Patient Quality, Safety & Outcomes Committee

Tue 06 December 2022, 09:30 - 12:00

Microsoft Teams

Agenda

09:30 - 09:45
15 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Draft Minutes of the last meeting held on 16th August 2022

Attachment *Chair*

1.4 DRAFT PQSOC Minutes 16.8.2022 (Chair Approved).pdf (13 pages)

1.5. Committee Action Log

Attachment *Chair*

1.5 PQSOC Action Log December 2022.pdf (7 pages)

09:45 - 09:55
10 min

2. Committee Governance

2.1. Review of Committee Programme of Business

Attachment *Chair*

2.1 MASTER PQSO_Committee Work Programme 2022-23.pdf (7 pages)

09:55 - 09:55
0 min

3. Items for Approval/Ratification/Decision

None included on this agenda.

09:55 - 11:40
105 min

4. Items for Discussion

4.1. Quality & Safety Outcomes Report, December 2022

Presentation *Clinical Executives*

4.1 PQSOC December 2022.pdf (32 pages)

4.2. Contractual Arrangements with WAST- inter-site transfers

Attachment *Director of Operations*

- 4.2 PSCOC September 2022 v2.0 04.10.2022.pdf (10 pages)
- 4.2a Appendix 2 GUH Inter Hospital Transfer Service Evaluation.pdf (65 pages)
- 4.2b Planned Care Programme Board Terms of Reference 2016 02 25.pdf (3 pages)

4.3. Maternity Services Improvement Plan and Update

Attachment *Director of Nursing*

- 4.3 Findings of the Independent Review of Maternity Services at SaTH.pdf (4 pages)
- 4.3a ABUHB Maternity and Neonatal Services - Improvement Plan(1).pdf (10 pages)

4.4. Nosocomial Covid-19 Review: Investigating and Learning from cases of Hospital Acquired Covid-19

Presentation- to follow *Director of Nursing*

4.5. Quality & Engagement (Wales) Act: Preparedness for Implementation

Presentation- to follow *Director of Nursing*

4.6. Healthcare Inspectorate Wales

4.6.1. GUH ED Review

Attachment *Director of Nursing*

- 4.6.1 HIW - ED GUH - Published Inspection Report - 10.11.22.pdf (63 pages)
- 4.6.1a ED GUH Improvement Plan - September 2022.pdf (11 pages)

4.6.2. Immediate Assurance- GP Practice

Verbal *Director of Nursing*

4.6.3. Improvement Plan re: Mental Health Units at YYF

Attachment *Director of Nursing*

- 4.6.3 03144 - Ysbyty Ystrad Fawr - HIW Improvement Plan - November 2022.pdf (14 pages)

4.6.4. HMP Prison Services, ABUHB Self-Assessment

Attachment *Director of Nursing*

- 4.6.4 Self-Assessment into Governance Arrangements at HMP Usk and Prescoed.pdf (5 pages)
- 4.6.4a ABUHB Self-Assessment - Delivery of Healthcare Services to HMP Swansea.pdf (17 pages)

4.6.5. Update and Tracking of Improvement Actions Arising from previous Inspections and Reviews

Attachment *Director of Nursing*

- 4.6.5 HIW Inspections Update - September 2022.pdf (5 pages)
- 4.6.5a HIW Improvement Plans - Current Status & Outstanding Actions - September 2022.pdf (9 pages)

4.6.6. HIW Annual Report 2021/22

Attachment *Director of Nursing*

- 4.6.6 HIW Annual Report 2021-2022.pdf (82 pages)
- 4.6.6a 2022.09.23 Alun Jones to NHS CEO's & Chairs Health Boards and Trusts Wales - HIW Annual Report 2021-2022.pdf (1 pages)

4.7. Clinical Effectiveness and Standards Committee Report

Attachment *Medical Director*

- 4.7 PQSOC CSEG report.pdf (5 pages)
- 4.7a CSEG Sep meeting notes for Nov 2022.pdf (8 pages)
- 4.7b AMaT update for PQSOC Dec 2022.pdf (2 pages)
- 4.7c ABUHB_Clinical_1092 Clinical Audit Strategy 2022 - 2025.pdf (12 pages)

4.8. Learning from Death Report

Attachment *Medical Director*

- 4.8 PQSOC Learning from Death December 2022.pdf (20 pages)

4.9. Health & Safety Compliance Report

Presentation *Director of Therapies & Health Sciences*

- 4.9 H&S Assurance Report - PQSOC - Dec 2022.pdf (15 pages)

11:40 - 11:55
15 min

5. Items for Information

5.1. Highlight Reports:

5.1.1. Quality and Patient Safety Operational Group

Attachment *Director of Therapies & Health Sciences*

- 5.1.1 QPSOG report from 14 09 and 09 11 2022.pdf (3 pages)

5.1.2. Childrens Rights and Participation Forum

Attachment *Director of Nursing*

- 5.1.2 Highlight Report Children's Rights Forum 12.08.22(1).pdf (3 pages)

5.1.3. WHSSC QPS Committee Report

Attachment *Director of Nursing*

- 5.1.3 Quality & Patient Safety Committee Chairs report.pdf (14 pages)
- 5.1.3a Appendix 2 WHSSC Quality Newsletter.pdf (16 pages)
- 5.1.3b Appendix 3 - WHSSC Quality Internal Audit Report.pdf (11 pages)

5.2. Internal Audit Reports presented to the Audit' Risk & Assurance Committee on 6th October 2022

5.2.1. Children's Community Nursing Service- Children & Young People's Continuing Care (Reasonable Assurance)

Attachment *Director of Nursing*

- 5.2.1 ABUHB 2022.23 CCC Internal FINAL Audit Report (1).pdf (20 pages)

5.3. Putting Things Right Annual Report 2021/22

Attachment *Director of Nursing*

- 5.3 PTR Annual Report 2021-2022.pdf (4 pages)
- 5.3a PTR Annual Report 2021-2022 - FINAL.pdf (38 pages)

11:55 - 12:00
5 min

6. Other Matters

6.1. Items to be Brought to the Attention of the Board and Other Committees

Verbal *Chair*

6.2. Any Other Urgent Business

Verbal *Chair*

6.3. Date of the Next Meeting: Tuesday 7th February 2023

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Patient Quality, Safety and Outcomes Committee held on Tuesday 16th August 2022 at 9.30 am via Teams

Present:	
Pippa Britton	Independent Member (Chair)
Paul Deneen	Independent Member
Helen Sweetland	Independent Member

In attendance:	
Jennifer Winslade	Director of Nursing
Glyn Jones	Interim Chief Executive Officer
James Calvert	Medical Director
Peter Carr	Director of Therapies and Health Science
Chris O'Connor	Director of Primary Care, Community & Mental Health
John Carroll	Deputy Divisional Nurse
Lara Homan	Lead Nurse, Learning Disabilities
Leanne Watkins	Director of Operations
Moira Bevan	Head of Infection Prevention and Control Nurse
Fiona Bullock	Deputy Head of Safeguarding
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
Rhian Guard	Principle Auditor, NWSSP
Stephen Chaney	Deputy Head of Internal Audit, NWSSP
Delyth Brushett	Audit Wales
Linda Alexander	Deputy Director of Nursing
Lucy Bennett	Corporate Service Manager (secretariat)

Apologies:	
Rani Mallison	Director of Corporate Governance
Louise Wright	Independent Member
Shelley Bosson	Independent Member

	Preliminary Matters
PQSOC 1608/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 1608/02	**Apologies for Absence** Apologies for absence were noted.
PQSOC 1608/03	**Declarations of Interest** There were no Declarations of Interest to record.
	Committee Governance
PQSOC	**Draft Minutes of the Meeting Held on the 7th June 2022**

1608/04	The minutes of the Patient Quality, Safety and Outcomes Committee meeting held on the 7th of June 2022 were noted as a true and accurate record.
PQSOC 1608/05	**Committee Action Log** The Committee discussed the actions and members were assured that all actions had clear timelines. Members thanked the teams involved for the completion of previous actions.
	Items for Discussion
PQSOC 1608/06	**Urgent and Emergency Care** Leanne Watkins, Director of Operations, provided the Committee with an overview of the Health Board's plan and progress in response to the Welsh Government 'Six Goals for Urgent and Emergency Care' and how these plans have now been aligned within the Health Board's 'Six Goals' Programme Plan. Two areas of focus within the Six goals framework were noted as: • Urgent Primary Care Centres and • Same Day Emergency Care (SDEC). Members were advised that the SDEC opened on the 8th of August 2022 and early performance data would be shared with members, in due course. **Action: Director of Operations** Members notedthe continual focus on safety in urgent and emergency care, and that critical safety concerns were highlighted in weekly Senior Leadership Response meetings, in addition to 'Safety Huddles' being undertaken on each site. The Health Board welcomed the installation of the patient experience software, CIVICA, across all sites. This improved methodology of capturing and utilising systematic data would be utilised to further enhance patient experience and provide a mechanism for patients to feedback their experiences directly to the Health Board. The 'Lessons Learnt' Grange University Hospital (GUH) review data was discussed, and the Committee noted improvements in patient care and mortality rates as a result of system changes. Current workforce supply issues throughout the Health Board were noted. An example of this was provided and the Committee noted that the overflow waiting area in GUH Emergency Unit was not able to be staffed sufficiently which meant that patient safety had been prioritised over patient experience. Paul Deneen, Independent Member, requested feedback from the opening of the SDEC. Members were informed that within the first week of the SDEC, 66 patients were seen, of which 10% required admission. These numbers aligned with predicted data. Early data indicted patient waiting times had significantly improved and initial patient experience feedback was positive. A full report on SDEC to come back to the Committee. **Action: Director of Operations/Secretariat**

	It was further agreed that weekly data on SDEC would be shared with members outside of the meeting. **Action: Director of Operations** Paul Deneen, Independent Member, requested information on the numbers of patients coming through SDEC from out of the Gwent area. Members were informed that out-of-area patients were tracked through Health Board internal control mechanisms. The Committee was advised that current data showed an increase in patients presenting to Ysbyty Ystrad Fawr (YYF). A bespoke piece of work was underway to determine the reason for such high numbers presenting to YYF, with a focus on patient experience. Helen Sweetland, Independent Member, requested further information on the Flow Centre. Members were informed that the Flow Centre was based in Vantage House, Cwmbran, alongside the GP out of hours service and Welsh Ambulance Service Trust WAST. The Flow Centre had a mix of staff including call handlers, nurses, doctors. The proximity to WAST and GP out of hours enabled appropriate diverts to provide the best patient care and was an important element of the Health Board's Urgent and Emergency Care strategy. A 'test of change' for the Flow Centre would be taking place in October 2022, using learning to determine future best practice. Members were invited to visit both the new SDEC facility and the Flow Centre. The Committee **NOTED** the contents of the report and the action to improve patient experience and outcomes across the urgent and emergency care system.
PQSOC 1608/07	**Patient Quality and Safety Outcomes Report, July 2022** Peter Carr, Director of Therapies and Health Sciences, provided an overview of the Outcomes report. The report was produced using the themes of the Health Care Standards (HCS) and any high-risk areas. The Committee was informed that three areas of concern continued to be reported as 'red'. These were noted as: • Stroke Services, • Urgent Care and WAST • Cancer Services. Members were informed that Stroke services were monitored against nationally agreed key performance indicators (KPIs) and UK Stroke Audit benchmarking data. The Health Board aimed to use qualitative data through patient experience, alongside quantitative data to continually improve Stroke services. The following key points were noted: • Data indicated improvements from the time of arrival to a patient receiving a CT scan within one hour. • One Health Board target was for patients to be transferred to the Hyper Acute Stroke Unit (HASU) within four hours of arrival. Members were informed that current Urgent Care pressures influenced the delivery of the Stroke pathway therefore, this was an area of focus for improvement.

