GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD MEWNOL Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	10 June 2025
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Receipt of Getting it Right First Time (GIRFT) Reports Governance Review
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance/Board Secretary

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To report to the Quality, Safety & Experience Committee on the findings and recommendations following a governance review of how Getting it Right First Time (GIRFT) reports and other external reports that do not have a pre-defined process are received into the operational and corporate structures of Hywel Dda University Health Board and subsequently tracked and implemented within the organisation.

Cefndir / Background

In September 2024, a Getting it Right First Time (GIRFT) Report on Emergency Department Medicine, Glangwili Hospital (GGH), undertaken in June 2024, was received into the Health Board in September 2024.

The report concluded that ‘The Emergency Department at Glangwili Hospital is currently putting patients at risk of harm and is distressing for staff. It was one of the two EDs in Wales which caused the most concern to the GIRFT team.’

The first time this particular GIRFT report came to the appropriate assurance Committee of the Health Board, the Quality, Safety & Experience Committee (QSEC), was 13 February 2025. This was submitted as a late paper to the In Committee session of the meeting following discussion at Executive Team (ET) on 5 February 2025 where concerns had been raised regarding the operational governance of the report and the quality of the management response.

It was agreed, through the Chair of QSEC, that the report would be presented to the In Committee session of QSEC whilst the operational governance concerns were worked through and the management response prepared.

These operational governance concerns have provided the impetus for this review following In Committee QSEC’s request that an exercise be undertaken into how GIRFT reports and other

external reports that do not have a pre-defined process are received into the operational and corporate structures and subsequently tracked and implemented within the organisation.

Asesiad / Assessment

Timeline of Events

- GIRFT Report on Emergency Department Medicine (EDM) received into the Health Board in September 2024 by the operational services involved with the review;
- GIRFT EDM (GGH) report initially discussed at the Acute Leadership Group (now superseded by the Community and Integrated Medicine Clinical Care Group);
- GIRFT EDM (GGH) report placed on the Integrated Quality, Finance & Performance Delivery Group (IQFPDG) agenda on 23 October 2024;
- GIRFT EDM (GGH) report discussed each month at IQFPDG within the Six Goals section of the agenda given the similarity of the report's findings and recommendations regarding waiting times, patient flow and medical challenges;
- At IQFPDG on 22 January 2025, the Chief Operating Officer was tasked with submitting the GIRFT EDM (GGH) report to Executive Team (ET) for consideration of the recommendations and the management response
- The GIRFT EDM (GGH) report was presented to ET on 5 February 2025 with the outcome that the Chief Operating Officer work with the Community and Integrated Medicine Clinical Care Group Service Director '*to improve the report ahead of presentation to QSEC though the inclusion of actions undertaken and the response to the GIRFT Report*'.
- The GIRFT EDM (GGH) report was submitted (as a late paper following discussion with the QSEC Chair) to In Committee QSEC for its 13 February 2025 meeting

Whilst a documented process for the receipt of GIRFT reports and the drafting of management responses as developed by the Health Board's Assurance & Risk Team was in place at the time the GIRFT EDM (GGH) report was received by the Health Board, it would appear that this was not followed by the service involved.

The process, which had been approved at the Operational Performance, Governance and Planning (OPGP) meeting in December 2023 by the Chief Operating Officer and also made available to staff within the Health Board via the Assurance and Risk Sharepoint site, required that:

'*On receipt of a GIRFT report, service leads are to complete a proforma to confirm if the recommendations have been accepted or not, with management responses provided in the form of an action plan detailing how they will be implemented, who will own the recommendations, and with realistic completion dates assigned.*

The completed action plan would then need to be reviewed and signed off by the General Manager/Directorate lead as well as the Director of Secondary Care (where appropriate). An SBAR should then be submitted to the OPGP for final approval by the Chief Operating Officer, detailing any concerns with the report content or recommendations and a proposal for which Board Committee the report should be aligned to.

Once approved at OPGP, finalised action plans to be sent to the Head of Assurance and Risk for addition to the Health Board's central Audit & Inspection tracker, prior to then forwarding to the relevant Committee Services Officer for inclusion at the next Board Committee meeting.

Progress against recommendations would be requested from the service lead by the Assurance and Risk Team and reported to the ***Audit & Risk Assurance Committee (ARAC)*** *on a bi-monthly basis, as well as in Directorate Improving Together sessions.*

In addition, progress against the implementation of GIRFT recommendations is reported to the Audit and Risk Assurance Committee on a bi-monthly basis in the Health Board-wide Audit Tracker paper and to the relevant assurance Committee at appropriate junctures.'

The potential for GIRFT reports to become 'lost in the system' is acknowledged, stemming from the fact that GIRFT reviews are essentially peer reviews and, once prepared, they are issued to whoever the GIRFT reviewers have been dealing with at a service level, rather than the Chief Executive or relevant Executive Director concerned.

