Quality, Safety & Experience Committee Special Meeting

Tue 26 October 2021, 09:00 - 11:00

MS Teams

Agenda

1. Welcome & Introductions

Susan Elsmore

2. Apologies for Absence

Susan Elsmore

3. Declarations of Interest

Susan Elsmore

4. Chair's Action taken since the last meeting

Susan Elsmore

5. Hot Topics - Verbal

Ruth Walker / Stuart Walker

6. Quality, Safety and Experience Themes and Trends 2020-2021

Angela Hughes

6 QSE definitions and Background information Final.pdf (14 pages)

7. Items to bring to the attention of the Board/Committee

Susan Elsmore

8. Review of the Meeting

Susan Elsmore

9. Date and time of next Meeting: 15 December 2020 at 9.00am

Susan Elsmore

Report Title:	Quality, Safety and Experience Themes and Trends 2020-2021	**Agenda Item no.**	**6**
Meeting:	**QUALITY, SAFETY & EXPERIENCE COMMITTEE**	**Meeting Date:**	**26 October 2021**

Status:	**For Discussion**	★	**For Assurance**		**For Approval**		**For Information**

Lead Executive:	**Executive Nurse Director and Executive Medical Director**
Report Author	**Assistant Director of Patient Experience and Associate Medical Director (Clinical Governance and Patient Safety)**

Background and current situation:

The report is supported by the presentation which will illustrate the Quality, Safety and Experience Themes and Trends which covers the period of 1st April 2020 to 31 August 2021

The presentation will discuss in more detail the themes and trends and actions taken in relation to:

- Patient Safety Incidents
- Concerns –Complaints including referrals to the Public Service Ombudsman for Wales
- Redress and Claims
- Inquests
- Mortality Reviews and the Medical Examiner
- Covid 19 Investigations
- National Clinical Audits
- Patient Safety Notices and compliance
- Horizon Scanning of future legislation and guidance

The past year has been unprecedented and has meant adaptation of reporting and working requirements across the UHB this paper shares those changes.

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

The QSE Committee are asked to note the work we have undertaken during this extraordinary year and supports the presentation on themes and trends that will be presented at the Committee.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

National Changes, Reporting arrangements and definitions

In addition, the past year has seen a national change on the reporting of serious incidents which are now referred to as NRI-Nationally reported incidents. Following publication of the National Patient Safety Incident Reporting Policy (the Policy) in May 2021 the NHS Wales Delivery Unit (DU), as the shadow form of the NHS Wales Executive, was commissioned by Welsh Government to lead the implementation process. In turn, the DU established national mechanisms for collaborating and co-producing the national approach with all Welsh NHS organisations.

The current definition of a nationally reportable incident is;

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

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients receiving healthcare. We know the vast majority of incidents do not result in harm or significant harm, but do provide extensive opportunities for learning and improvements in safety to prevent future harm occurring. There will be occasions, however, when serious incidents do occur, resulting in serious harm, which can be life impacting or sadly result in an avoidable death. In such cases the consequences for patients, families and carers, as well as the staff providing that care can be devastating. When incidents such as these occur a comprehensive response is required to ensure immediate make safe actions are taken. This must be prior to any wider learning identified from an investigation into the event and to ensure those affected are fully supported and involved in any investigation process as required.

Sometimes a serious "near miss" can provide important learning and therefore also needs careful consideration to prevent future harm. Patient safety incidents can be single isolated events or multiple recurring events, which can signal more systemic failures in care, including omissions in care provision or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organization's ability to deliver a service, such as a failure in an IT system.

Incidents should be investigated appropriately and proportionately with actions taken accordingly, in line with PTR requirements

The reporting of patient safety incidents at a national level will:-

- provide oversight and assurance relating to the most 'serious' incidents occurring in healthcare
- enable the identification of organisational and/or system risks
- Inform learning and action, including the development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and any potential service reforms.

