual handling training sessions were being provided, staff were not attending sessions. A Llewellyn advised that manual handling training was an issue across the Health Board and advised that attendance at training sessions was being monitored closely within Mental Health and added that the issues being experienced within Mental Health were in relation to the availability of training as opposed to non-attendance.

D Jouvenat extended her congratulations to the two Healthcare Support Workers who had recently won the RCN Nursing Award in the Nursing Support Worker category for their work on *Maintaining Standards and Reducing Restrictive Interventions* at Ty Llidiard which was a fantastic achievement.

L Edwards made reference to the staffing challenges identified within the alert/escalate section and questioned whether there would be an opportunity to review the roles of the various professions within the Health Board's inpatient services. L Edwards echoed the comments made by the Committee Chair in relation to the significant amount of work undertaken by the Team in relation to the Mental Health Inpatient Improvement Programme and welcomed the focus being placed on co-production by the Bridgend Community Mental Health Team.

In response to a question raised by P Roseblade as to whether there was reliance on existing staff to cover extra hours or whether extra hours were covered by bank and agency, A Llewellyn advised that additional hours were being covered by bank, agency and existing staff and added that the use of existing staff was being monitored closely to ensure the working time directive was being adhered to.

P Roseblade also raised concern in relation to the introduction of Right Care, Right Person by South Wales Police which could create dangerous environments and significant risks. A Llewellyn advised that the Police service had given assurance that where there was serious imminent risk to life and serious imminent risk of serious harm, they would continue to provide support and added that the Team would continue to develop plans to mitigate the risks moving forwards. The Committee Chair noted that this had also been discussed as an area of concern at the Mental Health Act Monitoring Committee and a suggestion had been made for this matter to be discussed further at a future Board Development Session.

Resolution: The report was **NOTED.**

5.2e **<u>Unscheduled Care Care Group</u>**

A Brown and E James presented the report and highlighted the matters contained within the alert/escalate section.

In response to a question raised by D Jouvenat as to whether the Health Board were able to send patients to other Health Board areas for an MRI scan if the Health Board did not have the capacity to undertake scans, A Brown advised that whilst it was dependent on the patient's situation, the Health Board had been able to refer patients to Cardiff & Vale and Swansea Bay Health Boards for their scans. Members noted it would be too high risk to transfer a patient for a scan who was acutely unwell.

P Roseblade made reference to the Acutely Unwell Study Day which had resulted in a number of training sessions being offered to clinical teams covering key topics which were well attended and sought clarity as to whether any results had been seen in terms of improved processes and reduced harm. E James advised that a reduction in trends had been seen in relation to sepsis in two out of three hospital sites and added that the Team were also seeing less patients coming to harm in relation to delays in treatment.

In response to a question raised by P Roseblade as to when the policies referred to in the update provided on Nutrition and Hydration would be in place and operational, R Hughes advised that the Nutrition and Hydration Steering Group had now formally met and would be reviewing policies moving forwards to ensure they were accurate and up to date.

Resolution: The report was **NOTED.**

5.2f Diagnostics, Therapies, Pharmacy & Sciences Care Group

L Love-Gould presented the report and highlighted the matters contained within the alert/escalate section.

P Roseblade made a general comment and advised that she was pleased to see that all of the Care Group Highlight reports had been submitted in the same format which helped Members to quickly understand where the key issues were.

In response to a comment made by P Roseblade in relation to the wording contained within the update against Parc Prison, controlled drugs, L Love-Gould advised that she would be happy to review the wording used and would submit an amended report. In response to a query raised by P Roseblade as to whether the discrepancies related to the paperwork and the recording element or was this related to discrepancies regarding the stock take of physical drugs. L Love-Gould advised that she need to confirm the position outside the meeting.

D Hurford made reference to the Pathology Service who were moving at pace in relation to service improvements and added that a new Clinical Director was now in post who had been challenging the long-standing approach that had been in place within the service for some time.

G Hughes provided Members with an update in relation to Mortuary Capacity and advised that significant investment had been made into an additional 100 spaces at Prince Charles Hospital. Members noted that there were challenges in place in relation to the time being taken for Medical Examiner investigations to be undertaken alongside associated post-mortems and added that this was being discussed by Medical Directors at an All-Wales level. Members noted that the Health Board had positive relationships in place with Funeral Homes

which was helping to address the position in relation to movement of deceased patients.

G Hughes advised that he was pleased to see the continued reduction in Radiology backlog with some interim appointments made to increase capacity. Members noted that as part of Planned Care Recovery Funding, two Sonographers had been recruited into the service and would be in post by the end of March and noted that a mobile MRI scanner would be on site at the Llantrisant Health Park which would help to further reduce the backlog.

Resolution: The Care Group Highlight Report was NOTED.

Actions: Wording contained within the update against Parc Prison, controlled drugs to be amended

Confirmation to be provided outside the meeting as to whether the discrepancies referred to related to the paperwork and the recording element, or was this related to discrepancies regarding the stock take of physical drugs

7.2 Emergency Ambulance Services Committee (EASC) Quality & Safety Highlight Report

S Harrhy presented Members with an update in relation to red performance and ambulance handover delays and the actions being taken by the Health Board.

P Roseblade welcomed the Highlight Report which she had found to be helpful and enabled the Committee to triangulate internal information with external information and advised that it would be helpful if future reports could include some graphs which showed WAST lost hours and the planned and actual production hours which would provide a holistic view of the position. S Harrhy advised he would be happy to include this data moving forwards and added that in terms of unit hours production, the amount of resource WAST were putting out on a daily basis had been over 95% for the last couple of months which had resulted in a positive impact on performance. In relation to actual production hours, S Harrhy advised that this had been over 95%, with some days achieving 100%.

In response to a question raised by K Palmer as to whether there were any barriers that the Health Board needed to unblock to help improve the position further in relation to ensuring ambulances were

being located in the right places, S Harrhy advised that at present the Health Board just needed to continue to keep focussing on the existing actions and be open to doing things differently if the current actions were not successful. S Harrhy advised that at present there were more calls being received than available ambulances, which was resulting in ambulances being allocated a call from the Hospital as opposed to the standby point, which was impacting on red call performance.

G Hughes questioned what level of confidence was in place that as soon as a crew had been released that they then automatically returned to their standby point. S Harrhy advised that monitoring was being undertaken on a weekly basis of the times vehicles were being released to the time a vehicle became active, with monitoring also being undertaken of the amount of hours lost for meal breaks.

Resolution: The report was **NOTED.**

Action: Future reports to include some graphs which showed WAST lost hours and the planned and actual production hours to provide a holistic view of the position

6. GOVERNANCE, RISK AND ASSURANCE

6.1 Organisation Risk Register – Risks Assigned to the Quality & Safety Committee

G Watts presented the report and asked the Committee to review and discuss the organisational risk register and consider whether the assigned risks had been appropriately assessed.

The Committee Chair advised that she had raised some questions in relation to the risk register ahead of the meeting as outlined below, together with the responses received to date:

- An update was requested in relation to Risk 4491 which had a review date of 30 November 2023. The following response was received:
  Update January 2024 - due to ongoing pressures risk reviewed and score and mitigation remains unchanged. The following updates are however noted in terms of the Six Goals Plan: 1. Capital work underway in Prince Charles Hospital for Same Day Emergency Care (SDEC) unit completion. This timeframe has moved to February due to contracting delays.

2. Acute frailty established in Princess of Wales Hospital and Royal Glamorgan Hospital; recruitment completed for service in Prince Charles Hospital awaiting start dates. Deputy Medical Director (Acute Services) to meet with Care of The Elderly (COTE) Teams to establish progress.
3. Navigation hub screening calls from nursing homes and pulling proactively from WAST stac (Ambulance demand). Pilot phase completed and successful, Navigation Hub used as business as usual. Next steps are to develop ticket to ride model and expand to residential homes. Also exploring opportunities to work with WAST with Advanced Paramedics being incorporated as part of the navigation hub MDT.
Next review: 22.2.2024

- Risk 3133 which related to Mandatory Training and a query raised as to whether this was being monitored by the People & Culture Committee. The following response was received:
It was confirmed by the Assistant Director of Governance & Risk that this would be added to the update being presented to People & Culture Committee.

- Update required against risk 4152 which had a review date of 11 December 2023, with the latest update advising that the risk would be reviewed 15 January 2024. The following response was received:
This has now been updated within the master document.

The Committee Chair encouraged Members to submit specific questions in relation to the Risk Register prior to the meeting to enable responses to be collated.

P Roseblade advised that she was pleased to see the positive comments that had been received from attendees in relation to the Risk training sessions and added that it was evident that these were having a positive impact on the updates that were now being submitted.

P Roseblade made reference to Risk 3337 which related to the Welsh Clinical Care Information System and advised that the update provided appeared to indicate that the Health Board were no longer proceeding with the system. G Hughes advised that there were some significant challenges with the system deployment and added that a rapid piece of work was being undertaken by the Team to explore alternative solutions which could be mobilised quickly.

K Palmer once again made reference to the adult weight management risk (Risk 5462) and again expressed concern that patients were being take off the waiting list if they had not responded to correspondence. G Hughes advised that waiting lists were constantly being validated and added that there was clarity within the access policy as to the number of times a patient will be contacted using a variety of contact methods. G Hughes advised that a patient would only be removed from the list if they advised that they no longer wished to remain on the list. L Love-Gould advised that if patients are not motivated to respond and want to attend sessions then this would make the benefits of the intervention much lower and added that the offer needed to be made to patients where the biggest impact would be gained given the limited resource in place.