The Health Board has tried to influence this to ensure these reports are received more formally into the organisation rather than directly to operational services albeit with little success. In addition, and despite numerous requests, these reports are not always shared with Corporate teams for tracking.

Whilst IQFPDG had been sighted on the GIRFT EDM (GGH) report at a number of its meetings, this may have been by default as it was linked in with the work on the Six Goals, a standing item on IQFPDG's agenda, whereas a GIRFT report on a different subject matter may have been overlooked; it would also appear that an Action Plan in response to this GIRFT report was only latterly presented to IQFPDG.

Given the recent revisions to the Health Board's Operations structure, the Assurance & Risk Team has developed a new process for the management of GIRFT reports as well as for peer reviews or reports that are received by the Health Board that do not have a pre-defined process which is also made available to staff via the Assurance & Risk Sharepoint site - Assurance (see Appendix 1)

This new process requires the following:

'Within one month of receipt of report, please complete the table below to confirm:

a) If the recommendation is accepted or not (justification must be documented if not accepted);
b) A management response to accepted recommendations detailing
    a. how it will be implemented, ie the actions that will be undertaken to fully implement the recommendation. Consideration must be given to what is within the means and capacity of the service in order to deliver, with any barriers to its implementation, or additional resource requirements clearly documented
    b. who will own this recommendation
c) A realistic and achievable completion date, taking into account your capacity;
d) The evidence/documentation that will demonstrate the recommendation has been fully implemented as this will need to be uploaded to AMAT before it will be fully approved as completed; and
e) Any recommendation that cannot be fully implemented must be escalated through the relevant management structure and action plans must be signed off by the relevant Clinical Care Group.

After sign off by Clinical Care Group/Director, action plans must be reviewed by IQFPDG prior to onward submission to Formal Executive Team for approval. Once approved, action plans should be sent to the Head of Assurance and Risk for initial upload to the Audit Management & Tracking (AMaT) system.

The report and action plans will then be presented to QSEC (or other Board level Committee) at its next meeting to provide assurance that the management response will address the areas of concern/improvement detailed in the report.

Progress against recommendations must be regularly provided on AMaT by the relevant recommendation owners, with monitoring of their delivery undertaken by the relevant Clinical Service Group, with oversight from the Clinical Care Group. Any exceptions to the implementation of recommendations are required to be reported to IQFPDG.

Non-compliance of implementing recommendations within agreed timescales is one of the criteria considered within the Governance domain within the Health Board's Improving Together Framework

This new process will be tested on the next anticipated GIRFT report in relation to Critical Care to ascertain how well the process is working within the new Operations structure.

The GIRFT Critical Care management response and action plan, when subsequently presented to QSEC, will include a summary of its passage through the operational governance arrangements required by the new process to provide further assurance to the Committee.

Argymhelliad / Recommendation

To receive assurance from the governance review undertaken into how GIRFT reports and other external reports that do not have a pre-defined process are received into the operational and corporate structures of HDdUHB, and the revised processes in place to ensure these are appropriately tracked and implemented within the organisation.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Not Applicable
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	GRIFT Review Papers and Agenda from various meetings Risk and assurance sharepoint
Rhestr Termau: Glossary of Terms:	Not Applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Health Board Chair Quality Safety and Experience Committee Chair Chief Operating Officer Chief Executive Officer Deputy Chief Executive Officer Executive Director of Nursing, Quality and Patient Experience.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	It is essential external reviews are received and actioned appropriately within the Health Board.
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Compliance with internal guidance on receipt of GRIFT reports would reduce the risk.
Cyfreithiol: Legal:	Not applicable

Enw Da: **Reputational:**	Potential for media interest from the findings of the GRIFT review.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not Applicable

ACTION PLAN / DEVELOPMENT OF MANAGEMENT RESPONSES

<u>Process</u>

Within one month of receipt of report, please complete the table below to confirm:

a) If the recommendation is accepted or not (justification must be documented if not accepted);
b) A management response to accepted recommendations detailing
    a. <u>how</u> it will be implemented, ie the actions that will be undertaken to fully implement the recommendation. Consideration must be given to what is within the means and capacity of the service in order to deliver, with any barriers to its implementation, or additional resource requirements clearly documented
    b. <u>who</u> will own this recommendation
c) A <u>realistic</u> and <u>achievable completion date,</u> taking into account your capacity;
d) The evidence/documentation that will demonstrate the recommendation has been fully implemented as this will need to be uploaded to AMAT before it will be fully approved as completed; and
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Non-compliance of implementing recommendations within agreed timescales is one of the criteria considered within the Governance domain within the Health Board's Improving Together Framework

Report:

Issued By:

Issued On:

Lead Officer:

Suggested Overseeing Committee:

Recommendation	Management Response	Recommendation Owner (name, job title and CCG)	Completion Date - Please enter a specific implementation date for your action. For recommendations that are reliant on factors external to the Health Board, please note as "External"	Expected Evidence of Implementation
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Prepared By: ………

Prepared On: ………

Approved By: ………

Approved On: ………