

Quality & Safety Committee

Tue 23 January 2024, 09:30 - 12:30

Virtually via Teams

Agenda

09:30 - 09:35 **1. PRELIMINARY MATTERS**

5 min

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

09:35 - 10:05 **2. SHARED LISTENING & LEARNING**

30 min

2.1. Listening & Learning Story - Care of the Older Person

Discussion Adam Cook-Young, Clinical Practitioner

Strategic Goal: Improving Care

Domains of Quality: Person Centred

2.2. Spotlight Presentation - Sepsis

Discussion Richard Jones, Consultant Anaesthetist/Vanessa Jones, Acute Deterioration Lead

Strategic Goal: Improving Care

 2.2 Sepsis Spotlight Presentation QSC 23 January 2024.pdf (19 pages)

10:05 - 10:10 **3. CONSENT AGENDA**

5 min

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

10:10 - 10:15 **4. MAIN AGENDA**

5 min

4.1. Matters Arising not contained within the Action Log

Discussion Carolyn Donoghue, Committee Chair/Independent Member

10:15 - 10:55 **5. SETTING THE SCENE - SERVICE DELIVERY**

5.1. Report from the Clinical Executives

Discussion Greg Dix, Executive Director of Nursing/Dom Hurford, Executive Medical Director/Lauren Edwards, Executive Director of Therapies & Health Sciences

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

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

 5.1a Clinical Executive Directors report QSC 23 January 2024.pdf (14 pages)

 5.1b Appendix 1 Clinical Executive Directors Report QSC 23 January 2024.pdf (1 pages)

5.2. Care Group Highlight Reports

Discussion Care Group Leads

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


Strategic Goal: Improving Care, Creating Health, Inspiring People

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


 5.2a Appendix 1 Pre-op checklist (final 2023) QSC 23 January 2024.pdf (2 pages)

 5.2a Planned Care Highlight Report QSC 23 January 2024.pdf (6 pages)

 5.2b PC C Highlight report QSC 23 January 2024.pdf (6 pages)

 5.2c Children Families Care Group Highlight Report QSC 23 January 2024 - CH.pdf (7 pages)

 5.2c Appendix Maternity & Neonatal Metrics January 2024 QSC 23 January 2024.pdf (11 pages)

 5.2d MHLD Highlight report for QSC 23 January 2024.pdf (6 pages)

 5.2e USC Highlight Report QS 23 January 2024 final.pdf (9 pages)

 5.2f DTPS Highlight Report QSC 23 January 2024 final (002).pdf (12 pages)

10:55 - 11:35
40 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 Goal: Improving Care

Domains of Quality: Effective

 6.1a Org Risk Register - Cover Paper QSC 23 January 2024.pdf (7 pages)

 6.1b Appendix 1 - Org Risk Register QSC 23 January 2024.xlsx (6 pages)

6.2. Mortality Indicators and Mortality Reviews

Discussion Dom Hurford, Executive Medical Director

Strategic Goal: Improving Care

Domains of Quality: Effective, Safe, Timely

 6.2 Mortality Reviews and Mortality Indicators QSC 23 January 2024.pdf (7 pages)

6.3. Incident Management Framework

Discussion Nigel Downes, Assistant Director of Quality & Safety

Strategic Goal: Improving Care

Domains of Quality: Safe

11:35 - 12:10 7. DELIVERING OUR PLAN

35 min

7.1. Patient Safety & Quality Dashboard Report

Discussion Nigel Downes, Assistant Director of Quality & Safety

Strategic Goal: Improving Care

Domains of Quality: Safe

📄 7.1a Patient Safety & Quality Dashboard Report QSC 23 January 2024.docx (22 pages)

📄 7.1b ED monthly Heat map PCH QSC 23 January 2024.xlsx (3 pages)

📄 7.1c ED monthly heat map RGH QSC 23 January 2024.xlsx (3 pages)

📄 7.1d ED monthly heatmap POW QSC 23 January 2024.xlsx (3 pages)

7.2. EASC Quality & Safety Highlight Report

Discussion Gwenan Roberts/Stephen Harry TBC

Strategic Goal: Improving Care

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

📄 7.2 EASC Update QSC 23 January 2024.pdf (5 pages)

7.3. Quality Strategy Annual Plan

Discussion Lauren Edwards, Executive Director of Therapies & Health Sciences

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

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

📄 7.3a Quality Strategy Action Plan Update QSC 23 January 2024.docx (9 pages)

📄 7.3b Appendix 1 Quality Strategy Action Plan QSC 23 January 2024 (1).xlsx (9 pages)

12:10 - 12:20 8. DELIVERING OUR IMPROVEMENT PROGRAMMES

10 min

8.1. Mental Health Adult Inpatient Improvement Programme

Discussion Ana Llewellyn, Care Group Nurse Director

Strategic Goal: Improving Care

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

📄 8.1 MH In-patient Improvement QSC 23 January 2024.pdf (6 pages)

12:20 - 12:25 9. CONSENT AGENDA

5 min

9.1. FOR APPROVAL

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

Decision Carolyn Donoghue, Committee Chair/Independent Member

📄 9.1.1 Unconfirmed Minutes Quality and Safety 21 November 2023 QSC 23 January 2024.pdf (18 pages)

9.1.2. Committee Annual Cycle of Business 2024

Decision Carolyn Donoghue, Committee Chair/Independent Member

 9.1.2a Committee Annual Cycle of Business QSC 23 January 2024.pdf (3 pages)

 9.1.2b Quality Safety Committee Cycle of Business QSC 23 January 2024.pdf (4 pages)

9.1.3. Quality & Safety Committee Terms of Reference

Decision Gareth Watts, Director of Corporate Governance/Board Secretary

In light of the review being undertaken in relation to Board Committees it has been agreed to defer the annual review of the Terms of Reference to July 2024


9.1.4. Concerns Policy

Decision Greg Dix, Executive Director of Nursing

Strategic Goal: Improving Care

Domains of Quality: Safe, Person Centred

 9.1.4a Concerns Policy & Procedures QSC 23 January 2024.pdf (4 pages)

 9.1.4b Concerns Policy & Procedure Final for Approval QSC 23 January 2024.pdf (31 pages)

9.1.5. Clinical Policies Approval Process

Decision Dom Hurford, Medical Director

Strategic Goal: Improving Care

Domains of Quality: Effective

 9.1.5 Revised Clinical Policies Process QSC 23 January 2024.pdf (7 pages)

9.2. FOR NOTING

9.2.1. Action Log

Information Carolyn Donoghue, Committee Chair/Independent Member

 9.2.1 Action Log QSC 23 January 2024.pdf (11 pages)

9.2.2. Committee Forward Work Plan

Information Carolyn Donoghue, Committee Chair/Independent Member

 9.2.2 Quality & Safety Committee Forward Work Programme QSC 23 January 2024.pdf (5 pages)

9.2.3. WHSSC Quality & Patient Safety Committee Chairs Report

Information Dilys Jouvenat, Independent Member

 9.2.3 WHSSC Quality Patient Safety Committee Chairs Report QSC 23 January 2024.pdf (12 pages)

9.2.4. Healthcare Inspectorate Wales Improvement Plan Tracker Report

Information Greg Dix, Executive Director of Nursing

Strategic Goal: Improving Care

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

 9.2.4 HIW Tracker report Oct-Dec 23 QSC 23 January 2024.pdf (6 pages)

12:25 - 12:30
5 min

10. ANY OTHER BUSINESS

10.1. Highlight Report to Board - Verbal

Information Carolyn Donoghue, Committee Chair/Independent Member

10.2. How did we do in this Meeting - Verbal

Information Carolyn Donoghue, Committee Chair/Independent Member

10.3. Identification of Future Spotlights and Thematic Presentations

Discussion Carolyn Donoghue, Committee Chair/Independent Member

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

- Internal Data Deep Dive into Neonatal Morbidity and Mortality at Cwm Taf University Health Board

12:30 - 12:30 **11. DATE AND TIME OF NEXT MEETING - THURSDAY 14 MARCH 2024 AT**
0 min **9:00AM**

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



(Agenda Item)	23/01/2024	Quality & Safety Committee	Sepsis
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Report Details:

FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Richard Jones, Consultant Anaesthetist
Presented By:	Richard Jones, Clinical Lead for Resuscitation and Acute Deterioration Vanessa Jones, Acute Deterioration 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



Sepsis

The Cwm Taf Morgannwg journey
Dr Richard Jones
Quality and Safety Committee 23rd January 2024

Late November RGH very busy
no ITU beds as awaiting an admission
from theatre

Patient story

8am: Outreach referred a patient on Ward 12

S Patient X, 76, unwell, NEWS **8**, rapid deterioration that morning

B Admitted day before, unwell following a fall

Normally fit and well

A A-E assessment, performed by Outreach team

Identified as chest sepsis

R Sepsis 6 administered:

Oxygen, fluids, blood cultures, bloods (lactate), Antibiotics, catheter, all in 1 hr

Chest X-ray

Critical care review regarding admission

Continuous monitoring

Ongoing Plan

Delay to admit to critical care while they discharged and moved patients

Ongoing treatment plan put in place. Outreach would continue to monitor

Over the next few hours Patient X continued to deteriorate with an increasing oxygen demand and low BP.

Placed on a monitor and started on Non-invasive ventilation.

Constant monitoring from Outreach and on-going updates to the Critical Care team.

Arterial line inserted allowing a peripheral vasopressor infusion to be commenced to support his low blood pressure.

Ongoing Plan

In practice this made an HDU bed on Ward 12.

2pm: transferred to Critical Care.

Patient X required inotropic support for his BP and hemofiltration support for his kidneys

He narrowly avoided intubation and was discharged a week later

Relative Feedback

The patient's family were kept up-to-date at all stages.

After the patient was discharged, the family sent a card of thanks and expressed how impressed they were that Outreach had been able to provide HDU level of support on a ward bed, something they didn't think would or could have been done from personal experience.

The family said that the rapid diagnosis, escalation and response to the patients sepsis saved his life.

Where are we with Sepsis?

What is Sepsis?

Screening

Tools

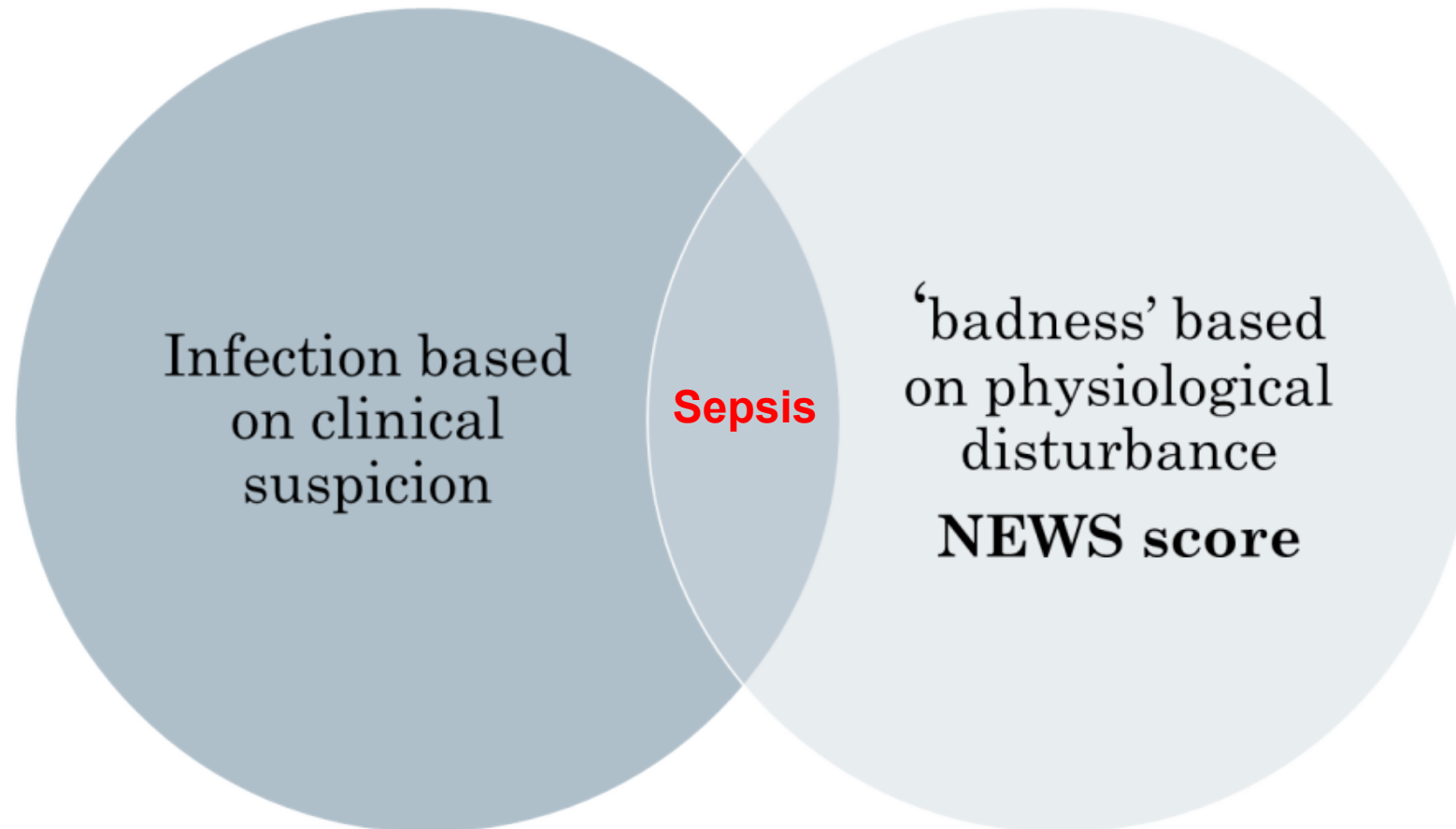
Bundles

Outcomes

Current situation

Future Plans

What is Sepsis?



NEWS Cymru CTMUHB

Patient Observation Chart
NEWS Cymru

Hospital No: _____ Date Admitted: _____
Name: _____ Ward: _____
DOB: _____ Consultant: _____
(use PI ID sticker)

Hospital / Site: _____

Year: () DDMM
USE 24 Hour Clock
Time
Frequency of observations
Hour

Respiratory Rate
(record respiratory rate for 1 full minute)
≥25 3
21-24 2
12-20 0
9-11 1
≤3 3

Oxygen Therapy
Not on Oxygen 0
Oxygen % 2
≥96 0

Oxygen Saturation
(record respiratory rate for 1 full minute)
Acceptable
94-95 1
92-93 2
≤91 3

Pulse
(record manually)
(Beats/min)
Acceptable
≥131 3
121-130 2
111-120 2
101-110 1
91-100 1
81-90 0
71-80 0
61-70 0
51-60 0
41-50 1
≤31-40 3
≥220 3

Blood Pressure
(mmHg)
(Score uses systolic BP only)
Acceptable
211-219 0
201-210 0
191-200 0
181-190 0
171-180 0
161-170 0
151-160 0
141-150 0
131-140 0
121-130 0
111-120 0
101-110 1
91-100 2
81-90 3
71-80 3
61-70 3
51-60 3
≤41-50 3

Conscious Level
A C V P U
Check Glucose
Alert 0
New Confusion 3
Vocal 3
Pain 3
Unresponsive 3

Temp °C
≥39.1 2
38.1-39 1
37.1-38 0
36.1-37 0
35.1-36 1
≤35 3

Total NEWS Score
Staff Initials
Counter signature (if required)

NEWS score	Clinical response required	Frequency of monitoring
0-2	Continue routine NEWS monitoring	Minimum 12 hourly
3-5 3=THREAT	Inform nurse in charge. Consider Sepsis. If Suspicion of Infection, use the Sepsis Screening Tool Start a fluid balance chart.	4 hourly
6-8 6=SICK	Nurse in charge to contact Clinical team/Outreach to review patient WITHIN 30 MINUTES. If Suspicion of Infection: Initiate the Sepsis 6	1 hourly
9-11 9=NOW	Fast Page (using 2222) the Rapid Response team and Patient's team to review WITHIN 15 MINUTES.	30minutes
12 or above	Cardiac Arrest Team Response	Continuous

Concern about the patient or difficulty obtaining any single parameter should lead to escalation regardless of score.

NOT FOR NEWS.
Document reason in patient's notes

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6-8 6=SICK	Nurse in charge to contact Clinical team/Outreach to review patient WITHIN 30 MINUTES. If Suspicion of Infection: Initiate the Sepsis 6	1 hourly
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12 or above	Cardiac Arrest Team Response	Continuous

NEWS2

NEWS key		FULL NAME		
0	1	2	3	
		DATE OF BIRTH	DATE OF ADMISSION	
		DATE	DATE	
		TIME	TIME	
A+B Respirations <small>8 breaths/min</small>	≥25		3	
	21–24		2	
	18–20			
	15–17			
	12–14		1	
	9–11		3	
A+B SpO ₂ Scale 1 Oxygen saturation (%)	≥98		1	
	94–95		2	
	92–93		3	
	≤91			
SpO₂ Scale 2* Oxygen saturation (%) <small>Use Scale 2 if target range is 96–98%, eg in hypoxaemic respiratory failure</small>	≥97 on O ₂		3	
	95–96 on O ₂		2	
	93–94 on O ₂		1	
	≥93 on air			
	88–92		1	
	85–87		2	
	84–85		3	
	≤83%			
	<small>ONLY use Scale 2 under the direction of a qualified clinician</small>			
	Air or oxygen?	Acute		2
O ₂ L/min Device				
C Blood pressure <small>using correct systolic BP only</small>	≥220		3	
	201–219			
	181–200			
	161–180			
	141–160			
	121–140			
	111–120		1	
	101–110		2	
	91–100		3	
	81–90			
	71–80			
C Pulse <small>Beats/min</small>	≥131		3	
	121–130		2	
	111–120			
	101–110		1	
	91–100			
	81–90			
	71–80			
	61–70			
	51–60		1	
	31–40		3	
≤30				
D Consciousness <small>Score for level of confusion (in case of chronic)</small>	Alert			
	Confusion		3	
	V			
	U			
E Temperature <small>°C</small>	≥39.1°		2	
	38.1–39.0°		1	
	37.1–38.0°			
	36.1–37.0°		1	
	35.1–36.0°		3	
≤35.0°				
NEWS TOTAL				
Monitoring frequency			Monitoring	
Escalation of care Y/N			Escalation	
Initials			Initials	

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

Screening

A method for supporting CLINICAL DECISION MAKING

Undertreatment leads to harm

Overtreatment leads to harm

Screening cannot be 100% predictive



Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Adult Sepsis Screening Tool

The use of this tool should not replace clinical judgment

EMERGENCY DEPARTMENT use

Time of arrival to ED

Pre-Hospital (WAST/GP) NEWS

Date: _____ Trigger Time: _____

Ward/Depart: _____

Completed by: _____

1. NEWS ≥ 3
NEWS Score or patient looks sick?

2. Could this be due to an infection?
Pneumonia
Urinary tract infection
Unknown (likely chest or urine source)
Intra-abdominal/ biliary
Cellulitis, joint, wound or device infection
Meningitis
Other (specify: _____)
Completely unknown

3. NEWS ≥ 6 or is at least ONE of the following present:
Respiratory rate ≥ 25 per minute
Needs oxygen to keep SpO₂ $\geq 92\%$ (88% in COPD)
Heart rate > 130 per minute
Systolic BP ≤ 90 (or drop >40 from normal)
NEW altered mental state
Non-blanching rash, mottled/ ashen/ cyanotic
Not passed urine in last 18 h/ UO <0.5 ml/kg/hr
Neutropenia or chemo within last 6 weeks

4. NEWS 3-5 or at least ONE of the following present:
Respiratory rate 21-24
Heart rate 91-130 bpm or new dysrhythmia
Systolic BP 91-100mmHg
Not passed urine in last 12-18 hours
History of new onset altered mental state
Temperature $<36^{\circ}\text{C}$
Trauma/ surgery/ procedure in last 6 weeks
Impaired immune system
Clinical signs of wound, device or skin infection
If patient has AKI and lactate > 2 mmols escalate to SEPSIS PROBABLE

SEPSIS UNLIKELY
Consider other diagnoses
Continue to monitor patient
Review if patient condition changes or NEWS increases

SEPSIS Probable
Inform senior clinical decision maker
This is a time critical condition
Start SEPSIS 6 NOW
Administer antibiotics within 1 hr
Inform Outreach Team

SEPSIS Possible
Inform senior clinical decision maker
Consider investigations X-ray/CT
Bloods for FBC, U&E, Gluc, LFT, Coag, VBG
Review results
Begin at least 1 hourly observations
Make antimicrobial decision within 3 hrs YES / NO

Please complete all actions within 1 hour following assessment

Sepsis Six Bundle

Actions	Time	Name	Comments / Reason not done
1. Ensure Senior clinician attends			
2. Give Oxygen to ensure sPO ₂ $\geq 94\%$ (88-92% if COPD)			
3. Take Blood Culture (prior to Antibiotics)			
4. Give IV Antibiotics as per UHB micro guide (1st dose within 1 hour) Check current antibiotics/micro results if already prescribed			
5. Give Fluid: 500 mlis stat of Plasmalyte/Hartmann's and review			
6. Take blood for Lactate and Hb (target-70g/l)			Result:
Start Fluid Balance chart (consider catheter)			
REASSESS after Sepsis 6 Systolic BP ≥ 90 mmHg Reduced level of consciousness Resps > 25 pm Lactate not improved	Time of review		
ESCALATION If yes please refer to senior immediately +/- consider Critical Care (if appropriate) Consider repeat fluid bolus especially if lactate > 2 mmols and hypotensive. (Up to 30mls/kg within first 3 hrs of resuscitation)	Refer Y/N		
	Time of Referral		

FIRST DOSE ANTIBIOTICS for probable sepsis

SCAN ME

Please review antibiotics at 24hrs

Please insert this copy in patients notes and keep duplicate sheet for audit

Association of Medical Royal Colleges (AoMRC)

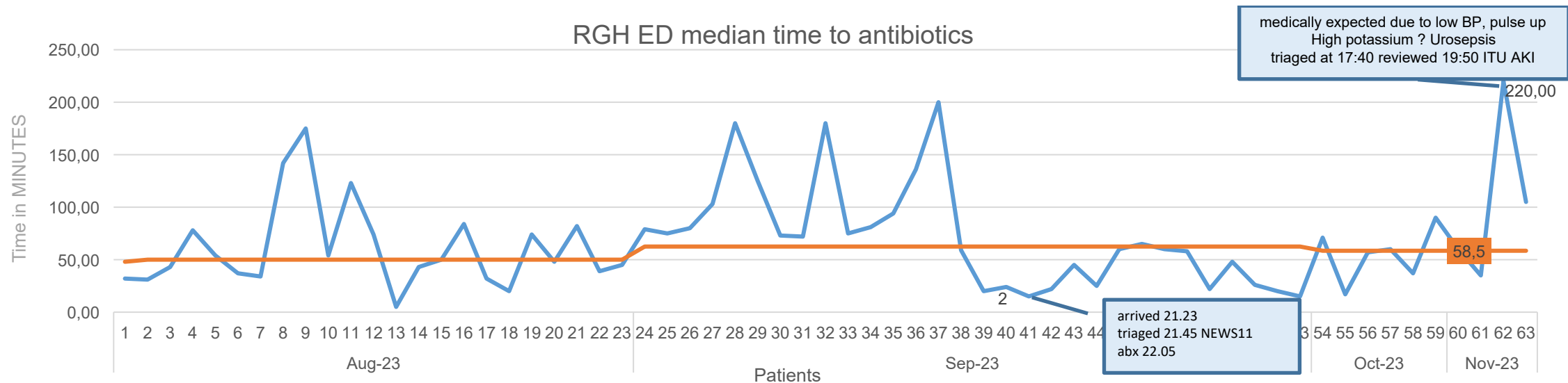
Vital signs	Vital signs: NEWS-2 'Physiology first'	0	1-4	5-6	≥ 7	
Initial assessment	History, examination, lab results	<i>If clinical or carer concern, continuing deterioration, surgically remediable sepsis, neutropaenia, or blood gas / lab evidence of organ dysfunction, including elevated serum lactate, upgrade actions at least to next NEWS-2 level →</i>				
	Comorbid disease, frailty, patient preferences?	<i>Consider influence of comorbid disease, frailty and ethnicity on NEWS-2, and patient preferences for treatment intensity, limits, end-of-life care</i>				
Initial (generic) actions	Monitoring and escalation plan	Standard observations	<ul style="list-style-type: none"> Registered nurse review < 1 h Obs 4-6 hrly if stable. Escalate if no improvement 	<ul style="list-style-type: none"> Obs hourly. Review < 1 hr by clinician competent in acute illness assessment Escalate if no improvement 	<ul style="list-style-type: none"> Obs every 30 mins. Review < 30 min by clinician competent in acute illness assessment. Senior doctor review < 1 hr if no improvement: refer to Outreach or ICU 	
	Initial treatment of precipitating condition	Standard care	< 6 hr	< 3 hr	< 1 hr	
Likelihood of infection & specific actions	Unlikely	Standard care	Review daily and reconsider infection if diagnosis remains uncertain			
	Possible	Review at least daily	<ul style="list-style-type: none"> < 6 h Source identification & control plan documented. 	<ul style="list-style-type: none"> < 3 h: Microbiology tests Antimicrobials: administer or revise 	<ul style="list-style-type: none"> < 1 h: Microbiology tests Antimicrobials: administer or revise (broad-spectrum if causative organism uncertain). 	
	Probable or definite	<ul style="list-style-type: none"> < 6 h Diagnostic tests & R plan 	<ul style="list-style-type: none"> < 6 h Microbiology tests Antimicrobials: administer or revise Source identification & control plan. D/w ID/micro if uncertain, & review 	<ul style="list-style-type: none"> < 6 h Source identification & control plan documented. 48 – 72 h Review antimicrobials with ID/micro/senior clinician 	<ul style="list-style-type: none"> < 3 h Source identification Source control initiated according to clinical urgency 48 – 72 h: Review antimicrobials with ID/micro/senior clinician 	

Bundles

- Standardised Response
- Sepsis 6
- Key factor is Antibiotic timing

Post treatment Review

Bundles



medically expected due to low BP, pulse up
 High potassium ? Urosepsis
 triaged at 17:40 reviewed 19:50 ITU AKI

arrived 21.23
 triaged 21.45 NEWS11
 abx 22.05



Outcomes

Measurable outcomes aren't meaningful

Meaningful outcomes aren't measurable

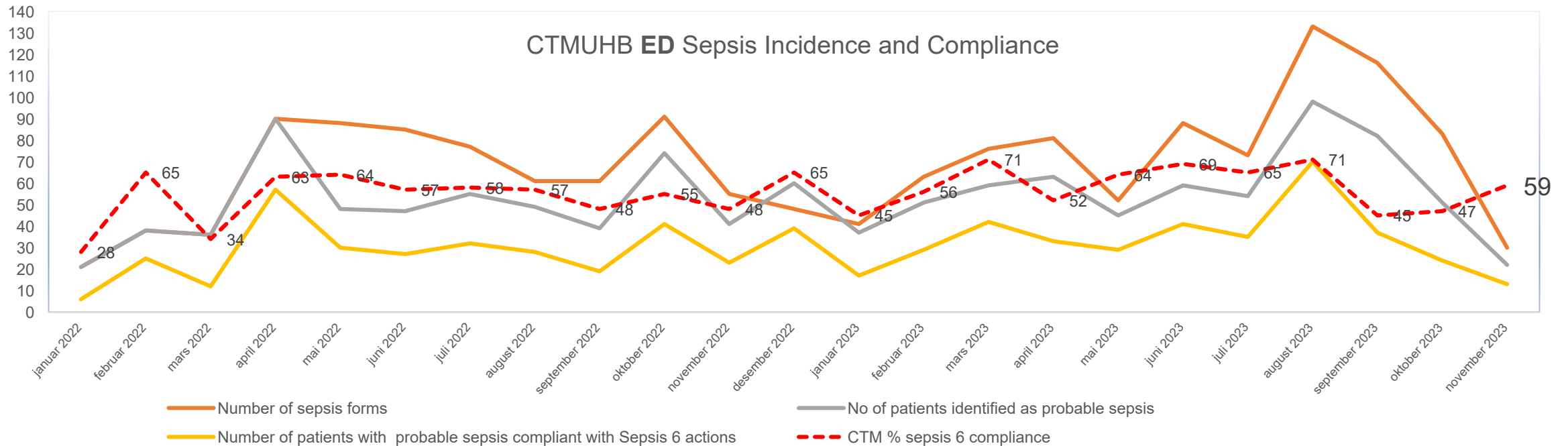
WG don't currently request data on sepsis

Evidence for benefit

Focus on Processes

Reinforce the Culture

Current situation



Overall CTMUHB compliance with sepsis 6 (with a focus on antibiotics) is currently **59%**

Future plans

- Re-design sepsis screening tool and roll-out across the LHB.
- Increase the use of the Sepsis Screening tool.
- Introduce a Patient and Carer concern element to the tool.
- Roll out to Mental Health wards and Community hospitals.
- Paediatrics will introduce the new national PEWS system to complement their sepsis screening tool.
- Maternity will introduce the new national MEWS system. This will help us gather data on Maternal sepsis.

Future plans

- Seek informatics support to capture progress on a dashboard.
- Influence Welsh Government and CTM Q+S to re-focus on Sepsis assurance data.

@cwmtafmorgannwg

Find us on





Agenda Item

5.1

Quality & Safety Committee

Clinical Executive Directors Report

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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
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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	
CTM UHB	Cwm Taf Morgannwg University Health Board
CTM	Cwm Taf Morgannwg
NHS	National Health Service
MDT	Multidisciplinary Team
SCBU	Special Care Baby Unit
IPC	Infection Prevention and Control
QA	Quality Assurance
HB	Health Board
IM	Independent Member
CMO	Chief Medical Officer
YCC	Ysbyty Cwm Cynon
CD	Clinical Director
HCS	Health Care Science
AHP	Allied Health Professions
DTPS	Diagnostics, Therapies, Pharmacy and Sciences Care Group
PCIP	Planned Care Innovation Programme
WMS	Weight Management Service
T2D	Type 2 Diabetes
PHM	Population Health Management
DPIA	Data Protection Impact Assessments
R+D	Research and Development
DHCW	Digital Health and Care Wales

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 together with risks identified as we continue to provide high quality patient centred care across the whole of Cwm Taf Morgannwg UHB.

Additional quality based information continues to be reported through the Quality Dashboard.

Section 1 Nursing & Midwifery

This summary presents a comprehensive overview of the current landscape at CTM University Health Board (UHB), highlighting the pivotal achievements and ongoing challenges faced by the Nursing Directorate.

As we navigate through a dynamic healthcare environment, our commitment to advancing patient care, staff well-being, and operational efficiency remains steadfast.

This section outlines our recent successes which demonstrate our dedication to innovation, quality improvement, and effective leadership. Simultaneously, it acknowledges the challenges that lie ahead, requiring strategic focus and collaborative efforts to ensure the continuous provision of high-standard healthcare services.

Through this Nursing & Midwifery summary, we aim to provide a clear understanding of our progress, the hurdles we face, and the strategies employed to overcome them, reflecting our dedication to excellence in nursing and healthcare delivery within CTM UHB.

1.2 Specific Matters for Consideration

NHS Executive Visit and Enhanced Monitoring Review

The recent period has seen significant achievements at CTM UHB, highlighted by the visit from the NHS Executive on 5th December 2023. This visit was integral to an enhanced monitoring review focusing on maternity neonates / quality governance / planning and performance. During this significant engagement, the Multidisciplinary Teams (MDT) effectively showcased the numerous improvements made across CTM over the last five years. This provided a platform for direct interaction between our frontline staff and the NHS Executive. We eagerly await further updates following the subsequent tripartite meeting which took place on the 18th December 2023.

1.3 Successful Pilot of Ward Accreditation Programme

Another notable success has been the Ward Accreditation Programme, which has recently completed its pilot phase. This programme, aimed at enhancing the quality and safety at the ward level, has demonstrated significant positive outcomes. The overarching objectives include providing a comprehensive overview of ward-level quality and safety, empowering ward staff to take ownership of these aspects, reducing incidents and potential harm to patients, facilitating early identification of improvement areas, and fostering a culture of safety. The structure observation framework and key questions are as follows:

Safe

- **Q1:** Understanding of infection control within staff roles.
- **Q2:** Knowledge around Deprivation of Liberty Safeguards (DOLS), mental capacity, and consent.
- **Q3:** Compliance with hand hygiene and infection control protocols.
- **Q4:** Familiarity with emergency procedures and equipment handling.

Effective

- **Q5:** Approach to patient assessments and care planning.
- **Q6:** Understanding of medication management and error prevention.
- **Q7:** Familiarity with the latest guidelines and best practices in patient care.

Caring

- **Q8:** Sensitivity towards patient dignity and privacy.
- **Q9:** Communication skills in patient interactions.
- **Q10:** Responsiveness to patient needs and concerns.

Success has been determined through ability to triangulate the output of the observation exercise with data in relation to incidents of falls, pressure damage, episodes associated with infection, prevention and control breaches as well as concerns and approaches to communication, bereavement care and staff well-being. This has enabled the pilot to establish a consistent methodology to determine the appropriate award and thus demonstrate scalability. Following the pilot's success, plans are underway to extend this programme across all CTM wards.

1.4 Nurse Bank Modernisation with the People Team

The modernisation of the nurse bank, in collaboration with the People Team, stands as a third major achievement. This initiative has been instrumental in streamlining staff management processes and enhancing collaboration with safeguarding and clinical leaders within CTM. The project's ongoing aims include ensuring the availability of competent temporary staff, providing a skilled and knowledgeable workforce, supporting flexible working opportunities, and ensuring

staff are well-acquainted with local health board policies and procedures while maintaining consistent compliance with all relevant policies and processes.

1.5 Estates Upgrades at Princess of Wales Hospital

The first significant challenge we face is the necessary estates upgrades at the Princess of Wales Hospital, particularly within the maternity and Special Care Baby Unit (SCBU). These upgrades, crucial for meeting medical standards, will involve the temporary closure of the SCBU and potential delays to the Labour Ward's work schedule. The Care Group is actively engaging with Capital Estates to plan these upgrades while ensuring business continuity. Final plans and impact assessments are pending and will be a crucial part of our strategy moving forward.

1.6 Initiation of the CTM Clinical Education Academy

The upcoming launch of the CTM Clinical Education Academy poses another challenge, requiring the formation of a project stakeholder group and the establishment of a substantive faculty. This faculty will act as a council of senior education leaders, playing a key role in clinical education within CTM. The projected launch date in September 2024 places a tight timeline on this ambitious project, to be led by the Deputy Executive Director of Nursing and the Head of Clinical Education.

1.7 Infection Prevention and Control Across New Care Group Structure

Infection Prevention and Control (IPC) remains a challenging area, particularly in supporting the new care group structure across CTM. The focus is on managing organisms in clinical and community settings, re-establishing IPC standards in clinical practice, and ensuring the service is informed by the best evidence. This involves a strategic balance of IPC with other key objectives across various healthcare sectors. The strategic review and development of the CTM IPC strategy are ongoing, with a target of readiness for the first quarter of 2024/25.

1.8 – All sites and community teams have been incredibly busy since the committee last met and regrettably, our ED's remain crowded on most days and patients boarding in uncommissioned areas on wards continues. This in turn can lead to a poor experience of care and on occasions, patient dignity can be compromised. The ward teams ensure that appropriate risk assessments are in place when boarding is necessary to maintain effective hospital flow and patient safety. Patients waiting in our hospital beds for onward community care provision are at risk of deconditioning and in some areas harm events have increased namely pressure ulcers and falls in this patient group. Further work is required to ensure visibility of harm of patients that are both medically and therapy optimised for discharge is captured through our governance systems.

Conclusion

In conclusion for the Nursing & Midwifery update, this period at CTM UHB has been marked by a blend of achievements and challenging endeavours. The successes achieved reflect our commitment to continuous improvement and excellence in healthcare, while the challenges identified necessitate strategic focus and dedicated efforts. The ongoing development of these initiatives is critical to the

future growth and success of our healthcare services, ensuring that CTM UHB continues to be a leader in the healthcare sector.

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:

- Theatre Utilisation Process
- Appraisal process – external QA review
- Healthcare Pathways

2.1 Achievements

Theatre Utilisation Process

We have matured to a point whereby this is now a business as usual process. The Executive team are still attending but are no longer leading. There has been strong praise for our adoption and way of tackling issues. This now forms part of the HB wide standardisation of working and the approach taken.

Appraisal process

Feedback on the external Quality Assurance review which focused on CTM appraisal process was found to be very positive.

Further information and feedback on the QA review which was commissioned by the CMO will be presented to the committee in more detail in a future report. Positive feedback and comments were noted and shared on the processes in place and the way in which CTM appraisal process is managed.

One issue which was identified within the review relates to the Chair of the appraisal panel; the recommendation from the review is that the position of Chair of the appraisal panel should be held by an IM.

This action has been discussed with the current chair of the panel and will be further considered and taken forward following receipt of the final feedback report.

Healthcare Pathways

Healthcare Pathways is a National programme which is being led by Primary Care with the aim to set standards across Wales in order to have a consistent approach across all health boards. This standardisation of agreed pathways will help and support primary care clinicians to provide support and care in the community.

CTM is in a strong position to drive this initiative forward in its delivery by Primary Care / Community who will ensure its delivery and will engage with secondary care for their support and input when required as the clinicians will jointly develop local agreements about the management of their patients within the scope of local healthcare systems.

The programme creates alternative pathways which is not focused solely on secondary care outpatient appointments.

The official launch of the Healthcare Pathways will be held in March 2024. Formal communication and launch details will be issued and communicated to all staff ahead of the launch date in order to fully inform and allow for colleagues to fully engage and support this roll out.

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

- (NW) Coroner outcome
- ERCP (Endoscopic Retrograde Cholangio-Pancreatography)
- Palliative Care service
- Mortality

NW Coroner Outcome

Care failings were found in this very sad Coroner case. As this case was pre-Maternity changes within Neonates and Maternity most of the required changes have already been met.

The NW inquest raised recommendations that should be applied across all specialities within the health board.

Recommendations include, need to ensure clear documentation and the understanding of when a consultant needs to attend out of hours.

ERCP (Endoscopic Retrograde Cholangio-Pancreatography)

As a consequence of recent ERCP related deaths an initial internal review was conducted but found no common themes and provided a good level of assurance to the clinicians and management team. Despite this assurance, a further deep dive by the Gastroenterology teams has been agreed which is to be commenced and the findings will be fed back to the Medical Director, who will ensure this committee is fully briefed of the findings and recommendations to be actioned.

A robust governance plan will be developed in order to ensure good governance and a full methodology is followed for the deep dive. If there are any significant findings identified from the internal deep dive review an external review will be commissioned.

Palliative Care service

Recent workforce issues have been identified within YCC which has led to issues with providing cover for the service. Through mitigating actions and steps taken the site remains open.

A review of the wider Palliative /End of Life strategy plans has been brought forward by the Care Group. This includes a review of the wider strategy plan for how we deliver palliative/end of life service and the role of each site and areas of service in this service delivery, this includes YCC.

Mortality

An electronic form has been developed for use by the bereavement team, this is undergoing validation prior to implementation.

Organ Donation and Transplantation

We received an excellent report from NHS Blood and Transplant (appendix 1), highlighting exceptional performance for CTM's quality of care in organ donation. From 6 consented donors, CTMUHB facilitated 4 actual solid organ donors resulting in 9 patients receiving a transplant during the time period. Additionally, 4 corneas were received by NHSBT Eye Banks from CTMUHB. A more detailed report will be shared at the next Board meeting.

Section 3 Therapies and Health Science

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

3.1 Leadership Development for Professional Leads

One of the ambitions of the CTM Allied Health Professions and Health Care Science Delivery Plan is the provision of a tailored leadership opportunity for our Professional Heads of Service. A bespoke leadership training package has been developed and funded by the University of South Wales. The content has been tailored to suit the identified learning needs of our professional leads and will cover:

- Self-awareness and preferred leadership styles
- Compassionate Leadership behaviours and role modelling
- Transformational change and critical thinking
- Influencing and impact evaluation
- Implementing strategy for area of responsibility in line with IMTP and CTM2030
- Engagement, followership and networking for impact.

The course, offered initially to service leads, comprises of an initial in-person session followed by 5 virtual learning sessions, 2 action learning sets and plenary held via Teams. As well as the bespoke content, significant benefit is anticipated from bringing the Professional Heads of Service together in a learning/development context. The initial session was delivered on 27/11/23 and received positive feedback from attendees.

3.2 Appointment to the Clinical Director for Health Care Science (CD for HCS)

Phase 2 of the Operating Model saw the development of the post of CD for HCS, combined with the role Assistant Director for Therapies and Health Science. Although Clinical Director for Allied Health Professions (AHP) positions are now well-established across the NHS Wales, the equivalent clinical leadership role for scientists is not. It is an exciting development that CTM is the first Health Board in Wales to develop such a post. The profile, development and transformation of our local and regional Health Care Science services are vital to the modernisation of healthcare provision across Wales.

Following a robust recruitment process, we are pleased to report that Melanie Barker has been appointed and will commence in this role in January 2024, sitting within the Diagnostics, Therapies, Pharmacy and Sciences Care Group (DTPS).

3.3 Planned Care Innovation Programme

The Planned Care Innovation Programme (PCIP) was launched in April 2022 to support people working in the health and care sector to take forward innovative ideas to improve planned care services across Wales. Led by the Bevan Commission, the programme aimed to tackle some of the challenges facing the delivery of planned care services in Wales. Building on the success of the Bevan Commission's Exemplar Programme, the Welsh Government awarded funding to support 17 innovative projects from across health and social care in Wales to deliver their innovative projects and work towards the adoption and spread of these nationally.

Of the 17 projects, 4 were designed by CTM and two of these were within and allied health (Speech and Language Therapy) and healthcare science (Radiography) services:

- A Prudent Social Communication Pathway in Speech & Language Therapy
- Radiology Pathway Navigation - A New Direction.

Both of these projects have delivered improvements for our patients and colleagues, and both have been identified as high impact projects with potential for wide scale adoption, adaptation and spread across Wales.

3.4 Weight Management Service (WMS)

Although the adult WMS is now established, demand is outstripping capacity. A range of actions have been taken in an attempt to address this, including group interventions and expansion of the clinical team, but the position remains challenging. The Adult WMS appears on the Corporate Risk Register and updates are provided within the Integrated Performance Dashboard presented to Board.

It has become apparent that there is an emerging need for a paediatric WMS within our communities. Some Level 1 weight management services exist across the Health Board, namely PIPYN (3-7yrs Merthyr only) and Henry (0-5 CTM wide), but these programmes are currently fixed term funded until end March 24. There is no Level 2 (multicomponent service) or Level 3 (specialist multi-disciplinary team) service. No resource has been identified as yet, but the Department of Nutrition and Dietetics are working with the Care Group leadership team to explore opportunities and the absence of a paediatric WMS has recently been added to the Risk Register.

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.

This section covers the following 3 areas:

- Type 2 Diabetes Prevention
- Population Health Management
- Health Protection, including vaccination and immunisation

4.1 Type 2 Diabetes Prevention

Key achievement in this work includes:

- Executive Development Day in September 2023 attended by the Chair and Executive Director of Knowledge and Research of Public Health Wales. This gained support from the Board to proceed with work on prevention.
- Agreement of a joint programme of work with Public Health Wales covering primary, secondary and tertiary preventions areas.
- Support gained from the Project management office to support the programme.
- Engagement with the Internal and External Stakeholders Groups chaired by the Medical Director
- Engagement with the Diabeter Project in the Value Based Health Care programme.

Key issues and challenges:

- Consultant capacity to lead and engage with this work with 2.5 whole time equivalent vacancies and maternity leave.
- Investment to support prevention activity. Currently only a small proportion of prediabetes programme (secondary prevention) coverage in Cwm Taf Morgannwg funded by the All Wales Diabetes Prevention Programme and Strategic Primary Care Programme. In addition, the eligible population in the small proportion of practices engaged include only those who have had a bold glucose test result in the pre-diabetes range. It does not proactively test the population.
- 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).
- Increasing rates of Type 2 diabetes over the last decade and modelling of trends showing increasing rates over the next decade. With approximately 10% of the NHS budget spent on diabetes this raises questions about sustainability of the NHS to meet this expected increase.
- Persistently high rates of obesity, the most modifiable risk factor for T2D in adults and children in Cwm Taf Morgannwg.

4.2 Population Health Management (PHM)

Key achievement in this work includes:

- Successful PHM workshop held in December 2023, with good engagement from primary care. Workshops explored the barriers within the work stream

and the opportunities going forward. It was a very constructive workshop enabling planning for the next year.

- 48/49 GP practices have signed up to share data that allows them to see the number and identities of patients in each segment and their risk profile to enable intervention.
- The Taff Ely Frailty Service project has evaluated well and has been presented at the Cwm Taf Morgannwg Research and Development (R+D) conference.
- Presentation to the National NHS Inequalities Board in December 2023 to gain agreement on key definitions of PHM and support to build core PHM capabilities.

Key issues and challenges:

- Information governance constraints with multiple Data Protection Impact Assessments (DPIA) requirements.
- Contract negotiation with partners for access to population health data.
- Clarifying ownership of PHM and routes of accountability for delivery.
- Digital Health and Care Wales (DHCW) priority to funded work. Development needed in PHM front end in Primary Care to allow data to be accessible for use.
- Funding for the Frailty Service in Taff Ely for 2024-25

4.3 Health Protection, including vaccination and immunisation

Key achievement in this work includes:

- Delivery of the Winter respiratory vaccination programme with offers of vaccinations for Covid and Influenza to all eligible groups.
- Development of a Vaccination and Immunisation Strategic Plan and a Vaccine Equity Strategic Plan in line with the requirement of the National Immunisation Framework and endorsed by Cwm Taf Morgannwg University Health Board.
- Joint poster presentation at the UK National Vaccination Conference, with the Vaccine Preventable Disease Programme in Public Health Wales, on the successful two-year-old Fluenz pilot, which was awarded first prize. Also presented at the Cwm Taf Morgannwg R+D conference.
- Action to offer catch up vaccines to children who had not completed one or two doses of the Measles, Mumps and Rubella vaccine was taken over the summer months increasing take-up. Frequently asked questions were available on the Cwm Taf Morgannwg web site and shared with primary care.
- Vaccination awareness session at Parc Prison Youth offending facility healthcare champions in the youth wing.

Key issues and challenges:

- Consultant capacity to lead this work with 2.5 whole time equivalent vacancies and maternity leave. This includes:

- Attendance and participation at Incident and Outbreak control meetings within Cwm Taf Morgannwg e.g. Legionnaire’s Disease and Tuberculosis
- Limited public health capacity for the local and national groups for health protection all hazards approach
- Limited Public Health leadership for eradication programmes e.g. Hepatitis B and C.
- Limited capacity to action national development work e.g. pandemic preparedness, emergency planning.
- Timeframe for consultant recruitment likely to be six months or more due to recruitment process approval and delays.
- Transitional funding from Welsh Government resulted in temporary contracts being extended by the Health Board, the consequence of which were:
 - Temporary staff leaving roles to take up permanent contracts elsewhere.
 - Closure of some vaccination centres due to inadequate staff resources.
 - Lower uptake of vaccination across a range of eligible groups.
 - Greater risk of winter pressures within the Health Board.
 - Limited behavioural insight support to address inequity in uptake vulnerable groups.
 - Limited communications support for the campaigns.
 - An increasingly pressured and demoralised workforce.
- Late notification by Welsh Government that GP vaccination fees for Covid were being reduced resulted more practices opting out and only half of practices participating.
- Funding allocated for 2024-25 is approximately 20% lower than 2022-23 and forms part of the discretionary grant with risks the allocation may be compromised.

4.4 Key Risks / Matters for Escalation

There are currently no further risks which require escalation to the Quality and Safety Committee. 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.

5. 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 (Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.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 (Ilyw.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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Content of this report is applicable to all patients



<p><i>Have you undertaken an Equality Impact Assessment Screening?</i></p>		<p>and provides equal access to healthcare with specific EqIAs completed at the right point of time</p>
<p>Cyfreithiol / Legal</p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	
<p>Enw da / Reputational</p>	<p>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.</p>	
<p>Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i></p>	<p>There is no direct impact on resources as a result of the activity outlined in this report.</p>	

6. Recommendation

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

7. 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 report.

November 2023

Dear P Mears and Mr Hurford,

The number of donors and transplants in the UK have continued to improve and we have returned to pre-pandemic levels. Please accept our recognition and thanks for the effort of your staff.

This letter explains how your Health Board contributed to the UK's deceased donation programme.

Organ and tissue donation and transplantation activity - Apr-Sep 2023

From 6 consented donors, Cwm Taf Morgannwg Health Board facilitated 4 actual solid organ donors resulting in 9 patients receiving a transplant during the time period. Additionally, 4 corneas were received by NHSBT Eye Banks from your Health Board.

Quality of care in organ donation - Apr-Sep 2023

When compared with national data, during the time period your Health Board was:

- Exceptional for the referral of potential organ donors
- Exceptional for Specialist Nurse presence when approaching families to discuss organ donation
- Your Health Board referred 41 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 10 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse participated in 6 organ donation discussions with families of eligible donors. There were no occasions when a Specialist Nurse was absent for the donation discussion.
- In Wales, 44% of the population have registered an NHSBT Organ Donor Register (ODR) opt in decision. This compares to 43% of the population nationally.

Up to date Health Board metrics are always available via our Power BI reports found here:

<https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/>.

What we would like you to do

- Ensure your Health Board supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Health Board has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.
- An opt-in registration on the NHSBT Organ Donor Register results in the highest rates of consent/authorisation, please support your Organ Donation Committee in their efforts to promote the NHSBT Organ Donor Register where possible.

Deemed Consent Legislation - Wales

Wales introduced deemed consent in December 2015. In Wales, between 1 December 2015 – 30 September 2023, there were 208 occasions when consent was deemed from 326 occasions where deemed consent applied.

Why it matters

In the first six months of 2023/24, 71 people benefited from a solid organ transplant in Wales. However sadly, 9 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,



Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant



Preoperative Checklist

Date..... Ward.....

Consultant..... Theatre.....

Addressograph
Preferred name

ALLERGY/HAZARD Please State:

If natural latex rubber please inform theatre immediately.

Infection prevention & Control concerns? Please state:

If yes, please inform theatre ASAP

LATERALITY (please circle)

RIGHT **LEFT**

Is the patient being barrier nursed? (please circle)

YES **No**

Pre-operative marking verification checks		Responsibility	Sign and print name
Check 1	<ul style="list-style-type: none"> Check patient's identity, notes & images. Mark intended site with indelible pen. 	Surgeon	
Check 2	<ul style="list-style-type: none"> Prior to leaving ward, surgical site mark is inspected & confirmed against notes. All notes accompany patient to theatre- Digital or Paper (please circle) 	Ward staff	

Enter Yes/No or NA (not applicable) as required. Circle/Enter Details where indicated.

	Ward	Theatre	Comments		
Any specific communication needs? e.g. Sensory, LD, Dementia, Language.					
Identity Band present and details correct?			Not to be put on limb for surgery. Red arm band applied if any Allergies		
Last Meal >6 Hours? (Oral/Peg/Feeding tube)			Date: Time:		
Last Oral Fluids >2 Hours?			Date: Time:		
Consent Form signed and dated?					
Patient notes available for theatre?					
Prescription chart available for theatre?					
X-rays?					
Fluid Balance chart (if required)?			Catheter Bag Emptied? Yes/No		
NEWS Chart available for theatre?					
Is the patient pregnant? (12 to 55 inclusive, need to acknowledge and all gynaecology surgery, require a pregnancy test)			Pregnancy Test Required? Yes/No Result: Positive + / Negative - Where indicated, has pregnancy loss remains documentation been completed? Yes/No		
Pressure Area Assessment?			Score: Red Amber Green Body Chart: Yes/No? (Please circle)		
Premedication? Consider Oral vs IV Paracetamol			Date: Time:		
Inhaler available?			Last taken:		
Weight: Height:			If weight >100Kg please inform Theatre		
Diabetic?			If yes- last BM: Date: Time:		
VTE Risk Assessment Completed?			TED Stockings prescribed? Yes/No		
Implants/Prosthesis/Metalwork?			If yes, specify:		
Implanted Cardiac Device? e.g. ICD, Pacemaker, ILR.			If yes, specify type of device: Cardiac physiologist Required? Yes/No/NA		
Dental Caps/Crowns/Bridge/Dentures? If yes, please circle.			<table border="1" style="width: 100%;"><tr><td> </td><td> </td></tr></table> Dentures removed? Yes / No /Dental Pot		
Jewellery			Removed? Yes / No Taped? Yes / No		
Glasses/Contact Lenses/Hearing aids?			Removed? Yes / No. Returned to Ward? Yes/No.		

Wigs/Hairpieces/Hairgrips/ Extensions?

Removed? – Yes/No

Pre-operative Test Results

PREGNANCY TEST RESULT

Females 12-55 years

L.M.P. _____

Attach result here

URINALYSIS

Attach result here

Any additional specific information needed to hand over to theatre team?

Pre-operative marking verification checks

Responsibility

Sign and print name

Check 3

In anaesthetic room & prior to anaesthesia recheck mark, site and all images available

Anaes Support Staff

Check 4

As part of WHO briefing

Theatre staff directly involved in the intended procedure



Agenda Item

5.2a

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
(Insert Details)	Click or tap to enter a date.	

Acronyms / Glossary of Terms	
T&F	Task & Finish
CNS	Clinical Nurse Specialist
USC	Unscheduled Care
NRI	Nationally Reportable Incident
GIRFT	Getting it Right First Time



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 December 2023.

2. Purpose of this Meeting

2.1 This report had been prepared to provide the Committee with details of the key issues considered by the Planned Care Group, Quality, Safety, Risk & Experience Group at its meeting on 19th December 2023

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

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

3. Highlight Report

Alert / Escalate	<p>Princess of Wales Hospital</p> <ul style="list-style-type: none"> Ward Controlled Access on inpatient wards. CTMUHB Task and Finish Group established to mitigate risk. First meeting planned for November 2023 <p>Urology</p> <ul style="list-style-type: none"> Urology Sustainability Programme Group commenced in October with key focus on the review of medical, nursing and CNS workforce and job plans to support the ability to enable routine cancer care delivery and reduce waiting lists. <p>USC demand impacting on elective care capacity.</p> <ul style="list-style-type: none"> Aiming to continue with urgent cancer surgery Loss of elective surgery being performed early January 2024.
Advise	<p><u>Organisational Risk Register</u></p> <ul style="list-style-type: none"> 3 Planned Care risks have been escalated to the Organisational with a risk score of 20. <ul style="list-style-type: none"> 4491 Demand for Planned Care services exceeds capacity. 4071 Failure to meet Cancer targets – some improvements noted but some service improvements linked to diagnostic capacity. 4103 Sustainability of a Safe and effective Ophthalmology service - Ophthalmology Harm review funding agreed up until March 2024. <p>NRI Summary for Care Group as November 23</p> <ul style="list-style-type: none"> Total of 31 open NRIS for care group



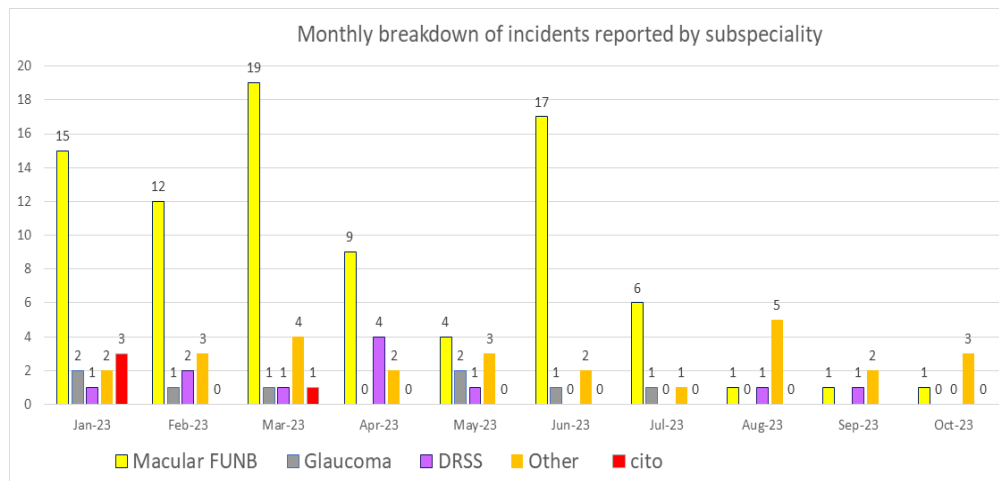
- **21 overdue**
- Large majority of cases are over 180 days+ (6 months)
- PCH - 2 overdue (1x closure bundle submitted)
- RGH - 0 overdue
- POW – 19 overdue (18 x ophthalmology). Inability to recruit a Family Liaison Officer having an impact on this.

