Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Emrys Elias**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**13 October 2020**

Summary of key matters considered by the Committee and any related decisions made

1. Development Day

Committee members received a summary of the development day which was held on 15 September. Feedback form the event had been positive and all Health Boards were represented. The event will be held on an annual basis.

2. Terms of Reference

Members received and considered a paper with revised Terms of Reference. Members noted the revisions to Sections 13 and 14 of the Terms of Reference presented and resolved to approve the revised Terms of Reference for recommendation to the Joint Committee for final approval.

3. Renal Network

The Chair of the Renal Network asked the committee to note that guidelines have been developed and approved regarding the use of PPE in renal dialysis and reminded Health Boards that it was their responsibility the ensure that the was an adequate supply available to support the guidelines.

4. Commissioning Team updates

Reports from each of the Commissioning teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

- **Cancer and Blood**

Members were updated on the risks to thoracic surgery provision for lung cancer patients in mid and south west Wales as a result of COVID-19. A single prioritised waiting list and collaborative working will ensure equitable access to the available capacity in both centres based on clinical need regardless of the patient's area of residence. The single pathway has the ability to refer to other centres depending on capacity and the urgency of treatment.

- **Cardiac**

Members received an updated position regarding cardiac surgery services. It was noted that the WHSSC Corporate Directors Group had recognised the expertise of both the vascular and the TAVI team within SBUHB and given the assurance regarding the governance and safety aspects of recommencing this procedure received, they were able to recommence sub-clavian access. Ongoing work would continue to consider a longer term regional model.

Concern was raised regarding the length of time that cardiac services had been in escalation. Whilst assurance was given that a number of measures had been taken to address the issues within the given timeframe. Internal work was ongoing on reviewing the escalation process, performance framework and the impact of COVID-19 on RTT. That work would be presented at the next meeting on 19 January 2021.

Members were informed that there had been a COVID-19 outbreak on the cardiac ward at Morriston Hospital. All elective work would be suspended for a two week period as a consequence. Welsh Government and neighbouring Health Boards had been informed.

- **Mental Health & Vulnerable Groups**

A detailed summary of the services in escalation was received. It was noted that an enhanced recovery plan was required for this the Forensic Adolescent Consultation & Treatment Service (FACTS) and as a result was being placed into escalation level 3. The provider had been notified.

Members were made aware of a recent serious untoward incident in the South Wales Tier 4 CAMHS unit which was already in escalation level 3. In addition members were notified that the Health Board had also placed the serviced in enhanced monitoring with Executive oversight. The NCCU Quality Assurance Improvement Service (QAIS) has also joined the working party to consider some of the issues relating to concerns with the doors and would be undertaking a formal visit to the unit next week. HIW are also into the process of undertaking a Tier 1 quality check on the service and the report will be shared with WHSSC once available.

Members were informed that due to a National bed crisis in CAMHS a bed management bureau had been set up to coordinate admissions and discharges to facilitate patient flow and ensure a consistent approach.

Regis Healthcare has had a second outbreak of COVID-19 on the unit. Individual risk assessments are being undertaken prior to admission to balance the risk of admitting to the unit at this time. Public Health wales are involved in all discussions.

Members received a detailed update on the adult mental health complex case and recent developments.

On 22 September NHS England announced that they have commissioned an independent review of the Tavistock & Portman Foundation Trust Gender identity Development Service (GIDS). The findings will be presented to NHS England and Improvement's Quality and Innovation Committee at the end of the year. It will focus on how care can be improved for children and young people including key aspects of care such as how and when they are referred to specialist services, clinical decisions around how doctors and healthcare professionals support and care for patients with gender dysphoria. The Care Quality Commission (CQC) is due to carry out a focused inspection of The Tavistock and Portman NHS Foundation Trust, Gender Identity Services for children and young people, during the autumn. The inspection will cover parts of the safe, effective, caring, responsive and well-led key questions and will include feedback from people using the service, parents, relatives, carers, and staff. A Judicial Review involving the Tavistock & Portman is also currently ongoing.

- **Neurosciences**

Members received an update that since September 2019, the service had reported zero breaches >36 weeks due to the COVID-19 pandemic but that the situation had now changed and the WHSS Team was aware that patients were waiting in excess of 52 weeks.

- **Women & Children's**

It was reported that the Task and Finish Group set up to support the development of the service specification and process for selecting a Lead Provider to deliver a 24/7 service had met on three occasions. The service specification was complete and would be published once agreed through the WHSSC Policy Group. There was however a lack of support from some of the clinicians on the Task and Finish Group for the Lead Provider model, mandated by the Joint Committee decision in March 2020. As a consequence a discussion would be taken back to Joint Committee at its meeting in November. In the interim though all Health Board providers of neonatal transport and WAST had been asked to confirm their operational plans, timelines and costs to deliver an interim 24 hour service. Responses were due to be returned to WHSSC by the end of October with an anticipated start date within 3 months

Concern was expressed by the QPS Committee on the differential rates of recovery across providers in Wales and England and the impact this is having on access to specialised services and the potential inequity. The example of paediatric surgery was of particular concern to the Committee resulting in longer waiting times in Welsh providers than in English ones.

The Committee discussed the backlog in cleft surgery at Swansea Bay University Health Board and the impact that this could have on a child's development. It was noted that Health Boards are using the Royal College of Surgeon prioritisation process to manage surgical waiting lists but that this process did not always work well for children who need surgery at specific stages of their development rather than in a month, 3 months etc. The Committee noted that the WHSS Team had raised this with Welsh Government and Health Boards.

