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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 October 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Planning Objectives Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Daniel Warm, Head of Planning

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

A revised set of Planning Objectives has now been incorporated into Hywel Dda University Health Board's (HDdUHB) plan for 2022/25 that set out the aims of the organisation, *i.e.* the horizon that HDdUHB is driving towards over the long term, as well as a set of specific, measurable Planning Objectives, which move the organisation towards that horizon over the next three years.

Each of the Planning Objectives has an Executive Lead and this report is to provide the Quality, Safety and Experience (QSEC) with an update on the progress made in the development (delivery) of the Planning Objectives under the Executive Leadership of the:

- Director of Nursing, Quality and Patient Experience
- Director of Public Health
- Director of Operations
- Medical Director

that are aligned to QSEC, for onward assurance to the Board.

Cefndir / Background

This report is presented as an update to demonstrate where progress has been made in delivering those Planning Objectives aligned to the Quality, Safety and Experience Committee.

There are 6 Planning Objectives in total which are attributed to the following Executive Lead as set out and detailed at Appendix 1.

Asesiad / Assessment

Appendix 1 provides an update on each of the Planning Objectives aligned to the Quality, Safety and Experience Committee, identifying their current status, whether these are achieving/not achieving against their key deliverables, together with a summary of progress to date.

A summary of this information is set out below:

Planning Objective	Lead Executive	Status	If Planning Objective is 'behind'	Date of next Planning Objective 'deep-dive' by Committee
1E	Director of Nursing, Quality and Patient Experience	On-track	Not applicable (N/A)	October 2022
3C		On-track	N/A	TBC (previous 'deep-dive' August 2022)
5X		On-track	N/A	December 2022
4G	Director of Public Health	On-track	N/A	February 2023
5K	Medical Director	On-track	N/A	February 2023
5W	Director of Operations	On-track	N/A	December 2022

Argymhelliad / Recommendation

The Committee is asked to receive an assurance on the current position in regard to the progress of the Planning Objectives aligned to the Quality, Safety and Experience Committee, in order to onwardly assure the Board where Planning Objectives are progressing and are on target, and to raise any concerns where Planning Objectives are identified as behind in their status and/or not achieving against their key deliverables.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 To receive an assurance on delivery against all Planning Objectives aligned to the Committee.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Putting people at the heart of everything we do 3. Striving to deliver and develop excellent services 5. Safe sustainable, accessible and kind care
Amcanion Cynllunio Planning Objectives	1E_22 Personalised care for patients waiting 3C Quality and Engagement Requirements 5K_22 Clinical effectiveness self assessment process 5P_21 Liberty Protection Safeguards
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	3 Year Plan and Annual Plan Decisions made by the Board since 2017-18 Recent *Discover* report, published in July 2020 Gold Command requirements for COVID-19 Input from the Executive Team Paper provided to Public Board in September 2020
Rhestr Termau: Glossary of Terms:	Explanation of terms is included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Public Board - September 2020 Executive Team

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	Any financial impacts and considerations are identified in the report
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Any issues are identified in the report
Gweithlu: **Workforce:**	Any issues are identified in the report
Risg: **Risk:**	Consideration and focus on risk is inherent within the report. A sound system of internal control helps to ensure any risks are identified, assessed and managed.
Cyfreithiol: **Legal:**	Any issues are identified in the report
Enw Da: **Reputational:**	Any issues are identified in the report
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	Not applicable

APPENDIX 1 – Update of Planning Objectives aligned to QSEC as at 23rd September 2022

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
1E	During 2022/23 roll out the processes developed in 2021/22 to maintain personalised contact with all patients currently waiting for elective care which will: 1. Keep them regularly informed of their current expected wait 2. Offer a single point of contact should they need to contact us 3. Provide advice on self-management options whilst waiting 4. Offer advice on what do to if their symptoms deteriorate 5. Establish a systematic approach to measuring harm – bringing together the clinically assessed harm and harm self-assessed by the patient and use this to inform waiting list prioritisation 6. Offer alternative treatment options if appropriate 7. Incorporate review and checking of patient consent By the end of March 2023 to have this process in place for all patients waiting for elective care in the HB	Director of Nursing, Quality and Patient Experience	3/31/2023	On track	• A process to maintain personalised contact with patients awaiting elective care established and roll out plan in place. • Waiting List Support Services (WLSS) funding agreed until March 2023 to demonstrate value and impact • > 15,000 Stage 4 patients will be contacted during 22/23 • To date 7100 stage 4 patients have been contacted (Orthopaedics, ENT, Urology, Dermatology, Ophthalmology, Gynaecology) with an offer of support via a single point of contact, information and advice on how to prepare for treatment (Waiting Well) and resources to support self-management. • Online self-management and waiting well resources developed and have been accessed over 4000 times • Roll out to plan to General Surgery October 2022 • Additional roll out to support patients on waiting lists for Community Paediatrics and Long COVID services in progress • Active engagement with 3rd sector, Education Programmes for patients (EPP) and services in Local Authorities to improve offer of support to patients/ alternative services