Ophthalmology incidents

The table below demonstrates the improving processes for the macular service and embedding the learning following our serious incidents / concerns.

The last 4 months have seen large decrease in datix submissions, particularly for the macular service. Patients who are waiting for time critical intravitreal injections are now being given appointments on time and with meticulous monitoring, assurance is in place to ensure that patients no longer 'getting lost' to follow up.

Whilst there is still work to be undertaken to clear the back log of harm reviews and complete the cluster report, the clinical and administrative teams and clinician recruitment is making an impact within this service.





Assure	<p>Ophthalmology (GIRFT)</p> <ul style="list-style-type: none"> • WG funding agreed to support using outsourcing private clinic to undertake assessment and treatment of 60 CTM patients per week who are presenting with new Glaucoma. By end March 24, 720 patients will have been reviewed. Allowing these slots to be allocated internally as part of risk stratification to clear backlog of existing long waiting patients. • Improved systems in place for booking patients/ waiting lists/ delays/ admin recruitment • Recruited more staff to cover clinical sessions <p>Theatre Efficiency/Productivity (GIRFT)</p> <ul style="list-style-type: none"> • RGH workforce aligned to POW & PCH Start & finish times • T&F group to focus on creation of additional theatre capacity at RGH (Tirion theatre) to enable increase in orthopaedic capacity • Recruitment of 3 x Practice Educators on all 3 sites • Creation of dashboard for each site to view theatre turnaround times and productivity. • Pan CTM Pre-operative Patient Safety checklist updated and approved at Planned Care Q&S Committee (Appendix 1). <p>Royal Glamorgan</p> <ul style="list-style-type: none"> • Significant reduced Bowel Screening Wales (BSW) waiting times from 25 weeks in October to 11 weeks in December. • Ward 8+9 New Nurse Call buzzer system work completed and risk removed from Risk Register <p>Prince Charles Hospital</p> <ul style="list-style-type: none"> • The re-start of Special Care Dentistry lists at PCH, with aim to move this service from PoW to PCH to enable increased ophthalmology surgery lists in PoW. <p>Princess of Wales</p> <ul style="list-style-type: none"> • Proposed introduction of the ward based caterers by December 2023 • JAG accreditation review in November - Feedback extremely positive. Assurance regarding robust governance process with considerate, kind, staff.
Inform	Monthly Ward Assurance



Percentage of compliance against the 10 key ward assurance audits (2023)

Average % by Ward

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
PCH Critical Care Outreach	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PCH Day Surgical Unit	98.08%	98.58%	99.08%	99.00%	97.82%	99.76%	98.45%	100.00%	97.78%	98.56%
PCH Empty ward	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PCH Endoscopy Unit	94.14%	85.08%	91.79%	98.62%	96.12%	90.28%	97.31%	93.76%	96.91%	98.81%
PCH Maxillo Facial OPD	100.00%	96.00%	95.55%	96.00%	96.19%	98.70%	99.45%	98.88%	98.66%	99.17%
PCH Pre Assessment Clinic	91.38%	91.38%	93.10%	88.50%	100.00%	96.55%	99.15%	99.10%	100.00%	100.00%
PCH Protected Elective Surgical Unit	N/A	78.84%	89.42%	N/A	N/A	N/A	N/A	N/A	100.00%	N/A
PCH Theatre Department	96.25%	94.63%	94.17%	92.13%	97.93%	96.98%	96.88%	94.68%	86.06%	95.36%
PCH Ward 04 (?)	N/A	N/A	N/A	N/A	66.70%	100.00%	100.00%	100.00%	100.00%	100.00%
PCH Ward 05	96.11%	97.44%	86.45%	96.54%	91.30%	93.88%	96.65%	94.13%	94.25%	94.92%
PCH Ward 06	97.59%	92.54%	94.31%	92.54%	96.06%	96.24%	93.88%	96.81%	97.04%	96.96%
PCH Ward 07 (formerly ward 3)	90.74%	92.96%	88.49%	96.69%	91.07%	94.20%	93.86%	96.83%	96.67%	99.14%
PCH Ward 08	91.21%	94.92%	90.10%	96.80%	94.82%	90.15%	97.23%	95.90%	89.04%	95.46%
PWH Anaesthetics Department	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PWH Bridgend Clinic	94.70%	93.64%	91.59%	94.84%	94.36%	97.06%	92.91%	92.04%	94.07%	90.98%
PWH Day Surgery Unit	N/A	N/A	98.33%	95.83%	99.17%	96.37%	98.13%	95.00%	94.07%	94.17%
PWH Endoscopy Unit	98.38%	98.16%	96.13%	97.13%	97.31%	97.89%	98.03%	99.64%	98.70%	99.01%
PWH ENT Unit	N/A	100.00%	100.00%	100.00%	100.00%	99.27%	100.00%	98.90%	100.00%	100.00%
PWH Ophthalmology Day Surgery Unit	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.00%
PWH Theatre Department	N/A	N/A	N/A	N/A	100.00%	100.00%	100.00%	N/A	N/A	100.00%
PWH Urology Unit	N/A	N/A	100.00%	100.00%	100.00%	99.28%	99.28%	99.33%	99.30%	98.68%
PWH Ward 07	92.07%	N/A	93.87%	N/A	87.90%	87.46%	100.00%	N/A	97.50%	91.52%
PWH Ward 08	87.57%	N/A	89.40%	91.48%	94.21%	90.19%	91.34%	94.00%	89.33%	94.47%
PWH Ward 09	94.54%	96.40%	96.09%	98.03%	87.88%	93.61%	96.32%	N/A	92.90%	86.68%
PWH Ward 16	94.04%	93.77%	91.66%	96.90%	91.78%	N/A	91.18%	94.06%	94.50%	80.24%
PWH Ward 21 Short Stay Unit	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RGH Anaesthetics Department	N/A	N/A	N/A	N/A	N/A	N/A	88.90%	N/A	N/A	N/A
RGH Critical Care Outreach	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RGH Day Surgical Unit	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	100.00%
RGH Endoscopy Unit	N/A	N/A	N/A	N/A	100.00%	93.33%	96.00%	96.00%	96.00%	100.00%
RGH Hummingbird Centre	N/A	N/A	N/A	N/A	N/A	100.00%	100.00%	100.00%	97.70%	97.70%
RGH Maxillo Facial OPD	100.00%	N/A	100.00%	100.00%	100.00%	100.00%	100.00%	98.85%	100.00%	100.00%
RGH Outpatients Department - Main	98.75%	100.00%	100.00%	98.87%	98.90%	98.03%	97.37%	98.33%	96.67%	98.20%
RGH Outpatients Department - Surgical	N/A	N/A	N/A	N/A	N/A	N/A	77.80%	87.50%	N/A	N/A
RGH Snowdrop Breast Unit	N/A	N/A	100.00%	93.60%	93.90%	94.73%	98.03%	98.17%	99.00%	99.17%
RGH Theatre Department	98.75%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.88%	100.00%
RGH Urology Treatment Centre	N/A	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.75%
RGH Ward 02	84.83%	94.33%	95.04%	96.94%	94.07%	89.99%	92.91%	94.93%	95.21%	98.71%
RGH Ward 03	92.43%	91.82%	91.43%	94.98%	94.26%	94.58%	96.97%	94.20%	96.71%	96.45%
RGH Ward 07 ITU	N/A	N/A	N/A	N/A	N/A	N/A	87.50%	87.50%	100.00%	100.00%
RGH Ward 08	88.55%	90.31%	87.56%	93.16%	90.34%	90.12%	93.52%	93.28%	95.35%	95.66%
RGH Ward 09	94.74%	94.19%	94.45%	97.30%	94.43%	96.01%	95.83%	95.22%	94.63%	97.02%
RGH Ward 10	95.49%	93.89%	96.27%	98.46%	95.74%	97.19%	98.48%	98.10%	99.58%	94.88%
RGH Ward 11	N/A	N/A	N/A	N/A	N/A	N/A	100.00%	100.00%	100.00%	100.00%
RGH Ward 15	99.95%	99.63%	99.37%	100.00%	98.55%	98.88%	99.34%	99.65%	98.49%	100.00%

- Senior Nurses for Theatres to undertake review of AmaT audits and scope how it can be adapted for DSU.
- Improved compliance with completion of audits on Ward 7 & 9 in PoW.

Appendices

Appendix 1 – CTM Pre-Operative Patient Safety Check list



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

5. Recommendation

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



Agenda Item

5.2b

Quality & Safety Committee

Highlight Report from the Primary Care and Communities Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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	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
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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	
AMD	Age-related Macular Degeneration
CDS	Community Dental Service
DN	District Nursing
GA	General Anaesthetic
GDP	General Dental Practice
GDS	General Dental Service
HBs	Health Boards
HMP	His Majesty's Prison



POCD	Package of care Delays
RN	Registered Nurses
SMOR	Substance Misuse Observation Record
YBN	Y Bwthyn Newydd
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
HEIW	Health Education Improvement Wales

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 8th December 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

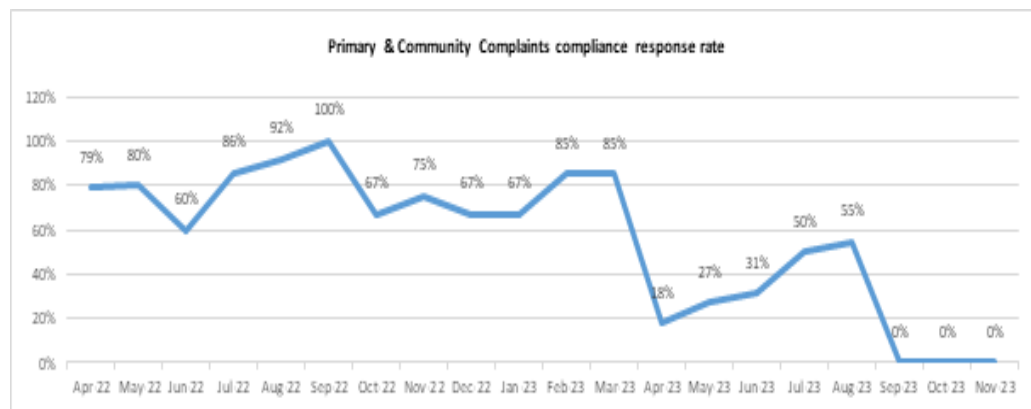
- **Paediatric General Anaesthetic Lists.** Currently on the risk register (score 12). There is approx. 1000 children waiting for a GA assessment or GA. Conversion rate for GA has risen from 48% (pre-covid) to 80% due to the number on the waiting list and increased requirement for GA treatment. The team have met with Secondary care and have agreed to hold an additional list to reduce the waiting list and Primary Care to bid for empty theatre lists to be utilised for the service. Also, additional support to be provided



	<p>by paediatric specialist in CDS if GDP unable to manage the urgent care required.</p> <ul style="list-style-type: none"> • YBN POWH IPC issues – area to temporarily relocate for 3 weeks to ensure Estates are able to undertake the required work.
Advise	<ul style="list-style-type: none"> • YCC, Gap within consultant cover in YCC remains a quality risk. Meetings have been held with the medical team in planned care to provide interim cover and consultant support whilst a longer term plan is being reviewed. • Diabetic retinopathy- the service is reduced as two providers have pulled out of the scheme. Mitigations are being explored with HEIW to train up cluster optometrists. The duration of training may mean a lag of a few months, therefore will reduce the number of patients coming out of secondary care into the scheme. • AMD Community clinics to go live in February 2024 to enable stable patients to be assessed within practice in addition to urgent patients. • GDS Dental waiting list currently stands at 13,000 patients. This is increasing month on month. There is a plan in place to review the list for validation due to multiple names being on list/those that have already found a dentist that need removing. A SMS messaging service is to be set up to ask patients if they need to remain on the list. • First Contact Physiotherapy services have been commissioned from the Health Board. Cluster funds continue to be used to finance and support delivery of this service. North & West Bridgend clusters needing to make decisions due to extremely tight budget whether to continue investing or consider new/innovative projects. • Advance Care Planning (ACP) a recent mortality review identified a number of missed opportunities to initiate ACP discussions within Older People’s Mental Health, District Nursing and a Care Home. This highlights the need for further training and education in these areas. There is a plan to scope and review the service, identify the required learning and implement improvement actions required. • HMP Parc – Medicine management policy to be devised for the SMORS process. • Pharmacy medication risks at HMP Parc require further review and pathways to be developed to prevent further medication incidents. Task and finish group meeting arranged.
Assure	<ul style="list-style-type: none"> • Cluster managers are working on a project proposal template to ensure that number of years for funding and exit strategies are considered at the start, alongside evaluation tools being reviewed and consistent template for use across the clusters. • Community Hospitals Bed redesign work commenced. • Nursing workforce information work commenced across all ward areas. • POCD data has significantly improved across Community Hospitals.



- **RN Vacancies in Community Hospitals** International nurses have been appointed into both community hospitals for the first time (5 wte for YCR and 4 wte for YCC)
- **Nursing collaborative** meetings scheduled from January 2024 onwards.
- Centralised Civica administration team implemented to streamline the data entry on Civica across locality to improve data entry and to capture accurate demand on the **District Nursing service**. Extra administrative post awaiting recruitment to support the centralised team.
- Complaint closure compliance, there are 2 open formal concerns within the care group and the small number of open concerns can skew the compliance data.



- There is a reduction in the number of formal concerns across the care group. This is due to two contributing factors
 - The implementation of the concerns process embedded at HMP Parc
 - The standardisation of concern recording within Primary Care, in line with other HBs across Wales.
- There is 1 open Nationally Reportable Incident, which is in compliance.
- All the Community wards and HMP Parc are now using AMAT. Compliance with ward audits as of the end of December is shown below.



	Project	Number of audits	Current compliance
	Health & Safety	1	G 98.5%
	Health and Care Standards	1	G 99.2%
	Infection Control	4	G 98.3%
	Medicines Management	3	G 98.3%
	Patient Safety	12	G 96.1%
INFORM	<ul style="list-style-type: none"> • Insulin transcribing issue for housebound patients now resolved. DNs have been provided with training to transcribe to support the patients. • DN night service now aligned as one service pan CTM • Safe Care Collaborative 14th September 2023 story boards presented by Quality Improvement (QI) team regarding community projects (CAPU and Falls). • Community Acquired Pressure Ulcers (CAPU) (WWIC project) Tissue Viability service in collaboration with Arjo and WWIC undertook a Pressure ulcer Prevalence audit at Ysbyty Cwm Cynon and Ysbyty Cwm Rhondda w/c 18th September 2023. The work and resulting outcomes will help drive improvements to patient safety in relation to pressure ulcer prevention. • Consideration of investment to digitalise documentation across DN service. • DN Team Leaders had the learning and development opportunity to attend the NHS Wales and Civica Scheduling Webinar on the 7th November 2023. Health boards across Wales shared their learning and experience of Civica. • The DN Senior Nursing Team represented the Health Board at this webinar to share how we implemented Civica and the barriers presented. • Clinical Lead at HMP Parc awarded a Chief Nursing Officer (CNO) Excellence Award for her work within Dementia Care. • HMP Parc - Sexual health promotion introduced • HMP Parc – training analysis commenced • HMP Parc - Hypo Guidelines agreed 		
Appendices			

4. Assessment

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



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

5. Recommendation

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



Agenda Item

5.2c

Quality & Safety Committee

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

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Suzanne Hardacre Director of Midwifery & CYP Nursing Mohamed Elnasharty Medical Director
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
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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
HIV	Human Immunodeficiency Virus



HoM	Head of Midwifery
HoN	Head of Nursing
IFS	Intrapartum Fetal Surveillance Standards
IMSOP	Independent Maternity Services Oversight Panel
IPAAF	Integrated Performance, Assessment and Assurance Framework
ISH	Integrated Sexual Health
JICPA	Joint Inspectorate Review of Child Protection Arrangements
LW	Labour Ward
MNSB	Maternity and Neonatal Safety Board
NIPEC	Newborn Infant Physical Examination Cymru
NSAG	National Steering Advisory Group (Women's)
OCP 2	Organisational Change Procedure (Phase 2)
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
SBUHB	Swansea Bay University Health Board
SCBU	Special Care Baby Unit
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 7th December 2023.
- 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	<ul style="list-style-type: none">• Essential work required to Special Care Baby Unit (SCBU) and the Labour Ward (LW) at Princess of Wales (POW) Hospital Bridgend (medical gases, air exchange & electrical upgrades) require services to be decanted elsewhere in order maintain business continuity. Care Group met with Capital Estates on 4th January 2024 to explore options. Work likely to take place during summer 2024.• CTMUHB met with Welsh Health Specialised Services Committee (WHSSC) on 21st December to discuss cot configuration, impact and workforce requirements. Local Quality Impact Assessment being prepared.• Health Visiting – number of empty caseloads & sickness absence within Bridgend impacting delivery of Health Child Wales Programme (HCWP). Deep dive in progress with support from Employee Well-Being team.
Advise	<ul style="list-style-type: none">• NHS Executive colleagues visited Prince Charles Hospital (PCH) Maternity, Neonatal Services and Gynaecology Assessment Units at both PCH and Royal Glamorgan Hospital (RGH) on 5th December 2023 as part of enhanced monitoring review. Awaiting formal feedback from tripartite meeting held on 18.12.23.• School Entry Hearing Service (SEHS) – current responsibility remains within school nursing service. Direction from Welsh Government (WG) requires handover of the programme to audiology services.• Re-commissioning of previous obstetric theatre (RGH) into day surgery unit. Community midwives currently use this area as office space. Care group has been tasked with finding alternative accommodation. Options being sought at RGH and across community sites.• Consultant Midwife for Population Health and Quality Improvement reviewing maternal population health across the service. The review will explore outcome measures, clinical outcome data and public health data to determine a work-plan for 2024/25.• Nursing and Midwifery leadership arrangements complete as part of OCP2.• Neonatal Nursing responsibilities transferred from the Head of Nursing (HoN) Children & Young People (CYP) to Heads of Midwifery (HoMs) from 5th January 2024. This move will further strengthen 'one perinatal service'.



	<ul style="list-style-type: none"> • Psychosexual counselling provision for SBUHB post disaggregation of sexual health Service Level Agreement (SLA). CTM are to provide a psychosexual counselling service for SBUHB where a female counsellor is required. Agreed on a cost per case basis until 31st March 2024. Arrangements from 1st April 2025 to be determined.
Assure	<ul style="list-style-type: none"> • Maternity & Neonatal Guidelines: Swansea Bay University Health Board (SBUHB) host a Digital Guideline Platform known as 'WISDOM'. We are experiencing delays uploading ratified guidelines onto WISDOM across Wales. Escalated to National Steering Advisory Group (NSAG) and Maternity and Neonatal Network 2.1.24. CTMUHB Risk Assessment in place, for discussion at next All Wales Directors of Midwifery meeting 16.1.24. • Gap Analysis underway at SCBU POW to ensure all IMSOP Deep Dive recommendations are sustainably embedded across both sites. Outcome to be presented at future Quality Safety Committee. • Newborn and Infant Physical Examination Cymru (NIPEC) Standards received from Welsh Government (WG). Plans in place to develop accurate data capture. • Maternity and Neonatal Services Integrated Performance Assessment and Assurance Framework (IPAAF) sessions held with Senior Responsible Officers (SROs) in November / December. Maternity remains in Maturity / Exemplar, Neonates now moved into Maturity (previously Results). • Chief Midwifery Officer (CMO) for Wales visited POW SCBU on World Prematurity Day. Areas of good practice were identified along with some areas for improvement which are being addressed. Formal response returned to CMO on 12.1.24. • Junior doctor industrial action 15th – 18th January 2023 Action plan developed for full rota coverage of essential services. • Safeguarding Level 3 compliance increasing across the Care Group (CYP now 67%). Safeguarding improvement plans being progressed with support from corporate safeguarding colleagues following the Joint Inspectorate Review of Child Protection Arrangements (JICPA) in Bridgend.
Inform	<ul style="list-style-type: none"> • Head of Midwifery for PCH commenced in post 4.12.23 • Diverse Cymru training planned across the Care Group 22.2.24.



- CTMUHB colleagues are working nationally to develop all Wales standards and training for Intrapartum Fetal Surveillance (IFS).
- Gap analysis completed against "NHS Race and Health Observatory's review of neonatal assessment and practice in Black, Asian, and Minority Ethnic Newborn Recommendations of July 2023". To be presented at Maternity Neonatal Safety Board (MNSB) 20.2.24.
- Formal notification for the closure of the Early Years Integration Transformation Programme received from WG on 19.12.23. Head of Nursing liaising with Workforce colleagues to support affected colleagues.
- Sexual Health outreach practitioner (commissioned by RCT) appointed on 15th Dec.
- NEW Youth walk-in Clinic for under 18's commencing 15th January 2024 in Aberdare Health Centre to improve access to Integrated Sexual Health (ISH) care for young people
- Advanced HIV pharmacist in post for 12 month secondment in ISH.
- An Advanced Nurse Practitioner (ANP) in HIV Care has won a Seren Award for her work in developing the service and adherence to the all Wales HIV Action Plan
- Clinical Services Strategy meetings initiated within the Care Group. First meeting held 18.12.23.
- Vanguard training with WG taking place in relation to continuing care for children & young people. CTMUHB Workshop scheduled 29th January with Local Authority colleagues to plan next steps in relation to developing an integrated approach

Risk Register (15 & Over)

Risk No	Risk	Risk Score
3008	Injury due to manual handling compliance being low	16
2808	Waiting times for performance Neurodevelopmental team	15



	Risk No	Risk	Risk Score
	5413	No maintenance schedule in place for aged obstetric theatre bed - unable to be robustly maintained within standards. <i>This risk is being considered for escalation to the Organisational Risk Register at the next Operational Management Board.</i>	16
Appendices	Maternity and Neonatal Metrics		

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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective
	If more than one applies please list below: <ul style="list-style-type: none"> Culture and Valuing People Data to Knowledge Leadership Learning, Improvement & Research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe
	If more than one applies please list below: <ul style="list-style-type: none"> Timely Efficient Equitable Effective Person-Centred
	No - Not Applicable



**Effaith Amgylcheddol/
Cynaliadwyedd (5R) /
Environmental
/Sustainability Impact
(5Rs)**

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.

Maternity and Neonatal Metrics:

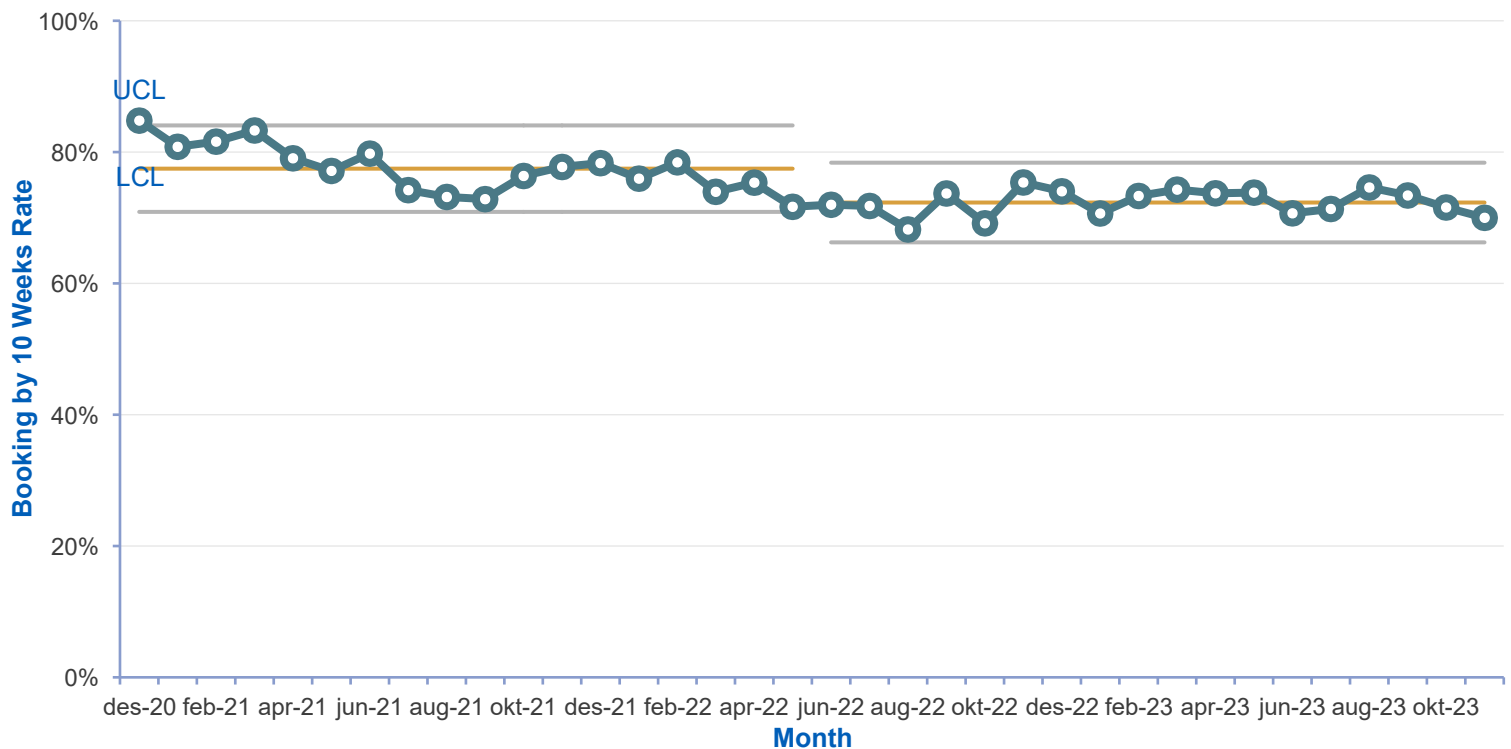
January 2024

(Data for Decemberr 2020- November 2023 unless otherwise stated)

Elinore Macgillivray, Consultant Midwife for QI and Population Health

Rate of Initial Booking by 10 weeks

Compliance with Booking by 10+6 Weeks Rate



Created at 12:46 on 04-01-2024

Improving compliance with booking by 10+6 weeks has remained a challenge, with QI work ongoing.

The current median is 73% (target 85%).

A new digital system was launched in August 2023 and has been well received.

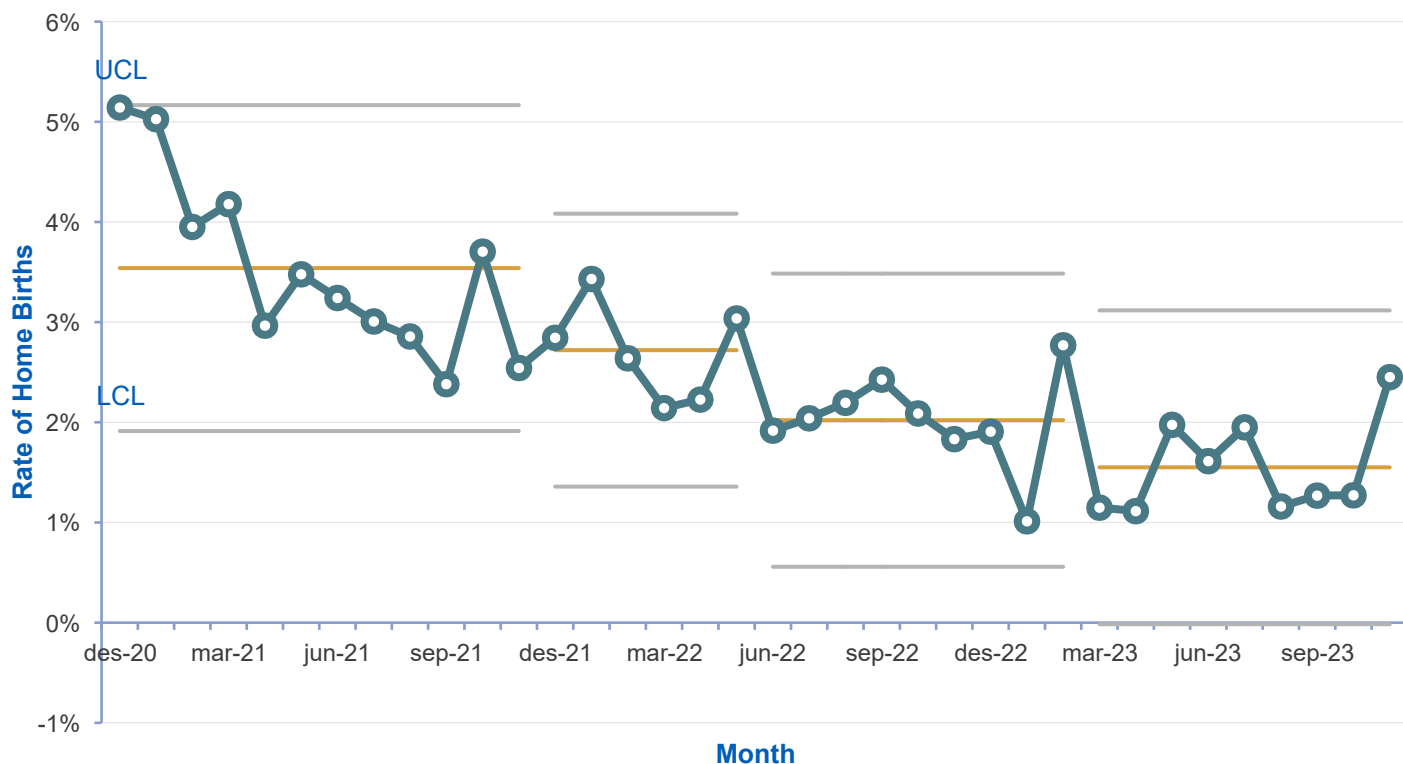
Although compliance has not improved, there have been other unexpected improvements associated with the system, including:

Population data, which can be used to develop the service.

Since adding a question about smoking/ vaping status, several women have been supported by the HMQ for Baby team to stop smoking/vaping prior to their booking appointment. This would not have been possible previously.

Home Birth Rate

Home Birth Rate December 2020- November 2023



Created at 12:11 on 04-01-2024

The median rate of home births has decreased steadily over the past 3 years.

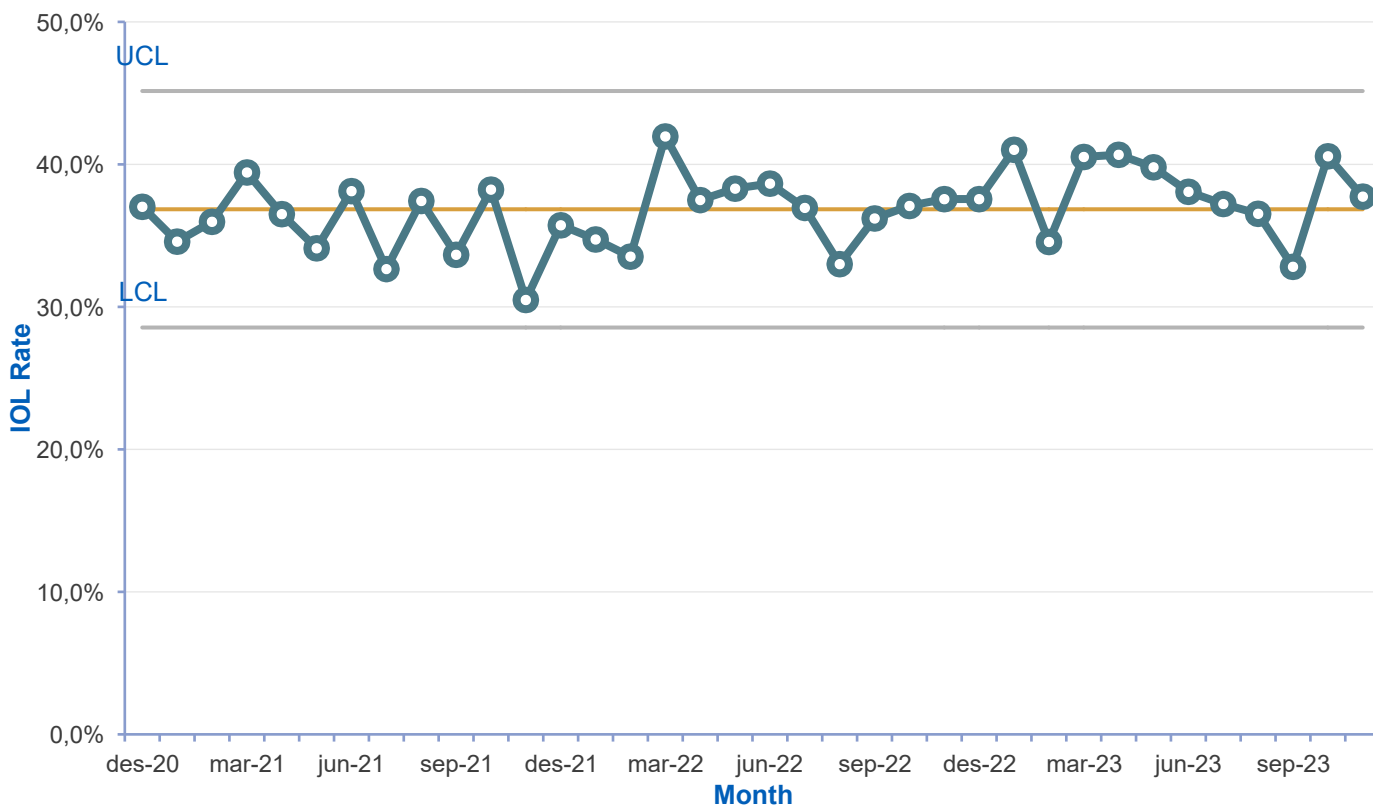
The median has shifted from 3.5% in early 2021 to its current median of 1.5% (as of March 2023).

This is part of an overall picture of rising intervention rates which is being seen across Wales.

Work is ongoing to increase engagement with midwifery led care.

Induction of Labour Rate

Induction of Labour Rate December 2020 - November 2023



Created at 12:29 on 04-01-2024

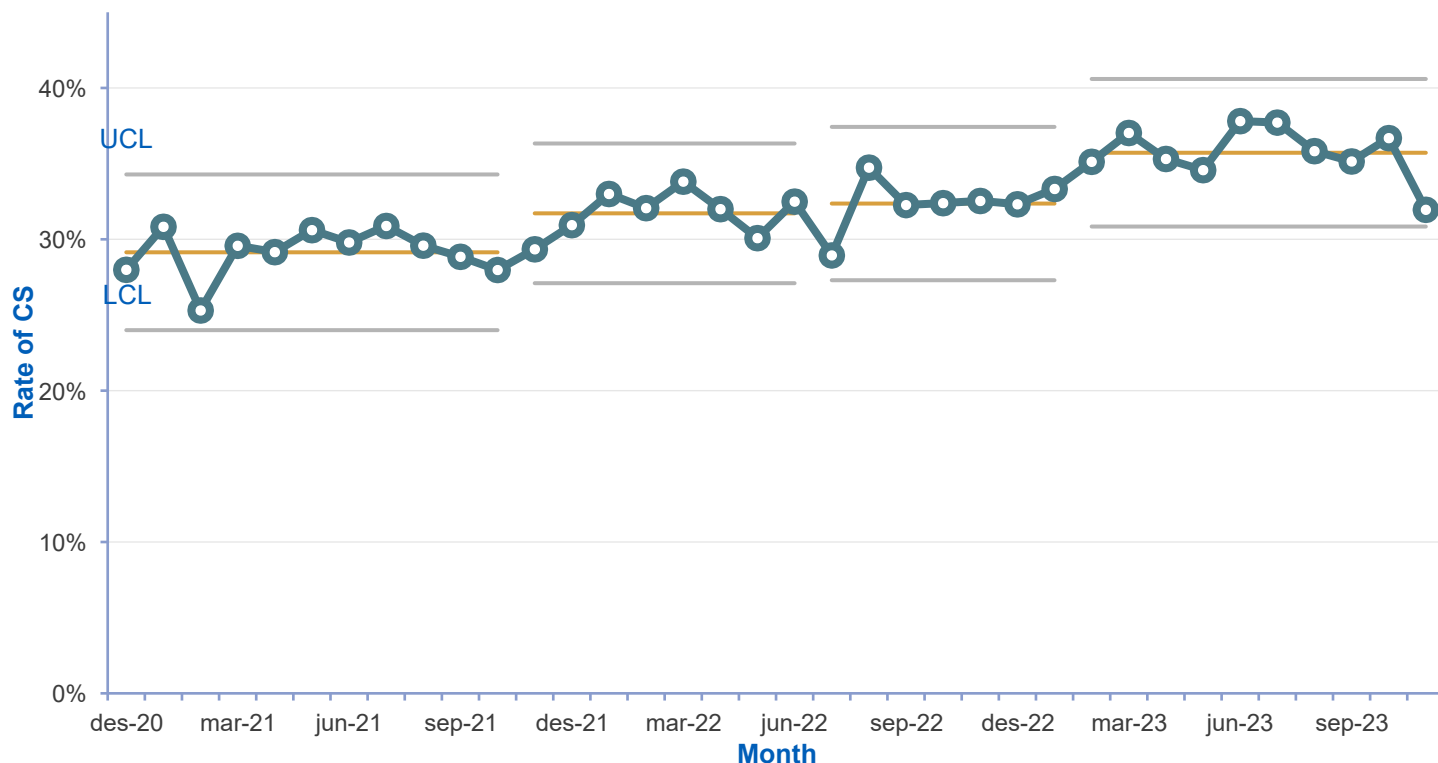
The median rate of IOL has remained stable for a number of years at around 37%.

QI work is ongoing to improve quality and experience of IOL from decision making to flow.

IOL workshops to support women and birthing people in making informed decisions and understanding the IOL process are being planned.

Rate of Caesarean Sections

Rate of Caesarean Sections (all categories)



Created at 13:08 on 04-01-2024

The rate of caesarean sections (total all categories) has risen significantly over the past 3 years.

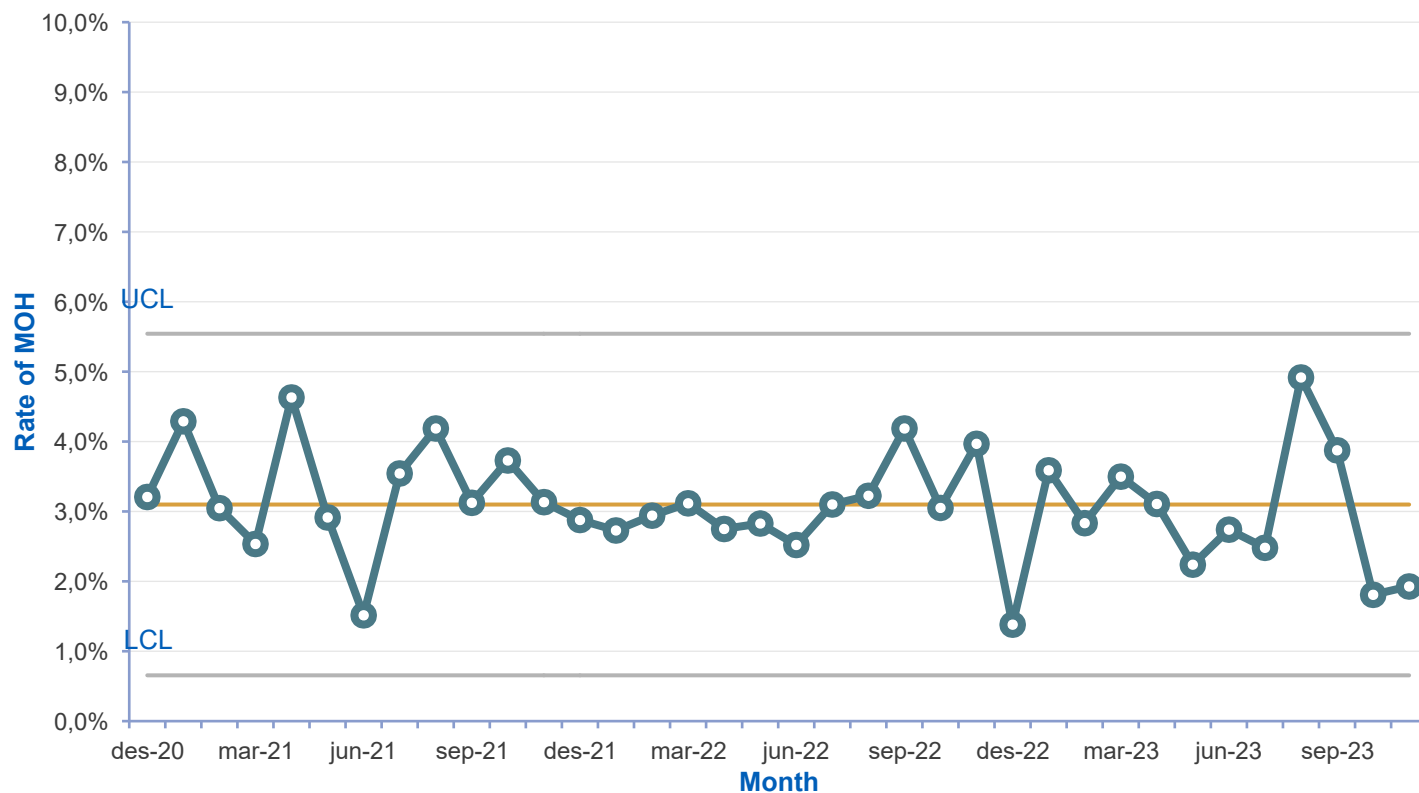
The median rate of caesarean sections was 29% in 2021 and is now 36% as of March 2023.

This trend is being observed across Wales.

Work is ongoing to understand the reasons for the rise.

Postpartum Haemorrhage \geq 1500ml (MOH)

Rate of PPH \geq 1500ml (Massive Obstetric Haemorrhage)



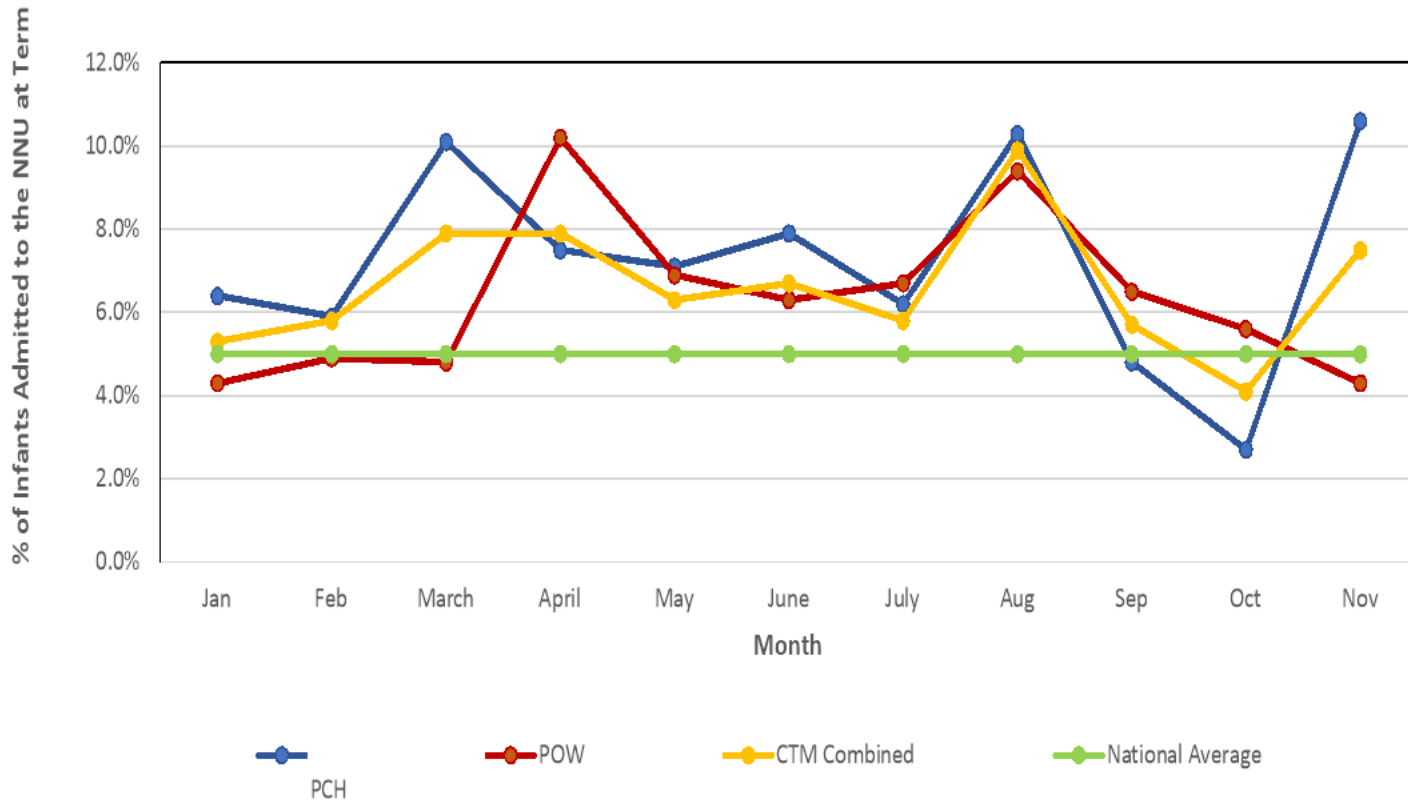
Created at 12:37 on 04-01-2024

Despite rising rates of intervention, the median rate of massive obstetric haemorrhage (MOH) has remained stable at just over 3%.

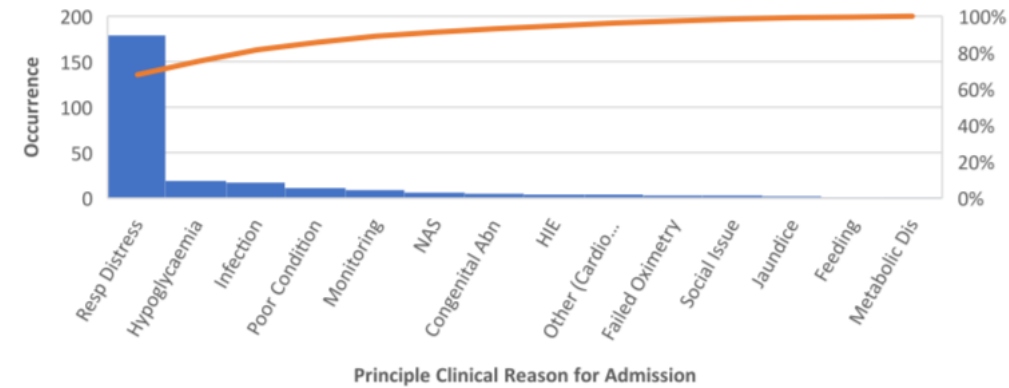
All data points are within normal variation and sub-optimal PPH management has not been identified as a concern via governance and risk.

Avoiding Term Admissions to the Neonatal Unit (ATAIN)

ATAIN Rate Jan-Nov 2023
CTM Combined



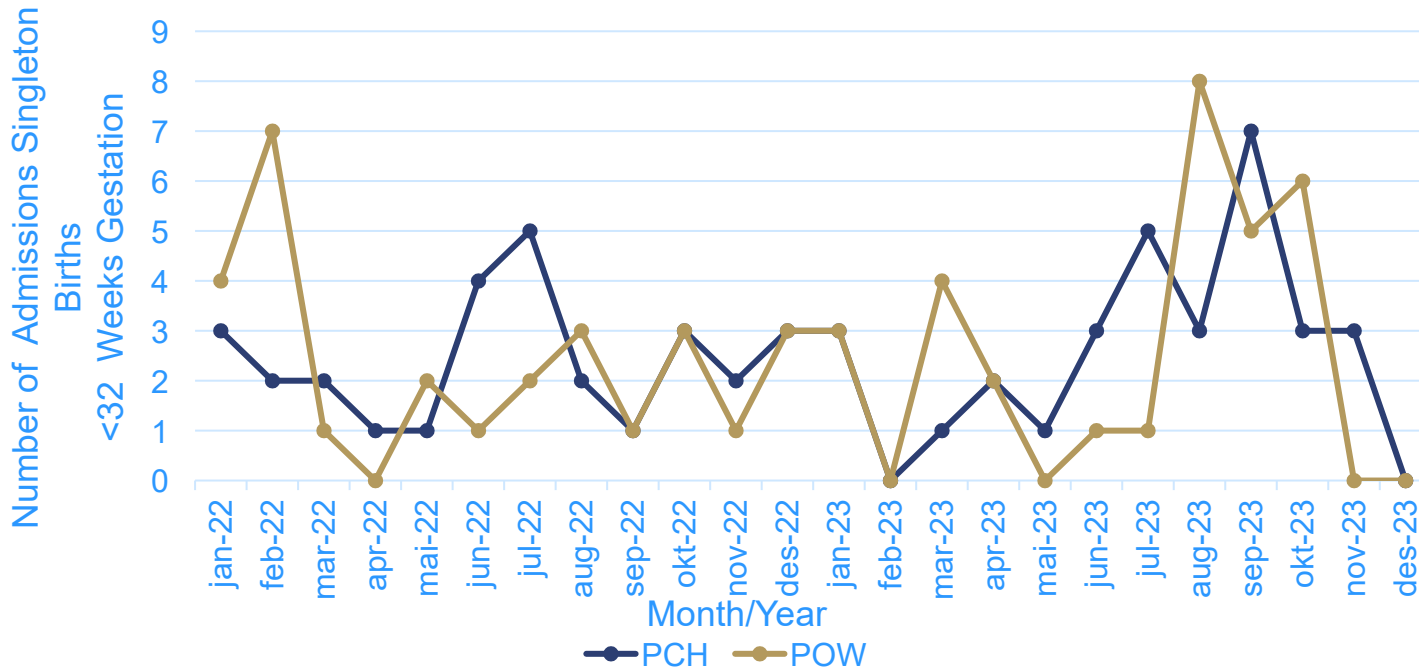
Principle Clinical Reason for Admission to the Neonatal Unit at Term
(Occurrence)
CTMUHB Wide
(Jan-Nov 2023-)



- Primary principle reason for term admissions is **respiratory** related illnesses-
- CTMUHB has now introduced 'management of respiratory pathway for the management of babies at birth'. Flowchart can be adopted for all babies >34 weeks gestation-
- Data to be monitored over time to assess if this is positively impacting respiratory related admissions to our neonatal units.

Exception Reportable Births* - <32 Week Gestation

Number of Exception Reportable Births Jan 2022- Dec 2023



Exception Reportable Births:

- Increase in births/admission to the NNU's in August, September and October 2023.
- Further monitoring needed over the next few months to ensure our numbers to not remain exceptionally high.
- Datix submitted for each exception reportable birth.
- Each birth is reported to the Wales Maternity and Neonatal Network.

Scrutiny and Learning:

- Each birth is scrutinised by the Periprem Cymru team- reviewing optimisation prior to birth and to review why the birth occurred in our unit. *(was there and opportunity to transfer to a tertiary centre? Did the women present in advanced labour? Did the clinical condition of the mother/baby mean transfer was not a viable option?)*
- All identified learning from case reviews shared with staff via newsletters/visual boards in the clinical area.

*Any birth/admission to the neonatal unit in CTMUHB meeting the following criteria:

- Singleton Birth <32 weeks gestation
- Multiple Birth <33 weeks gestation
- Birth Weight <1500g's



An Update on the 23-24 Quality Improvement Plan: Projects

Drymester: supporting women to remain alcohol free in pregnancy, launched 27th November 23. Training has been provided and a training video is available. New evidence based alcohol assessment paperwork in the maternity handheld record. The expectation is that alcohol consumption should be asked about as a routine part of any antenatal assessment and support by an alcohol liaison nurse offered where needed. **On track**

Self-referral maternity service digital booking system is now embedded, with ongoing QI. A survey shared to gather feedback had a very positive response. Question about ethnic group added December 23 so we can plan our resources according to need. **Complete**. In continuous improvement and sustainability. Data reviewed through WESEE.

Developing a postnatal contraception service. Plan to launch a test phase in January 2024 to understand demand. Further plans to scale training for midwives and the service will be based on the data from this test phase, including demand & women's experience. **Delayed to Feb/ March 2024**

Induction of labour ongoing QI collaborative, including developing an out of hospital IOL service and digital booking platform. IOL workshops are being planned to support women with information to support decision making. IOL audit in progress to understand flow. **On track**

Women's Physiotherapy ante and postnatal education classes. Launch January 2024 across the Health Board. Test phase for 3 months. 3 classes will be offered- early pregnancy (dating scan onwards), third trimester (approximately 32 weeks) and postnatal (approximately 4 weeks). These will be available to all women. **On track**

Understanding the rise in caesarean section rates. Audit underway to review current practice and identify where QI might be needed. **In progress**

BSOTS triage model. **Complete**. Fully implemented on both acute sites, with monthly monitoring meetings in place to ensure sustainability of improvements and to provide a forum for continuous improvement.

Equality, Diversity and Inclusion (EDI)

The Diverse Cymru Cultural Competence Certification Scheme Self-Assessment Evidence Workbook is in draft, containing a plan for required actions, including dates for completion. Diverse Cymru training is being organised for the multi-professional team for 22nd February 2024.

Statutory and mandatory training is being reviewed to ensure inclusion of EDI as a routine part of annual training.

A gap analysis against Race and Health Observatory's review of neonatal assessment and practice in Black, Asian, & minority ethnic newborn recommendations has been completed. Improvement actions identified include:

- Multi-professional simulation training to include the use of black and brown resuscitation dolls.
- A data bank of images of Black, Asian and ethnic minority neonates to be available for training and education of HCPs and students, as well as to aid diagnosis in practice.

Actions already completed include:

- Bilirubinometers are available to all community midwifery teams and on the acute units across the Health Board.
- All NIPE tests in CTM include pre and post ductal oxygen saturation monitoring.

Data from the digital system including country of birth and ethnic group are being used to plan services that better meet the specific needs of our local population.

Workforce & Staffing – Training Compliance (Midwifery)

Merthyr & Cynon Midwifery Acute Compliance (Inc. ANC)				
	TOTAL LIVE	IN	OUT	%
PROMPT	96	75	21	78%
NLS	96	87	9	91%
BLS	96	87	9	91%
CTG	96	83	13	86%
GAP/GROW	96	82	14	85%
M+S	96	67	29	70%

Merthyr & Cynon Midwifery Community Compliance (inc. community MCA/HCSW)				
	TOTAL LIVE	IN	OUT	%
PROMPT	45	32	13	71%
Com PROMPT	45	43	2	96%
NLS	45	42	3	93%
BLS	45	41	4	91%
CTG	37	30	7	81%
GAP/GROW	37	27	10	73%
M+S	45	34	11	76%

Bridgend Midwifery Acute Compliance (inc. ANC)				
	TOTAL LIVE	IN	OUT	%
PROMPT	65	57	8	88%
NLS	65	56	9	86%
BLS	65	56	9	86%
CTG	65	55	10	84%
GAP/GROW	65	54	11	83%
M+S	65	54	11	83%

Bridgend Midwifery Community Compliance (inc. Tirion birth centre and community MCA/HCSW)				
	TOTAL LIVE	IN	OUT	%
PROMPT	32	23	9	72%
Com PROMPT	32	28	4	88%
NLS	32	28	4	88%
BLS	32	28	4	88%
CTG	22	20	2	91%
GAP/GROW	22	19	3	86%
M+S	32	26	6	81%

A new digital training database was developed in December 2023. This will significantly reduce the time taken by Practice Development Midwives to monitor training compliance and generate reports.

In the transition between the previous database (Excel based) and the digital database, compliance appears to have decreased. This is a transitional issue and will be resolved in time for the next reporting period.