K Palmer made reference to Risk 3826 which related to Emergency Department overcrowding and advised that whilst she was pleased to see progress in this area, she recognised that this was still a significant challenge for the Health Board. G Hughes advised that Emergency Department overcrowding was an area of concern for the Executive Team and added that discussions regarding this had been held several times at Quality & Safety Committee and the Planning, Performance & Finance Committee. Members noted that addressing the overcrowding issues would be difficult given the numbers of clinically optimised patients who had not yet departed hospital beds which had resulted in there being no onward flow to wards. G Hughes advised that the Health Board was currently operating at a bed occupancy in excess of 100% and added that the only ways to address this issue would be to reduce bed occupancy or invest in additional beds which would require significant capital and revenue investment. In response to a question raised by K Palmer as to whether virtual wards were part of the mitigation to address Emergency Department overcrowding, E James confirmed that virtual wards were being explored to help address the issues.

K Palmer also made reference to Risk 5646 which related to Right Care, Right Person and advised that it would be helpful to have more understanding against this risk given that South Wales Police colleagues had informed Members at the Mental Health Act Monitoring Committee that this wouldn't have a significant impact for the Health Board.

Resolution: The report was **NOTED.**

6.2 Mortality Indicator and Mortality Reviews

D Hurford updated the Quality and Safety Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process.

The Committee Chair advised that she was encouraged to see the progress being made in this area.

Resolution: The report was **NOTED.**

6.3 Incident Management Framework

N Downes presented the framework and highlighted key updates for Members to note. The Committee Chair recognized that the report had been scrutinized at other forums.

In response to a question raised by K Palmer as to how near misses were being reported and captured and whether there was a process in place that encouraged staff to report near misses, N Downes confirmed that staff were being encouraged to report near misses to ensure learning was being put into place. N Downes advised that the Incident Management Framework was part of a suite of documents which included concerns and complaints and policies and procedures. G Dix added that 4800 incidents were generally being reported each month and advised that whilst serious incidents and duty of candour triggers were regularly being reported, further work needed to be undertaken to ensure that near misses and low harm events were also being captured and reported.

The Committee Chair advised of the need to ensure that clarity was included within the policy that it was important that staff reported near misses.

Resolution: The Incident Management Framework was **APPROVED**

7. DELIVERING OUR PLAN

7.1 Patient Safety & Quality Dashboard

N Downes presented Members with the Patient Safety & Quality Dashboard and highlighted the key matters for Members attention. B Gammon also presented Members with the Peoples Experience

Activity report and highlighted the key matters for Members attention.

The Committee Chair welcomed the Peoples Experience Report which she found to be positive.

In response to a question raised by P Roseblade as to whether it would be possible to show what the trend data looked like once an investigation had been undertaken into a severe incident to determine whether there was any under reporting or over reporting, N Downes agreed to review whether it would be possible to present this data outside the meeting and advised that he would present an update to the next meeting.

In response to a concern raised by N Milligan in relation to the high numbers of patient falls being reported on Ward 15 at Princess of Wales Hospital since September 2023 and the reasons behind this given that the falls programme continued to implement agreed initiatives, E James advised that Ward 15 was a Dementia/Delirium ward with patients on that ward being actively encouraged to not be continuously in their beds and to use the day room. Members noted that whilst there were regular incidents of falls being reported on the ward, the incidents were low harm incidents and assurance had been provided that appropriate staffing was in place with no staffing gaps. N Milligan extended her thanks to E James for providing the update and the assurance in relation to the position.

Resolution: The report was **NOTED.**

Action: Review to be undertaken to determine whether trend data could be included in future reports to determine whether there was any over reporting/under reporting of severe incidents. Update to be included in next iteration of report.

7.3 CTM Quality Strategy Work Plan Update

L Edwards updated the Committee on the development of the work plan, identification of annual objectives, and progress against delivery.

K Palmer welcomed the report which she found to be helpful and informative, and advised that whilst discussions had been held within this Committee in relation to Healthcare Pathways and the Ward Accreditation Programme, she sought clarity as to whether these

were two positive examples that needed to be added to the plan or whether this would cause duplication. L Edwards advised that she would be happy to take a look at this suggestion outside the meeting.

The Committee Chair advised that Committee Members would welcome a further update on progress at a future meeting and L Edwards agreed to review the timings as to the most appropriate time for an update to be presented.

Resolution: The report was **NOTED.**

Actions: Consideration to be given outside the meeting as to whether the work being undertaken on Healthcare Pathways and the Ward Accreditation Programme needed to be added to the plan as positive examples.

Review to be undertaken as to the most appropriate time to present the next update to the Committee.

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1 Mental Health Adult In-Patient Improvement Programme

A Llewellyn provided committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.

L Edwards once again stated that a huge amount of time and energy had been undertaken on this piece of work, which was evident from the update provided within the report. L Edwards advised that it needed to be recognised that the amount of work undertaken by the Team put the service in really good stead for the unannounced inspections given the amount of preparation and paperwork provided, with clarity on processes being in place. Members noted that this gave the Team confidence given that they had provided the assurances and evidence to such high standards.

K Palmer extended her thanks to the Team for the progress that had been made and added that she had found it helpful from a reader's point of view to see that the four remaining actions were in progress and at what stage each of the actions had reached.

The Committee Chair welcomed the report and also extended her thanks to the Team for the improvements made. In response to a

query raised by the Committee Chair as to whether the change in organisational structure brought an added risk to the programme, A Llewellyn advised that whilst this was an added risk, this was being managed and mitigated. A Llewellyn added that a National Mental Health Inpatient Improvement Programme was also being developed which would create an opportunity to align the local programme to the national programme.

The Committee Chair advised that Members had taken great assurance from the work being undertaken and the way in which progress was being presented to the Committee.

Resolution: The report was **NOTED.**

9. CONSENT AGENDA

9.1 FOR APPROVAL – The following items were APPROVED BY Committee Members.

9.1.1 Unconfirmed Minutes of the meeting held on 21 November 2023

9.1.2 Committee Annual Cycle of Business 2024

9.1.3 Quality & Safety Committee Terms of Reference

9.1.4 Concerns Policy

9.1.5 Clinical Policies Approval Process

9.2 FOR NOTING – The following items were NOTED by Committee Members.

9.2.1 Action Log

9.2.2 Committee Forward Work Plan

9.2.3 WHSSC Quality & Patient Safety Committee Chairs Report

9.2.4 Nosocomial Investigation Update Report

9.2.5 Healthcare Inspectorate Wales Improvement Plan Tracker Report

10. ANY OTHER BUSINESS

There was no other business to report.

10.1 Highlight Report to Board – Verbal

The Committee Chair advised that this would be drafted by the Corporate Governance Team outside the meeting.

10.2 How did we do in this meeting?

The Committee Chair advised that she would welcome feedback to be shared outside the meeting as to how Members and attendees felt the meeting went.

10.3 Identification of Future Spotlights and Thematic Presentations

Members agreed to consider any themes or discussion points that would support a targeted presentation or a focus at the Committee.

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

Members noted that the following items would be discussed at the In Committee session:

- Internal Data 'Deep Dive' in to Neonatal Morbidity and Mortality at Cwm Taf University Health Board
- Nationally Reportable Incidents / Maternity Incident Cluster January 2024

11. DATE AND TIME OF NEXT MEETING

The next meeting take place on Thursday 14 March 2024 at 9:00am.

12. CLOSE OF MEETING

Agenda Item Number: 9.1.2

Minutes of the Meeting of Cwm Taf Morgannwg University (CTMUHB) Quality & Safety In Committee held on the 23 January 2024 as a Virtual Meeting via Microsoft Teams

Members Present:

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

In Attendance:

Greg Dix	Deputy Chief Executive /Executive Director of Nursing
Gethin Hughes	Chief Operating Officer
Philip Daniels	Executive Director of Public Health
Dom Hurford	Executive Medical Director
Sallie Davies	Deputy Medical Director
Mohamed Elnasharty	Medical Director, Children & Families Care Group
Gareth Watts	Director of Corporate Governance & Board Secretary
Sarah Fox	Head of Midwifery
Nigel Downes	Assistant Director of Quality & Safety
Jodie Hodges	Local Perinatal Safety Champion
Emma Walters	Head of Corporate Governance & Board Business (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:

- Helen Lentle, Independent Member
- Hywel Daniel, Executive Director for People
- Suzanne Hardacre, Director of Midwifery & Nursing
- Cally Hamblyn, Assistant Director of Governance & Risk

1.3 Declarations of Interest

There were none.

2 MAIN AGENDA

2.1 Internal Data 'Deep Dive' into Neonatal Morbidity and Mortality at Cwm Taf University Health Board.

S Fox presented the report and highlighted the key matters for Members attention.

G Dix extended his thanks to J Hodges for undertaking an analysis of the Hypoxic-ischaemic encephalopathy incidents and advised that the report highlighted that whilst three of the cases could not have been predicted or prevented in their nature, there was incidental and thematic learning that would be addressed following completion of the Route Cause Analysis investigations.

The Committee Chair extended her thanks to S Fox for presenting the report which was clear and detailed.

Resolution: The Report was **NOTED**.

2.2 NRI / Maternity Incident Cluster January 2024

M Elnasharty presented the report which provided the Committee with an update on the Rapid Reviews that had been undertaken of three adverse incidents that had occurred within Maternity & Neonatal Services. The Committee were also provided with an update following the recent unannounced visit undertaken by Healthcare Inspectorate Wales to Prince Charles Hospital Maternity Services.

In relation to the three adverse incidents, G Dix advised that the cases had been discussed with the Chief Nursing Officer and Welsh Government and advised that he felt sadness for the families that had been affected and also for the staff who had worked incredibly hard to improve maternity and neonatal services over the last five years. Members were provided with assurance that these cases had not been caused by lapses of care, with high standards of care remaining in place.