	• The data for patients seen by a stroke consultant within 24 hours of arrival was highlighted as 100% for May 2022 and 94.5% for June 2022. • Current workforce issues within the Health Board's Stroke Specialist Therapy departments were discussed. Pro-active work was being undertaken to mitigate the staffing challenges caused by sickness and other leave. • The Health Board was working alongside the Stroke Association and the Community Health Council to raise awareness of the first signs of stroke to the public. Getting to the hospital in the critical timeframe of 4 hours enabled Thrombolysis and/or Thrombectomy treatments to be administered. As part of the learning and improvement work for stroke services, the Health Board had invited an external organisation, 'Getting It Right First Time' (GIRFT) to review services. Alongside this, Health Inspectorate Wales (HIW) were undertaking an all-Wales review of stroke services. The GIRFT draft report had been received with recommendations outlined. The Health Board would develop a management response and associated action plan in response to GIRFT recommendations, aligning to recommendations received from HIW. The action plan would be monitored and reviewed by the Stroke Delivery Group. Engagement with external partners such as the Stroke Association and the Community Health Council would further strengthen Stroke services for the population. It was agreed that a detailed report on the management response and action plan to come back to the Committee with a date to be confirmed with the Secretariat. **Action: Director of Therapies & Health Sciences/Secretariat** Paul Deneen, Independent Member, highlighted the work required around Stroke rehabilitation. Members were informed that current workforce issues throughout the pathway impacted rehabilitation services. The Health Board worked with 3rd sector partners such as the Stroke Association to provide continued rehabilitation, care, and support for all patients through the 'Life After Stroke' service. Helen Sweetland, Independent Member, requested the numbers of Stroke patients arriving at GUH per day. The Committee was advised that approximately 2 Stroke patients arrive at GUH per day, with varied treatment requirements based on individual care needs. Paul Deneen noted the data in relation to patients attending the Minor Injuries Units from other Health Board areas and requested information on how this was funded. Glyn Jones, Interim Chief Executive, informed members that current contractual arrangements stated that patients attending Minor Injuries would receive treatment funded by ABUHB, however, patients who are admitted to hospital from other Health Board arrears would be funded by the relevant, respective Health Board. The Committee **NOTED** the report.
PQSOC 1608/08	**Clinical Audit Strategy 2022-2025**

	James Calvert, Medical Director, presented the report providing oversight of the Health Board's Clinical Audit Strategy 2022-2025. The Health Board aspired to develop a quality management system, aligning to Welsh Government requirements, to support the provision of improved care to the population. The Committee discussed the following key points: • AMaT, a digital clinical audit management tool, had been procured to provide organisational oversight of all clinical audits and the development and monitoring of improvement plans. The implementation and monitoring of the AMaT system and the progress of the Clinical Audit Strategy will be overseen by the Health Board Clinical Standards and Effectiveness group. • Individual responsibility for Clinical Audit governance will be built into future job planning. Job planning will be supported by the job planning E-System, currently out for tender and being implemented in October 2022. The Clinical Audit Strategy four priority areas, as outlined in the report, were discussed. These were: • Scrutiny of national clinical audit performance with robust development and monitoring of improvement plans • Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk • Trainees are supported to participate in meaningful clinical audits that support clinical governance • Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required. • Recruitment was underway for a Clinical Governance Analyst who would be responsible for supporting Divisions in developing quality clinical audit dashboards. Discussions had taken place with the external data provider, Caspe Healthcare Knowledge Systems (CHKS), ensuring alignment, not duplication of data collection. The Chair of the Committee requested a review of the key priorities and implementation of the AMaT system to come back to the Committee. Timeframe to be agreed outside of the meeting. **Action: Medical Director/Secretariat** Members were informed that Quality Improvement, coordinated alongside divisional leads, would be an element of focus for medical students and trainees going forward. Paul Deneen, Independent Member, welcomed the enhanced level of scrutiny and ease of data access with the new AMaT system. Paul queried if the new system would replicate any current systems used by the Health Board. James Calvert stated that additional investigation was required to assess the function and use of the Datix system once the AMaT system was in place. The initial priority of the AMaT system would be the tracking of actions from Clinical Audits. Linda Alexander, Deputy Director of Nursing, informed members that an All-Wales approach to the implementation of AMaT was required and that meetings were taking place in September 2022 with other Health Boards to discuss the approach further.

	The report was **RECEIVED** by the Committee. The Medical Director suggested an assurance report to come as a standing item to each meeting of the PQSOC. This report would include assurance based on previous meeting actions. The Chair to link with the Medical Director, Director of Nursing and Deputy Director of Nursing outside of the meeting to discuss a mechanism of assurance reporting for future meetings alongside an agreement with the Director of Corporate Governance. **Action: Committee Chair/Medical Director**
PQSOC 1608/09	**Clinical Audit Activity Report (Local and National), Quarter 1, 2022-23** James Calvert, Medical Director, presented the report, providing oversight of results from National Clinical Audits and Confidential Inquiries, including improvements underway to address performance. Members were informed that the actions outlined in the report were not deemed as Specific Measurable Achievable Realistic and Timebound (SMART) and further discussions would take place with the secretariat of the Clinical Standards and Effectiveness Committee to discuss the scrutiny of actions taken from audits. The Chair requested that further review of the audits with no actions against them come back as an update to the Committee. **Action: Medical Director/Secretariat** James Calvert welcomed feedback from the Committee on what they would like included in future reports. Members recommended Health Board improvement plans against targeted actions be included in future reports, with a focus on the improvement of patient care and experience. The report was **RECEIVED** by the Committee.
PQSOC 1608/10	**Psychosis Audit** James Calvert, Medical Director, presented the report, noting that this related to a previous Committee action. The report provided assurance of work undertaken to address required improvements outlined in the National Clinical Audit of Psychosis with respect to the Early Intervention Service (EIS) (2020/2021). Members were informed that the two-week access period to Psychosis Services was currently achieved for 36% of patients. This was due to insufficient staffing to meet demand. The staffing position was being addressed within the Mental Health and LD Division by assessing and reviewing skill mix and workforce models. The Committee received an update in respect of screening for physical health conditions for patients experiencing episodes of Psychosis. At present, 32% of psychosis patients received full physical health screening. The Mental Health and Learning Disabilities teams have mapped all areas for improvement and incorporated a Standard Operating Procedure to facilitate improved physical health screening for patients.

	The delivery of Cognitive Behavioural Therapy (CBT) for 'at risk' patients was discussed. There had been successful recruitment of a Clinical Psychologist, specialising in Cognitive Behavioural Therapy (CBT), in addition to support for all clinical staff to attend the Diploma in CBT for psychosis training to support a CBT informed approach to patient care. Paul Deneen, Independent Member, requested explanation of why the Health Board was an outlier in numbers of patients requiring Early Intervention Psychosis care. Members were informed that this may be due to the high level of expertise and care available in ABUHB Mental Health Services, and the ability to identify patient needs early in the assessment process. The Chair of the Committee requested a target date for the action *Development of a strategy to address inequalities in access to the service* as outlined in the report. **Action: Medical Director/Secretariat** The committee **RECEIVED** the report and **NOTED** the improvements implemented to address the findings of the National Clinical Audit of Psychosis (2020/2021).
PQSOC 1608/11	**Update on Cancer Services, and Associated Risks** James Calvert, Medical Director, provided an overview of cancer performance including identified improvement actions to address the current challenges. James Calvert discussed the report, noting it included contextual information of overall performance. The following key points were noted: • The 62-day cancer pathway had deteriorated since October 2020; however, the Health Board had delivered more cancer interventions in the last quarter than ever before. This therefore indicated that there was a deteriorating position against significant increased activity, due to increased demand. • There had been a 46% increase in referrals in Colorectal services since pre-covid. Further work is being carried out in the community to encourage engagement with screening. • Referrals had also increased in Dermatology, Breast and Urology pathways. Individual working groups had been appointed within the pathways to assess staffing shortfalls and pathway capacity. • The Health Board was utilising data to predict capacity based on demand. The Lightfoot data models had been presented to the Cancer Board. The Committee was advised that Aneurin Bevan was the only Health Board in Wales utilising the innovative Lightfoot predictive data to inform system planning and subsequently improve patient care. • Contracts with external providers were discussed and it was noted that the Health Board would be working alongside Velindre Cancer Centre to assess pathway delays once patients were referred for treatment outside of the Health Board. • Pathology demand had increased and was noted as an area of high risk. This was due to insufficient working space affecting the ability to recruit to address demand, in conjunction with a UK wide shortage of Pathologists. A Pathology business case for service improvement had

	been developed and was due to be presented to the Pre-Investment Panel (PIP) for further consideration. • A communication strategy was being developed for Primary Care services to provide relevant information to patients being referred onto a cancer pathway. In addition, staff were receiving training to improve communication, providing the best information and support to patients who choose to cancel/rearrange appointments. • As a result of a 2-part communication workshop, an action plan had been established with an initial target of first contact for patients on a cancer pathway of 14-days. Helen Sweetland, Independent Member, noted the issues with pathology services and queried whether the Welsh Government had plans to support the All-Wales cancer genetics services. The Health Board was not aware of current plans for improvement in this area, but regular discussions were taking place on an All-Wales level to look to improve services. Paul Deenen, Independent Member, noted the numbers of people presenting late with cancer and requested further information on what actions were being taken forward to address this. Members were informed that work was being carried out with Primary Care Services and with Public Health Wales to improve communications by raising awareness, alongside investing in preventative measures to improve population health. A paper on Public Health plans to improve late presentation to come back to the Committee for information. **Action: Medical Director/Secretariat** The Committee thanked the Medical Director for the comprehensive update and **NOTED** the report.
PQSOC 1608/12	**National review of Venous Thromboembolisms (VTE) Report** James Calvert, Medical Director, provided an overview of the report outlining the Health Board's action plan in response to the national review of Venous Thromboembolisms. Members were informed that the Health Board did not currently have the authority to prioritise mandatory training based on areas of need and mandatory training was determined on an All-Wales level. The recommended actions, as outlined in the report, were discussed. Work was underway to provide assurance that each recommendation would be achieved over the next 12 months. The Committee **NOTED** the report and acknowledged the work underway towards compliance with the recommendations.
PQSOC 1608/13	**Safeguarding Annual Report 2021/22** Fiona Bullock, Deputy Head of Safeguarding, presented the report to the Committee. The report included progress, performance, risk and learning together with an overview of emerging themes and trends, and a proposed work programme for 2022/'23.