Medical workforce training compliance is not available for December 2023. A new process has been established and the data will be available for the next reporting period



Agenda Item

5.2d

Quality & Safety Committee

Highlight Report from the Mental Health and Learning Disabilities Care Group

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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
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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

BCBC	Bridgend County Borough Council
CMHT	Community Mental Health Team
CSGs	Clinical Service Groups
CRHT	Crisis Resolution Home Treatment Team
FACS	Forensic Adolescent Consultation Service
HIW	Health Inspectorate Wales
LA	Local Authority
MHLD	Mental Health and Learning Disability
NRI	Nationally Reportable Incident



OPMHS QSRE RGH RTE SSP WCCIS WHSSC	Older Peoples Mental Health Services Quality Safety Risk and Experience Meeting Royal Glamorgan Hospital Rhondda Taf Ely Locality Student Streamlining Project Welsh Community Care Information System Welsh Health Specialised Services Committee
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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 6th December 2023.
- 1.2 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

- 2.1 The purpose of the Care Group is to provide assurance to the Board on the provision of workplace health & safety and safe and high-quality care to the population we serve, including prevention through public health, primary and secondary care.
- 2.2 The Mental Health and Learning Disabilities Care Group QSRE Board will:
 - Put the needs of patients, carers and the public at the centre of all its business.
 - Provide evidence based and timely advice to the Mental Health and Learning Disabilities Care Group, based on local need, to assist in discharging its functions and meeting its responsibilities.
 - Provide assurance to the Mental Health and Learning Disabilities Care Group in relation to the arrangements for safeguarding the public and continuously improving the quality and safety of the services we provide.
 - Ensure that care is delivered in accordance with the Health & Care Standards for Health Services in Wales.
 - Ensure that services are delivered in compliance with regulatory legislation and accreditation bodies.

3. Highlight Report

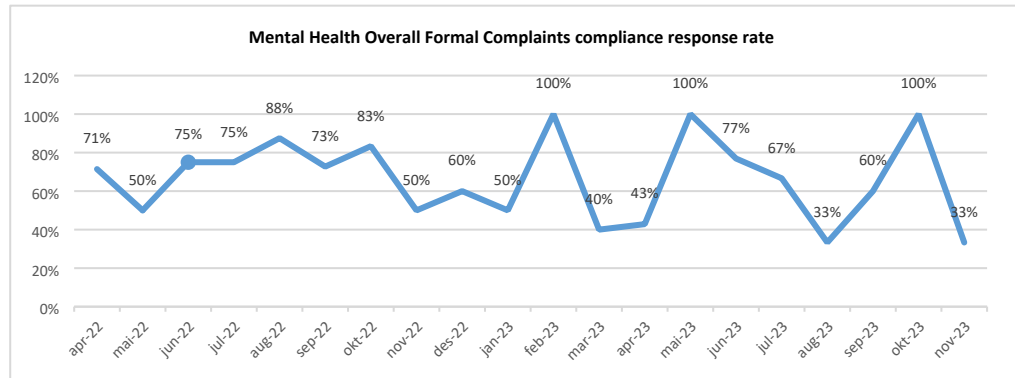
ALERT / ESCALATE	<ul style="list-style-type: none"> • Registered Nurse vacancies remain a significant challenge and a key area of focus, for example the RGH Mental Health Unit which has 6 wards has 27 band 5 vacancies which is 49% of the total band 5 establishment. This picture is mirrored on Ward 14 and Ward 2, Angelton clinic. <p>The recently completed nursing establishment review has been considered by the Care Group Senior Leadership Team who are</p>
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	<p>currently exploring the financial implications and opportunities of the recommendations.</p> <p>The Head of Nursing is leading on the development of a recruitment and retention plan, which includes actions such as working closely with the local universities to maximise SSP opportunities for recruitment.</p> <ul style="list-style-type: none"> The continued limited availability of CPR, manual handling and some other face-to-face training that is outside of the control of the care group is impacting on mandatory and statutory training compliance and Health Board reputation with HIW.
ADVISE	<ul style="list-style-type: none"> A new risk has been added to the Organisational Risk Register with a score of 20 and risk ID of 5646. This is an emerging risk related to Right Care Right Person, a police-led initiative which will see the withdrawal of police support for welfare checks, support when people unexpectedly leave health premises, conveyance of people to hospital and some aspects of the Mental Health Act. There is a timeline for implementation and the Health Board is working to understand the specifics of the impact and potential mitigations. <p>There are 2 other risks currently escalated to the Organisational Risk Register at this time relating to the MHLD Care Group, and these are:</p> <ul style="list-style-type: none"> Risk ID 4691 – New Mental Health Unit (Risk Score:15) Risk ID 4337 - Use of Welsh Community Care Information System (WCCIS) in Mental Health Services (Risk Score: 15) <ul style="list-style-type: none"> There were 2 unannounced HIW inspections in November, at Angleton Clinic and the RGH adult MH wards. Both were largely positive and acknowledged recent improvements however immediate assurance was required around mandatory training at RGH, these issues of training availability have previously been escalated through committee. An action plan to address the issues highlighted has been developed and accepted. There are staffing shortages in the Merthyr CRHT which has resulted in increased bank hours and some gaps in rosters. This will ease due to recent recruitment and in the meantime RTE CRHT have been cross covering and working in collaboration to support the team and their ability to function.
ASSURE	<ul style="list-style-type: none"> Complaint closure compliance is a key priority for the Health Board. Compliance in the MHLD Care Group was 100% in October and 33% in November. The low volume of formal complaints (8 received in total in October and November) can artificially skew the reporting



and contributes to a 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 4 open formal complaints.

- There are 4 open Nationally Reportable Incidents (down from 7 since the last report) 3 of those overdue for completion.
- All the MHLD wards are now using AMAT. Compliance with ward audits as of the end of December is shown below.

Project	No. audits	Current compliance	Improvement	Overdue actions
Health & Safety	1	G 94.2%	▼	2
Health and Care Standards	1	G 98.2%	▲	2
Infection Control	4	G 100.0%	▲	0
Medicines Management	2	G 98.4%	▼	2
Patient Safety	13	A 93.6%	▲	12

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 estates issues in RGH and issues with the nurse call alarm system referenced in the last report have now largely been resolved. Progress on these issues will continue to be monitored via the Estates, Fire and Health and Safety Group chaired by the Service Director.
- There has been successful Healthcare Support Worker (HCSW) recruitment in both Angleton clinic and Ty Lliardiard which will take some pressure of the staffing teams by increasing the number of substantive staff which will in turn positively effect the quality and safety of the care we provide.

	<ul style="list-style-type: none"> The Veterans Mental Health team has introduced a new clinic in Bridgend to accommodate increased referrals into the service.
INFORM	<ul style="list-style-type: none"> There are still 4 temporarily decommissioned beds on Ward 14, POW due to an infestation and awaiting new flooring. There have been no issues with acuity or demand to date. Two HCSWs won the RCN Nursing Award in the Nursing Support Worker category for their work on <i>Maintaining Standards and Reducing Restrictive Interventions</i> at Ty Lliard and received their award in person at the ceremony in Liverpool in November. The CMHTs in Bridgend have held open days for people who use the service and their carers in conjunction with BCBC and third sector providers to gain feedback and look for ways to co-produce services in the future. A dedicated primary care liaison role for people with a learning disability has been introduced in the Taff Ely cluster. The post holder is working closely with the cluster and Improvement Cymru to develop a quality improvement project to improve compliance with annual health checks for people with a learning disability. The OPMHS inpatient team at Angelton clinic continue to work with Improvement Cymru on falls prevention and recently presented their work so far at the Safe Care Collaborative.
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	Learning, Improvement & Research



<i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	If more than one applies please list below: Culture and valuing people, Learning, improvement and Research, Leadership
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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

5.2e

Quality & Safety Committee

**Highlight Report from the Unscheduled Care Group
Quality & Safety Committee**

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Quality & Safety Committee	23/01/2024	

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



Q&S	Quality & Safety
HIW	Health Inspectorate Wales
USC	Unscheduled Care Group
ED	Emergency Department
AMaT	Audit Management and Tracking System
IPC	Infection prevention control
UHW	University of Wales Hospital
ANTT	Aseptic non touch technique
AMU	Acute Medical Unit
ANP	Advanced Nursing Practitioner
COTE	Care of the Elderly
ACE	Acute care of the elderly unit
MRI	Magnetic resonance imaging
OCP	Operational Change Policy
PJ Paralysis	A global movement to help patients get up, dressed and moving.
G&FF	Ground and First Floor Capital Programme
AMaT	Audit Management and Tracking
RADAR	Recognition of Acute Deterioration and Resuscitation
MRI	Magnetic Resonance Imaging
SMT	Senior Management Team
AECU	Ambulatory Emergency Care Unit
BSW	Bowel Screening Wales
JAG	Joint Advisory Group
GI	Gastrointestinal
RTT	Referral to Treatment
LGI	Lower Gastrointestinal

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 8th January 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	<p>Patients with pacemakers and other implantable cardiac devices are unable to receive MRI scans in CTM. To do so would require a service development involving the cardiac physiology team and radiology. This would require some investment.</p> <p>A recent clinical incident highlighted a case where a patient may have come to harm as a result of the inability to undertake a MRI head as the patient had a permanent pacemaker. This is being investigated via the usual DATIX process, but discussion in the Medicine Directorate governance meeting highlighted this as representing an ongoing risk.</p> <p>The existing business case for this service development will be reviewed and submitted for discussion in Operational Management Board for review.</p>
Advise	<p>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 85% in October to 50% in November 2023. This is due to the large number of historical complaints being closed. Currently there are 15 open complaints and 2 over the 30 day compliance. This is a huge improvement to February 2023 where there were 93 open complaints and 51 over the 30 day compliance. The USC leadership team have provided a commitment to support, improve trajectories and have developed a mechanism to escalate when clinicians and nurses are unable to achieve 30 day compliance. This has been closely monitored by the USC Senior Leadership Team which has resulted in a significant improvement.</p> <p>AMaT</p> <p>A high-level report has been produced to give an oversight of the outstanding actions on AMaT allowing the Directors to drill down into specific areas. Attached is the compliance for all areas within the USC care group to highlight areas which require improvement.</p> <p>Following the last Quality and Safety Committee meeting assurances were sought around if areas were not compliant or audit data showed a deterioration then what interventions were in place to support targeted improvement. Across USC clinical areas the RADAR team have advised that sepsis champions are now within ED, who undertake regular refresher sessions on the shop floor with staff. All staff have attended or are booked to attend the Acutely Unwell Study Day which is run by the outreach team.</p>



	<p>Along-side this multiple training sessions via table top exercises have been offered to clinical teams covering key topics such as sepsis, escalation of the deteriorating patient, end PJ paralysis, red to green, pressure damage and fluid balance. These have had really positive attendance and we are seeking ways to collaborate cross sites to expand learning opportunities.</p> <p>Following the previous Q&S Committee report presented in November 2023 where we reported the inquest held following a patient that died following aspiration of food content following an incorrectly provided meal, the Nutrition and Catering group is underway to review the catering model pan CTM. The last meeting held was the 21st December 2023, whereby the group agreed upon three primary work streams, based on the Nutrition and Hydration Strategy:</p> <ol style="list-style-type: none"> 1. Integration of bed plan, digital allergen recording, and catering. 2. Development of a Dysphagia Policy 3. Revision and updating of the Enteral Nutrition Policy. <p>The goals and outcomes of the group is to prevent malnutrition and dehydration, establish clear systems, manage risk, support service development, and develop research and audit projects to scrutinize and evaluate the effectiveness of the Nutrition Strategy.</p> <p>USC has successfully secured funding from Welsh Government for the following, RGH and PCH nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), a complete ward refurbishment to ward 19 RGH and a scoping exercise to expand the RGH ED footprint. This will improve patient experience within these departments. This is linked to the organisational risk 3826-Emergency Department overcrowding which is detailed below.</p> <p>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. Each clinic that has been stood down will be individually risk reviewed.</p>
Assure	<p>Following the publication of the HIW National Review of Patient Flow a journey through the stroke pathway. An Improvement Plan was submitted to HIW on 6th October 2023, following approval by the Executive Director lead for stroke services.</p> <p>The Senior Management Team (SMT) for USC have undertaken a review of the historical action plan aligned to the stroke strategy</p>



	<p>group where many of these actions have been closed. Membership and terms of reference have also been reviewed with the Director of Therapies and this will be discussed during the next stroke operation group. The USC SMT have had further engagement with colleagues from Cardiff & Vale University Health Board 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. This is linked to Organisational Risk ID 4632 - Provision of an effective and comprehensive stroke service across CTM (encompassing prevention, early intervention, acute care and rehabilitation).</p> <p>Ward accreditation programme is being implemented in CTM to demonstrate our commitment to provide quality care to our patients against measured standards. This will include patient safety, satisfaction and the well-being of our employees. A pilot phase was completed in December 2023 at PCH. It focused on three inpatient adult wards which included acute areas to test and refine the accreditation process. The pilot phase is vital in assessing the program’s effectiveness and identifying areas for improvement before expanding to other areas, thereby ensuring a comprehensive and successful integration.</p> <p>Following the recent re-introduction of student nurses back to the Emergency Department at PCH, the University of South Wales have been monitoring progress closely. The department are pleased to notify that they have received 98% positive feedback and are looking to increase the number of student placements available.</p> <p>The Emergency Department National survey has received over 800 responses in November 2023 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 CTM to ensure that the information is available to the public to access and leave feedback.</p> <p>Following feedback from clinical services plan engagement sessions, several services have highlighted the importance of up to date demand and capacity mapping across services in Medicine. This will be undertaken over the coming months, linking in with newly appointed directorate management team leads to facilitate.</p>
Inform	<p>Organisational Risk Register updates Datix Risk ID 3826 - Emergency Department (ED) Overcrowding. A review is to be undertaken of the ambulatory Standard operating procedure (SOP) relating to fit2sit and the potential to expand ambulatory footprint at the POWH site. This is being explored with the clinical team. The operational capital</p>



group meeting held 18th October advising that they have been successful in obtaining WG funding as outlined above.

Datix Risk ID 1133 linked with 3826 - Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Nurse establishment review continues in RGH ED, invest to save paper has been submitted for RGH ED nursing staff. Awaiting outcome, Health Care Support Workers will be submitted next and can then to look to reduce.

Datix Risk ID 4732 - Lack of orthogeriatrician as NICE guidance and KPI1 NHFD. Previous update remains, Orthogeriatrician service model is being reviewed within CTM as part of the trauma and orthopaedic reconfiguration of service. USC will held responsibility for Consultant orthogeriatrician to be working with the wider COTE team on each site. Awaiting disestablishment of posts in planned care in order to fund.

Impact of Endoscopy delays on patients from a Quality & Safety perspective, approval has been given on the business paper for Endoscopy workforce. Detailed staff numbers identified in business paper, due to inadequate workforce numbers and unable to work without overtime or agency staff.

The new workforce model will support the new Joint Advisory Group (JAG) on Gastrointestinal (GI) Endoscopy accredited unit at PCH as part of the G&FF Capital Programme, this will be a purpose built 3 room unit.

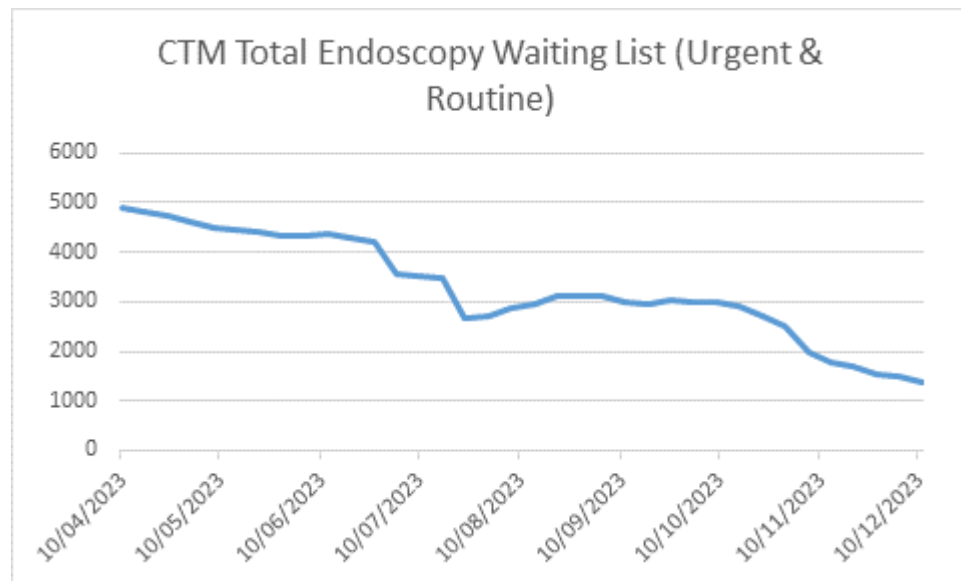
Endoscopy Transformation Programme ongoing with developments and improvement already underway including weekly 6/4/2-1 and weekly Task and Finish Group. A number of actions completed which has resulted in an increase in throughput due to ongoing productivity and efficiency schemes including digital solutions, booking processes and pathway management.

Bowel Screening Wales (BSW) – Recovery plan developed which includes a short term plan to clear current backlog to run alongside the sustainable plan. Insourcing tender completed and awarded, working through the interdependencies before agreeing a start date this will be completed by March 2024.

Endoscopy – continues to face challenges with competing priorities with the service trying to deliver and maintain the cancer pathway, accommodate longest waiters for delivery of the Referral to treatment timed targets (RTT) targets - 156 & 104 weeks all over 156 & 104 weeks in both Gastro and Surgery are



now partially booked, the service are now targeting down to 52 weeks. We continue to work towards hitting the 8 week diagnostic target whilst reducing the backlog of surveillance patients. BSW waits has seen a significant improvement but still remains a challenge due to backlog and next steps of the Optimisation Programme. This continues to impact on CTM's overall Lower Gastrointestinal (LGI) diagnostic waits – a short and long term plan has been developed. It has now been agreed that CTM were correctly reporting screening and tracking of participants, this will now need to be adopted by all Health Board's across Wales.



BSW – Down to 110 in December 2023 (was 249) participants waiting for screening colonoscopy with waits now down to 10 weeks (was 24 weeks). An urgent budget review is underway to support the sustainability plan and next steps in the optimisation programme, the need to increase lists to 8 this year and 11 per week by Oct 2024. Currently delivering an average of 7 lists per week. This will include 2 additional lists running from POW (currently unfunded and awaiting approval).

Currently, any long waiting patients with UGI and LGI cancer are taken through the harm review process with the support from cancer services (planned care) and rapid reviews are undertaken if there are a significant harm identified.

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 will begin from January 31st 2024. Following this once operational colleagues are in post the governance and reporting structures pan CTM will be finalised and organigrams shared via Operational Management



	Board and Quality and Safety Committee to give clarity on ward to board assurance within the new operating model.
Appendices	Nil

4. Assessment

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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board



Agenda Item

5.2f

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	23/01/2024
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
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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
BB	Blood Bank
COO	Chief Operating Officer
DI	Designated Individual
DTPS	Diagnostics, Therapies, Pharmacy & Science



HIW	Healthcare Inspectorate Wales
HTA	Human Tissue Authority
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
LIMS	Laboratory Information Management System
LA	Local Authority
ME	Medical Examiner Service
OMB	Operational Management Board
OOH	Out of Hours
PCH	Prince Charles Hospital
POW	Princess of Wales Hospital
QA	Quality Assurance
QMS	Quality Management System
RGH	Royal Glamorgan Hospital
SOP	Standard Operating Procedure
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 Group up to December 2023.
- 1.2 Key highlights from the meeting are reported in section 2.
- 1.3 The Committee is requested to **NOTE** the report.

2. Highlight Report

Alert / Escalate	<p><u>Pathology</u></p> <p><u>LIMS 2.0</u></p> <p>LIMS 2.0 is a mission critical Programme for NHS Wales, and one of the highest priority Programmes for delivery by DHCW (Digital Health Care Wales). The current Pathology LIMS (laboratory information management system) will be out of technical support in June 2025, the upgrade to LIMS 2.0 must be completed by this date in order to maintain an operational Pathology service (with fully supported LIMS) across NHS Wales. The Pathology LIMS is the computer system that runs every pathology service from the receipt of samples to analysis and reporting. The scope includes all blood science, histology including cancer testing, blood transfusion, microbiology, POCT and mortuary services. It</p>
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provides a complex feed to upstream and downstream computer systems such as WCP, ICNet, GP link, WPAS which are all essential for patient care.

There is no alternative solution available as the existing LIMS (TCL2016) will be switched off at the end of the existing contract in 2025, the new TCLE LIMS 2.0 system must be delivered in April 2025 in line with the national timetable. Without a fully functional LIMS system, the Health Board will not be able to deliver a pathology service. This impact on the Health Board would be catastrophic. Currently there is no dedicated resource within CTM Pathology to deliver this project, and due to there being no capacity from within the service to support this project, this is now a considerable risk to the organisation.

A risk has been recorded on the Pathology risk register (5299), with a view to escalating through the DTSP care group to the organisational risk register in January 2024. In conjunction a paper is being developed to outline the resource requirement and options available to support delivery of this project within the required timeframe, and also the risks of not delivering on time. This paper will be presented to OMB in January 2024 and an urgent meeting has been held with COO and Director of Digital w/c 2nd January 2024.

Mortuary Capacity:

There is a risk (3131 & 5404) that the Health board mortuaries could become overwhelmed and breach HTA licence terms in Winter if the gap between demand and capacity to manage death certification, post mortems, death registration and discharge to Funeral Directors care are not addressed. Previous SBAR with recommendations has been presented for Health Board consideration. In the interim period, the Pathology team and Care Group have been working with Local Authorities (LA) around escalation and surge management over Xmas and New Year period. Planning session held on 28th December to discuss arrangements for a collaborative workshop being arranged for early 2024 with LA, Coroner, ME service and HB. It is the intention that this group will work in partnership to review 'business as normal' and escalation working to effectively manage demand on the mortuaries and develop a plan to manage the demands of care of the deceased across the Health Board region.

Radiology-

Backlog of reporting – additional allocated funds have allowed WLI to recommence, as well as outsourcing for routine and some



urgent work (USC and some urgent managed in house). Oldest unallocated CT now from mid-December. MRI reporting backlog still remains an issue, particularly neuro, so these will be prioritised for report, but the position is slowly improving. Plain films awaiting report are those already seen by a secondary care team. Primary care images are prioritised. Monitoring of improvement and progress is continuing on a weekly basis and is reported through OMB and the integrated performance score card.

Advise

Pharmacy and Medicines Management –

Parc Prison

Datix from HMP Parc: there are some controlled drugs discrepancies occurring; they are being appropriately identified and investigated. This is understandable with the volume of controlled drugs being dispensed, however meds management has detected a training need re attention to safe and secure controlled drugs management and is putting an appropriate training package in place.

Meds management have developed a SOP for the issuing of in-possession medication at HMP Parc by Health Care Support Workers.

Training will be organised and delivered before 27th December due to the urgency with staffing issues. As Parc prison sits under Primary care approval was sought from both DTSPS and Primary care Q&S leads. Both care groups approved on 21/12/23, DTSPS during their QSRE meeting and Primary care via email as their next QSRE meeting was Feb 24. (official approval will be documented in their Feb agenda) The chair of the Meds Management QSRE was also supportive of this approach.

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 in 2024.

Nuclear Medicines Risk

Regional problem continues to impede the service we provide for Breast and Urology patients requiring nuclear medicine diagnostics, on-going discussion with Swansea Bay around increasing the provision through the existing SLA and reducing the contract with Cardiff to rebalance. NHS executive are aware



of the regional challenge and are supporting direction of travel while longer term solutions are explored further.

Pathology

UKAS:

Pathology UKAS assessment has been ongoing since 7th September ending in a remote Virology assessment on 13th December.

Unfortunately the Haematology/Blood Bank assessment that was planned for mid-November was cancelled due to the assessor being taken ill – this has now been re-scheduled for w/c 5th February 2024.

All findings to date have been minor, and evidence that has been submitted to clear the findings has been accepted first round.

We are currently in the process of collecting evidence to clear 5 Virology findings from the remote assessment on 13th December – the submission deadline for these is 2nd February, no issues are anticipated in submitting this evidence.

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

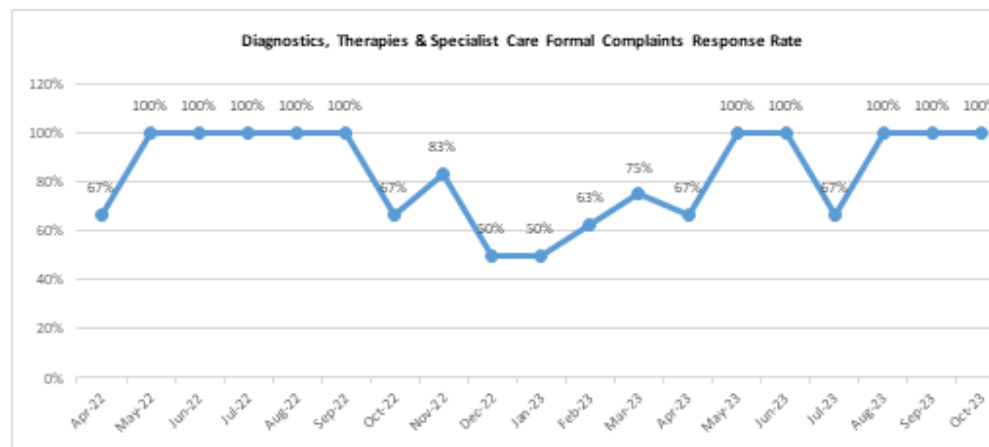
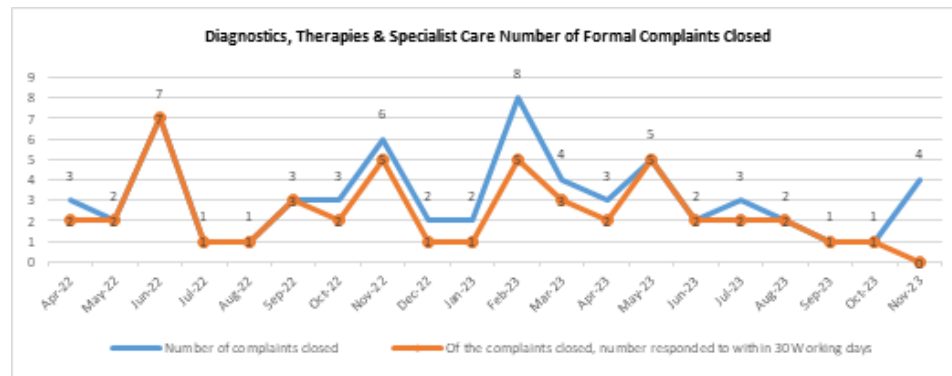
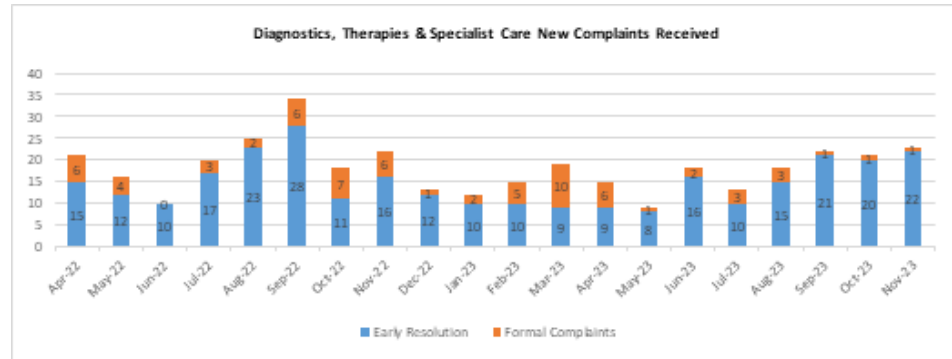


	<p>the mortuaries were not subject to the same level of governance as the mortuaries themselves. WG made a number of recommendations for community body stores. Additional resource will be required to comply with these recommendations and options are being explored within the Care Group.</p>
Assure	<p><u>Pharmacy and medicines management</u></p> <ul style="list-style-type: none">• Permanent pharmacist support now secured on paediatric ward in RGH to mitigate identified risk.• Haematology team shortages (due to be resolved mid-January 2024) have caused increased strain on the aseptics team; Datix are being monitored to ensure this risk is sufficiently mitigated with support from other teams. A lenolidamide Datix has been submitted and scrutinised and was not a result of the staffing shortages within the team. <p><u>Pathology</u></p> <p>New Policy: Procedure for the Independent Authorisation of Blood Component Transfusion.</p> <p>This procedure sets out the governance arrangements for Independent Authorisation of Blood Component Transfusion (IABT).</p> <p>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 will need to be taken to OMB under the new process for policy approval as this is a HB wide policy.</p> <p>Haematology Harm Reviews.</p> <p>All Haematology harm reviews have now been completed by Clinical Haematology Lead. All have returned as no or low harm.</p>



Inform

DTPS Complaints received and compliance



Data set shows 2 complaints in Nov both within 30 days, and nothing over 30 days or 6 months so we are **100% compliant**.



DTPS Patient Safety Incidents

Breakdown of open incidents by service (Nov '23)

Total Number of Open Incidents on DCIQ System	365	361	339	317	351	335	300
New Incident	100	105	104	101	114	135	115
Management review/Make it safe plus	97	98	77	80	87	80	66
Under Investigation	95	103	89	87	89	103	88
Awaiting Closure	81	82	102	91	87	76	70
Closed	936	1335	1473	1633	1732	1900	1816

Service	Number under investigation
Therapies	22 open, 2 in new incident
Radiology	77 open, 40 in new incident
Pathology	87 open, 9 in new incident
Medicines	134 open, 64 in new incident

Moderate/Severe incidents

October : 4 x moderates , 1 x severe

November : 3 x moderate , 1 x severe

8 downgraded , 1 x NRI (41271)

NRIs

Total Number of NRIS	New NRIS	Total Number of LRIs	New LRIS
5 (4 overdue)	1 (41271)	2 (1x pathology, 1x Radiology)	3x IRMERS all closed)

Service	Open number of NRIs	Overdue NRIs	Number scheduled for Panel
Therapies	0	N/A	N/A
Radiology	5	4	1x case 2021 2x case 2022 2x case 2023
Pathology	0	N/A	N/A
Medicines	0	N/A	N/A



LRIIs

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)

LFER

1 for Care group

SB&EM reviewing Jan 24

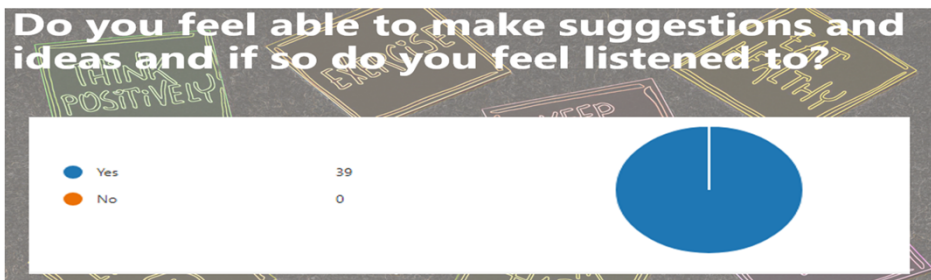
Good News

Major incident Dec 2023

Teams from pathology, radiology, pharmacy and Physiotherapy were all on standby to support. Grateful to all for their professionalism and planning. Some lessons to learn for the organisation around comms in these situations going forward.



Good news – SLT staff well-being survey



Awards




Pharmacy won a national award for a pharmacy led anticoagulation initiation and monitoring device.



Therapies & Pharmacy

The MDT Care Homes projects in Bridgend won a prestigious Medi Wales Award 'Social Care Innovation through Collaboration Award' – Awarded to personnel who have collaborated to innovate on a social care project that has resulted in major impact and benefit. Team members include SLT, DT and pharmacy. This collaborative project brought together multiple agencies, including care homes, NHS departments, and Technology Enabled Care Cymru, to co-



	<p>develop an integrated service for managing swallowing, nutrition, and medication in care homes.</p> <p>The project aimed to reduce hospital admissions by providing early intervention and preventive care. It streamlined access to specialist services, reducing wait times significantly and improving health outcomes for residents.</p> <p>Engaging deeply with care home staff and residents, the project prioritised their needs and preferences, leading to improved well-being and quality of life for the residents. The collaboration led to substantial cost savings and a 55% reduction in potential hospital admissions.</p>
	
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	A Healthier Wales If more than one applies please list below:



<u>150623-guide-to-the-fg-act-en.pdf</u> <i>(futuregenerations.wales)</i>	
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Data to Knowledge
	Leadership Learning, Improvement and Research
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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

6.1

Quality & Safety Committee

Organisational Risk Register

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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	Gareth Watts, Director of Corporate Governance / Board Secretary
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gareth Watts, Director of Corporate Governance / Board Secretary

Pwrpas yr Adroddiad / Report Purpose	For Review
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Service, Function and Executive Formal Review	December 2023	RISKS REVIEWED
Operational Management Board / Offline via Email	December 2023	ENDORSED NEW RISKS FOR ELG
Executive Leadership Group (ELG)	15 th January 2024	EXECUTIVE SIGN OFF RECEIVED

Acronyms / Glossary of Terms	

1. SITUATION/BACKGROUND

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

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

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 9th January 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 **589** members of staff trained to date since training commenced in 2021.
- 2.6 Focussed sessions to discuss risk has 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:
- 21 attendees have provided formal feedback (using the URL Code for the Evaluation Form) from the November 2023, December 2023 and January 2024 sessions. 76% provided a score of 5/5 in terms of content of the session and the remaining 24% provided a score of 4/5.
 - 100% of the 21 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.
 - 95% of the 21 attendees said they felt more confident to escalate a risk through the organisation.
 - Some of the comments received through evaluation have been included below:

"Good delivery of training session, presenter knowledgeable of session contents and professional in delivery of contents. Helpful links and ongoing support offer. Organisational changes impact on new/ revised way of working, well defined and explained in the risk management session, would highly recommend staff to attend training session".

"Engaging session, presented the subject matter in a way that was easy to understand, good use of examples and taking us through a live risk was helpful. Enjoyable session helped by a good presentation style".

"Really clear explanation of risk and Datix. Will get my team on training ASAP".

"I feel more confident that I know who to contact for support escalating a risk even if I don't necessarily feel more confident doing it independently".

"Find Datix very difficult to use. However this session helped clarify why it's important to record risk and went some way to demystifying how to



do it. Still feel the legacy system will be a challenge but worth persevering with."

Once For Wales – New Datix Risk Module

- 2.8 The implementation of the new Datix Risk Module has been delayed. The Assistant Director of Governance & Risk represents the Health Board on the All Wales Task and Finish Group and is contributing to the developments and improvements sought from the opportunity to develop a new module.
- 2.9 The Once-for-Wales Programme Management Board met in December 2023, and they took the decision to extend the current Datix contract by a further three years which will take the Health Board up to the end of November 2027. A timeframe as to when the new OFW risk module will be achieved is awaited. In the meantime, there is a pilot of the new system underway in another Health Board whose feedback is eagerly awaited.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 NEW RISKS

Central Function - Medical Directorate

- **Datix Risk ID 5640 – Potential Junior Doctors Industrial Action.** New risk escalated in December 2023. Risk score of 20.

Mental Health & Learning Disabilities Care

- **Datix Risk ID 5646 – The Impact of "Right Care Right Person" approach.** Escalated in December 2023. Risk score of 16.

3.2 CHANGES TO RISKS

a) Risks where the risk rating **INCREASED** during the period

Nil on this reporting period.

b) Risks where the risk rating **DECREASED** during the period

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- **Datix Risk ID 2713 – "Backlog of Reporting Radiology Examinations".** Risk reviewed in November 2023. Risk reduced from 20 to 16 due to additional funding secured, non-recurrent until end of March 2024, to be used for outsourcing reports.



3.3 CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER

Diagnostics, Therapies, Pharmacy and Specialties Care Group

- Datix Risk ID 4798 – Staffing levels do not meet standards for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.** Following a review of this risk in December 2023 the target score had been reached and the risk has now been closed. Speech and Language Therapy (SLT) staff are now in post across all three critical care units. Gaps between current staffing levels and Guidelines for the Provision of Intensive Care Services (GPICS) standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for Princess of Wales, with clinical incidents being reported and a new risk is being developed (Risk ID 5658, which is being considered for escalation to the Organisational Risk Register).

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

Consequence	5			4253 3337 4768 3993 4887 4080	5276		
	4				4906 4753 3131 5477 4908 5404 5579 5374	4152 3133 4752 4922 5254 4907 5646 2713	4491 4071 4103 4841 3826 1133 5590 5462 5640
	3						3638 4691 4732 4928 4691
	2						2808 4732 4650
	1						
	CxL	1	2	3	4	5	
	Likelihood						



3.5 Matters to Note / Notified emerging risks

- The Assistant Director of Transformation is currently developing a new risk for escalation relating to the “Community Brain Injury Service in Bridgend”, the risk development is still progressing and is yet to be escalated to the organisational risk register.
- Diagnostics, Therapies, Pharmacy and Specialties Care Group have identified a new risk for approval relating to the “Lack of Dietetic service provision to Princess of Wales Critical Care”, 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.
- Datix Risk ID 5642 Adult Weight Management Service is being reviewed to consider incorporating the any additional risk areas identified relating to compliance with National Institute of Clinical Excellence (NICE) guidance and it is anticipated that these updates will be reflected in the March iteration of the organisational risk register as appropriate.
- 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.

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 (Ilyw.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 (<i>Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)</i>) / Link to Domains of Quality (<i>Duty of Quality Statutory Guidance (gov.wales)</i>)	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required for the organisational Risk Register. Individual risks may have had a QIA.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	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 (<i>Pobl /Ariannol</i>) / Resource Impact (<i>People / Financial</i>)	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	
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	
5640	Executive Medical Director	Medical Directorate	Medical Directorate Manager	Sustaining Our Future	Patient / Staff /Public Safety	Potential Junior Doctors Industrial Action	If...the NHS Wales Junior Doctors take industrial action related to a dispute over pay erosion between 15th-18th January 2024 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. 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.	Planning, Performance & Finance Committee Quality & Safety Committee	20	C4xL5	C3xL5	New risk escalated January 2024	↔	04.12.2023	05.01.2024	15.1.2024 & 12.2.2024
5590	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	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.	Quality & Safety Committee	20	C4xL5	4 C4xL1	↔	23.10.2023	9.1.2024	9.2.2024	
5276	Director of Digital	Central Function - Digital and Data	Assistant director of therapies and health science	Sustaining Our Future	Business Objectives - Operational Patient safety	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.	Digital & Data Committee Quality & Safety Committee	20	C5xL4	5 (C5xL1)	↔	26.10.2022	09.01.2024	09.02.2024	
4491	Chief Operating Officer	Deputy Chief Operating Officer - Acute Services.	Deputy Chief Operating Officer - Acute Services.	Improving Care	Patient / Staff /Public Safety	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: - Specialty specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology - it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	Update July 2023 - The financial Planned Care Recovery package agreed in June 2023 and the schemes are now in motion which is resulting in a positive impact on backlogs and ongoing demand. The Health Board has trajectories in place for planned and cancer targets which is monitored weekly by the Planned Care Director and their wider team. Clinical strategy work is ongoing which will serve to strengthen the Health Board's ability to create more capacity within the system. The Health Board is also starting to look at a Demand Management Plan as currently referrals to CTM are higher than pre-Covid levels. In order to sustain performance the Health Board needs to tackle this issue along with Primary Care colleagues and in this regard have produced a heat map to identify those practices that the Health Board needs to work collaboratively with as a priority. In addition the Six Goals Plan was agreed in June 2023 and the plans to increase Same Day Emergency Care (SDEC) plans across CTM are in motion. The Health Board is now focusing on its outcome matrices to ensure it captures investment return effectively. Update November 2023 - due to ongoing pressures risk reviewed and score and mitigation remains unchanged. The following updates are however noted in terms of the Six Goals Plan: 1. Capital work underway in Prince Charles Hospital for Same Day Emergency Care (SDEC) unit completion January 2024. 2. Acute frailty established in Princess of Wales Hospital and Royal Glamorgan Hospital, recruitment completed for service in Prince Charles Hospital awaiting start dates 3. Navigation hub screening calls from nursing homes and pulling proactively from WAST stac (Ambulance demand). Next review 30.11.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	13.7.2023	31.10.2023	30.11.2023	
4071	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	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 Board's 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 recommending 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 rigorous monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update January 2024 - Further work undertaken in streamlining the Haematology pathway. Work undertaken with Bowel screening Wales. Next review 5.2.2024.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2024	05.01.2024	05.02.2024	
4103	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety	Sustainability of a safe and effective Ophthalmology service	IF: The Health Board fails to sustain a safe and effective ophthalmology service. Then: The Health Board's ability to provide safe high quality care will be reduced. Resulting in: Sustainability of a safe and effective Ophthalmology service	Measure and ODTIC DU reviews nationally. • Clinical staffing structure stabilised and absence reduced (new consultant, nurse injectors, ODTIC'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 ODTIC (January 2020 start date). • Intra-vitreal injection room x2 established with nurse injectors trained. • Follow up appointments not booked being closely monitored and outsourcing enacted. 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 ODTIC in Maesteg Hospital, implementation of Glaucoma shared care pathway, implementation of Diabetic Retinopathy shared care pathway, regional work streams, trial of new Glaucoma procedure (IMS), streamlining pathways. • Quality and Performance Improvement Manager post created to provide dedicated focus, detailed demand and capacity analysis being undertaken. All patients graded according to the WG risk stratification R1, R2, R3. Additionally, several specific waiting lists are further risk stratified to ensure that the highest risk patients are prioritised.	July 2023 Update: Cataract and General - Performance continues to improve with additional internal activity at weekends. Cardiff & Vale UHB continue to support with capacity for stage 1 and 4 activity for cataracts. Currently there are 559 patients >104 weeks RTT. This position continues to decrease. The regional work is progressing with the option appraisal complete and business case submitted. Validation work continues routinely in tandem with the booking of weekend work and RTT rules. Glaucoma and Macula - The Care group are focussing on the high risk sub services with specific action plans for the services. Business cases are in development, resource will be required to support follow up waiting list review and mitigation in Glaucoma. Focused piece of work being undertaken to review the macular FUNB patients with a key focus on: • Securing additional hours for consultant hours to review each individual case and prioritise clinic appointments accordingly. • Additional weekend clinic appointments in July 23 • Additional nursing posts being advertised as part of PCR funding to meet the demand for harm reviews and appoint a family liaison officer to support the increased reporting and RCA investigations. • HiW action plan being reviewed to ensure timely actions and reviews Update January 2024 - risk mitigation reviewed with no change or further updates. Next review 5.2.2024.	Quality & Safety Committee	20	C4 x L5	12 C4 x L3	↔	01/04/2024	05.01.2024	05.02.2024	
4632	Executive Director of Therapies and Health Sciences.	Unscheduled Care Group	Head of Strategic Planning and Commissioning	Improving Care	Patient / Staff /Public Safety	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 January 2024 - New governance arrangements will provide a greater level of focus and assurance in relation to an organisational approach relating to Stroke: • Operational Group established, first meeting held in September 2023 with a focus on the performance and actions for improvement. • Close working amongst executive team to escalate and address operational and clinical issues in relation to stroke pathway • Consultant recruitment still problematic and as such alternative options being explored re SAS doctors to provide an increased level of robustness. • Quarterly briefings to Quality and Safety Committee • 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 CS Review date 28/02/2024.	Quality & Safety Committee	20	C4 x L5	12 (C4 x L3)	↔	11.05.2021	05.1.2024	28.02.2024	

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	
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	
1	5462	Executive Director of Therapies and Health Sciences.	Diagnostics, Therapies, Pharmacy and Specialities Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Adult weight management service - Insufficient capacity to meet demand Impact on the safety - Physical and/or Psychological harm	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 11.03.24 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.	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	Emergency Department (ED) Overcrowding Impact on the safety - Physical and/or Psychological harm	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 major 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 Y5 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 January 2024 - Unscheduled Care Senior Management Team reviewed risk, a review is to be undertaken of the ambulatory SOP relating to fit2st and the potential to expand ambulatory footprint at the Princess of Wales site. This is being explored with the clinical team. • The operational capital group meeting held 18th October advising that they have been successful in obtaining WG funding for RGH nurse call bell and emergency call system within Ambulatory Emergency Care Unit (AECU), a complete ward refurbishment to ward 19 RGH and a scoping exercise to expand the RGH ED footprint. This will improve patient experience within these departments. • This remains an ongoing risk for all 3 sites and will be reviewed regularly as implementation of targeted improvement takes place. Nurse establishments are being reviewed to ensure safe staffing. With the recent onset of winter pressures, risk rating to remain at 20, C4, likelihood 5. New review date 28/02/2024.	Quality & Safety Committee Planning & Performance Committee	20 16	C4xL5	12 (C4xL3)	↔	24.09.2019	05.1.2024	28.02.2024
13	1133 Linked to risk 3826	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Long term sustainability and staffing of the Emergency Department (ED) at the Royal Glamorgan Hospital. (RGH). Impact on the safety - Physical and/or Psychological harm	If: The Clinical Service Group (CSG) is unable to deliver a sustainable staffing model for the Emergency Department at the RGH; Then: the Health Board will be unable to deliver safe, high quality services for the local population; Resulting in: compromised safety of the patients and staff and possible harm.	ED sustainable workforce plan developed and being implemented (May 2021). Option 1 funded so risks around sustainability remain particularly in respect of the consultant workforce. Financial position remains a challenge as locum and agency staff still used. No agreed plan to align staffing to benchmarking standards and the staffing levels on other sites within CTM. Boundary change and challenges across CTM continue to have a significant impact on the RGH site.	Update January 2024 - Senior Management Team risk reviewed, nurse establishment review continues in RGH Emergency Department (ED), invest to save paper submitted for RGH ED nursing staff. Awaiting outcome, Health Care Support Workers will be submitted next and can then to look to reduce. Risk rating remains C4 & L5, risk score 20. Review date 28/02/2024.	Quality & Safety Committee People & Culture Committee - Workforce aspect	20	C4xL5	8 (C4xL2)	↔	20.02.2014	05.1.2024	28.02.2024
14	5646	Chief Operating Officer	Mental Health Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	The impact of "Right Care Right Person" approach. Impact on the safety - Physical and/or Psychological harm	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.	Quality & Safety Committee Mental Health Act Monitoring Committee	16	C4xL4	12 (C3xL4)	↔	08.12.2023	03.01.2024	28.02.2024
15	2713	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialities Care Group	Radiology Service Manager	Improving Care	Patient / Staff /Public Safety	Backlog of Reporting Radiology Examinations Impact on the safety - Physical and/or Psychological harm	If there is consistent backlog of Radiology reports THEN there will be 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.	Quality & Safety Committee Planning Performance & Finance Committee	16 20	C4xL4	4 C4xL1	↔	08.02.2017	20.11.2023	15.01.2024
16	5579	Interim Executive Director of Public Health	Diagnostics, Therapies, Pharmacy and Specialities Care Group	Head of Nutrition and Dietetics, Therapies, PCH	Creating Health	Patient / Staff /Public Safety	Lack of Children and Young Persons Weight Management Service Impact on the safety - Physical and/or Psychological harm	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 January 2024 Current actions: pathways and workforce models are in development, aiming for fully costed business case to be completed by end of January 2024.	Population Health & Partnerships Committee Quality & Safety Committee	16	C4xL4	8 C4xL2	↔	13.10.2023	13.12.2023	31.01.2024
17	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 Impact on the safety - Physical and/or Psychological harm	If: The Health Board is unable to meet the demand for the predicted influx of Covid19 related, FUNIS 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 January 2024: Backlog remains for redress cases: Team Lead triaging backlog of cases, to ensure that cases are prioritised appropriately. Duty of Candour continues to be an area of increased activity, which should see more of an increase with the introduction of fixed recoverable costs in lower value claims. This is due to be implemented in April 2024. New 'Invest to Save' bid is in review stage of development, prior to submission. Other mechanisms such as overtime are being explored to manage the backlog.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024
19	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 Impact on the safety - Physical and/or Psychological harm	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 manage cases in an 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 January 2024 Links made with Once for Wales Central Team to assist with better reporting. A new report has been developed which gives more useful information in respect of inquests and any outstanding elements. 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.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024
21	4922	Director of Corporate Governance Interim - Executive Director of Nursing	Central Support Function - Quality Governance (Compliance)	Assistant Director of Governance & Risk	Improving Care	Statutory Duty, Regulation, Mandatory Requirements	Covid-19 Inquiry Preparedness - Information Management Impact on the safety - Physical and/or Psychological harm	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 of 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 January 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. The Covid-19 Inquiry Information Manager is exploring automation options with the Head of Information to explore whether this will support a more efficient archiving approach.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	23.11.2021	05.01.2024	01.03.2024
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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
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 January 2024 Weekly Coroner meetings continuing. The number of Post Mortem (PM) requests has increased significantly as deaths increase. Additional private provider sessions to mitigate increase but current PM backlog is at 8 days. Risk to be reviewed 31.1.2024.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	13.04.2023	02.01.2024	31.01.2024
3131	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	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 January 2024 Escalation plan in place and level 2 escalation triggered. Occupancy increases over festive period has placed challenge on capacity. Currently this has not required further escalation although position remains fragile. Risk to be reviewed 31.1.2024.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	05.03.2018	02.01.2024	31.01.2024
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	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 January 2024 The Legal Services team are prioritising other areas of work which have risk of penalties i.e. LFERs and Inquests New invest to save bid has been prepared and is being reviewed. Other mechanisms such as overtime are being explored.	Quality & Safety Committee	16	C4xL4	8 (C4xL2)	↔	07.10.2022	28.12.2023	01.02.2024
3133	Chief Operating Officer	Central Support Function -Facilities	Governance and compliance manager, Facilities	Improving Care	Patient / Staff /Public Safety	Poor compliance with Medical Gas Safety Training .	IF: Staff are not able to attend Medical Gas Safety training or courses are being continuously rescheduled. New staff trained at induction. 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 January 2024 - E-Learning (ESR/All Wales) package still not active (out of Clinical Engineering hands to activate this), compliance for Nursing staff has not increased significantly since last review. The ownership of this risk needs to be placed with the appropriate Clinical Service Group for this risk for Nurse training attendance - to be discussed with Patient, Care and Safety Function of appropriate action to move the risk ownership. Next review 29.3.2024.	Quality & Safety Committee.	16	C4 x L4	8 (C4xL2)	↔	01/05/2018	04.01.2024	29.03.2024
4152	Chief Operating Officer	Diagnostics, Therapies, Pharmacy and Specialties Care Group	Care Group Service Director.	Improving Care	Patient / Staff /Public Safety	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 and 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 - 53weeks - 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.	Quality & Safety Committee	16	C4 x L4	4	↔	01/06/2020	3.11.2023	11.12.2023
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	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 January 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. Work continues on these. A review of the level of this risk will be undertaken after this target has passed with a view to downgrade.	Quality & Safety Committee	16	C4 x L4	8 (C4xL2)	↔	02.11.2021	28.12.2023	01.02.2024

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1	4732	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director	Improving Care	Patient / Staff /Public Safety	Lack of orthogeriatrician as NICE guidance and KP11 NIFD 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.	Quality & Safety Committee	15	C3 x L5	4 (C2 x L2)	↔	31.8.2023	05.01.2024	28.02.2024
35	4080	Executive Medical Director Executive Director of People	Central Support Function - Medical Directorate & People Directorate	Assistant Medical Director	Improving Care	Patient / Staff /Public Safety	Failure to recruit sufficient medical and dental staff. If: The CTMUBH fails to recruit sufficient medical and dental staff. Then: the CTMUBH'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 affecting team communication. This may affect 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 CTMUBH 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 November 2023 - the Health Boards Non Consultant Rate Card is now active. Medical Workforce Productivity Programme continues as detailed in the August update above and at this point risk score remains unchanged. Risk score will be reviewed in January 2024. Review scheduled for the 31.1.2024.	Quality & Safety Committee People & Culture Committee	15	C5 x L3	10 (C5xL2)	↔	01.08.2013	31.10.2023	31.01.2024
36	2808	Chief Operating Officer	Children and Families Care Group	Clinical Service Group Manager	Improving Care	Patient / Staff /Public Safety	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. ADO's limited to only those cases where clinically necessary. Clinical Lead role created to support this (as below). Recruitment 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 at January 2024 - Activity ongoing in terms of further investment in the service. NDIP funding is currently on hold and further updates on this is awaited from Welsh Government. Job descriptions have been drafted in readiness for funding being made available. The risk of funding not being realised has been escalated internally due to the impact on new patient appointments if this gap cannot be resourced. Timeframe 31.3.2024. Risk will be reviewed 1.3.2024.	Quality & Safety Committee	15	C3 x L5	9 (C3xL3)	↔	14.07.2017	10.1.2024	01.03.2024
37	3993	Executive Director of Strategy & Transformation	Central Function - Planning Project Risk	Head of Capital, Strategic and Operational Planning	Improving Care	Patient / Staff /Public Safety	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 November 2023 - October Programme Board agreed a preferred option, this option requires significantly less capital. The option has been presented to Welsh Government Capital Team, however, there are revenue elements to the option which require further exploration with Welsh Government. Update January 2024 - A request was made to South Wales Fire & Rescue Service (SWFRS) to extend the Fire Enforcement Notice by a period of 2 years to enable the remedial scheme to be implemented. SWFRS 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.	Quality & Safety Committee Health, Safety & Fire Committee	15	C5xL3	8	↔	31.01.2020	09.01.2024	31.01.2024
38	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 Future	Patient / Staff /Public Safety	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 CTMUBH staff who currently use WCCIS via local authority over to CTMUBH 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	The Mental Health Care Group High Quality Record's workstream has developed a Clinical Information Access and Recording matrix (CIARM) for clinical team /staff access ("who accesses what system for what purpose") for all systems across the mental health service to enable safe sharing of information across sites. It is anticipated that digitisation of audit of compliance will be complete by 31 March 2024. In relation to WCCIS Digital Health Care Wales (DHCW) commissioned a review of the requirements under the existing programme and it has been confirmed that this will be withdrawn in January 2026. There is no confirmation of a national replacement system as yet. Director of Digital advised that a paper is planned for submission to the Improving Care Board on the 10th January 2024 regarding the consideration of future options. Next review 31.3.2024.	Quality & Safety Committee	15	C5xL3	6	↔	07/11/2018	08.1.2024	31.3.2024
41	4691 Linked to RTE Risks 4803, 4799, 3273 and 3019.	Chief Operating Officer	Mental Health Care Group	Interim Partnerships and Strategic Planning Lead for Mental Health and Learning Disability Services	Sustaining Our Future	Operational: Core Business Business Objectives Environmental / Estates Impact Projects Including systems and processes, Service /business interruption	New Mental Health Unit If: Mental health inpatient environments fall short of the expected design and standards. Then: Care delivered may be constrained by the environment, which is critical to reducing patient frustration and incidents as well as presenting more direct risk as a result of compromised observations. Resulting In: Compromised safety of patients, potential avoidable harm and compromised safety for staff in the workplace and extended lengths of stay.	Assistant Director of Strategic Transformation - Mental Health has commenced in post. This new role will lead a range of strategic programmes including recommencing a capital business case for a new Mental Health Unit. Annual revisiting of all patient ligature risks and completion of Statement of Needs via capital process for any ligature risks assessed as needing resolution. All anti ligature works planned for 2022 - 2023 have now been completed. A scoping document case to be prepared and submitted to Welsh Government Inpatient Improvement Programme has been established - April 2023.	1. Discussions to commence with Welsh Government in relation to the inpatient environment. 2. SCN completed to support strategic and systematic review of inpatient development opportunities. 3. Develop a strategic outline business case following no.2 4. If the strategic outline business case is accepted, progress to the development of an outline then a full business case. 5. Align with the learning from the Inpatient Improvement Programme with the aim of optimising the patient experience. Update January 2024 - MHLD Care Group Director - 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	08.01.2024	28.02.2024
42																	

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
Nil this period.											

	A	B	C	D	E	F	G	H	I	J	K
	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
1	4798	Executive Director of Therapies & Health Sciences Therapies hosted by Merthyr & Cynon Integrated Locality Group	Improving Ca	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Staffing levels do not meet standards for critical care services at Prince Charles Hospital, Royal Glamorgan Hospital and Princess of Wales Hospital.	If the therapy services (physiotherapy, speech and language therapy, dietetics, occupational therapy) continue to not be at the recommended staffing levels according to national level requirements (GPICs), Then: the critical service will be unable to meet the need of patients requiring therapy, Resulting in: significant negative impact on patient outcomes, ability to recover from critical illness and length of stay in critical care unit and consequently in hospital longer than needed.	Currently staff stretch to cover and prioritise patient need as much as possible. During winter pressures have tried in the past to recruit locums but availability still remains an issue for some services and not sustainable. Sighted within HB Critical Care Board as significant gap and within peer review response.	Update January 2024 - SLT staff are now in post across all three critical care units. Gaps between current staffing levels and GPICS standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for POW, with clinical incidents being reported	Quality & Safety Committee	Jan-24	Following a review of this risk in December 2023 the target score had been reached and the risk has now been closed. Speech and Language Therapy (SLT) staff are now in post across all three critical care units. Gaps between current staffing levels and Guidelines for the Provision of Intensive Care Services (GPICS) standards remain for Physiotherapy, Occupational Therapy and SLT, however no clinical incidents or concerns are being reported. However, a gap remains in relation to funding of Dietetics for Princess of Wales, with clinical incidents being reported and a new risk is being developed.
2											



Agenda Item

6.2

Quality & Safety Committee

MORTALITY INDICATORS AND MORTALITY REVIEWS

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Esther Flavell – Clinical Lead for Mortality Review Mark Townsend –Head of Clinical Audit and Quality Informatics Matthew Smith –Mortality Review & Learning 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
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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
HMR	Hospital Mortality Review
DNACPR	Do not Attempt Cardio Pulmonary Resuscitation



1. Situation /Background

1.1 The purpose of this report is to update the Quality and Safety Committee on compliance with the Cwm Taf Morgannwg University Health Board (CTMUHB) mortality review process in line with the All Wales Learning From Mortality Review Model Framework and to highlight the learning from mortality reviews to ensure lessons learnt are shared to improve the quality of patient care.

