GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Quality and Safety Assurance Report

QSEC Meeting February 2023

Situation

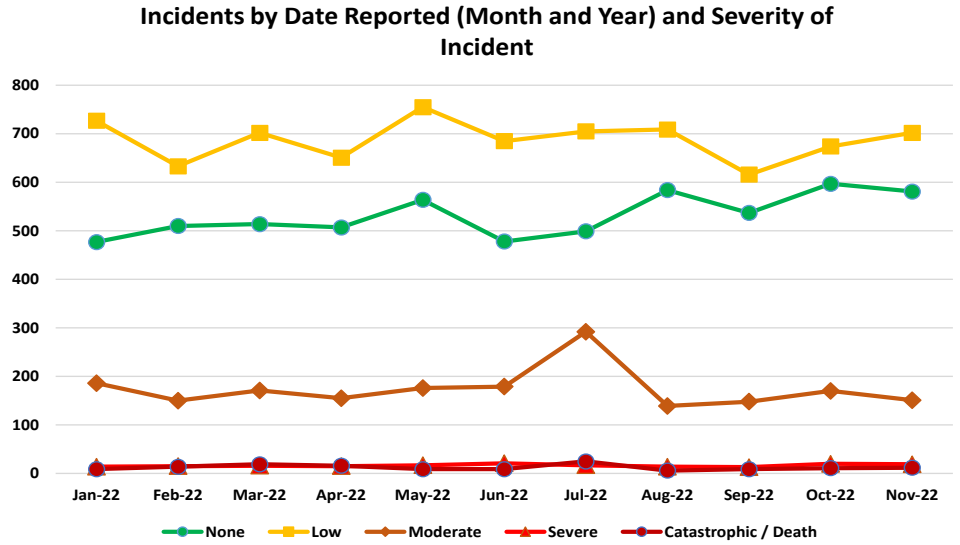
The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with an overview of quality and safety across the Health Board.

The Health Board uses a number of assurance processes and quality improvement strategies to ensure high quality care is delivered to patients.

This report provides information on concerns including patient safety incidents, externally reported patient safety incidents, nosocomial COVID-19 infections, Welsh Health Circulars and Healthcare Inspectorate Wales (HIW) Inspections.

Incident Reporting

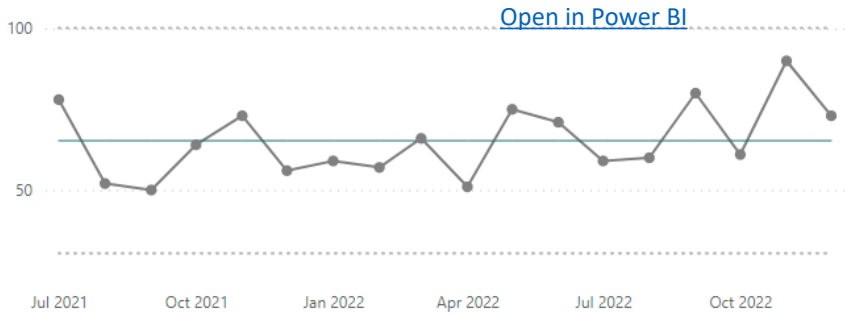
In November and December 2022, 3,057 incidents were reported of which 2,624 were patient safety related

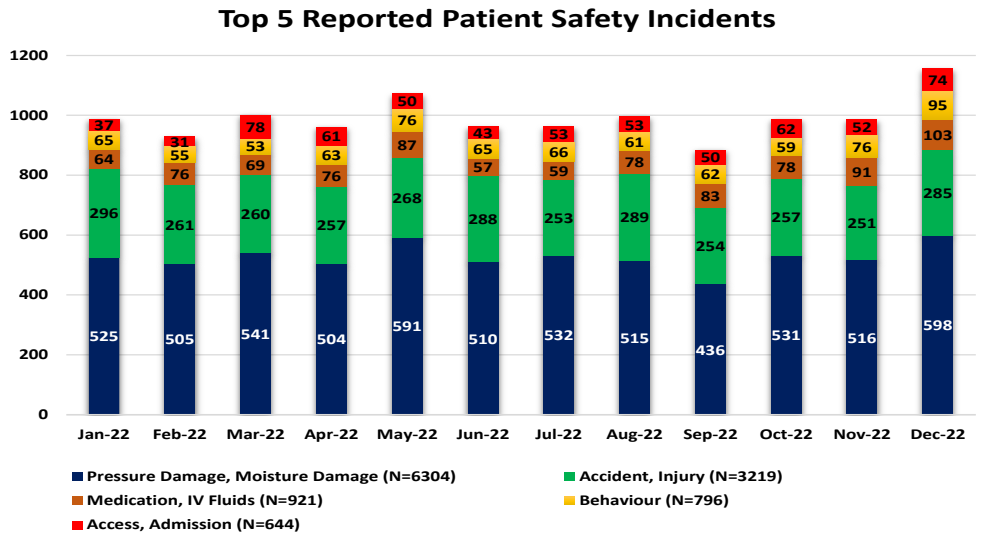


There were 14,818 Patient Safety Incidents reported on the new system between 1 January 2022 – 31 December 2022.

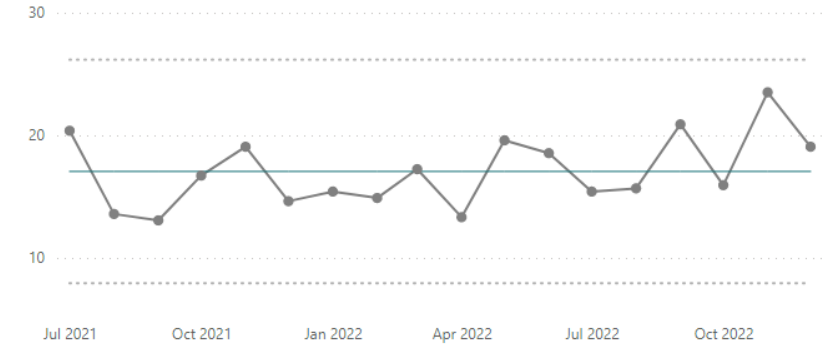
Of the 14,818, 7,831 have been closed and 4,152 have had the severity amended. 2,209 Incidents were downgraded whilst 1,943 were upgraded.

