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Cwm Taf Morgannwg University Health Board – Review of the temporary closure of the Ysbyty Cwm Cynon Minor Injuries Unit

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Introduction

1 Minor injuries services are part of a range of urgent care services provided by Cwm Taf Morgannwg University Health Board (the Health Board). The Health Board delivers its minor injuries services from two dedicated Minor Injury Units, which are located at Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon (YCC).

2 The Minor Injuries Units, which are led by Emergency Nurse Practitioners[1] (ENPs), are designed to enable residents to access medical treatment for minor injuries in a more timely and accessible way, thereby enabling the Health Board's main emergency departments to focus on treating more urgent cases.

3 In September 2021, the Health Board decided to temporarily close the Minor Injuries Unit (the MIU) at YCC due to concerns relating to the fragility of the service and competency-based training compliance. Prior to its closure, the service operated between 9.00am and 4.30pm from Monday to Friday, excluding Bank Holidays.

4 The Health Board reopened the MIU, albeit on a phased basis, in May 2022[2].

About this report

5 In November 2021, we decided to undertake a high-level review to examine the issues surrounding the temporary closure of the MIU at YCC. We interviewed senior managers within the Health Board and reviewed the relevant documents. This report sets out the key findings and recommendations arising from our review.

Main conclusions

6 We found that the MIU closed at short notice largely due to shortcomings in the managerial oversight arrangements of the MIU, which led to:

- the unit operating with staff whose competence to work autonomously had not been adequately assessed, despite concerns over staff training and supervision being raised as far back as 2018-19;
- a fragile unit that was operating sub-optimally due a lack of investment in support staff to enable ENPs to manage workload demands efficiently; and
- staff not having up-to-date performance appraisals; however, this situation is not unique to the MIU.

[1] Emergency Nurse Practitioners are registered nurses who have completed further training in the management of minor injuries and who practice without consultant supervision to see, treat, and discharge patients.

[2] https://ctmuhb.nhs.wales/news/latest-news/the-minor-injuries-unit-at-ysbyty-cwm-cynon-to-reopen-its-doors-next-week/

7 We found that the closure of the MIU led to reduced service options available to residents and increased the number of individuals attending the Emergency Department at Prince Charles Hospital (PCH), which was already operating under significant pressure.

8 Although the Health Board determined that the risk of harm to patients of being seen at YCC was minimal, we found that this was not formally reported to the Quality and Safety Committee, thus limiting opportunities to enable full scrutiny and provide assurance. Furthermore, we found that the Health Board has not assessed or reported on the impact on the patient experience, or the quality of the care provided to residents required to attend the Emergency Department at PCH following the closure of the MIU.

9 More positively, we found that the Health Board's arrangements for communicating the closure to patients, the Quality and Safety Committee, and other key stakeholders as well as its arrangements for redeploying MIU staff were effective.

Key findings

Managerial oversight of the MIU

The closure of the MIU could have been avoided if action had been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018-19 around staff training and qualifications.

10 In September 2021, the Health Board decided to close the MIU at YCC at short notice due to concerns raised by the Integrated Locality Group (ILG) that:

- MIU staff did not have the appropriate training and competencies in place to work autonomously with no medical supervision on site; and
- the MIU was fragile and operating sub-optimally due a lack of investment in support staff to enable ENPs to manage workload demands efficiently.

11 In order to practice autonomously, ENPs in Wales are required to complete the Agored Cymru[3] Level 7 Diploma in the Autonomous Management of Minor Injuries. This is the nationally recognised programme of development for Emergency Practitioners. The MIU was closed by the Health Board due to concerns that the relevant staff did not have this qualification in place. Similar concerns were raised as far back as 2018-19, but no action or follow-up was taken at the time.

12 However, a review undertaken by the Health Board following the closure of the MIU found that two of the ENPs had completed a Cardiff University accredited

[3] Agored Cymru is an education provider that creates nationally recognised, quality assured qualifications and units across a diverse range of subjects in Wales.

course for Emergency Nurse Practitioners prior to the launch of the Agored Cymru Level 7 Diploma in 2016. It continues to be a recognised course for ENPs, providing they continue to maintain evidence of their advanced practice via the Agored Cymru portfolio.