The Committee Chair advised that the Committee were assured by the work that had been undertaken and added that the Committee's thoughts were with everyone involved in these cases, including families and staff.

Resolution: The Report was **NOTED**

3. ANY OTHER BUSINESS

There was no other business to report.

4. DATE AND TIME OF THE NEXT MEETING

The next In Committee meeting of the Quality & Safety Committee is to be confirmed.

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 March 2024)
7.1	November 2021 January 2022	**Quality Dashboard** Future hot topics to be presented to the Committee via the Quality Dashboard in relation to Pressure Ulcers and the Deep Dive being undertaken on Thrombosis. Spotlight report to be presented to the July meeting in relation to Medication Errors	Assistant Director of Quality & Safety	January 2024	**Partially Complete - One action in Progress** Spotlight report on Community Acquired Pressure Damage presented to the March 22 meeting. **Completed.** Spotlight report on Patient Falls presented to the May 22 meeting. **Completed.** Spotlight Report on Medication Errors included in the Quality Dashboard report to the July 22 meeting. **Completed.** Spotlight on Thrombosis to be agreed. **In Progress**
2.1	24 January 2023	**Listening & Learning Story** Presentation to be shared at a future meeting in relation to the wider piece of work being undertaken in relation to the Volunteer Service.	Director of Nursing	January 2024	**In progress** Date to be agreed. Being considered alongside other Listening & Learning stories that need to be scheduled into the programme.
6.4	21 September 2023	**Learning From Events Reports**	Assistant Director of Concerns and Claims	23 January 2024	**In progress** Was due to be presented to the 23 January 2024

		Further update on progress to be presented to the January meeting of the Committee as an appendix to the Quality Dashboard report.		Now 14 March 2024	meeting – now deferred to 14 March 2024. **On agenda as an appendix to the Quality Dashboard report**
6.5	21 September 2023	**CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unity Interim Learning Report** Outcome of the Demand & Capacity work to be presented to a future meeting of the Committee	Head of Covid19 Nosocomial Investigation Team	16 May 2024	**In progress** Report to be presented to the meeting being held on 16 May 2024
5.2c	23 January 2024	**Children & Families – Care Group Highlight Report** Deep Dive to be presented to a future meeting outlining the outcome of the review into Health Visiting issues experienced in the Bridgend areas.	Director of Midwifery	14 March 2024	**In progress** Update to be presented to the March meeting of the Committee. This report will be discussed at the In Committee session
7.2	23 January 2024	**Emergency Ambulance Services Committee (EASC) Quality & Safety Highlight Report** Future reports to include some graphs which showed WAST lost hours and the planned and actual production hours to provide a holistic view of the position	Chief Ambulance Services Commissioner	11 July 2024 (to be agreed)	**In progress** Committee Chair has suggested bi-annual updates are provided on this item

7.3	23 January 2024	**CTM Quality Strategy Work Plan Update** Consideration to be given outside the meeting as to whether the work being undertaken on Healthcare Pathways and the Ward Accreditation Programme needed to be added to the plan as positive examples Review to be undertaken as to the most appropriate time to present the next update to the Committee	Executive Director of Therapies & Health Sciences	16 May 2024	**In progress** The work being undertaken on Healthcare Pathways and the Ward Accreditation Programme to be added to the next iteration of the plan which will be presented to the Committee at its meeting on 16 May 2024

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 March 2024)
5.2d	25 July 2023	**Mental Health & Learning Disabilities Care Group Highlight report** Update to be provided to the next meeting in relation to the outcome of the Demand & Capacity exercise undertaken by the Resuscitation Team in relation to CPR training compliance	Executive Director of Nursing	21 September 2023 Now 21 November 2023 Now 23 January 2024	**Completed** Deputy Director of Nursing had planned to present a Strategy for Implementation to the 14 March 2024 meeting in relation to Basic Life Support Training and other Resuscitation Training across the organisation. A discussion was held on this

				Now 14 March 2024	at the agenda planning session for the March meeting where it was agreed that it would be more appropriate for this report to be presented to the People & Culture Committee. The Committee Chair therefore made a Committee Referral to the Committee requesting that this matter is discussed at their February 2024 meeting.
8.3	25 July 2023	**Mortality Assurance Report** Further update on progress to be presented to the Committee in three months	Medical Director	21 November 2023 Now 23 January 2024	**Completed and Ongoing** Report presented and discussed at the January 2024 meeting. This item has now been added to the annual cycle of business for regular reporting.
5.1	21 September 2023	**Report from the Chief Operating Officer** Report on Sepsis to be presented to the next meeting of the Committee	Medical Director	21 November 2023 Now 23 January 2024	**Completed** Spotlight report presented to the January 2024 meeting. Committee Members advised that they would like regular reporting on this matter so this will need to be added to the annual cycle of business

5.1	21 November 2023	**Report from the Clinical Executives** Feedback to be shared with the Deputy Director of Nursing regarding the content of the report to help inform future iterations	Deputy Director of Nursing	23 January 2024	**Completed** Feedback was shared regarding report content
5.2f	23 January 2024	**Diagnostics, Therapies, Pharmacies and Sciences – Care Group Highlight Report** Wording contained within the update against Parc Prison, controlled drugs to be amended	Clinical Director, Allied Health Professionals	23 January 2024	**Completed** Report amended and republished
2.2	21 September 2023	**Care Group Spotlight Presentation – Planned Care – Focus on Ophthalmology Backlog** Report to be prepared for a future meeting of the Board highlighting the positive steps that had been taken to address the backlog within Ophthalmology	Chief Operating Officer	Completed	**Completed** The Committee Chair and Chief Operating Officer have agreed that given this has been reported positively through the Committee Highlight Report and Integrated Performance Report to Board, this action can now be closed.
5.2f	23 January 2024	**Diagnostics, Therapies, Pharmacies and Sciences – Care Group Highlight Report** Confirmation to be provided outside the meeting as to whether the discrepancies referred to related to the	Clinical Director, Allied Health Professionals	14 March 2024	**Completed** Confirmation provided via the meeting chat during the meeting that discrepancies did relate to paperwork and the increased volume of paperwork associated to controlled drugs.

		paperwork and the recording element, or was this related to discrepancies regarding the stock take of physical drugs			
5.1	23 January 2024	**Clinical Executives Report** Update on the ward accreditation programme to be presented to a future meeting to include an update on timescales for roll out and content of programme	Executive Director of Nursing	14 March 2024	**Completed** Update report shared with Members by email by the Executive Director of Nursing on 12 February 2024
2.3	16 March 2023	**Care Group Spotlight Report – Unscheduled Care** Data to be shared with Members outside the meeting in relation to ambulance handovers to include the data for each individual hospital for the numbers for requested for immediate release and number agreed.	Care Group Nurse Director – Unscheduled Care	24 May 2023 Now 25 July 2023	**Completed** This action has now been superceded.
5.2a	23 January 2024	**Planned Care – Care Group Highlight Report** Update to be shared with Members by email in relation to the review being undertaken into ward controlled access issues	Chief Operating Officer	14 March 2024	**Completed** Response shared with Members by email on 7 March 2024

6.1	25 July 2023	**Quality Dashboard** Response to be provided outside the meeting as to what percentage of incidents classed as catastrophic or death was directly attributed to the Health Board and what percentage was not directly attributed	Assistant Director of Quality & Safety	21 September 2023 **Now 14 March 2024**	**Completed** This action has been completed and the data is contained within Section 2.2 "Closed Incident by Severity Post Investigation" table.
7.1	23 January 2024	**Patient Safety & Quality Dashboard** Review to be undertaken to determine whether trend data could be included in future reports to determine whether there was any over reporting/under reporting of severe incidents. Update to be included in next iteration of report	Assistant Director of Quality & Safety	14 March 2024	**Completed** This action is complete. The data is contained within Section 2.2 "Data Comparison Severe & Catastrophic / Death Incidents" table.

Agenda Item
9.2.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Emma Walters, Head of Corporate Governance & Board Business
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	

1. Situation /Background

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

1.2 The Cycle of Business covers the period 1 January 2024 to 31 December 2024.

1.3 Any changes made to the Annual Cycle of Business since the last meeting will be identified in red moving forwards.

2. Specific Matters for Consideration

2.1 The Cycle of Business has been developed to help plan the management of Committee matters and facilitate the management of agendas and Committee business.

3. Key Risks / Matters for Escalation

3.1 Please refer to **Appendix 1** – Quality & Safety Committee Cycle of Business for further detail. Any changes have been identified in red.

4. Assessment

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

(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

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

5. Recommendation

5.1 The Quality & Safety Committee are asked to **NOTE** the Annual Cycle of Business for 2024.

Quality & Safety Committee

Cycle of Business

(1st January 2024 – 31st December 2024)

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 2024 to 31st December 2024.

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.