Patient safety incidents moderate harm or worse: investigated



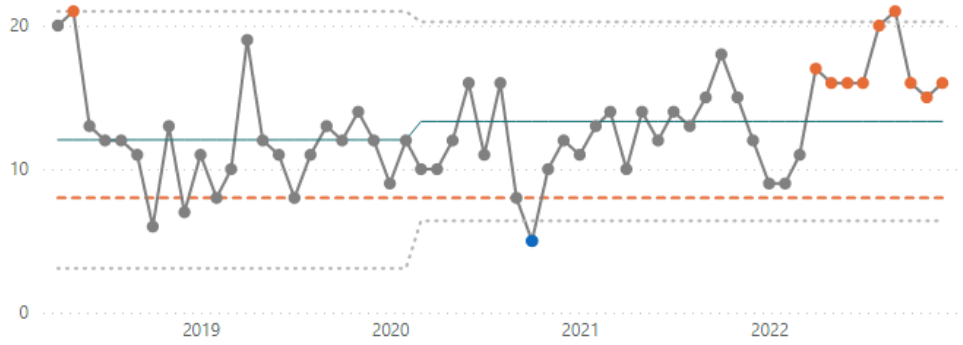


Incidents causing moderate harm or worse per 100,000 population

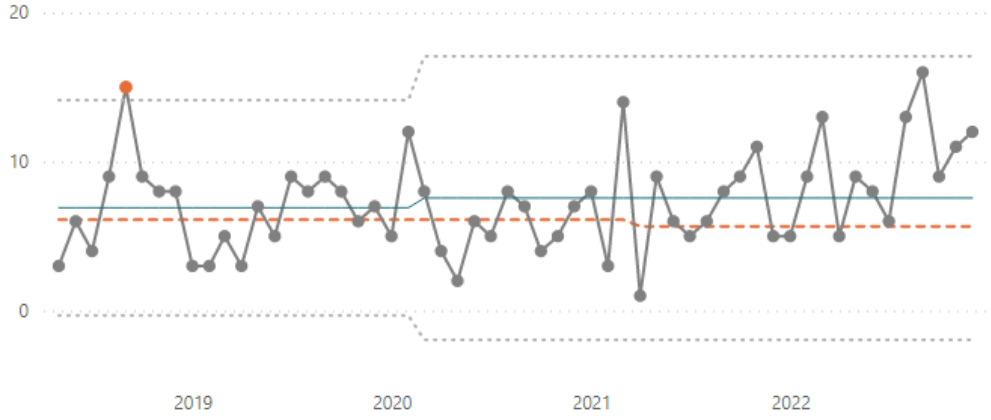


Focus on Infection Control

Number of confirmed C.difficile cases (5A)



Number of confirmed Klebsiella cases (5A)



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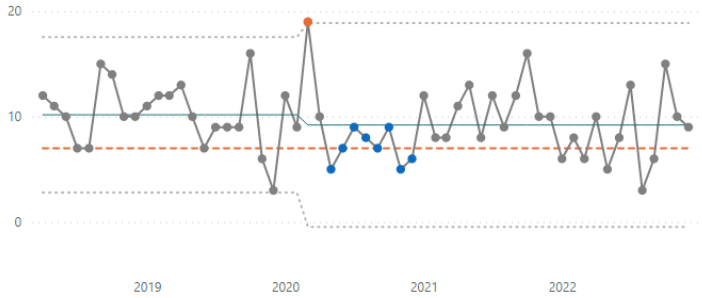
IPAR PBI Report Dec2022

Data as of 18/01/23, 11:55

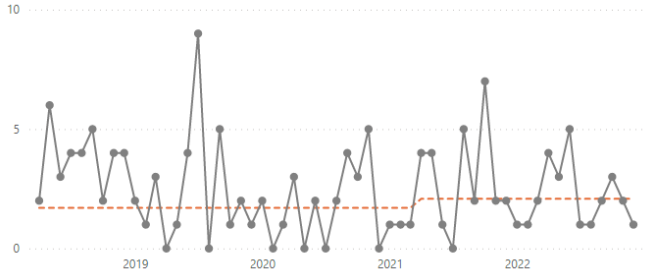
Background

It is acknowledged that the increasing number of cases of CDI Clostridioides *difficile* infection and Klebsiella sp. bacteraemias is a growing concern nationally. HDdUHB is currently under Enhanced Monitoring for all Healthcare Acquired Infection (HCAI) with particular emphasis on the increased CDI and Klebsiella sp. The newly developed HDdUHB HCAI improvement plan (appendix 2) outlines planned actions aimed at reducing these infection rates in detail.

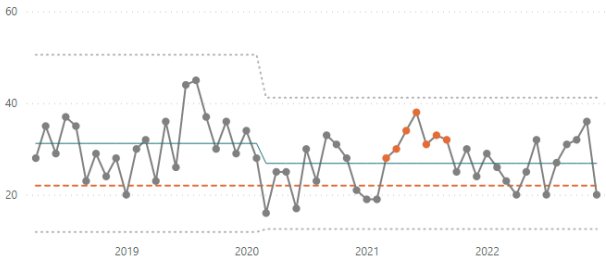
Number of confirmed S.aureus cases (5A)



Number of confirmed P.aeruginosa cases (5A)



Number of confirmed E.coli cases (5A)



Infection control (continued)