Phase one of the Policy came into effect on 14 June 2021. This phase primarily related to reporting individual incidents with harmful outcomes to the NHS Wales Delivery Unit. Phase two delivered a significant shift in national incident reporting, with the focus expanding beyond individual incidents causing significant harm to also look at learning from across a range of incidents and harm outcomes. There was also a pressing need to provide clarity in relation to reporting hospital acquired infections, in particular nosocomially acquired Covid-19. The phase two incident work has been undertaken in full alignment with the national work around nosocomial Covid-19,

As with concerns, it is important that the investigation of patient harm continues, to ensure good quality care provision is maintained and the learning shared. For this reason organisations must report and investigate all incidents locally in line with PTR (Putting Things Right) guidance.
NHS organisations are not required to undertake full root cause analysis for each and every incident. The investigations carried out should be proportionate to the incident being reviewed

and should ensure immediate 'make safes' are put in place with all learning shared across the organisation in the usual way.

Never Events, in-patient suicides, maternal deaths, and avoidable healthcare acquired pressure damage and incidents affecting a significant number of patients have continued to be reported to the Delivery Unit (DU) immediately. Where there is uncertainty as to the level of harm caused and whether there are causative factors related to their healthcare provision, all NHS Organisations now have 7 days to fact find and report to the DU.

The formal 60 day performance target for SI closure reporting was removed at the commencement of the pandemic. During this time we continue to work towards the 60 days with the emphasis on proportionality of investigation for all incidents

Future Considerations

It is also important to take into account implementation of the forthcoming Duties within the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Duty of Quality requires organisations to set out all decisions that are taken to secure improvement in the quality of services provided within the NHS in Wales, in the journey towards ever higher standards of person-centered health services.

The Duty of Candour focusses on the need to be open with patients, families and carers when things go wrong, building on the requirements already set out in PTR. Evidence suggests that increased openness, transparency and candour are associated with the delivery of higher quality health and social care. When the duty of candour is implemented (projected to be in April 2023), the outcome of candour investigations will also be an important source of learning and improvement. As set out in the guidance, the new duty of candour requires NHS bodies to be open and transparent with patients and their families when the duty of candour applies. The Duty is triggered when:

- A service user to whom health care is being or has been provided by the body has suffered an adverse outcome; and the provision of health care was or may have been a factor in the service user suffering that outcome.

A service user is treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that they could experience; any unexpected or unintended **harm that is more than minimal**. For the purposes of the duty of candour, harm includes psychological harm and in the case of service user who is pregnant, loss of or harm to the unborn child. **Further consideration is being given to what is meant by psychological harm.**

In both England and Scotland, harm that triggers the duty of candour is "moderate" harm and above, (moderate and severe harm or death).

It is important to acknowledge that the threshold for the duty of candour trigger is slightly different to the NRLS threshold, in that, the duty of candour trigger is specific to service user/s experiences that resulted or could have resulted in, any unexpected or unintended harm that is more than minimal.

The Once for Wales Concerns Management System (OfWCMS) which has been rolled out across Wales from April 2021, supports the quality assurance agenda with timely access to

patient incident and concerns related information which will help inform service planning and provision at a local and national level. Organisations need to ensure they have systems in place and can evidence :

- robust processes in place,
- routine services quality monitoring
- Incident management and patient safety incident reporting ,
- responding to alerts,
- notices and other improvement actions
- Learning from deaths
- Monitoring harm on waiting lists
- Clinical audit Quality indications and benchmarking
- Patient experience / concerns

Proportionate investigations should seek to identify learning opportunities and/or identify any areas of concern in the care provided, which caused or contributed to the death, including concerns raised by the family. Where an investigation confirms concerns in care were directly attributable to severe harm or an individual's death, an individual patient safety incident should be retrospectively reported at the earliest opportunity. These systems are currently in place within the UHB.