1.2 The table below outlines the number of ME referrals received (as of 3rd January 2024), since the introduction of the Datix Mortality Review Module on 1st April 2022 the number currently in progress and the number closed.

	Total Referrals	Awaiting Screening Panel	Under Investigation/ Action Required	Closed
CTMUHB	2261	137 (6%)	228 (10%)	1896 (84%)

1.3 The 3 most common reason for referral are:

- DNACPR partially completed, commonly not being countersigned
- Hospital Acquired Covid 19
- Communication issues - Communication with Family / Patient and also Communication between Staff / Wards / Hospital in CTMUHB

Learning from Mortality Reviews

1.4 Medical Examiner Service is now reviewing approximately all of CTMUHB, in-hospital deaths.

1.5 Hospital Mortality Review (HMR) panels, previously known as Stage 2 Mortality Review, have continued across CTMUHB. During the Covid pandemic, a large backlog accrued. A decision was made to focus primarily on "New" cases occurring from 1st April 2023 onwards with a focus on ensuring HMR are completed in a timely manner. A 28 day target (internally set) has been set for completion when a HMR is required. Backlog cases continue to be completed during panel where time allows and the number continues to decrease significantly.

The tables below show the number of cases identified for HMR for each of the 3 localities for 2022-23 & 2023-24 (as of 3rd January 2024), the number where the review has been completed and the percentage completed within 28 days of screening panel.



	2022-23		
	Number of HMR	Number Complete	Completed <28 days (Analysed retrospectively)
Bridgend	200	105 (53%)	10%
Merthyr	172	163 (95%)	13%
Rhondda	243	203 (84%)	8%

	2023-24		
	Number of HMR	Number Complete	Completed <28 days of Screening Panel
Bridgend	78	70 (90%)	74%
Merthyr	60	53 (88%)	65%
Rhondda	82	77 (94%)	82%

- 1.6 Stage 3 Mortality Review panel continues to be held on a monthly basis via Teams. There are currently 14 cases either waiting to be reviewed or in progress. The table below shows the number of cases escalated to Stage 3 Panel by specialty 2021-2024 (as of 3rd January 2024).

	2021-22	2022-23	2023-24
General Medicine	12	8	5
Trauma & Orthopaedics	9	3	2
Respiratory	7	4	1
Accident & Emergency	6	1	3
Care of the Elderly	6	3	1
General Surgery	5	2	1
Cardiology	2	1	1
Gastroenterology	4		
Endocrinology	1	1	
Mental Health	1	1	
ENT	1	1	
Vascular		1	
Maxillo Facial		1	

- 1.7 Each review with the medical examiner or at level 2 or 3 provides an opportunity to gather and share learning. Themes noted at Mortality Review include:
- Ownership of patients requiring care of more than 1 specialty.
 - Poor/Unclear care plans leading to lack of co-ordinated care
 - Advanced Care plans to avoid unnecessary hospital visits



- Few instances noted of delays in Cancer diagnosis during height of Covid Pandemic
- Delay in starting Sepsis treatment
- Management of anticoagulated patients requiring emergency surgery
- Improvements in End of Life Care – following the “Unnecessary Observations & Tests/Use of End of Life Care Priorities Guidance”
- De-escalation / ceiling of care should be discussed and agreed earlier in the patients admission in many cases being reviewed

1.8 Current CTMUHB Mortality figures show that <1% of all hospital deaths have a degree of suspected avoidability due to problems in healthcare

Ongoing Development

1.9 Whole Mortality Data - Work is ongoing to develop a Mortality Dashboard to collate all information related to Mortality across the Health Board. A scoping exercise has been undertaken and data is collected in a number of different locations across CTMUHB and in differing formats. This work is intended to bring all Mortality data together, ensuring data can be collated and presented in a consistent format, with the ability to drill down with a greater degree of accuracy. This is currently in development with IT and the Information Department.

1.10 Specialty deep dive reviews will be commenced in January 2024. The first of which will be undertaken for Trauma & Orthopaedics. These will be undertaken by the Clinical Lead for Mortality Review and the Learning from Mortality Review Manager.

Baseline Population Numbers

1.11 The population CTM health board serves comprises the local authority areas of Bridgend, Rhondda Cynon Taf and Merthyr. The total population for each region of population density is shown in the table below. This is taken from the Office for National Statistics (ONS) using their 2021 dataset as the latest whole year published.

Estimated data from 2021 for population of local areas to CTMUHB

Area	Estimated pop 2021	People/km 2021
Bridgend	145,500	580
RCT	237,700	560
Merthyr	58,800	528

1.12 SHMI and HMSR are versions of RAMI (Risk Adjusted Mortality Index) used in England. We have not used RAMI as a way of measuring Mortality in Wales since the 2014 Palmer Report which stated that All Deaths should undergo review (which we were already doing). England is still sampling.



1.13 The following table shows the number of deaths per area for each month of 2022 for each local authority area. Again, the data sets are from the ONS using their 2022 dataset.

Deaths per region 2022(taken form ONS website)

Area	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Bridgend	135	128	148	131	147	117	124	132	132	124	124	135
RCT	218	186	219	176	241	186	234	219	193	192	203	254
MCT	65	57	70	66	53	62	42	46	47	59	64	65

ONS data for deaths per month for Wales 2023

Month	Deaths	Involving COVID	Covid Proportion of Deaths
Jan	3952	229	5.8
Feb	2989	76	2.5
March	2967	112	3.8
April	2747	116	4.2
May	2862	90	3.1
June	2494	46	1.8
July	2579	28	1.1
August	2545	27	1.1
September	2508	72	2.8
October	2841	83	2.9
November	2717	51	1.9
December	Awaited	Awaited	Awaited

2. Specific Matters for Consideration

2.1 The Committee is asked to note that a "National Learning from Deaths" Programme will be developed to maximise learning, using two key approaches:

Extrinsic:

- Regular national meetings, e.g. monthly, which look at both processes & quality, as well as themes e.g. suicides, peri-operative deaths
- Multiple Sources (e.g. Medical Examiners, Clinical Reviews, Coroners Inquests and Regulation 28s, Serious incidents etc.)
- Communication via safety alerts, newsfeeds via DU Website and briefings into local bulletins
- Discussions with other health boards and ME services to improve communication and feedback

2.2 Intrinsic:

- A system of regular peer review of organisations to facilitate formative assessment and learning prompted by colleagues
- Continue to involve clinicians at an early stage for reflection



- This coordinated approach to analysing information from different sources will help target and prioritise the key risks that require local and national attention.

3. Key Risks / Matters for Escalation

- 3.1 Addressing the monthly MR caseload and backlog of MR cases has been challenging with limited centralised resources to support the MR process.
- 3.2 Limited clinical reviewers with appropriate MR experience has also contributed to the MR backlogs. SPA allocated time is being addressed in the recently approved Consultant SPA paper. Monthly MR training sessions continue to be available.

4. Assessment

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



Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	There is no direct impact on the reputation of the Health Board as a result of the activity outlined in this report.	
Effaith Adnoddau (Pobl / Ariannol) / Resource Impact (People / Financial)	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Next Steps

- 5.1 Continuation of current Mortality Review Process
- 5.2 Continued development of Datix Mortality Module at an All Wales Level
- 5.3 Introduction of "Deep Dive" programme of work
- 5.4 IT development of CTMUHB Whole Mortality Dashboard

6. Recommendation

- 6.1 That the Committee **NOTE** the contents of the paper.



Agenda Item

6.3

Quality & Safety Committee

Incident Management Framework

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Cyflwynydd yr Adroddiad / Report Presenter	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval
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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

The Incident Management Framework has been developed to provide a comprehensive structured guide to incident reporting and management within Cwm Taf Morgannwg University Health Board (CTMUHB). The document will outline the process to be followed in order to:

- Report incidents
- Maximise the learning from incidents
- Ensure that all incidents are investigated appropriately
- Identify any actions to prevent recurrences
- Ensure robust monitoring of incident reporting, investigation and relevant actions.

It is intended that this will be an interactive reference document to be used as a toolkit in conjunction with the [Incident Management SharePoint Pages](#) and Concerns Policies and Procedures.

2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	15.01.24
Informal Consultation with interested parties	18.09.23 – Meeting held with key operational leads
Formal Consultation	18.12.23 to 08.01.24 – Circulated via Care Group Directors and Corporate Leads. Added to SharePoint.
Committee – For approval	23.01.24 – Quality & Safety Committee

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 The Complaints and Legal Team have been engaged in the consultation

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



3. Key Risks / Matters for Escalation



3.1 In response to the consultation the following amendments have been made:

- Reference to Commissioned services
- Change from 5 days to 72 hours to undertake a rapid review meeting
- Inclusion of Lead Nurse in Quality Assurance Process

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	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)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Learning, Improvement & Research
	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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

(Insert Report Title)

Page 3 of 4

Choose an item.
Click or tap to enter a date.



Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome: This document forms a key part of the quality and safety arrangements for the Health Board.	If no, please include rationale below:
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome: No adverse equality issues have been identified.	If no, please include rationale below:
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below) Implementation of the Incident Management Framework is key to the Health Board's Quality and Safety Agenda. 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 **APPROVE** the Incident Management Framework.

6. Next Steps

- 6.1 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.



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Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Incident Management Framework

INITIATED BY:	Patient Care & Safety Unit
APPROVED BY:	Quality & Safety Committee
VERSION:	Draft
OPERATIONAL DATE:	01.02.24
REVIEW DATE:	3 Year or system and operational changes require

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Section 1: Introduction & Overview

Definition

An incident is defined as any unexpected or unintended occurrence, which could have, or did, lead to harm, damage or loss for one or more patients receiving NHS funded care, staff or member of the public on NHS premises. This definition includes any unexpected or unintended incident, which could have led to harm but that harm was prevented by way of some intervention.

The Incident Management Framework has been developed to provide a comprehensive structured guide to incident reporting and management within Cwm Taf Morgannwg University Health Board (CTMUHB). The document will outline the process to be followed in order to:

- Report incidents
- Maximise the learning from incidents
- Ensure that all incidents are investigated appropriately
- Identify any actions to prevent recurrences
- Ensure robust monitoring of incident reporting, investigation and relevant actions.

It is intended that this will be an interactive reference document to be used as a toolkit in conjunction with the [Incident Management SharePoint Pages](#) and Concerns Policies and Procedures. Implementation of the document is supported by a training strategy.

The Health Board recognises its responsibilities to have effective incident management systems as well as implement Health and Safety legislation as it affects the workplace.

The effective reporting and management of incidents, near misses and hazards, by all staff working in the health community and directly employed in Cwm Taf Morgannwg University Health Board, is a key component of Quality, Safety and Governance to ensure safe and effective care for patients and maintain staff safety.

It is important to remember that incident management and investigation is not intended to apportion blame, but to focus on essential learning that can contribute to continuous improvement. In addition incident reporting:

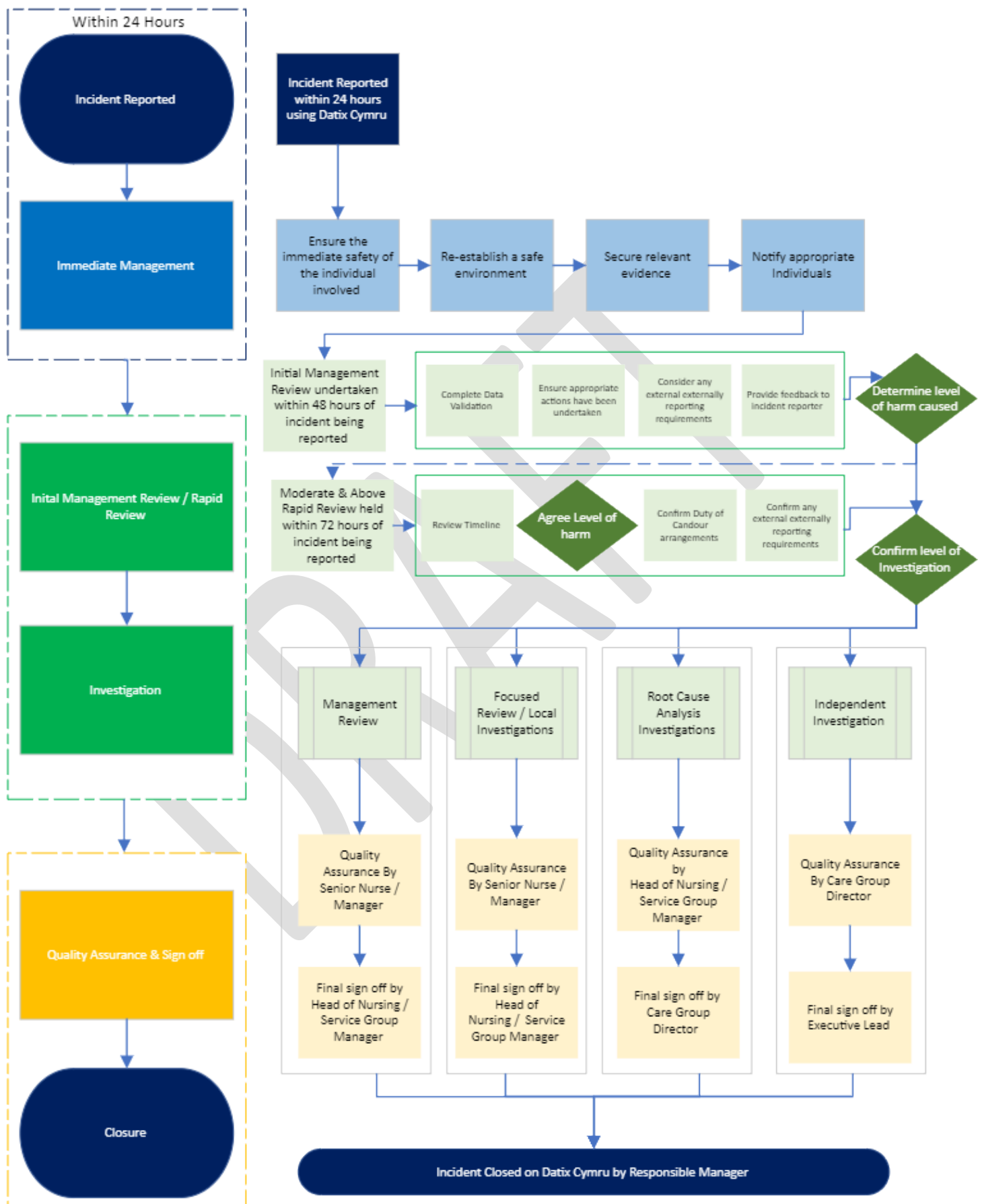
- Enables early action to occur so that likelihood of recurrence is reduced;
- Enables a review of what measures are in place to prevent incidents;
- Fulfils the Health Board's legal and statutory obligations to record and report certain defined incidents;
- Provides an early warning of potential complaints or litigation and helps identify any likely litigation cost to the Health Board;
- Alerts the Board to conditions of risk.

Essential to an effective incident management process is the timely and accurate updating of the Datix Cymru Incident Functionality. This MUST be undertaken at all stages of the process.

Support, Training and Resources

Support in relation to incident management can be obtained from the Business Intelligence Team (Datix Cymru), Quality & Safety Teams and Health & Safety Teams.

Section 2: Incident Reporting & Management At A Glance



Section 3: Roles & Responsibilities

The Board

Statutory responsibility for ensuring compliance with the incident reporting system lies with the Health Board, with the following reporting arrangements to provide assurance:

- All Major or Catastrophic incidents must be immediately reported to the appropriate Executive Lead and Chair of the Health Board.
- The Health Board will be provided with an Annual Concerns Report
- The Quality & Safety Committee and relevant Sub-Committees will receive quarterly reports detailing trends, themes and lessons learnt
- Care Groups will receive regular reports detailing trends, themes and lessons learnt.

Chief Executive

The Chief Executive has overall accountability, on behalf of the Health Board, for ensuring the implementation of this policy throughout the organisation.

Executive Directors

Executive Directors delegate their responsibilities for day to day matters to the designated Care Group Directors, Service Managers and professional leads for accurate reporting, investigation and ensuring that learning is identified and appropriate action is taken to reduce incidence of similar issues arising again.

Responsible Directors / Managers

Care Group Directors, Service Managers and professional leads will be responsible for ensuring that appropriate arrangements are in place within their areas for the reporting, investigation and follow up of incidents in accordance with this policy. Furthermore these Directors / Managers are responsible for the review of data on incidents in order to identify and monitor trends/problems, and for taking appropriate action. In addition they will be responsible for sharing Organisational Learning and ensuring that lessons are shared across the Health Board i.e. across Care Groups.

All Staff

Staff are responsible for:

- Reporting and escalating incidents in accordance with this policy and cooperating where appropriate in any subsequent investigations
- Engaging in learning and outcomes from investigations
- Raising concerns to their line manager through the incident reporting system or as outlined within 'Speaking Up Safely' regarding the delivery of care / services to patients
- Raising concerns about the safety of their environment or work activities, in line with the Health Board's Health & Safety policy.

Executive On Call

The Executive on call is responsible for the application of this policy in the event of incidents occurring out of hours. All major or catastrophic incidents should be reported immediately to the Executive on call.

Independent Contractors and Commissioned Services

There is no contractual obligation for Independent Contractor Services to report incidents to the Health Board. However, they are encouraged to work with the organisation in promoting safer working practices and sharing lessons learned. These include:

- Incidents which have occurred in a particular practice, where others would benefit from the shared learning and
- Incidents which have occurred in secondary care, and need to be referred back for investigation, but have become evident in primary care

Independent contractors and Commissioned Services are requested to:

- Complete the electronic incident report form
- Investigate, and discuss if appropriate in the practice team meetings
- Implement changes if appropriate
- Share lessons learned

It is the responsibility of the Independent Contractor Services and Commissioned Services to have systems in place for reporting and managing incidents as part of their governance arrangements. The Health Board is required to monitor this as part of their contractual arrangements.

Section 4: Incident Reporting

All Incidents should be reported using the on-line incident reporting system (Datix Cymru) **within 24 hours** of the incident being identified unless there are exceptional circumstances. The online form is accessible from the [Health Board intranet](#). A guide for all staff, on how to use the online incident report form, is accessible from the same location.

Where/if there are exceptional operational circumstances that present difficulties in accessing the online reporting facility, an electronic (attached to an email) or paper based version should be completed and forwarded to the line manager, who will ensure that the information is subsequently reported using the online reporting system.

As far as possible, the person most directly involved in the incident should complete the incident report.

The reporter will make a judgement on the actual outcome of the incident using the [Level of Harm Grading Framework](#).

The assessment of the severity should not delay the completion / submission of the incident report. The reporter should make the most reasonable assessment possible based on the information available at the time. In determining the severity of the incident, the reporter should consider the harm attributed by an action or inaction by the Health Board. The grading of an incident is subject to review throughout the review and investigation process as facts and issues emerge.

On clicking the 'Submit' button, the reporter of the incident will receive an instant, on screen, acknowledgement of the incident report having been received.

Section 5: Immediate Management of Incidents

a. Notifications / Initial Contacts

Each Department, Service, Care Group Leads should define its specific arrangements for the following:

- Incidents occurring within normal working hours (Monday-Friday, 09.00 – 17.00)
- The senior person on duty to be informed of any safety incident
- The process of escalation for externally reportable incidents
- Incidents occurring outside normal working hours
- Notifying the On-Call Manager of serious incidents occurring outside of normal hours and the action being taken.

These arrangements should be communicated to all staff.

b. Immediate Safety of the individual involved

The responsible manager will ensure the immediate safety and care of the individual involved. Where the person has sustained an injury, an appropriate level of examination and treatment must be offered.

Where the person involved is a patient consider if any safeguarding action and referral is required. If the patient is not an inpatient, this might include referral to inpatient services. If the referral is declined, this should be documented in the medical records.

The consultant or lead professional in charge of the patient's care must be informed, who should consider the communications with the patient/relatives/carers at this time (refer to Duty of Candour).

If the incident occurs in a community setting, and it is considered that the GP should be made aware, the patient should be advised to contact the GP, or the member of staff should personally notify the GP as soon as practicable after the incident. If the incident is sufficiently serious, the GP should be notified immediately and/or an ambulance should be called.

If the incident relates to the use of equipment, disconnect or isolate the equipment and refer to Clinical Engineering for medical devices or contact the Estates Department in relation to non-medical devices. Refer to equipment section.

A record of a patient safety incident should be written in the patient's clinical notes in addition to completion of an incident report on Datix Cymru. However, the incident report itself and any subsequent investigation notes do not form any part of the patient's record and it should not be printed and filed in the patient's clinical notes.

When an inpatient has been the subject of an incident, the discharge letter sent to the patient's GP should contain summary details of:

- the nature of the incident and related care and treatment
- the current condition of the patient
- key investigations
- recent results
- prognosis

c. Re-establishing a safe environment

Appropriate action must be taken to contain the situation, as agreed with the responsible manager/senior person on duty. If a significant event has occurred, the scene may need to be protected to undertake the investigation. There should be notification to or advice sought from specialist advisors/departments, as necessary (e.g. Health & Safety, Infection Control, Pharmacy, Clinical Engineering etc). Consideration should be given in relation to the safety and impact on other patients, public, staff and other services.

d. Secure relevant evidence

1. Equipment

It is important that there is a common sense approach and that there is discussion within the Care Group/Unit or with relevant specialists in any given situation.

Where it is suspected that drugs may be defective/contaminated/out of date etc, they must be taken out of use and contact made with Pharmacy for advice.

If the incident is serious all the relevant evidence must be preserved and kept secure. There may be a police investigation as well as a Health Board investigation. If necessary, secure the area, to ensure that everything is left untouched. Lock doors and put up signs clearly stating that no-one is permitted to enter the area. Explain the reason for the closure to patients, relatives, visitors and staff in the vicinity, ensuring that confidentiality is not breached.

If the incident involves the use of medical equipment, the item(s) of equipment must be removed from use, appropriately labelled and retained for inspection by the Clinical Engineering Service or other specialist departments.

If the incident involves the use of non-medical equipment, it must be removed from use, appropriately labelled and retained for inspection by Estates or IT. All accessories and disposables/consumables must be retained intact. Settings must not be adjusted. The equipment must be clearly labelled as 'Evidence - Not To Be Used' and it must be stored in a place and manner such that it cannot be accidentally or intentionally brought back into use in the intervening period until all investigations are complete and formal approval has been given for the re-introduction of the item. The supplier or manufacturer of an item should not be contacted at this particular time.

Advice can be sought from specialist departments, the Patient Safety or Health & Safety Teams.

2. Witness recollection of events

Any witnesses to an incident should complete a recollection of events form on which they should record the facts of what they witnessed. These can be found on the [SharePoint site](#).

These can be attached as a 'Document' to the on-line incident report, by the incident reporter. If this is not yet available at the time of completing the on-line incident report, it should be attached to the incident record in the Datix Cymru system, when it is available, in accordance with the arrangements defined by the Care Group.

Witnesses should be reminded that no allegations are being made against them and that the purpose of providing a report is simply to obtain factual information that could be of assistance in establishing the facts leading up to the incident.

A formal statement may also be requested later, as part of an investigation of an incident.

Section 6: Management Review & RAPID Review

Incidents should be thoroughly investigated as appropriate to ensure that lessons are learned and, the risk of recurrence removed if possible, or minimised. A robust and timely investigation will also provide reassurance to patients, their families, carers and colleagues. The level of investigation will be proportionate and determined by key factors including the level of severity (actual or potential) and the mechanism for investigations available i.e. clinical review, RCA methodology, referral to safeguarding. The Patient Safety or Health & Safety team should be consulted for advice and support if there are any concerns in relation to the level of investigation required.

The purpose of the investigation is for learning from events. The investigation will determine fully the issues involved, identify the cause, ascertain the circumstances, identify consequences and implement improvements to ensure the risk of similar incidents is minimal.

a. Initial Management Review & RAPID Review

The initial review of an incident must be completed on the Datix Cymru system by the responsible manager within 48 hours of the date that the incident is reported and include as a minimum:

- Confirmation that the matter reported constitutes a reportable incident
- Determine the perceived level of harm caused as a result of the incident
- Data validation to ensure all the information is accurate and comprehensive. A data validation checklist is available [here](#)
- Ensure that all appropriate actions in response to the incident have been taken or are underway. This includes commissioning an appropriate proportionate investigation
- Ensure that all appropriate communications are undertaken
- Ensure that appropriate and timely feedback is provided to the incident reporter
- Consider any externally reportable requirements i.e. NHS Executive, Health & Safety Executive, Healthcare Inspectorate Wales, Human Tissue Authority, Information Commissioner

As part of the review, the incident should be assessed for future risk potential in line with the Health Boards [Risk Assessment Procedure](#).

b. Rapid Review

The decision whether to convene a RAPID review meeting should be based around the nature, complexity and level of harm of each incident. As a minimum a RAPID review will take place for all incidents identified as moderate and above following initial management review. The Care Group Quality & Safety Team or your local Health and Safety Coordinator can offer advice and support in assessing each incident on a case-by-case basis. Details of the Care Group Quality & Safety Teams can be found [here](#) and Health & Safety Teams can be found [here](#)

A RAPID review meeting, where possible, should be held within 72 hours of an incident being identified to ensure the discussion and investigation process is commenced in a timely manner. The incident is reported to the Care Group Quality & Safety Team or your local Health and Safety Coordinator who will organise the RAPID review alongside the clinical lead for the area in which the incident occurred. This can be held either in person or virtually to maximise the opportunity for attendance. Those in attendance should be drawn from the local area within which the incident occurred, but who were not directly involved. This may include, but is not limited to, Head of Nursing, Lead Nurse, Senior Nurse, Ward Manager, Service Lead, Medical and Governance representatives. The level of accountability and staff present will be relevant to the seriousness / impact of the incident and will need to be agreed, for example a Never Event should be led by an Executive Level chair or nominated Deputy. Terms of Reference for the Rapid Review Meeting can be found [here](#).

Where an incident is of a serious nature, likely to require central Patient Safety Team or Health & Safety Team involvement or advice in a complex case, a representative from the team can be invited to attend. Details for the central Patient Safety Team can be [here](#) and Health & Safety Teams can be found [here](#).

The RAPID review should follow the agreed [template](#), although remain flexible to allow for the flow of discussion between attendees. Minutes should be kept of all discussions and documented within the proforma, and this should be uploaded to the documents section of Datix Cymru as soon as possible following the meeting. The team should allocate this task at the beginning of the meeting to ensure it is completed.

The tabular timeline must be completed prior to the RAPID review meeting taking place.

The main purpose of the RAPID Review meeting is to:

- Review and consider the findings of the initial scrutiny of the incident
- Agree the perceived level harm that has occurred as a result of an action or inaction by the Health Board
- Identify any immediate actions required to mitigate the risk of re-occurrence
- Confirm Duty of Candour arrangements have been made and agree the lead for further Duty of Candour discussions
- Set the Terms of Reference (ToR) and scope for the investigation
- Agree the lead Investigator and supporting investigation team
- Identify any risks associated with the incident / complex complaint
- Consider whether an early warning notification requires submission
- Lay out arrangements for any further investigation team meetings
- Confirm timescales for the investigation (this will be between 30 and 120 working days)
- Identify a Family / Staff Liaison Officer

The outcome of this meeting will be summarised on the management review form on Datix Cymru (under incident investigation) or on a Rapid Review [document](#) which must be uploaded onto Datix Cymru by either the responsible lead from the area or the Patient Safety Improvement Manager (to be agreed during the RAPID Review Meeting. This documentation acts as a source of assurance for the Care Group Triumvirate Team and Executive Directors that appropriate actions have been taken to ensure the immediate safety of the patient(s)/staff following an incident and to mitigate risk of re-occurrence.

Section 7: Duty of Candour for Patient Safety Incidents

All healthcare professionals have a duty of candour. This is a professional responsibility to be honest when things go wrong, providing truthful information and an apology. An apology *'means an expression of sorrow or regret in respect of a notifiable safety incident'*.

The Duty of Candour is a legal requirement for NHS Organisations in Wales to be open and honest with patients receiving care and treatment. This is outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The Duty of Candour applies if the care we provide has, or may have contributed to unexpected or unintended moderate or severe harm, or death.

A summary of the Duty of Candour procedure is outlined below:

- On first becoming aware that the Duty of Candour applies, the NHS must notify the patient or a person acting on their behalf. This contact should be 'in person' which means by telephone, video call or face to face.
- The purpose of the 'in person' notification is to offer an apology, provide an explanation of what is known at that time, offer support, explain the next steps and provide point of contact details.
- Once the 'in person' notification has been made, a written notification must also be sent to the patient or the person acting on their behalf within five working days. The purpose of the written notification is to confirm everything that was said in the 'in person' notification.
- The NHS will undertake an investigation of the incident to determine what happened and why and what can be done to prevent it from happening again. This will be undertaken in accordance with the NHS Wales 'Putting Things Right' Procedure.

These discussions can form part of the initial meeting with the family which should take place as soon as possible following the incident. It is important to provide the family with an opportunity to ask questions. It is essential that you do not have to wait until the outcome of an investigation to speak to the patient and/or family, but you should be clear about what has and has not yet been established.

The questions raised by the patient and/or family should be reflected and answered within the investigation and final report.

It is essential the patient knows whom to contact in the healthcare team to ask any further questions or raise concerns. You should also give patients information about independent advocacy, counselling or other support services that can give them practical advice and emotional support. You should record the details of your apology in the patient's clinical record. Note that an apology is not an admission of culpability and will not be viewed as such. It is simply the right thing to do when something goes wrong.

When apologising to patients and explaining what has happened, it is essential that staff realise that there is not an expectation to take personal responsibility for the incident, however the patient has the right to receive an apology from the most

appropriate team member regardless of who or what may be responsible for what has happened.

Healthcare professionals (colleagues) must be open to take part in reviews and investigations when requested. They must support and encourage each other to be open and honest, and not stop someone from raising concerns. They must encourage a learning culture by reporting adverse incidents that lead to harm, as well as near misses.

Full Information in relation to the Duty of Candour requirements can be found [here](#)

Section 8: Support for Patients & Families

At the start of the investigation a patient / family liaison officer who will act as the single point should be identified where appropriate. The Family Liaison Officer will support the patient or family with any questions that they wish to include in the investigation, provide regular progress updates in relation to the process and an expected timescale for completion.

A range of services are available to support patients and families, details of which can be found [here](#).

Section 9: Support for Staff

The 'assist me' pack has been designed to assist managers to support colleagues when involved in a traumatic/stressful incident, complaint or claim. In the majority of cases this will be through their Line Manager as the first point of contact. In cases where this is not appropriate, a point of contact 'staff liaison' will be identified by the Line Manager. 'Assist me' information and documentation can be found on the [Incident Management SharePoint Pages](#).

The Line Manager should arrange a "one to one" meeting with the individual member of staff concerned to discuss the issues identified, offer support and determine the level and type of further support required by the member of staff which may be through internal or external sources i.e. People's Services, Occupational Health, Wellbeing Services, and/or Staff Side representatives.

Debrief Sessions

Following an incident, particularly those resulting in significant harm, a debrief session should be arranged to support staff through the process, providing a safe space for everyone to speak openly and honestly without feeling judged. It will also provide an opportunity for staff to engage in reflective practice and identify practical solutions in the immediate aftermath of the incident occurring.

The aim of the session will be to identify:

- What it is everyone wants from the session?
- How everyone is feeling
- What went well – what were the strengths
- What individuals are worried about
- Any system failures or incidental learning
- Suggested solutions or recommendations
- The next steps

In addition it should be ensured that everyone leaves the meeting feeling they know what is expected of them and how to access support, wellbeing, Clinical Psychologist.

Information for Health Board staff wellbeing and support services can be accessed by visiting the [Wellbeing SharePoint Services](#).

Feedback following an incident

Following the completion of an incident investigation, staff involved should be contacted via phone/email/letter to be given the opportunity to be invited to receive formal feedback and discuss the findings of the investigation. It is important to emphasise that feedback from an investigation will not be a punitive process, but one of support and learning in a non-judgemental way and will be confidential. If there are any concerns about an individual's professional competency or conduct, education, support and learning will be provided by the Health Board for the individual and wider team learning. Staff may also be invited to attend a learning event, created from the findings of the incident and investigation.

Section 10: Externally Reportable Incidents

The Health Board has a duty to inform certain external agencies of specific types of incidents. These include the Health and Safety Executive (HSE) and National Reporting to NHS Executive. Details of other types of incidents where external reporting should be considered can be found [here](#).

Health and Safety Executive (RIDDOR)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) requires employers and others to report certain types of injury, some occupational diseases and dangerous occurrences that **"arise out of or in connection with work"**. Generally, this covers incidents associated in some way with work activities, equipment or environment, including how work is carried out, organised or supervised.

RIDDOR places a legal duty on employers, self-employed people and people in control of premises to report:

- **Death** - the death of any person, whether or not they are at work if it results from a work accident or occupational injury;
- **Major Injury** – accidents or incidents which result in an employee or a self-employed person suffering a major injury;
- **Over-seven-day injuries** - accidents or incidents which result in an employee or a self-employed person dying, suffering a major injury, being absent from work or unable to do their normal duties for more than **seven** consecutive days (not counting the day of the accident but including non-work days such as weekends, rest days or holidays);
- **Injuries to people not at work** - accidents or incidents which result in a person not at work (e.g. a patient, service user, visitor) suffering an injury and being taken to a hospital, or if the accident happens at a hospital, suffering a major injury which would otherwise have required hospital treatment;
- **Occupational Diseases** - an employee or self-employed person suffering one of the specified occupational diseases;
- **Dangerous Occurrences** - specified dangerous occurrences (near miss accidents or incidents), which may not result in a reportable injury, but have the potential to do significant harm.

When there has been an incident which is RIDDOR reportable the Health, Safety and Fire Team must be contacted with the incident reference number. A RIDDOR form will be sent to the Manager to fill in. This must be completed and returned to the Health, Safety and Fire Team as soon as possible so that the Health and Safety Executive (HSE) can be informed. Staff who are absent from employment for over-seven-days due to injuries must be reported to the HSE within fifteen days. All other RIDDOR reportable injuries must be reported to the HSE within a maximum of ten days of the incident occurring.

The Regulations require that the Health Board keeps a record of an incident if the employee has been incapacitated for more than **three** consecutive days (absent from work or unable to do their normal duties for over-three-days). This is recorded via the incident reporting system. It is important that the Health, Safety and Fire Team is notified of the length of time an employee is off work or has been incapacitated.

More detailed information can be found on the [Health & Safety SharePoint Pages](#).

National Reporting to NHS Executive

The following definition of a nationally reportable patient safety incident applies:

A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients during NHS funded healthcare.

The above definition of an incident is applicable to all NHS funded services, regardless of speciality, delivered in all secondary or primary care settings, including community based services. When considering whether to report an incident, the following should be applied:

- a patient safety incident will be nationally reported within seven working days from the occurrence, or point of knowledge, if it is assessed or suspected an action or inaction in the course of a patient's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or caused or contributed to severe harm
- as it will not always be possible to determine the extent to which a patient safety incident caused or contributed to the harm or death of a patient within seven working days, responsible bodies should report in line with the criteria where it is known, and/or suspected, that a patient safety incident has caused or contributed to harm or death. In this scenario, for clarity, the responsible body should specify on the form that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date as outlined [here](#)
- all such incidents must be reported to the NHS Executive within seven working days from the occurrence, or point of knowledge.

Specific National Incident Categories

Whilst these fall under the broad definition of a nationally reportable incident as set out above, they have been drawn out in the policy to ensure clarity on expectations around national reporting.

- Suspected homicides where the alleged perpetrator has been under the care of mental health services in the past 12 months
- In-patient Suicides
- Maternal Deaths
- Never Events (current list is available [here](#))

- Incidents where the number of patients affected is significant such as those involving screening, IT, public health and population level incidents, possibly as the result of a system failure
- Unusual, unexpected or surprising incident

In addition to those incidents identified above, avoidable pressure damage and patient falls should be reported retrospectively following approval at the appropriate scrutiny panel.

Once approved by the Care Group Director, Nationally Reportable Incident Forms should be submitted to the Corporate Patient Safety Team for processing and submission to the NHS Executive. The Care Group should outline their arrangements for the completion and approval of Nationally Reportable Incident Notifications Forms.

Section 11: Safeguarding Considerations

Consideration of safeguarding must be made at the start, during and the end of any investigation. Where concerns are identified a report must be made, with the relevant referral form completed and sent to the Multi Agency Safeguarding Hub (MASH).

The Health Board has a legal duty to report safeguarding concerns so if there is any doubt in relation to whether there is a safeguarding element or not to an incident, please contact the Corporate Safeguarding Team, the MASH or the Emergency Duty Team if out of hours to discuss.

A brief overview of adults and children's safeguarding is outlined below to help with consideration during investigations.

An adult at risk is defined as anyone:

- Over 18
- Is, or may be, in need of community services due to having a mental or other disability
- Is, or may be, unable to take care of him/herself or are unable to protect him/herself.

A child at risk is defined as a child who:

- Is experiencing or is at risk of abuse, neglect or other kinds of harm;
- Has needs for care and support (whether or not the authority is meeting any of those needs).

It is important to note:

- The use of the term 'at risk' means that actual abuse or neglect does not need to occur, rather early interventions to protect a child at risk should be considered to prevent actual harm, abuse and neglect.
- The two conditions necessary to demonstrate a child is at risk of abuse or neglect ensures that protection is provided to those with care and support needs who also require actions to secure their safety in the future.
- Risk of abuse or neglect may be the consequence of one concern or a result of cumulative factors.

In relation to Safeguarding, harm is defined as:

- Ill treatment including sexual abuse, neglect, emotional abuse and psychological abuse.
- Impairment of physical or mental health (including that suffered from seeing or hearing another person suffer ill treatment).
- Impairment of physical intellectual, emotional, social or behavioural development (including that suffered from seeing or hearing another person suffer ill treatment).

Child deaths

Reporting of a child death in line with the Procedural Response to Unexpected death in Children (PRUDiC) process are outlined below:

- An Early Warning Notification should be submitted to Welsh Government for all PRUDiC cases
- Not all PRUDiC cases need to be reported as a Nationally Reportable Incident
- Some PRUDiC cases **may** also need to be reported to the NHS Executive as a Nationally Reportable Incident if the criteria is met. This will depend on the individual circumstances of the case and whether it meets the criteria set out above.
- Good practice recommendation is that a RAPID review meeting takes place within the Care Group following the PRUDiC meeting to establish if the Nationally Reportable Incident threshold is met. Please consider whether the circumstances surrounding the child death meets the criteria for referral for a Child Practice Review.
- Each PRUDiC case should be assessed on an individual basis and where the NHS organisation considers the underlying incident meets the criteria, then this should be reported as a Nationally Reportable Incident at the earliest opportunity. Cases can be reported retrospectively if the assessment changes at any time during, or following completion of the review.

All child deaths will be subject to notification to the Child Death Review programme and will be completed by the Corporate Safeguarding Team.

Full information and contact details in relation to Safeguarding and Public Protection can be found on the Health Board's [SharePoint Pages](#).

Section 12: Proportionate Investigation

The level of the investigation should always be proportionate to the issue identified and should be considered on a case-by-case basis. The nature, severity and complexity of each incident will determine the appropriate level of investigation.

The levels of investigation can be broadly categorised as the following:

- Management Review
Initial management review will be sufficient for non-complex, straightforward incidents, normally resulting in no or low harm that are completed fully within the Datix Cymru system.
- Focused Review / Local Investigations
A proportionate investigation for less complex incidents, which can be managed, by individuals or small groups at a local level. For this type of investigation a focused review investigation tool must be completed within the Datix Cymru system. Where a focused review tool is not available the proportionate

investigation screen must be completed within the Datix Cymru system. It is recommended that is supported by a timeline of events and SBAR report.

- **Root Cause Analysis (RCA) Investigations**

This is a comprehensive investigation suited to complex issues, which should be managed by a multidisciplinary team involving experts and/or specialist investigators. Incidents requiring this level of investigation usually result in severe harm or death.

- **Independent Investigation (Internal or External)**

This is an independent investigation of serious incidents where the integrity and objectivity of an internal investigation would be difficult to maintain. The investigator and team are all independent of the organisation where the incident occurred. Examples of incidents, which may indicate an independent investigation, include incidents of high public interest, those attracting media attention or Mental Health related homicides.

For some incidents, the level of investigation required may be clear from the outset, however, where it is not clear this can be determined following the initial management review or a RAPID review meeting. A never event must always have an RCA investigation as minimum.

Investigation tools

There are several analysis tools available to support the levels of investigation highlighted above and these should be uploaded to Datix Cymru or included in the report to demonstrate thought processes and decision-making.

These tools support in:

- Gathering information
- Identification of care or service delivery issues, contributory factors & good practice
- Analysis of findings, identification of causal factors, root causes and lessons learned
- Documenting the investigation findings

The team should choose which tools are required for the type of investigation being undertaken to identify root causes and contributory factors, however the following tools are recommended for their thoroughness and reliability.

Fishbone or Cause and Effect Diagram

A fishbone diagram, as the name suggests, mimics a fish skeleton. The underlying problem is placed as the fish's head (facing right) and the causes extend to the left as the bones of the skeleton; the ribs branch off the back and denote major causes, while sub-branches branch off the causes and denote root causes. You may wish to use the contributory factors classification framework below to help you.

Use this tool when you are trying to determine why a particular problem is occurring. It will help you to fully understand the issue and to identify all the possible causes – not just the obvious.

How to use it?

1. Agree on a problem statement (effect) and consider it in detail: who is involved, when and where it occurs. Engage your team to agree the problem

statement. Include as much information as possible in the 'what', 'where', 'when' and 'how much' of the problem and use data to specify the problem if possible.

2. Write the problem in a box and draw an arrow pointing towards it.
3. Aim to construct the diagram with the people involved in the problem.
4. Explore the major categories of causes of the problem. Write the categories of causes as branches from the main arrow.
5. Further explore all the possible causes of each major category branch
6. Keep exploring causes for each branch until you cannot delve any deeper.
7. You can use a cause and effect diagram as a working document that is updated as and when you collect more data, or to test possible solutions.
8. Where contributory factors are clustered most heavily on one spine of a fishbone diagram, are these linked to a single underlying cause?

"5 Whys" Analysis Tool

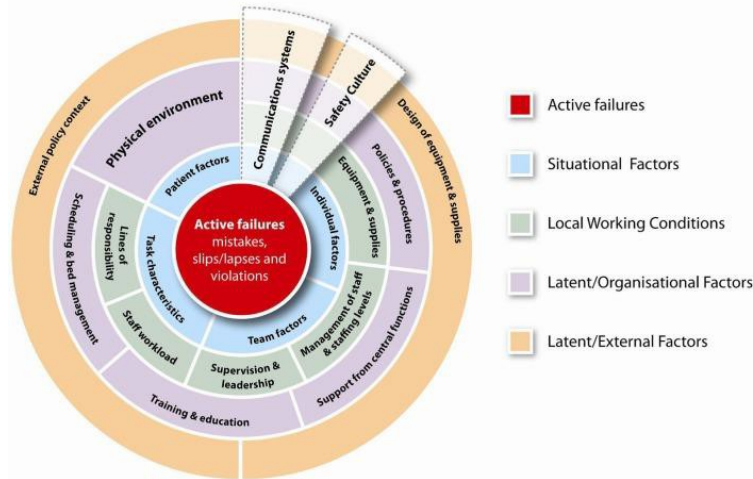
The simplest way of conducting the 'Five Whys' test is to simply write it down on a piece of paper. However, the fishbone above can help during the initial process of identifying problems. The diagram can reveal problems that may need the five whys for a deeper look. Then, you can gather all of the root-cause-effect relationships and evaluate which of them had the greatest impact on the original problem.

How to use it?

1. Agree on a problem statement and consider it in detail: who is involved, when and where it occurs. Engage your team to agree the problem statement. Include as much information as possible in the 'what', 'where', 'when' and 'how much' of the problem and use data to specify the problem if possible.
2. Write the problem in a box at the top of a page
3. Aim to construct the diagram with the people involved in the problem. You may get different answers from different people, but this will help you to evaluate all angles.
4. Now ask yourselves why did this happen and write the answer below your problem statement.
5. Keep asking 'why' until you exhaust all the underlying reasons behind the problem. You may not need five whys but be careful not to stop too early, otherwise you may not reach the ultimate root cause. If the problem is complex, you may need many more levels of why before you have exhausted them all.

Yorkshire Contributory Factors Framework (YCCF)

The Yorkshire Contributory Factors Framework is a tool which has an evidence base for optimising learning and addressing causes of safety incidents by helping reviewers and investigation identify contributory factors of incidents. Whilst a form is available for completion during the investigation, the contributory factors MUST be completed on Datix Cymru.



All template investigation tools are available on the [Incident Management SharePoint Pages](#).

Redress arrangements for Patient Safety Incidents

In line with the requirements set out in Putting Things Right and Duty of Candour, investigations should consider if any failings identified constitute a breach of duty of care and require further investigation under Redress processes. Further guidance on breach of duty and qualifying liability investigations is included in the Concerns Policy & Procedures. Advice should be sought from the Health Board’s Legal Services Team as part of the process.

Section 13: Action Planning and Completion of Learning

A SMART action plan should be aligned to the investigation that clearly sets out the actions that will need to be taken in response to the report to provide assurance. These actions should be pulled from the learning and recommendations that have been identified in the investigation.

Components of an Action Plan include:

- A well-defined description of the goal to be achieved
- Tasks/ steps that need to be carried out to reach the goal
- People who will be in charge of carrying out each task
- When will these tasks be completed (deadlines and milestones)
- Resources needed to complete the tasks
- Measures to evaluate progress
- Arrangements for sharing learning arising of out incident investigations

These actions should be added to Datix Cymru under the specific incident number for the investigation in order to robustly monitor completion. The evidence to support each action should be uploaded and saved to Datix Cymru for assurance and accessibility. The named individual on the action plan is responsible for ensuring the actions are completed and updating Datix Cymru, including relevant evidence.

Section 14: Quality Assurance & Final Sign Off

All incidents will be subject to quality assurance linked to the type and level of investigation undertaken. Whilst Care Groups will determine the granular detail of their

quality assurance, sign off and closure process they should be in the line with the following parameters:

Level of Investigation	Quality Assurance to be completed by	Final Sign off & Closure by
Management Review	Senior Nurse / Manager / Lead Nurse / Operational Manager	Head of Nursing / Service Group Manager
Focused Review / Local Investigations	Senior Nurse / Manager / Lead Nurse / Operational Manager	Head of Nursing / Service Group Manager
Root Cause Analysis Investigations	Quality & Safety Team Lead Nurse / Head of Nursing / Service Group Manager	Quality Assurance Panel Care Group Director
Independent Investigation	Care Group Director	Executive Lead

Quality Assurance Process & Sign off for Nationally Reportable Incidents

The quality assurance process differs slightly according to the level of investigation undertaken, with the depth of scrutiny and breadth of panel attendees increasing according to the level of investigation. Once the investigation is complete, the report and action plan will be submitted to the relevant Care Group Quality & Safety Team who will undertake quality assurance of the investigation using the agreed checklist and support the scrutiny of the report and action plan by a multi-disciplinary team within a Quality Assurance panel. The Terms of Reference Template can be found [here](#).

The panel will decide whether the report meets key objectives according to the Health Board Quality Assurance template.

Once the panel have considered the documents, they will either return the bundle to the author for further amendments according to comments on the Quality Assurance template or confirm the bundle is suitable to proceed for closure. On agreement that the bundle is complete and ready for consideration for closure, the Quality & Safety Team will arrange for the approved bundle to be submitted for closure to the Central Patient Safety Team.

Once the investigation has been finalised to the satisfaction of the Quality Assurance Panel, Quality & Safety Team and Investigation teams, the incident can be progressed to closure.

A Nationally Reportable Incident closure bundle including the report, action plan and Quality Assurance checklist should be signed off by the Care Group Directors then forwarded by the Care Group Quality & Safety Team to the Patient Safety inbox, alongside the closure notification form. It will then be collated and forwarded to the Executives for sign off prior to submission to the NHS Executive.

Section 15: Escalation & Monitoring

Delays with process outlined within the framework will be escalated via the appropriate Care Group hierarchy.

Monitoring of the implementation of the Incident Management Framework will be undertaken via a number of mechanisms including:

- Corporate review by the Quality & Safety, Patient Safety, Health & Safety and Business Intelligence Teams
- Weekly audits of closed cases
- Reporting of incident management compliance via the Health Board's Governance Structure.

DRAFT



Agenda Item

7.1

Quality & Safety Committee

PATIENT SAFETY & QUALITY DASHBOARD

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence Kellie.I.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
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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 01.11.23 to 31.12.23 taken from systems on 03.01.24, 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 continued to decrease.
- Decrease in the number of open formal complaints, specifically those open over 30 working days.
- Compliance with the 30 working day target for responding to complaints decreased during November 2023, but returned to over 70% in December 2023.
- Number of new PSOW referrals being received decreased during November and December 2023.
- Reduction in the number of overdue Nationally Reportable Incidents.
- Decrease in the number of medication incidents reported.
- Increase in pressure damage incidents reported.

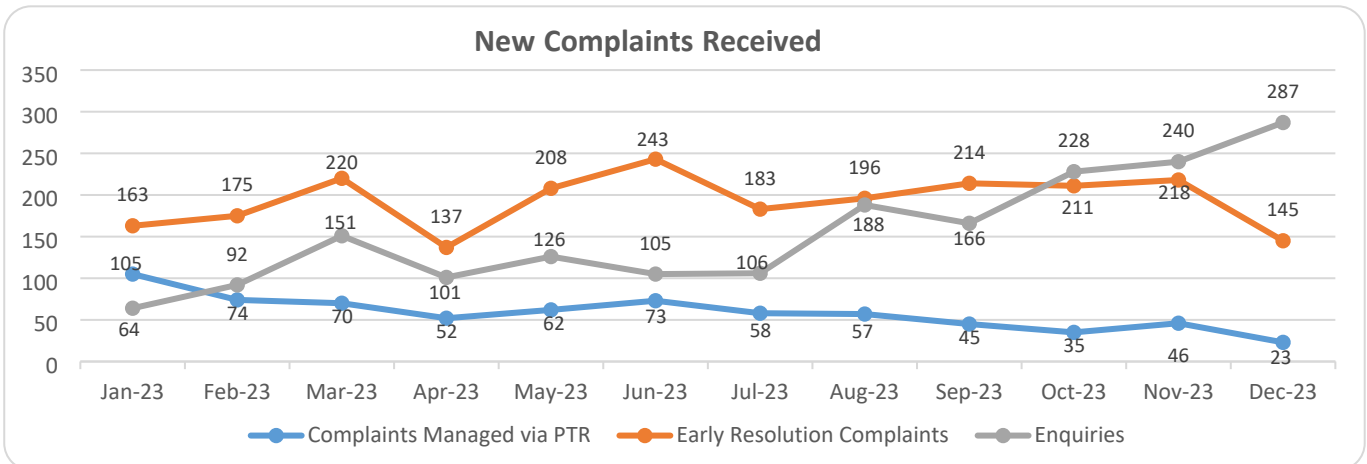
2. Specific Matters for Consideration

2.1 Patient / Service User Feedback

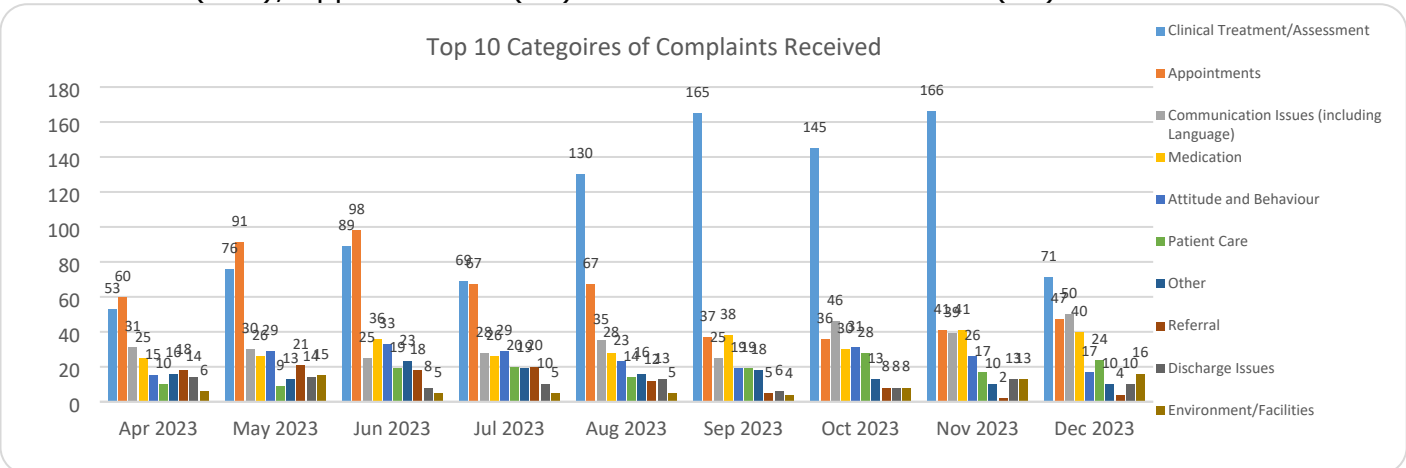
Complaints

New Complaints Received

Between the 01.11.23 and 31.12.23 the Health Board received a total of 432 complaints. Of these, 69 were categorised as formal and managed under the Putting Things Right Regulations (PTR). This represents a continuation of the decrease in the number of formal complaints highlighted in the last report to Committee. The decrease in complaints is reflective of embedding of the improved triage process, realignment of the recording of complaints relating to Primary Care, in line with the All Wales process, and proactive management of queries relating to waiting times. This is also reflective, along with the embedding of the Patient Advocacy Liaison Service (PALS), in the increase in the number of enquiries logged. The trend in relation to the management of feedback being received is reflected in the chart below.

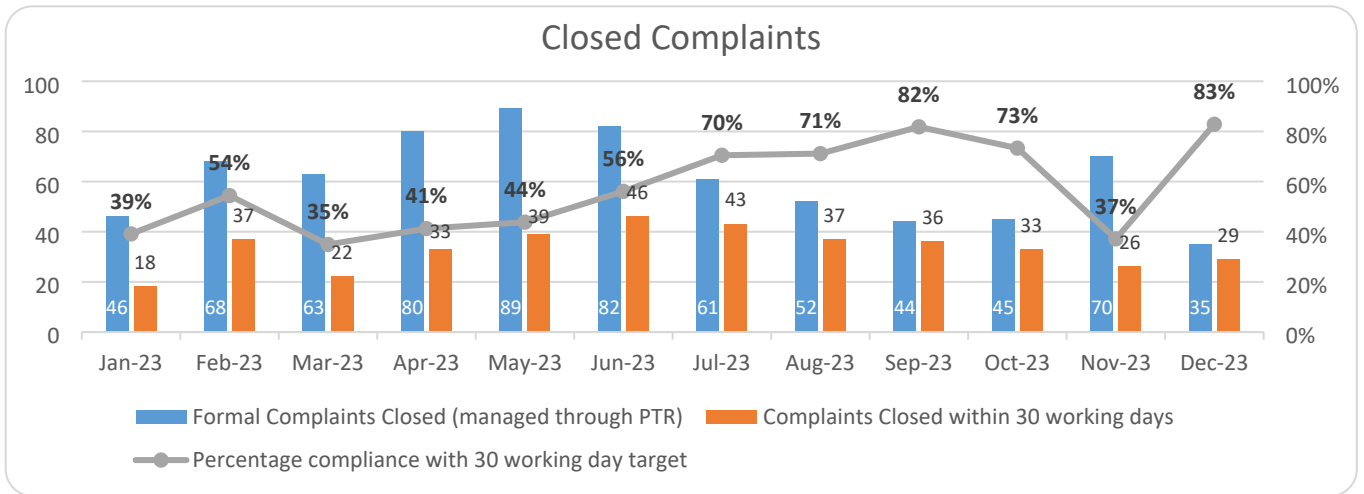


For all complaints received in November and December 2023, the top 3 types of complaints received remain consistent with previous months. These relate to Clinical Treatment / Assessment (237), Appointments (88) and Communication Issues (89).