Actions and update

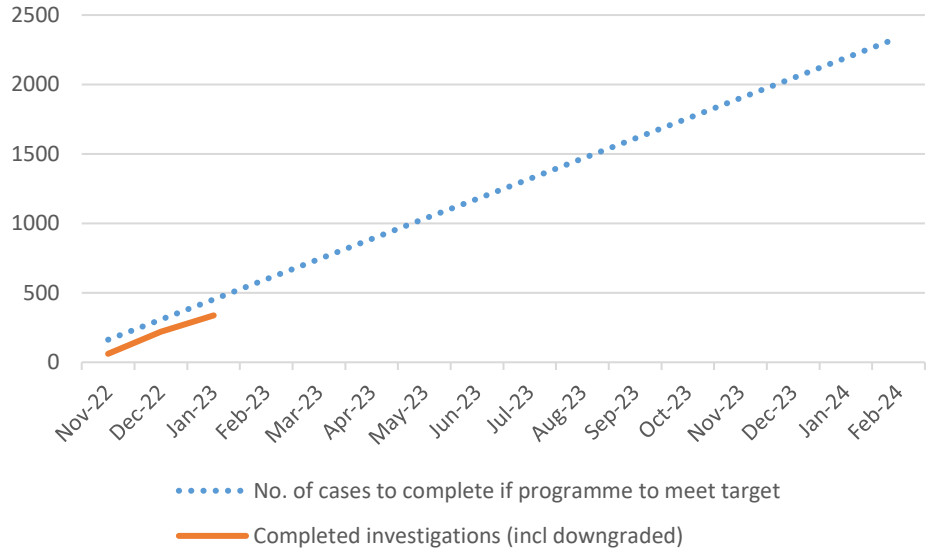
- A number of the actions replicate the focused work undertaken in Prince Philip Hospital (PPH) (June to October 2021) following a period of increased incidence (PII) of CDI cases, where excellent engagement from the triumvirate team had a positive impact resulting in PPH moving from having the highest CDI rates to currently being the fifth lowest (out of 18 hospitals) in Wales with sustained improvement.
- Surveillance of Klebsiella sp. bacteraemia to date indicates that patients generally have complex co-morbidities with the overall underlying primary source being either urinary or hepatobiliary (not necessarily alcohol related). Further in-depth surveillance is in-progress to inform targeted activity. Interventions to include increased focus on hand hygiene for both staff and patients (one study identified that 42% of patient's' hands were colonised with *Klebsiella*), strict adherence to management of catheters – greater focus on Urinary Tract Infection (UTI) prevention and HOUDINI awareness (Reducing catheter-associated UTI rates in hospital - Case study - GOV.UK (www.gov.uk), tracheostomy and wound care, and maintenance and care of equipment to help prevent transmission of this organism.
- "Post COVID" IP&C training on Aseptic Non Touch Technique (ANTT), invasive device management and bundle compliance has been re-instated to address bacteraemia incidence. Link nurse and community champion programme is being re-established.
- As a result of the recognised community burden the Health Board has allocated increased ICN presence to work collaboratively with community and primary care teams. Focused work includes care home training and public awareness campaigns. At an individual and cluster level working with GP's to raise awareness of CDI symptoms, levels of clinical suspicion and latest National Institute for Clinical Excellence (NICE) treatment guidelines.

Nosocomial COVID Review Programme

The Nosocomial COVID Review Programme Team supported by the Quality Assurance and Safety Team continue to progress the review of each patient.

Where it is assessed or suspected that an action or inaction, has, or is likely to have caused or contributed to the patient's unexpected or avoidable death, or caused or contributed to severe harm to the patient, a proportionate investigation is also undertaken in line with Putting Things Right.

On conclusion of the initial review, the review is screened by Head of Quality and Governance/Patient Safety and Assurance Manager or the COVID Lead Investigator and a decision is made as to whether the case should be presented to the Corporate Assurance Nosocomial (CAN) COVID Scrutiny Panel