Near miss reporting

Near misses can provide a valuable source of learning. All NHS organisations are expected to share learning from near misses as part of the national reporting and learning framework. All patient safety incidents must be investigated proportionately in line with PTR requirements. The depth of the investigation will vary according to the issues under consideration and the level of harm caused

In line with the revised Framework all NHS organisations must ensure robust processes are in place to inform and assure their Boards that the quality of their investigation processes is of a high standard, patients and families are being engaged in the investigation process, appropriate actions are being taken and that learning is being shared across their organisations, to allow Boards to be assured that incidents have been dealt with appropriately and can be closed. Investigation outcomes will need to be shared nationally as set out in the implementation guide.

Commissioned services

We commission some NHS services, from neighboring health boards / NHS trusts (including WAST) or outside of Wales. Where this happens the following principles apply to ensure equity: -

- the organisation where the patient safety incident occurred is responsible for reporting and investigating in line with its relevant national framework;
- when notified of an incident the service commissioner should liaise with the investigating organisation as appropriate as part of the investigation
- assurance should be sought that the patient and / or their family form part of the investigation process
- assurance must be obtained to confirm any immediate make safes have been put in place which protects the ongoing safety of patients or consideration is given to remove patients from a particular care setting where appropriate

• Any incident learning should be shared with the service commissioner, as part of its internal assurance processes that commissioned services outside of its boundaries are safe and of high quality.

Early warning notifications
Early warning notifications replace 'no surprises' and should be used in circumstances where the Welsh Government needs to be alerted to an immediate issue of concern or prior warning of something due to happen which might relate to the following:

• has the potential to affect a number of patients/ staff / communities etc
• has a significant impact on service provision;
• may have an adverse impact in the media; • might cause national or political embarrassment;
• following an inquest which has resulted in a Regulation 28 or public interest in a Public Services Ombudsman for Wales (PSOW) report OR
• A positive good news story. NHS organisations are expected to work closely with local and national communications teams where required to mitigate potential impact through the media.

Concerns- Complaints

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (hereafter, the 'Regulations') apply to all Welsh NHS bodies, primary care providers and independent providers in Wales, providing NHS funded care and were introduced in April 2011. The Regulations set out the process for the management of concerns and is known as Putting Things Right (PTR). The Regulations are supported by detailed guidance on raising a concern

The process:

• Aims to make it easier for people to raise concerns; to be engaged and supported during the process; to be dealt with openly and honestly; and for bodies to demonstrate learning from when things went wrong or standards needed to improve.
• Introduced a single more integrated approach, bringing together the management of complaints, incidents and claims, based on the principle of 'investigate once, investigate well'

As a Health Board we are committed to listening to people who use our services, resolving their concerns where possible in a proportionate and empathetic manner. We aim to provide an effective and timely process for responding to concerns, which enables the Health Board to improve services based on lessons learnt, with the aim of achieving high quality, compassionate and effective care for all service users, whether in provided or commissioned services.

Redress:

A case moves into redress if we identify that there is or maybe a qualifying liability i.e. we have identified in breach in our duty of care (Care was not reasonable or there was an omission in care)and we know the patient suffered harm because of the breach or we need to investigate further to establish if harm was caused

We are committed to using the redress process when appropriate this enables a timely resolution for those people seeking an apology, remedial treatment and/or financial compensation to the value of £25,000. if we can demonstrate to the WRP that we have followed process, from an

investigation and legal context, that we have evidenced the improvements needed to ensure that the learning is used to mitigate the risk of a case like this reoccurring then we can reclaim the £25,000 settlement and the expert fees incurred. However, the UHB will bear the costs of the claimant's legal fees, if they choose to engage a solicitor which under PTR are capped at £1,920.00.

Redress legal costs significantly save the Health Board. When a matter settles under the Putting Things Right scheme, costs are mostly settled for £1920. These costs can increase slightly where a matter needs approval in Court where there is a child or a person who lacks capacity being paid compensation. This could increase costs by an additional £1,752. However, this is still a significant reduction than if the case was settled as a Clinical Negligence claim, potentially savings tens of thousands in costs alone.