13 The Health Board also found that staff had commenced the Agored Cymru Level 7 Diploma and had portfolios of evidence in place for the study days they had completed, which had been assessed and signed-off by PCH Emergency Department Consultants. However, they were unable to practice autonomously until they completed all of the study days and had their portfolios of evidence assessed and signed-off by Registered Agored Cymru Assessors. None of the PCH Emergency Consultants are Registered Agored Cymru Assessors.

14 Furthermore, our review found that MIU staff did not have up-to-date performance appraisals in place, thus highlighting further weaknesses in the Health Board's arrangements for oversight and professional development of staff.

15 The Health Board's review also highlighted other concerns relating to the fragility and efficiency of the service due a lack of investment in support staff to enable ENPs to manage workload demands efficiently, as well as concerns about the lack of appropriate oversight and supervision of the MIU.

16 In order to address these issues, the Health Board has:

- established a Clinical Education Forum, as a sub-committee of the Quality and Safety Committee, to oversee educational governance and leadership;
- created a new Band 8a Senior Nurse post with responsibility for practice development;
- plans in place to support the relevant MIU staff to complete the Level 7 Diploma and maintain their ongoing evidence of practice;
- plans in place to support Emergency Medicine Consultants and Advanced Practitioners to become Registered Agored Cymru Assessors;
- established new oversight and management arrangements for MIU staff via a new Clinical Director; and
- plans in place to review MIU staffing arrangements, including the skill mix.

17 Despite the positive steps taken by the Health Board to address the situation, it is reasonable to conclude that the closure of MIU could have been avoided if action had to been taken sooner to strengthen managerial oversight of the unit as well as to address the concerns raised in 2018/19 around staff training and qualifications.

Impact of the MIU closure

Although the Health Board has indicated that the impact was minimal, the closure of the MIU increased footfall to an already pressured Emergency Department, and no assessment of the impact on patients has been undertaken.

18 By closing the MIU, the Health Board reduced the service options available to its population, and increased the number of individuals attending the Emergency Department at Prince Charles Hospital (PCH) by around 30 each day. According to the Health Board, the impact on the Emergency Department at PCH has been minimal. However, at the time of our work, the Emergency Department at PCH was operating under considerable pressure. It is reasonable to conclude, therefore, that the closure of the MIU – a service designed to reduce demand on emergency departments – contributed to this pressure.

19 We found that the Health Board has not assessed or reported on the impact on the patient experience, or the quality of the care received by patients redirected to the Emergency Department at PCH following the closure of the MIU.

Communication and redeployment arrangements

Arrangements to communicate the closure to stakeholders and to redeploy staff were effective.

20 The arrangements for communicating the closure of the MIU were effective:

- a full initial disclosure was presented to the Health Board's Quality and Safety Committee in September 2021;
- Welsh Government was formally informed of the closure;
- the closure was discussed with Community Health Council and Local Authority partners; and
- information for patients was published on the Health Board's website.

21 In terms of redeployment arrangements, the ENPs were relocated to the PCH Emergency Department until their competencies could be fully assessed. The movement of this cohort of staff enabled the Health Board to establish a minor injuries pathway within the main Emergency Department, which has proved successful. In January 2022, the Health Board moved its Trauma Clinic Service into the vacant MIU at YCC.

22 At the time of our work, the Health Board was unable to reopen the MIU as this would destabilise the minor injuries pathway at Prince Charles Hospital. As a result, the Health Board agreed to recruit an additional 4.8 WTE Band 7 ENPs to provide a dedicated MIU at both PCH and YCC. At the time of our work, the recruitment was in progress but not yet complete.

Quality and Safety Committee oversight

There have been gaps in the reporting the ongoing position regarding the closure of the MIU to the Quality and Safety Committee.

23 As noted previously, a full initial disclosure was presented to the Health Board's Quality and Safety Committee in September 2021.

24 At the time, the Health Board informed the Quality and Safety Committee that it would seek to establish if any harm had come to patients seen at the MIU. Following a review of patient files, the Health Board concluded an assessment of harm was not required as the risk of harm was minimal due to the patient cohort having low levels of acuity. However, the outcome of this work was not formally reported to the Quality and Safety Committee.