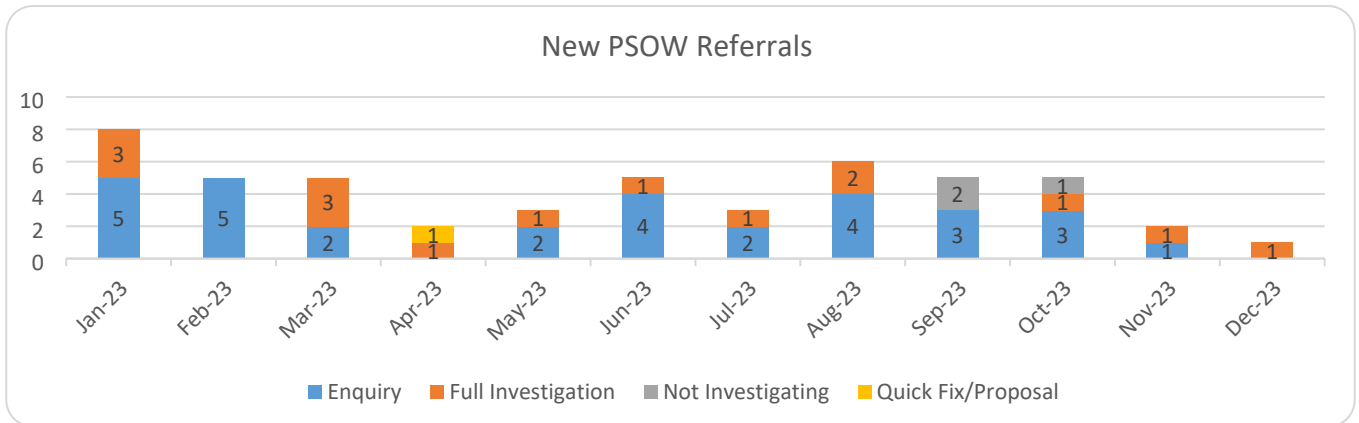
Closed Complaints

Within the period of 01.11.23 to 31.12.23, the Health Board closed a total of 105 formal complaints (managed through PTR). 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. As at 03.01.24, the Health Board had 45 open formal complaints. Of these, 10 complaints were open over 30 working days.

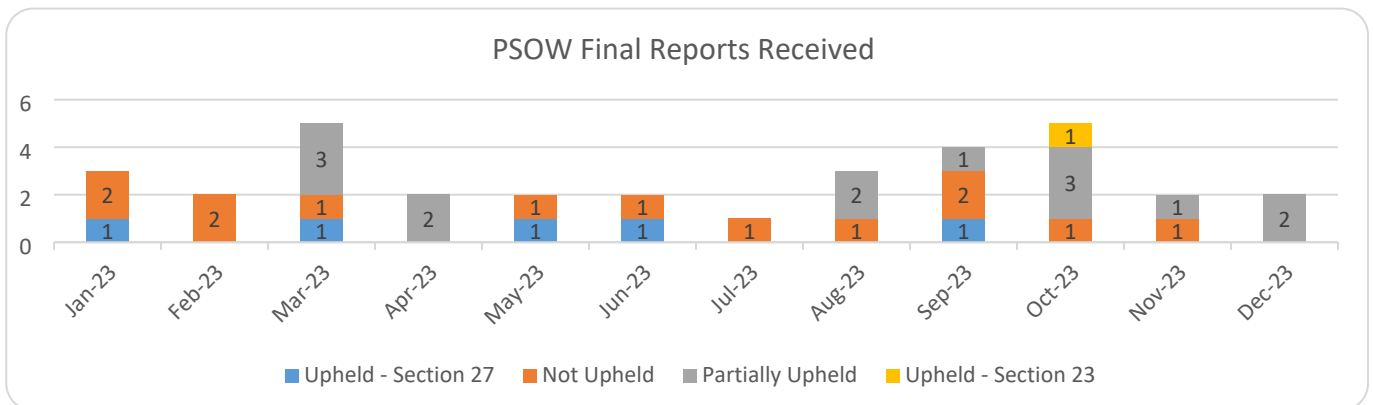


Public Services Ombudsman for Wales

The Health Board received notification of 3 new referrals to the Public Services for Ombudsman for Wales (PSOW) between 01.11.23 and 31.12.23. This remains relatively consistent with previous months. Of the 3 referrals, 2 were received as a full investigation and 1 as an enquiry.



During the same period, the PSOW issued 4 final reports to the Health Board, 3 were partially upheld and 1 was not upheld.



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

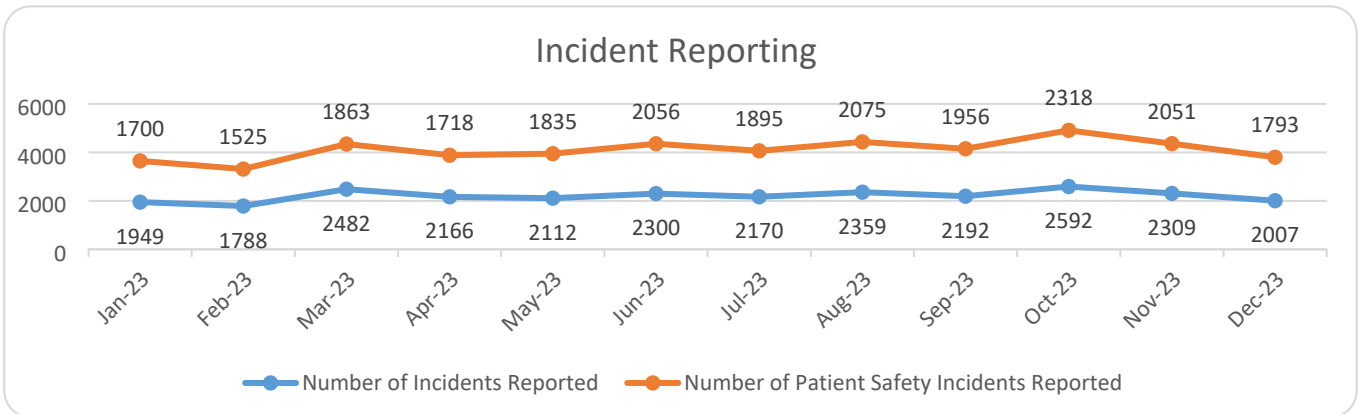
		Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Total
Diagnostics, Therapies and Specialist Care	Not Upheld	0	0	0	0	1	0	0	0	0	1
	Upheld	0	1	0	0	0	0	0	0	0	1
	Total	0	1	0	0	1	0	0	0	0	2
Community	Partially Upheld	0	0	0	0	0	0	0	1	0	1
	Total	0	0	0	0	0	0	0	1	0	1
Families and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

As at 03.01.23, the Health Board currently has 45 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 9 of the 45 cases. 9 are at final report stage with actions being implemented by the Care Groups.

2.2 Patient Safety Incidents

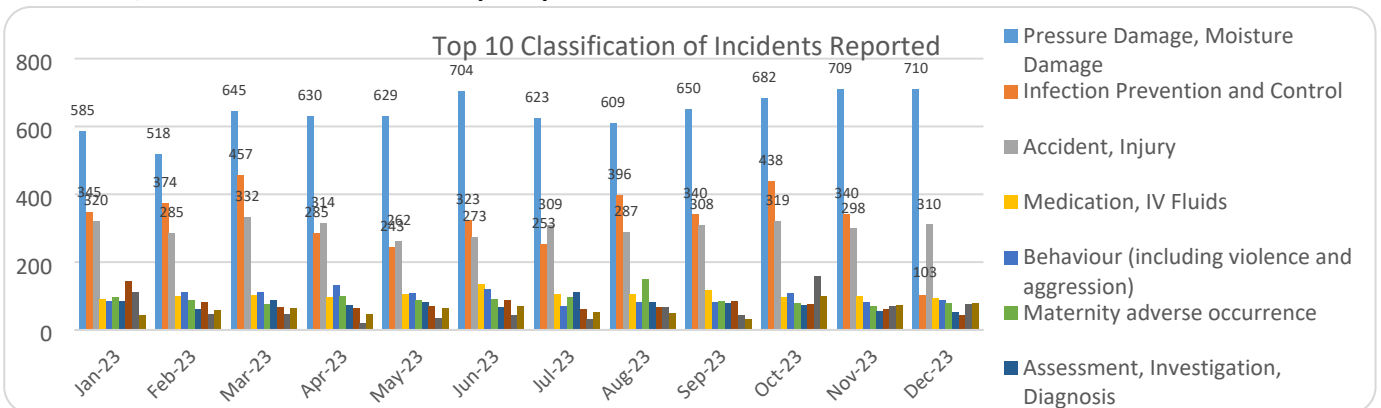
Total Patient Safety Incidents

A total of 4,316 incidents were reported between 01.11.23 and 31.12.23, this represents a decrease of 468 when compared with the previous 2 months (4,784).



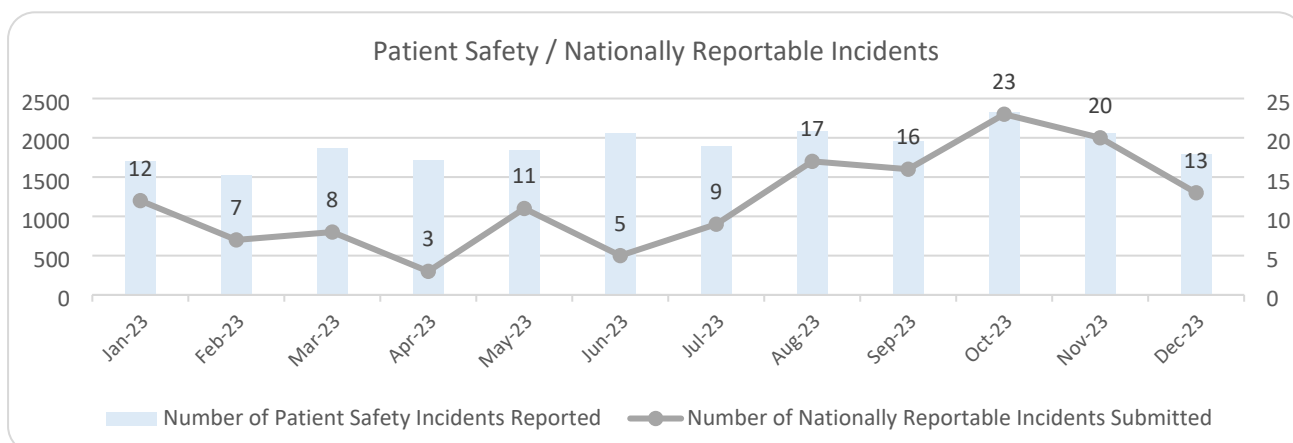
Following a steady decrease between October 2022 and February 2023, the number of incidents reported where the patient is identified as the person affected has remained relatively consistent. Of the 4,316 incidents reported, 89% (3,844) were reported as the patient affected.

The top 3 types of incidents reported for November and December 2023, linked to a patient affected are: Pressure Damage /Moisture Lesion (1,419), Accident, Injury (608) and Infection, Prevention & Control (443).



Nationally Reportable Incidents

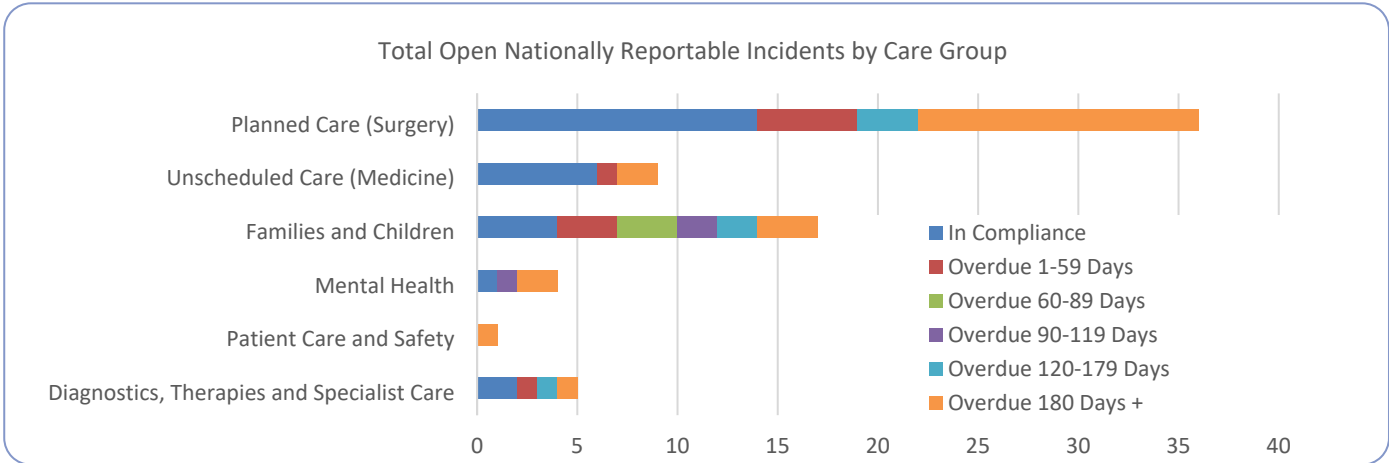
Between 01.11.23 and 31.12.23, 33 Nationally Reportable Incidents were submitted to the NHS delivery unit. The ratio of Nationally Reportable Incidents to the overall number of patient safety incidents is demonstrated in the chart below.



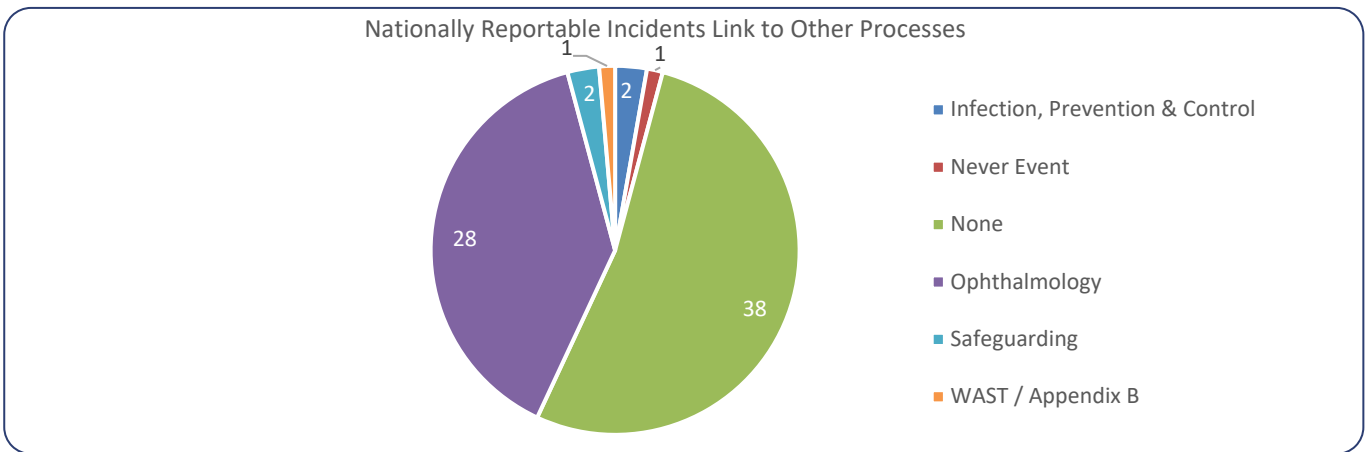
As highlighted in previous reports to Committee, it should be noted that Nationally Reportable Incident data is presented based on the date the notification was submitted to the NHS Executive (formerly known as the "Delivery Unit"). This is reflected in the increase in both January 2023 (12) and May 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 increase in Nationally Reportable Incidents since August 2023 can be attributed to change in reporting requirements for infection, prevention and control related incidents, i.e. outbreaks and ward closures. The trend for the classification of Nationally Reportable Incidents submitted is reflected in the table below:

	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Access, Admission	7	1	5	0	1	0	0	0	1	0	0	1	1	1
Accident, Injury	2	0	0	1	0	0	0	0	0	0	0	0	0	0
Assessment, Investigation, Diagnosis	2	1	0	0	1	0	1	1	2	1	3	0	5	3
Infection Prevention and Control	0	0	0	0	0	0	0	0	0	6	10	13	5	1
Infrastructure (including staffing levels)	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Maternity adverse occurrence	0	1	1	2	1	0	2	0	1	4	0	0	0	1
Medication, IV Fluids	0	1	0	0	0	1	0	0	1	0	0	1	0	0
Patient/service user death	2	0	0	1	1	0	3	1	0	1	0	0	0	0
Pressure Damage, Moisture Damage	1	2	2	2	2	1	5	3	2	5	2	7	8	5
Safeguarding	0	1	1	0	0	0	0	0	0	0	0	0	0	0
Transfer, Discharge	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Treatment, Procedure	0	1	3	0	2	1	0	0	2	0	1	1	0	2
Total	19	8	12	6	8	3	11	5	9	17	16	23	20	13

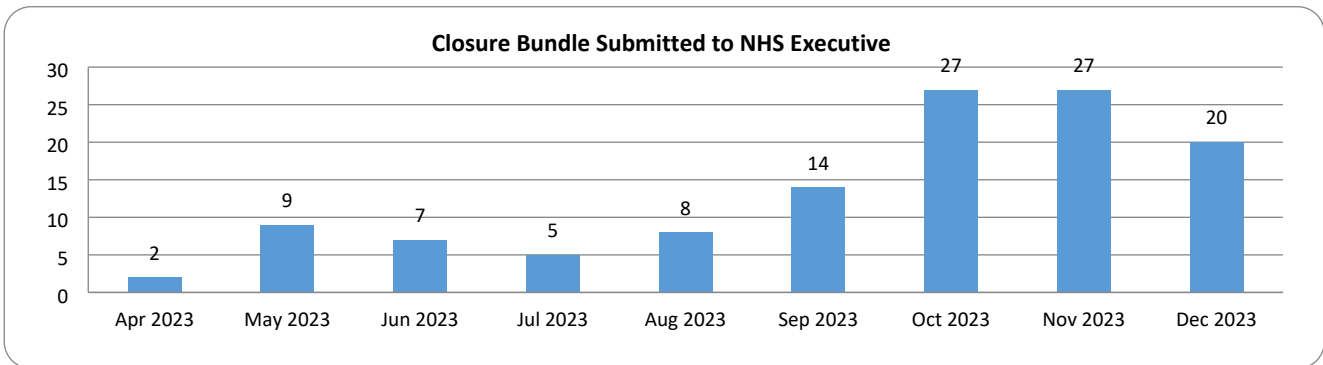
As at the 29.12.23 the Health Board currently has 72 open Nationally Reportable Incidents, of which 45 are overdue the timescale for completion. An overview of the open Nationally Reportable Incidents by Care Group is provided in the chart below:



Of the open Nationally Reportable Incidents, 34 are linked to other processes which are reflected in the chart below:

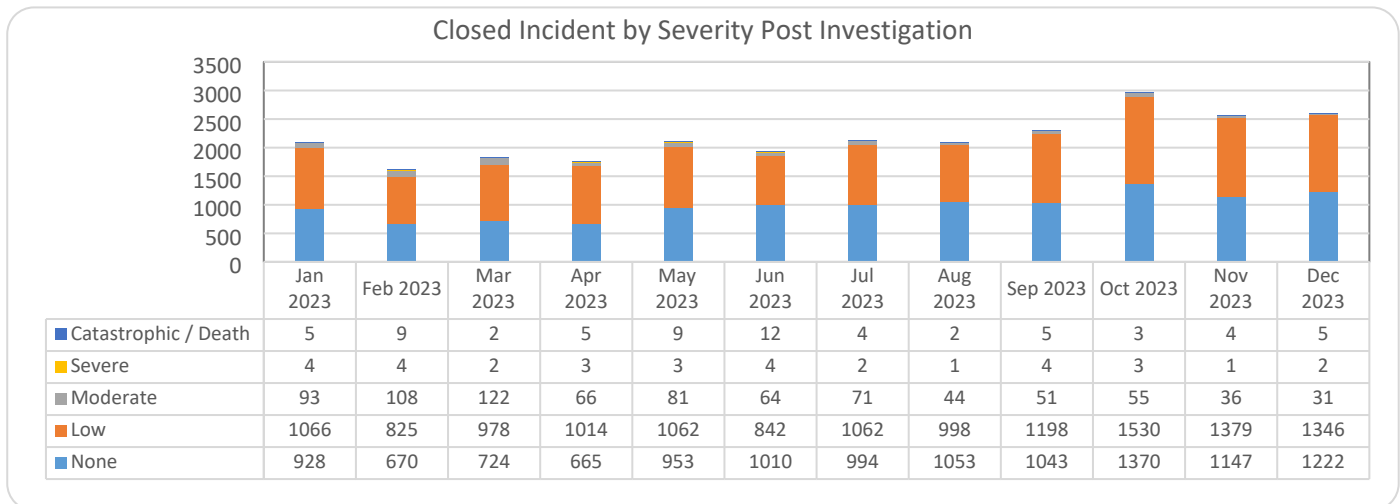


A consolidation exercise of all open Nationally Reportable Incidents was undertaken and a trajectory plan established to address the number of outstanding Nationally Reportable Incidents. This is reflective in the increase in the number of closure bundles submitted since October 2023.



Closed Patient Safety Incidents

Between the 01.11.23 and 31.12.23 a total of 5,173 patient safety incidents were closed. Of the 5,173 patient safety incidents closed, 12 were closed with severity post investigation of severe harm (3) or catastrophic/ death (9). It should be noted, however, that an outcome of catastrophic / death may not be directly caused or attributable to an intervention (action/inaction) by the Health Board (e.g. an unexpected Mental Health death). The 12 month trend is reflected in the table below.



Duty of Candour

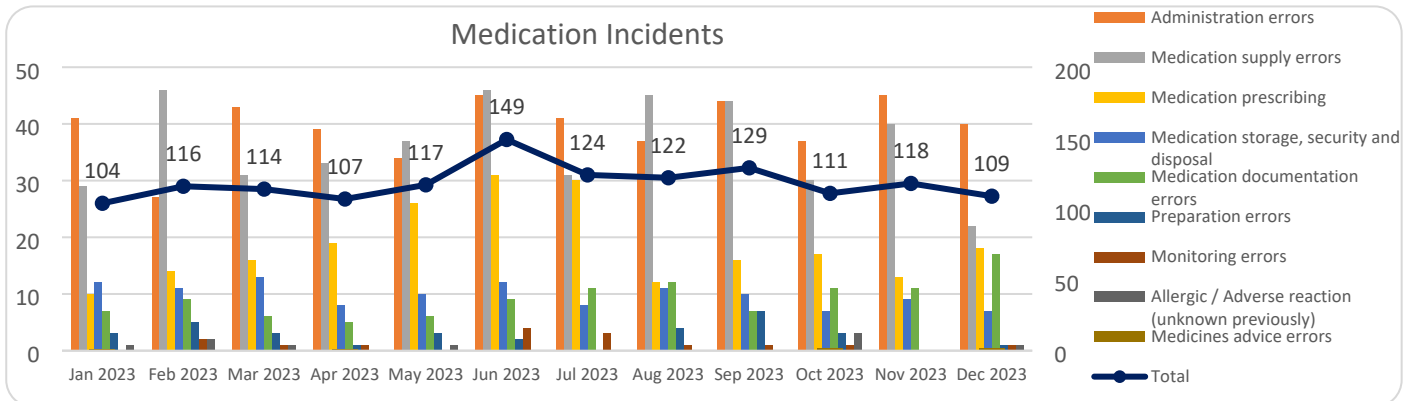
The Duty of Candour regulations were implemented from the 01.04.23. To enable monitoring of requirements, a number of metrics have been devised, which are summarised in the table below. As the implementation of the Duty of Candour progresses, further analysis of the data can be undertaken and included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

Number of Incidents	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023
Occurring during the month	1718	1835	2056	1895	2075	1956	2318	2051	1793
Initial Management Review Completed	1546	1445	1532	1468	1285	1579	1691	1584	1241
Where Duty of Candour Triggered	12	7	12	11	13	8	14	8	1
Where In-person notification completed	5	4	7	4	12	6	11	7	1
Where letter of notification sent	1	3	4	4	8	3	8	5	0

2.3 Specific Quality & Safety Metrics

2.3.1 Medication Safety

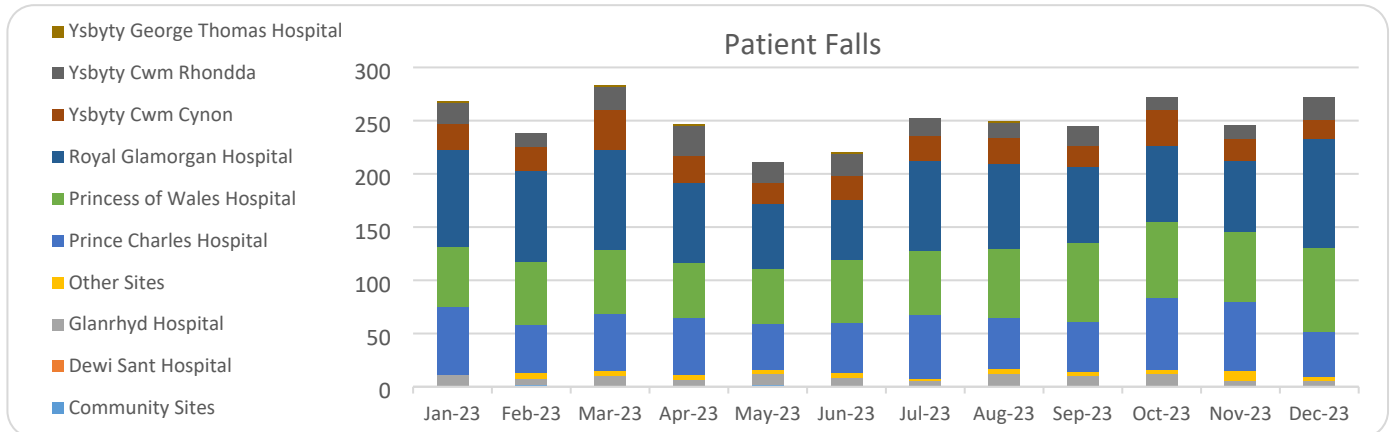
A total of 227 medication incidents were reported as occurring between 01.11.23 and 31.12.23. This is an increase of 13 when compared with the previous 2-month period. Of the total number of medication incidents reported, the top 3 types of medication incidents relate to administration errors (85), supply errors (62), and prescribing (31).



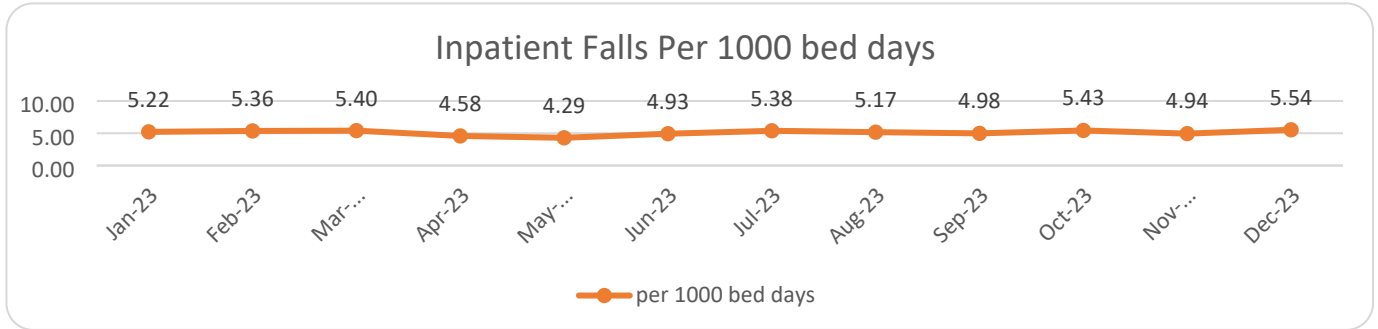
89% of the medication incidents were reported as resulting in no (105) or low (97) harm, with the remaining reported as resulting in moderate harm (18) and severe (7) harm. It should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.

2.3.2 Patient Falls Incidents

A total number of 517 falls, where the person affected was a patient, were reported during November and December 2023. This remains relatively consistent with previous months (a decrease of 4). Of the falls incidents within the time period, 91% were reported as no (141) or low (333) harm. The remaining incidents were reported as moderate (46) and severe (1) harm. No incidents relating to patient falls were reported as resulting in death. Once again, it should be noted that this is the reporter's view of the level of harm and is subject to change following investigation.



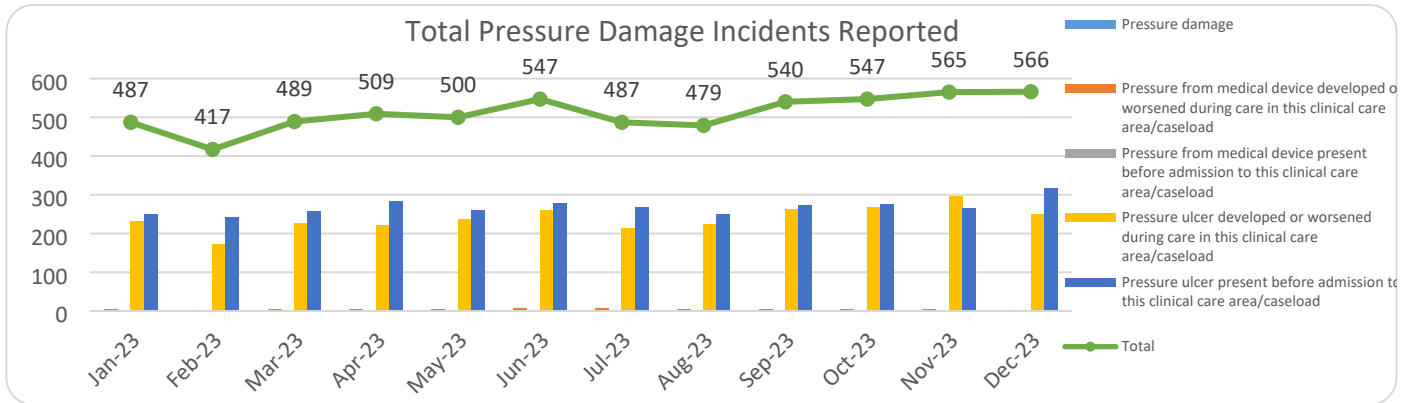
During the time period, the highest number of inpatient falls occurred on Ward 15 at Princess of Wales of Hospital (24), Ward 4, Royal Glamorgan Hospital (16) and the Acute Medical Unit at Princess of Wales Hospital (15).



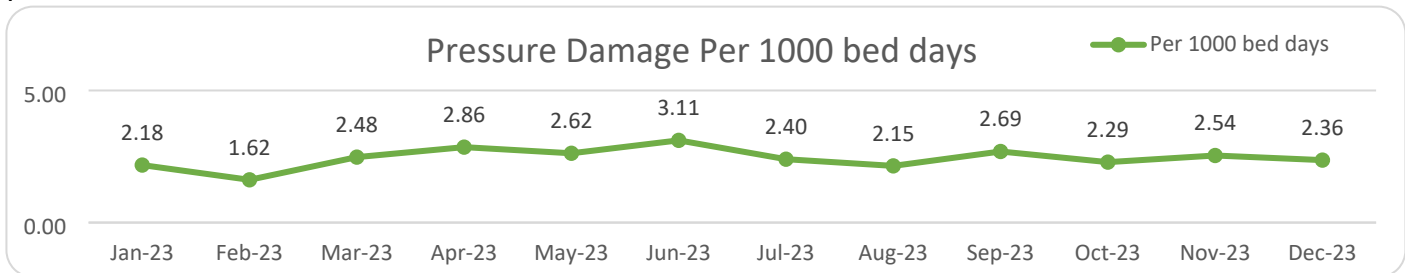
The falls improvement programme continues to implement agreed initiatives to reduce the number of patient falls.

2.3.3 Pressure Damage

Between the 01.11.23 and 31.12.23, a total of 1,131 pressure damage incidents were reported, of which 550 were reported as developing or worsening during the current case load. The remaining pressure damage incidents (581) were reported as being present before admission to this clinical care area/caseload.



Of the 550, identified as developing or worsening during current caseload, 248 were identified as occurring within the community. This represents an increase of 17 when compared with the previous two months.



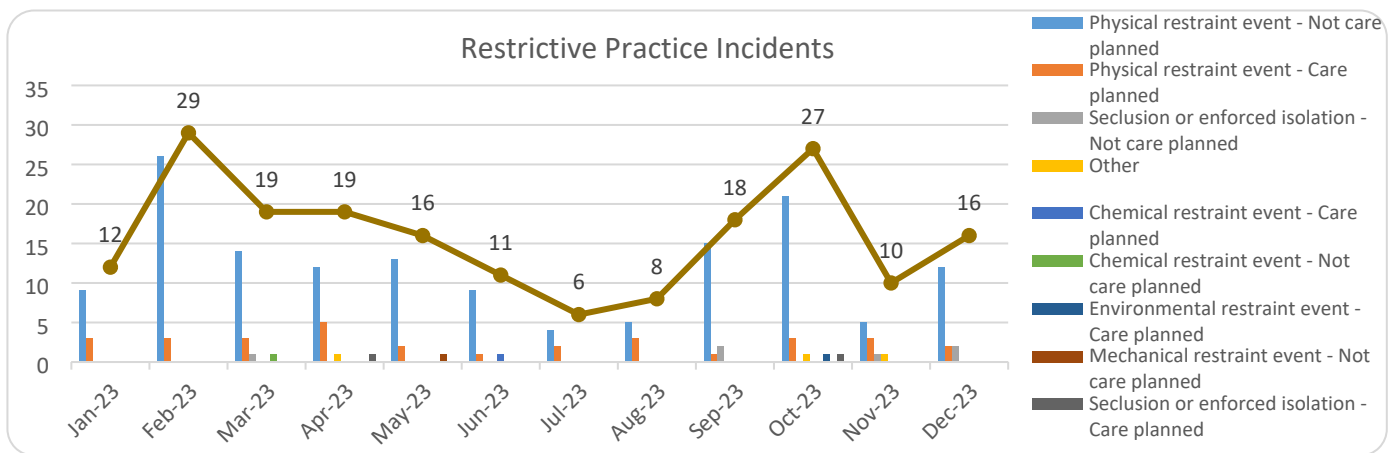
The pressure damage improvement programme continues to progress with a particular focus on grading of pressure damage and completion of required documentation.

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

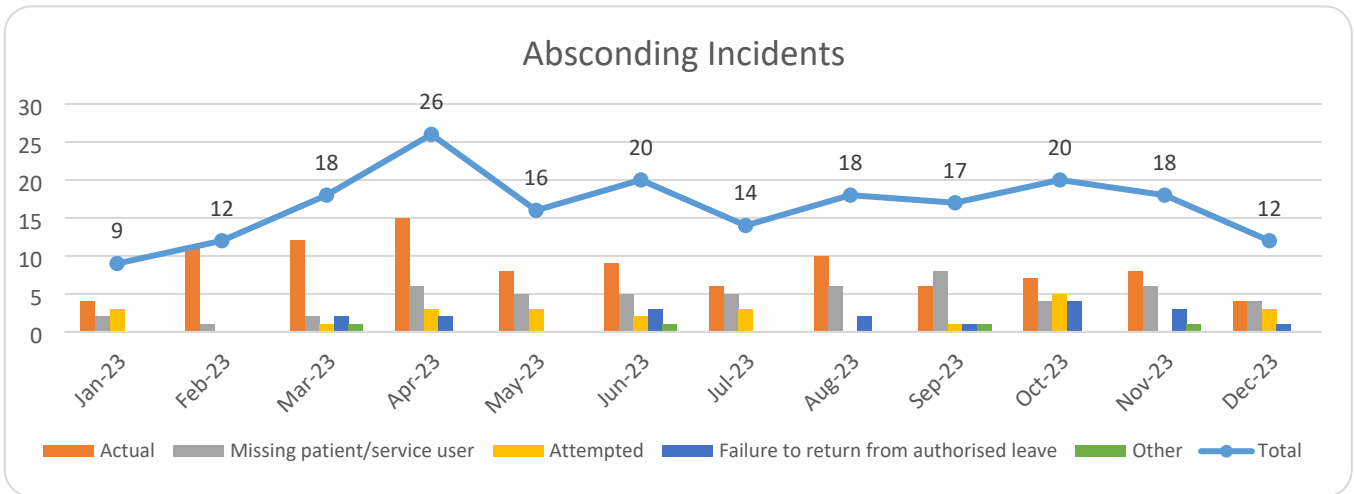


Between 01.09.23 and 31.10.23, a total of 26 incidents relating to using Restrictive Practices were reported within Mental Health. This is a decrease of 19 incidents when compared to the previous two months.

Of the 26 incidents, 20 were reported as not care planned, 5 were reported as care planned and 1 as other. The highest number of incidents were reported as occurring on the Psychiatric Intensive Care Unit at Princess of Wales Hospital (9).

Absconding incidents

During September and October 2023, a total of 30 Absconding incidents were reported, a decrease of 7 when compared with the previous 2-month period. 12 were recorded as actual absconding, with the remaining recorded as missing patient / service user (10), failure to return from authorised leave (4), attempted (3), and other (1). The highest number of incidents were reported as occurring in the Emergency Care Department at Prince Charles Hospital (9).



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)	Choose an item.
	If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome: This report outlines key areas of quality across the Health Board.	If no, please include rationale below:
Cydraddoldeb	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>



<p><i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i></p>	<p>Outcome:</p>	<p>If no, please include rationale below:</p> <p>This is an overarching position report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.</p>
<p>Cyfreithiol / Legal</p>	<p>There are no specific legal implications related to the activity outlined in this report.</p>	
<p>Enw da / Reputational</p>	<p>Yes (Include further detail below)</p> <p>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.</p>	
<p>Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i></p>	<p>There is no direct impact on resources as a result of the activity outlined in this report.</p>	

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 1 - People's Experience Activity Report October - December 2023
Quality & Safety Committee

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Jenny Oliver, Head of People's Experience
Cyflwynydd yr Adroddiad / Report Presenter	Becky Gammon, Assistant Director of Nursing & People's Experience
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director
Pwrpas yr Adroddiad / Report Purpose	For Noting

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

Acronyms / Glossary of Terms			
CTM	Cwm Taf Morgannwg	BAME	Black Asian & Minority Ethnic
PALS	Patient Advisory Liaison Service	POW	Princess of Wales Hospital
RPB	Regional Partnership Board	PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital	USW	University of South Wales

1. Situation /Background

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

2. Specific Matters for Consideration

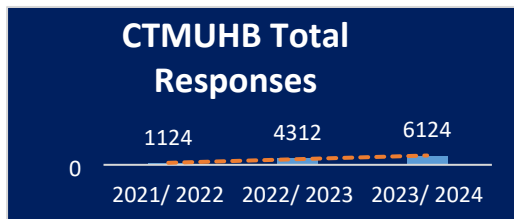
Population Engagement – Key events

People’s Experience Roadshow in conjunction with the Values Based Health Care team was held November 23 which proved very successful and informative. Several stakeholders attended to provide an understanding of the services and support available within hospital and community settings with further engagement events planned across the HB.

An annual Christmas Carol Service, held in December 23 was well received and attended by 75 members of the public. Clinical Bereavement Lead presented at the Health Board safeguarding roadshow to highlight the work undertaken to support ‘care after death’ services supporting staff and families. People’s Experience and Chaplaincy teams supported Baby Loss Awareness Week Wave of Light Service for our service users and staff to attend.

Patient Feedback/Civica system

The patient’s voice is an integral element in driving service improvement, utilising Civica, peoples feedback system which includes Short messaging Service (SMS), text service, paper and quick reader (QR) codes generates reports using qualitative/quantitative data is a key performance driver. Currently there are a total of 40 active surveys across various specialties.



The above graph demonstrates an increase in service user feedback over the last financial year across all 40 surveys, from 1,540 responses in the previous quarter to 3329.

November 1st 23 saw the launch of an All Wales Emergency Department survey. This is generated using the same core questions across every Emergency Department in Wales allowing benchmarking of themes across Wales while supporting local adaptation for other specific questions to be added. Below indicates the data capture across all the Emergency departments in CTM.



Question:	Oct	Nov	Benchmark
4. Did you feel that you were listened to?	88	84	85
5. Were you able to speak in Welsh to staff if you needed to?	21	44	85
6. From the time you realised you needed to use this service, was the time you waited:	58	60	85
7. Did you feel well cared for?	82	79	85
8. If you asked for assistance, did you get it when you needed it?	83	80	85
9. Were the facilities clean (for example the room or trolley)	83	83	85
10. Did you feel you understood what was happening in your care?	85	81	85
11. Were things explained to you in a way that you could understand?	89	86	85
12. Were you involved as much as you wanted to be in decisions about your care?	84	83	85
13. Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	78	74	85
Overall:	80	78	
Respondents:	151	733	

This can be broken down further to each hospital and is shared with the senior teams across unscheduled care (Appendix 1)

Overall satisfaction is showing a slight decline in service user satisfaction from 88% in September 23 to 80 % in December 23. While further interrogation of the data is underway initial results and themes through the qualitative data received is mainly attributed to waiting times and Waiting for discharge. However, it should be noted there are a number of positive comments relating to professionals, helpfulness and kindness of staff. There is a piece of work taking place to review how the themes can be aligned to the quality indicators to aid data analysis against the key themes, Safe, Timely, Equitable, Efficient, Effective and Person centred.

Chaplaincy

Below is a breakdown of the Chaplain services supporting staff through personal issues as well as supporting staff that have been exposed to acute clinical incidents such as paediatric or team bereavements.

Patients	1,112
Relatives/carer's	246
Staff	275

Some examples of patient support is through arranging and coordinating events for events such as Baby Loss Awareness week, Remembrance Day, World Prematurity Day, Annual Memorial services – Llwydcoed, Glanrhyd and YCC.

Bereavement

The HB continues to work towards the Bereavement Framework set by WG and has received feedback from October's return submission. This provides a platform for the services involved (Pathology and People's Experience) to look at how care after-death services are supported going forward.

This role has been instrumental in supporting families and staff who have experienced sudden and traumatic deaths, enabling a more personalised wrap-around service for those who needed extra support at this time. The Welsh Government has now committed to providing funding on a recurrent basis to continue the implementation of the bereavement framework

Volunteers

All three emergency departments are now supported by volunteers, with new volunteers also starting in maternity services in Princess of Wales and Ysbyty Cwm Cynon to support activities with patients. Work continues to explore how the HB can increase our volunteer numbers and the team is seeing this reflected in the number of people attending drop-in information sessions (20 members of the public attended the last session).

Head of People’s Experience is exploring how training in British Sign Language and sensory impairment loss can expand their skills to support patients.

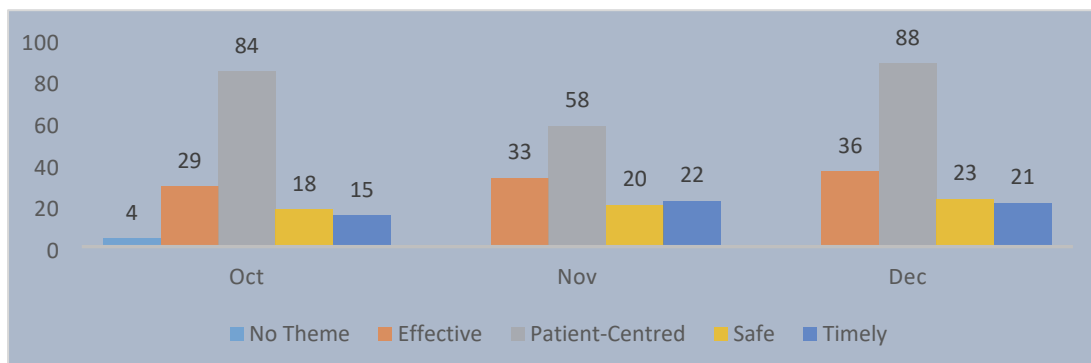
Veterans

Currently CTMU HB has been awarded Bronze accreditation against the Veterans Employer Recognition Scheme and is currently looking to apply for silver recognition.

Patient Advisory Liaison Service (PALS) Team

Teams are now embedded across the whole of the HB, within the three main acute sites, they continue to make excellent progress with contacts with service users resulting in 451 contacts between October and December 23.

The graph below shows the main subject fields detailed on Datix linked to the STEEEP indicators: (safe, timely, efficient, effective, equitable, patient-centred)



Work continues to increase the presence of the PALS service within the HB and communities we support. A meeting is being arranged with LLAIS to introduce the team and look at how we can work collaboratively going forward.

The aim of the service is to pro-actively manage issues before they reach a complaint stage whilst understanding the complexities of how we can support our communities within the different arenas of the CTM 2030 delivery indicators.

Unpaid Carers

The HB successfully appointed a member of staff into the Carer’s Co-Ordinator role who started December 23 funded via the Regional Partnership Board, confirmation that this post will be funded for 2024/25 has been advised, allowing innovating developments in this area, such as recording of data within the electronic nursing records for unpaid carers and how we can utilise this data to provide support and signposting.

3.0 Key Risks / Matters for Escalation

Civica system

In order to gain an accurate insight from the data provided, the Health Board needs an automated structure that will allow the sending of text messages that provide a link to the specific patient survey as soon as a patient has interacted with our services. This, in turn, will increase accessibility and uptake of patient feedback. Currently, there has only been the capacity to automate 9 surveys due to IT and staffing capacity to manage this. This is impacting the amount of data the Health Board is able to receive and utilise.

4. Recommendation

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

5.0 Assessment

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



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

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: If no, please include rationale below: This is an overarching report. If service change arises the specific areas and activity impacted will be subject to the appropriate impact assessment.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: If no, please include rationale below: This is an overarching report. If service change arises the specific areas and activity impacted will



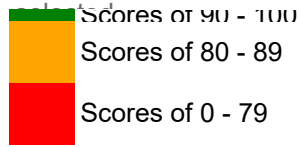
		be subject to the appropriate impact assessment.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	
Enw da / Reputational	Yes (Include further detail below)	
	Activity where performance falls short within the areas that the PALS support may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

Appendix 1

Details of Emergency department data breakdown

Monthly Performance Heat Map

Showing: Survey results for chosen area displayed as a heat map. For twelve months previous to date



Start Date: 12/1/2022 12:00:00 AM

End Date: 11/30/2023 11:59:00 PM

Question:	Survey	2022	2023	2023	2023	2023	2023	2023	#	2023	2023	2023	Benchmark
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	
4. Did you feel that you were listened to?	Emergency	-	-	-	-	-	-	-	-	-	83	80	85
5. Were you able to speak in Welsh to staff if you needed to?	Emergency	-	-	-	-	-	-	-	-	-	7	46	85
6. From the time you realised you needed to use this service, was the time you waited:	Emergency	-	-	-	-	-	-	-	-	-	42	51	85
7. Did you feel well cared for?	Emergency	-	-	-	-	-	-	-	-	-	73	74	85
8. If you asked for assistance, did you get it when you needed it?	Emergency	-	-	-	-	-	-	-	-	-	69	74	85
9. Were the facilities clean (for example the room or trolley)?	Emergency	-	-	-	-	-	-	-	-	-	79	78	85
10. Did you feel you understood what was happening in your care?	Emergency	-	-	-	-	-	-	-	-	-	72	76	85
11. Were things explained to you in a way that you could understand?	Emergency	-	-	-	-	-	-	-	-	-	81	82	85
12. Were you involved as much as you wanted to be in decisions about your care?	Emergency	-	-	-	-	-	-	-	-	-	74	79	85
13. Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency	-	-	-	-	-	-	-	-	-	58	70	85
Overall:	Department	-	-	-	-	-	-	-	-	-	68	73	
Respondents:		0	0	0	0	0	0	0	0	0	29	195	

Questions

4	Did you feel that you were listened to?	Emergency Department Survey
5	Were you able to speak in Welsh to staff if you needed to?	Emergency Department Survey
6	From the time you realised you needed to use this service, was the time you waited:	Emergency Department Survey
7	Did you feel well cared for?	Emergency Department Survey
8	If you asked for assistance, did you get it when you needed it?	Emergency Department Survey
9	Were the facilities clean (for example the room or trolley)?	Emergency Department Survey
10	Did you feel you understood what was happening in your care?	Emergency Department Survey
11	Were things explained to you in a way that you could understand?	Emergency Department Survey
12	Were you involved as much as you wanted to be in decisions about your care?	Emergency Department Survey
13	Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency Department Survey

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Site	Prince Charles Hospital
Locality	Bridgend Locality ,Corporate Function / Operations ,Merthyr & Cynon Locality ,Rhondda & Taff Locality
Service Group	Clinical Support Services ,Community ,Corporate Function / Operations,Estates and Facilities ,Medicine ,Mental Health ,Pharmacy & Medicines Management ,Primary Care - Merthyr & Cynon ,Surgery, Anaesthetics, Theatres and Critical
Specialty	Adult Mental Health ,Corporate Development,Critical Care,Dietetics ,Dispensing Services ,District Nursing,Emergency Care ,Estates and Facilities ,General Medicine,General Surgery ,Gynaecology ,Head & Neck,Nutrition and
Sub specialty	Audiology ,Biochemistry ,Blood Bank ,Breast Care ,Cardio Pulmonary ,Cardiology ,Cellular Pathology ,Colo-rectal ,Community Midwifery,Corporate Development,Crisis Resolution Home Treatment ,Critical Care,CT,CTM SPCT North Hospital

Monthly Performance Heat Map

Showing: Survey results for chosen area displayed as a heat map. For twelve months previous to date

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79



Start Date: 12/1/2022 12:00:00 AM

End Date: 11/30/2023 11:59:00 PM

Location	All Filters Selected
Survey	Emergency Department Survey
Question	All Questions Selected
Response	All Responses Selected
Category	Standard
Start Date	#Error
End Date	#Error

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

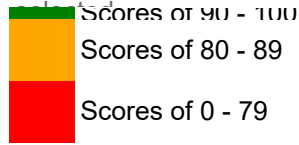
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Question:	Survey	2022	2023	2023	2023	2023	2023	2023	2023	#	2023	2023	2023	Benchmark
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	
4. Did you feel that you were listened to?	Emergency	-	-	-	-	-	-	-	-	-	-	88	82	85
5. Were you able to speak in Welsh to staff if you needed to?	Emergency	-	-	-	-	-	-	-	-	-	-	0	48	85
6. From the time you realised you needed to use this service, was the time you waited:	Emergency	-	-	-	-	-	-	-	-	-	-	58	55	85
7. Did you feel well cared for?	Emergency	-	-	-	-	-	-	-	-	-	-	80	78	85
8. If you asked for assistance, did you get it when you needed it?	Emergency	-	-	-	-	-	-	-	-	-	-	85	79	85
9. Were the facilities clean (for example the room or trolley)?	Emergency	-	-	-	-	-	-	-	-	-	-	82	79	85
10. Did you feel you understood what was happening in your care?	Emergency	-	-	-	-	-	-	-	-	-	-	88	81	85
11. Were things explained to you in a way that you could understand?	Emergency	-	-	-	-	-	-	-	-	-	-	89	86	85
12. Were you involved as much as you wanted to be in decisions about your care?	Emergency	-	-	-	-	-	-	-	-	-	-	85	82	85
13. Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency	-	-	-	-	-	-	-	-	-	-	79	71	85
Overall:	Department	-	-	-	-	-	-	-	-	-	-	80	77	
Respondents:		0	0	0	0	0	0	0	0	0	0	52	242	

Questions

4	Did you feel that you were listened to?	Emergency Department Survey
5	Were you able to speak in Welsh to staff if you needed to?	Emergency Department Survey
6	From the time you realised you needed to use this service, was the time you waited:	Emergency Department Survey
7	Did you feel well cared for?	Emergency Department Survey
8	If you asked for assistance, did you get it when you needed it?	Emergency Department Survey
9	Were the facilities clean (for example the room or trolley)?	Emergency Department Survey
10	Did you feel you understood what was happening in your care?	Emergency Department Survey
11	Were things explained to you in a way that you could understand?	Emergency Department Survey
12	Were you involved as much as you wanted to be in decisions about your care?	Emergency Department Survey
13	Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency Department Survey

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Site	Royal Glamorgan Hospital
Locality	Bridgend Locality ,Corporate Function / Operations ,Merthyr & Cynon Locality ,Rhondda & Taff Locality
Service Group	Clinical Support Services ,Community ,Corporate Function / Operations,Estates and Facilities ,Medicine,Mental Health,Pharmacy & Medicines Management ,Primary Care - Rhondda & Taff,Surgery , Anaesthetics ,Theatres and Critical
Specialty	Adult Mental Health ,Corporate Development,Critical Care,Dietetics ,Dispensing Services ,District Nursing,Emergency Department,Estates and Facilities ,General Medicine,General Surgery ,Gynaecology ,Head & Neck,HSDU,Nutrition and
Sub specialty	Audiology ,Biochemistry ,Blood Bank ,Breast ,Breast Care ,Cardio Pulmonary ,Cardiology ,Cellular Pathology ,Colo-rectal ,Community Midwifery,Corporate Development,Crisis Resolution Home Treatment ,Critical Care,CT,Dermatology

Monthly Performance Heat Map

Showing: Survey results for chosen area displayed as a heat map. For twelve months previous to date

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79



Start Date: 12/1/2022 12:00:00 AM

End Date: 11/30/2023 11:59:00 PM

Location	All Filters Selected
Survey	Emergency Department Survey
Question	All Questions Selected
Response	All Responses Selected
Category	Standard
Start Date	#Error
End Date	#Error

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

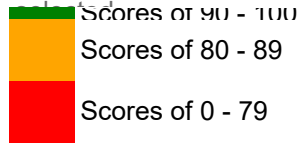
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End Date: 11/30/2023 11:59:00 PM

Question:	Survey	2022	2023	2023	2023	2023	2023	2023	2023	#	2023	2023	2023	Benchmark
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	
4. Did you feel that you were listened to?	Emergency	-	-	-	-	-	-	-	-	-	-	90	87	85
5. Were you able to speak in Welsh to staff if you needed to?	Emergency	-	-	-	-	-	-	-	-	-	-	34	49	85
6. From the time you realised you needed to use this service, was the time you waited:	Emergency	-	-	-	-	-	-	-	-	-	-	62	68	85
7. Did you feel well cared for?	Emergency	-	-	-	-	-	-	-	-	-	-	88	83	85
8. If you asked for assistance, did you get it when you needed it?	Emergency	-	-	-	-	-	-	-	-	-	-	89	85	85
9. Were the facilities clean (for example the room or trolley)?	Emergency	-	-	-	-	-	-	-	-	-	-	83	88	85
10. Did you feel you understood what was happening in your care?	Emergency	-	-	-	-	-	-	-	-	-	-	89	83	85
11. Were things explained to you in a way that you could understand?	Emergency	-	-	-	-	-	-	-	-	-	-	93	88	85
12. Were you involved as much as you wanted to be in decisions about your care?	Emergency	-	-	-	-	-	-	-	-	-	-	87	84	85
13. Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency	-	-	-	-	-	-	-	-	-	-	87	78	85
Overall:	Department	-	-	-	-	-	-	-	-	-	-	85	82	
Respondents:		0	0	0	0	0	0	0	0	0	0	51	203	

Questions

4	Did you feel that you were listened to?	Emergency Department Survey
5	Were you able to speak in Welsh to staff if you needed to?	Emergency Department Survey
6	From the time you realised you needed to use this service, was the time you waited:	Emergency Department Survey
7	Did you feel well cared for?	Emergency Department Survey
8	If you asked for assistance, did you get it when you needed it?	Emergency Department Survey
9	Were the facilities clean (for example the room or trolley)?	Emergency Department Survey
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11	Were things explained to you in a way that you could understand?	Emergency Department Survey
12	Were you involved as much as you wanted to be in decisions about your care?	Emergency Department Survey
13	Using a scale of 0 – 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?	Emergency Department Survey

Available Filters:

Note: The available filter selection is dependent on the report that is being generated.