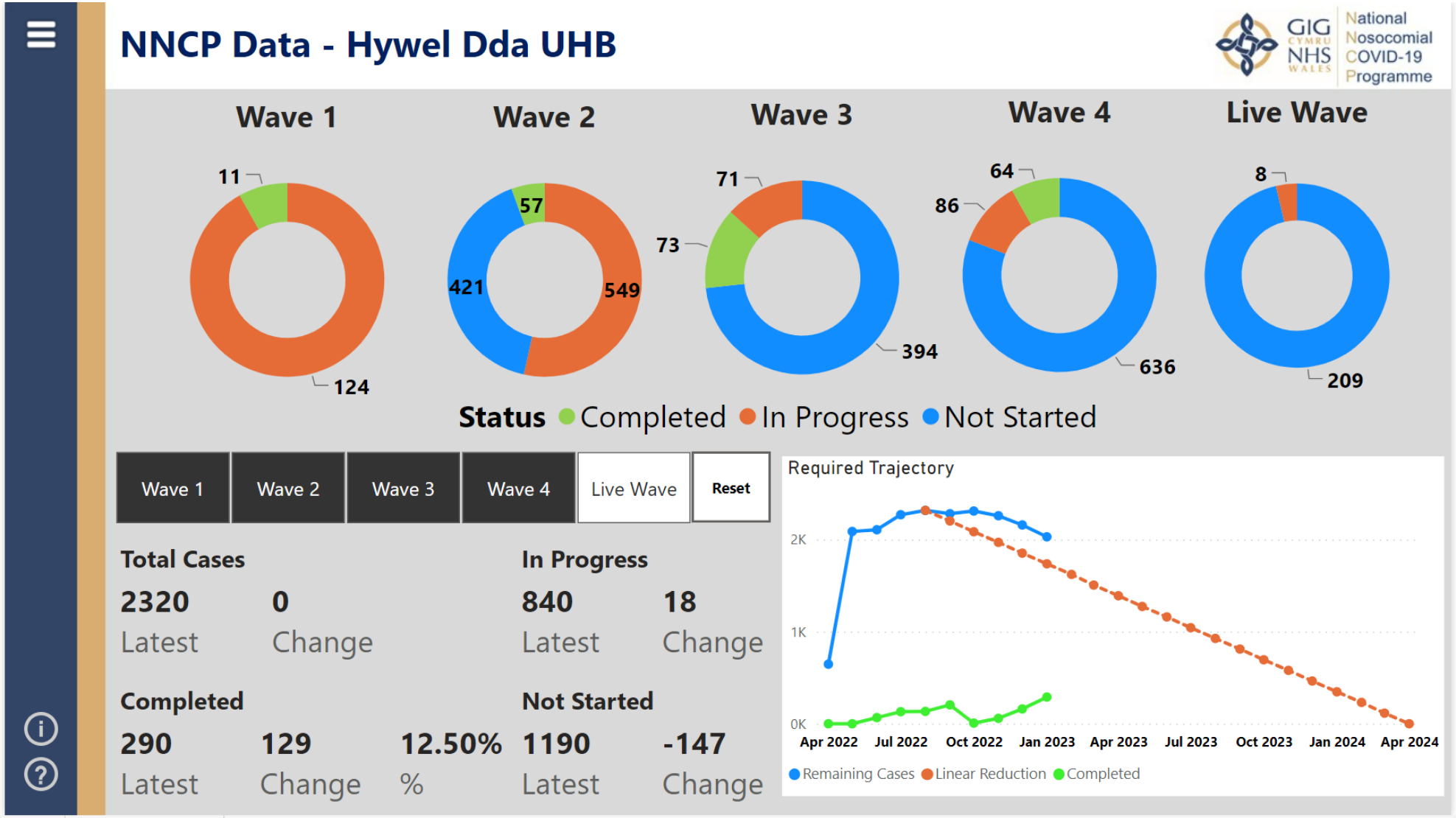


	Wave 1 (27/2/2020 - 26/7/2020)	Wave 2 (27/07/2020 - 16/05/2021)	Wave 3 (17/05/2021 - 19/12/2021)	Wave 4 (20/12/2021 - 30/04/2022) **	Live 01/05/2022 -
Total Incidents	119	1042	356	801	690
Under Investigation	45	230	94	218	50
Not Started	0	388	213	467	607
Referred to Scrutiny Panel	24	175	34	62	17
Completed Investigations	41	226	13	53	5
Downgraded / Re-categorised	9	24	2	2	11

Figures as at 18/01/2023

Data position

NHS Wales DU data as at 06/01/2023



Highlight Report (submitted on 06/01/2023)

GIG CYMRU NHS WALES
National Nosocomial COVID-19 Programme

Key Accomplishments in the previous period:

CAN COVID Scrutiny Panel continue to meet regularly although the panel frequency was reduced over the Christmas period.

CAN Strategic Oversight Group has met in this reporting period.

Communication (verbal and written) with families of deceased patients continues to progress.

Progress being made with reviews through use of bank staff (previously senior and experienced nurses and other Allied Health Professionals (AHP).

Upcoming Activities in this period:

Efforts continue to be made to recruitment to fixed term positions.

CAN Scrutiny Panel meeting to be held weekly to ensure progress with cases (262) ready for consideration by panel.

COVID investigation lead in post and is working through the cases where the review is complete but where a decision is required as to whether consideration is required by Scrutiny Panel e.g. scrutiny panel will consider those cases where it is deemed the harm is moderate or above.

CAN Strategic Oversight Group to be held every other month.

Items for escalation to Programme Board:

Recruitment to the fixed term COVID review team continues to be a challenge. Recent advert for administration support (two adverts) has been unsuccessful.

The Quality Assurance and Safety Team and COVID Bank team (which has expanded and is made up of retired senior/experienced nurses and other AHPs) continue to progress the reviews whilst the recruitment to the COVID review team continues.

As the COVID team expands, the office space for the team is becoming more challenging (health records must remain on site so home working not an option). A rota is in place, however office space is at a premium.

Top 3 Risks:

Risk name	Risk Score	Measure to reduce the risk
Availability of office space to undertake the review (unable to take health records off UHB site)	16	Limited office space available and therefore rota established to make best use of office space. Exploring block booking of meeting room adjacent to team office.
Access to health records when the Scrutiny Panel requests further investigation – records for deceased patients have been sent for scanning and are not currently available.	16	Issue escalated to relevant Executive Directors
Administration support for CAN Scrutiny Panel, CAN Strategic Oversight Group and retrieval of health records etc	12	Quality Assurance and Safety Team are undertaking the notes retrieval. Patient Safety and Assurance Manager maintaining decision and action log for Scrutiny Panel. Head of Quality and Governance preparing agenda etc for Scrutiny Panel

Learning identified through the Nosocomial COVID Review Programme

Good practice

- Timely Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions with rationale and discussions documented
- Ceilings of care being agreed and documented
- Regular medical reviews (well documented)
- Use of technology for communication between patient and family
- Documentation of bed location and rationale for moving patients
- Family members visits being facilitated when end of life
- Documentation of Personal Protective Equipment (PPE) usage when patients are being visited by relatives

(Note – the above is not consistent across wards and sites)

Areas for Improvement

- Medically fit for discharge patients becoming COVID positive whilst waiting for package of care or nursing home placement
- Use of technology for communication between patient and family
- Symptomatic patients – missed opportunities for re-testing when patient potentially symptomatic of COVID (diagnosis of different infection)

<u>Challenges</u>

- Wandering patients
- Ageing estate

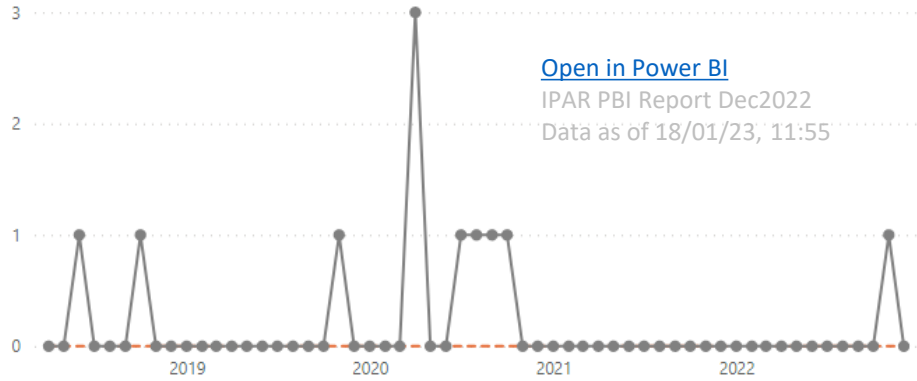
See also learning reported to QSEC in February 2022 and August 2021