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					• Patient Advisory Liaison Service (PALS) team have contacted patients to evaluate their experience of service. • Communication of progress with the project continued with CHC. • Communication with Powys THB re support for cross border referrals. • Wider communication plan to be rolled out to primary care, public and other key stakeholders by October 2022. • Trialling giving WLSS leaflets to all newly Trauma & Orthopaedics patients listed for surgery within the Outpatient Department to make service self-sustaining and cost-effective. • WLSS is working with the Communication hub and therapy service to develop seamless access pathways for patients to prehabilitation programmes and Education Programmes for patients (EPP). • The ophthalmology roll out formed part of the Warwick Behavioural Change Programme projects. Outcomes of this project will support and inform future communication strategies with patients awaiting elective care. Risk/issues: • Current automated PROM/PREM system (DrDoctor) used within the Health Board triggered by clinic appointments on Welsh Patient Administration System (WPAS) so

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					unable to be utilised to capture patient reported harm/ experience for patients on waiting lists. Working on alternative ways to capture self-reported harm.
3C	From April 2022, establish an implementation group to identify the actions required to respond to the emerging requirements of the Quality & Engagement Act. The specific actions that will be put in place to support organisational readiness will be informed by the work undertaken to review the Health & Care Standards during 2021/2022 and the receipt of any formal guidance related to the Act.	Director of Nursing, Quality and Patient Experience	3/31/2023	On track	• The Health Board implementation group is continuing to meet regularly to discuss opportunities for early implementation. • The guidance from Welsh Government is awaited as well as further detail relating to the arrangements for reporting on quality and implementation of duty of candour.
4G	Over the period 2022/23 - 2024/25 implement the Health Board's "Healthy Weight: Healthy Wales" (HWHW) plan, undertake an evaluation of the impact and in light of this learning, by September 2024 develop a refreshed plan for the following 3 year planning cycle	Director of Public Health	30/09/2024	The All Wales Weight Management Pathway (AWWMP) is on track. The Whole System Approach (WSA) work is behind.	• An overview of Healthy Weight : Healthy Wales (HWHW) and progress to date was provided to the Health Boards Executive Team in an SBAR on 06.07.22 • **All Wales Weight Management Pathway** - Following an all Wales peer-review process the Forward Plan for 2022/23 was submitted to Welsh Government in June 2022. The 3 main areas of focus for the remainder of this financial year are: 1. Completion of recruitment to the Level 3 weight management service and communication to the public and professionals about single point of entry (L2/3) and self-referral routes to the service,

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					2. Establishment of 3 task and finish groups, led by the Clinical Pathway Lead to do the work needed across disciplines and organisations to model capacity and demand and plan and cost the model of provision for Level 2 adults, for maternity and for children, young people and families. 3. This work is being aligned closely with the work on the All Wales Diabetes Prevention Programme and more recently the Strategic Programme for Primary Care in order to maximise reach and population outcomes by utilising different funding streams. • **Whole Systems Approach (WSA**) - A regional approach is being taken with Swansea Bay UHB. This includes pooling grant allocations for substantive posts and joint activity. A Memorandum of Understanding has been signed between DsPH to enable recruitment to a regional structure to drive forward the systems approach across both health boards. . • Covid-19 and the deviation from the nationally agreed structure has resulted in significant delays but a grant offer letter has now been received by the Deputy Director of Public Health allowing recruitment to be progressed. Once recruitment has been undertaken for the 8b Regional Lead Role then there will be

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					further discussion about the use of the remaining staffing budget between Swansea Bay and Hywel Dda to meet the needs of the HWHW agenda in their area and maximise fit within their existing local team structures. The resultant South West Wales HWHW team, with Consultant input from each Local Public Health Team will provide the operational leadership, co-ordination and support to the workforce and acts as a focal point for the agenda.
5X	Develop a plan to introduce a comprehensive quality management system to support and drive quality across the organisation. Implementation to begin by April 2022 and completed within 3 years. The system will be supported by the HBs "Improving Together Framework" and EQIiP Programme as delivery vehicles	Director of Nursing, Quality and Patient Experience	3/31/2025	On track	• A draft framework has been completed. • Dashboards are in the process of being developed to support triangulation of data. • Overarching meeting structure which will oversee the implementation of the Quality Management System across the Health Board is currently being reviewed.
5W	Develop and deliver an implementation programme that will ensure effective operational implementation of the Liberty Protection Safeguards (LPS) legislation across the health board by 1st October 2023.	Director of Operations	9/30/2023	On track	• 1st April 2022 implementation date postponed by UK Government. New date to be announced in winter 2022/23. Unlikely that implementation will occur before October 2023. • UK and Welsh Governments have completed a 16-week consultation on the revised Mental Capacity Act (MCA) Code of Practice (which incorporates new chapters on Liberty Protection Standards (LPS)) and the four Welsh Regulations.