	Members were informed that safeguarding was a key commitment of the Health Board, acknowledging that everyone had a pivotal role in ensuring patients, their families and the public receive high standards of care, complying with UK and Welsh Government safeguarding legislation. Key initiatives in response to risks emerging due to lockdown and subsequent hidden harm, as well as rising austerity in Wales, were discussed. Linda Alexander, Deputy Director of Nursing, thanked the safeguarding teams for their dedicated work and noted that further safeguarding training was required to support Health Board staff. Peter Carr, Director of Therapies and Health Science, provided assurance to the Committee that the Executive Team were committed to work with the Safeguarding teams to ensure learning informed safeguarding practice throughout the Health Board. Paul Deneen, Independent Member, highlighted the importance of Health Board wide compliance with mandatory safeguarding training. The report highlighted a significant number of child deaths relating to asphyxiation. A rapid review had taken place, in collaboration with Welsh Government. A 'Suicide and Self-Harm for Young People' strategic group had been developed within the Gwent Safeguarding Board, of which Health Board stakeholders were key contributors. Paul Deneen, Independent Member, questioned if the review had flagged links between child deaths and social media platforms. Fiona Bullock informed members that there had been no evidence linking cases in the Health Board area to social media platforms. The Committee **NOTED** the report.
PQSOC 1608/14	**Infection Prevention and Control (IPAC) Annual Report 2021/22** Moira Bevan, Head of Infection Control, presented the report to the Committee. The report outlined the infection prevention work undertaken in 2021/22, management arrangements and progress against performance targets. The following key points were noted: • The Health Board had been successful in receiving transformational funding, allowing for additional support for prevention of infection in the wider community, particularly care homes. • The purchase of new machinery and the opening of the decontamination unit in GUH had supported service improvement and this was evidenced through improved performance data. • Further assurance was provided through the facilities audit team who regularly audited areas throughout the Health Board. • A COVID investigation team had been established by the Health Board to assess the harm from COVID on the population. • Relating to the older Health Board estates, an assessment of Health Board facilities was required to ensure required standards were met for infection prevention and control. • Ongoing training was a focus for the IPAC teams and an educational lead was to be piloted to support further training needs.

	Committee members thanked the IPAC team for all the hard work undertaken. The Committee **NOTED** the Annual Report and: - • The significant work programme and the impact of Covid-19. • The achievements of 2021/22. • The areas of concentration and priorities for 2022/23.
PQSOC 1608/15	**LD Directorate Update** Chris O'Connor, Director of Primary Care, Community and Mental Health Services, supported by John Carroll, Deputy Divisional Nurse and Lara Homan, Lead Nurse, Learning Disabilities provided an update to the Committee. The report was in response to a previous Committee action requesting an update on the review of care for individuals with Learning Disabilities (LD). John Carroll gave an overview of the Improving Care, Improving Lives Report. The Health Board, alongside partners, were in the process of developing a response to the recommendations within the report, as outlined in Appendix 1 of the papers. The Health Board had presented the work-to-date to the National Implementations Assurance Group in response to recommendations and had received positive feedback on progress made. The Learning Disabilities team planned to meet with the National Implementations Assurance Group in November 2022, to participate in the development of an All-Wales approach in response to the Improving Care, Improving Lives report. Lara Homan provided an overview of the progress made within primary and secondary liaison services with the aim to reduce health inequalities for people with Learning Disabilities. The Primary Care Liaison Service had collaborated with the Neighbourhood Care Networks, establishing relationships with GP surgeries, and supporting with the embedding of the learning disability annual health checks. The model used for annual health checks had been recognised and celebrated by Public Health Wales and would form a template for best practice across Wales. The Secondary Health Liaison service had recently piloted the recruitment of a consultant into the team, to improve communication and support for patients in acute and general healthcare settings with a Learning Disability. The Chair thanked the team for the report and discussed the importance of raising awareness of available services and support to friends, families and carers of individuals with learning disabilities. Paul Deneen, Independent Member, welcomed further discussions on the monitoring of commissioned placements for patients with Learning Disabilities. Chris O'Connor informed members that the Health Board had 7 patients with Learning Disabilities in hospital commissioned placements and, appropriate to individual needs, the Health Board's priority was to support patients with Learning Disabilities with care closer to home.

	Helen Sweetland, Independent Member, queried how information was shared with emergency units on available support for patients with Learning Disabilities. Members were informed that the Learning Disability team carried out regular visits to units and wards, produce regular communications and attend inductions for new staff to raise awareness. The Committee **NOTED** the report and **NOTED** the following: • Progress made with the Improving Care, Improving Lives Action Plan and support the continued joint work. • Progress made with both secondary and primary liaison services and consider the continued development and strengthening of health liaison teams. • The continued work in monitoring the quality of commissioned packages of care in in-patient settings.
PQSOC 1608/16	**Committee Risk Report, July 2022** Danielle O'Leary, Head of Corporate services, Risk and Assurance, presented the risk report to the Committee. The following key points were highlighted: • Work had been completed with Divisions to ensure risks were captured appropriately and consistently on the Datix system. • Divisional engagement continued, and a plan highlighting the benefits associated with the Risk Management Strategy had been developed and endorsed by the Audit, Risk and Assurance Committee. An update on this plan would be circulated to members of the Committee, aligning with the update to Audit, Risk and Assurance in October 2022. **Action: Head of Corporate Services, Risk and Assurance** • Work continued to improve assurance mechanisms to the Board in relation to Health Board commissioned services. The Head of Corporate Risk and Assurance was due to meet with clinical service leads in August 2022 to determine assurance through continued monitoring, aligning with the developmental plans for the Board Assurance Framework. • In relation the CAHMS risk profile (CRR028), significant developments had been made. The Health Board was awaiting final funding approval from Welsh Government to develop a ward for children and young people in crisis. Contingencies were in place should the funding not be approved. The Committee would receive an update on the position of the funding at the next meeting. **Action: Head of Corporate Services, Risk and Assurance** The Committee was asked to acknowledge the de-escalating trajectory of CRR010 – *Inpatient falls*, and to endorse the new risk in relation to Cancer Services, CRR039 - *Risk of delayed cancer treatments delivered to patients due to deteriorated position in cancer performance specifically in relation to 62 day waits.* Shelley Bosson, Independent Member, had shared the following requests outside of the meeting:

	• Outlining required updates to the risk report. The report had been amended in July 2022 to reflect new risks aligning to correct risk reference numbers. • Further assurance was required around inter-site transport risks. The Head of Corporate Risk and Assurance suggested an item for discussion to come back to the Committee to provide further assurance. The Committee endorsed this approach. **Action: Director of Operations** The Committee **NOTED** the report.
PQSOC 1608/17	**Committee Annual Workplan 2022-23** Danielle O'Leary, Head of Corporate Services, Risk and Assurance, presented the annual workplan to the committee. The plan had been circulated to members outside of the meeting for comments. The Committee **APPROVED** the Committee Annual Workplan.
	Items for Information
PQSOC 1608/18	**Highlight Report: Patient Quality, Safety & Outcomes Group** Peter Carr, Director of Therapies and Health Sciences, informed members that work was being undertaken, alongside the Director of Corporate Governance, to review the Terms of Reference for the Patient Quality, Safety and Outcomes Group. Any updates would be reported back to the Committee. The Committee **NOTED** the report for **INFORMATION**.
PQSOC 1608/19	**Healthcare Inspectorate Wales, 2022-2023 Operational Plan** The Committee **NOTED** the report for **INFORMATION**.
PQSOC 1608/20	**PROMPT Wales Quality Assurance Review** The Committee **NOTED** the report for **INFORMATION.**
PQSOC 1608/21	**WHSSC QPSC Chairs Report to the 12th July 2022 Joint Committee- for information** The Committee **NOTED** the report for **INFORMATION.**
	Other Matters
PQSOC 1608/22	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** None noted.
	Date of Next Meeting
PQSOC 1608/23	The date of the next meeting was noted as: - Tuesday 18th October 2022 09:30 -12:30 via Microsoft Teams.

Patient Quality, Safety & Outcomes Committee
December 2022
Agenda Item: 1.5

Patient Quality, Safety & Outcomes Committee

Action Log - December 2022

Agreed Actions:

Overdue	Not yet due	Due	Transferred	Complete	In Progress

Action Ref	Action Description	Due	Lead	Progress	Status
1910/13 Annual Assurance Report on Health & Care Standards: Nutrition and Hydration	An update, inclusive of report from Patient Dining Review.	**February 2023**	**Director of Therapies & HS / Secretariat**		**Not yet Due**
PQSO 0706/06.1	A progress report on implementation of the recommendations included	**December 2022**	**Interim Director of Nursing**	Item added for discussion on the PQSOC agenda in December 2022, *Tracking of*	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
Audit Wales Review of ABUHB's Quality Governance Arrangements and Management Response	within the report be scheduled for October 2022.			*Improvement Actions Arising from Inspections and Reviews.*	
PQSO 0706/08 Covid-19 Concerns and Claims: The National Framework & Investigative Process	Regular updates on the investigation process and progress would be monitored through the Committee.	**February 2023**	**Interim Director of Nursing**	Included in the Committee work programme for February 2023.	**Not yet due**
PQSO 0706/10.1 Healthcare Inspectorate Wales (HIW) Unannounced Visit to the Grange University Hospital (November 2021)	A further update on the final response to HIW, progress and compliance against actions to come back to its October 2022 meeting.	**December 2022**	**Interim Director of Nursing**	Item added to the PQSOC agenda for discussion October 2022, *ABUHB Final Response to HIW Unannounced Visit to GUH November 2021 and Compliance against actions.*	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
PQSO 0706/11.1 The Independent Review of Maternity Services at SATH (The Ockenden Review)	The action plan arising from the Health Board's assessment be monitored as part of the Committee's future workplan.	**December 2022**	**Interim Director of Nursing**	Included in the Maternity Services Improvement Plan update at December 2022 meeting.	**Complete**
PQSOC 0706/12.2 Patient Quality and Safety Outcomes Report	'Getting it Right First Time' (GIRFT) Stroke Review would be presented to the Committee following its publication, including the Health Boards management response.	**February 2023**	**Director of Therapies and Health Sciences**	The Health Board stroke services are subject to three external reviews currently. The GIRFT review, the HIW pathway review, and the Delivery Unit imaging pathway review. The intention is to integrate our management response and action plan for all three. A detailed update to be presented to the Committee.	**Not yet due**
PQSOC 0706/13 Operation Jasmine and the Coroner's Inquests- further	A further update on implementation of the improvement plan to be presented to the Committee in February 2023.	**February 2023**	**Director of Nursing**	Added to the committee work programme for February 2023	**Not yet due**

Action Ref	Action Description	Due	Lead	Progress	Status
reflection and learning					
PQSOC 1608/06 Urgent and Emergency Care	Weekly data on SDEC to be shared with members outside of the meeting.	**October 2022**	**Director of Operations/ Senior Programme manager**	Information to be shared with the Committee including updated numbers. Then monthly distribution of data to be shared with members.	**In Progress**
PQSOC 1608/06.1 Urgent and Emergency Care	Members requested a full report on the opening of SDEC and the impact on patient care to come back to the Committee.	**February 2023**	**Director of Operations**	Formal evaluation of SDEC requested by Board in March 2023. This will also encompass YYF SDEC. To be presented to the Committee prior to Board.	**Not yet due**
PQSOC 1608/08 Clinical Audit Strategy 2022-2025	A review of the Clinical Audit Strategy four key priority areas and the implementation of the AMaT system to come back to the Committee.	**February 2023**	**Medical Director**	Included on the agenda for October 2022. October 2022 meeting cancelled due to system pressures. To be included in Clinical Audit Update in February 2023.	**Not yet due**
PQSOC 1608/08.1 Clinical Audit	The Medical Director suggested an assurance report to come as a standing item to each meeting of the PQSOC. This report would include	**October 2022**	**Committee Chair and Lead Executives**	Review and revision of the Health Board's Quality Strategy underway which will include reporting requirements. It is intended	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
Strategy 2022-2025	assurance based on previous meeting actions. The Chair to link with the Medical Director, Director of Nursing and Deputy Director of Nursing outside of the meeting to discuss a mechanism of assurance reporting for future meetings.			that the Quality Strategy will define the approach to Quality Improvement, Quality Assurance and Governance and the qualitative and quantitative data requirements, this will include the quality sub-groups and the committee reporting structure. A workshop will be taking place in December to revise the PSQOC reporting format.	
PQSOC 1608/09 Clinical Audit Activity Report (Local and National), Quarter 1, 2022-23	Information on the audits outlined in the report without actions against them come back as an update to the Committee.	**February 2023**	**Medical Director**	The Quality and Patient Safety team are actively working on process improvement for the tracking and capturing of audit outcomes. An update will be provided to the committee in February 2023 to allow time for implementation.	**Not yet due**
PQSOC 1608/10 Psychosis Audit	A target date for the action *Development of a strategy to address inequalities in access to the service* to be shared, as outlined in the report.	**December 2023**	**Medical Director**	The actions will be presented to the Clinical Standards and Effectiveness Group in November 2023 with a target date of	**Not yet due**