25 Furthermore, we found that there has been no further reporting to the Quality and Safety Committee on the situation since the initial report in September 2021. Independent Members, therefore, have not been given opportunities to fully scrutinise the actions taken by the Health Board to remedy the situation, and subsequently provide assurance to the Board that the concerns relating to the MIU are being adequately addressed.

Recommendations

26 Whilst the Health Board has identified a series of actions to address these shortcomings and reopen the MIU on a phased basis, we believe there are important and wider lessons to be learned. Our recommendations, which are detailed in **Exhibit 1**, are designed to support this learning, and to reduce the risk of similar incidents occurring in the future. The Health Board's management response to these recommendations will be summarised in **Appendix 1** once considered by the relevant committee.

Exhibit 1: recommendations

Recommendations
Reviewing managerial oversight arrangements of remotely operating services R1 Our work has found shortcomings in the managerial oversight arrangements of the MIU at YCC. In order to assure itself that these issues are not widespread across the organisation, the Health Board should review the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.

Improving oversight of competency-based training arrangements at the MIU and across the wider organisation

R2 Our work has highlighted concerns with the Health Board's competency-based training arrangements at the MIU. In order to assure itself that these issues are not widespread across the organisation, the Health Board should undertake a review of its competency-based training arrangements (at the MIU and across the wider organisation) to ensure:

a) effective policies and procedures are in place to support staff to complete all relevant competency-based training in a timely manner;
b) competencies requiring assessment are assessed by qualified assessors in a timely manner; and
c) evidence of competency-based training completed by staff is recorded appropriately; and
d) competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams.
e) the findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.

Improving performance appraisal compliance rates

R3 Our work has found that staff in the MIU did not have up-to-date performance appraisals. However, there is also a similar picture across the Health Board. The Health Board, therefore, need to agree a range of appropriate actions to improve compliance rates across the organisation. The People and Culture Committee should continue to monitor compliance rates and provide effective challenge when the Health Board is failing to demonstrate ongoing improvement.

Enhancing Quality and Safety Committee oversight

R4 Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.

Appendix 1

Management response to audit recommendations

Exhibit 2: management response

Recommendation	Management response	Completion date	Responsible officer
Reviewing managerial oversight arrangements of remotely operating services R1 Our work has found shortcomings in the managerial oversight arrangements of the MIU at YCC. In order to assure itself that these issues are not widespread across the organisation, the Health Board should review the managerial oversight arrangements of services which are staffed by the Health Board but operate remotely to ensure they are sufficiently robust and effective. The findings of the review	The Health Board (HB) has now completed the initial phase of operational restructure resulting in a care group model encompassing services delivered across the HB. As a result, services delivered outside of the three acute sites have been incorporated to care groups relevant to the speciality and service being delivered.	Complete	Chief Operating Officer

Recommendation	Management response	Completion date	Responsible officer
should be reported to the Quality and Safety Committee to provide the required assurances.	Structural adjustment to the service reporting lines such as the Minor Injury service across the HB being managed by and reporting to the Unscheduled Care Group. It is through this reporting method; the care groups will seek to monitor and respond to operational and clinical governance matters whilst also providing the organisation and the Board with the appropriate assurances.		