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Quality & Safety Committee Cycle of Business (1st January 2024 – 31st December 2024)

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
SHARED LISTENING & LEARNING														
Shared Listening & Learning Story	Executive Director of Nursing	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
Thematic Spotlight Presentation	Lead Clinical Executive	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
SETTING THE SCENE – SERVICE DELIVERY														
Report from the Clinical Executives	Clinical Executives	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
Care Group Highlight Reports	Executive Director of Nursing	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
GOVERNANCE, RISK AND ASSURANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance/ Board Secretary	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
Healthcare Inspectorate Wales Action Plan Tracker	Executive Director of Nursing	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi-annually	🏳						🏳					
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.	Executive Director of Nursing	Annually	🏳 Defer to Mar 24		🏳									
Infection, Prevention & Control Report (Annual Report and Mid-Year Update) Exception reports will be presented as and when required	Executive Director of Nursing	Bi-Annually					🏳 End of year update				🏳 Annual Report		🏳 Mid Year update	
DELIVERING OUR PLAN														
Quality Dashboard Report	Executive Director of Nursing	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
DELIVERING OUR IMPROVEMENT PROGRAMMES														
Stroke Services Progress Report	Executive Director of Therapies and Health Sciences	Quarterly			🏳				🏳				🏳	
Mental Health In-Patient Improvement Progress Reports	Executive Director of Therapies and Health Sciences	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	🏳		🏳		🏳		🏳		🏳		🏳	

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
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	✓ Defer to July 24						✓					
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually							✓					
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	✓				✓				✓			
Putting Things Right Annual Report	Director of Corporate Governance	Annually							✓					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually					✓						✓	
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually											✓	
Welsh Ambulance Services NHS Trust Patient Experience Report Update has been included in the Unscheduled Care Group Highlight Report for July 2023	Director of Nursing	Quarterly	✓				✓		✓				✓	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					✓							
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					✓						✓	
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	Executive Director for People	Quarterly			✓				✓				✓	

Item of Business	Executive Lead	Reporting period	23 Jan 2024	Feb 2024	14 Mar 2024	April 2024	16 May 2024	June 2024	11 July 2024	Aug 2024	12 Sep 2024	Oct 2024	14 Nov 2024	Dec 2024
Radiation Safety Committee Annual and Mid Year Updates	Director of Therapies & Health Sciences	Bi-Annually												
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually												
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	Defer to May 2024											
Ombudsman's Annual Letter and Annual Report	Director of Nursing	Annually												
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually												
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually												
Organ Donation Committee Annual Report	Medical Director	Annually												
Access to Medicines Committee	Medical Director	Annually												

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**
Request made by the Quality & Safety Committee Chair	Additional Item	Annual Quality Work Plan	Director of Nursing	Discussion held at agenda planning. Noted that an Annual Quality Report would need to be produced as opposed to an Annual Quality Work Plan. Date for presentation of the Annual Quality work plan to be confirmed
Request received from the Head of Nosocomial Investigation Team	Additional Item	CTMUHB Nosocomial Covid 19 Incident Management Programme - Delivery Unit (NHS Executive) Interim Learning Report	Executive Director of Nursing	**In progress** Report received at the meeting held on 21 September 2023. Further update on progress to be presented to the Committee in **May 2024.**
Email Request received from the Senior Nurse Community Children's Nursing Services	Additional Item	Was Not Brought Policy – For Approval	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**
Email Request received from the Head of Safeguarding	Additional Item	Deprivation of Liberty Protection Safeguards Policy	Director of Nursing	Was planned for 21 November 2023 – **To be deferred – date to be confirmed**

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Suggested as an item for discussion at the September 2023 Board meeting	Additional Item	Consequences of Endoscopy Delays from a Quality & Safety Perspective	Chief Operating Officer	Impact of Endoscopy Delays to be included in the Planned Care Group Highlight Report for the 23 January 2024 meeting. Suggested at agenda planning session that a more detailed Spotlight Report is shared on Endoscopy Delays at the March 2024 meeting with an associated Listening & Learning Story. **New date to be identified**
Email request received from the Director of Improvement & Innovation	Additional Item	ICTM Annual Report	Director of Improvement & Innovation	Planned for 14 March 2024 – **On agenda**
Email request received from the Medical Directorate Business Manager	Additional Item	New NICE Guidance Process	Medical Director	Was planned for 14 March 2024 – Now 16 May 2024
Email request received from the Welsh Language Services Manager	Additional Item	In-patient Active Offer Policy	Executive Director of Nursing	Was planned for 14 March 2024 – Now 16 May 2024

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Completed Activity From the Forward Work Programme:

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request from the Patient Care & Safety Team	Additional Item	Concerns Policy	Director of Nursing	**Completed** Received and approved at the meeting held on 23 January 2024
Request made by the Chair and Vice Chair at the agenda planning session for the July Board	Additional Item	Mortality Report	Medical Director	**Completed and Ongoing** Report presented to the meeting held on 23 January 2024. Item has been added to the annual cycle of business for regular reporting
Request received from the Patient Care & Safety Business Manager	Additional Item	Incident Management Framework	Executive Director of Nursing	**Completed** Report received and approved at the meeting held on 23 January 2024
Identified as an agenda item at the Hosted Bodies Audit & Risk Committee held on 16/8/23	Additional Item	EASC Quality & Safety Composite Report	Chief Ambulance Services Commissioner	**Completed** Report received at the meeting held on 23 January 2024
Item agreed at agenda planning session	Additional Item	Spotlight Presentation on Sepsis	Medical Director	**Completed** Presentation received at the meeting held on 23 January 2024
Item referred to at the November 2023 Quality & Safety Committee	Additional Item	Quality Strategy Annual Plan	Executive Director of Therapies & Health Sciences	**Completed** Received at the meeting held on 23 January 2024

Agenda Item
9.2.4

Quality & Safety Committee

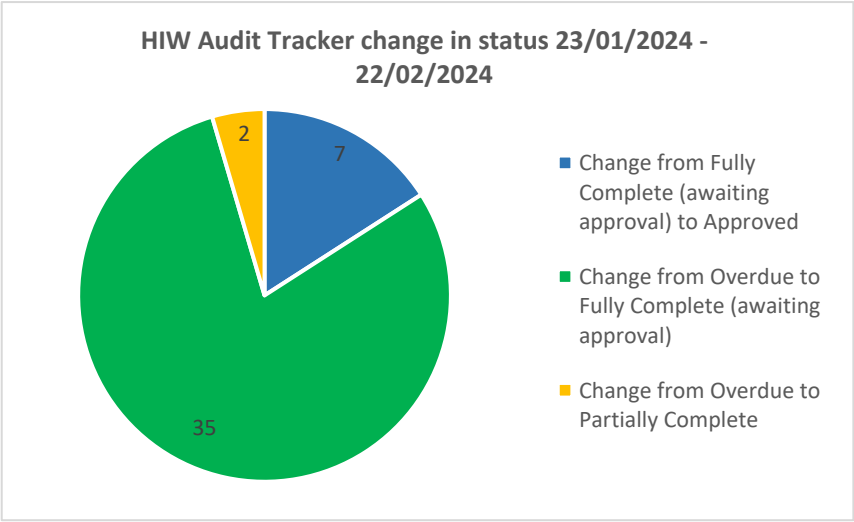
HEALTHCARE INSPECTORATE WALES IMPROVEMENT PLAN TRACKER REPORT SEPTEMBER-OCTOBER 2023

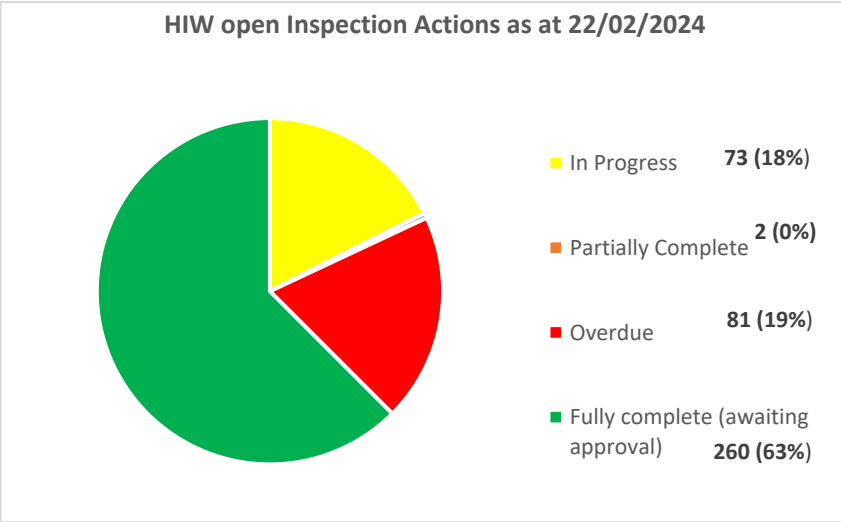
Dyddiad y Cyfarfod / Date of Meeting	14th March 2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Claire Brown Head of Quality Assurance and Compliance
Cyflwynydd yr Adroddiad / Report Presenter	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

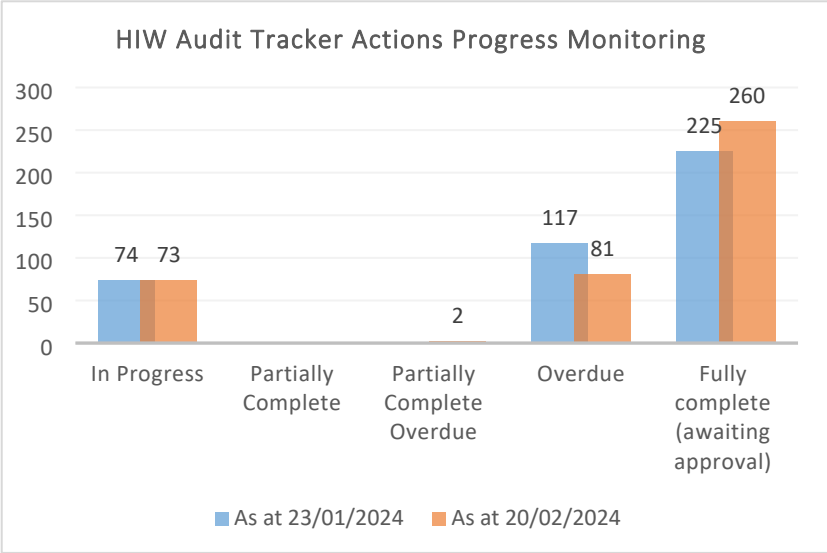
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

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







		Actions by Status- As at End February 2024		
Total Number of Actions	**Actions passed due date**	**Actions ongoing/partial complete**	**Yellow- Actions on Target to meet original or revised completion date**	**Fully Complete Awaiting Approval**
416	81	2	73	260

1. Situation /Background

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

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

1.3 All open and live HIW inspection improvement plans are now recorded on AMaT however due to areas requiring further development within the system there is still a significant element of manual inputting of Data in order to present this report. The request for system changes to support the use of AMaT to track and manage improvement plans for HIW have been submitted to the AMaT team and are in the process of being developed.