Action Ref	Action Description	Due	Lead	Progress	Status
				December 2023 for finalisation.	
PQSOC 1608/11 Update on Cancer Services, and Associated Risks	A paper on Public Health plans to improve late presentation of cancer to come back to the Committee for information.	**February 2023**	**Director of Public Health & Strategic Partnerships**	Added to forward work programme for February 2023.	**Not yet due**
PQSOC 1608/16 Committee Risk Report, July 2022	An update on the plan highlighting the benefits associated with the Risk Management Strategy to be circulated to members of the Committee, aligning with the update to Audit, Risk and Assurance in October 2022.	**February 2023**	**Head of Corporate Services, Risk and Assurance**	Item deferred. Included in Committee Risk Report at February 2023 meeting.	**Not yet due**
PQSOC 1608/16.1 Committee Risk Report, July 2022	CAHMS risk profile (CRR028): An update on the funding position from Welsh Government to be included in the Committee Risk Report at the next meeting.	**February 2023**	**Head of Corporate Services, Risk and Assurance**	Item deferred. Included in Committee Risk Report at February 2023 meeting.	**Not yet due**
PQSOC 1608/16.2 Committee Risk	Committee members requested further re-assurance around inter-site transport risks. An item for discussion to	**December 2022**	**Director of Operations**	Item added to the PQSOC agenda for discussion December 2022.	**Complete**

Action Ref	Action Description	Due	Lead	Progress	Status
Report, July 2022	come back to the Committee to provide further assurance.				

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE
PROGRAMME OF BUSINESS 2022/23- December 2022

The scope of the Patient Quality, Safety & Outcomes Committee extends to the full range of ABUHB responsibilities. This encompasses all areas of patient experience, quality and safety relating to patients, carers and service users, within directly provided services and commissioned services. The Committee will embrace the Health and Care Standards as the Framework in which it will fulfil its purpose

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board in March 2022;
- the Board's Assurance Framework (based on its Annual Objectives for 2021/22 and 2022/23);
- delivery of the Board's Experience, Quality & Safety Objectives set out within the IMTP 2022-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Preliminary Matters									
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓	✓	✓	✓
Committee Requirements as set out in Standing Orders									
Development of Committee Annual Programme of Business 2022/23	Annually	Chair & Director of CG			✓				
Review of Committee Programme of Business	Standing Item	Chair			✓	✓	✓	✓	✓
Annual Review of Committee Terms of Reference 2022/23	Annually	Chair & Director of CG						✓	
Annual Review of Committee Effectiveness 2022/23	Annually	Chair & Director of CG							✓
Committee Annual Report 2022/23	Annually	Chair & Director of CG							✓
Quality Domain: Safe Care									
Pharmacy and Medicines Management Annual Report	Annually	Medical Director						✓	
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director						✓	
Learning from Death Report	Bi-Annually	Medical Director		✓			✓		
Cleaning Standards Annual Report	Annually	Director of Operations						✓	
Nutrition and Hydration Standards and Strategy'	Annually	Director of Therapies & HS						✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Falls and Prevention Management Report	Bi-Annually	Director of Therapies & HS						✓	
Health and Safety Compliance Report	Annually	Director of Therapies & HS					✓		
Safeguarding Annual Report	Annually	Director of Nursing			✓				
Safeguarding Group Highlight Report	Quarterly	Director of Nursing			✓		✓		✓
Operation Jasmine Action Plan	Bi-Annually	Director of Nursing		✓				✓	
Children's Rights & Participation Forum	Bi-Annually	Director of Nursing				✓			✓
Infection Prevention and Control Annual Report	Annually	Director of Nursing			✓				
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓		✓	
Blood Management Annual Report	Annually	Medical Director						✓	
Organ Donation Annual Report	Annually	Medical Director						✓	
Quality Domain: Effective Care									
Quality Assurance Framework Annual Review and Evaluation of Progress	Annually	Clinical Executives						✓	
Commissioning Assurance Framework, Development and Implementation	Bi-Annually	Clinical Executives					✓		
Clinical Effectiveness and Standards Committee Report	Bi-Annually	Medical Director				✓			✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Annual Clinical Audit Plan (prior to ratification) by the Audit, Risk & Assurance Committee	Annually	Medical Director			✓				
Clinical Audit Activity Report (Local and National) Feb 23 to include Annual Clinical Audit Draft Internal Audit Report	Quarterly	Medical Director			✓			✓	
Quality Improvement Annual Report	Annually	Director of Public Health							✓
Research and Development Annual Report	Annually	Director of Public Health							✓
Medical Devices Annual Report	Annually	Director of Therapies & HS					✓		
Point of Care Testing Annual Report	Annually	Director of Therapies & HS					✓		
Quality and Safety Outcomes Report	Standing Item	Clinical Executives	✓	✓	✓	✓	✓	✓	✓
Committee Risk Report, including BAF	Standing Item	Director of Corporate Gov	✓	✓	✓	✓	✓	✓	✓
WHSSC QPS Committee Report	Standing Item	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality Domain: Dignified Care & Individual Care									
Patient Story	Standing Item	Clinical Executives	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓			

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Putting Things Right Reporting (complaints, compliments, and redress)	Standing Item[1]	Director of Nursing	✓	✓	✓	✓	✓	✓	✓
Quality & Engagement (Wales) Act, Preparedness and Implementation	Annually	Director of Nursing				✓		✓	
Patient Experience Report	Quarterly	Director of Nursing		✓			✓		✓
Dementia Care Annual Report	Annually	Director of Nursing							✓
Clinical Negligence Claims and Coroners Inquests Report	Bi-Annually	Director of Nursing				✓			✓
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓	✓	✓	✓
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓				✓	
Service Specific Deep-Dive Assurance Reviews									
Learning Disabilities	Annually	Director of PCCMH			✓				
Urgent and Emergency Care Demand and Impact on Outcomes	Quarterly	Director of Operations			✓		✓		✓
Maternity Services: Organisational Improvement and Action Plan	Bi-Annually	Director of Nursing		✓		✓			
Child and Adolescent Mental Health Crisis Hub and Safe Accommodation	Annually	Director of Nursing							
Self-Harm & Suicide - Children & Young People	Annually	Director of Nursing							

[1] Via Quality and Safety Outcomes Report
[2] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Primary Care Quality	Bi-Annually	Director of PCCMH							✓
Independent Audit, Regulation and Inspection									
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual Internal Audit Plan						
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives	As scheduled within the Annual External Audit Plan						
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓			➲	✓	
Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update	Bi-Annually	Director of Primary, Community Care & Mental Health			✓			✓	
Internal Audit Review – Medical Devices – Action Plan Update	Bi-Annually	Director of Therapies & HS			✓		✓ (linked to Annual Report)		
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓		✓		✓
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing	As published						
Inspections of the Community Health Council	Ad-hoc	Director of Nursing	As published						
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓		✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2022/23						
			5th April	7th June	16th Aug	18th Oct	6th Dec	7th Feb	April 2023
Healthcare Inspectorate Wales Operational Plan	Annually	Director of Nursing			✓				
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing						✓	

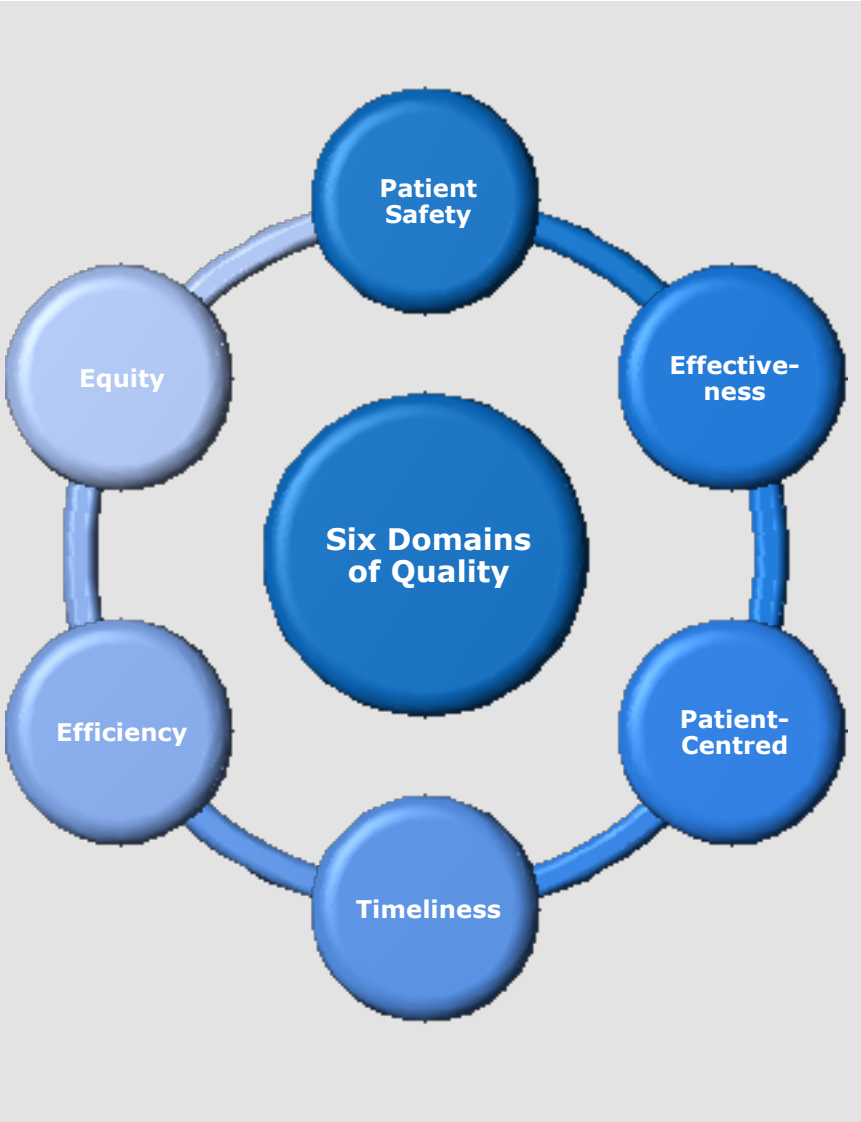
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Patient Quality, Safety and Outcomes Committee

Performance Report

December 2022



Overview

The Patient, Quality and Safety performance report provides committee with an overview of the Health Boards quality and safety metrics and summary of performance. It is aligned to the ministerial priorities and key challenges, which are:

- Workforce
- Quality and Safety
- Urgent Care
- Planned Care
- Cancer

People Plan:

Key Achievements

Staff Health & Wellbeing

WELLBEING:
- Wellbeing Centre of Excellence- consolidation
- Trauma Pathway positively evaluated
- Financial wellbeing resources launched

STAFF ENGAGEMENT:
- #PeopleFirst: Staff Engagement Programme established
- Peer support networks established for Theatres, Anaesthetics, Critical Care and Menopause
- Calendar of EDI events, newsletter and networks established

PEOPLE PRACTICES:
- Trained Mediators for all divisions
- PADR group re-established- quality conversations