Recommendation	Management response	Completion date	Responsible officer
Improving oversight of competency-based training arrangements at the MIU and across the wider organisation R2 Our work has highlighted concerns with the Health Board's competency-based training arrangements at the MIU. In order to assure itself that these issues are not widespread across the organisation, the Health Board should undertake a review of its competency-based training arrangements (at the MIU and across the wider organisation) to ensure: a) effective policies and procedures are in place to support staff to complete all relevant competency-based training in a timely manner; b) competencies requiring assessment are assessed by qualified assessors in a timely manner; and c) evidence of competency-based training completed by staff is recorded appropriately; and	a) Competency based training has been established against the national training arrangements for minor injury practitioner utilising the framework provided through Agored Cymru. Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital sites to ensure adequate supervision and maximum training opportunities. This process is being led by the Senior Nurse and Advanced Nurse Practitioner for Professional Development. b) The HB has now established the appropriate number of appropriately trained assessors across minor injury units and hospital sites. This has been further enabled through the	Complete Complete	Unscheduled Care Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
d) competency-based training completion rates are monitored and reviewed on a regular basis by the relevant management teams: and e) The findings of the review should be reported to the Quality and Safety Committee to provide the required assurances.	adjustment in the educational leadership model as well as the implementation of the HB wide care group structure. c) Through the leadership of the Senior Nurse for professional development, the management teams can monitor the progress of training of new trainee practitioners as well as the continued development of established practitioners. d) With the formation of the Unscheduled Care Group (USCG), urgent care service leaders are currently reviewing a model of	Complete April 2023	Unscheduled Care Director of Nursing & Medical Director

Recommendation	Management response	Completion date	Responsible officer
	assurance and learning on all aspects of emergency care innovation and education across the HB. During this transitional phase, each local leadership team now has dedicated Practice Development Nurses working with the Senior Nurse for Professional Development to ensure local compliance and escalations where required. e) As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee in March 2023.	March 2023	Unscheduled Care Director of Nursing & Medical Director
Improving performance appraisal compliance rates	The Health Board recognises the importance of PADR and	Completed	Executive Director for People / Deputy

Recommendation	Management response	Completion date	Responsible officer
R3 Our work has found that staff in the MIU did not have up-to-date performance appraisals. However, there is also a similar picture across the Health Board. The Health Board, therefore, need to agree a range of appropriate actions to improve compliance rates across the organisation. The People and Culture Committee should continue to monitor compliance rates and provide effective challenge when the Health Board is failing to demonstrate ongoing improvement.	the impact it has on employee development, performance and wellbeing. The Health Board has revised its Appraisal process and through the introduction of 'PDR: Your Conversation' it has placed increased emphasis on the importance of values and Behaviours and staff wellbeing at the heart of the conversation. PADR compliance is included in the suite of metrics that is reported to People and Culture Committee as a regular agenda item and provides an opportunity to		Director of People – Health Board Wide leads.

Recommendation	Management response	Completion date	Responsible officer
	scrutinise the trend data and performance. The data is also shared with Care Groups and Corporate Directorates to enable improvement plans to be developed and monitored.		
	A Communications and Engagement plan is being launched in February by the Learning and Development department which will include a mix of written guidance and video presentations to reinvigorate PDR and other core learning and improve performance. Bespoke training is also available for teams.	February 2023	Executive Director For People / Deputy Director of People
	Current and new practitioners now practice on a rotation basis across the community hospital and acute hospital	March 2023	Unscheduled Care Group Directors (Operations, Nursing and Medicine)

Recommendation	Management response	Completion date	Responsible officer
	sites to ensure adequate supervision and maximum training opportunities. In reporting to the USCG, each local acute site emergency department leadership team is responsible for the support and development of staff and practitioners across the department and respective unit.		
	The USCG Director of Nursing is to present to the People and Culture Committee this financial year on the current arrangement and feedback as well as future care group plans	February 2023	Unscheduled Care Group Director of Nursing

Recommendation	Management response	Completion date	Responsible officer
	attending to the development and wellbeing of the team.		
Enhancing Quality and Safety Committee oversight R4 Our work has found that despite the full initial disclosure to the Quality and Safety Committee in September 2021, there was no further reporting on any assessment of potential harm, and lessons learned. The Health Board, therefore, should provide an update report to the committee outlining the lessons learned, and confirmation of any outcomes from the work to assess harm.	As part of an overall appraisal in the quality, safety, and patient experience within emergency care services across the HB, the USCG is preparing a report/presentation for the Quality and Safety Committee this financial year. Furthermore, as part of the ongoing service delivery reviews within the newly established care group model, the USCG will seek to provide a report to the Quality and Safety Committee in full on the Minor Injury Service provision across the HB early in 2023/24.	March 2023 May 2023	Unscheduled Care Group Director of Nursing Unscheduled Care Group Directors (Operations, Nursing and Medicine)

Exhibit source: Audit Wales

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