Nationally Reportable Incidents

NRI - Type	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	Total
Access, Admission	5	0	3	4	10
Assessment, Investigation, Diagnosis	1	2	0	1	3
Behaviour (including violence and aggression)	1	1	1	1	3
Infection Prevention and Control	0	0	0	0	0
Maternity adverse occurrence	0	0	0	1	1
Medication, IV Fluids	1	0	1	0	2
Patient/service user death	6	9	2	8	20
Pressure Damage, Moisture Damage (avoidable harm)	1	1	0	2	2
Treatment, Procedure	1	1	0	2	2
Accident, Injury	0	2	0	1	2
Monitoring, Observations	1	0	0	0	1
Transfer, Discharge	0	0	2	0	2
Total	17	16	9	20	48

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.



Never Event – November 2022

Patient attended Day surgery unit for a gynaecology surgical procedure within main theatres. All went as planned and the patient returned home the same day as scheduled.

A few days later, the patient returned to Day surgery unit and asked to speak with the nurse who had looked after them. The staff member was on duty and attended to the patient where the patient explained that the patient had passed something through their vagina on the day after surgery. The patient then produced a small white round plastic piece which resembled a crown and handed it to the nurse.

Learning identified

Ensuring all removable parts of instruments are included in the swab and instruments counts within theatre.

Never Event – January 2023

A size 28mm femoral head was inserted in a 32mm acetabular cup during a hip replacement procedure. This was identified when the implant identifiers were entered by the arthroplasty specialist physiotherapist in the national joint registry when the patient attended for their 6 week follow up.

HIW Quality Checks/Inspections: summary for 1st December 2022 – 20th January 2023

New Quality Checks/Inspections & Reviews

Area of Review	Recommendations	Update
Argyle Medical Group Inspection January 2023 (awaiting publication)	TBC	An announced Quality Check took place on 5 January 2023 at the Argyle Medical Group GO surgery. Feedback on the quality related to environmental risk assessment and protocols dates. **The draft report is awaited**.
A&E Glangwili Hospital (GH) Inspection December 2022 (awaiting publication)	TBC	An unannounced inspection took place between 5 and 7 December 2022. There were several areas of immediate assurance required including securing the gas storage room, promotion of privacy and dignity within the surge areas at times of high capacity, resuscitation trolley checks, regularity of assessments for waiting patients, sepsis screening and the safety and wellbeing of children waiting within the department. The Immediate Assurance improvement plan has been submitted 18/01/23. **The draft report is awaited.**
Maternity (GH) November 2022 (awaiting publication)	TBC	An unannounced inspection took place on 29 and 30 November 2022. There were several areas of positive feedback, no immediate concerns highlighted and the expected recommendations relate to mandatory training and appraisal compliance. The draft report has been received with factual accuracy checks and the improvement plan submitted 23/01/23. **The final report is awaited.**
IRMER Inspection (GH) November 2022 (awaiting publication)	TBC	An announced inspection took place on 15 and 16 November 2022. The verbal feedback highlighted no immediate concerns and the expected recommendations relate to the standard of appointment letters, compliance with IRMER regulations, although acknowledgment that work is well underway to address this aspect, processes require updating and staff training. The draft report has been received with factual accuracy checks and the improvement plan submitted 20 January 2023. **The final report is awaited.**
Angharad ward, Bronglais Hospital (BH) Paediatric ward October 2022 (awaiting publication)	8	An unannounced inspection took place on 4 and 5 October 2022. The draft report highlighted no immediate concerns, the recommendations relate to timely CAHMS assessments, cleaning chemical storage, the requirement for a new clinical medication fridge, the development of menus, the replacement of flooring and reminders to staff regarding allergies and weight recording on drug charts and the countersignature and printing of names on documentation. A factual accuracy response and the improvement plan were submitted 25 November 2022. **The final report is awaited**.

New national review - National Review of Do Not Attempt Cardio Pulmonary Resuscitation.

A letter has been received from HIW requesting:

- A sample of 30 DNACPR forms
- The last 3 DNACPR audits undertaken and any associated action plans
- A copy of the training package for DNACPR and our overall organisational compliance in percentage for this training
- The last 3 complaints and serious incidents investigated where DNACPR has been a core feature

HIW Quality Checks/Inspections: continued

An update on previous Quality Checks/Inspections/ Reviews

Area of Review	Recommendations	Update
Bryngofal ward, PPH July 2022 https://www.hiw.org.uk/sites/default/files/2022-10/20221012PrincePhilipHospital-Full-EN.pdf	19	An unannounced inspection took place on 11 July 2022. The verbal feedback highlighted no immediate concerns and the recommendations relate to maintenance and refreshing environment, reorganisation of clinical room and the use of an office for staff, the provision of a fridge for patient use, consideration of staff uniforms on escort duty, training records, medication records and highlighting attention to the Consultant Psychiatrist and the Psychologist posts currently vacant. At the point of updating this report **8 recommendations remain outstanding**, almost all of which relate to Estates matters.
Ward 7 PPH February 2022	19	The inspection took place in November 2021 where 19 recommendations were raised on matters such as workforce, medicines management, governance and leadership, infection prevention, risk and health and safety. **All recommendations are now complete**.
National Review of Mental Health Crisis Prevention	19	This final report into the national review, published in March 2022, involved services benchmarking themselves against the recommendations suggested. The improvement plan, submitted 27th May 2022, requires some redesign of pathways of care and development of services, communication and engagement with primary care services and development of some staff roles and recruitment into new staffing models. The final completion date for recommendations is March 2023. At the point of updating this report, **7 recommendations remain open**.
Ystwyth Medical group Quality Check	0	The quality check took place on 7 February 2022. The review covered environment, infection, prevention and control and governance and staffing. **The report made no recommendations the service**.
National Review of Stroke Pathways	0	The Health Board's contribution to this review, an onsite inspection, took place at BH between 28 – 30 March and 16 May 2022 for the clinical areas. HIW also interviewed the corresponding staff at PPH, GH and WH for Stroke and Patient Flow. A letter has been received from HIW which states that "during our onsite fieldwork on 28, 29 and 30 March 2022, and 16 May 2022 within Bronglais General Hospital, we **did not identify any areas of immediate concern** for patient safety, and we therefore did not need to write to you in line with our immediate assurance process." **We await the final All Wales report which is due for publication in Spring 2023**