Employer of Choice

CHOOSE TO STAY:
- SAS contract successful implementation
- Nursing & Midwifery Leadership Academy
- Drop in sessions for staff- advice and support

CHOOSE TO JOIN:
- 50+ Overseas nurses recruited
- HCSW campaigns
- New recruitment partners – medical safer staffing posts filled

CHOOSE TO GROW:
- Aneurin Bevan Apprentices- successfully evaluated
- Employability schemes

WELSH LANGUAGE:
- Staff skills audit to identify and address bilingual skills need
- Improved WL recruitment co-ordination

Workforce Sustainability

SUSTAINABILITY:
- Examples of extended/ enhanced roles -Clinical endoscopists, ICT, outreach support worker (TB), HCSW education lead, consultant nurse menopause, medical e-systems roles

TRANSFORMATION:
- Learning from Primary Care Transformation Programme

AGILE WORKING:
- Refreshed Framework developed to support staff, practices and behaviours
- Best practice agile work space model developed
- Agile working spaces created across sites with staff engagement

DIGITAL
- Medical e-systems programme plan
- Robotics to support resource bank

People Plan 2022-2025:

Key Next Steps

Staff Health & Wellbeing

WELLBEING:
- Refreshed bid for revenue resources to fully support WcoE concept over next 2 years
- 6th Wellbeing survey - over 16,000 responses over 2 years
- Launched 'Avoidable Harm in employee investigations' learning events
- Develop and enhance financial wellbeing offer

STAFF ENGAGEMENT:
- #PeopleFirst project: over 200 staff consulted and 150 staff issues addressed
- Working with Cardiff University on what comprises a Healthy Working Day for our staff
- Embedding intersectionality
- Developing anti-racist action plan

PEOPLE PRACTICES
- PADR review to improve value, learning and compliance
- Development of training for absence management – "Putting Policy into Practice"
- Comprehensive review of Values and Behaviours Framework

Employer of Choice

CHOOSE TO STAY:
- Targeted roll out of drop in events
- HCSW career pathways (non clinical to clinical)
- Leadership development- launching bespoke Clinical Director (CD X)

CHOOSE TO JOIN:
- Launch second apprenticeship cohort

CHOOSE TO GROW:
- Continue to develop opportunities to expand widening access- foundational economy principles
- Internships - first Health Board in Wales to host HEIW fully funded internships

WELSH LANGUAGE
- Welsh Language L&D strategy
- Welsh Language and EDI Month to raise awareness

Workforce Sustainability

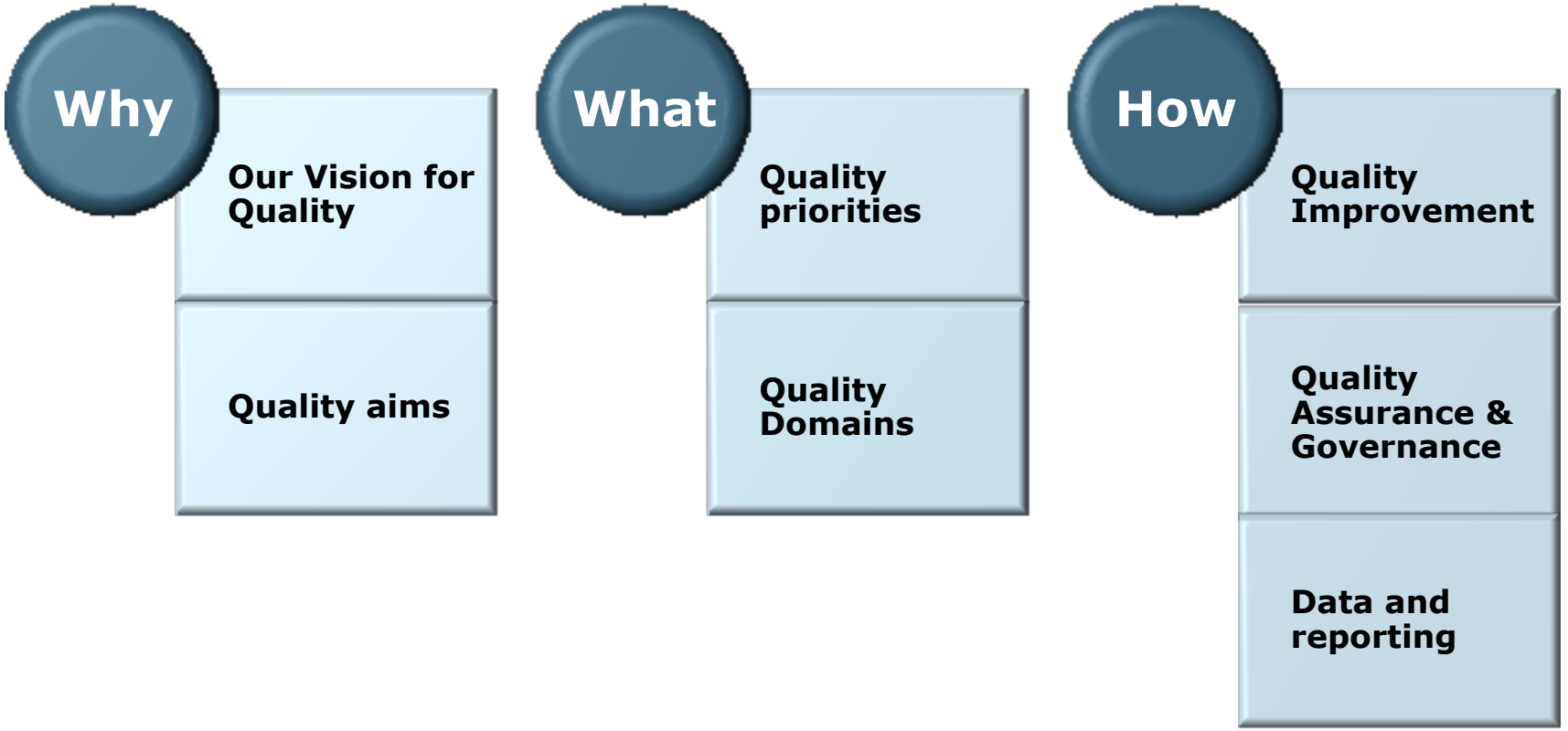
SUSTAINABILITY:
- Implement and review of agency reduction plan
- Creative problem solving- addressing key organisational issues through facilitated problem solving event e.g. efficiencies
- Expand safer staffing review for medical posts

TRANSFORMATION
- Creation of new workforce transformation team with funding from RPB to support transformation and sustainability
- Collaboration with Gwent Workforce Board
- NCN Development Plan

AGILE WORKING
- Create connections between good practice areas to focus on efficiencies
- Trial and evaluate a ready to use agile area

DIGITAL
- Procurement of Medical E-Systems
- Roll out of Safe Staffing tool
- Expand use of robotics to transactional processes

Quality Strategy Structure



How we Deliver a Strategy for Quality

Purpose & Vision

- Agreed direction - **improvement and safety**
- Understanding where we are
- Reflection Post Covid
- Development - shared purpose, approach and strategy

Ambition

- Engagement ward to Board
- Patient and family involvement
- TQM
- Robust data and experience measurement
- Sharing learning

Delivery

- Safe Care Partnership and Collaborative
  - Leadership
  - Patient Deterioration

- QI Capability building
- System safety assurance review
- Platforms (e.g. AMAT)
- Quality Governance

Leadership and Culture

Data and Analytics

Learning & Improvement

Transparency & Engagement

Develop ABUHB Quality Strategy incorporating Risk and Governance

- A Quality Governance Day with Exec Leads, QPS, Risk and Governance and QI (ABCi) will take place with an aim to review the assurance framework for Committees and Operational Group.
- Develop a Quality Based Management System - the need for instant access to data in real time, sitting in one place to give an overarching view within each Directorate / Division.
- Develop a standardised annual plan for each Directorate to report on Quality based data (i.e. clinical outcome measures, complaints, Datix incidents etc), to inform a quality improvement plan and adoption of risk registers.
- Further work on Patient experience reporting to include stories and thematic experience data.
- Triangulated learning data to be published to include actions taken and an evaluation of the impact.
- Standardised agendas and templates for Directorate and Divisions to report Patient Safety and Quality outcomes.

Management of Risk and Patient Safety

- Review of current Health Board endorsed Risk Management Strategy to ensure alignment with latest, evidence based best practice and revised, Board approved Risk Appetite Statement.

- Benefits realisation plan linked to the objectives of the strategy, progress monitored by the Audit, Risk and Assurance Committee.

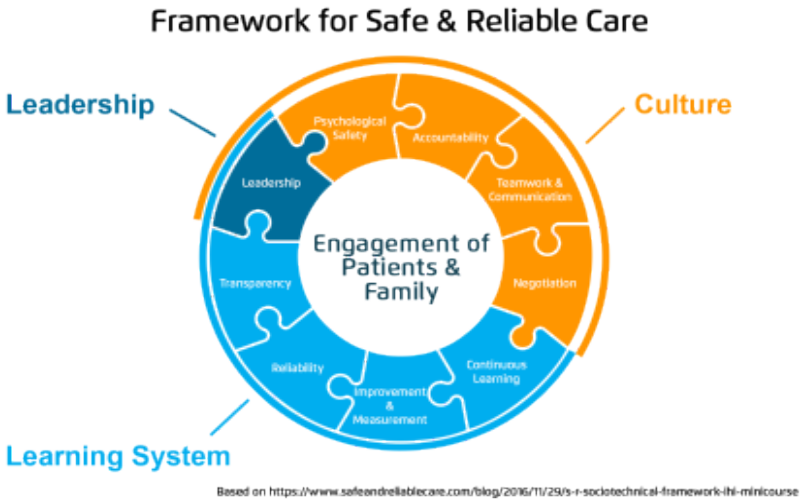
- Establishment of a Risk Management Community of Practice to:
  - "Use the Community of Practice as a space to raise queries, concerns, or areas of good practice to share learning amongst colleagues." Risk Management Community of Practice ToR2022

- Contribution to the development and anticipated National RL DATIX Risk Management module, ensuring that the electronic risk management system is user friendly, captures appropriate data and allows for clear tracking, escalation and consistent reporting. The Health Board is hoping to 'go live' with the new system in 2023.