1.4 Communication has been sent out of all Heads of Quality within Care Groups to seek their support in updating the AMaT system by a prescribed date before each Quality and Safety committee. The Assurance and Compliance team and the Patient Safety team are now working closely together to ensure a smooth transition in the role of providing assurance and compliance for recording and reporting purposes. This will allow for a systematic and robust process for continuous monitoring of all the HIW inspection improvement plans and activity.

2. Specific Matters for Consideration

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

2.2 Care Groups are responsible for providing regular updates on the improvement plans within their care group portfolios in order that the tracker can remain live and up to date ensuring all actions are completed in a timely manner.

2.3 Where actions are reported as complete/closed the Care Groups are responsible for ensuring the supporting evidence is available to support the closure and completeness of such actions. The introduction of the Audit Management and Tracking system (AMaT), whereby Care Groups are able

to update independently directly into the system will support a more effective and efficient process by which the reviews can be updated.

2.3 A breakdown of the status position with regards to all actions up to the end of February 2024 is detailed below.

- A total of **416 actions** are reported with a further breakdown of the stages towards compliance reported in table 1 located in the dashboard at the beginning of this report.

This is further broken down as follows:

- **81** actions reported as Red with the actions being those which are incomplete and have passed the agreed due date;
- **2** actions reported as Amber which are those actions partially complete/ongoing to meet deadline date;
- **73** actions reported as Yellow which are those on target to meet original or revised completion date;
- **260** actions reported as Green completed actions

2.4 **Current Position**

- There were no new **Improvement Plans** added to the tracker during this period.
- 35 Improvement plans were fully completed and are awaiting Executive approval.
- 7 Improvement Plans are now fully completed, approved and proposed for closure within AMaT from last month.

2.5 The Committee are asked to note that in response to the 18 overdue actions within the National Review of Mental Health Inspection (REF-2021/137) which are not displaying an update, this has been escalated to the Mental Health and Learning Disabilities Care Group who would like to assure the Committee they will provide an update on progress as soon as possible which will be reflected in the next Quality and Safety Committee report.

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

3. Key Risks / Matters for Escalation

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

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

3.3 HIW Inspection activity work has started transitioning across to the Assurance and Compliance team following agreement of a new and revised reporting process which was presented to and agreed by the Audit & Risk committee in February 2024.

3.4 Directors of Nursing will be receiving emails requesting their support in the rollout of AMaT for HIW inspections. The Directors of Nursing will then be able to assign actions to relevant leads in order to provide regular updates to directly into the automated system by prescribed dates for the Quality Assurance and Compliance team to review and report to Audit and Risk Committee and Quality and Safety Committee as required.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals *150623-guide-to-the-fg-acten.pdf (futuregenerations.wales)*	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd *(Canllawiau Statudol Dyletswydd*	Whole-systems Perspective

Ansawdd (llyw.cymru)) / **Link to Enablers of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	If more than one applies please list below:
Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /* **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Equitable, Safe, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd	Yes: ☐	No: ☒
Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Outcome:	If no, please include rationale below: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is an overarching position update report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment which will be undertaken by the responsible Care Group.

Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.

5. Recommendation

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

6. Next Steps

6.1 Working in partnership continues to ensure a smooth and robust transition across to the Assurance and Compliance team who will co-manage the compliance of HIW Inspections moving forward.

Agenda Item
9.2.5

Quality & Safety Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) NATIONAL CLINICAL AUDIT PROGRAMME UPDATE 2023-2024

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit & Quality Informatics, Lauren Dyton – Clinical Audit Manager
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
TARN	Trauma Audit Research Network
CA&QI	Clinical Audit & Quality Informatics Department
NEIAA	National Early Inflammatory Arthritis Audit
NAIF	National Audit of Inpatient Falls
NELA	National Emergency Laparotomy Audit
SWTN	South Wales Trauma Network

PWH	Princess of Wales Hospital
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
AMaT	Audit Management and Tracking
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
MINAP	Myocardial Ischaemia Audit Project
NICE	National Institute for Health and Care Excellence
HQIP	Healthcare Quality Improvement Partnership
WG	Welsh Government
NCA&ORP	National Clinical Audit and Outcome Review Plan
COPD	Chronic Obstructive Pulmonary Disease
DHCW	Digital Heath Care Wales
NHFA	National Heart Failure Audit
NNAP	National Neonatal Audit Programme
ICS	Integrated Care Systems
PROMs	Patient Reported Outcome Measures
GIRFT	Getting It Right First Time
BSR	British Society for Rheumatology
EIA	Early Inflammatory Arthritis
QS	Quality Standard/Quality Statement
NCDA	National Core Diabetes Audit

1. Situation /Background

1.1 The purpose of this report is to provide an update for the Quality and Safety Committee on progress against the CTMUHB Clinical Audit Forward Plan 2023-2024 aligned to the NCA&ORP for 2023/24. WG did not release an All Wales plan for 2023-24 and therefore the CTMUHB plan was based on information from the HQIP directory of United Kingdom wide agreed audits.

1.2 **26** out of 33 national audits and **7** out of 12 clinical outcome reviews (tier 1) are green fully compliant and **10** amber where the audits or reviews are delayed, a backlog exists work is ongoing to partially or fully comply with the national audit deadlines. **1** audit is red the NCDA as CTMUHB was not in a position to share the diabetes audit data for 2023 with the NCDA audit group via DHCW this year, owing to the absence of the necessary data disclosure agreements on a pan Wales basis, we will be an 'outlier' for the NCDA.

1.3 The DNACPR audit outcome findings have been finalised and will be shared in bi-monthly audit meets across the organisation in the coming months.

1.4 The AMaT system continues to develop with work in progress to further develop the use of the inspections module by the corporate governance team.

2. Specific Matters for Consideration

2.1 Clinical Audit Forward Plan 2023-2024 Current Position

A number of audits are amber due to competing demands on clinician time, these include:

NJR at the PWH not covered by the directorate and therefore agreement to fund overtime received allowing the Clinical Audit team to provide cover at short notice to meet the deadline of the 28 February 2024. Ongoing discussion taking place to transfer funding for the data capture responsibilities to Clinical Audit team for 2024/25, as per other sites.

Additional support also provided to address backlog of NHFD cases necessary to meet the audit deadline.

NEIAA due to clinical pressures and limited administration resources to support the service particularly in the PWH.

NAIF clinical input for case note reviews has been identified across all 3 District General Hospital sites, which has led to an improving picture of compliance.

NELA current compliance lower than anticipated at RGH, enhanced engagement with NELA leads, anaesthetic and surgical staff to encourage active data submission.

TARN interim measures in place following the taking down of the system by the University of Manchester (refer to key risk point 3.1) which has impacted on national data capture.

NHFA is amber due to limited Heart Failure nurse support, but nursing resources have been diverted from the MINAP national audit support at the PWH to assist in addressing the NHFA backlog.

Significant difficulties have been noted in 2023/2024 in securing the necessary medical and nursing input to achieve compliance with tier 1 national audits due to increased clinical demands with no or limited capacity then to participate in clinical audit. However, the clinical audit team continue to work to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

2.2 Key clinical audit publications, findings and actions

NNAP 2023 Report (based on NNAP data on babies admitted to neonatal care in England and Wales between 1 January and 31 December 2022)

NNAP assesses whether babies admitted to neonatal units receive consistent high-quality care in relation to the NNAP audit measures aligned to a set of professionally agreed guidelines and standards. The NNAP also identifies variation in the provision of neonatal care at local unit, regional network and national levels and supports stakeholders to use audit data to stimulate improvement in care delivery and outcomes.

National recommendations highlighted in the report centre on the following themes: Outcomes of neonatal care; Optimal perinatal care; Parental partnership in care; Neonatal nurse staffing and Care processes.

On the theme of Optimal perinatal care NNAP recommends that the WG should ensure that pre-term birth is optimally managed by a multidisciplinary team by:

- Ensuring that preterm birth lead teams (including an obstetrician, neonatologist, neonatal nurse and midwife) are commissioned at all neonatal services,
- Requiring that ICS, Health Boards in Scotland and Local Health Boards in Wales ensure that all neonatal services take a perinatal team approach to design and delivery of care that includes parents with diverse backgrounds and diverse experiences of neonatal care,
- Ensuring that perinatal teams conduct reviews of preterm birth cases to identify opportunities for improvement to maximise quality of care, and the delivery of the interventions identified by national improvement initiatives.

At CTMUHB a dedicated multidisciplinary task and finish team has been established to review the local NNAP findings and national recommendations, following which an improvement action plan has been developed, focussing on enhancing the delivery of interventions identified by national improvement initiatives, ensuring data completeness for NNAP care measures and improving access to retinopathy of prematurity services.

NEIAA State of the Nation Report 2023 (based on 2022/23 data)

NEIAA measures the quality of care delivered to patients in England and Wales with suspected and newly diagnosed EIA. Quality of care is measured against the best practice guidelines set out by NICE quality standard 33 (QS33). The fifth NEIAA annual report and the first State of the Nation report for the programme, presenting data on five key metrics of care: time to referral, time to assessment, time to treatment, response to treatment and patient-reported outcome measures.