HIW Quality Checks/Inspections: continued

An update on previous Quality Checks/Inspections/ Reviews

Area of Review	Recommendations	Update
Llandovery Hospital Quality Check	0	The quality check took place on 15 March 2022, following postponement from 2021. The review covered environment, infection, prevention and control, governance and staffing, and some aspects of Covid-19 management. **The report made no recommendations for the service**.
Tregaron Community Hospital	29	An on-site inspection was undertaken on 7 and 8 September 2021; 29 recommendations were raised on matters including patient experience, delivery of safe and effective care and quality of management and leadership. At the point of collating this report, **all recommendations are complete.**
HIW IR(ME)R July 2021 WGH	40	The improvement plan included access to services, listening to feedback, staff training and some All Wales actions. At the point of collating this report there is **1 recommendation open,** linked to an All Wales piece of work with an extended completion date of March 2023.
Welsh Ambulance Services NHS Trust Acute improvement plan	31	This Welsh Ambulance Service improvement plan dating from September 2021 includes recommendations that affect or impact and require action for Acute/Emergency services and departments. At the point of updating this report there are **4 recommendations open** for sites to take forward. Services are chased to complete these actions in a timely manner.
Withybush General Hospital, St Caradog Ward	4	This improvement plan details recommendations in relation to Fire Safety and Health and Safety. There remain **2 recommendations open** at the point of collating this report with extended completion dates. The service and Estates are chased to complete these actions in a timely manner.

As of 20 January 2023 the current position is a total of 11 reports/inspections with 42 recommendations open. These continue to be tracked by the Quality Assurance and Safety Team (QAST) team and support is provided to services for advancing to completion. Those recommendations that have exceeded their due date are extended to completion, with discussion.

Learning identified through recent HIW Inspections

Good practice

- Staff responding to patients with a kind and caring manner (even when departments under significant pressure)
- Information regarding “Putting Things Right” being readily available for service users in range of formats
- Information displayed on actions taken following feedback from service users
- Commitment to learning from HIW inspection findings and making improvements where needed demonstrated

Areas for Improvement

- Completion of mandatory and statutory training
- Preventing unauthorised access to storerooms e.g. cleaning cupboard, medicines rooms, oxygen cylinder stores
- Promoting privacy and dignity at times of surged capacity
- Checking of resuscitation trollies/ensuring records of checks are accurate and up to date
- Reassessment of patients following initial triage

Risks and Mitigations

- All correspondence received by third parties such as the Welsh Government (WG), the Delivery Unit or HIW in relation to their activity is logged on receipt by the QAST.
- A robust process is in place for co-ordinating and quality checking responses, including gaining executive approval of HIW submissions, by the required deadlines.
- Recommendations arising from HIW, et al, such as immediate assurance plans or final reports are being migrated into the new AMAT software, in the meantime, QAST is pursuing services for updates in advance of any due date.
- The QAST team is supporting services to develop their improvement plans.
- QAST is providing updates for reporting to the Audit and Risk Team for each Audit and Risk Assurance Committee (ARAC) meeting.
- HIW activity forms part of the quality governance arrangements within Directorates.

Implementation of Welsh Health Circulars (WHCs)

- This report provides QSEC with progress in relation to the implementation of WHCs under its remit. The Committee is asked to gain assurance from the lead Executive/Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.
- The report details the WHCs closed since August 2022, when WHCs were last reported to QSEC.
- The report also details the status of all outstanding WHCs by using a RAG system. WHCs are not always clear in terms of implementation timescales, a result of which previously these were reported as "Amber" (i.e. on schedule). The Assurance and Risk Team have been seeking updates from leads on these WHCs to determine the planned date for implementation by the Health Board where a specific date is not provided in the guidance itself. The following RAG status is applied to WHCs:
- Green = completed,
- Amber = a plan is in place and on schedule to be completed by the timescale provided by the Lead Officer (if a timescale is not provided within the WHC),
- Red = behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.
- Currently the number of WHCs are as follows:

  -15 WHCs closed (noted as green (completed);

  -6 WHCs currently 'amber';

  -13 WHCs currently 'red' (further detail can be found in these slides).
- It is noted that operational demands and pressures have impacted on services' ability to reply to requests for implementation dates, however the Assurance and Risk Team will continue to seek updates on progress on the implementation of these WHCs, and will also raise these at local Quality Governance meetings. Progress of WHCs is reported to the Senior Operational Business meetings, as well as being included in the new 'Improving Together' sessions.
- Attached in Appendix 1 is an update in respect of the 'amber' and 'red' WHCs that fall under the remit of QSEC.