Next steps

- Review current structures for what works well
- Define Pillars of Quality and pledges
  - Complaints, incident reporting, H&S, IPC, Safeguarding
  - Consider adding medicines management
- Map goals and timeframes – SMART objectives
- Directly involve our patients and staff
- Reinstate safety walk arounds
  - Lead with curiosity, listen and support
  - Speak up for Patient Safety, embrace culture of psychological safety
  - Build leadership from Board to Ward
  - Encompassing staff experience and patient stories
- Develop plan for learning and sharing of incidents
  - Introduce learning events and newsletter
  - Consider communication strategy for learning and sharing
- Embrace a Just Culture of openness and transparency
- WG Quality & Engagement Act underway, Duty of Candour and Duty of Quality
- Safe Care Collaborative underway

Safe Care Collaborative - update



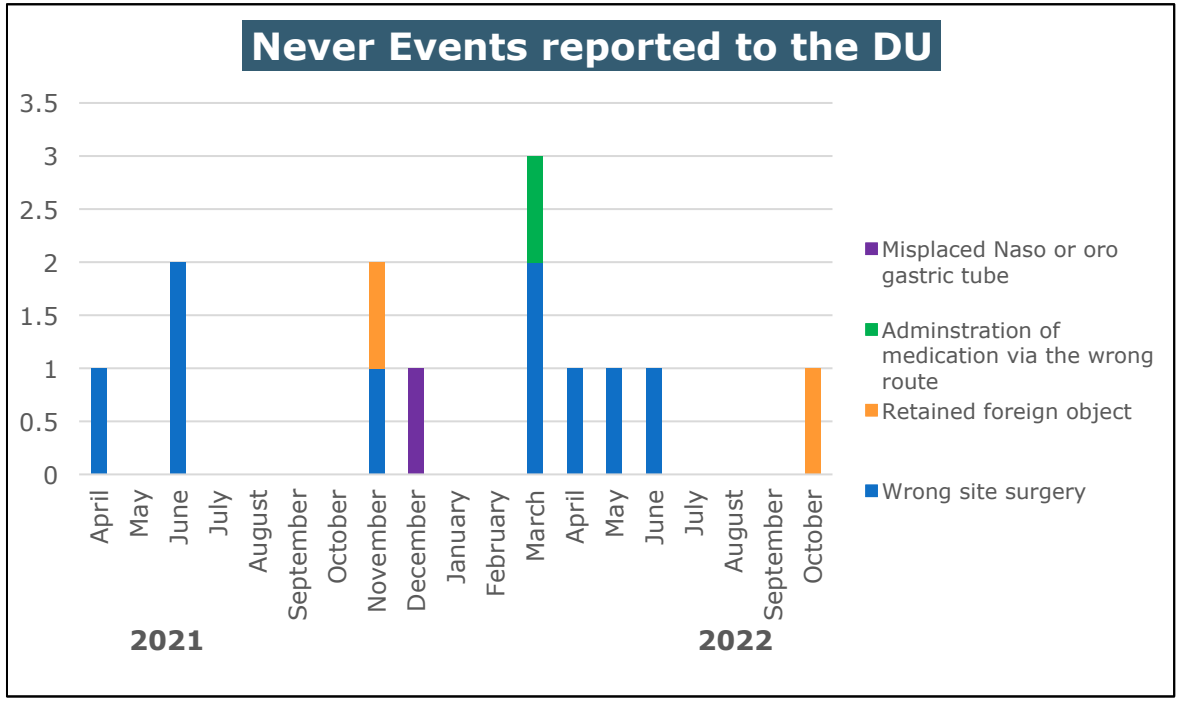
Programme of work

- Regular observation, escalation and response
- Improve use of Careflow data at ward and at aggregate level
- Communication between teams during step up/step down
- Focus Discharge processes
- Keeping patients at home/hospital admission avoidance
- Collaboration across the system between primary, secondary, community, mental health and social services
- Better use of data to evaluate and improve services

- Aim – to provide nationally coordinated, locally delivered support for safe, reliable and effective care. It will support national collaboration and cross boundary learning.
- Collaboration between Improvement Cymru and Institute for Healthcare Improvement
- March 2022 – March 2024, **Launch – 29/30th November**
- Four Components
  - **Leadership**
  - **Safe and effective community care**
  - **Safe and effective ambulatory care**
  - **Safe and effective acute care**

Collaborative Workstream	ABUHB Team
Acute	Medical Assessment Unit at GUH
	Ward C0 (ENT surgical ward)
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU)
	Monmouthshire Integrated Team
Community	Clinical Assessment & Treatment in Care Homes (CATCH)
	Mental Health OT Team

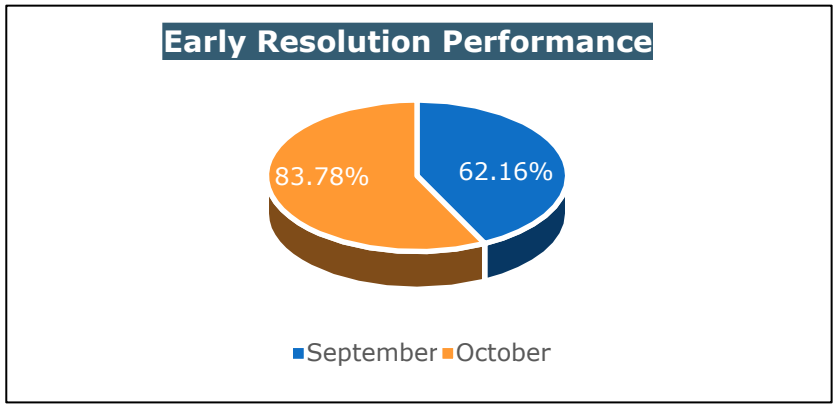
Never Events

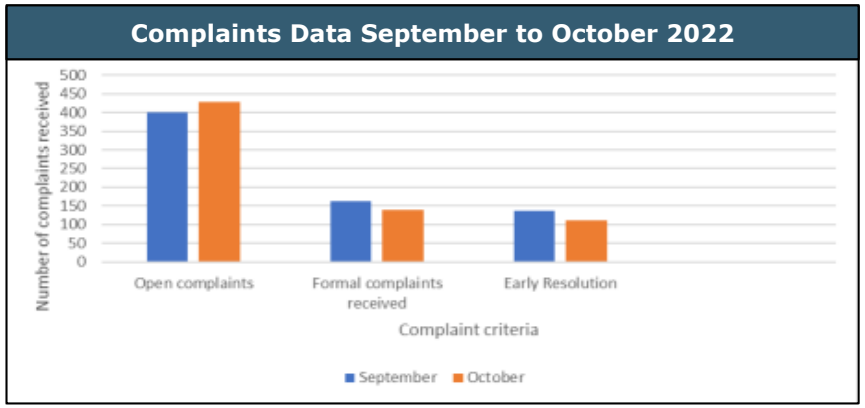


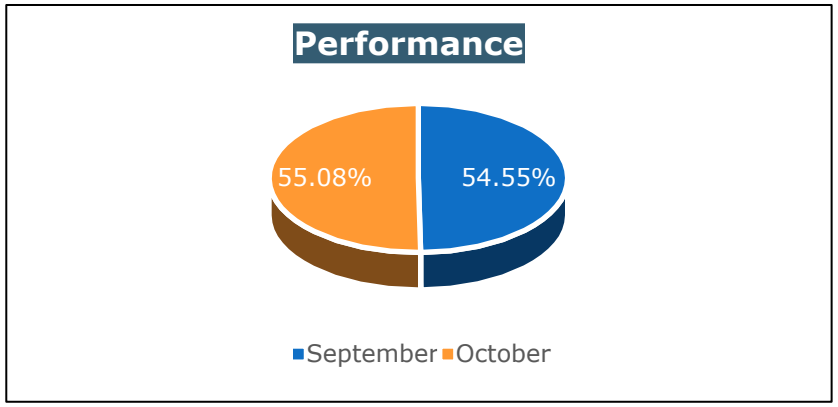
- Never Events comprise 20% of ABUHB's
- NRIs - 11 out of the 13 reported NEs are surgical related (highest reporters of wrong site surgery & NEs comprise 5% of NRIs nationally).
- ABUHB aware of its high number of wrong site procedure Never Events. A large amount of improvement work has gone into making processes more robust, using systems thinking lens for investigations, training IOs using Human Factors and the introduction of the Theatre Safety Collaborative Group for education, sharing and learning.
- There is a Health Board wide wrong site procedure action plan.

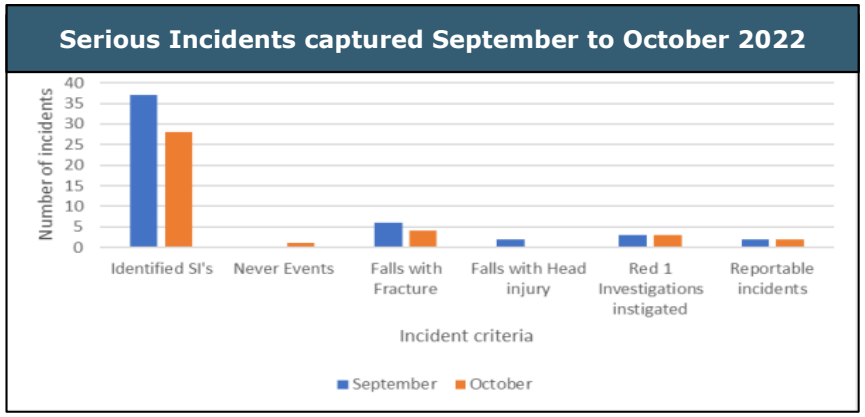
Issue	Cause	Remedial Action	Who	When
Reoccurrence of similar Never Events	Learning from Never Events not embedded within the organisational culture.	Theatre safety meetings taking place	Theatre Safety Group	Ongoing
		Benchmarking audit underway across theatres to ensure care and risk management is unified	Theatre Safety Group	
		Divisional Leads to outline improvement plan for sharing learning	Divisional QPS leads	
		Embed into organisational IO training	PTR Team	
		Thematic review undertaken	Medical Director	
		Exec led meeting with Divisions to implement learning	Exec leads	
		Session on human factors to be delivered	Theatres Lead	
		Working collaboratively across the Division (encompass other directorate e.g. pain, anaesthetics and critical care.	Theatres Lead	