Summary of National findings

- Referral to specialist rheumatology services has improved with 56% of patients (vs 54% in year 4) being referred within three working days. (QS33 2013: QS 1)
- Assessment delay has increased with only 39% of patients (vs 41% in year 4) being seen for their first appointment within three weeks of receipt of referral. (QS33 2013: QS 2)
- Treatment delay has decreased with 56% of patients (vs 52% in year 4) receiving treatment within six weeks of receipt of referral. (QS33 2013: QS 3)
- Response to treatment has not changed with 36% of patients reporting a good response to treatment within three months of diagnosis.
- Clinically meaningful improvements were recorded for all PROMs between baseline and 3-month follow-up.

National Recommendations

- Ensure that public awareness is raised to encourage early presentation in primary care of people with suspected EIA and early referral into specialised rheumatology services. (QS33 2013: QS 1)
- early inflammatory arthritis pathways should be mandated in secondary care to provide timely assessment, diagnosis and access to treatment for patients with EIA. (QS33 2013: QS 2 & 3)
- NEIAA data alongside the strategies described in the elective recovery programme, GIRFT and the outpatient recovery and transformation programme must be used to inform and expediate post COVID-19 pandemic recovery strategies for secondary care rheumatology services.
- Collection of outpatient secondary care diagnostic information should be mandated as a priority to inform service design and delivery. (GIRFT recommendations 7 and 8)
- The rheumatology multi-disciplinary team provision should be expanded to meet the rising demand and expectations in line with

recommendations in the BSR rheumatology workforce report. (QS33 2013: QS 2 and 3)

Local improvement activity is taking place and action is being taken to address clinical staffing shortfalls and access to treatment for patients with EIA. In addition, the Clinical Audit Department is working closely with the multidisciplinary teams to improve data capture levels for NEIAA across CTMUHB

2.3 **Clinical Audit Training**

In November 2023, the Clinical Audit department provided clinical audit training for a student nurse as part of the ongoing work with the University of South Wales. Feedback from the 3rd year student nurse was very positive.

Active engagement with the Learning & Development team continues to encourage young people to consider a role in the field of clinical audit through the Jobs Growth Wales+ scheme.

AMaT ward and area module dashboard and action plan training has been extended to Health Visitors through quarter 3, 2023/24.

2.4 **AMaT Implementation**

The AMaT system continues to develop with work in progress to further develop the use of the inspections module by the corporate governance team.

2.5 **NICE Compliance Programme of work**

The assurance oversight, scrutiny and a governance function in relation to NICE guidance within CTMUHB is the responsibility of the care groups. However, in collaboration with the Medical Director's office a process to disseminate new NICE guidance and to receive feedback from care groups and annotate compliance statements on the AMaT system is under development.

2.6 **CTMUHB Clinical Audit Forward Plan 2024-25**

Welsh Health Circular and NHS Wales National Clinical Audit and Outcome Review Plan for Wales has yet to be published. The CTMUHB Clinical Audit Forward Plan for 2024-25 has been developed based on the HQIP audit directory, but may need to be updated following release of the Welsh Health Circular by WG.

3. Key Risks / Matters for Escalation

3.1 On 9 June, the University of Manchester confirmed it had taken down the Trauma Audit Research Network's National Major Trauma Database, resulting in the inability to submit or access data.

SWTN liaised with Health Boards and WG to address the issue.

The SWTN is working in collaboration with DHCW regarding the creation of a long-term data capture solution for use by Health Boards in Wales. This will be piloted in March 2024, subject to the appropriate data disclosure agreements and governance arrangements being established.

3.2 CTMHUB has not participated in the 2023 **NCDA** as CTMUHB was not in a position to share the diabetes audit data for 2023 with the NCDA audit group via DHCW this year, owing to the absence of the necessary data disclosure agreements on a pan Wales basis with DHCW. The All Wales Clinical Governance Group are to review.

3.3 Limited clinical input across the Health Board and a reduced clinical audit team is affecting compliance with tier 2 organisation priority audits only 3 out of 8 were undertaken for 2023/24.

4. Assessment

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

Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
		If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee **NOTE** receipt of the compliance position and mitigating action being taken to achieve compliance for the CTMUHB.

6. Next Steps

6.1 To ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

Agenda Item
9.2.6

Quality & Safety Committee

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD (CTMUHB) CLINICAL AUDIT FORWARD PLAN FOR 2024-2025

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Mark Townsend – Head of Clinical Audit and Quality Informatics
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford – Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms	
CTMUHB	Cwm Taf Morgannwg University Health Board
NCA&ORP	National Clinic al Audit & Outcome Review Plan
CA&QI	Clinical Audit and Quality Informatics
HQIP	Healthcare Quality Improvement Partnership

1. Situation /Background

1.1 The purpose of this report is to provide the Quality and Safety Committee with the CTMUHB Clinical Audit Forward Plan 2024-2025. WG did not release an All Wales NCA&ORP for 2023-24 and no date has been set for release of the All Wales 2024-2025 plan therefore the CTMUHB forward plan is based on information from the HQIP directory of United Kingdom wide agreed audits. (See Appendix 1: Clinical Audit Forward Plan 2024-25).

2. Specific Matters for Consideration

The clinical audit team are currently working to ensure completion of the full CTMUHB Clinical Audit Forward Plan 2023-2024, by the end of March 2024.

3. Key Risks / Matters for Escalation

3.1 The challenging backdrop of reduced budget, decreased staffing and increased demand to deliver an increasing programme of tier 1 national audits resulting in reduced capacity to support tier 2 essential organisation priority clinical audits.

4. Assessment

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

Dolen i Feysydd Ansawdd *(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru))* / **Link to Domains of Quality** *(Duty of Quality Statutory Guidance (gov.wales))*	Effective
	If more than one applies please list below: Efficient, Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd?* / **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☒	No: ☐
	Outcome: The potential consequences on quality of service have been considered and any necessary mitigating actions outlined in the paper	If no, please include rationale below:
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb?* / **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: This is not a policy or service review
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau *(Pobl /Ariannol)* / **Resource Impact** *(People / Financial)*	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee NOTE receipt of the CTMUHB Clinical Audit Forward Plan for 2024-2025.

6. Next Steps

6.1 To ensure delivery of the full CTMUHB Clinical Audit Forward Plan for 2024-2025, by the end of March 2025.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Knowing How Well We Are Doing

Clinical Audit Forward Plan 2024-25

Standard 3.1:
Safe and Clinically Effective Care
Effective Care

Version 1.0, 07 February 2024

The following key criteria will also be used for judging success:

- 100% participation, appropriate levels of case ascertainment and submission of complete data sets by all health boards and trusts (where applicable) in the full programme of National Clinical Audits and Clinical Outcome Reviews.
- Improvements in the quality and safety of patient outcomes and experience brought about by learning and action arising from the findings of National Clinical Audit and Clinical Outcome Review reports.

The findings and recommendations from national clinical audit, outcome reviews and all other forms of reviews and assessments will be one of the principal mechanisms for assessing the quality and effectiveness of healthcare services provided by health boards and trusts in Wales.

A Welsh Health Circular and Annual Plan is due to be published in June 2024 to clarify the mandatory audit list. The Cwm Taf Morgannwg University Health Board (CTMUHB) Clinical Audit Forward Plan has been developed based on the HQIP audit directory, but may need to be updated following the final release of the Welsh Health Circular by WG.

Compliance Key

RED	Cause for concern. Full compliance not achieved by audit deadline.
AMBER	Tier 1: **National audit** delayed, backlog exists but plan in place to comply with national audit deadline. Tier 2: **Organisation priority audit** delayed by one quarter, but plan in place to comply with revised audit deadline.
GREEN	Audit on track at 31/03/2024 or completed, evidence of audit compliance documented on AMaT system.
BLUE	Audit and action plan completed by clinical audit leads and signed off on AMaT system.

Submission deadlines and planned report release deadlines are constantly changing and in most cases being delayed.

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
Acute						
National Joint Registry (NJR)	operates continuous data capture	**February 2025**	September 2024	Trauma and Orthopaedics	Fully compliant RGH and PCH, PoWH compliance affected by clinical pressures, work ongoing to ensure full compliance	AMBER
National Emergency Laparotomy Audit (NELA)	operates continuous data capture	**June 2024**	November 2024	Surgery / Anaesthetics	Organisation wide compliance	GREEN
Case Mix Programme (CMP) ICNARC	operates continuous data capture	**Monthly**	March 2025	Anaesthetics	Organisation wide compliance	GREEN
Major Trauma Audit # (TARN)	operates continuous data capture	**Awaiting details at time of reporting**	TBC	Emergency Medicine	National TARN System unavailable for data submissions due to a cyber-attack. DHCW and NHS England developing a new data collection systems for 2024/25	**N/A**
Long Term Conditions						
National Diabetes Audit * **Note this covers the following areas :** • National Diabetes Foot Care Audit (NDFCA)	operates continuous data capture	**N/A**	May 2024	Therapies	Organisation wide compliance	GREEN

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
• National Diabetes Inpatient Audit (NDISA)	operates continuous data capture	Participation commencing March 2024	N/A	General medicine	Organisations in Wales not required to participate	**N/A**
• National Pregnancy in Diabetes Audit (NPID)	operates continuous data capture	**February 2024**	TBC	Obstetrics and Gynaecology	Organisation wide compliance	**GREEN**
• National Core Diabetes Audit (NCDA)	Data capture from Primary Care at specific intervals	**Pending agreement**	N/A	Primary Care	Organisation unable to participate due to a technical anomaly / outlier	**RED**
National Diabetes Paediatric Audit (NPDA) * #	operates continuous data capture	**N/A**	July 2024	Paediatrics	Organisation wide compliance	**GREEN**
National Respiratory Audit Programme (NRAP)* # **Note this covers the following areas:** Adult Asthma Secondary Care	operates continuous data capture	**May 2024**	June 2025	General medicine	Organisation wide compliance	**GREEN**
COPD Secondary Care	operates continuous data capture	**May 2024**	June 2025	General medicine	Organisation wide compliance	**GREEN**
Paediatric Asthma Secondary Care	operates continuous data capture	**May 2024**	June 2025	Paediatrics	Organisation wide compliance	**GREEN**