WHCs closed (implemented) since August 2022

WHC No	Name of WHC	Date Issued	Lead Executive/ Director
026-18	Phase 2 – primary care quality and delivery measures	16/07/2018	Director of Primary Care, Community and Long Term Care
030-18	Sensory Loss Communication Needs (Accessible Information Standard)	28/09/2018	Director of Primary Care, Community and Long Term Care
032-19	Sensory Loss Communication Needs (Accessible Information Standard) - of parents and carers of patients and service users.	20/09/2019	Director of Primary Care, Community and Long Term Care
018-20	Last person Standing	01/10/2020	Director of Primary Care, Community and Long Term Care
003-22	Guidance for the provision of continence containment products for adults in Wales 2022	21/10/2022	Director of Nursing, Quality and Patient Experience
012-22	Donation and Transplantation Plan for Wales: 2022-2026	16/06/2022	Director of Operations
014-22	AMR & HCAI improvement goals for 2021-23	01/03/2022	Director of Nursing, Quality and Patient Experience
015-22	Changes to the vaccine for the Human Papillomavirus (HPV) immunisation programme	25/05/2022	Director of Public Health
016-22	The National Influenza Immunisation Programme 2022-23	01/06/2022	Director of Public Health
022-22	The Role of the Community Dental Service and Services for Vulnerable People	22/08/2022	Director of Primary Care, Community and Long Term Care

WHCs closed (implemented) since August 2022

WHC No	Name of WHC	Date Issued	Lead Executive/ Director
023-22	Changes to the vaccine for the Human Papillomavirus (HPV) immunisation programme	09/09/2022	Director of Public Health
026-22	Approach for Respiratory Viruses - Technical Guidance for Healthcare Planning	11/10/2022	Director of Public Health
027-22	Urgent polio catch-up programme for children under 5 years old	24/10/2022	Director of Public Health
031-22	Reimbursable vaccines and eligible cohorts for the 2023/24 NHS Seasonal Influenza (flu) Vaccination Programme	08/12/2022	Director of Public Health
035-22	Influence (flu) Vaccination programme mop up 2022-2023	22/12/2022	Director of Public Health

WHCs which have not been implemented within stated timescales (Red RAG status).

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
046-16	Quality Standards for Adult Hearing Rehabilitation Services 2016	23/11/2016	Director of Operations	Not provided	No Risk

Only the following areas have actions that are outstanding:

- Clinical Effectiveness - Outcomes are analysed at service level to identify trends and patterns within the data and are compared against different factors.
- Service improvement - document relating to a systematic approach to the coordination, identification and appraisal of Audiological innovations still to be approved by senior Audiology Team

There is an All Wales working Group discussing version 3 of the Quality Standards, which can include patients with cognitive issues, on which the service has representation.

The Adult Hearing Rehabilitation Quality Standards audit took place on 14/11/2022. The service achieved an overall score of 93.47% (against a target of 90%). This is a significant improvement on the last audit. The service is waiting on the final report from the Audiology Standing Specialist Advisory Group who are meeting on 09/02/2023.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
006-18	Framework of Action for Wales, 2017-2020	01/02/2018	Director of Operations	Not provided	1457

An update on the Hearing Well Project Board action plan was provided to WG in December 2022 . Eleven are fully completed and 6 have elements still outstanding; these are unable to be completed due to issues with securing funding to progress further. It is anticipated that this Framework will be extended to 2023, however no formal confirmation obtained from WG to date.

WHCs which have not been implemented within stated timescales (Red RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
033-18	Airborne Isolation Room Requirements	25/07/2018	Director of Nursing, Quality and Patient Experience	Not provided	TBC

Whilst actions have been taken locally to mitigate the risk relating to this WHC, this requires Capital investment including any current and future needs. Isolation pods have been purchased and are deployed based upon Risk Assessment. However, this continues to be an issue which can be addressed through strategic infrastructure changes. A number of Air Purifiers have been purchased and allocated according to clinical need in order to mitigate some of the risk associated with Airborne transmission.

Conversations have taken place with the Clinical Teams to agree a plan although a consensus has not yet been reached. Further work needs to be undertaken with the Strategic Planning team to fully implement this WHC. This is been progressed through a sub group of the Ventilation group.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
017-19	Living with persistent pain in Wales guidance	07/05/2019	Director of Operations	Not provided	Not provided

Referral rates into the bio-psychosocial pathway for Persistent Pain remain high, which would reflect the wider impact of the pandemic, with higher referral rates from other secondary care services. All initial assessments are conducted virtually using T/C and Attend Anywhere. Pre and Post Patient Reported Outcome Measures (PROMS) are being collected using the Doctor platform whereby preliminary data showing value to patients and outcomes from our service is very positive.

HDdUHB has developed, in partnership with a Healthcare digital company and support of the Bevan Commission and TriTech, a bilingual electronic Pain Management Programme (e-PMP). HDdUHB is currently conducting a research study on the efficacy of this intervention and recruitment for this will end in March 2023. Once the study is completed, the UHB will begin using this to evaluate its efficacy in clinical practice, using the Primary Care Cluster Projects as the pilot sites for this work.

WHCs which have not been implemented within stated timescales (Red RAG status).

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
014-20	Ear Wax Management Primary Care and Community Pathway	29/09/2020	Director of Operations	Not provided	1457

Business Case for 1st Point of Contact Audiology has been shared on 22 September 2022 with Primary Care Directors, Service Delivery Managers (SDM) for Scheduled Care and Assistant Director of Therapies (AoTH) requesting funding for equipment and salaries using existing staff, which has not progressed. This was included in Audiology Integrated Medium Term Plan (IMTP) but pushed down the list of the Scheduled Care IMTP (funding still not agreed).

Audiology now provides a wax management service for existing NHS hearing aid users and any new patients who are found to have wax that prevent the completion of their pathway. Since its introduction in June 2021 over 1800 patients have been seen.

Audiology is working with each county to introduce ambulatory nurse-led micro suction clinics so that wax management is provided across the UHB. The Audiology team has trained the new staff in otoscopy. Services in Ceredigion are now up and running and Pembrokeshire and Carmarthenshire are due to start in February 2023. Fortnightly meetings are held to monitor progress.

First point of contact access to Audiology services was included in the IMTP 22/23 submission but no response on approval yet received.

Recurrent funding for at least 5 B7 Advanced Audiologists and associated equipment and locations is required in order to close this WHC.