Complaints and SIs





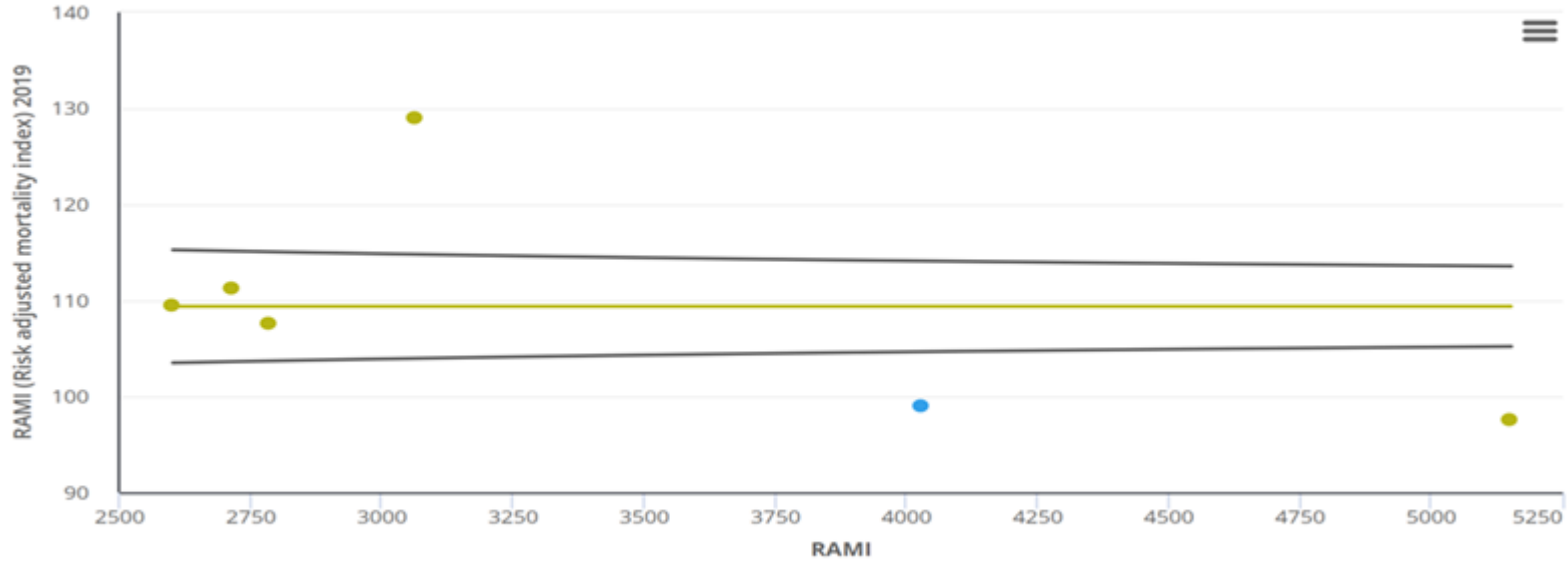




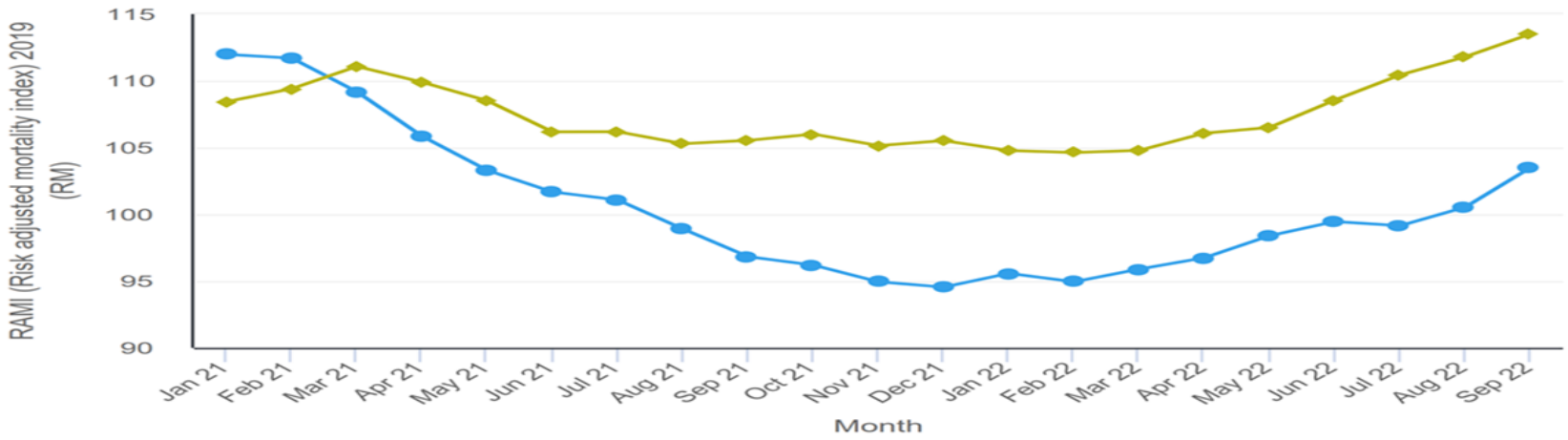
Issue	Cause	Remedial Action	Who	When
Reduced compliance in closure of formal concerns within 30 working days	Staffing pressures due to PTR sickness and Divisional operational pressures had results in reduced prioritisation of Complaints and SI process.	Meet with Divisional Triumvirates, QPS leads and Complaints Coordinators to revisit process and expectations.	Assistant Director of Nursing /PTR Senior Team	Ongoing
Establish how to communicate and spread the learning from Concerns and SI's across Divisions	Define lead and ownership of action plan and dates for completion to enable reassurance.	Work with Exec Team to foster a learning culture across the organisation.	Exec Team	Ongoing
	Learning not updated on RLDatix system	Work with IO's to upload learning upon completion of investigations.	Corporate SI Team	

Risk Adjusted Mortality Index (RAMI)

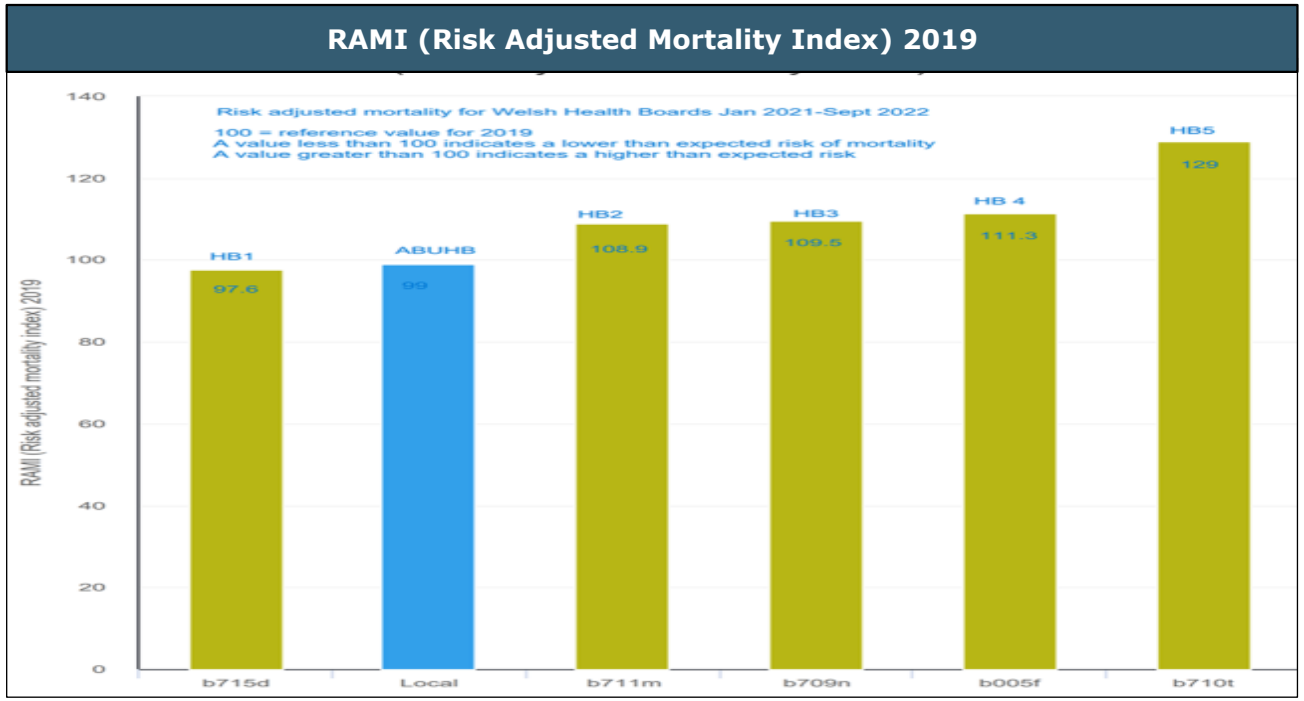
CHKS iCompare



RAMI (Risk Adjusted Mortality Index) 2019



RAMI



- ABUHB Risk adjusted Mortality Index (RAMI) is 98, demonstrates a comparable mortality rate to Welsh peers.
- This rate is below that of other health boards in Wales for the past 20 months.
- Data since the opening of the GUH shows a significant improvement in the Health Boards Risk Adjusted Mortality Data over time.

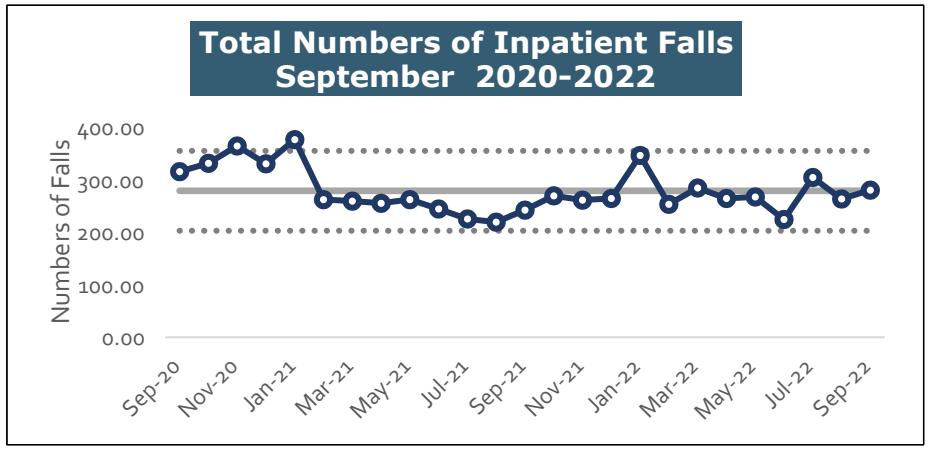
Issue	Cause	Remedial Action	Who	When
Understanding CHKS data and clinical outcomes	Information Directorate unable to provide allocated resource to review CHKS data	The recruitment of a Senior Information Manager, who will work on the CHKS database and support data for clinical outcomes.	Assistant Director for QPS	Post on TRAC and being advertised
		Thorough analysis of mortality data and allow a deep dive approach for learning from death for specific conditions.		
		Working collaboratively with Information and QPS.		
		To provide clinicians with information to help manage services.		

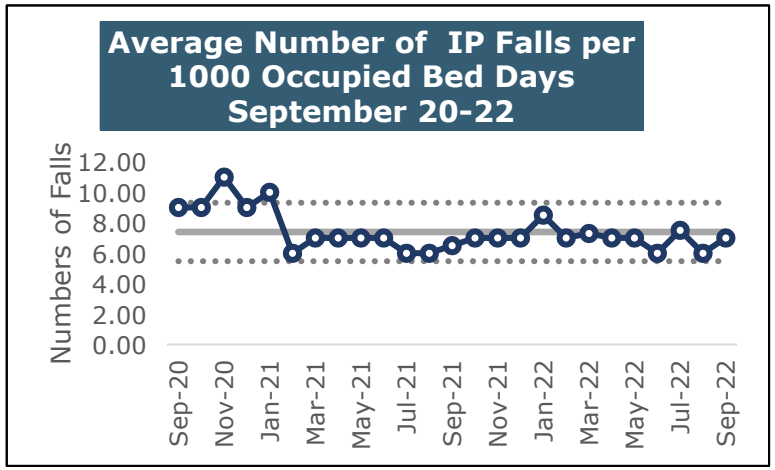
Falls Data

For the period September 2020-22 the mean average for numbers of falls per month was 278. With the exception of January 2022 the numbers of falls incident have in the main remained below this value.

For the given 24 month period:

- 67% of the months were below the mean average value
- 29% of the months were above the mean average value
- 6% were aligned to 7 falls per month.



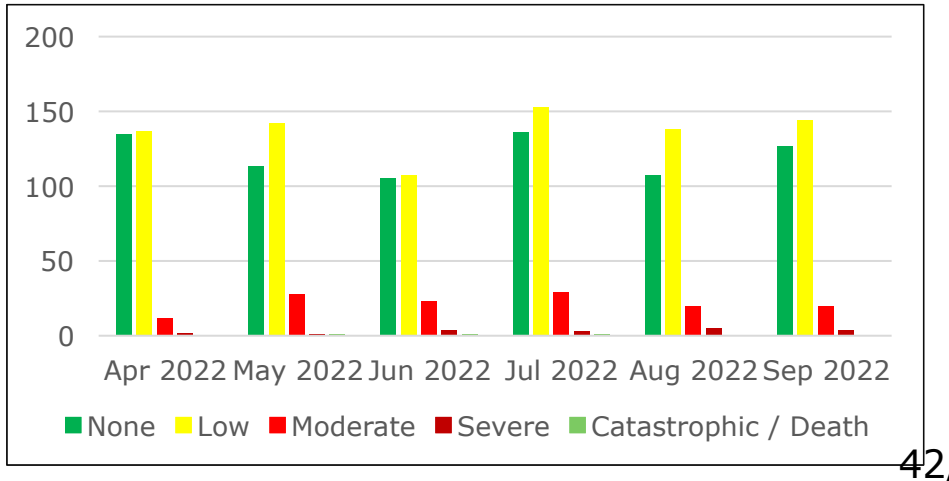


The national mean rate of falls is **6.6 per 1000 occupied bed days** (OBDs) with ABUHB at a mean average value of 6.85 as of February 2021

For the period April to September 2022.