The Once for Wales system will assist greatly with the reporting of Redress cases as we have In October 21 implemented the specific redress Module , whereby reports will be obtainable to reflect the opening and closing of Redress cases for a specific time period and per Clinical Board.

WRP-Welsh Risk Pool

The Health Board had completed the work to comply with the new WRP Guidelines in carrying out a retrospective Learning from Events form for almost 300 Clinical Negligence cases. As a result of the pandemic there was a temporary lapse of the deadline for this work to be completed and for any new triggering cases, although this has reverted back to the 60 day deadline for learning assurance plans to be submitted. This was a substantial additional workload which could have had a significant financial implication if not completed in accordance with the deadlines.

In January 2020, the WRP issued an updated version of their Guidelines with a change of the review of over one million pound cases which were previously reviewed by Welsh Government. These would now be reviewed by the WRP at the Learning from Events Panel with WG being invited to attend. This would speed up this part of the process concerning these high value claims. The Health Board would still be required to produce the evidence of learning in the same way.

There has been a change with deferred cases and any cases that have been deferred for payment as further information is required must be submitted with the additional evidence in an agreed timeframe and failure to do so will mean a permanent deferral and the Health Board would be liable for all associated costs of a claim

The WRP has also undertaken some audits this past year and the results are awaited

Coronavirus Pandemic

During the pandemic Legal and Risk Services had also reverted to solely working at home with all case conferences, trials being held electronically which has been successful. During the pandemic there was a temporary reduction of new Claims which allowed the Solicitors to focus their attention on finalising a number of cases during the period.

It is anticipated that there will be an emerging theme of new Claims arising from the period of Covid-19 cases. The Health Board is monitoring this situation and has developed records of key documents that relate to this period to assist swift investigation being conducted.

Internal Audit

The review was undertaken with_the objective of the audit being to provide assurance to the Health Board's Audit and Risk Committee that the correct process is being followed and that Claims are accurate. The purpose of the review was to provide assurance to the Audit and Risk Committee that the Claims Reimbursement Process is in compliance with the Welsh Risk Pool Standard

RATING	INDICATOR	DEFINITION
Substantial Assurance		The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Public service Ombudsman for Wales (PSOW)

During 2019/20 the Health Board had a total of 62 concerns referred to PSOW and the Ombudsman chose to investigate 26% of these cases. In that time period 19 concerns were upheld in whole or in part. No public interest reports were issued.

The table shows the number of complaints received by PSOW for all Health Boards in 2020/2021. These complaints are contextualised by the number of people each health board reportedly serves.

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	96	0.16
Betsi Cadwaladr University Health Board	184	0.26
Cardiff and Vale University Health Board	62	0.12
Cwm Taf Morgannwg University Health Board	86	0.19
Hywel Dda University Health Board	64	0.17
Powys Teaching Health Board	16	0.12
Swansea Bay University Health Board	79	0.20
Total	587	0.19

Appendix B - Received by Subject

Cardiff and Vale University Health Board	Complaints Received	% Share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	1	2%
Clinical treatment in hospital	50	81%
Clinical treatment outside hospital	3	5%
Complaints Handling	4	6%
Confidentiality	0	0%
Continuing care	2	3%
COVID19	0	0%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Medical records/standards of record-keeping	1	2%
Medication> Prescription dispensing	0	0%
NHS Independent Provider	0	0%
Non-medical services	1	2%
Other	0	0%
Patient list issues	0	0%
Poor/No communication or failure to provide information	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
	62	

It is pleasing to note that in this time period we had no concerns raised regarding the handling of complaints

Ombudsman Standards Authority

The Complaints Standards Authority (CSA) was created under the Public Services Ombudsman (Wales) 2019 Act. The aim of the CSA is to drive improvement in public services. They have introduced a model Complaints Handling Process-this in the main mirrored work already in place in the Health Board and has not therefore required a change to our process.