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
Pulmonary Rehabilitation	operates continuous data capture	**Due to restart participation in 2024/25**	TBC	General medicine / Therapies	Service not operational	**N/A**
National Early Inflammatory Arthritis Audit * # (NEIRT)	N/A	**May 2024**	October 2024	Rheumatology	Action being taken to improve compliance	**AMBER**
All Wales Audiology Audit #	operates continuous data capture	**N/A**	TBC	Ears, Nose and Throat	Organisation wide compliance	**GREEN**
Older People						
Sentinel Stroke National Audit Programme (SSNAP) (SSNAP) *	operates continuous data capture	**N/A**	TBC	General medicine / Therapies	Organisation wide compliance	**GREEN**
Falls and Fragility Fractures Audit Programme Including: • Inpatient Falls * (NAIF)	operates continuous data capture	**March 2025**	TBC	General Medicine / Trauma & Orthopaedics	Support arrangements under review to ensure compliance by end of March 2024	**AMBER**
• National Hip Fracture Database (NHFD)	operates continuous data capture	**January 2025**	TBC	General Medicine / Trauma & Orthopaedics	Organisation wide compliance	**GREEN**
• Fracture Liaison Service Database (FLS-DB)	operates continuous data capture	**Participation April 2024**	N/A	General Medicine / Trauma & Orthopaedics	N/A	**N/A**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Dementia Audit * (NDA)	Completed 5 Year cycle	**N/A**	N/A	Mental Health / Care of the Elderly	Organisation wide compliance	GREEN
End of Life						
National Audit for Care at the End of Life (NACEL) *	Data collection to commence January 2024	Data collection to commence January 2024	TBC	Palliative Care / Medicine	N/A	**N/A**
Heart						
National Cardiac Audit Programme (NCAP) • National Heart Failure Audit * (NHFA)	operates continuous data capture	**June 2024**	TBC	Cardiology	Action being taken to improve compliance	AMBER
• Cardiac Rhythm Management * (CRM)	operates continuous data capture	**N/A**	TBC	Cardiology	Organisation wide compliance. (excludes Bridgend)	GREEN
• Myocardial Ischaemia National Audit Project (MINAP)*	operates continuous data capture	**June 2024**	TBC	Cardiology	Action being taken to improve compliance	AMBER
Cardiac Rehabilitation Audit (CRA)	operates continuous data capture	**N/A**	December 2024	Cardiology	Organisation wide compliance	GREEN
Cancer **						

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Bowel Cancer Audit (NOGCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Oesophago-Gastric Cancer Audit (NOGCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
National Audit of Metastatic Breast Cancer (NAoMe) *	operates continuous data capture	**TBC**	TBC	Surgery	N/A	**N/A**
National Audit of Primary Breast Cancer (NAoPri) *	operates continuous data capture	**TBC**	TBC	Surgery	N/A	**N/A**
National Lung Cancer Audit (NLCA) *	operates continuous data capture	**N/A**	TBC	Respiratory Medicine	Organisation wide compliance. Managed through cancer services.	GREEN
National Prostate Cancer Audit (NPCA) *	operates continuous data capture	**N/A**	TBC	Surgery	Organisation wide compliance. Managed through cancer services.	GREEN
Women's and Children's Health						
National Neonatal Audit Programme Audit * # (NNAPA)	operates continuous data capture	**N/A**	October 2024	Paediatrics	Organisation wide compliance.	GREEN

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

National Audit	Audit Period	Submission Deadline	Planned Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/24
National Maternity and Perinatal Audit *# (NMPA)	operates continuous data capture	**N/A**	TBC	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
National Perinatal Mortality Review Tool (PMRT)	operates continuous data capture	**N/A**	The PMRT is available for continuous use	Obstetrics / Midwifery	Organisation wide compliance.	GREEN
Other						
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12) *# (NASECYP)	Series of data collection cohorts within the audit	Various deadlines for cohorts	July 2024	Paediatrics	Organisation wide compliance.	GREEN
National Clinical Audit of Psychosis * (NCAP) EIP Audit	February – July 2024	**N/A**	July 2024	Mental Health	Organisation wide compliance.	GREEN

(* denotes NCAPOP Audits)
(# denotes reports likely to include information on children and / or maternity services)
(** It is anticipated that there will be a number of additional cancer audits added to the programmed during 2024/25).

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

Clinical Outcomes Review Programme (2024/25)

The Clinical Outcome Review Programme (CORP) is designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by enabling learning from adverse events and other relevant data. It aims to complement and contribute to the work of other agencies such as NICE, the Royal Colleges and academic research studies which support changes to improve NHS healthcare.

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2023/24	RAG Status 2023/24
• Juvenile Idiopathic Arthritis	operates continuous data capture	**March 2024**	November 2024	General Medicine	N/A	**N/A**
• National Confidential Inquiry into Suicide and Safety in Mental Health	operates continuous data capture	**N/A**	April 2025	Mental Health Programme	Organisation wide compliance.	**GREEN**
• NCEPOD – Transition from Child to Adult Services	Completed	**N/A**	N/A	Child Health Clinical Outcome Review Programme	Due to limited clinical resources only partial compliance achieved. Report published June 2023	**AMBER**
• NCEPOD – Crohn's Disease	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published July 2023	**AMBER**
• NCEPOD – Testicular Torsion	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published February 2024	**AMBER**
• NCEPOD – Community Acquired Pneumonia	Completed	**N/A**	N/A	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved. Report published December 2023	**AMBER**

NHS Wales National Clinical Audit and Outcome Review Plan Annual Rolling Programme 2024/25

Outcome Reviews in which all Welsh Health Boards and Trusts must participate (across sites where services are provided)

The Clinical Outcome Review Programme (Tier 1)	Audit Period	Completion Deadline	Report Publication	Programme	Compliance Position 2023/24	RAG Status 2023/24
• NCEPOD - Endometriosis	Completed	**N/A**	June 2024	Medical & Surgical programme	Due to limited clinical resources only partial compliance achieved.	**AMBER**
• End of Life	2023/24	**TBC**	November 2024	Medical & Surgical programme	In progress at time of reporting	**N/A**
• Rehabilitation after Critical Illness	2023/24	**TBC**	January 2025	Medical & Surgical programme	In progress at time of reporting	**N/A**
• Blood Sodium	2024/25	**TBC**	TBC	Medical & Surgical programme	N/A	**N/A**
• MBRRACE – Perinatal Mortality Surveillance	operates continuous data capture	**TBC**	October 2024	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**
• MBRRACE – Saving Lives Improving Mothers Care	operates continuous data capture	**TBC**	November 2024	Maternal, Newborn and Infant Clinical Outcome Review Programme	Organisation wide compliance.	**GREEN**

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/2024
Case Note Documentation Audits:	Revised methodology TBC					
• Acute Hospital Documentation Audit		**TBC**	TBC	Acute inpatient activity	Limited Clinical Audit resources focused on national audit compliance.	**RED**
• Community Hospital Documentation Audit		**TBC**	TBC	Community hospital inpatient activity	Limited Clinical Audit resources focused on national audit compliance.	**RED**
• A&E Documentation Audit		**TBC**	TBC	Emergency Medicine	Limited Clinical Audit resources focused on national audit compliance.	**RED**
Consent to Treat Audit	TBC	**TBC**	**TBC**	Surgery	Organisation wide compliance.	**GREEN**
Do Not Attempt Cardiopulmonary Resuscitation Audit	TBC	**Quarter 3**	**March 2025**	Critical Care	Organisation wide compliance.	**GREEN**
National Ophthalmology Audit (Adult Cataract surgery) * (NOD)	operates continuous data capture	**TBC**	TBC	Ophthalmology	Participation in RGH and PCH only.	**AMBER**
Appendectomy Audit	Prospective audit methodology TBC	**TBC**	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance.	**RED**

Organisation Priority Audits (Tier 2)	Audit Period	Completion Deadline	Report Publication	Specialty	Compliance Position 2023/24	RAG Status 2023/2024
Tracheostomy Care Audit	**TBC**	**TBC**	TBC	Surgery	Limited Clinical Audit resources focused on national audit compliance.	**RED**

mneAgenda Item
9.2.8

Quality & Safety Committee

Highlight Report from the Radiation Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Paul Johnston, Superintendent Radiographer
Cyflwynydd yr Adroddiad / Report Presenter	Mel Barker, Assistant Director of Therapies and Health Sciences
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Radiation Safety Committee	22/02/2024	

Acronyms / Glossary of Terms	
HIW	Healthcare Inspectorate Wales
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RSC	Radiation Safety Committee

1. PURPOSE

1.1 This report had been prepared to provide the Committee with details of the key issues considered by the Radiation Safety Committee at its meeting on 22nd February 2024

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 issues or risks for escalation.
ADVISE	Concern regarding the management of radiation safety in the dental department in PCH persist and the department has not provided the committee with any assurance of compliance with the IR(ME)R regulations despite discussion with the Clinical Service Group Manager. Mel Barker, as chair of RSC, will arrange a meeting with the service to discuss further. Princess of Wales Hospital is still without a nominated Laser Protection Adviser (LPA). Progress appears to have been made with Cardiff in being able to access advice under a Service Level Agreement (SLA) but confirmation is awaited. The Health Board needs to make a change to the classification of staff in nuclear medicine to 'Classified Workers' under the Regulations, following advice and guidance from HSE. There will be some time commitment in the departments to complete the relevant paperwork but these staff will also need to have health monitoring by an appointed HSE doctor. We have investigated and the Health Board does not have such a member of staff so will need to be sourced externally and will come with an associated cost (yet to be determined). The reason for the move is due to the potential radiation dose if the person administering the radiopharmaceutical were to have a needlestick injury or even suffer skin contamination form a droplet spill. POW will be having an HIW inspection of its nuclear medicine service on 5th & 6th March 2024. All relevant paperwork has been completed and submitted within the timescales and there are no major concerns regarding the inspection.
ASSURE	Reports were received by the committee from most areas utilizing ionising radiation in the Health Board, as well as a report from Clinical Engineering regarding the management of non-ionising radiation also. There were no significant issues or concerns raised from any of the areas.