Filter Option	Selection
Site	Princess of Wales Hospital
Locality	Bridgend Locality ,Corporate Function / Operations ,Merthyr & Cynon Locality,Rhondda & Taff Locality
Service Group	Clinical Support Services ,Community ,Corporate Function / Operations,Estates and Facilities ,Facilities ,Medicine,Mental Health ,Pharmacy & Medicines Management ,Surgery, Anaesthetics, Theatres and Critical Care,Therapies,Unscheduled
Specialty	Adult Mental Health ,CAMHS ,Care of the Elderly ,Catering,Corporate Development,Critical Care,Dietetics ,Dispensing Services ,Emergency Care ,Estates and Facilities ,General Medicine,General Surgery,Gynaecology,Head &
Sub specialty	CAMHS,Cardiology ,Care of the Elderly ,Catering,Community Mental Health Team,Corporate Development,Critical Care,Dermatology ,Diabetes,Dietetics ,Dispensing Services ,Emergency Care ,Endoscopy,Estates and Facilities ,General

Monthly Performance Heat Map

Showing: Survey results for chosen area displayed as a heat map. For twelve months previous to date

Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79



Start Date: 12/1/2022 12:00:00 AM

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Location	All Filters Selected
Survey	Emergency Department Survey
Question	All Questions Selected
Response	All Responses Selected
Category	Standard
Start Date	#Error
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Scores of 90 - 100

Scores of 80 - 89

Scores of 0 - 79

Start Date: 12/1/2022 12:00:00 AM

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Agenda Item

7.2

Quality & Safety Committee

Highlight Report from the Emergency Ambulance Services Committee

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public
	Not Applicable
Awdur yr Adroddiad / Report Author	Stephen Harrhy, Chief Ambulance Services Commissioner
Cyflwynydd yr Adroddiad / Report Presenter	Stephen Harrhy, Chief Ambulance Services Commissioner
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Stephen Harrhy, Chief Ambulance Services Commissioner

Pwrpas yr Adroddiad / Report Purpose	For Noting
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)

Committee / Group / Individuals	Date	Outcome
CTMUHB Board Development Session	19/10/2023	Noted

Acronyms / Glossary of Terms

ACCTS	Adult Critical Care Transfer Services
APP	Advanced Paramedic Practitioner
CAREMORE	Care Standards; Activity; Resource Envelope; Models of care; Operational arrangements; Review of performance and Evaluate
CHARU	Cymru High Acuity Response Unit
EASC	Emergency Ambulance Services Committee
EMS	Emergency Medical Services (emergency ambulance)



NEPTS	Non-Emergency Patient Transport Service
ICAP	Integrated Commissioning Action Plans (HBs and WAST)
IMTP	Integrated Medium Term Plan
PRU	Physician Response Unit
SDEC	Same Day Emergency Care
WAST	Welsh Ambulance Services NHS Trust

1. Introduction

- 1.1 This report has been prepared to provide assurance to the Quality and Safety Committee with updated details of the key issues considered at the CTMUHB Board Development session on 19 October 2023.
- 1.2 The Emergency Ambulance Services Committee (EASC) is a Joint Committee of all health boards which is hosted by CTMUHB.
- 1.3 Key highlights from the meeting are reported in section 3.

2. Purpose of this Meeting

- 2.1 The purpose of the EASC is to plan and secure sufficient ambulance services for the people of Wales.
- 2.2 The EASC Standing Orders are included as Schedule 4.2 of the CTMUHBs version.
- 2.3 The Joint Committee's role is to:
 - Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
 - Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services
 - Produce an Integrated Medium-Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans
 - Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the EASC Team) in accordance with any specific directions set by the Welsh Ministers
 - Establish mechanisms for managing the commissioning risks;
 - Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.



3. Highlight Report

Alert / Escalate	<p>Discussed in detail at the Board Development session held on 19 October 2023 which included performance and quality & safety perspectives:</p> <ul style="list-style-type: none"> • Red and Amber performance. Of particular note within the dashboard for the latest reporting period (October): <ul style="list-style-type: none"> - 999 call volumes in October 2023 were 7.7% lower than October 2022 - 7.4% reduction in incidents in October 2023 compared to October 2022 - Hear and Treat levels are 2.3% higher in October 2023 compared to October 2022 - Red incidents in October 2023 were 7.8% higher compared to October 2022. - Amber incidents in October 2023 were 6.1% higher compared to October 2022. • Hours lost to handover delays <ul style="list-style-type: none"> - Ambulance handover lost hours in October 2023 are 19.8% lower compared to October 2022. Some improvements on a number of metrics, % handed over in 15 min and handovers over 4 hours have been seen in 2023 but between September 2023 and October 2023 there has been a 18.4% increase in handover lost hours. - Since July 2023, the total cumulative handover lost hours have continued to increase month on month. In September 2023, the total ambulance lost hours were 19,617. - To note, the EASC IMTP performance ambition for ambulance handover delays, were <ul style="list-style-type: none"> - 15,000 lost hours by the end of Q2 and - 12,000 lost hours by the end of Q3. <p>Additionally, the 2019 EMS Demand and Capacity Review was predicated on 6,000 lost hours per month.</p>
Advise	<p>Key areas of work for the EASC Team include:</p> <p>Integrated Commissioning Action Plan (ICAP)</p> <ul style="list-style-type: none"> • Coordination of meetings between health boards and WAST – range of matters but primarily to improve performance and address quality and safety concerns for patients • Development of a handover delay improvement trajectory aligned to the actions set out in the ICAP • Delivery of actions set out in ICAP • Build relationships between health boards and WAST • Shared learning opportunities from ICAP <p>Commissioning</p> <ul style="list-style-type: none"> • Reviewing options to support seasonal variation



	<ul style="list-style-type: none"> • CTMUHB Critical Care Reconfiguration Programme ambulance requirements (EASC, WAST & ACCTS) • Review of Non-Emergency Patient Transport Service Commissioning Framework aligned to IMTP's • Ongoing engagement regarding the Review of the Emergency Medical Retrieval and Transfer Service (EMRTS) (Air Ambulance) • Expansion of Cymru High Acuity Response Unit (CHARU) aligned to the Red Improvement Plan (Performance) • Portering services for EMS handovers and NEPTS stretcher patients • ED Conveyance alternatives: <ul style="list-style-type: none"> - Navigation Hub - Same Day Emergency Care (SDEC) - Advanced Paramedic Practitioners (APPs) - Physician Response Unit (PRU) • Analysis of CTM Ambulance demand through the lens of deprivation and demographics • Focus on Care Homes and people who have fallen • Connected Support Cymru
Assure	<ul style="list-style-type: none"> • Quality and Safety Report received at every EASC meeting; latest reports available here: https://easc.nhs.wales/the-committee/current-and-past-papers/december-2023/ • Latest Quality and Safety Dashboard utilising Quality Domains here: https://easc.nhs.wales/the-committee/current-and-past-papers/december-2023/2-2-1-quality-and-safety-dashboard/ • All Wales Data shared across the whole system on a daily, weekly and monthly basis
Inform	<ul style="list-style-type: none"> • Commissioning process includes – use of Quality and Delivery Frameworks (using CAREMORE) for all Commissioned Services – 5 Step Care Model https://easc.nhs.wales/commissioning/wast-collaborative-commissioning-and-model/ • Annual Commissioning Intentions developed https://easc.nhs.wales/the-committee/current-and-past-papers/december-2023/2-3-1-ems-commissioning-intentions-2024-25/ • CTMUHB have over 80 active Community First Responders with recruitment and training ongoing • Development of EASC Integrated Medium Term Plan for 2024 – 2027 in progress
Appendices	Nil

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 <i>150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)</i>	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Whole-systems Perspective
	If more than one applies please list below: Data to Knowledge
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Effective
	If more than one applies please list below: Efficient; Equitable; Person centred; Timely and 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 Quality and Safety Committee is asked to **NOTE** the highlights outlined in section 3 of this report.



Agenda Item

7.3

Quality & Safety Committee

CTM Quality Strategy Work Plan Update

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Melanie Barker – Assistant Director of Therapies and Health Science
Cyflwynydd yr Adroddiad / Report Presenter	Lauren Edwards – Executive Director of Therapies and Health Science
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Lauren Edwards, Executive Director of Therapies & Health Science

Pwrpas yr Adroddiad / Report Purpose	For Noting
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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

CTM	Cwm Taf Morgannwg University Health Board
ELG	Executive Leadership Group
SOP	Standard Operating Procedure
AHP	Allied Health Professionals
HCS	Healthcare Scientists



1. Situation /Background

- 1.1 CTM's Quality Strategy sets out our quality ambitions and our quality goals, structured around the six dimensions of quality for 2022-25.
- 1.2 Within the Quality Strategy is the commitment to devise an Annual Quality Work Plan to focus our efforts on the delivery of SMART quality objectives.
- 1.3 The Quality Strategy states that identification of these annual objectives will be data-driven and risk-stratified to ensure a targeted approach to improving quality.
- 1.4 Within the Quality Strategy our 6 inter-dependant quality ambitions are based on the 6 dimensions of quality and shape our strategic quality goals. These in turn provide the framework for our Annual Quality Work Plan, containing SMART objectives against which we monitor and report our progress at regular intervals, adjusting our plans as required. Where appropriate, priorities have been mapped against NHS Wales Performance Framework & Guidance Document 2022-23.
- 1.5 At ELG on the 2nd October, a discussion was held, revisiting the ambitions of the Quality Strategy and a draft template shared which had been designed to capture both current and planned delivery of key metrics, helping to inform both progress to date and to identify the work plan for 2024.
- 1.6 Following discussions at ELG, the template to inform the Quality Strategy Work Plan was reformatted and shared with the Chairs of each of the four CTM2030 Boards, with a request to capture targets against which they would be measuring progress against the ambitions of the Quality Strategy. Deadline for returns was the 30th November.
- 1.7 The intention being that following submissions, returns would be collated into a Quality Strategy Work Plan to help us understand what is currently being delivered and what is planned to be delivered in years 2/3. This would also identify any gaps where further work is needed to identify suitable metrics to demonstrate delivery.
- 1.8 Initial responses to the request for data were limited, with colleagues suggesting that this may be duplicating requests for data that was already provided and available. The update on progress has therefore been drawn from a range of sources e.g. email updates, performance reports, and committee presentations.

2. Specific Matters for Consideration

- 2.1 The purpose of this paper is to update the Committee on the development of the work plan, identification of annual objectives, and progress against delivery.
- 2.2 The Committee is asked to note progress against delivery to date and future plans.
- 2.3 The Committee is asked to note that there are areas where progress is underway but where evidence was not available on this occasion. Work will continue to seek evidence in an efficient and comprehensive way.



2.4 The complete Annual Quality Work Plan can be found in the appendix of this document but a snapshot of progress for each of the 6 dimensions of quality is outlined in the tables below.

2.5

Quality Ambition	SAFE CARE	
Strategic Quality Goals	<ul style="list-style-type: none"> Develop and empower our colleagues to deliver outstanding care. Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Learning Framework 	
Our True North	<ul style="list-style-type: none"> No avoidable harm (e.g. from falls, pressure ulcers, medication errors) A Just and Restorative Culture across CTM Complaints, inquests, claims and external reviews receive prompt and robust responses. All learning is swiftly embedded with assurance regarding sustainability. 	
Journey to Success	Metric Being measured	Progress
Relaunch of Falls Strategy	<ul style="list-style-type: none"> Recruitment progressing to Falls Programme posts. Training, induction and project work progressing Following a period of co-production the initial phased roll out of Falls Programme has been designed alongside service users in our communities 	In Progress
Launch of Just and Restorative programme, with visible Board level and senior leadership support	Executive lead identified; work streams established (Understanding Data; Education and Training; Policy and Procedures); delivery meetings have commenced; robust governance structure established with reporting mechanisms.	Delivered. Ongoing
Positive feedback from colleagues	Programme of events completed to increase NHS Staff Survey completion within CTM.	In progress – awaiting results
	Established Staff Recognition Programme	Delivered. Ongoing

2.6

Quality Ambition	TIMELY CARE	
Strategic Quality Goals	<ul style="list-style-type: none"> Improve access to urgent and emergency care. Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes. 	
Our True North	<ul style="list-style-type: none"> Everybody receives prompt care in the most appropriate setting and from the most appropriate person Our acute hospitals experience no ambulance handover delays, no delays for assessment and admission, and no delayed discharges 	



	<ul style="list-style-type: none"> Everybody on our waiting lists is optimised to achieve the best possible outcomes (waiting well, patient activation, prehab) 	
Journey to Success	Metric Being measured	Progress
↑ advanced and consultant practitioners (nursing, AHP, healthcare science, pharmacy, physician's associates)	Baseline data collected regarding ACPs in post across CTM. Advanced Clinical Practice SOP and Processes in place. Panels for portfolio ratification scheduled.	In Progress
Regional solutions for pathology and radiology	Regional Pathology Project actively working towards regional solutions for cellular pathology in collaboration with ABUHB and CVUHB. Regional radiology and endoscopy solutions being developed for Llantrisant Health Park.	In Progress
Successful delivery of Planned Care Recovery & transformation programmes	Acute Clinical Services Plan in development. Significant clinical engagement. Associated governance structure in place.	In progress
Project to review services for: long-term conditions; rehabilitation; reablement	Long Term Conditions - CTM AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health, My Way' – this programme builds on existing services, enhancing a needs-based approach, where patients can access help when and where they need it, for complex long term conditions.	In Progress

2.7

Quality Ambition	EFFECTIVE CARE
Strategic Quality Goals	<ul style="list-style-type: none"> Develop evidence-based models of care with our partners, making the most effective use of skills and resources. Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't
Our True North	<ul style="list-style-type: none"> Consistent use of Friends and Family Test (FFT), PROMs and PREMs across our physical health and mental health services All services developments informed by data and evidence (clinical and non-clinical) Continuous development and transformation of our people



Journey to Success	Metric Being measured	Progress
Feedback data shared with teams to ensure a clear understanding of what works well and opportunities for improvement	PDR – Your Conversation compliance is currently 62.60%. This is +0.58% on the previous month. PDR – Your Conversation compliance is +5.69% year on year, showing the impact that the new process and links to pay progression are having.	In Progress
Increased QI skills and capacity across services	Target to increase Simply Do Users by March 24. Target: 1250, Current 1131. Target to increase Simply Do Ideas completed by March 2024. Target: 20, Current: 31.	In Progress
Increased working with our academic partners	Data available to support more education activity, particularly in relation to Pharmacy student undergraduate placements, and specific work with USW re closer partnership working. Exec attendance at HEI Partnership Meetings.	In Progress
Consistent improvement in training compliance	Health Board compliance for all levels of training currently sits at 68.86%. This is +0.80% on the previous month and +7.50% year on year. Compliance for level 1 currently sits at 77.67%. This is +0.73% on the previous month and +8.46% year on year	Delivered in year. Ongoing monitoring.
Increased uptake of leadership courses	CTM AHP and HCS University of South Wales leadership course developed and running Nov 23-June 24. CTM leadership courses Ignite, Aspire and Inspire continue to run. Dec 23: total registrations 1,024; total active learners 903; conversion rate 71%.	Delivered. Ongoing

2.8

Quality Ambition	EQUITABLE CARE
Strategic Quality Goals	<ul style="list-style-type: none"> • New models of care are designed using population health data and reflect local need. • We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.
Our True North	<ul style="list-style-type: none"> • Population health data informs our service developments • High engagement with vaccination campaigns across all geographical locations within CTM • Low levels of smoking and obesity across our footprint • Equitable health outcomes for people experiencing mental ill health



Journey to Success	Metric Being measured	Progress
↑ percentage of adults losing clinically significant weight through the All Wales Weight Management Pathway	The Adult Weight Management Service is now active and offering intervention for level 2 and 3 of the All Wales Weight Management Pathway. To date, 443 patients have been offered an intervention.	In Progress
↑ Type 2 Diabetes prevention work	Agreement of a joint programme of work with Public Health Wales covering primary, secondary and tertiary prevention areas. Engagement with the Internal and External Stakeholder Groups, chaired by the Medical Director Engagement with the Diabetes Project in the Value Based Health Care programme	In progress
↑ Population Health Management approaches	PHM workshop held with good engagement. Workshop explored barriers and opportunities 48/49 GP practices have signed up to share data that allows them to see the number and identities of patients in each segment and their risk profile to enable intervention. Presentation to the National NHS Inequalities Board in December 2023 to gain agreement on key definitions of PHM and support to build core PHM capabilities.	In Progress

2.8

Quality Ambition	EFFICIENT CARE	
Strategic Quality Goals	<ul style="list-style-type: none"> • Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste. • Support our colleagues to stay well and reduce agency use across CTM. 	
Our True North	<ul style="list-style-type: none"> • High-quality information and education supports people to stay well and/or seek early • Low reliance on agency staff • A highly skilled support workforce 	
Journey to Success	Metric Being measured	Progress
Relaunch of the FAST campaign to support early recognition of stroke symptoms	FAST campaign relaunched across Wales In April 2023.	Delivered
Project SEARCH Interns transitioning to paid employment.	Total employed/volunteering: 28 Total Interns to date in CTM: 36	In Progress



Annual ↑ in support staff workforce who have completed level 1 competencies of the Core Skills and Training Framework	Level 1 Compliance for Equality, Diversity & Human Rights remains the highest at 84.26% followed closely by Health, Safety and Welfare at 83.10% and Safeguarding Children at 83.10%. All subjects (apart from Resuscitation) are now above 75%. Focus across the HB needs to be provided to improve Resuscitation Training which is at 57.08%.	In Progress
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2.9

Quality Ambition	PERSON-CENTRED CARE	
Strategic Quality Goals	<ul style="list-style-type: none"> Increase co-production across CTM, delivering care that is responsive to people's needs and wishes. Reduce variability in how well we engage and support carers. 	
Our True North	<ul style="list-style-type: none"> Care is designed in partnership with patients and their families Care is always personalised 	
Journey to Success	Metric Being measured	Progress
Bereavement and dying well service developments	CTM appointed a Clinical Bereavement Lead (CBL) to oversee the implementation of the National Bereavement Framework. A strategic gap analysis was undertaken and strategic improvements implemented	Delivered
Increased patient-rated engagement measures within Ty Llidiard, CAMHS Tier 4	Specific PREM implemented to improve approach to ward round and ensure this reflected and was designed around young people	Delivered

3. Key Risks / Matters for Escalation

3.1 There are currently no key risks or matters for escalation.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	Creating Health, Inspiring People, Sustaining Our Future
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	Ageing Well, Dying Well, Growing Well, Starting Well
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant /	Not Applicable



Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	Safe Effective Efficient, Equitable, Person Centered, Timely
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable If more than one applies please list below:

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	



5. Recommendation

5.1 The Committee are asked to note progress against delivery to date.

6. Next Steps

6.1 As an organisation, we will continue to monitor and report our progress against the SMART quality objectives that we have committed to achieve.

6.2 We will do this at regular intervals and will adapt our plans based upon progress and learning.

Appendices.

Appendix 1 – Quality Strategy Work Plan

Appendix 2 – CTM Quality Strategy 2022-25 (available on request)

The information collected in this template will help inform how we are delivering the objectives of the CTM Quality Strategy over the three year period based around the six dimensions of quality, with each dimension having its own tab.

Progression towards delivering our Quality Strategy objectives will be monitored through our governance structures, inclusive of feedback and collaboration with our stakeholders, and will form part of our formal reporting structures. Through regular review, our Board and Quality and Safety Committee will ensure that our Quality Strategy and annual quality work plans continue to meet the needs of our organisation and our communities.

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	Progress
Safe Care	Develop and empower our colleagues to deliver outstanding care. Develop a Just Culture that promotes safety through supporting people to speak up, with an effective Learning Framework	No avoidable harm (e.g. from falls, pressure ulcers, medication errors)	Training packages developed with increasing numbers of attendances		Undetermined
			Effective cascade of good practice		Undetermined
			Assurance process for embedded learning		Undetermined
			Relaunch of Falls Strategy	<ul style="list-style-type: none"> Recruitment progressing reasonably well, new starters (Techs and 1 registrant) started, training, induction and project work progressing well Following a period of co-production the initial phased roll out has been designed alongside service users within our communities The falls programme is as a prevention service; focusing around self-referral in the first instance Delivered in local community settings; fire stations, Church halls, libraries, providing education and signposting in supermarkets etc. Walking aid clinics, Stay Steady clinics will be set up, with an intention of delivering equitable access across the CTM footprint Will be looking at questionnaire for Trauma clinics and Emergency Departments to capture those with first falls – e.g. wrist fractures (as evidence shows a proportion of these will go on to have far more expensive injuries with subsequent falls e.g. fractured hip) 	In Progress
			MDT review of all incidents to ensure holistic learning and actions		Undetermined
			QMS ensures rapid identification of outliers, triggering a deep dive and action plan		Undetermined

A Just and Restorative Culture across CTM	Launch of programme, with visible Board level and senior leadership support	IA working group to support implementation of a restorative just and learning approach at CTM has been formed with a wide range of key stakeholder across the organisation. A high level plan has been drafted setting out what our focus will be and what our measures of success are and how we will evaluate impact. This plan is currently being socialised with the organisation and the working group for feedback. We have a high level plan of actions and outcomes for the next three years and again we are currently receiving feedback from the working group on these to ensure they are realistic. We have formed 3 task and finish groups for this project, one looking at policy and procedures to ensure our system supports the restorative, just and learning approach. The other group is looking at what our evidence/data currently suggests about our culture and looks to identify where we can improve. Finally, we have a task and finish group looking at Education and Training to support awareness and skills development in this area.	In Progress	
	Just and Restorative Culture Champions	We have also appointed an Executive Sponsor for this work to ensure oversight, governance and Senior Leadership buy-in and support. Our Executive Sponsor is Lauren Edwards. The work on the Restorative Just and Learning approach forms part of a wider plan for CTM on creating a Compassionate, Inclusive and Just Culture which will enable all our People to thrive. This Culture Plan will support us in working towards our CTM 2030 Strategic goals and also incorporates work on our Values and Behaviours, Leadership, Equality Diversity and Inclusion.	Delivered	
	Policies reviewed at point of renewal to ensure they are conducive to a Just and Restorative Culture approach		Undetermined	
	Positive feedback from colleagues	Awaiting feedback from Staff Questionnaire. Staff Recognition Programme in place	In Progress Delivered	
	Reduction in formal disciplinary and grievance numbers; improved retention rates	Emailed for further information.	Undetermined	
	Complaints, inquests, claims and external reviews receive	Improved responsiveness to complaints and claims	Upward trend in improved responsiveness	In Progress
		Our stakeholders are assured of our open and learning culture		Undetermined
		Listening & Learning Framework embedded		Undetermined
		Team aware of their local learning as well as organisational themes		Undetermined

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	Progress	
Timely Care	Improve access to urgent and emergency care. Support people whilst they are waiting, optimising their health and wellbeing in order to achieve the best possible outcomes.	Everybody receives prompt care in the most appropriate setting and from the most appropriate person	Successful delivery of the 6 Goals for Urgent and Emergency Care		Undetermined	
			↑ usage of primary/community services		Undetermined	
			↑ advanced and consultant practitioners (nursing, AHP, healthcare science, pharmacy, physician's associates)	Advanced Clinical Practice SoPs and Processes in place. Panels for portfolio ratification scheduled.	In Progress	
			Effective use of a skilled support workforce		Undetermined	
			Partnership working with voluntary sector		Undetermined	
			Regional solutions for pathology and radiology	Regional Pathology Project actively working towards regional solutions for cellular pathology in collaboration with ABUHB and CVUHB. Regional radiology and endoscopy solutions being developed for Llantrisant Health Park.	In Progress	
			↑ cancer pathway performance		Undetermined	
			Successful delivery of Planned Care Recovery & transformation programmes	Acute Service Clinical Plan in development.	In Progress	
			Our acute hospitals experience no ambulance handover delays, no delays for	↓ handover delays; ↓ ED waits >12hrs		Undetermined
				↑ discharges before midday; ↓ LoS	Launch of Optimise Dec 23	Undetermined
		↑ numbers on D2RA pathways within 48hrs			Undetermined	
		Everybody on our waiting lists is optimised to achieve the best possible outcomes (waiting well, patient activation, prehab)	Partnership working with Social Care and Welsh Ambulance Service Trust		Undetermined	
			Project to review services for: long-term conditions; rehabilitation; reablement	Long Term Conditions - CTMUHB AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health My Way' – this programme builds on existing services, enhancing a 'needs based' approach, where patients can access help when and where they need it, for complex long term conditions. Q4 2023/24 - Collaborative working with WISE service will enable a comprehensive CTMUHB level 3 rehabilitation offer in the community with coaches and peer support. Q1 2024; the level 4 secondary care rehabilitation service will look to expand to self-referral, and gradually expand the remit of the service driven by clinical evidence based and as training and education of the workforce continues.	In Progress	
			↓ numbers waiting >14 wks for therapies		Undetermined	
			A supported self-management offer; shared decision making; motivational interviewing	Long Term Conditions - CTMUHB AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health My Way' – this programme builds on existing services, enhancing a 'needs based' approach, where patients can access help when and where they need it, for complex long term conditions. Q4 2023/24 - Collaborative working with WISE service will enable a comprehensive CTMUHB level 3 rehabilitation offer in the community with coaches and peer support. Q1 2024; the level 4 secondary care rehabilitation service will look to expand to self-referral, and gradually expand the remit of the service driven by clinical evidence based and as training and education of the workforce continues.	In Progress	
			Comprehensive prehab offer; MECC		Undetermined	

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	Progress
Effective Care	Develop evidence-based models of care with our partners, making the most effective use of skills and resources. Measure the impact and effectiveness of what we do, building on what works well and making brave decisions about what doesn't	Consistent use of Friends and Family Test (FFT), PROMs and PREMs across our physical health and mental health services	Programme for gradual roll-out of FFT, Patient Rated Outcome Measures and Patient Rated Experience Measures		Undetermined
			Feedback data shared with teams to ensure a clear understanding of what works well and opportunities for improvement	PDR – Your Conversation compliance is currently 62.60%. This is +0.58% on the previous month. PDR – Your Conversation compliance is +5.69% year on year, showing the impact that the new process and links to pay progression are having.	In Progress
			Patient and carer feedback triangulated with quality indicators to identify outliers, triggering deep dive and action plan		Undetermined
		All services developments informed by data and evidence (clinical and non-clinical)	Increased Research & Development activity	Emailed for further information	Undetermined
			Increased QI skills and capacity across services	Increase Simply Do Users by March 24. Target 1250 - Current 1131. Increase Simply Do Ideas completed by March 2024. Target 20 - Current 31.	In Progress
			Increased working with our academic partners	Data to support more education activity, particularly in relation to Pharmacy student undergraduate placements, and specific work with USW re closer partnership working.	In Progress
			Active partners in supporting community and voluntary sector developments		Undetermined
		Continuous development and transformation of our people	Consistent improvement in training compliance	Overall Health Board compliance for all levels of training currently sits at 68.86%. This is +0.80% on the previous month and +7.50% year on year. Compliance for level 1 currently sits at 77.67%. This is +0.73% on the previous month and +8.46% year on year	Delivered
			Increased uptake of leadership courses	CTM AHP & HCS USW leadership course agreed and running Nov 23 - June 24. CTM leadership courses Ignite, Aspire and Inspire continue to run. Dec 23 - total registrations 1,024, total active learners 903, conversion rate 71%.	Delivered
			Wellbeing offers developed in response to local need		Undetermined

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	Progress
Equitable Care	New models of care are designed using population health data and reflect local need. We regularly and effectively engage with our patients, communities and stakeholders to understand barriers to seeking early help for health needs.	Population health data informs our service developments	Profile of service usage by socioeconomic determinants of health (SEDH – income, health, education, employment, housing)	Continued work through the CTM Healthy Housing Alliance, bringing together relevant partners across CTM to identify and realise opportunities for joint working and co-ordination in relation to housing and health. Anchor Institute work,	In Progress
			Lifestyle campaigns developed and driven by data		Undetermined
			Targeted programmes to ↓health inequalities	Navigation hub – KPI's Number of referrals for urgent and emergency care (UEC) pathway to AHP's UEC KPI's – 2 – 72 hour access to AHP HOT Clinics, Navigation Hub MDT	Undetermined
			↑ performance in Welsh-medium care provision		Undetermined
			↑ Type 2 Diabetes prevention work	Agreement of a joint programme of work with Public Health Wales covering primary, secondary and tertiary	In Progress
			↑ Population Health Management approaches	PHM workshop held with good engagement. Workshop explored barriers and opportunities	In Progress
		High engagement with vaccination campaigns across all geographical locations within CTM	Annual ↑ in uptake of COVID-19 vaccinations	Vaccination drive underway as uptake low	Undetermined
			Annual ↑ in uptake of flu vaccinations	Vaccination drive underway as uptake low	Undetermined
			Annual ↑ in children who receive 3 doses of the hexavalent '6 in 1' vaccine by age 1		Undetermined
			Annual ↑ in children who receive 2 doses of the MMR vaccine by age 5		Undetermined
		Low levels of smoking and obesity across our footprint	↑ percentage of adults losing clinically significant weight through the All Wales Weight Management Pathway	The Adult Weight Management Service is now active and offering intervention for level 2 and 3 of the All Wales Weight Management Pathway. To date 443 patients have been offered an intervention	In Progress
			↑ percentage of babies who are exclusively breastfed at 10 days old		Undetermined
			↑ percentage of adult smokers who make a quit attempt via smoking cessation services	Plans underway to relaunch Smoking Cessation Sub Group in April 2024. First HB in Wales to participate in the Smoking, Nicotine and Pregnancy Trial (SBAP 3)	Future Deliverable - Yr 2
			↑ projects with Leisure Centres and local community activity groups		Undetermined
		Equitable health outcomes for people	Annual ↓ in patients waiting >28 days for a first appointment for CAMHS		Undetermined
			Annual ↑ in the percentage of adult mental health assessments undertaken within 28 days of referral		Undetermined

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	
Efficient Care	Enable our colleagues to do tasks/roles that they are best suited to do, thus cutting out waste. Support our colleagues to stay well and reduce agency use across CTM.	High-quality information and education supports people to stay well and/or seek early help	Relaunch of the FAST campaign to support early recognition of stroke symptoms	FAST campaign relaunched across Wales In April 2023.	
			Development of a suite of high-quality patient education programmes and information to support effective self-management	Long Term Conditions - CTMUHB AHPs are developing a multidisciplinary model of care for Long Term Conditions termed 'My Health My Way' – this programme builds on existing services, enhancing a 'needs based' approach, where patients can access help when and where they need it, for complex long term conditions. Q4 2023/24 - Collaborative working with WISE service will enable a comprehensive CTMUHB level 3 rehabilitation offer in the community with coaches and peer support. Q1 2024; the level 4 secondary care rehabilitation service will look to expand to self-referral, and gradually expand the remit of the service driven by clinical evidence based and as training and education of the workforce continues.	
		Low reliance on agency staff	Work with partners to ensure a directory of support services available in our communities	WISE data	
			↑ uptake of wellbeing offers resulting in ↓ sickness and turnover rates across CTM	Look at latest sickness info	
			Delivery of Nursing and Medical Productivity Programme aims and outputs		
		A highly skilled support workforce	↑ number of shifts filled by Staff Bank	Emailed for further information.	
			Project SEARCH interns transitioning to paid employment.	TOTAL EMPLOYED/Volunteering 28 Total Interns to date in CTM 36 POW - Urology are one of our new departments who have just come on board. They have embraced the internship experience fully and the intern that they have been hosting has been outstanding. So much so that they are looking into funding with a view to him securing a permanent position there via the apprenticeship route. We also have another meeting scheduled with Radiology with a view to taking on one of our supported interns. Again, he has proved to be invaluable and an asset to the department PCH - We have had a guest speaker from the college visit to discuss the Welsh Language provision and we have other guest speakers from local employers and third sector organisations planned for January 2024 onwards. The interns also attended a careers event at Rhydycar Leisure Centre to explore the various opportunities on offer. RGH - We are looking to launch a Supported Internship Program in RGH from September 2023. This will NOT be under the umbrella of Project Search. The Supported Internship will have less restrictions and operate the same as the projects in POW & PCH. This is simply because, Coleg Y Cymoedd run a successful program without the Project Search licence. A meeting with Elite and Coleg Y Cymoedd has now taken place. There is a new Manager in post at the college and he was very keen to learn more about the supported internship. HL forwarded information on to him explaining the internship and supporting information about our present and past internships. HL has still had no response from Gavin Owen (CTM) with regards to trying to locate a base room on site for the project. This is proving difficult. Some staff have engaged with supporting interns and have expressed an interest from various sites. The main difference with this supported internship, is that the interns can be based on any RGH site e.g.,	
			Annual ↑ in support workforce completing AGORED training		
			Annual ↑ in support staff workforce who have completed level 1 competencies of the Core Skills and Training Framework	Level 1 Compliance for Equality, Diversity & Human Rights remains the highest at 84.26% followed closely by Health, Safety and Welfare at 83.10% and Safeguarding Children at 83.10%. All subjects (apart from Resuscitation) are now above 75%. Focus across the HB needs to be provided to improve Resuscitation Training which is at 57.08%.	
			Support skills development in care workers		
			Strategic Programme for Primary Care :Primary and Community Care	↑ uptake of urgent primary care offers	
				↑ range of services available via Primary Care	
↑ integrated community teams					
		Early intervention and advanced practice models across our communities			

Progress
Delivered
In Progress
Undetermined
Undetermined
Undetermined
Undetermined
In Progress
Undetermined
In Progress
Undetermined
Undetermined
Undetermined
Undetermined
Undetermined

Quality Ambition	Strategic Quality Goals	Our True North	Journey To Success	Metric Being Measured (Give brief description)	Progress	
Person-Centered Care	Increase co-production across CTM, delivering care that is responsive to people's needs and wishes. Reduce variability in how well we engage and support carers.	Care is designed in partnership with patients and their families	↑ training in co-production		Undetermined	
			Voice of the patient evident in care and treatment plans		Undetermined	
			Carers Support Programme and training		Undetermined	
			Patient and carer feedback is used to inform service developments		Undetermined	
			Roll-out of co-produced Children's Charter	Ongoing work - Infant Pledge/Baby Charter to sit alongside Children's Charter	Undetermined	
			Care is always personalised	Bereavement and dying well service developments	<p>CHW has appointed a Clinical Bereavement Lead (CBL) utilising Welsh Government funding to oversee the implementation of the National Bereavement Framework. A strategic gap analysis was undertaken to identify areas of improvement and drive targeted support within specific arenas. Strategic improvements implemented.</p> <ul style="list-style-type: none"> • Creation of monthly Bereavement Link Nurse Forum • Implementation of a communal cremation service to support women and their families who have experienced pregnancy loss under 16 weeks and over 16 weeks • Development of bereavement booklets explaining service delivery and signposting • Collaborated with Human Tissue Authority colleagues to improve patient experience • Increased engagement with third-sector organisations to provide bereavement support • Representative at National Forum to inform the creation of Children & Young People's Pathway • Panel member on project board developing suicide training which extends to staff commissioned by NHS Executive. • Implemented process to ensure deceased patients' wishes are reflected when no NOK are identified. • Attend all unexpected children's deaths PRUDIC meetings to liaise and provide support for bereaved families. • Provide bereavement training to newly qualified/areas and return to practice nurses. • In partnership with the University of South Wales, developed and implemented an interactive bereavement training module. First one in the UK 	Delivered
				Increased patient-rated engagement measures within Ty Lliard, CAMHS Tier 4	<ul style="list-style-type: none"> • Weekly community meeting to give feedback and areas for improvement • Open door approach with nursing team • Information 'business' cards given to all families • Development of a people's experience group <p>Specific PREM implemented to improve approach to ward round and ensure this reflected and was designed around young people</p>	Delivered
		External reviews of our services report evidence of person-centred care		Undetermined		



Agenda Item

8.1

Quality & Safety Committee

Mental Health Adult Inpatient Improvement Programme

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024	
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
(Insert Details)	Click or tap to enter a date.	
Acronyms / Glossary of Terms		
HIW	Healthcare Inspectorate Wales	
MHLD	Mental Health and Learning Disabilities	
QSRE	Quality Safety Risk Experience	
SRO	Senior Responsible Officer	



1. Situation /Background

- 1.1 This report provides committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme.
- 1.2 In February 2022, HIW wrote to the Health Board to advise that they would be undertaking a local review of the quality of discharge arrangements for adult patients from inpatient mental health services in CTM. This review was commissioned in response to serious incident intelligence.
- 1.3 The review included both fieldwork and a review of evidence, including a review of patient records. The proposed timescale for publication was August 2022, however HIW continued to seek evidence from the Health Board through to December 2022.
- 1.4 In June 2022 HIW identified a number of significant patient safety concerns and issued an immediate assurance improvement plan relating to: discharge governance; communication arrangements between teams (including the issue of the lack of a single electronic record); significant limitations in the involvement of patients and carers; and risk management and discharge arrangements.
- 1.5 The discharge review was published on 7th March and includes a further 40 recommendations: [Reviewing the Quality of Discharge Arrangements from Adult Inpatient Mental Health Units within Cwm Taf Morgannwg University Health Board \(hiw.org.uk\)](https://hiw.org.uk/reviewing-the-quality-of-discharge-arrangements-from-adult-inpatient-mental-health-units-within-cwm-taf-morgannwg-university-health-board/)

2. Specific Matters for Consideration

- 2.1 The Health Board Improvement Plan was published by HIW on 6 September 2023: [CTMUHB MH Discharge Review - Improvement Plan Final EN.pdf \(hiw.org.uk\)](#)
- 2.2 As part of HIW's Local Review process a further improvement plan will be submitted to HIW three months and eighteen months after acceptance of the initial improvement plan.
- 2.3 A Mental Health Inpatient Improvement Programme has been developed with a number of work streams. The HIW actions and the four improvement themes referenced above are aligned to these work streams.
- 2.4 The scope of the Adult Inpatient Improvement Programme is broader than the HIW Discharge Review. However, given the timescales the first phase of the improvement programme will be to deliver the 40 recommendations. These 40 recommendations are made up of 145 individual actions. Of the 9 work streams, the 8 work streams with HIW recommendations are currently active.



Mental Health In-Patient Improvement Programme

Executive Lead: Lauren Edwards, Executive Director of Therapies and Health Science
Care Group SRO: Ana Llewellyn, Nurse Director

<p>Project: Quality of Leadership and Management</p> <p>Care Group SRO: Elaine Lorton</p>	<p>Project: Safe and Effective Care</p> <p>Care Group SRO: Mary Self</p>	<p>Project: Quality of Patient Experience</p> <p>Care Group SRO: Andrea Davies</p>
<p>Workstreams:</p> <ul style="list-style-type: none"> A Skilled & Motivated Workforce 	<p>Workstreams:</p> <ul style="list-style-type: none"> Evidenced Based Model of Care Safe Discharge High Quality Clinical Records Policies and Procedures Ward Assurance 	<p>Workstreams:</p> <ul style="list-style-type: none"> Access and Alternatives to Admission People's Experience Safe and Therapeutic Environments

- 2.5 The work streams have been allocated to a Care Group Director who acts as the Senior Responsible Officer (SRO) role for quality assuring the evidence before submission to the Improvement Board.
- 2.6 The 40 recommendations are made up of 145 individual actions. Recommendations are only put forward to the Improvement Board for ratification when all of the actions relating to that recommendation are complete and have supporting evidence that has been approved by the SRO.
- 2.7 The Improvement Board, which is chaired by the Executive Director of Therapies and Health Science last met on 21st November 2023.
- 2.8 A further 28 recommendations were determined to be complete at the Improvement Board taking the total completed recommendations to 32.

Recommendations	Number completed and approved by Improvement Board	Number with planned later timescales	Number with slipped timescales
40	32	4	4



2.9 The four recommendations with slipped timescales were as follows:

Recommendation	Requirement	Revised Timescale
2	WARRN training to 85% - currently at 66%	31/1/24
8	Other training to 85%: <ul style="list-style-type: none"> • Care and Treatment Planning at 62% • Information Governance at 81% • Prevention and Management of Violence and Aggression at 79% 	31/1/24
15	Most of the actions for this recommendation complete but there is outstanding action for a Section 140 Policy to be developed.	31/3/24
38	This recommendation relates to the ability for social worker partners to be able to access datix.	31/1/24

2.10 The Improvement Board determined that whilst there was evidence of progress against all of the recommendations the four recommendations above required some further work before they could be determined as complete.

2.11 The Health Board submitted an updated improvement plan with associated evidence to HIW on 30th November as requested.

2.12 At the time of writing the Health Board is awaiting confirmation from HIW that this improvement plan has been accepted.

2.13 HIW also undertook an unannounced inspection of the four wards at Royal Glamorgan Hospital from 20th -22nd November 2023 and the inspection team provided commendation on the significant improvement when they provided verbal feedback to the leadership team. This also served to reinforce the Improvement Board’s assessment of the progress made.

2.14 The Improvement Programme intends 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. It will also serve as an opportunity to include some of the recommendations from the latest unannounced inspection into the wider improvement programme.

2.15 Workstream leads and SROs will meet on 23rd January 2024 to review the programme. The next formal meeting of the Improvement Board will be on 27th February 2024.



3. Key Risks / Matters for Escalation

- 3.1 Committee members are asked to note the slippage on fully completed recommendations and to also note that 3 recommendations have revised completion dates of January 2024 and a 4th recommendation has a revised completion date of March 2024.

4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol 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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality</i> (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 <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality</i> (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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: No change to service provision
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 27th February 2024 and will review progress and evidence against the HIW recommendations.

**Minutes of the Meeting of Cwm Taf Morgannwg University
(CTMUHB)**

**Quality & Safety 21 November 2023 at 9:00 am 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
Richard Hughes	Deputy Director of Nursing
Hywel Daniel	Executive Director for People
Gareth Watts	Director of Corporate Governance & Board Secretary
Emma James	Care Group Nurse Director
Suzanne Hardacre	Director of Midwifery
Nigel Downes	Assistant Director of Quality & Safety (In part)
Sallie Davies	Deputy Medical Director
Stephanie Muir	Assistant Director of Concerns & Claims
Julie Denley	Deputy Chief Operating Officer
Lisa Love-Gould	Clinical Director, Allied Health Professionals
Ana Llewellyn	Care Group Nurse Director
Kellie Jenkins Forrester	Head of Concerns and Business Intelligence
Donna Walker	Bereavement Clinical Lead (In part)
Amy Davies	Consultant Geriatrician
Lucie Williams	Head of Nursing, Primary & Community Care
Claire Ellis	Head of Quality & Safety (Observing)
Lydia Thomas	Head of Quality & Safety (Observing)
Victoria Healey	Head of Quality & Safety (Observing)
Jenny Oliver	Governance & Patient Experience Manager
Becky Gammon	Assistant Director of Nursing & Peoples Experience
Claire O Keefe	Head of Safeguarding
Alex Brown	Unscheduled Care, Care Group Medical Director
Owen Weeks	Unscheduled Care, Care Group Medical Director (In part)

Chris Beadle
Gaynor Jones
Emma Walters

Assistant Director of Health, Safety & Fire
Staff Side Representative (In part)
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:

- Greg Dix, Executive Director of Nursing/Deputy Chief Executive;
- Mary Self, Care Group Medical Director;
- Mohamed Elnasharty, Care Group Medical Director;
- Stephen Sarasin, Care Group Medical Director;
- David Miller, Care Group Medical Director

1.3 Declarations of Interest

The Committee Chair declared that she was also Chair of the Welsh Wound Innovation Centre which was referenced within one of the reports on the agenda today.

2. SHARED LISTENING AND LEARNING

2.1 Listening & Learning Story – Bereavement Services

D Walker shared the Listening & Learning presentation and story that related to Bereavement Services.

The Committee Chair extended her thanks to D Walker for sharing the story which was really powerful and advised that she felt the lady was very brave in sharing her story. D Walker advised that the family were incredibly brave and added that one of the most incredible things was that her husband was able to go on to provide a support group to other people who had lost close ones within his local gym. He felt that he was able to do this as a result of the bereavement service giving him the strength to achieve this. Members noted that the family also wanted to provide support to other people during Men's Mental Health Awareness week which highlighted the significant impact the service could have.

The Committee Chair recognized the enormous change that had been made within a year within the service and the story identified clearly how valuable the service was to families and to staff.

S Hardacre extended her thanks to D Walker for sharing the powerful story and shared her thanks for the all the work the Team had been undertaking over the last year in terms of improving pregnancy loss at all gestations and the impact this was having could be clearly seen. S Hardacre sought clarity as to how the teams were able to offer support and added that clearly there was some angst there for this family and that the family had to request to speak with Bereavement services and questioned how the service could be made more available so that families did not have to request access to the service. D Walker advised that the Team were providing a Paediatric booklet for bereavement, which would contain all the contact details and telephone numbers that people would need to link into. Members noted that there was no service within the Health Board where we contact out for all people who had lost someone but this would be a gold standard development for the future. D Walker advised of the need to ensure communication was really open and honest.

G Jones sought confirmation as to whether the Health Board was still using To Wish Upon a Star as they always provided the Health Board with bears and memory boxes and also furnished a room in A&E. D Walker confirmed that the Health Board still worked with To Wish Upon a Star and advised that this family in particular did not wish to use the service. Members noted that a memory box was given to them at A&E but the family felt this was too much for them at the time and only wanted to liaise with the Health Board's bereavement service. To Wish Upon a Star had been informed of the family and would be happy to speak with the family once they felt ready to do so.

G Hughes advised that he found the story to be moving and clearly the impact the intervention had on this family was immense in enabling them to survive after such a tragic event. G Hughes sought clarity as to what support the Bereavement Team required so that they were able to continue to provide this excellent service. D Walker advised that she has excellent support in place from the management team who were very supportive and added that if there was a Bereavement Team in place this would be helpful. D Walker advised that she able to signpost out at this stage given that she was the only person in post within the service which was helpful. Members noted that there were bereavement officers that sit under the Pathology Team and support was also being provided by the Hospital Chaplaincy Service and the Patient Advice and Liason Officers who all do a sterling job.

The Committee Chair once again extended her thanks to D Walker for sharing the story.

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

2.2 Care Group Spotlight Presentation – Frailty

A Davies shared the presentation with Members of the Committee. The Committee Chair extended her thanks to A Davies for sharing the detailed presentation.

G Hughes welcomed the presentation and advised that this piece of work allowed us to be clear on the patients who can be discharged home with some support, the patients who need to stay in hospital for a short stay admission who were then supported prior to discharge and the patients who need clear management plans in place as they require a longer stay in hospital. Members noted that work had been undertaken and some additional funding had been secured to expand ACT to work seven days a week so it was able to provide a more robust service and additional capacity to support the ACE team. Members noted that Bridgend Local Authority had also committed to putting in some care hours as part of the ACE model, and in addition to this the Team had managed to secure some support from St John's via the Welsh Ambulance Services NHS Trust (WAST) who would provide a night sitting service to some patients. Members noted that focus would be placed on this in the first instance so that a really robust and comprehensive model could be developed that could be

used as a blueprint for expanding the service across the whole of Cwm Taf Morgannwg.

Members noted that work was also being undertaken to review the Care of the Elderly ward provision where patients were currently being admitted on a spread across a number of wards. Members noted that consideration was being given to having a ward specifically for the cohort of patients who would benefit from Therapy, a very acute ward for Care of the Elderly patients and a ward for patients awaiting onward transfer. Members noted that the interplay with the navigation hub was an important part of this development and noted that there was a need to ensure the right things were being done for the Health Board's older population.

D Hurford extended his thanks to A Davies for sharing the presentation and added that she had really driven this unit forward alongside her colleagues. D Hurford advised that the service was quite radical, particularly for Wales, and advised of the need to look at further development of the service given the pressures being faced with an ageing population.

The Committee Chair once again welcomed the presentation and the progress being made and advised that the presentation had touched on so many issues that had resonated with the Committee, for example, patient falls and maintaining independence.

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. The Committee Chair advised that she did have some concerns in relation to some consent agenda items which she had discussed with the Head of Corporate Governance and Board Business as she felt that there were some items which were not getting the focus that they should be which would be reviewed moving forward. The Committee Chair advised that she had a concern in relation to the Infection, Prevention & Control report which she felt required discussion on the main agenda at future meetings.

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

R Hughes presented the report that provided an overarching update on the achievements, projects and current challenges within the portfolio of the three Clinical Executive Directors, Medical Director, Executive Director of Therapies and Health Science and the Executive Director of Nursing.

D Hurford provided Members with an update in relation to the Medical Directorate position and advised that the report contained an error in relation to the update provided in relation to Appendicitis guidelines and advised that confirmation of the guidelines would happen at the next surgical meeting in two weeks' time. D Hurford advised that he would ensure the statement was corrected within the report and would share a revised report with Members.

L Edwards provided an update in relation to the Therapies & Health Sciences portfolio and advised Members that the Quality Strategy Annual Plan would be presented to the January 2024 meeting of the Quality & Safety Committee.

R Hughes provided an update on the programmes of work which were underway in relation to the Executive Director of Nursing portfolio. Members noted that a piece of work was being undertaken in relation to the way patient stories were being captured.

R Hughes advised that he would find it helpful if Members could share their views and feedback on the content of the report to help inform future iterations.

Resolution: The report was **NOTED**.

Actions: Statement to be corrected within the report in relation to Appendicitis guidelines.

Feedback to be shared with the Deputy Director of Nursing regarding the content of the report to help inform future iterations.

5.2 Care Group Highlight Reports

5.2a Planned Care Group Highlight Report

N Downes presented the matters contained within the alert/escalate section of the report.

In response to a query raised by P Roseblade as to when the Robot would be operational, G Hughes confirmed that the first case was planned for the 24th January 2024.

The Committee Chair made reference to the five incidents that had been rated as severe at Royal Glamorgan Hospital which was concerning and sought clarity whether there were any trends that the Committee needed to be made aware of. N Downes provided Members with a response to this query later in the meeting and confirmed that out of the five incidents, four had been downgraded and one was being managed as a concern.

Resolution: The report was **NOTED**.

Action: Response to be provided to Members outside the meeting as to whether there were any trends the Committee needed to be made aware of in relation to the five incidents that had been rated as severe at Royal Glamorgan Hospital.

5.2b Primary & Community Care Group Highlight Report

L Williams presented the matters contained within the alert/escalate section of the report.

Resolution: The report was **NOTED**.

5.2c Children & Families Care Group Highlight Report

S Hardacre presented the matters contained within the alert/escalate section of the report.

Resolution: The report was **NOTED**.

5.2d **Mental Health & Learning Disabilities Care Group Highlight Report**

A Llewellyn presented the matters contained within the alert/escalate section of the report.

Following concerns raised by Members at the last meeting in relation to the anonymous concern and staffing levels, A Llewellyn provided members with an update against these two areas.

In relation to the anonymous concern, Members noted that feedback was delivered to colleagues at the start of November where four main themes were identified, which included issues in relation to staffing levels, issues in relation to leadership and culture, Estates issues and issues relating to the management of clinical incidents. A Llewellyn advised that all of these themes would now be added to the Inpatient Improvement Programme of work for action.

In relation to staffing levels, Members noted that a Nursing Establishment review report had been developed which included some recommendations in relation to a skill mix review, which would need to be worked through further from a financial perspective. Members noted that staffing levels were currently mitigated by long term and established Bank nursing in addition to some agency nursing.

Members welcomed the news that two Healthcare Support Workers had been nominated for and had won a national Royal College of Nursing award.

R Hughes provided an update on the work being undertaken to address the issues being experienced in relation to the provision of Basic Life Support Training and other Resuscitation training across the Organisation. Members noted that R Hughes was in the process of developing a strategy for implementation on how to address the position which would be shared with Committee Members at the January 2024 meeting. The Committee Chair advised that issues in relation to mandatory training appeared to feature in a number of reports and discussions. D Jouvenat confirmed that statutory and mandatory training was being reviewed by the People & Culture Committee.

The report was **NOTED**.

Resolution:

5.2e **Unscheduled Care Group Highlight Report**

E James presented the matters contained within the alert/escalate section of the report.

N Milligan raised concerns in relation to NEWS compliance which was currently at 86%. N Milligan advised that consideration needed to be given to how effective compliance was, particularly as there were some concerns in relation to accuracy of scoring, observations as per score and the 12 hour observation as a minimum and added that it would be helpful if an update could be included in a future report in relation to this to show that the Health Board is compliant and effective in relation to NEWS scoring.

P Roseblade made reference to the Coroner's inquest that had been referred to in the alert/escalate section and advised that it would be helpful if a short synopsis could be included in future reports as to the nature and outcome of the inquests being referred to.

The Committee Chair advised Members that a spotlight report on Sepsis would be presented to the January 2024 meeting.

Resolution: The report was **NOTED**.

Actions: Future reports to include an update on how effective NEWS compliance was in relation to accuracy of scoring, observations as per score and the 12 hour observation.

Future reports to include a short synopsis as to the nature and outcome of Coroner's inquests that were being referred to.

5.2f **Diagnostics, Therapies, Pharmacy & Specialties Care Group Highlight Report**

L Love-Gould presented the matters contained within the alert/escalate section of the report.

The Committee Chair welcomed the report which she found to be very positive.

Resolution: The report was **NOTED**.

8.2 **Stroke Services Progress Report**

A Brown presented the report and highlighted the key updates to Committee Members. L Edwards reminded Members that discussions had been held previously in relation to certain metrics that the Health Board would find it difficult to impact upon without significant investment and the increased governance structures that had been put into place in relation to this programme of work. Members noted that the Team were doing as much as they could within its current resource and noted that without significant investment they would be unable to move significantly forward.

In response to a question raised by P Roseblade as to what Welsh Government's role was in helping to improve the stroke metrics across Wales, L Edwards confirmed that the benchmarking data did highlight the significantly challenged position across Wales and advised that the main focus at present was the establishment of comprehensive regional Stroke Centres. Members noted that in order for these Centres to work effectively, local services needed to be able to accept patients back within 72 hours for intensive rehabilitation. A Brown added that the key metrics identified were reliant on workforce at the front door and flow through the acute hospital sites which were the two areas under significant pressure across the whole of the NHS in Wales and added that this would have an impact on repatriating patients within 72 hours.

D Hurford advised that this network was similar to other networks which all relied on rapid repatriations and advised that the difficulty within Stroke was the reduced workforce availability, with very few Stroke Physicians available to be able to put a model in place and run it as a network.

The Committee Chair advised that she found the report to be incredibly helpful and provided clarity and assurance over the plan being followed and the roles of the different governance groups that were in place

Resolution: The report was **NOTED**.

6. GOVERNANCE, RISK AND ASSURANCE

6.1 Organisation Risk Register – Risks Assigned to the Quality & Safety Committee

G Watts presented the report and highlighted the key matters for Members attention.

The Committee Chair advised that she felt concerned that Members were not submitting questions beforehand in relation to this item and encouraged Members to submit questions in advance. The Committee Chair advised that if Members felt they did not have time to submit questions in advance then they were more than welcome to raise questions at the meeting.

The Committee Chair made reference to the risk relating to Medical Gas Safety training which had been on the risk register since 2018 and advised that Committee Members had already reflected on generic training issues earlier in the meeting.

K Palmer welcomed the report which she found to be helpful and added that she could clearly see a number of risks had mitigating actions and controls in place. K Palmer advised that there were some risks where she did not get assurance from in relation to the actions highlighted, and particularly referred to the risk relating to business interruption on the Radiologists and the risk relating to Emergency Department Overcrowding which had been escalated from 16 to 20. K Palmer advised that it would be helpful if action being taken could be included within the next iteration of the report. The Committee Chair agreed with the comments made by K Palmer and advised that she did not find it helpful when the update provided stated that there was no change to this risk at this time.

The Committee Chair provided assurance to K Palmer that the Risk Register had improved significantly over the last year. D Hurford added that a number of risks had been removed from the Risk Register following focussed discussions and advised that if there were any risks which were of concern then the Executive Team would be happy to review these as a matter of priority.

Resolution: The report was **NOTED**.

Action: More detail to be provided in the next iteration of the report on the actions being taken against the risks relating to business interruption within Radiology and the Emergency Department Overcrowding Risk.

6.2 Healthcare Inspectorate Wales Action Plan Tracker

R Hughes presented an update to the Quality & Safety Committee on progress against the open actions held on the Healthcare Inspectorate Wales (HIW) tracker.

A Llewellyn advised Members that an unannounced inspection had recently been undertaken at Angelton Clinic and Healthcare Inspectorate Wales were also currently undertaking an inspection of the Mental Health Unit at Royal Glamorgan Hospital which would result in some additional improvement plans being required.