Complaint Handling Processes – Statement of Principles Effective complaints handling processes should be:

1) Complainant Focused
2) Simple
3) Fair & Objective
4) Timely & Effective
5) Accountable
6) Committed to Continuous Improvement

Complainant Focused • The complainant should always be at the center of the complaints process. • Service providers need to be flexible when responding to complainants' differing needs.

Simple • Complaints processes should be well-publicized, have easy-to-follow instructions and have no more than two stages. • Information on advocacy services and support should be available. • Complaints responses should set out clearly the next stage and the right to approach the Ombudsman.

Fair & Objective • Complainants should receive a complete and appropriate response to their concerns. • Complainants and staff complained about should be treated equally and with dignity

Timely & Effective • Complaints should be resolved promptly, when possible • Investigations should be thorough, yet prompt. • Complainants should be kept informed throughout of the progress of a lengthy investigation.

Accountable • Complainants should receive an honest and clear explanation of the findings of an investigation. • Service providers should explain to complainants what changes will be made if their complaint is upheld, whenever possible.

Committed to Continuous Improvement • Information from complaints should be collated and analyzed. • Data should be shared with the organization's senior leaders and the Ombudsman to support improvement in complaint handling and in service delivery. • Decision makers should regularly review the information gathered from complaints when planning service delivery.

Learning from Deaths

Following the atrocities from Harold Shipman and Mid Staffordshire Trust, mortality reviews were developed and introduced in to NHS Wales as a system of learning and assurance. This was mandated from 2013 for hospital deaths and have been crucial in confirming important areas for continuous improvement, including sepsis and the recognition of the unwell and deteriorating patient. An all-Wales group was established to support the implementation and to guide a standardised approach.

The national group evolved to oversee the introduction of the Medical Examiner (ME) service and to develop a governance framework in line with Putting Things Right and Duty of Candour. Medical Examiners independently scrutinise all deaths that are not investigated by HM Coroner. There are three main drivers for the creation of Medical Examiners (MEs): improved patient safety; death certification accuracy and to support and inclusion of the bereaved relatives as highlighted in the Quality and Safety Framework: Learning and Improving (Welsh Government 2021).

. Pre-COVID about 200 deaths per month occurred in our hospitals. The aim was to do send all hospital deaths to the ME office by the end of October 2021. This service cannot expand without additional resource. Thus a business case has been drafted accordingly. It should be noted that Medical Records has been commended for the quality of the digitized notes received by the MEO. The overall aim is for the ME to review all deaths in Wales, not just the hospital deaths. Themes and trends will also be collated on an all-Wales basis to highlight national priorities for improvement.

At present the 2013 level 1 reviews and death certification details are entered on to our own Electronic Mortality Audit Tool (EMAT) which feeds into a mortality dashboard in the Business Intelligence System. An all-Wales Datix mortality module has been procured and is being implemented whilst further developments are undertaken. Expertise within the UHB is contributing to this to ensure we gain rather than lose from migrating on to the new system, although in the short term this is unlikely.

COVID Reviews and Investigations

Following the global Coronavirus pandemic, which has affected the lives of so many there is a need to review the patients who have tested positive for Covid-19, whilst in-patients under the care of Cardiff and Vale Health Board. Our reviews should be measured and proportionate but of sufficient quality to identify learning and instances of harm. It is recognised that a hospital or care setting is a high risk environment for the transmission of Covid-19. This transmission leads to a significant risk to patient safety potentially leading to harm.

This project plan sits under the umbrella of the draft *'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021)* which supports the *Communicable Disease Outbreak Plan for Wales (2020)* by identifying , reviewing and reporting patient safety incidents relating to nosocomial transmission of Covid-19 in line with the *National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR)*.