	The meeting had excellent representation with a wide range of staff from different departments and expertise present. External representation was also evident as our Medical Physics Experts from Cardiff and Swansea were also in attendance
INFORM	Please note the contents of this report.
APPENDICES	**NOT APPLICABLE**

2. Assessment

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

3. Recommendation

3.1 The Quality and Safety Committee is asked to **NOTE** the highlights outlined in this report.

Agenda Item
9.2.9

Quality & Safety Committee

Covid-19 Public Inquiry Preparedness

Dyddiad y Cyfarfod / Date of Meeting	14/03/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Cally Hamblyn, Assistant Director of Governance & Risk
Cyflwynydd yr Adroddiad / Report Presenter	Cally Hamblyn, Assistant Director of Governance & Risk
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Noting

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	**Date**	**Outcome**
Not applicable.	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
Not applicable.	

1. Situation /Background

1.1 The purpose of this paper is to provide the Quality & Safety Committee with a progress update in respect of the Health Board's preparedness for the Covid-19 public inquiry.

1.2 The Covid-19 pandemic, which took hold in March 2020, has been one of the greatest challenges faced by the country and in the history of the NHS; challenges which have been predicated on unprecedented levels of demand across the whole system that have called for an equally unparalleled response.

1.3 In 2021, the Prime Minister announced his intention to commission an independent public inquiry into the Covid-19 pandemic enabling the UK government to discharge its obligations and examine the actions it took to respond to the pandemic and to learn every possible lesson for the future. On the 15th December 2021, the Rt Hon Baroness Heather Hallett DBE was appointed as Chair of the forthcoming public inquiry into the Covid-19 pandemic.

1.4 The Inquiry was established under the Inquiries Act 2005, with full powers, including the power to compel the production of documents and to summon witnesses to give evidence on oath. The Inquiry began circa spring 2022.

1.5 The Modules of the Inquiry are announced and then are opened in sequence, after which Core Participant applications are considered. Each module has a corresponding preliminary hearing and full hearing, details of which are published by the Inquiry.

1.6 The current modules are:

1. Resilience and preparedness
2. Core UK decision-making and political governance
3. Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK
4. Vaccines and therapeutics
5. Procurement
6. Care sector

Future modules:

- Testing and tracing
- The Government's business and financial responses
- Health inequalities and the impact of Covid-19
- Education, children and young persons
- Other public services, including frontline delivery by key workers

2. Specific Matters for Consideration

2.1 The Health Board Members are collectively and statutorily accountable for the safe and effective provision of health services to the population of Wales both in peace time and during a crisis with the responsibilities of the organisation set out in legislation.

2.2 Regulatory and inspectorate bodies such as Audit Wales and Internal Audit have already concluded, during separate reviews, that the Health Board largely maintained good governance throughout the pandemic to ensure the right decisions were made in the right way and at the right time. However, many decisions were made tactically, pragmatically and delivered at speed within newly formed operational strategies during this time and it is vital, therefore, that the Health Board takes steps now to ensure that the wealth of evidence is collated in full and reviewed to ensure that it has all been catalogued and securely stored.

Inquiry Preparedness - Preparations to Date:

2.3 *Core Participant Status*
The Health Board has Group Core Participant Status for Module 3 *(Impact of the Covid-19 Pandemic on Healthcare)* along with the following NHS Wales organisations:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Hywel Dda University Health Board
- Swansea Bay University Health Board
- Velindre University NHS Trust (excluding NHS Wales Shared Services Partnership)

The Health Board has not pursued individual or group core participant status for any other modules at this point. These decisions were approved by the Board.

2.4 *Legal Guidance and Support*

- The Health Board continues to instruct Legal & Risk Services to act on its behalf as legal advisors. The appointed team meet regularly with Health Board Leads, attend the Working Group as required and provide regular briefings on the progress of the inquiry and themes arising from Preliminary Hearings into Modules.
- Kings Counsel has been instructed given the significant impact on the Health Boards population and high nosocomial rates. Counsel has provided support to the Health Board in relation to witness statements requested under Module 2b.
- Joint Legal Representation has been instructed to act on behalf of the Core Participant Group for Module 3 and costs are shared equally as appropriate between health bodies.

2.5 *Senior Responsible Officer (SRO)*

In September 2023, Gareth Watts was appointed as the SRO for the Health Boards response to the Covid-19 Public Inquiry. This was previously held by Greg Dix, Executive Director of Nursing / Deputy Chief Executive.

2.6 *Programme Management Approach*

- There is a Covid-19 Pandemic Inquiry Working Group which has two clear functions, this is to:
  - **Prepare:** the CTMUHB for the COVID-19 Public Inquiry
  - **Respond:** Provide the UK government, when requested, with accurate and complete information pertaining to the COVID-19 public inquiry
- Whilst initially meeting monthly the group now meets at least quarterly and briefings are issued in between meetings as appropriate.
- A preparedness plan continues to be updated via the working group.
- The Health Board is represented on the Group: 'All Wales Covid-19 Public Inquiry Channel", established by Legal & Risk Services, the purpose of this channel is twofold. Firstly, to provide a place for members to communicate with each other and share useful information and, secondly, to allow Legal & Risk Services to communicate updates quickly to organisations.

2.6 *Information Project Management*

- On the 30th May 2023, following a third round of recruitment the Health Board was successful in appointing a Covid-19 Inquiry Programme Information Manager on a fixed term position. This position is fixed until 31st March 2025.
- The impact of the period of limited activity prior to this position commencing has significantly affected the Health Boards pace in ensuring its preparedness in terms of archiving and cataloguing information. This has been recognised as a significant risk and has been escalated to the Organisational Risk Register (Datix Risk ID 4922 - Covid-19 Inquiry Preparedness - Information Management – Risk Score of 16.
- The Working Group have identified areas of information that need to be retained and considers that information related to the modules is now stored centrally, albeit in raw form.
- The current priority is to catalogue and populate a timeline specific to the Health Board that captures the journey through the pandemic and the response taken.
- There is a significant amount of data that requires coding and cataloguing to support the effective response to any requests from the Inquiry. This system will need to be a secure and searchable electronic storage tool.
- The Covid-19 Inquiry Information Programme Manager has been working with the Head of Information in the digital team to explore automation options to support the archiving and cataloguing of information and a hybrid approach of automation and manual filing has been achieved. While the automation will undoubtedly save time – it will

extract properties data from files within a specified folder, this can then be manipulated to speed up the coding as well as the capture of this data, there is still a need for manual elements such as description and identifying keywords.

2.7 *Wellbeing Support*

- Dedicated resources to support staff have already been considered and any staff called to give evidence or impacted by the inquiry (past or present) are supported by the Health Board.

2.8 *Nosocomial Investigations*

- The Working Group does have a lead representative from the Nosocomial Work Programme.

3. Key Risks / Matters for Escalation

3.1 Organisational memory risk - consideration is provided to the records when staff move roles across NHS Wales in terms of their O365 account, this is assessed on a case by case basis.

3.3 Additionally, consideration should also be given to the retention and storage of emails outside of the seven year automatic retention period and whether emails of key decision makers are retained and backed up separately. The issue presented is that pandemic related emails cannot be extracted from the day to day business and so every email will need to be retained and could create a challenge in relation to the Data Protection Act 2018. Under the current arrangements there is capability to recover emails and one drive documents even after deletion; however, this is only for a period of 7 years which may not cover the period of an inquiry.

3.4 Research and decisions are needed to consider how telephone calls, voice mail, text messages, WhatsApp messages and social media may feature as part of the inquiry and the Health Board's evidence portfolio given the complexities of including these in the record given their very nature. This extends to the collation of Teams 'chats'.

3.5 Resource impact – the level of activity and legal support required is uncertain at this stage. The financial risk in relation to the legal fees likely to be incurred was escalated via the Corporate Development functions Integrated Medium Term Plan (Financial Return) and is identified as an unavoidable cost pressure for which funding has been identified based on actual costs.

4. Assessment

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

Impact Assessment		
Ansawdd *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /* **Quality** *Have you undertaken a Quality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report.
Cydraddoldeb *Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /* **Equality** *Have you undertaken an Equality Impact Assessment Screening?*	Yes: ☐	No: ☒
	Outcome:	If no, please include rationale below: Not applicable for this report.
Cyfreithiol / Legal	Yes (Include further detail below)	

	Please see section 2.4.
Enw da / Reputational	Yes (Include further detail below)
	Trust and confidence in the services provides by the Health Board.
Effaith Adnoddau *(Pobl /Ariannol) /* **Resource Impact** *(People / Financial)*	Yes (Include further detail below)
	Staff time, resource and financial impact as outlined in this report.

5. Recommendation

5.1 The Quality & Safety Committee are asked to:

- **NOTE** the contents of the report and receive assurances on the preparations for the inquiry to date.
- **NOTE** the risks identified in section 3 of the report.

6. Next Steps

6.1 The Health Board will continue to prioritise the development of a full electronic catalogue / repository as a priority during 2024-2025.