WHCs which have not been implemented within stated timescales (Red RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
009-21	School Entry Hearing Screening pathway	25/03/2021	Director of Operations	Not provided	1456

Audiology met with SDM Senior Nurse for School Nursing and Childhood Immunisations to discuss the WHC. This was escalated to the General Manager (Scheduled Care), who considered options within SBAR/Business Case.

IMTP request was declined. Updates are reported to WG from Head of Audiology as requested.

A report was due to be presented at the August, October and December 2022 Scheduled Care QSE meetings but these were either cancelled due to operational pressures or moved to the next meeting. The next planned meeting is 02/02/2023. This will then need to be escalated to a subsequent Operational Quality Safety and Experience Committee meeting for further agreement.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
025-21	Carpal Tunnel Syndrome (CTS) Pathway	15/09/2021	Director of Operations	Not provided	No risk

Secondary Care is scheduling a meeting with Primary Care leads to discuss the implementation of this WHC and formulate a development plan that outlines the transition to the new CTS Pathway. Secondary Care already practice according to this pathway, however discussions are required with primary care to ensure they fully understand the requirements.

No further progress update received as of January 2023. Assurance and Risk Officer will continue to seek updates.

WHCs which have not been implemented within stated timescales (Red RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
002-22	NHS Wales National Clinical Audit and Outcome Review Plan - Annual Rolling Programme for 2022/23	14/06/2022	Director of Nursing, Quality and Patient Experience	Not provided	TBC

* Appointment of a new Clinical Director for Clinical Audit.
* Clinical Audit Department working with auditing teams to increase participation by refining processes
*Cardiology SDM has met with Senior Nurses at all sites to increase participation in MINAP and Heart Failure
*New support for Heart Failure Audit in PPH identified and in place
*Clinical Director for Clinical Audit working with CAD to identify priority areas to focus on in early 2023; N.B. Current participation is higher than it was previously however the improvements are not significant enough to warrant removal from the above mentioned concems
*National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – variable concerns at 4/4 sites though there have been improvements in participation at 3 of 4 sites
* National Heart Failure Audit – concerns at 1/4 sites improvements expected on 2 sites with plans to increase for all 4.
*The UHB has an approximate compliance of 84% with the whole programme. A new and identical WHC will be released next year and this one will be superseded.

There are many actions to be undertaken in order to comply with this WHC and in reality, these will not all be achieved by 31/03/2023, and therefore this WHC is being reported as red. These actions do not sit with NQPE but with a variety of individual services. Assurance and Risk team to meet with Clinical Audit Manager to discuss how the risks are articulated for this WHC.

WHCs which have not been implemented within stated timescales (Red RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
004-22	Guidance for the provision of continence containment products for children and young people: a consensus document	21/10/2022	Director of Operations	Not provided	TBC

SDM Community Paediatrics is facts finding form Public Health including Health visiting, school nurses and Community children's nurses. Meeting scheduled for 20 February 2023 with SDM for Acute Paediatrics, DoN for family and child health and also the lead nurses for Community and Acute Paediatrics to summarise and identify gaps in the service. More updates are likely to be received by 31 March 2023.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
006-22	Direct paramedic referral to same day emergency care: All Wales policy	21/04/2022	Director of Operations	Not provided	TBC

WHC received in May 2022. At January 2023, no progress update has been received in relation to this Circular or confirmation on UHB implementation date. No further progress update received as of January 2023. Assurance and Risk Officer will continue to seek updates.

WHCs which have not been implemented within stated timescales (Red RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
018-22	Revised Guidelines for Managing Patients on the Suspected Cancer Pathway	30/06/2022	Director of Operations	Not provided	No risk

A progress update on the implementation of this WHC and UHB implementation date has been requested from Cancer Services in December 2022, but no update received as at January 2023. Assurance and Risk Officer will continue to seek updates.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
021-22	National Optimal Pathways for Cancer (2022 update)	28/07/2022	Director of Operations	Not provided	No risk

A progress update on the implementation of this WHC has been requested from Cancer Services in October and December 2022, but no progress update received as of January 2023. Assurance and Risk Officer will continue to seek updates.

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	UHB Implementation date	Datix risk reference
028-22	More than just words Welsh language awareness course	10/11/2022	Director of Communications	Not provided	TBC

The Welsh Language (WL) Service Manager has confirmed that this will be addressed by the Workforce and Organisational Development (W&OD) and WL groups. The roll-out and reporting via ESR, whilst supported and promoted by Welsh Language, will likely come from W&OD. WL team will be supporting rollout with reporting on ESR coming from W&OD.

WHCs which have not been implemented but are on schedule or have no compliance date stated on WHC (Amber RAG status)

WHC Ref	Name of WHC	Date Issued	Lead Executive/ Director	Implementation date
022-16	Principles, Framework and National Indicators: Adult In-Patient Falls	06/04/2016	Director of Operations	31/03/2023
022-21	Publication of the Quality and Safety Framework	17/09/2021	Director of Nursing, Quality and Safety Experience	01/04/2023
017-22	Wales rare diseases action plan 2022 to 2026	16/06/2022	Medical Director	31/12/2026
019-22	Non Specialised Paediatric Orthopaedic Services	21/06/2022	Director of Operations	01/04/2025
029-22	Urgent polio catch-up programme for children under 5 years old (follow up)	22/11/2022	Director of Public Health	31/01/2023
001-23	Eliminating hepatitis (B and C) as a public health threat in Wales – Actions for 2022-23 and 2023-24	12/01/2023	Director of Public Health	31/03/2024

Recommendation

The Quality, Safety and Experience Committee is requested to note the safer care collaborative work and take assurance that processes, including the Listening and Learning Sub Committee, are in place to review and monitor:

- patient safety highlighted through:
    - Incident reporting;
    - Review of nosocomial COVID-19 infection
- patient experience highlighted through HIW Inspection
- compliance with Welsh Health Circulars
- quality improvement.