Criteria for determining if a Covid-19 infection is healthcare-associated

HCAI category	Criteria
Community onset	Positive specimen date ≤2 days after admission to Trust
Indeterminate healthcare-associated	Positive specimen date 3-7 days after admission to Trust
Probable healthcare-associated	Positive specimen date 8-14 days after admission to Trust
Definite healthcare-associated	Positive specimen date 15 or more days after admission to Trust

Patient care reviews are undertaken in line with Putting Things Right regulations and should scope the level of potential risk the UHB is carrying through the identification of learning and potential harm.

Definitions of harm relating to patient safety incidents are provided within the Putting Things Right guidance (PTR guidance v3 2013). The draft *'NHS Wales National Framework - Management of Patient Safety Incidents following Nosocomial Transmission of COVID-19 (2021)'* states that it is important to remember that in the context of this framework, 'harm' relates to the harm occurring as a result of nosocomial transmitted Covid-19. PTR is concerned not only with harm that has occurred as the result of a patient safety incident, but also harm that could have occurred as a result of that incident.

They define harm as –

Moderate Harm:

- Resulted in avoidable, semi-permanent injury or impairment of health or damage that requires intervention
- Additional interventions, required in addition to any baseline treatments for original hospitalisation treatment plan i.e. planned surgery/procedure
- Intended treatment is cancelled or significantly delayed
- Increase in length of stay by 4 – 15 days

Severe Harm:

- Issues that have resulted in avoidable, permanent harm or impairment of health, or damage leading to incapacity or disability
- Additional interventions required such as ITU care
- Cancellation or significant delay in urgent treatment
- Increase in length of stay by >15 days

- A concern outlining noncompliance with national standards with significant risk to patient safety

Covid-19 can lead to death soon after diagnosis, but it may also cause death many weeks later. Someone who tests positive can of course die from another cause such as cancer or heart disease at any time.

A death in someone who has tested positive becomes progressively less likely to be directly due to Covid-19 as time passes, and more likely to be due to another cause. However, there is no agreed cut-off after which Covid-19 can be excluded as a likely cause and sadly, some people die from their infection many weeks later.

Coronavirus can also contribute to a death without being the main or underlying cause. The World Health Organisation (WHO) recognises this complexity and states that: A Covid-19 death is defined for surveillance purposes as a death resulting from a clinically compatible illness in a probable or confirmed Covid-19 case, unless there is a clear alternative cause of death that cannot be related to Covid-19 disease (e.g. trauma). This definition therefore requires a clinical assessment of each case.

Two toolkits have been developed in response to the need to review patient care under the circumstances outlined above - a *Rapid Patient Assessment* and the *Covid-19 Patient Investigation Toolkit*.

The *Rapid Patient Assessment Toolkit* is to be primarily utilised for Patients who acquired Covid-19 on day 8 onwards into their healthcare stay (swab taken on day 8 onwards). The *Covid-19 Patient Investigation Toolkit* will be commenced in the event that harm has been identified or where death has occurred and Covid-19 is listed on the death certificate.

In the event of Nationally Reported Incident (NRI) being identified then a root cause analysis will be undertaken in line with the current NRI framework.

The purpose of undertaking a review into a patient's care is to identify the likely root cause of acquisition of Covid-19, review the patient's care and identify any failings which may have contributed to harm. This will be undertaken following the principles of Duty of Candour and identify and share any learning points.

Learning will enable the identification of actions required to reduce future risk, these will be recorded in a Clinical Board action plan and feed into an over-arching Cardiff and Vale Action Plan to ensure widespread cross Board learning and enable future planning.

This approach is currently different in each UHB, we have therefore asked that the threshold for investigation is consistent across all UHB's. This work is being undertaken by the DU and is yet to conclude. The outcome of this work may impact on our current approach.

Clinical Effectiveness Committee

In December 2020 the Clinical Effectiveness Committee (CEC) was established, and is rapidly gathering momentum. To date the committee has met 6 times. In May 2021 for the first time,

Clinical Boards and Directorate members were invited to attend to present their national audit findings.