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					The health board's submission was compiled by the Head of Consent and Mental Capacity and was be approved via Operational Planning and Development Programme before submission on 7th July 2022. • LPS will apply to inpatients (16+) who lack capacity, across all our services and will require frontline staff to undertake 3 statutory assessments to authorise a deprivation of liberty. To support this Welsh Government have agreed a three-year funding programme to support implementation across health and social care (£8 million in 2022/23, and £17 million in each of 2023/24 and 2024/25). The phase 1 tranche of funding for 2022/23 is being used to establish two temporary posts. Phase 2 has recently been received. • Work to support effective implementation continues, and the Consent and Mental Capacity Team have expanded provision of MCA training for clinical staff in order to embed the essential knowledge required to underpin LPS implementation.
5K	"Establish a process to ensure effective clinical practice is embedded within individual practice and clinical service areas. The process is part of the Health Board's Quality Management System, alongside	Medical Director	3/31/2023	On track	• The Clinical Director for Effective Clinical Practice and the Head of Effective Clinical Practice and Quality Improvement (Medical Directorate) have met with most Directorate and County Triumvirate teams to engage on effective clinical practice and

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
	Clinical Audit and Quality Improvement, and sits within the Quality and Governance structure, by the end of 2022/23. This will be achieved by: • Supporting the assessment of practice against local and national clinical effectiveness standards and ensuing that findings are used improve the services provided to our patients; • Supporting services to identify, understand and act upon findings from external reviews that are relevant to effective clinical practice e.g. GIRFT, Royal College Peer Reviews"				inform the strategic framework and delivery plan. Additionally, a member of the Clinician Effectiveness team attends the majority of the Quality and Governance Group meetings, and reports are routinely shared detailing newly published and updated NICE and other national guidance. • The AMaT system is now being used in targeted areas within the Health Board, which includes the maternity service, and for the Pelvic Health programme workstreams. AMaT has been used to assess the status of the majority of Health Technology Wales guidance. Wherever possible, the Clinical Audit and Clinical Effectiveness teams are working in conjunction with service areas to utilise the Clinical Guidelines and Clinical Audit Modules of the system. This will ensure that any data available within the system will make a valuable contribution to the quality dashboards that are in development. Further roll out at the current time is impacted significantly by capacity and resources within the respective teams. The Patient Safety and Assurance Team and the Assurance and Risk Team are beginning to explore the Inspections

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**

					Module within AMaT, however again this will be on an incremental basis.
					• Existing policies have or are undergoing consultation at present:
					  • New Interventional Procedures Policy – consultation complete, Owning Group approval obtained and awaiting approval at the Clinical Written Control Documentation Group
					  • Management of NICE and other National Guidance Policy – consultation complete and awaiting Owning Group approval prior to approval at the Clinical Written Control Documentation Group
					• Correspondence from Welsh Government indicates their intention to develop an All-Wales Interventions Not Normally Undertaken (INNU) Policy and the Health Board will contribute to this wherever possible.
					• The Clinical Standards and Guidelines Group has met twice and discussed in detail two areas (NICE guideline 211 Rehabilitation after traumatic injury and NICE Guideline 206 - Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					and), inviting the leads (where identified) in to discuss the guidelines they are reviewing, and to support the assessment against these guidelines, in order to support the adoption, implementation of and adherence to the guidance. • The Effective Clinical Practice Strategic Plan has been reviewed by the Effective Clinical Practice Advisory Panel, and comments are to be discussed with the Executive Lead and AMD for Quality and Safety. A supporting Delivery Plan has been developed, which details how the Effective Clinical Practice Strategic Plan will be delivered, and the practical targets that will be worked towards to support the delivery of the strategic plan. • There has been input into the developing Improving Together framework, including hyperlinking from the Improving Together intranet pages to the newly developed Clinical Effectiveness pages, which contain information in relation to clinical effectiveness, guidance and AMaT. This will be developed further over time. • A Multidisciplinary Mortality Review Panel is operational and reviewing case referrals from the Medical Examiner Service. The Panel meets fortnightly and advises on the appropriate route for cases where issues

PO Ref	Planning Objective	Executive Lead	Date of Completion of PO	Current Status of achieving PO within Completion Date (Delete as appropriate)	• **Summary of Progress to date (including barriers to delivery)** • **For actions behind schedule, please provide an explanation** • **For actions behind schedule, what quarter will these now be achieved**
					have been identified by the Medical Examiner (ME) Service. Cases requiring further proportionate investigation are shared with the appropriate teams and once investigations are completed, themes are being captured. Processes are currently being embedded and refined where appropriate. • All sites are fully operational sending notes to the Medical Examiner Service except for Glangwili General Hospital who had been unable to carry out the scanning due to staffing vacancies. However, following recent successful recruitment a small number of cases are being scanned and sent to the ME Service, which will increase further when the Medical Examiner Service has capacity to take additional cases from mid-October onward • The Senior Leadership team will be monitoring progress of the objective through a series of regular meetings