K Palmer made reference to the 17 actions that were passed their due date and advised that she could not get a sense from the report how important these actions were, what the potential impact of these actions were and whether the Committee needed to be made aware of any issues regarding the 17 actions that had passed their due date. The Committee Chair added that it would be helpful if the report could include a rate of progress made since the last report together with how many actions had been completed. R Hughes advised that he would be happy to include an update on these suggestions in the next iteration of the report.

G Hughes advised that some of the actions were complex and agreed that clear delivery and completion dates needed to be included against the recommendations to provide assurance to the Committee that actions were being taken forward and remained on track to meet their intended delivery target.

Resolution: The report was **NOTED**.

Action: Future iterations of the report to include rate of progress made since the last meeting against the recommendations which remained open, how many actions had been completed and clear delivery and completion dates to be identified against each open recommendation.

6.3 Update on the Mental Capacity Act

C O'Keefe presented the report and highlighted key updates for Members to note. The Committee Chair welcomed the report which clearly identified the significant amount of work being undertaken in this area and following discussion it was agreed that a further report would be presented to the Committee outlining progress in May 2024.

Resolution: The report was **NOTED**.

6.4 Health, Safety & Fire Sub Committee Highlight report

N Milligan presented the report and drew Members attention to the item contained within the alert/escalate section which related to the boarding of patients and the need to undertake a risk assessment of the areas patients were being placed whilst being boarded. Members noted that in one incident a patient had been boarded directly underneath a wall mounted TV which not only caused a safety issue but also caused a dignity issue. N Downes advised that he had discussed this particular incident with J Trewartha and had agreed to undertake an investigation from a patient safety perspective.

H Daniel advised that this issue was different to the issues previously discussed in relation to boarding of patients in front of fire exits and added this related to the principles in relation to boarding. Members noted that boarding was part of the Health Board's escalation plans in extremis and was also part of the Welsh Government Framework.

In response to a query raised by the Committee Chair as to whether the Committee could still be assured that no patients were being boarded in fire exists and causing fire safety risks in the way in which they were positioned, G Hughes and H Daniel both confirmed that this practice was no longer happening.

Resolution:

The report was **NOTED** and the Fire Safety Policy was **APPROVED**.

7. DELIVERING OUR PLAN

7.1 Quality Dashboard

N Downes presented Members with the Patient Safety & Quality Dashboard and highlighted the key matters for Members attention.

N Milligan requested clarity as to what was meant by a medication supply error. L Williams advised that a few of these errors had been reported within Parc Prison and advised that whilst they are recorded as a medication supply error on Datix, it was actually related to the availability of the medication being available for the patient.

In response to a comment made by P Roseblade regarding the date reported in section 2.2 in relation to Patient Safety Incidents which appeared to be comparing a three month period to a two month period, N Downes advised that this was a typographical error contained within the report and should read 31/10/2023 as opposed to 31/11/2023. N Downes also apologised for the calendar months

being recorded in German and not English and advised that this would be rectified for the next iteration of the report.

In response to a query raised by P Roseblade regarding the never event referred to within the report, N Downes confirmed that this was a historic never event that was still in progress.

The Committee Chair made reference to falls and pressure areas which continued to be an area of focus and added that she did not feel assured that any impact was being seen from the work being undertaken to address the position. R Hughes advised that the first Falls meeting would be taking place in December 2023 which would be taking a strategic focus on Falls and advised that he drew some confidence from the inpatient falls per 100 bed days and added that from a national audit perspective, the Health Board was sitting at 5.17 against a benchmark of six. R Hughes also advised that there was assurance in place regarding falls where there is harm, and added that 91% of falls had no or low harm. Members noted that the falls where there was significant harm of moderate and above were being investigated as part of a process and outcomes and appropriate learning was being seen from this. R Hughes advised that maybe consideration needed to be given as to how this information could be presented to the Committee in a format that was easy to digest and provided Members with the assurance required.

D Jouvenat highlighted an error within Appendix 3 and advised that she undertook the walkround with Paul Mears on the 27 July 2023 on behalf of Lynda Thomas.

K Palmer sought clarity as to whether monitoring is undertaken of ward improvement plans when specific issues on specific wards were being identified, for example Ward 14 at the Princess of Wales Hospital, and sought clarity how feedback was being provided to this Committee that there were improvements being seen in these areas. R Hughes advised that this information would normally be included within Care Group Highlight Reports. In relation to Ward 14, A Llewellyn advised that you would expect to see restricted interventions increasing/decreasing and advised that these incidents were not necessarily concerning given that use of restricted interventions would be clinically appropriate for this ward area.

N Milligan referred to the Patient Experience appendix and advised that she was reassured to see the significant amount of work being undertaken by the Hospital Chaplaincy services.

Resolution: The report was **NOTED**.

8. DELIVERING OUR IMPROVEMENT PROGRAMMES

8.1 Mental Health In-Patient Improvement Progress Report

A Llewellyn presented the report that provided committee members with an overview of progress of the Mental Health Adult Inpatient Improvement Programme. Members noted that Healthcare Inspectorate Wales had written to the Health Board outlining their expectations for an updated improvement plan by 30 November 2023. It was anticipated that 32 out of the 40 recommendations would be declared as completed by 30 November, with four recommendations having later timescales for completion and four recommendations being given revised timescales for completion of January 2024.

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 September 2023

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

9.1.3 Violence Against Women, Domestic Abuse and Sexual Violence Policy

9.1.4 Measles Policy

9.1.5 Meningitis Policy

9.1.6 Safeguarding Annual Report

9.2 FOR NOTING – The following items were NOTED by Committee Members.

9.2.1 Action Log

9.2.2 Committee Annual Cycle of Business

9.2.3 Forward Work Programme

9.2.4 Infection, Prevention & Control Mid Year Update

9.2.5 Prescribing Annual Report

9.2.6 RADAR Committee Annual Report

9.2.7 Clinical Audit Quarterly Report

9.2.8 Clinical Education Annual Report

9.2.9 Radiation Safety Committee Update

Members noted that there was no report on this occasion and the next report would be available in January 2024.

9.2.10 Covid 19 Inquiry Preparedness

9.2.11 Human Tissue Act (2004) Compliance and Progress Report

9.2.12 Organ Donation Committee Annual Report

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

10. ANY OTHER BUSINESS

Members were provided with an update in relation to the outcome of the Coroner's Report that had recently been issued in relation to a Neonatal death in 2019 at the Royal Glamorgan Hospital, which identified that this would have been a preventable death which had resulted in the Health Board being issued with an Article 2. D Hurford advised that this had been a very difficult case and added that the Executive Director of Nursing and Deputy Director of Nursing had been in close contact with the family. Members noted that there were a number of learning points identified which were being addressed by the Health Board and noted that multiple internal reviews had been undertaken on this very tragic incident.

10.1 Highlight Report to Board – Verbal

The Committee Chair advised that this would be drafted by the Corporate Governance Team outside this meeting and suggested that the two presentations received earlier in the meeting were added to the alert/escalate section as positive items for escalation.

10.2 How did we do in this meeting?

The Committee Chair advised that she would welcome feedback as to how Members and attendees felt the meeting went today given that it was quite difficult to balance items as there was such a vast array of information.

R Hughes advised that there was a significant amount of work being undertaken within the Care Groups and added that there was a need to ensure that the needs of the Committee were being met in terms of delivering assurance and added that if Members had any views on what could be done differently their feedback would be welcomed.

D Hurford referenced to the significant amount of information contained within the consent agenda and advised that if Members wished to raise questions on these items outside of the meeting then he would be happy to address any queries on a one to one basis if Members would find this helpful. D Hurford added that he would also welcome guidance from Members as to future topics they would wish to focus on.

G Hughes commented as to how the Executive Team could help Independent Members understand what areas they should be concerned about within each specialty and service and how the Executive Team could help Independent Members understand enough of the service to enable them to ask curious questions on the areas of importance.

N Milligan requested that if questions were raised and discussions were being held with Committee members outside the meeting regarding specific agenda items, it would be helpful if the response provided could be shared with all Committee Members as this may generate further questions.

The Committee Chair advised that this feedback would continue to be reviewed moving forwards and advised that she would find it helpful if the Infection, Prevention and Control report could be included on the main agenda for discussion moving forwards as she felt this was an important matter for discussion. The Committee Chair encouraged

Members to continue to ask questions, even between Committee meetings.

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. The Committee Chair advised that it would be helpful if some negative stories could be shared in addition to positive stories outlining lessons learnt.

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

There were no items identified for discussion during In Committee session.

11. DATE AND TIME OF NEXT MEETING

The next meeting take place on Tuesday 23 January 2024 at 9:00am.

12. CLOSE OF MEETING



Agenda Item

9.1.2

Quality & Safety Committee

Quality & Safety Committee Annual Cycle of Business

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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
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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



<i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 **APPROVE** 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.

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	R		R		R		R		R		R	
Thematic Spotlight Presentation	Lead Clinical Executive	All regular meetings	R		R		R		R		R		R	
SETTING THE SCENE – SERVICE DELIVERY														
Report from the Clinical Executives	Clinical Executives	All regular meetings	R		R		R		R		R		R	
Care Group Highlight Reports	Executive Director of Nursing	All regular meetings	R		R		R		R		R		R	
GOVERNANCE, RISK AND ASSURANCE														
Organisational Risk Register – Risks Assigned to Quality & Safety Committee	Director of Corporate Governance/ Board Secretary	All regular meetings	R		R		R		R		R		R	
Healthcare Inspectorate Wales Action Plan Tracker	Executive Director of Nursing	All regular meetings	R		R		R		R		R		R	
Mortality Indicators and Mortality Reviews	Executive Medical Director	Bi-annually	R						R					
National Collaborative Commissioning Unit Quality Improvement and Assurance Service Annual Position Statement	Director of Nursing, Performance and Quality, NCCU	Annually									R			
Continuing Healthcare (CHC) and Funded Nursing Care (FNC) Activity.	Executive Director of Nursing	Annually	R Defer to Mar 24		R									
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					R End of year update				R Annual Report		R Mid Year update	
DELIVERING OUR PLAN														
Quality Dashboard Report	Executive Director of Nursing	All regular meetings	R		R		R		R		R		R	
DELIVERING OUR IMPROVEMENT PROGRAMMES														
Stroke Services Progress Report	Executive Director of Therapies and Health Sciences	Quarterly			R				R				R	
Mental Health In-Patient Improvement Progress Reports	Executive Director of Therapies and Health Sciences	All regular meetings	R		R		R		R		R		R	
CONSENT AGENDA ITEMS – FOR APPROVAL/NOTING														
Minutes of the previous meeting	Director of Corporate Governance	All regular meetings	R		R		R		R		R		R	

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	R		R		R		R		R		R	
Committee Annual Cycle of Business	Director of Corporate Governance	All regular meetings	R		R		R		R		R		R	
Committee Forward Work Plan	Director of Corporate Governance	All regular meetings	R		R		R		R		R		R	
Committee Annual Report	Director of Corporate Governance	Annually					R							
Quality & Safety Committee Terms of Reference	Director of Corporate Governance	Annually	R Defer to July 24						R					
Quality & Safety Committee Annual Self-Assessment	Director of Corporate Governance	Annually							R					
WHSSC Quality & Patient Safety Committee Chairs Report	Director of Corporate Governance	Bi-monthly	R		R		R		R		R			
Putting Things Right Annual Report	Director of Corporate Governance	Annually							R					
Organisational Wide Policies for Approval	Director of Corporate Governance	As and when they arise												
Clinical Policies Highlight Report	Executive Medical Director	Bi-Annually					R						R	
Safeguarding & Public Protection Annual Report	Director of Nursing	Annually											R	
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	R				R		R				R	
Controlled Drugs Local Intelligence Network (CDLIN) Annual Report	Medical Director	Annually					R							
Cancer Services Annual Report	Medical Director	Annually					R							
Prescribing Annual Report	Medical Director	Annually											R	
RADAR Committee Highlight Reports (Annual Report and Mid-Year Update) - to include updates on Sepsis Compliance - Quality Improvement	Medical Director	Bi-Annually			R								R	
Clinical Audit Quarterly Report	Medical Director	Quarterly			R				R				R	
Clinical Audit Annual Plan	Medical Director	Annually			R									
Clinical Education Annual Report	Director of Nursing	Annually											R	
Individual Patient Funding Request Annual Report	New Chair being appointed	Annually									R			
Health, Safety & Fire Sub Committee Highlight Reports	Executive Director for People	Quarterly			R				R				R	



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			R								R	
Covid 19 Inquiry Preparedness	Director of Nursing	Bi-Annually			R								R	
Nosocomial Investigation Update Report	Director of Nursing	Bi-Annually	R Defer to May 2024				R		R					
Ombudsman's Annual Letter and Annual Report	Director of Nursing	Annually									R			
Human Tissue Authority Act Progress Report	Chief Operating Officer	Bi-Annually					R						R	
CWM TAF Morgannwg Carers End of Year Progress Report 2022/23	Director of Nursing	Annually							R					
Organ Donation Committee Annual Report	Medical Director	Annually											R	
Access to Medicines Committee	Medical Director	Annually											R	



Agenda Item

9.1.4

Quality & Safety Committee

Concerns Policy & Procedures

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Kellie Jenkins-Forrester – Head of Concerns & Business Intelligence Louisa Hayhurst – Complaints Manager
Cyflwynydd yr Adroddiad / Report Presenter	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Gregory Padmore-Dix, Deputy Chief Executive / Executive Nurse Director

Pwrpas yr Adroddiad / Report Purpose	For Approval
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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

This Policy was reviewed following:

- The centralisation of the complaints functionality within Cwm Taf Morgannwg Health Board.
- Transition from the Locality structure to the Care Group operating model.
- Implementation of Duty of Candour

This policy reflects the requirements outlined in the Putting Things Right guidance, recommendations from the internal audit review undertaken in 2021 and learning from upheld Public Services Ombudsman for Wales (PSOW) cases.

A range of standard operating procedures have been developed to support the practical implementation of this policy.

2. Specific Matters for Consideration

2.1 Engagement on this Policy and Procedure has taken place with:

Name Title	Date Consulted/Completed
Equality Impact Assessment	15.01.24
Informal Consultation with interested parties	18.09.23 – Meeting held with key operational leads
Formal Consultation	18.12.23 to 08.01.24 – Circulated via Care Group Directors and Corporate Leads. Added to SharePoint.
Committee – For approval	23.01.24 – Quality & Safety Committee

2.2 The policy has been reviewed and is consistent with the approach across NHS Wales / legislation.

2.3 The Quality & Safety and Health & Safety Teams have been engaged in the consultation.

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





3. Key Risks / Matters for Escalation

The key areas to note within the Policy are:

- Updating of terminology to reflect the Care Group Hierarchy
- Change from 2 to 5 working days in which to acknowledge complaints
- Inclusion of Duty of Candour requirements
- Transition from Serious Incident to National Reportable Incident

Following consultation the following addition was made:

- All responses where it is considered that there is a qualifying liability or a possible qualifying liability, will require review by the legal team.

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 (Ilyw.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 (Ilyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Safe
	If more than one applies please list below: Person Centred
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable
	If more than one applies please list below:



Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome: This document forms a key part of the quality and safety arrangements for the Health Board.	If no, please include rationale below:
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
	Outcome: No adverse equality issues have been identified.	If no, please include rationale below:
Cyfreithiol / Legal	Yes (Include further detail below)	
	The Concerns Policy & Procedures outlines the redress arrangements to be implemented within the Health Board.	
Enw da / Reputational	Yes (Include further detail below)	
	Implementation of the Concerns Policy & Procedures is key to the Health Board's Quality and Safety Agenda. 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 <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 **APPROVE** the Concerns Policy & Procedures.

6. Next Steps

- 6.1 Once approval is sought the author will share the Policy with the Corporate Governance Team for publication on SharePoint and the Health Board Internet Site.

**CWM TAF MORGANNWG (CTM)
Concerns
Policy & Procedures**

Policy Details:

Ref:	TBC
Policy Author:	Kellie Jenkins-Forrester – Head of Concerns and Business Intelligence Louisa Hayhurst – Complaints Manager
Executive Sponsor:	Executive Director of Nursing, Midwifery, and Patient Care
Approval / Effective Date:	
Review Date:	July 2024
Version:	4

Target Audience:

People who need to know this document in detail	All Health Board Staff dealing with Concerns
People who need to have a broad understanding of this document	Board Members
People who need to know that this document exists	All Health Board Staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	Date: N/A Approved
Welsh Language Standard 82	N/A
Date of approval by Equality Team:	Date:
Aligns to the following Wellbeing of Future Generation Act Objective	Provide high quality, evidenced based, and accessible care

Where	When	Why
Quality and Safety Committee		

Detail of change	Why change made?	Page number	Date of change	Version	Name of Policy Author
Inclusion of Duty of Candour requirements	Duty of Candour implementation 2023	21			
Change from Locality to Care Group	Should reflect new operating model	Through out			
Reference to Serious Incident replaced by Nationally Reportable Incident	Should reflect changes to National Incident Reporting Framework introduced on 14.06.2021	26			
Amendment to timescale in which to acknowledge complaints within 5 working days	To reflect updates to Putting Things Right Guidance	17			
Reference to the Community Health Council being replaced by Llais	To reflect the change in advocacy services offered	1			

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1. Purpose

The purpose of this policy is to support the effective management of complaints, patient safety incidents and redress. It is supported by the Health Board's incident reporting policy and procedure and should be read in conjunction with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 and Putting Things Right Guidance (2013).

The policy, accompanying Standard Operating Procedures and the Incident Management Framework, detail the Health Board's arrangements and applies to:

- a. Complaints
- b. Patient safety incidents
- c. Redress
- d. Duty of Candour

Arrangements for dealing with concerns will be available in a variety of media, formats and languages and will include the internet and via posters and leaflets in public areas.

2. Policy Aim

The aim of this Policy reflects the purpose of the Putting Things Right legislation and guidance:

- Develop a culture of accepting and supporting when dealing with concerns about treatment and care, with staff at all levels being encouraged to apologise for adverse outcomes and to offer explanations why they may have arisen.
- Ensure a patient/user focus rather than process-driven, approach is evident throughout the organisation, which also empowers people to raise concerns and have them dealt with as soon as they arise.
- Emphasise the importance of resolving concerns in a timely fashion, openly and honestly – a philosophy of “investigate once, investigate well”.
- Ensure staff can be confident that investigations will be fair and impartial and that they will be supported throughout the process.
- Ensure learning from concerns and errors drives quality improvement and reduces adverse events, and avoidable harm to patients/users.
- Allow for redress to be provided in circumstances where there is a qualifying liability in tort in relation to the provisions of qualifying services. Redress may encompass apologies, explanations, action plans, remedial treatment and, if appropriate financial compensation.

3. Policy Scope

- a. This policy applies to all staff, permanent and temporary, employed by or working within the Health Board, including independent providers who have responsibility to report, manage and or be involved in concerns raised.

- b. The Policy covers concerns about:
 - Services, care & treatment provided by the Health Board;
 - Services, care & treatment provided by Health Board staff;
 - Services, care & treatment provided by independent contractors;
 - Services, care & treatment provided by the independent or voluntary sector which are funded by the Health Board;
 - Independent contractors are required to have a concerns procedure in place for their NHS patients that is in line with the regulations;
 - This policy does not apply to clinical services provided privately, even when provided within Health Board premises.

4. Policy Framework

This addresses the management of concerns and redress and sets out the principles for the handling of the investigations. It is supported by action cards, and should be read in conjunction with:

1. National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
2. Putting Things Right Guidance on Dealing with Concerns about the NHS from 1st April 2013.
3. Incident Management Framework.
4. Concerns SharePoint pages.
5. Being Open Policy.
6. Quality & Safety Framework.
7. Duty of Candour regulations

5. Roles and Responsibilities

The Regulations specifically require every NHS organisation to make it clear who is responsible, in their organisation, for the undertaking of the distinct roles and regulatory responsibilities as set out below:

a. Care Group/ Unit Clinical Directors, Nurse Directors, Service General Managers, are responsible for ensuring:

1. That a culture of openness is promoted and encouraged to ensure that staff report all concerns that are patient safety incidents and that concerns are robustly investigated in line with the Regulations and acted upon;
2. Effective and practical local arrangements are in place across all provided and commissioned services to ensure full implementation of and compliance with this policy and that these are communicated to staff;
3. That all staff receive patient safety/ concerns training and Datix Cymru training pertinent to their roles and responsibilities. Refresher training needs of staff must be determined at a Care Group level and based on Care Group training needs analysis.
4. That there is appropriate cross Service Care Group/Unit co-ordination and liaison to achieve compliance with this policy;
5. That adequate and appropriate support is made available to staff who are involved in/are the subject of a concern;
6. That staff trained in patient safety/concerns investigations within the Care Groups/Units are released or have their duties appropriately adjusted to enable them to undertake or support investigations when required;
7. That all information pertaining to individual concerns including the outcomes of all investigations are fully and accurately recorded in Datix Cymru, that all documents are saved against the Datix Cymru record, and all action plans are completed through the Datix Cymru system so that compliance can be easily monitored and reviewed;
8. That all necessary actions are taken to prevent re-occurrence of issues arising from both individual and aggregated concerns;
9. Appropriate communication and reporting of relevant information to all appropriate Groups/Committees;
10. That lessons are shared across services and the Health Board as relevant;
11. Create a culture across services where issues are resolved as they arise and informally as far as possible – not allowing unnecessary escalation or protraction of concerns
12. Ensure that 80% of concerns are responded to within 30 working days and no concerns receive a response later than 60 workings days (Regulatory maximum time period);

13. The Care Group/unit Datix Cymru (patient safety) dashboard is reviewed regularly and core outcomes reported to Groups/Committees/Care Group/Unit meetings to assist decision making.

b. All Staff employed by the Health Board

All staff must:

1. Treat persons notifying concerns with respect and courtesy;
2. Address issues and concerns as they arise and escalate for assistance if unable to manage the matter;
3. Attend patient safety/ concerns training and Datix Cymru training pertinent to their roles and responsibilities;
4. Ensure that patient safety incidents that they are aware of are reported, no matter how minor they might appear. This ensures that the Health Board has the opportunity to take all appropriate actions under this policy including learning from such events and improving matters for the future;
5. Ensure they report patient safety incidents brought to their attention by patients and other persons. However, patients and other persons are equally entitled to complete and submit an incident report to the Health Board if they wish to do so. Staff should ensure assistance is given in such instances;
6. All staff should ensure they are aware of how to access copies of the Health Board's arrangements for handling Concerns, in all the formats, to enable them to satisfy any reasonable request made of them for this information;
7. Be open, honest and transparent at all times; and
8. Adhere to this Policy and supporting procedures.

c. Strategic oversight of the arrangements

A nominated Non-Officer Member must assume responsibility for maintaining a strategic overview of the operation of the Health Board's arrangements (under the Regulations), particularly as regards ensuring that:

- i. The Health Board complies with these arrangements and the officer supports a positive safety culture and commitment to being open;
- ii. The Health Board has arrangements in place to review the outcome of the investigation of any concern, in order to ensure that any deficiencies in actions or service provision that have been identified by the investigation, are acted upon and monitored;
- iii. Lessons learned are identified and disseminated throughout the Health Board in order to improve the services that it provides and to seek to reduce future risk.

In the case of CTM Health Board this role has been designated to the Chairperson of the Quality and Safety Committee.

d. Responsible Officer

The Regulations specify that the Responsible Officer is responsible for the effective day to day operation of the Health Board's arrangements for dealing with concerns in an integrated manner. The Executive Director of Nursing Midwifery and Patient Services is the Responsible Officer for CTM Health Board. [In relation to these regulations 'integrated manner' means that the process for dealing with concerns and claims management (where there is a duty under the Regulations to consider qualifying liabilities) are dealt with under a single governance arrangement.

The regulations allow for the functions of the Responsible Officer to be performed by the Executive Director of Nursing Midwifery and Patient Services or any person authorised by the Health Board to act on their behalf.

e. Senior Investigations Manager –

The Assistant Director of Quality and Safety is the Senior Investigations Manager for CTMU Health Board.

Under the Regulations, the Senior Investigations Manager is responsible for:

1. The handling and consideration of concerns in accordance with this Policy;
2. Performing such other functions relating to the handling and consideration of concerns as the Health Board may specify;
3. Ensuring co-operation with such other persons or bodies as may be necessary to facilitate the handling and consideration of concerns.

In relation to performing such other functions relating to the handling and consideration of concerns as the Health Board may specify', the Assistant Director of Quality & Safety is responsible for:

1. The operation of the Ombudsman and Complaints Team, Legal Services Department, Quality and Safety Team,
2. The development, integration and embedding of a comprehensive investigation and redress system for concerns,
3. Acting as the Health Board's Lead Investigation Officer; to lead, facilitate and provide advice on the investigation and analysis of concerns;
4. Overseeing the investigation of all serious concerns;
5. Personally investigating and analysing any individual concern when requested to do by the Executive Team;
6. Provide assurance to the Board on the Care Group/ units performance;
7. Ensure lessons learned are shared across Care Group/units.

f. Health Board – General

The Health Board is required by the Regulations to ensure that, at all times, the Senior Investigations Manager has a sufficient number of staff, of the required level of seniority and skills, to assist them in the carrying out of the functions that fall to the Senior Investigations Manager. Further, members of staff must receive adequate training to enable them to fulfil their responsibilities as specified.

The Health Board will ensure that all staff are informed about and receive appropriate training in respect of the operation of this Policy.

Non-Regulatory Responsibilities

g. Executive Team

The Medical Director and The Executive Director of Nursing Midwifery and Patient Services have joint responsibility for quality and safety and will provide leadership and support to ensure that the aims of this policy are achieved. They are both responsible for providing authority to admit a breach of duty in respect of their professional accountabilities and consider the Care Group/Unit Directors views on admissions.

h. Quality and Safety Committee

The Quality and Safety Committee:

- Considers Putting Things Right Policies to endorse approval by the Quality and Safety Committee and approves all relevant Standing Operating Procedures;
- Oversee compliance with the Health Boards Risk Management Strategy and Putting Things Right Policy and affiliated policies, as necessary to ensure compliance with the Strategy and Regulations;
- Receive reports at Corporate Directorate Level and Care Group/Unit Level in order that key issues can be identified and learning can be shared;
- Scrutinise themes and trends for escalation to the CTM Board;
- Receive exception reports on patient safety alerts and notices and agree actions required for action and monitoring;
- Highlight risk issues that require consideration at a Health Board wide level; and
- Highlight risks which require specialist review to the appropriate Corporate Group/Committee for consideration and the Executive Lead.

The purpose of the Quality & Safety Committee is to provide:

- Evidence based and timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the quality and safety of healthcare; and
- Assurance to the Board in relation to the Health Board's arrangements for safeguarding and improving the quality and safety of patient centred healthcare in accordance with its stated objectives and the requirements and standards determined for the NHS in Wales.

The Quality & Safety Committee will receive a Quality and Safety Dashboard at each meeting, to support achievement of these objectives. Additional reports will be commissioned from appropriate areas as required.

6. General Principles for the Handling and Investigation of Concerns

The Health Board's arrangements for the handling and investigation of concerns are intended to ensure:

- a. A single point for logging complaints as required by Putting Things Right;
- b. The expectation of the person notifying the concern is established and their involvement in the process secured wherever possible;
- c. Concerns are properly investigated and responded to efficiently and openly, applying Health Board values;
- d. Persons raising concerns are treated with respect and courtesy; and advised of the availability of assistance to enable them to pursue their concern and where they may obtain such assistance, if it is required. Also the name of the person who will act as the Health Board contact throughout the handling of the concern;
- e. Whilst noting that Redress is not applicable to primary care providers; consideration is given to the making of an offer of redress where the Health Board's investigation into the matters raised in the concern reveals that there is a qualifying liability in tort;
- f. Persons notifying concerns receive a timely and appropriate response within the bounds of receiving the appropriate consent;
- g. Persons who notify the Health Board of concerns are advised of the outcome of the Health Board's investigation providing the appropriate consent has been received by the Health Board;
- h. Appropriate action is taken in the light of the outcome of the investigation and there is learning and improvement.

An action card for dealing with a complaint and in accordance with the requirements of the Regulations is in Appendix 1.

7. Who can Raise A Concern / Complaint

a. Persons who can notify Concerns / Complaints

Almost anyone can raise a concern and the Health Board will be under a duty to consider whether it can be investigated. However, it may not always be possible to share the full details of the investigation with the person raising the concern, for instance if they are not the patient or a person recognised as having authority to access the information.

A concern may be notified by:

1. People who are receiving or have received services from the Health Board,
2. Any person who is affected, or likely to be affected by the action, omission decision of the Health Board, in relation to the functions of the Health Board;
3. Any non-officer member of the Health Board, e.g. an independent member;
4. Any member of staff of the Health Board;
5. Any person acting on behalf of any person from the above categories (1 to 4) who has died, is a child, lacks the capacity under the Mental Capacity Act (2005) to notify the concern themselves or has requested the person to act as their representative.
6. Assembly Members and Members of Parliament

b. Concerns Notified by a third party

Within Putting Things Right guidance (2013), when a third party acts as a representative on behalf of another e.g. a child or someone who lacks mental capacity if there are reasonable grounds to conclude that they are not suitable to act on their behalf, for example because it does not appear to be in the patients best interests, then they must be advised in writing. However, an investigation into the issues raised may still need to be undertaken. In this instance the Health Board is under no obligation to provide a detailed response to the person who raised the concern, unless it is reasonable to do so.

c. Concerns raised on behalf of a child / young person

Where a concern is notified by a child, the Health Board must provide the child with any reasonable assistance that the child requires in order to pursue the concern. Specialist advocacy may be required and advice regarding accessing this is available from <https://www.meiccymru.org/about/>.

In many instances, someone else (parent/carer/guardian) will raise a concern on behalf of a child / young person. This does not remove the right of the child / young person to take the concern forward themselves with support. The Health Board must satisfy itself whether the child / young person wishes to raise the concern themselves, with support, or if they are happy for the person who raised the concern to represent them. If the child / young person is not willing to proceed with an investigation then a decision will need to be taken about proceeding and specialist advice sought if appropriate. Particular regard needs to be given to safeguarding issues, and it may be necessary to proceed with an investigation, even if a child appears unhappy to do so. The Health Board is under no obligation to provide a response to the person who raised the concern in the first instance.

d. Concerns Notified by Staff

Staff are required to report any concerns with a person's care or treatment via Datix Cymru (the Health Board's on-line Incident Reporting mechanism). Where the initial investigation determines there has been harm, the regulations require the Health Board to:

1. Notify the patient or his/her representative of the notified concern, and
2. Involve the patient, or his/her representative in the investigation of the concern

This notification and involvement will be undertaken in accordance with the Duty of Candour requirements.

Where it is considered that it would not be in the interests, this may be due to mental capacity or health status then a best interest meeting should be convened and the safeguarding team contacted. The Health Board is required to:

- i. Make a written record of this decision and the reasons for it, and
- ii. Keep the decision under review during the investigation of the concern

8. Matters & Concerns Excluded From Consideration Under The Policy

Not all concerns can be dealt with under the regulations. Matters excluded are set out in regulation 14 of Putting Things Right and examples include:

- a. A concern notified by a Primary Care Provider relating to the contract under which it provides Primary Care services - these are to be managed through the contractual arrangements;

- b. A concern notified by any member of staff relating to that person's contract of employment - these are to be managed through the Health Boards workforce procedures;
- c. A concern that is being or has been investigated by the Public Services Ombudsman for Wales;
- d. A concern arising out of an alleged failure of the Health Board to comply with a request for information under the Freedom of Information Act 2000 – these would be dealt with by the Information Commissioners Office;
- e. Disciplinary proceedings that the Health Board is taking or proposing to take, arising from the investigation of a concern notified and dealt with in accordance with this Policy- these would be via the Health Boards workforce procedures;
- f. A concern that is notified verbally and is resolved to the satisfaction of the person who notified the concern within 1 working day of the concern being notified;
- g. A concern with the same subject matter as a concern that was previously notified verbally and was resolved to the satisfaction of the person who notified the concern within 1 working day, unless the Health Board considers that it is reasonable to re-open the concern and undertake an investigation under this Policy;
- h. A concern previously considered under this Policy or the Health Board's previous Complaints Policy and Procedure;
- i. A concern that is/becomes the subject matter of Civil Proceedings. If court proceedings are issued when a concern is already under investigation in accordance with the regulations, all further investigation of the concern must stop;
- j. A concern that is/becomes the subject of a concern related to an Individual Patient Funding (IPFR) Request. Reference should be made to the Welsh Health Shared Services Committee IPFR policy.
- k. Police criminal investigation
- l. A concern that involves Safeguarding, this would be passed to the Safeguarding team for immediate action.

The Health Board will advise the person who notified the concern, as soon as reasonably practicable, in writing, of the reason(s) for any decision that the concern is excluded from the scope of the Regulations and, thereby, this Policy. However, this is not required in relation to a concern that was notified verbally and resolved to the satisfaction of the person who notified the concern within 1 working day of the concern being notified.

9. Time Limits For The Notification Of Concerns

The Putting Things Right regulations require a concern to be notified:

- a. Within 12 months of the date on which the subject matter of the concern occurred, or
- b. Within 12 months of the date on which the subject matter of the concern came to the notice of the patient. (Where a patient has opted to have a representative act on his/her behalf, this date is the patient's date of knowledge, NOT the date that the representative was informed of the concern by the patient).

To investigate a concern after this 12 month deadline, the Health Board must consider whether the person raising the concern had good reason not to notify the Health Board of the concern earlier and whether, given the time lapse, it is still possible to investigate the concern thoroughly and fairly.

However, a concern under these regulations may not be notified 3 or more years after the date on which the subject matter occurred or after the date that the subject matter came to the notice of the patient. The Health Board will, therefore, refuse to consider any such concern. (Where a patient has opted to have a representative act on his/her behalf, this date is the patient's date of knowledge, NOT the date that the representative was informed of the concern by the patient). If the person who raised the concern is a child at the time of injury the three year period does not begin to run until the individual reaches the age of 18 years and runs out on their 21st birthday.

If the Health Board makes an exception to this it must make it clear to the person who raised the concern that the investigation may be limited in some aspects based on the information available as key staff may have left the Health Board and memory in relation to the circumstances may be compromised.

10. Withdrawal of Concern

A concern may be withdrawn at any time by the person who notified it. The withdrawal can be communicated to the Health Board by written, electronic or verbal means.

Where a withdrawal is communicated verbally, the Health Board is required to write to the person to confirm the withdrawal.

The Health Board can continue to investigate any concern that has been withdrawn, should it be considered reasonable and necessary to do so.

11. Concerns that Involve Other Organisations

Where the Health Board is notified of a concern that also involves the functions of another organisations, (whether this is known by the person notifying the concern or not), the Health Board is required to seek the consent of the person to contact any other relevant organisations and notify it of the concern. This consent must be sought within 2 working days of the receipt of the concern and done at the same time as acknowledging the concern. However there may be occasions when it is not immediately evident that Primary Care contractors records need to be reviewed and comments sought.

Once consent is received, the Health Board is required to contact all other relevant organisations involved in the concern within 2 working days of the consent being received.

The Health Board must agree with the other organisations and person raising the concern which organisation will take the lead, co-ordinate the investigation and provide the response. All relevant organisations should be included in any meetings arranged to discuss the concern.

12. Concerns Notified To The Health Board Involving Primary Care Providers

Regulations 18-21 deal with concerns notified about services provided by a primary care provider under a contract or arrangements with the Health Board.

When the Health Board receives a concern, notified by or on behalf of a person who is receiving or has received services from a Primary Care provider, it is necessary to determine whether it is appropriate for the Health Board to consider the concern or whether it is more appropriate for the concern to be considered by the Primary Care provider that is the subject of the concern. Before making

this decision, and within 2 working days the Health Board must determine, from the person who notified the concern, whether:

- a. The concern has already been considered by the Primary Care provider, and if so, whether a response has been issued by the Primary Care provider that is in accordance with the requirements in the Regulations
- b. The person who notified the concern consents to details of the concern being sent to the Primary Care provider who is the subject of the concern.

If the concern has been investigated by the Primary Care provider and a response issued then the Health Board must not re-investigate it. The person must be advised of this and reminded of their right to take the matter to the Public Services Ombudsman for Wales.

If the concern has not been investigated by the Primary Care Provider and the Health Board considers this is a concern that it should investigate consent is required to allow the Health Board to send details of the concern to the relevant Primary Care provider who is subject of the concern. If consent is not provided the Health Board must not investigate the concern as it would not be possible to investigate without the co-operation of the Primary Care Practitioner, and the Practitioner should, in the interest of fairness know when a concern about them is being investigated.

If the Health Board decides that it is appropriate for it to deal with a concern, it is required to advise the person who notified the concern and the Primary Care provider of this decision within 5 working days, giving the reasons for this decision. Primary Care Providers are under an obligation to co-operate with investigations undertaken by the Health Board. However, the Health Board may not make any determination about the liability in tort of a Primary Care Provider. If such matters are alleged by the person raising the concern or arise during the investigation, the Primary Care Provider should be advised to involve their Medical Defence Organisation. The person raising the concern will need to be notified that the Health Board cannot become involved in those aspects of any concern about a Primary Care Provider.

If the Health Board decides that it is more appropriate for the concern to be dealt with by the Primary Care provider, the Health Board is required to advise the person who notified the concern and the Primary Care provider of this decision and why the decision has been made. The person raising this concern may be unhappy with this decision and should be informed as part of this decision letter of their right to take their concern to the Public Services Ombudsman for Wales.

When the Primary Care provider receives the notification of the Health Board's decision, the Primary Care provider must deal with the Concern in accordance with the Regulations.

13. Handling Of Concerns

a. Verbal Concerns / Complaints

1. Where a concern is notified verbally, the member of staff to whom the concern has been notified must make every effort to respond to that complaint there and then. If unable to do so to the satisfaction of the complainant they must escalate to someone more senior e.g. Ward Manager, On-call Manager, and Departmental Manager etc. All attempts should be made to deal with these issues as soon after they arise taking no longer than the next working day. These should be documented as early resolution concerns using Datix Cymru.
2. If the complaint is resolved to the satisfaction of the complainant then the person dealing with the complaint must make a written record of the concern and offer a copy of the written record to the person who notified the concern.

b. Acknowledgment of Concerns

Complaints managed under Putting Things Right must acknowledge receipt of the concern within 5 working days of the day on which the concern is received. The acknowledgement may be made in writing or electronically, depending upon how the concern was notified to the Health Board.

Where the concern is notified verbally, the Health Board is required to acknowledge the concern in writing, outlining what the issues were and what has been agreed in relation to matters for investigation.

For care & treatment concerns attempts should be made to contact the person who raised the concern for a discussion prior to the acknowledgement being sent. This should be undertaken by a responsible officer for the area/ service concerned. The responsible officer should thank them for raising the concern, offer an apology and where the officer considers it appropriate offer a meeting to discuss the concerns further. Even where a meeting is being arranged, the concerns team will still issue a written acknowledgement outlining who to contact while the investigation is undertaken, in addition:

1. The manner in which the Health Board will handle the investigation, including consent to the use of medical records;

2. The availability of advocacy and support services that may be of assistance to the person in their pursuit of the concern;
3. The period within which the Health Board is likely to complete the investigation of the concern and send a response to the person.

Further details on investigating and responding to concerns is provided in Appendix 1.

c. Consent

Where the person has raised the concern then in doing so, they can be deemed to have given implied consent to an investigation. This will also apply if a concern is raised by a representative who has shown proof that they are legally entitled to act for the patient/data subject (e.g. the representative has a Power of Attorney and the terms of the Power of Attorney have been met). However, in order for individuals to be clear in the knowledge that their medical records may need to be accessed, and therefore shared with the person acting on their behalf, this should be explained in the acknowledgement letter so that they have the opportunity to indicate if they do not want their health records accessed .

Where a third party has raised a concern, then the patient or their representative will be asked to give written consent to allow access to medical records and the conduct of an investigation.

d. Grading of Concerns

The All Wales Grading Framework is based on a matrix developed by the former National Patient Safety Agency and is used to assess and manage incidents. The grading of a concern should be assessed on receipt of the concern and reviewed following the investigation.

This matrix will be adopted to determine the level of investigation required in dealing with all types of concerns in order to promote a consistent approach across the Health Board and to ensure a proportionate investigation (Appendix 2).

e. Quality of Response

It is essential that all responses are full, comprehensive, clear and answer the concerns raised. The response needs to be in layman's terms ensuring a meeting is offered on receipt of the responses and information is provided on how to access the Public Service Ombudsman office (Wales). The senior Care Group/Unit team will ensure that all responses are thoroughly quality assured, using the quality assurance checklist (Appendix 4) and approve the final response for sharing with the complainant. All staff who undertake quality assurance checks for concerns

must receive training on this process which can be accessed via the concerns team.

Regulation 24 requires the Health Board to take all reasonable steps to send the response to the person who notified the concern within 30 working days, beginning on the day that the notification of the concern was first received. It is essential the Concerns team advises the person who raised the concern of the predicted timescale for a response. If the Health Board is unable to provide a response within 30 working days, the following actions are required:

1. A written explanation setting out the explicit reasons for the delay must be provided to the person who raised the concern, with estimation or anticipated date for completion of response.
2. Some responses may take up to 60 working days (3 months), where a serious patient safety investigation is required. Rarely an investigation may take up to 6 months, however where this is the case close contact with the complainant must be maintained to provide regular updates of the stage of the investigation. Responses should not be sent later than 6 months, from the day that the notification of the concern was first received.
3. Timescales are reported at service, Care Group/unit and at corporate level through the management structures.

14. Learning from Concerns

The Health Board will ensure that it has arrangements in place to review the outcome of any concern that has been subject to an investigation under the Regulations, in order to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

1. Recognised, acknowledged, owned and acted upon
2. Where improvement requires embedding, an improvement plan will be developed using the template action plan in Datix Cymru within the Datix Cymru Action Plan module; and
3. Reviewed and reported regularly within the Care Groups, as highlighted within the Listening and Learning Framework, to ensure improvements are established minimizing the risk of reoccurrence.

Learning lessons throughout the Health Board and taking action to ensure any necessary improvements are made is critical to avoid such deficiencies recurring.

The Health Board has a number of mechanisms for sharing learning from patient experience and concerns, eg. Alerts, newsletters, intranet, training, meetings using the multi-disciplinary team forums within the Care Group/units for shared learning and improvement.

15. Being Open / Duty of Candour

A culture of openness, transparency and candour is widely associated with good quality care. The Health Board requires an organisational duty of candour requiring staff to be open and honest with patients and service users when things go wrong. The duty requires the Health Board to follow a process when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

16. Reopening Complaints

In the event that a complainant is dissatisfied with their response and there are no new issues to investigate then the complaint will not be reopened but a meeting with the complainant will be offered. Where the complainant remains dissatisfied then he/she will be advised to refer to the Public Services Ombudsman of Wales.

17. Alternative Dispute Resolution

Some complaints may be resolved by using alternative dispute resolution (ADR), such as mediation, facilitation or conciliation. This approach is often useful when the person who raised the concern is upset or there is unease between the Health Board and the person raising the concern. An ADR panel will be convened where:

- Staff or practitioners are having difficulty in dealing with the concern
- When the person who raised the concern feels anxious that the approach of the concerns team/lead person is not impartial;
- When there are misunderstandings with relatives, during the treatment of a patient.

ADR can lead to a 'shared view' of the situation including their differences. The Terms of reference for an ADR panel are enclosed in Appendix 5.

18. Where a Qualifying Liability does or may exist (Redress)

Regulation 26 requires that where the Health Board's investigation of a concern determines that a qualifying liability exists or may exist, it is required to determine whether or not an offer of Redress should be made. All responses where it is considered that there is a qualifying liability or a possible qualifying liability, will require review by the legal team.

Redress can take the form of:

- A formal apology.
- Remedial action.
- Investigation and explanation.
- Financial compensation up to £25, 000.00.

To establish liability, the following elements must be met:

- a. That the Health Board had / has a duty of care to the person. A legal duty of care arises when the health care system accepts the patient.
- b. The duty of care has been breached i.e. the standard of care / treatment provided fell below the expected standard.
- c. Causation of damage. Did the healthcare provider's acts or omissions caused harm to the patient as a result of the breach of duty of care?

If the Health Board considers that the qualifying liability justifies financial compensation exceeding £25,000, the Health Board must not offer Redress in the form of financial compensation under the Regulations. The Health Board may, however, make an offer of settlement outside of the provision of the Regulations.

A patient, or his or her representative, has 6 months from the date the offer is made, to respond to an offer of financial compensation made by the Health Board. After 6 months, the liability will no longer be considered as being the subject of an application for Redress.

In some situations, this can be extended to 9 months, please refer to the Putting Things Right Guidance, (2013).

Redress is not available and must not be offered in relation to a liability that is, or has been, the subject of Civil Proceedings. If Civil Proceedings are issued during the course of the Health Board considering Redress, the Health Board must cease all consideration of Redress and must advise the person who notified the concern accordingly.

Where the Care Group/ unit management team determine a breach of duty has occurred or considers this may be likely, the case will be discussed at the weekly Redress Meeting.

19. Confidentiality

Information contained within concerns falls within the definition of personal data contained within the General Data Protection Regulation (2016). The Health Board also has duties under the requirements of Caldicott and the Human Rights Act 1998 in respect of the right to privacy and also the Freedom of Information Act 2000 in respect of openness.

Information on concerns should not be disclosed/copied/ shown to any external agency without the permission of the Responsible Officer or nominated deputies. All requests for access to such information should, therefore, be directed to the appropriate Manager, or nominated deputy, for the service area that is the subject of the concern, in the first instance.

NHS Wales has adopted the Confidentiality: Code of Practice for Health and Social Care in Wales. All staff have an obligation of confidentiality regardless of their role and are required to respect the personal data and privacy of others. Staff must not access information about any individuals who they are not providing care, treatment or administration services to in a professional capacity. Rights to access information are provided for staff to undertake their professional role and are for work related purposes only.

Further information where required can be found via the organisation's Privacy Policy, and the Information governance Policy.

20. Managing Media Interest / Media Communications

The management of media interest/ in relation to incidents, either individually or generally, will be undertaken by the Health Board Communications Department

21. Disability and Special Requirements of a Complainant

Immediately a complainant identifies a disability or special requirements in relation to communication, every effort must be made to make reasonable adjustments to accommodate the special request/requirement. Once agreed this should be documented in Datix Cymru and shared with all staff who will communicate with the individual.

22. Dealing with Unreasonable Demands

People raising concerns have the right to be heard, understood and respected. On occasions there may be times when persons raising the concern out of character and become determined, forceful, and angry and make unreasonable demands of staff.

If staff encounter situations where person behave in an unacceptable manner towards them, then they should report to their line manager for support and advice. The complaints manager should be informed and this must be reported

on Datix Cymru. The complaints manager will provide verbal and written guidance on dealing this type of behaviour. Please see Appendix 3.

a. What is unreasonable, unacceptable aggressive or abusive, violent behaviour?

- Behaviour that produces damaging or harmful effects, physically or emotionally on other people.
- Persistent unacceptable behaviour – behaviour that is deemed unacceptable within one event or on a number of occasions within a period of time.

b. Examples of unacceptable or aggressive or abusive behaviour:

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g. both written and oral.
- Unreasonable demands e.g. Demands for responses within unrealistic timescales, repeatedly phoning, writing or insisting on speaking to particular members of staff.

23. Training

Whilst there are specific elements to the effective and efficient management of concerns which require training, the most enabling aspect of achieving this relates to staff in every part of the organisation fully embracing the Health Board's values in their interactions with everyone they come into contact with including, patients, relatives, carers and colleagues.

The different levels of training are outlined in the concerns training plan which outlines the training specific to Putting Things Right. At level 1 training is provided at staff induction and management of complaints is available via the learning portal on the Electronic Staff Record (ESR) site.

Level 2 training is specifically aimed at staff undertaking patient safety and grade 4 and 5 complaint investigations.

Additional training needs are identified through management structures and processes within the localities, e.g. via the Performance Annual Development Review (PADR) process.

The concerns team undertake local departmental level training and also at wider Health Board level in the form of annual learning events. Specific professional

groups also receive training, e.g. the new junior Doctors and new consultants. The concerns team are reactive to the Care group/unit training needs analysis to meet training requirements.

Appendix 1

Action Card for dealing with Complaints

Immediately
<ul style="list-style-type: none"> • Listen to the concerns raised, Say Sorry and acknowledge what has happened. Consider if there is harm and if any immediate make safe action is required. An apology, shall not of itself amount to an admission of negligence or breach of statutory duty. • Delayed or poor communication makes it more likely that a person will seek information in a different way such as complaining or taking legal action and this delays resolution and/or redress, wherever this is possible. • The way you say sorry is just as important as saying it. An apology should demonstrate sincerity and tailored to the individual's needs. • Stay calm, polite, use the person's name, make eye contact and speak calmly • Remember the person may be prompted by distress, bereavement, anxiety and frustration • Provide a copy of the Putting Things Right Leaflet in a suitable format
Early Resolution
<ul style="list-style-type: none"> • Every effort to respond to any concerns at the time they are raised should be made. If unable to do so to the satisfaction of the person raising the concern they must escalate to someone more senior e.g. Ward Manager, Departmental manager etc. All attempts should be made to deal with these issues as soon after they arise taking no longer than 24 hours. These should be documented as early resolution concerns in Datix Cymru. • If the complaint is resolved to the satisfaction of the complainant then the person dealing with the complaint must make a written record of the concern and offer a copy of the written record to the person who notified the concern. • Staff must advise people how to progress their complaint to be managed through Putting Things Right, if they are not satisfied with the outcome of their complaint at the end of the early resolution stage. • Frontline staff should be trained and encouraged to provide appropriate information on advice and advocacy support at this stage of the complaints process. • Training is available at induction and also via ESR. Staff are required to identify their training needs via the PADR process.
Complaints managed under Putting Things Right Regulations
<p>Where the person wishes to have their complaint managed through Putting Things Right or where there is an allegation of harm then the complaint must be managed under the Putting Things Right regulations. The complaint must be logged on Datix Cymru and formally acknowledged within 5 working days of the day on which the complaint was received. The acknowledgement may be made in writing or electronically, depending upon how the complaint was notified to the Health Board.</p> <p>Attempts should always be made to contact the person who raised the concern to have a discussion with them prior to the acknowledgement going out to thank them for raising the concern, offer an apology that they have needed to do so, and offer a meeting with the manager of the area or clinicians responsible for services concerned. The written acknowledgement must confirm this.</p>

The person making the complaint must be advised of timescales for investigating their concerns. This is within **30 working days**, however very occasionally it may take up to 60 working days where a serious patient safety investigation is required.

All formal complaints must be managed under the Putting Things Right regulations and handled by the Care Group/unit's central governance team. The complaint will be graded to decide on the appropriate level of investigation, see Appendix 2.

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Appendix 2



Grading Framework for Complexity of Complaint

Grade	NPSA level of harm	Examples of concerns	Redress Potential
1	<p>No harm</p> <p>Impact Prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS funded care OR Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.</p>	<p>Concerns which normally involve issues that can be easily / speedily addressed, with no harm having arisen. For example:</p> <ul style="list-style-type: none"> • outpatient appointment delayed, but no consequences in terms of health • difficulty in car parking • Concerns which have impacted on a positive patient experience 	Highly unlikely
2	<p>Low harm</p> <p>Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.</p>	<ul style="list-style-type: none"> • Concerns regarding care and treatment which span a number of different aspects/specialities • Increase in length of stay by 1 - 3 days • Patient fall - requiring treatment • Requiring time off work - 3 days • Concern involves a single failure to meet internal standards but with minor implications for patient safety • Return for minor treatment, e.g. local anaesthetic 	Unlikely
3	<p>Moderate harm</p> <p>Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.</p>	<ul style="list-style-type: none"> • Clinical / process issues that have resulted in avoidable, semi permanent injury or impairment of health or damage that require intervention; • Additional interventions required or treatment / appointments needed to be cancelled; • Readmission or return to surgery, e.g. general anaesthetic; • Necessity for transfer to another centre for treatment / care • Increase in length of stay by 4 -15 days • RIDDOR Reportable Incident • Requiring time off work 4 -14 days • Concerns that outline more than one failure to meet internal standards • Moderate patient safety implications • Concerns that involve more than one organisation 	Possible in some cases
4	<p>Severe harm</p>	<ul style="list-style-type: none"> • Clinical process issues that have resulted in avoidable; semi-permanent harm or impairment of health or damage leading to incapacity or disability; • Additional interventions required or treatment needed to be cancelled; 	Likely in many cases

	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.	<ul style="list-style-type: none"> • Unexpected readmission or unplanned return to surgery; • Increase in length of stay by >15 days • Necessity for transfer to another centre for treatment / care • Requiring time off work >14 days • A concern, outlining non compliance with national standards with significant risk to patient safety • RIDDOR Reportable Incident 	
5	<p>Death</p> <p>Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care, or Any patient safety incident that directly resulted in the death (or severe harm) of one or more persons receiving NHS-funded care.</p>	<ul style="list-style-type: none"> • Concern leading to unexpected death, multiple harm or irreversible health effects • Concern outlining gross failure to meet national standards • Normally clinical/process issues that have resulted in avoidable, irrevocable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and/or mental well-being. • Clinical or process issues that have resulted in avoidable loss of life • RIDDOR Reportable Incident 	Very Likely

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Appendix 3

ACTION CARD

Dealing with people who make unreasonable demands relating to concerns

People raising concerns have the right to be heard, understood and respected. However, there may be times when the distress of a situation leads to the person raising a concern to act out of character and become determined, forceful, and angry, and make unreasonable demands of staff or (rarely) use threatening behaviour and even resort to violence.

People who are unhappy about the outcome of the investigation of their concern, despite being advised about other avenues available to them, may also show aggression towards staff or continue to persistently pursue their concerns by phoning, writing or in person. The following steps may be considered and further information is available in the Putting Things Right Guidance- Appendix L.

Action Required

Notify and seek support from the Concerns Team

The Concerns Team will-

Put an arrangement in place whereby calls can only be received at set times on set days and **one member** of staff will be allocated as a contact point for written or verbal communication.

Restrict contact to written correspondence only.

Advise to only make appointments to meet with the complainant if there is no other way of communicating with them. Also advise to never meet them alone and always in working hours within a NHS facility where other staff are available for support. If there are threats or use of physical violence the incident should be reported to the police.

At each stage, it should be made clear to the person what actions are being taken and why, and outlined in a letter to the complainant from the concerns team.

Where previous concerns have been addressed, the complaints file should be closed and if new issues arise it should be explained that this will be managed as a new complaint. Any new correspondence will be acknowledged and the PTR Regulations followed in the usual manner.

Reporting Violent or Aggressive Behaviour

Incidents where violence and/or aggression occur **must** be reported and recorded via local reporting mechanisms.

Key Quality Assurance Questions for Consideration

COMPLAINT HANDLER QUALITY ASSURANCE CHECKLIST

Staff name:			
Datix reference			
Supervisor:			
Date of assessment:		Complete	Feedback

Action assessed	Assessed by	Comment
Concern acknowledged within 2 working days	Datix Progress Notes and Documents	
Introduction call completed and issues fully scoped	Datix Progress Notes and Documents	
Correct Clinicians identified for comments	Memo details saved to Datix documents for review	
Memo issued within 4 working days	Memo details saved to Datix documents for review	
Comments chased after 10 working days (if applicable)	Datix Progress Notes and Documents	
Delays raised in weekly Care Group review (if applicable)	Datix Progress Notes	
Does The Final Response Letter address all elements of original concern?	View original concern and memo to Clinicians to compare	
Is the language used appropriately sensitive to the patient and / or their family reading the response?	Review of Final Response Letter	
Is the response written in Layman's terms?	Review of Final Response Letter	
Does the response include all required PTR wording?	Review of Final Response Letter	
Has the record been closed appropriately?	Ensure all dates have been correctly entered	
Have progress notes been updated to show a full audit trail?	Cross reference Documents with Progress Notes	
Have all documents been uploaded to the Document section?	Cross reference Progress Notes with Documents	

Appendix 5

Alternative Dispute Resolution Panel –Terms of Reference

1. INTRODUCTION

Cwm Taf Morgannwg University Health Board manages Complaints in line with the requirements of *Putting Things Right (2011)*. The management of complaints is reviewed regularly, to take account the guidance provided by the Welsh Risk Pool safety and learning networks which includes network groups for complaints handling, Public Services Ombudsman of Wales improvement work, claims management and Redress.

Some complaints may be resolved by using alternative dispute resolution (ADR), such as mediation, facilitation or conciliation. This approach is often useful when the person who raised the concern is upset or there is unease between the Health Board and the person raising the concern. An ADR panel will be convened where:

- Staff or practitioners are having difficulty in dealing with the concern
- When the person who raised the concern feels anxious that the approach of the concerns team/lead person is not impartial;
- When there are misunderstandings with relatives, during the treatment of a patient.