Clinical audit is an integral component of the quality improvement process and is embedded within the Welsh healthcare standards. NHS Wales needs to be a learning organisation which regularly seeks to measure the quality of its services against consistently improving standards and, in comparison with other healthcare systems across the UK, Europe and the World.

A paper to September QSE outlined much of the findings and committee activity to date

In addition the Committee discusses any Patient Safety Notices where compliance is outstanding

Documents of Interest links and information

A Healthier Wales (AHW) sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in A Healthier Wales is "Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times."

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. Our philosophy of value-based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020 which places both an enhanced duty of quality and an organisational duty of candour will strengthen the approach to high quality, safe care.

The recently-published National Clinical Framework provides a clinical interpretation of A Healthier Wales and describes a learning health and care system, centered on clinical pathways that focus on the patient, grounded in a life-course approach. In recent years, major health condition delivery plans set out policy expectations for high priority clinical services. These plans came to an end in December 2020 and as described in the National Clinical Framework, will gradually be replaced by Quality Statements. These successor arrangements will help to set out what stakeholders think are important quality attributes of high priority clinical areas, such as cancer, heart disease and stroke services; as well as services such as critical care and end of life care

Welsh Government has recently published Looking forward to help health and social care emerge from the pandemic, describing the challenge as building the integrated health and social care service that we want going forward and to deal with the long-term impacts of COVID-19. The opportunity is to change for the better, recognising that COVID-19 is still with us.
A key aspect to this recovery is ensuring that care is as safe as possible, and that harm is minimised. The five harms we describe in health and care in Wales, are:

1. Direct harm from COVID-19 itself

2. Indirect harm from COVID-19 due an overwhelmed health and social care system and reduction in healthcare activity as a result

3. Harm from population based health protection measures i.e. educational harm

4. Economic harm both directly and indirectly as a result of COVID-19 i.e. unemployment as a result of lockdown

5. Harm as a result of exacerbation or introduction of new inequalities in society

The OECD Review of Health Care Quality published in 2016 commented that quality is at the heart of the healthcare system in Wales however it did make recommendations to strengthen what has already been built. These include a stronger relationship between health boards and Welsh Government, more visible accountability within health boards, with the technical, managerial and leadership capacity to drive up standards.

The Welsh Government's Health and Care Standards must also be taken into account by organisations in their discharging of the duty of quality. This framework of standards is designed to support the NHS and partner organisations in providing quality services across all healthcare settings. These standards describe what the people of Wales can expect when they access health services

Placing a duty of candour on NHS organisations, including providers of primary care, will improve service user experience, communication and engagement between the NHS and its service users. It will build on the work that has already been undertaken through the Putting Things Right arrangements for dealing with concerns, complaints and incidents.

This framework recognises that enabling people to access services using the Welsh language is an intrinsic part of the quality of care, and helps to ensure the safety, dignity and experience of Welsh speakers. Actions described within this framework will be developed in line with this principle and the More than just words framework

It is also important that we learn from specific patient safety and care issues that may emerge. In 2020, First Do No Harm, the report from the Independent Medicines and Medical Devices Safety Review, looked at the use of pelvic mesh as well as the use of sodium valproate and the harm caused to women and children as a result of these interventions. This report was specifically looking at the use of these interventions in England, but has valuable learning for the NHS in iimplementing the action points contained within the HEIW workforce strategy,

A Healthier Wales: Our Workforce Strategy for Health and Social Care will help organisations address staff shortages by improving staff retention as well as recruitment. The Strategy aims to enrich wellbeing and working experience for those who currently provide health and social care, including volunteers and carers, and to promote health and social care as the sector of choice for the future workforce. The overarching aim for 2030 is to provide the right number of motivated, dynamic and appropriately skilled people to help meet the health care needs of the population they serve in a sustainable, cost-effective way

Recommendation:

To **NOTE** the work to adapt reporting and working requirements across the UHB during the last year in line with the Welsh Government policy change and the COVID 19 pandemic.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*