5. Other Reports received

Members received reports on the following:

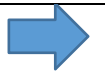
- **CQC/HIW Summary Update**
- **WHSSC Policy Group Report**
- **Concerns and SUI Report**
- **Risk Management Update**
- **Safeguarding Report**

Key risks and issues/matters of concern and any mitigating actions
Summary of services in Escalation (Appendix 1 attached)
Matters requiring Committee level consideration and/or approval
1.Neonatal transport paper to be considered at next Joint Committee 2.Joint Committee already aware of high risk complex mental health case 3.Changes to services in escalation and further work required on processes
Matters referred to other Committees
Safeguarding Report to CTMUHB (host organisation) Executive Safeguarding Group
Confirmed Minutes for the meeting are available from http://www.whssc.wales.nhs.uk/quality-and-patient-safety-committee-con

Date of next scheduled meeting:	19 January 2021

Summary of Services in Escalation

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Date of Escalation	Service	Provider	Level of Escala-	Reason for Escalation	Current Position	Movement from last month
April 2015 Escalated to Stage 3 December 2018 October 2020	Cardiac Surgery	CVUHB	3	• Failure to deliver and maintain the Referral to Treatment times targets	Emergency and elective work being undertaken where possible for the south Wales region. Current monitoring against RTT temporarily halted due to Covid 19	
April 2015 October 7, 2020 2020	Cardiac Surgery	SBUHB	2	• Failure to deliver the Referral to Treatment times targets	Emergency surgery and elective been undertaken. Current monitoring against RTT temporarily halted due to Covid 19	
March 2017	Thoracic Surgery	CVUHB	2	• Failure to maintain cancer targets/capacity to meet patient need	Emergency and Elective work only being undertaken in Cardiff for the south Wales region.	
March 2018	Sarcoma (South Wales)	SBUHB	2	• Risks to service quality and sustainability	Priority work being undertaken: 1. Biopsy Proven Sarcoma 2. Diagnostic biopsies for high	

					risk lesions. 3. Lipomata with atypical features on US/MRI that have been discussed at MDT	
February 2018 October 2020	Plastic Surgery (South Wales)	SBUHB	2	• Failure to achieve maximum waiting times target	Emergency surgery only being undertaken within the HB. No further update on plan for waiting times Current monitoring against RTT temporarily halted due to Covid 19	
November 2017	All Wales Lymphoma Panel	CVUHB & SBUHB	2	• Failure to achieve quality indicators (in particular, turnaround times)	No provider update on service being delivered during Covid.	

	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages and operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of-Area admissions	Letter sent to CEO in July 20 in advance of meeting asking for updates on the medical workforce issues including sustainability of current interim model and possible network arrangements with English providers. In addition relocation of the service onto a main hospital site has also been raised as strategic issue.	
March 2018 September 2020	Ty Llidiard	CTMUHB	3	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11th September	Further Serious untoward incident occurred on 11th September. Paper to CDG Board on 21st September and decision to support escalation level with weekly Exec meetings. Health Board formally notified on September 25th. Notification received that CTUHB have also put the service into Internal Enhanced Monitoring & Support. Formal quality escalation meeting October 8th Implementation of the Medical Emergency Response Team remains outstanding	

19 February 2016	Neurosurgery	C&VUHB	2	• Failure to maintain <36 week Referral to Treatment target	Emergency and limited urgent elective (tumour) work being undertaken. A number of patients will be waiting in excess of 52 weeks for surgery at the end of June. Current monitoring against RTT temporarily halted due to Covid 19	
June 2017	Paediatric Surgery	CVUHB	2	• Failure to maintain <36 weeks Referral to Treatment times	Only emergency/ life threatening / urgent surgery is taking place, so the number of patients waiting over 36 weeks is increasing – 200 reported at the end of July. Virtual clinical reviews of patients are being undertaken. Current monitoring against RTT temporarily halted due to Covid 19	

December 2017	Paediatric In-tensive Care	CVUHB	2	• Inadequate level of staffing to support the service	No further update on PICU during Covid.	

Septem-ber2019	Cochlear Im-plant Service	South Wales	4	• Quality and Patient Safety concerns from C&V Cochlear Implant team, from the pa-tients who were immediately transferred to the service in Cardiff following the loss of audiology support from the Bridgend service.	• C&VUHB were able to treat all patients who re-quired both urgent and routine surgery within 26 weeks by the end of March. • Transfer of services to C&V going ahead awaiting feed-back from CHC	
February 2020	TAVI	SBUHB	3	• Quality and Patient Safety concerns due to the lack of assurance provided to the WHSS team regarding the actions taken by the HB to address 4 Serious Incidents relating to vascular complica-tions.	• Action plan in place. Fol-lowing approval at CDG planned access via sub-clavian route re com-menced with support from MDT /Vascular team/ Senior anesthetic team. Ongoing monitor-ing	

July 2020	Thoracic Surgery	SBUHB	3	• Failure to maintain cancer targets and undertake elective surgery cases	• Concerns raised around the monitoring of Thoracic patients during Covid period and lack of surgical activity	
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Paper received by CGD Board on 28th September. Formal letter being drafted to Health Board. Exec Lead identified. Raised at SLA meeting