ADR can lead to a 'shared view' of the situation including their differences.

3. PURPOSE

The purpose of the Alternative Dispute Resolution Panel is to provide a forum of expertise for reviewing an unresolved complaint, to ensure that complaints are managed in line with the Regulations, and in a manner which minimises clinical, financial and organisational risks.

The panel will provide assurance to the complainant of further review of the concerns raised to assess if any further action by the health board is required.

The Panel will assess the complaint and the quality of response as well as any further communications between the complainant and the Health Board to assess if any further action is required.

4. SCOPE

The scope of the Panel is:

1. To take an independent overview of the complaint, the response and any other forms of communication between the complainant and the Health Board. Consideration will be given to:
2. The continued concerns of the complainant, the response already issued, any gaps in the continued concerns and the response.
3. Compliance with the Putting Things Right guidance and regulations
4. The panel will undertake a detailed analysis and scrutiny of the complaint, to assess the degree of effective management, including evidence of robust proportionate investigation, learning and improvement where required.

As part of this work, the Panel will review confidential issues and is required to work under the General Data Protection Regulations (2016) and the requirements of Caldicott and the Human Rights Act 1998 in respect of the right to privacy and also the Freedom of Information Act 2000 in respect of openness. As such, all reports and action plans should be clearly marked as confidential. Members of the Panel must raise concerns regarding confidentiality issues at any time during the meeting if they feel that an individual's position is being compromised or they need to declare an interest.

5. MEMBERSHIP

Executive Director of Nursing, Midwifery and Patient Services or nominated deputy

Assistant Director of Safety and Quality

Medical Director or nominated deputy

Board Secretary/Corporate Director

Head of Concerns and Business Intelligence

Invited colleagues to attend as required in order to present and to discuss specific issues, such as representatives from the relevant service areas and patient advocacy services, e.g. Community Health Council Representative, legal and risk services, violence and aggression lead.

6. QUORUM

A quorum will include: one Executive Director, Board secretary/ Corporate Director and one other member.

7. FREQUENCY OF MEETINGS

The Panel shall meet when Alternative Dispute Resolution is considered by the Assistant Director of Quality and Safety. Minutes and action points from meetings will be circulated within 7 days following the meetings. Papers for meetings will be circulated 7 days prior to the scheduled meeting date.

8. AUTHORITY

The Panel will require authorisation from the complainant to hold a panel and written consent will be obtained.

10. REVIEW

These Terms of Reference shall be adopted by the Alternative Dispute Scrutiny Panel and will be subject to review every two years by the Concerns scrutiny panel.



Agenda Item

9.1.5

Quality & Safety Committee

**Proposed Process for the Approval of Clinical Policies and Guidelines
within Cwm Taf Morgannwg University Health Board**

Dyddiad y Cyfarfod / Date of Meeting	24/01/2024
Statws Cyhoeddi / Publication Status	Open/ Public Not Applicable
Awdur yr Adroddiad / Report Author	Dr Esther Flavell, Assistant Medical Director Quality & Safety
Cyflwynydd yr Adroddiad / Report Presenter	Dom Hurford, Executive Medical Director
Noddwr Gweithredol yr Adroddiad / Report Executive Sponsor	Dom Hurford, Executive Medical Director

Pwrpas yr Adroddiad / Report Purpose	For Approval This is an adjusted document based on discussions with the medical director giving more ownership to the care groups for policy development and approval.
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Operational Management Board	14/06/2023 29/11/2023	Endorsed for approval Changes suggested

Acronyms / Glossary of Terms	
NICE	National Institute for Health and Care Excellence
QIA	Quality Impact Assessment



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

EIA	Equality Impact Assessment
IA	Impact Assessment
WCD	Written Control Document



1. Situation /Background

- 1.1 In accordance with the Health Board's 'Policy on Policies' all written control documents i.e. policies, procedures, strategies, protocols and guidelines need to be formally ratified by an appropriate forum prior to it becoming operational.
- 1.2 The scope of this report is limited to **Clinical** written control documents (WCDs).
- 1.3 The current process for approving Clinical Policies is multistep and can result in the delay in implementation, disengagement, the use of 'draft' documents, and items not being appropriately ratified.
- 1.4 The current process sees Clinical WCDs reviewed at a monthly meeting, chaired by the Assistant Medical Director for Quality & Safety. The group comprises a panel of interested parties who scrutinise and provide feedback on submitted policies. This can be an arduous and lengthy process and could be streamlined to facilitate an easier process whilst maintaining assurance that the scrutiny is robust and safe.
- 1.5 The purpose of this report is to propose a more efficient and effective process of approval.

2. Specific Matters for Consideration

- 2.1 The following outlines the proposed process of the approval of Clinical WCDs within the Health Board.
- 2.2 Proposed Clinical Policy route for approval
 - If Care Group specific then the relevant Clinical Care Group Director would review and endorse for onward approval (i.e. Paediatrics policy considered by the Children and Family Care Group).
 - If Health Board wide then the Care Group Directors or nominated lead, would ensure that the policy has been reviewed and appropriate discussions between care groups has occurred PRIOR to submission for review by the Operational Management Board.
 - The policy would then be received at the Operational Management Board for approval. The Care Group Director or appropriate medical deputy would need to be present.
 - Final and formal ratification and approval at Quality & Safety Committee through submission of a highlight report with links to policies that have been considered via the above steps.
- 2.3 Proposed Clinical Procedures, Strategies and Guideline route for approval.
 - If Care Group specific then the relevant Clinical Care Group Director would review and endorse for onward approval.
 - If Health Board wide, then the Care Group Director or nominated lead would ensure that that the policy has been reviewed and appropriate discussions between care groups has occurred PRIOR to submission to the operational management board.
 - The Clinical Guideline/Procedure would then be received at the Operational Management Board for approval. The Care Group Director or nominated deputy would need to be present.
- 2.4 National Clinical Policies and Guidelines



- Once the relevant Clinical Executive Director has determined it is appropriate for direct adoption then the Health Board will adopt any guideline or procedure guide published by a national recognised body (for example Royal Colleges, NICE, Regional groups).
- The document should be received at the Operational Management Board and Quality & Safety Committee 'for noting'.

3. Key Risks / Matters for Escalation

- 3.1 The above approach was approved and has been amended taking into account the suggestions by the Operational Management Board and the Medical Director. The policy has been adjusted so that policies are seen and developed within the care group structure before being taken to the Operational Management Board, giving Care Groups ownership. Care Groups will ensure that any cross-care group/specialty discussion has taken place prior to going to the Operational Management Board.
- 3.2 Care Group would determine that the Quality Impact Assessment, Equality Impact Assessment, and Sustainability Impact Assessment are all completed on the WCD as appropriate prior to seeking approval.
- 3.3 The result of these changes would be a streamlined system that remains robust in its consideration of Clinical WCDs and complies with Standing Orders.
- 3.4 In exceptional circumstances where urgent approval is required, the route to approval could be expedited with the agreement of the relevant Chair.
- 3.5 If supported the 'Policy on Policies' would be amended to reflect this process.

4. Assessment

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



<i>(Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) /</i> Link to Enablers of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	If more than one applies please list below:
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) /</i> Link to Domains of Quality <i>(Duty of Quality Statutory Guidance (gov.wales))</i>	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input checked="" type="checkbox"/>	No: <input type="checkbox"/>
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
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 <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	There is no direct impact on resources as a result of the activity outlined in this report.	

5. Recommendation

5.1 That the committee **APPROVE** the adjusted process for the approval of Clinical Policies and Guidelines within the Health Board.

6. Next Steps

- 6.1 Adoption of process across Care Groups
- 6.2 Disseminate process to Care Group leads for implementation

Appendix 1

Checklist for cross speciality policies

There are many policies where more than one specialty is involved. Examples include female incontinence, where therapies, Gynaecology and Urology are involved. All specialities need to be aware and have input into policy development that involves those of expertise.

This checklist can be used to ensure all stakeholders are consulted in the process where a new policy is developed or existing updated.

1. Author of policy states the primary care group and identifies other care groups that require input. Contact made with other care groups to inform and ask for input and a contact for discussion.
2. Policy developer writes policy after discussion with their own care group as detailed in the main guidance.
3. Once the policy is written, guidance is sought from the other stakeholders and agreement on content reached.
4. The policy is then taken through each relevant care group for discussion as per guidance in main document.

Example

Policy for management of female incontinence

Primary policy written by Gynaecology in children and families care group.

Initial contact made with Urology in planned care and Physiotherapy in therapies care groups

Policy written as per guidance in main document and taken to relevant care groups for comment.

Policy also goes to planned care and therapies for comment and discussion. Comments taken into account and evidence of discussion with each group documented.

Policy taken forward in usual way as per new guidance.

ACTION LOG QUALITY & SAFETY COMMITTEE					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at November 2023)
7.1	November 2021 January 2022	<p>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.</p> <p>Spotlight report to be presented to the July meeting in relation to Medication Errors</p>	Assistant Director of Quality & Safety	January 2024	<p>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.</p> <p>Spotlight on Thrombosis to be agreed. In Progress</p>
2.1	24 January 2023	<p>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.</p>	Director of Nursing	January 2024	<p>In progress Date to be agreed. Being considered alongside other Listening & Learning stories that need to be scheduled into the programme.</p>

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2.3	16 March 2023	<p>Care Group Spotlight Report – Unscheduled Care</p> <p>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.</p>	Care Group Nurse Director – Unscheduled Care	24 May 2023 Now 25 July 2023	<p>In Progress</p> <p>The report currently received in relation to ambulance handovers is for the whole of CTM. The Team have started to interrogate this data and will have to start manually recording at each front door. The Unscheduled Care Senior Management Team are also working collaboratively with WAST to ensure transparent and robust processes are in place.</p> <p>Once this is completed the data will be shared and presented to the Quality & Safety Committee.</p> <p>Status as at 21 November 2023 - Awaiting a revised action log update from the Chief Operating Officer</p>
5.2d	25 July 2023	<p>Mental Health & Learning Disabilities Care Group Highlight report</p> <p>Update to be provided to the next meeting in relation to the outcome of the Demand & Capacity exercise undertaken by the</p>	Executive Director of Nursing	21 September 2023 Now 21 November 2023	<p>In progress</p> <p>Deputy Director of Nursing provided an update to the meeting held on 21 November on the work being undertaken to address the issues being experienced in relation to</p>

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		Resuscitation Team in relation to CPR training compliance		Now 23 January 2024 Now 14 March 2024	the provision of Basic Life Support Training and other Resuscitation training across the Organisation and advised that he would be sharing the Strategy for Implementation with Members at the meeting being held on 23 January 2024. Will now be presented to the meeting being held on 14 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	In progress A verbal update was provided to Members at the meeting held on 21 September. Members noted that due to issues with the system it would not be easy to run a report off the system in relation to this data at present. Members noted that it was hoped that issues would be resolved in January 2024 and a report could be provided in March 2024.
8.3	25 July 2023	Mortality Assurance Report Further update on progress to be presented to the Committee in three months	Medical Director	21 November 2023 Now 23 January 2024	In progress Further report to be presented to the Committee at its meeting on 21 November 2023. This has

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					now been deferred to January 2024 – On agenda
2.2	21 September 2023	Care Group Spotlight Presentation – Planned Care – Focus on Ophthalmology Backlog Report to be prepared for a future meeting of the Board highlighting the positive steps that had been taken to address the backlog within Ophthalmology	Chief Operating Officer	Date to be confirmed	In progress To be scheduled into the Forward Work Programme for Board
5.1	21 September 2023	Report from the Chief Operating Officer Report on Sepsis to be presented to the next meeting of the Committee	Medical Director	21 November 2023 Now 23 January 2024	In progress This was originally scheduled for the 21 November meeting. This has now been deferred to the meeting taking place on 23 January 2024 – On agenda
6.4	21 September 2023	Learning From Events Reports Further update on progress to be presented to the January meeting of the Committee as an appendix to the Quality Dashboard report.	Assistant Director of Concerns and Claims	23 January 2024 Now 14 March 2024	In progress Was due to be presented to the 23 January 2024 meeting – now deferred to 14 March 2024
6.5	21 September 2023	CTMUHB Nosocomial Covid-19 Incident Management Programme Delivery Unity Interim Learning Report	Head of Covid19 Nosocomial Investigation Team	TBC (post April 2024)	In progress To be scheduled into the forward work programme once date agreed

Agenda Item 9.2.1

		Outcome of the Demand & Capacity work to be presented to a future meeting of the Committee			
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	In progress Email sent to Committee Members asking them to submit feedback

<i>PREVIOUSLY REPORTED Completed Actions</i>					
Minute Reference	Date of Meeting Action Originated	Issue	Lead Officer	Timescale for Action to be completed	Status of Action (as at November 2023)
6.1	25 July 2023	Quality Dashboard Public Services Ombudsman for Wales Report in relation to care and treatment in relation to a missed appendicitis to be shared with Members at the September meeting	Assistant Director of Quality & Safety	21 September 2023	Completed Verbal update provided by the Assistant Director of Quality & Safety Committee at the meeting held on 21 September 2023. Members noted that this had now progressed to a Claim and in this respect had been closed down by the Ombudsman
5.1	15 November 2022	Organisational Risk Register – Risks Assigned to the Quality & Safety Committee Medical Director to ensure interim timelines were put into place for the Task & Finish Groups referred to in relation to Risk 4080.	Medical Director	January 2023 Was August 2023 Now September 2023	Completed Risk 4080 no longer refers to Task and finish groups and the narrative has been updated in the risk to reflect the action from November 2022. The Medical Rate Card for Non-Consultant Staff was approved at the Executive Leadership Group and is now active.

Agenda Item 9.2.1

10.1	21 September 2023	Highlight Report to Board Committee Highlight report to reflect that Quality Governance had also been de-escalated in addition to Maternity & Neonates.	Head of Corporate Governance & Board Business	30 November 2023	Completed This has been included in the escalation section for the Committee Highlight report being presented to November Board as a positive escalation.
6.2	21 September 2023	Organisational Risk Register – Risks Assigned to the Quality & Safety Committee Future reports to include an explanation as to why the risk scores had been reduced	Assistant Director of Governance & Risk	21 November 2023	Complete Assistant Director of Governance & Risk highlighting through training and communication with Care Groups and Directorates. Datix Risk Module now includes a specific section to capture the rationale if a change to risk score is made. This will be an ongoing improvement action.
6.1	16 March 2023	Maternity Services & Neonates Improvement Programme Review to be undertaken of the metrics included within the report to ensure they aligned with data contained within other reports, for example, the number of	Director of Midwifery	24 May 2023 Now 21 September 2023	Complete Team are continuing to review the quality of information through the Patient Safety Meetings.

Agenda Item 9.2.1

		concerns and incidents being reported.			
5.1	21 September 2023	Report from the Chief Operating Officer Consideration to be given as to how progress being made against Stroke Actions were being presented to the Committee	Executive Director of Therapies & Health Sciences	21 November 2023	Completed Action plan presented to Committee Members at the meeting held on 21 November where Members confirmed they felt they had been provided with clarity and assurance in relation to the plan in place.
5.2	21 September 2023	Unscheduled Care Group Spotlight Report Spotlight report on Frailty to be presented to a future meeting of the Committee	Unscheduled Care Group Nurse Director	21 November 2023	Completed Spotlight report on Frailty received and discussed at the meeting held on 21 November 2023.
7.1	21 September 2023	Quality Dashboard Report Narrative to be included in the next iteration of the report in relation to what areas benchmarking could be undertaken in	Assistant Director of Quality & Safety	21 November 2023	Completed Update included in the November iteration of the Quality Dashboard report.
9.2.1	21 September 2023	Action Log Review to be undertaken in relation to discussions being held in regards to the Medical Staff Rate Card to determine which Committee remit this matter falls under.	Director of Corporate Governance/Board Secretary	21 November 2023	Completed It has been agreed that this would fall under the remit of the People & Culture Committee.
5.1	21 November 2023	Report from the Clinical Executives	Medical Director	21 November 2023	Completed

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		Statement to be corrected within the report in relation to Appendicitis guidelines			Report amended and shared with Members via Admincontrol.
5.2a	21 November 2023	Planned Care Group Highlight Report Response to be provided to Members outside the meeting as to whether there were any trends the Committee needed to be made aware of in relation to the five incidents that had been rated as severe at Royal Glamorgan Hospital.	Assistant Director of Quality & Safety	23 January 2024	Completed Response shared with Members during the meeting and an update was also shared with Members by email outside the meeting
6.2	21 September 2023	Organisational Risk Register – Risks Assigned to the Quality & Safety Committee Update to be provided against Risk 4217 at the next meeting to explain why reporting frequency would have reduced the risk score	Assistant Director of Governance & Risk	21 November 2023	Completed The risk consequence remains major with current partial mitigations, however, based on evidence (number of recorded preventable cases), the likelihood has been adjusted to monthly reducing the frequency risk score from a 4 (At least weekly, to a 3 (At least monthly).
5.2e	21 November 2023	Unscheduled Care Group Highlight Report Future reports to include an update on how effective NEWS compliance was in	Unscheduled Care Group Nurse Director	23 January 2024	Completed Update included in the January 2024 USC Care Group Highlight Report

Agenda Item 9.2.1

		relation to accuracy of scoring, observations as per score and the 12 hour observation.			
5.2e	21 November 2023	Unscheduled Care Group Highlight Report Future reports to include a short synopsis as to the nature and outcome of Coroner's inquests that were being referred to.	Unscheduled Care Group Nurse Director	23 January 2024	Completed Short synopsis included in the January 2024 iteration of the report.
6.1	21 November 2023	Organisational Risk Register More detail to be provided in the next iteration of the report on the actions being taken against the risks relating to business interruption within Radiology and the Emergency Department Overcrowding Risk.	Assistant Director of Governance & Risk	23 January 2024	Completed Included in risk register report being presented to the January 2024 meeting
6.2	21 November 2023	Healthcare Inspectorate Wales Action Plan Tracker Future iterations of the report to include rate of progress made since the last meeting against the recommendations which remained open, how many actions had been completed and clear delivery and	Executive Director of Nursing	23 January 2024	Completed January 2024 iteration of the report has been strengthened to include the information requested at the last meeting

Agenda Item 9.2.1

		completion dates to be identified against each open recommendation			
6.6	21 September 2023	Quality & Safety Committee Annual Self Effectiveness Survey One in person meeting to be held in 2024 to determine its effectiveness.	Head of Corporate Governance & Board Business	11 July 2024	Completed The 11 July 2024 meeting of the Quality & Safety Committee will be held in Rooms 1 & 2, Ysbyty Cwm Cynon



QUALITY & SAFETY COMMITTEE – FORWARD WORK PLAN

Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Email Request from the Patient Care & Safety Team	Additional Item	Concerns Policy	Director of Nursing	Planned for May 2023 – Deferred to 25 July 2023. Deferred to 21 September 2023. Now deferred to 23 January 2024 – On agenda
Request made by the Chair and Vice Chair at the agenda planning session for the July Board	Additional Item	Mortality Report	Medical Director	Report presented to the meeting held on 25 July 2023. Further report to be presented to the 21 November 2023 meeting. Now deferred to 23 January 2024 – On agenda
Request made by the Quality & Safety Committee Chair	Additional Item	Annual Quality Work Plan	Director of Nursing	Discussion held at agenda planning. Noted that an Annual Quality Report would need to be produced as opposed to an Annual Quality Work Plan. Date for presentation of the Annual Quality work plan to be confirmed
Identified as an agenda item at the Hosted Bodies Audit & Risk Committee held on 16 August 2023	Additional Item	EASC Quality & Safety Composite Report	Chief Ambulance Services Commissioner	Was planned for 21 November 2023 – Now 23 January 2024 – On agenda

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Origin of Request	Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)	Item Title	Lead Officer	Intended Meeting Date
Request received from the 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
Item agreed at agenda planning session	Additional Item	Spotlight Presentation on Sepsis	Medical Director	Was planned for 21 November 2023 – Now 23 January 2024 – On agenda

Agenda Item 9.2.3



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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.
Item referred to at the November 2023 Quality & Safety Committee	Additional Item	Quality Strategy Annual Plan	Executive Director of Therapies & Health Sciences	Planned for 23 January 2024 - On agenda
Request received from the Patient Care & Safety Business Manager	Additional Item	Incident Management Framework	Executive Director of Nursing	Planned for 23 January 2024 - On agenda
Email request received from the Director of Improvement & Innovation	Additional Item	ICTM Annual Report	Director of Improvement & Innovation	Planned for 14 March 2024



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 received from the Medical Director Business Manager	Additional Item	Organ Donation Committee Annual Report	Medical Director	Completed Received and noted at the meeting held on 21 November 2023. Added to the annual cycle of business for future reporting.
Email Request from the Lead Infection Prevention & Control Nurse	Additional Item	Measles Policy	Director of Nursing	Completed Received and approved at the meeting held on 21 November 2023.
Email Request from the Lead Infection Prevention & Control Nurse	Additional Item	Meningitis Policy	Director of Nursing	Completed Received and approved at the meeting held on 21 November 2023.
Additional report received from the Director of Midwifery	Additional Item	Cwm Taf Morgannwg Maternity Metrics - An update in comparison to Welsh Government (WG) Maternity and Birth Statistics 2022	Director of Nursing	Completed Received and noted at the meeting held on 21 November 2023
Item agreed at agenda planning session	Additional Item	Spotlight Presentation on Frailty	Medical Director	Completed Received and discussed at the meeting held on 21 November 2023
Action agreed at the July meeting of the Quality & Safety Committee	Additional Item	Update on Liberty Protection Safeguards	Director of Nursing	Completed Update provided at the November 2023 meeting advising Members that Liberty Protection Safeguards were no longer in place. An update was already provided in

Agenda Item 9.2.3



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				the plans for Deprivation of Liberty Safeguards was also provided at the November 2023 meeting and the plans to embed the Mental Capacity Act.
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Reporting Committee	Quality Patient Safety Committee (QPSC)
Chaired by	Carolyn Donoghue
Lead Executive Director	Director of Nursing & Quality
Date of Meeting	23rd October 2023

Summary of key matters considered by the Committee and any related decisions made

As the morning had been taken up with the Quality Patient Safety Development Day there was no presentation or Patient Story at this meeting. The Chair welcomed two new members to the committee representing Cardiff & Vale University Health Board and the Deputy Regional Director for Llais.

1.0 COMMISSIONING TEAM AND NETWORK UPDATES

Members received a report outlining the current Quality and Patient Safety issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below and updates regarding services in escalation are attached in the tables at the end of the report.

- **Cancer & Blood**

It was noted that no new risks for the portfolio had been added to the Risk Register since the last report.

- Members noted the improved traction on the performance issues within the All Wales Lymphoma Panel (AWLP) service and following the submission of a final report by the service, it is likely a recommendation will be made to reduce the level of escalation level by the next meeting.
- The Harm Review being undertaken on the North Wales (NW) plastics service remains outstanding. No timescales for completion were presented to the committee and members asked for further clarity.
- Whilst the Burns South Wales (SW) remains in Escalation Level 3 the capital case has been approved by Welsh Government and it is anticipated that the interim staffing arrangements can be sustained until the new build is complete.
- A Neuro Endocrine Tumour Stakeholder meeting was organised by Cardiff & Vale University health Board on the 17th October 2023.

- **Neurosciences**

Members noted that one new risk scoring above 15, relating to staffing levels within Neuro-rehabilitation at CVUHB, had been added since the last report was received. The committee was informed that due to quality issues with current provider commencement of Designated Provider process for the South Wales Deep Brain Simulation (DBS) service has been initiated. A letter has been sent to Llais informing them of the position.

- **Cardiac**

No new risks for the Cardiac portfolio had been added to the Risk Register since the last report. Members noted the updates against the two services, which currently remained in escalation at level 2.

- **Women & Children**

Members were concerned that there were five service areas with risks scoring 15 and above and that two new risks scoring above 15, both relating to Neonatal at CVUHB, had been added since the last report was received.

There are five service areas with high risks and in Escalation Level 3 are noted as follows and further detail and actions can be found in the summary of services in escalation, which is attached to the report.

- Paediatric Intensive Care (CVUHB)
- Paediatric Surgery (CVUHB)
- Neonatal Intensive Care (CVUHB)
- Paediatric Cardiac Surgery (UHBNSFT)
- Wales Fertility Institute (WFI) (SBUHB)

The committee were informed that an extraordinary Exec to Exec meeting with CVUHB was due to take place later that day to consider the areas of concern and agree a way forward. It has been proposed that all three will be brought into a single Escalation process with joint Exec Leads to provide additional support. It was also noted that Paediatric Surgery is not meeting contract volumes but ministerial measures are being met. A recommendation will be considered at the November Joint Committee for the escalation objectives to remain that Paediatric Surgery achieves contract volumes.

It was noted that the SBUHB assurance report was not submitted to HFEA on time. A further WHSSC escalation meeting is scheduled for the 27th October 2023, and the worst case scenario will be to source a new provider.

- **Mental Health & Vulnerable Groups**

One new risk has been added to the risk register regarding the magna security locks in the North Wales CAMHS unit. Assurance was received that this was being closely monitored and a meeting with the provider had identified the need for a capital bid to fund the necessary remedial works. A number of incidents had

been reported to WHSSC following that meeting and it was agreed that these would be further escalated to the BCUHB DoN for urgent consideration.

Members received an update regarding progress on the development of a Children and Young People's Gender Identity Service led through the NHS England transformation programme.

Members noted that there are a number of safeguarding concerns at an NHSE Eating Disorder provider and these have been escalated to NHSE for discussion and investigation. The relevant safeguarding teams are aware and the care coordinators from the Health Boards have been asked to review the individual patients. A more detailed report was to be received at the next meeting.

The new Eating Disorder unit in Tŷ Glyn Ebwy Hospital, Hillside, Ebbw Vale is due to be opened by the Deputy Minister for Health on the 9th November 2023. This will allow for repatriation of out of area placements and reduce the risk identified with one of the current independent providers.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members received an update of the quality issues for services relating to the Intestinal Failure Commissioning Team Portfolio and noted that no new risks for the portfolio had been added to the Risk Register since the last report.

2.0 OTHER REPORTS RECEIVED

Members received reports on the following:

- **Services in Escalation Summary**

A copy of each of the services in escalation is attached to the report at **Appendix 1**

- **CRAF Risk Assurance Framework**
- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**
- **Incident and Concerns Report**
- **Report from the WHSSC Policy Group.**

3.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee September 2023
- Welsh Health Circular: Speaking up Safely Framework
- QPSC Distribution List; and
- QPSC Forward Work Plan.

4.0 ANY OTHER BUSINESS

It was noted that there had been a Development Day for QPS members and Quality Leads from the Health Boards that morning. The theme of the session

<p>was to consider the impact of the Duty of Quality Act in terms of future reporting and monitoring of commissioned services. It had been well attended and a report will be presented at the next meeting.</p>	
<p>Key risks and issues/matters of concern and any mitigating actions Key risks are highlighted in the narrative above. Members expressed concerns regarding the number of services that were in escalation in the Women & Childrens portfolio and asked that these were escalated for the attention of the Joint Committee.</p>	
<p>Summary of services in Escalation</p> <ul style="list-style-type: none"> Attached (<i>Appendix 1</i>) 	
<p>Matters requiring Committee level consideration and/or approval</p> <ul style="list-style-type: none"> None 	
<p>Matters referred to other Committees As above.</p>	
<p>Confirmed minutes for the meeting are available upon request</p>	
<p>Date of Next Scheduled Meeting</p>	<p>5 December 2023</p>

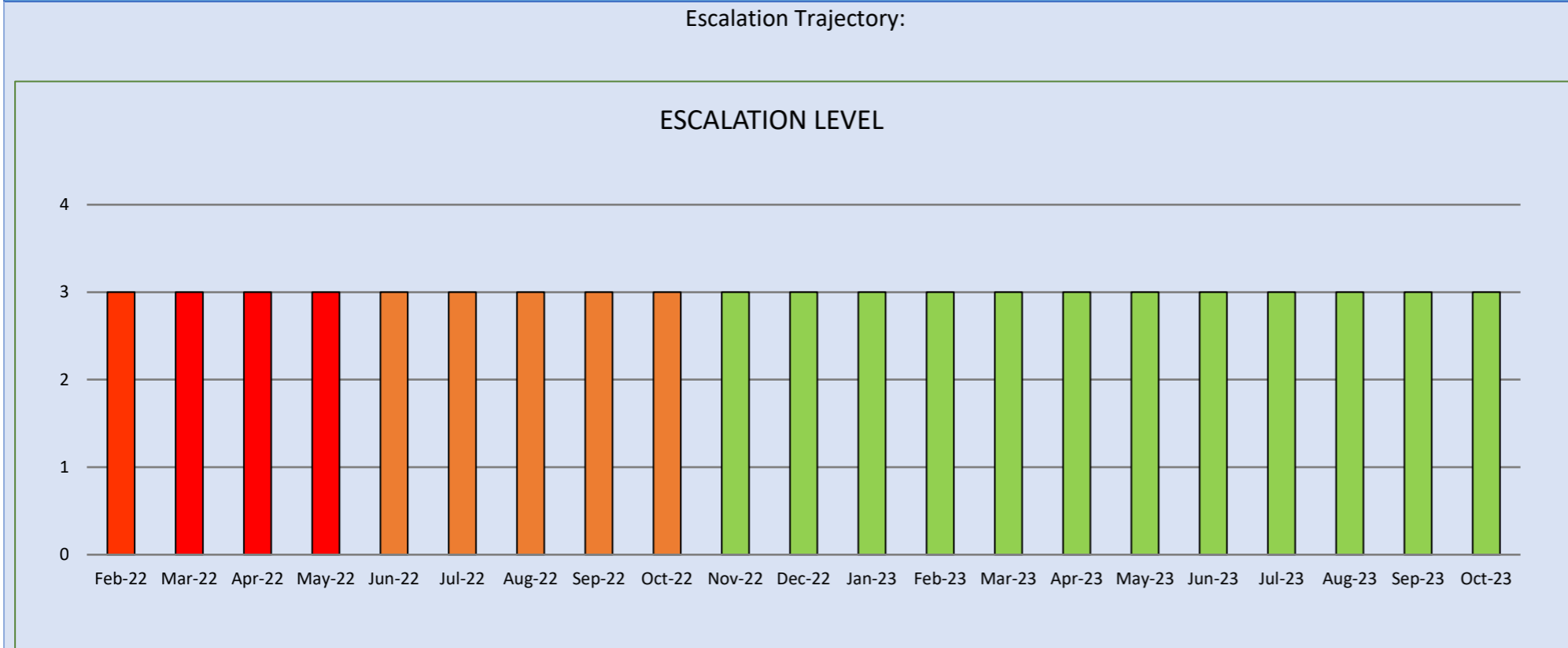
Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

Service in Escalation: Burns

Current Escalation Level
3

Escalation Trend Level		
Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	



Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	4
February 2022 – WHSSC escalation	3
August 2022 – WHSSC escalation	3
September 2022 – WHSSC escalation	3
December 2022 – WHSSC escalation	3

Rationale for Escalation Status :
 Remains at level 3.
 The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morrision Hospital is the end of 2023.
 The capital case may be delayed to the initial intended timeline as the case goes through the scrutiny process.

Background Information:

At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16 th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed

Appendix 1

	SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
	A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
	Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	Completed
	WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	Completed
	Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which went to their Investment in Infrastructure Board on 22 nd June; it had been hoped that the works would commence in May. There may, therefore, be a 2 month or so departure from original timelines. At the SLA with Swansea on 5 th June, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	Completed
	The capital case has now been approved by Welsh Government. The level of escalation will therefore be reviewed further to the next escalation meeting which is scheduled for November. It is anticipated that the interim staffing arrangements can be sustained until the new build is complete.	Senior Team SBUHB/WHSSC Med Director/ Senior Planner WHSSC	Ongoing	
Issues/Risks: <ul style="list-style-type: none"> July 2023 The Welsh Government Infrastructure Investment Board considered the burns case on June 22nd the outcome is not confirmed as yet. October 2023: the capital case has been approved by Welsh Government. Timeline tbc. 				

Service in Escalation: Paediatric Surgery

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23, 20/06/2023, 26/07/23, 12/09/23 & 10/10/23

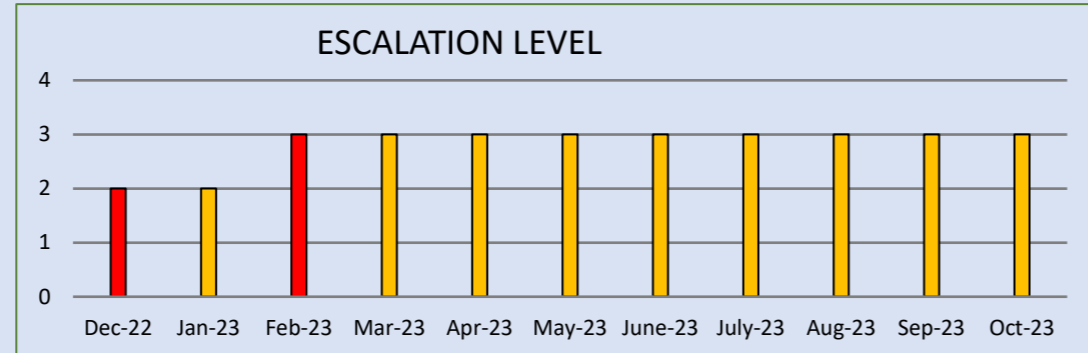
Date Last Reviewed by Quality & Patient Safety Committee: 16/08/23

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	3

Rationale for Escalation Status :

As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children’s Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.

- Original recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
- The original plan did not deliver contracted volume,
- Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in designing a number of new pilot schemes and securing additional capacity, some delays in implementation. **The current financial pressures and savings plans requested by WG have resulted in the Health Board re-profiling the trajectories and unlikely to meet contract volumes for the remainder of the financial year.**

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	Completed 20/06/23
Further reprofiling of waiting times being undertaken by the HB in line with meeting contract volumes by December 2023.	Senior Planning Manager	August 2023	Completed 06/10/23
Special Executive to Executive meeting scheduled with provider.	Director of Planning & Performance	23 October 2023	

Issues/Risks:

April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.

May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Appendix 1

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings:
Date Last Reviewed by Quality & Patient Safety Committee:
New Service in Escalation

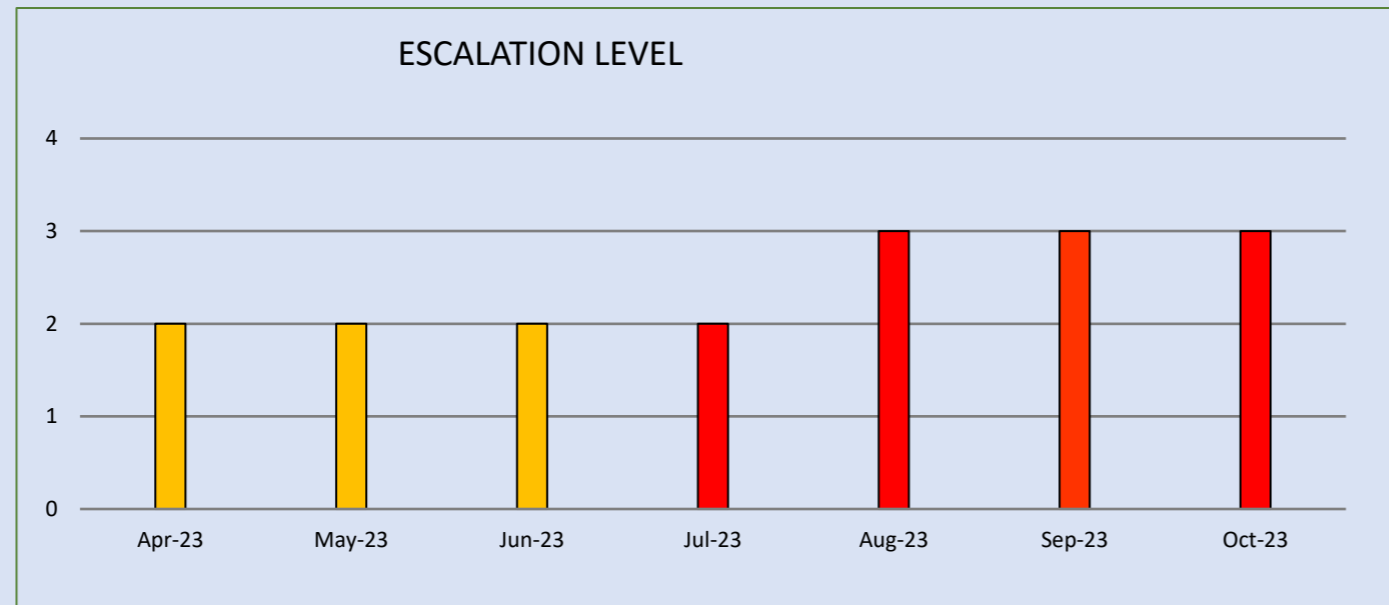
Service in Escalation: Paediatric Intensive Care

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level

Rationale for Escalation Status :

Following concerns regarding bed availability due to workforce shortages, refusal rates and pressure sore incidents the service was escalated to level 2. There was limited progress over a 3 month period against the objectives therefore the decision was taken to further escalate to level 3.

Background Information:

There is a risk that a Paediatric intensive care bed, in the Children’s Hospital for Wales, will not be available when required due to constraints within the service. There is a consequence that Paediatric patients requiring intensive care will be cared for in, inappropriate areas where the necessary skills or equipment is not available or the patient being transferred out of Wales. The availability of a bed and staffing constraints have been brought to the attention of WHSSC through various routes including HiW and the daily SITREP.

WHSSC assurance and confidence level in developments:

Low – HB have submitted draft action plan, a final version has been requested. The escalation is predominantly linked to workforce and the lead in time for mitigations is medium term, in particular the recruitment of International Nurses. New streamliners have begun in the HB and although supernumerary at present and will not directly fill PIC vacancies it will support the wider workforce challenges across the Children’s Hospital.

Issues/Risks:

Actions:

Action	WHSSC Lead	Action Due Date	Completion Date
Requested demand and capacity plan from HB to develop sustainable contracting framework for PIC and HD	Senior Planning Manager	31 October 2023	
Requested action plan to be developed against the escalation objectives.	Senior Planning Manager	31 October 2023	
Requested sight of the Pressure Sore report presented to the HB Quality and Patients Safety Committee.	Senior Planning Manager	31 October 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Appendix 1

Executive Director Lead: Nicola Johnson
 Commissioning Lead: Kimberley Meringolo
 Commissioning Team: Women and Children

Service in Escalation: Neonatal Intensive Care Unit

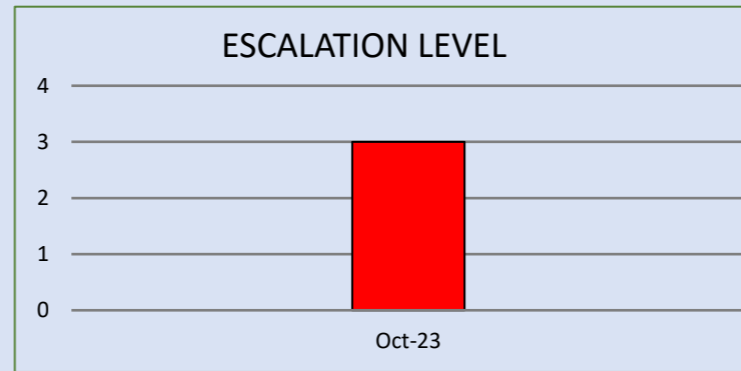
Date of Escalation Meetings:
 Date Last Reviewed by Quality & Patient Safety Committee:
 New Service in Escalation

**Current
Escalation Level
3**

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↑ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
September 2023	3

Rationale for Escalation Status :

High levels of cot closures reported across all three levels of care, blood stream infection rates and progress implementing the new cot configuration.

Background Information:

There are currently two risks on the CRAF relating to Neonatal services at Cardiff and Vale UHB, lack of cot availability due to workforce and the service being a negative outlier status for blood stream infections, on the National Neonatal Audit Programme (NNAP). Limited progress has also been made against implementing the workforce required to support the cot configuration.

WHSC assurance and confidence level in developments:

The service were only notified of escalation in late September therefore at the time of writing the report the objectives have not yet been set.

Actions:

Action	WHSC Lead	Action Due Date	Completion Date
Develop agreed objectives for escalation	Planning Manager	31 October 2023	
Health Board to develop detailed action plan against the agreed objectives	Planning Manager	14 November 2023	
Special Executive to Executive meeting scheduled with provider	Director of Planning	23 October 2023	

Issues/Risks:

Appendix 1

Executive Director Lead: Iolo Doull
 Commissioning Lead: Dominique Gray-Williams
 Commissioning Team: Women and Children

Service in Escalation: Wales Fertility Institute

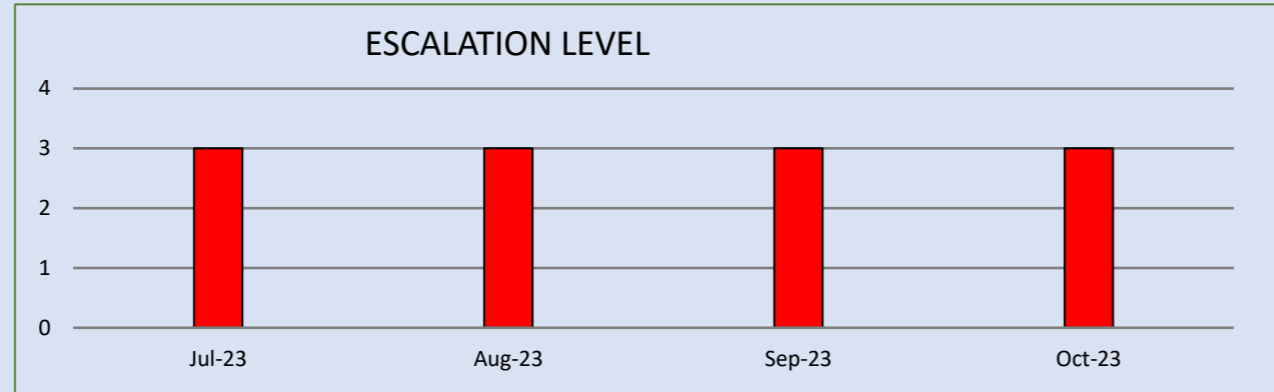
Date of Escalation Meetings: 07/08/23
 Date Last Reviewed by Quality & Patient Safety Committee:
 16/08/23

**Current
 Escalation Level
 3**

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔ October 2023
↔	Escalation remains the same	
↑	Escalation level escalated	

Escalation Trajectory:



Escalation History:

Date	Escalation Level
July 2023 – WHSSC escalation	3

Rationale for Escalation Status :

Concerns from a number of routes with regards to the service including the WHSSC contract monitoring data submission; adherence to WHSSC policies and HFEA performance outcomes below National average.

Background Information:

A number of concerns regarding the safety and quality of service had been raised through different routes, including HFEA re-inspection report January 2023, WHSSC quality and assurance meetings and WFI IPFR requests regarding Wales Fertility Institute leading to the escalation of the service. There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

WHSSC assurance and confidence level in developments:

Medium – The Health Board have instigated regular Gold Command and operational service improvement meeting with positive progress made in addressing HFEA concerns. The Action plan has been agreed and progress has been made with regards to WHSSC data submissions, however, the service need to ensure time is given both internally and to WHSSC to allow for review and consideration of documentation. The service are due to submit a progress report to the HFEA by the 18th October. HFEA re-inspection is due to take place in January 2024.

Actions:

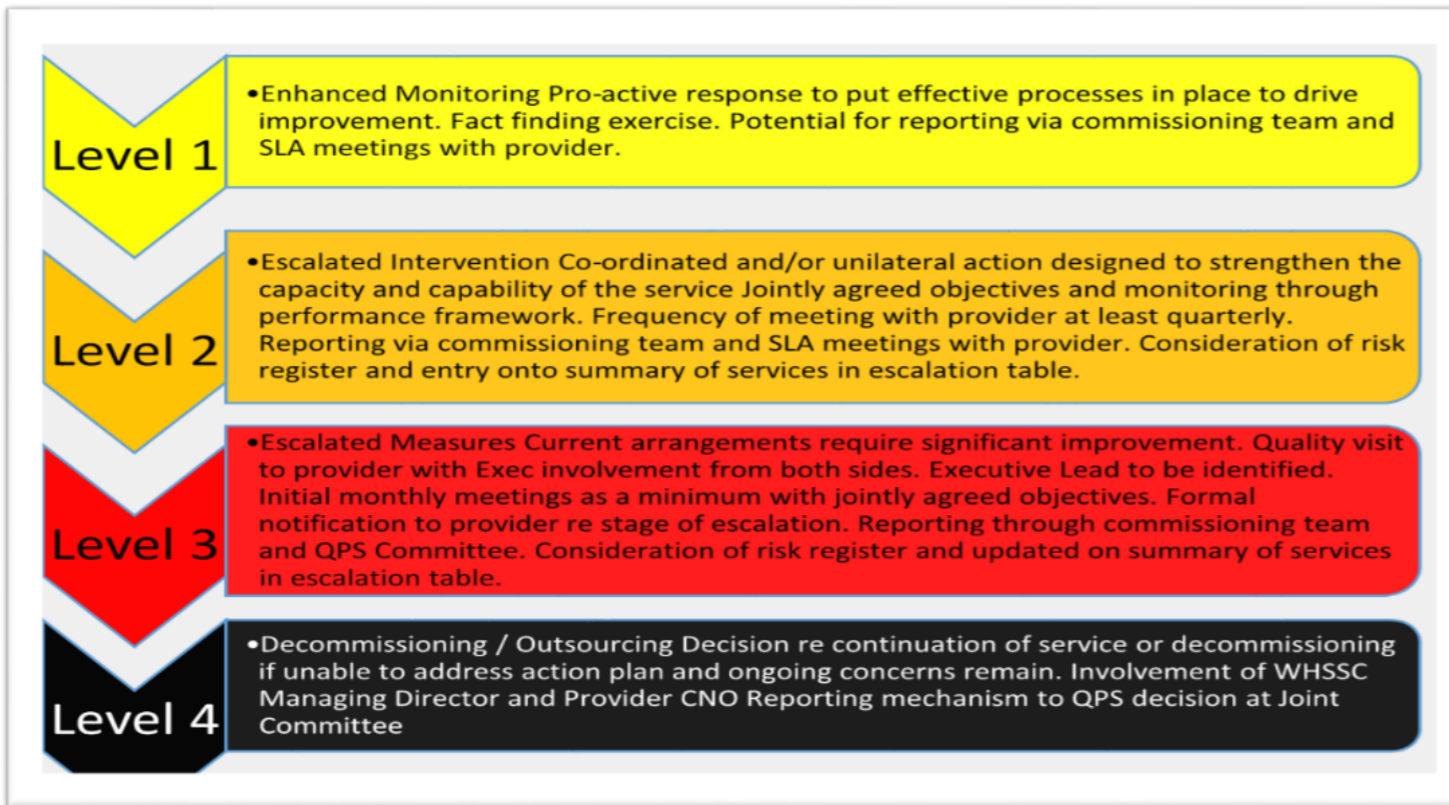
Action	Lead	Action Due Date	Completion Date
Initial escalation planning meeting Exec to Exec	Assistant Specialised Planner	7 th August 2023	7 th August 2023
Monthly escalation meeting to review progress against Action Plan Escalation meeting 19 th September 2023	Assistant Specialised Planner	Monthly	Ongoing
Quality visit	Assistant Specialised Planner	14 th November 2023	
SMART Action plan from WFI, action plan has been requested in order that it can be agreed with WHSSC colleagues	Assistant Specialised Planner/ Service Manager	7 th August 2023	7 th August 2023
SMART Action plan reviewed and agreed	Service Manager	19 th September 2023	19 th September 2023

Issues/Risks: There is a risk the Wales Fertility Institute (WFI) in Neath & Port Talbot Hospital is not providing a safe and effective service due to 7 major concerns identified during a relicensing inspection by HFEA in January 2023. There is a consequence that families who have treatment at this centre are not receiving the quality of care expected from the service and in turn impacting outcomes.

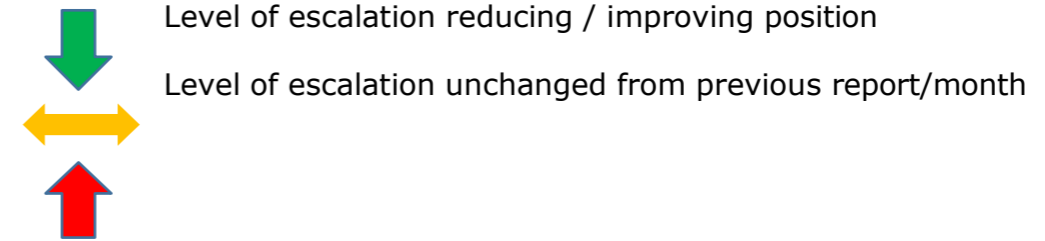
Appendix 1

Level 1 ENHANCED MONITORING	<p>Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes:</p> <ul style="list-style-type: none"> No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. Continued intervention is required at level 1 and a review date agreed. Escalation to Level 2 if further intervention is required <p>There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider</p>
Level 2 ESCALATED INTERVENTION	<p>Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include</p> <ul style="list-style-type: none"> Provider performance meetings Triangulation of data with other quality indicators Advice from external advisors Monitoring of any action plans <p>A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes:</p> <ul style="list-style-type: none"> Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	<p>Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives.</p> <p>Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum:</p> <ul style="list-style-type: none"> Chair (WHSSC Executive Lead) Associate Medical Director - Commissioning Team Senior Planning Lead – Commissioning Team WHSSC Head of Quality Executive Lead from provider Health Board/Trust Clinical representative from provider Health Board/Trust Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. <p>At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.</p>
Level 4 DECOMMISSIONING/OUTSOURCING	<p>Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation.</p> <p>The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue:</p> <ol style="list-style-type: none"> De-commissioning of the service Outsourcing from an alternative provider. This may be permanent or temporary Contractual realignment to take into account the potential need to maintain and agree an alternative provider. <p>Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level.</p> <p>At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.</p>

Appendix 1



SERVICES IN ESCALATION





Agenda Item

9.2.4

Quality & Safety Committee

Healthcare Inspectorate Wales Improvement plan tracker October-December 2023

Dyddiad y Cyfarfod / Date of Meeting	23/01/2024
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, 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
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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

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. The timeframe for this report is October to end of December 2023.
- 1.2 Oversight and continuous review for assurance of the actions continue to be reported by the relevant Care Group to their Care Group Quality, Patient Safety and Experience Committee meeting.
- 1.3 As previously reported the transition of the management for all HIW Inspection activity is in the process of transitioning to the Assurance and Compliance Team, therefore there is an opportunity to review and cleanse all the actions which remain open.

Following a period of settling in and allowance of time for the team to become familiar with the AMaT system, the team are now in a position for HIW inspection activity to transition over to the new team who will have responsibility for the management, monitoring and tracking of compliance following all HIW Inspections and associated activity across the health board.

During the last 3 months the team have further liaised with neighbouring Health Board colleagues building on the previous work and relationships already in place in order to review and reflect on the AMaT system and its usage both within CTM UHB and within wider health boards. The team have also further explored the AMaT facility with its developers in order to understand how this system will work and it's full recording and reporting functionality proposed for us within CTM UHB.

As of 1st January 2024, the Assurance and Compliance team will take over responsibility for all HIW Inspection activity and associated correspondence.

This will mean that going forward all HIW inspection activity and correspondence will be sent directly to the newly created generic mailbox for the Assurance and Compliance team who will manage and monitor its activity and record the details on AMaT.

This transition will also mean a new way of reporting to this Committee on all future reports received for assurance on compliance against all actions which have been agreed following any HIW Inspections across CTM UHB. This reporting will commence from the next meeting in March 2024.

2. Specific Matters for Consideration

2.1 Each of the Care Groups have provided updates against the open actions currently reported through the manual HIW tracker together with any change in the implementation date(s).

As of December 2023

- 16 reported as Red with the actions being those which are incomplete and have passed the agreed due date
- 13 reported as Amber – actions partially complete/ongoing to meet deadline date
- 80 reported as Yellow on target to meet original or revised completion date
- 426 reported as Green - Completed actions
- 7 removed as these are for external actioning i.e. Welsh Government or a revised action is to supersede the original action

3. Current Position

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

As the HIW tracker is an iterative record of actions a number of actions from Improvement Plans will be added to the new AMaT system as inspections by HIW have recently taken place, these include:

- Royal Glamorgan Hospital, Tirion Birth Centre 19-20 October 2023 - 5 main actions with a total of 22 sub actions to be completed by end March 2024. To date there are 13 actions reported as Green and 9 as Amber.
- Glanrhyd Hospital, Angelton Clinic 13-15 November 2023-25 main actions with a total of 67 sub actions to be completed by end April 2024. To date there are 62 reported as Green and 5 reported as Amber.
- Royal Glamorgan, Admissions Ward, Ward 21, Ward 22 and Psychiatric Intensive Care Unit (PICU) 20-23 November 2023-19 main actions with a total of 81 sub actions to be completed by end June 2024. To date there are 50 reported as Green and 31 reported as Amber.

Good progress has been made in all areas of the improvement plans, a further review of all outstanding actions will be undertaken during the recording and reporting of the electronic AMaT System.

Improvement Plans fully completed/closed during this reporting period

- Princess of Wales Hospital Ward 5 January 2023 – Appendix C

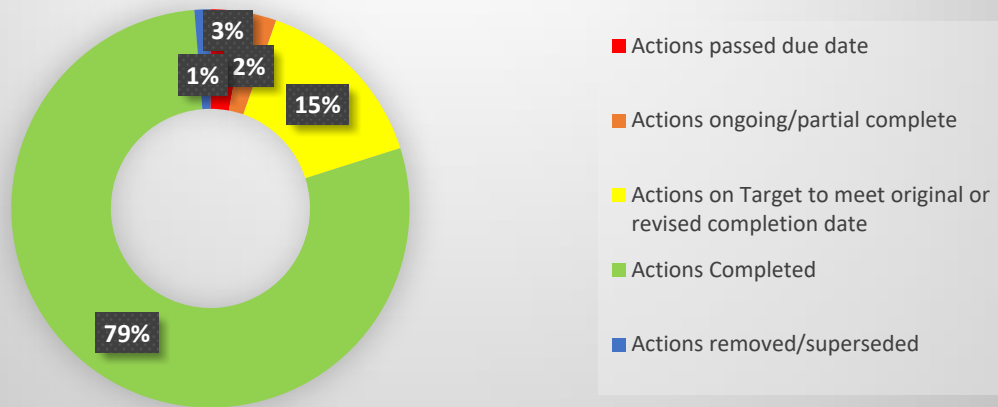
Healthcare Inspectorate Wales request updates on progress against the improvement plans where actions remain open and ongoing three months following an inspection.



Actions by Status-end December 2023

Total Number of Actions	Actions passed due date	Actions ongoing/partial complete	Actions on Target to meet original or revised completion date	Actions Completed	Actions removed/superseded
542	16	13	80	426	7

HIW Improvement Plan Actions October-December 2023



3. Key Risks / Matters for Escalation

- 3.1 As outlined above, compliance of all HIW Inspection activity will be managed, monitored and reported by the Assurance and Compliance team with a continued focus on actions which remain open.
- 3.2 Steps have been taken to seek updates from the Care Group leads in relation to outstanding HIW improvement plans in order to provide assurance of completed actions and closure of improvement plans in a timely and agreed timeframe. Those improvement plans which remain open will now be addressed through AMaT.



4. Assessment

Objectives / Strategy	
Dolen i Nod (au) Strategol BIP CTM / Link to CTMUHB Strategic Goal(s)	Improving Care
	If more than one applies please list below:
Dolen i Feysydd Strategol BIP CTM / Link to CTMUHB Strategic Areas	Living Well
	If more than one applies please list below:
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales
	If more than one applies please list below:
Dolen i Hwyluswyr Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Enablers of Quality (Duty of Quality Statutory Guidance (gov.wales))	Whole-systems Perspective
	If more than one applies please list below:
Dolen i Feysydd Ansawdd (Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) / Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective
	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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	This is an overarching status 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 <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	This is an overarching status update report. If



Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>		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	Yes (Include further detail below) Patient Care & Safety and the Quality of Care delivered is paramount, if the actions identified following any inspection are not fully implemented and sustained, this has the potential to impact on patient care & safety and organisational reputation leading to more frequent inspections from regulatory bodies to gain assurance	
Effaith Adnoddau <i>(Pobl /Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	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 Future reporting on all HIW Inspection activity will be presented by the Assurance and Compliance team.