Of the total numbers of falls incidents reported the severity of harm is categorised as follows:

- 43% - no harm
- 49% - low harm
- 7.1% - moderate harm
- 0.9 % Severe harm



Issue	Cause	Remedial Action	Who	When
• Variation in levels of completion of the domains of the Multifactorial Risk Assessment (MFRA).e.g. Lying and standing BP. • Inconsistencies in identifying and establishing proactive interventions in support of reducing falls and subsequently documenting as plans for care.	• Time constraints where there are competing demands to delivery clinical care against the backdrop of increasing patient comorbidities and enhanced care needs. • Variation in staffing levels substantive v's agency • Differing approaches to engaging a MDT in the holistic delivery of care.	Focused training activity in support of improving knowledge and skills in completing the risk assessments and translating into proactive care actions.	Divisional Management Teams	Ongoing
		Substantial oversight and monitoring of completion of the MFRA and care plan with associated audit activity.	Divisional QPS Leads	
		Observation activity and discussion forums to listen and learn form staff as to the challenges and to support change and improvements.	Training and Education Lead for PCC	
		Phased approach to the implementation of the WNCR MFRA.	Chief Nursing Information Officer	

Listening and Learning from Feedback

Issue	Cause	Remedial Action	Who	When
Limited patient experience data	No current electronic feedback system to gather patient experience.	Organisational hierarchy agreed. Friends and Family Test survey will be live via CIVICA end of December with roll out of other surveys as staff are trained.	Patient Centred Care Team	Ongoing
Volunteer recruitment unable to proceed at pace	Vacancies in Patient Centred Care Team. Short term funded posts means that staff leave to find permanent posts.	Posts out to advert. Scoping of sustainable PCCT in progress. Priority focus on volunteers already going through the recruitment process. Hold on further advertisements for volunteers until staff in post.	Patient Centred Care Team	Ongoing
Limited Patient/Staff Stories	Staff vacancies in Patient Centred Care Team. Only one member of staff in team able to produce narrated story (not visual). No current systematic plan to gather and store stories. Ongoing funding required for commissioned films.	Development of Patient/Staff story protocol in progress. To develop story repository system.	Patient Centred Care Team	Ongoing

Infection Prevention

ABUHB – Reduction Expectation Goals

Wales 2022/23 HCAI mandatory surveillance summary, Apr - Oct 22

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	126	35.93	6	1.71	76	21.67	82	23.38	198	56.45	65	18.53	13	3.71	276	78.69
Betsi Cadwaladr UHB	177	42.92	9	2.18	113	27.40	121	29.34	311	75.42	89	21.58	21	5.09	421	102.09
Cardiff and Vale UHB	92	31.10	8	2.70	75	25.36	81	27.38	184	62.21	74	25.02	16	5.41	274	92.63
Cwm Taf Morgannwg UHB	71	26.92	4	1.52	88	33.37	92	34.88	233	88.34	46	17.44	23	8.72	302	114.51
Hywel Dda UHB	122	53.39	6	2.63	57	24.95	63	27.57	200	87.53	67	29.32	20	8.75	287	125.61
Powys THB	7	8.97	0	0.00	0	0.00	0	0.00	1	1.28	1	1.28	1	1.28	3	3.85
Swansea Bay UHB	112	48.86	7	3.05	87	37.96	94	41.01	159	69.37	57	24.87	26	11.34	242	105.58
Velindre NHST	1		0	0.00	0	0.00	0	0.00	5		0		0		5	
Wales	708	38.10	40	2.15	496	26.69	533	28.68	1,291	69.47	399	21.47	120	6.46	1,810	97.40

ABUHB Best in Wales (with the exception of Powys/Velindre):
- Combined Target Staph Aureus
- Combined Target Gram Negative Bacteraemia

Established RNTG for Divisional monitoring and action planning with a focus on: -
- Prudent antimicrobial prescribing
- Environmental cleaning
- Fundamental infection prevention
- ANTT
- Device management

Issue	Cause	Remedial Action	Who	When
Delay with HPV cleaning in GUH	Due to challenges in rooms occupancy	Innovated ways to provide HPV cleaning achieved	IPAC	Ongoing
	Time frame for cleaning and demand for beds	Monitoring delivery through RNTG	RNTG/ Facilities	
C Diff rates	Lower numbers than this time last year therefore improvement continues	• Monitoring through RNTG • Review of the Cleaning Standards	IPAC/ Facilities	Ongoing
	4th Highest in Wales			

Clinical Audit

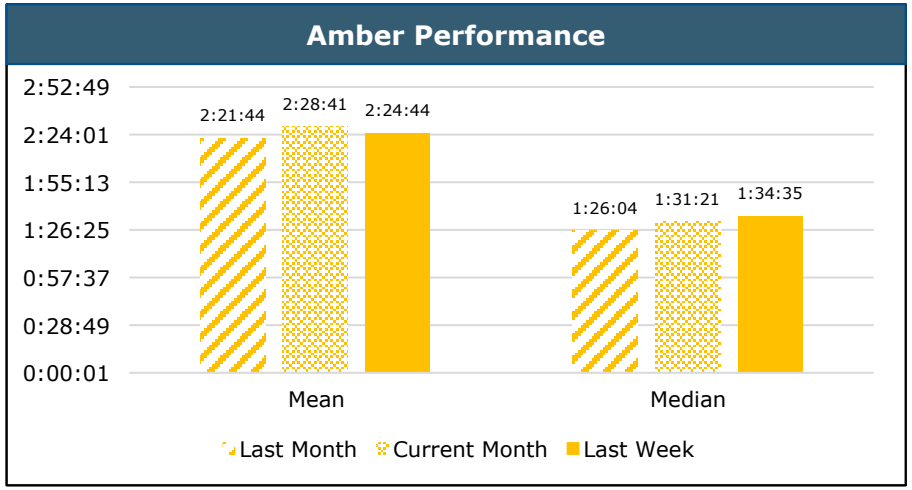
- The Clinical Audit Strategy was updated and published in Oct 2022.
- It provides the Strategic Direction, setting out the commitment to quality and effectiveness through applying clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.
- Work with Divisional Triumvirates to develop Clinical Audits plans aligned to quality and safety risk.
- Web-based Audit Management and Tracking (AMaT) system will allow efficient audit.
- Standardised reports will be produced documenting success, challenges and an action plan with specific timeframes and nominated lead.
- AMaT will empower Clinical Directors to track actions of audits more effectively. Data can be presented as a dashboard and easy-to-read graphical presentations. This will improve engagement with the clinical directors, QPS audit team and Clinical Standards and Effectiveness Group (CSEG).

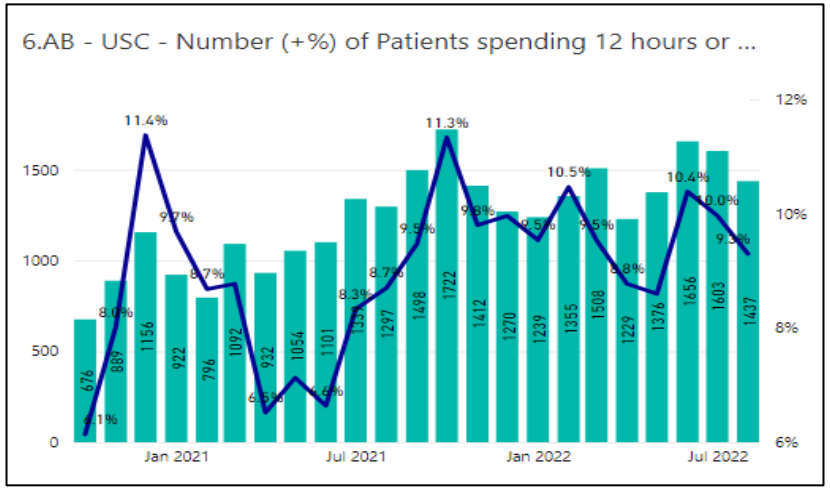
Six Goals Programme Highlight Report

Goal	Goal Priorities	Short Term Next Steps
1. Population Planning & Prevention	High intensity users, HRAC, Falls prevention/pathways,	- Review the service structure and support for HISU - Segment the HISU Data
2. Signposting	UPCC redirections GP+, IFD model, 111 Option 2, WAST Remote support	- Review the clinical criteria for 111 referrals to ED - Scoping exercise for UPC at GUH
3. Safe Alternatives to Admission	SDEC (GUH/eLGH/Specialities), Scheduled slots, Flow centre, Virtual advice	- SDEC Phase 1 launch August 22 - Scheduled MAU slot pilot June 22 - Begin process for FC staffing model review
4. Rapid Response	Handover, EDQDF, PRU, MH Crisis response, E-triage / Symphony, ED Referral Improvement	- Review other HB handover processes and role profiles - Engage WAST and if required develop PRU business case
5. Optimal Hospital Care	Discharge pathways, Safer principles, MDT Board rounds, system flow, Amber CEPOD	- Attend the DU led discharge workshop and Schedule local workshop - Refine the requirements for Amber CEPOD business case
6. Home First	Front Door Therapy services, Commissioned service for CFFD, Step closer to home, D2RA ethos, Direct Access pathways, home first	- Progress Front Door Therapies SBAR - Progress CFFD close to home options appraisal

Summary Position
• First Board held on 21st June • Positive engagement across partnership • Action Plan Complete and submitted to WG 30th June • Developing alternatives to unplanned hospital attendance through the Royal Gwent Hospital MAU hot slot pilot • Working with putting it right team to include patient experience feedback • Revisiting patient flow between hospital sites and the discharge pathway from GUH • Implementing Phase 1 of SDEC at GUH from August 2022 • System access review and action plan • Hot clinic and rapid access to specialist advice implemented and developed • 6 Goals communications plan implemented for staff, partners and public • Pilot of over 75s assessment via eLGH • Flow Centre sustainable staffing review • Recruitment to front door therapies roles

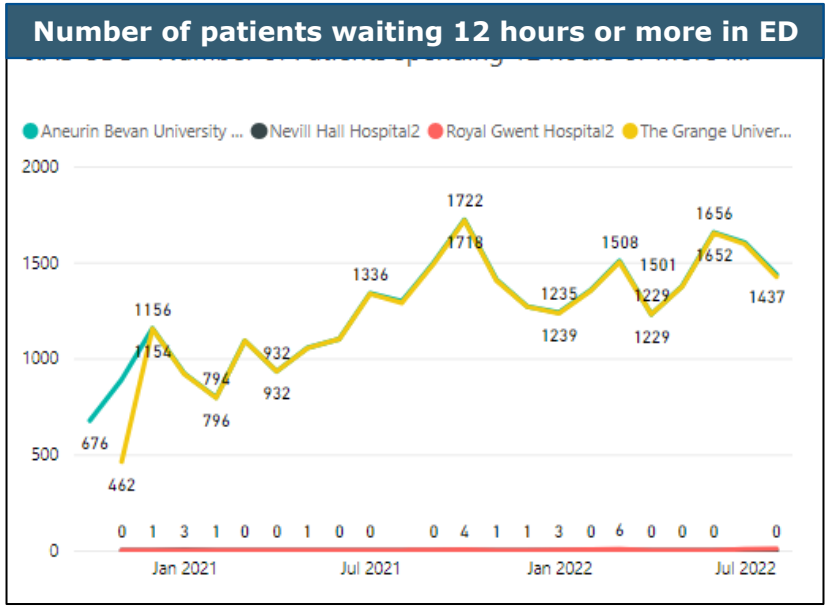
Urgent Care Performance





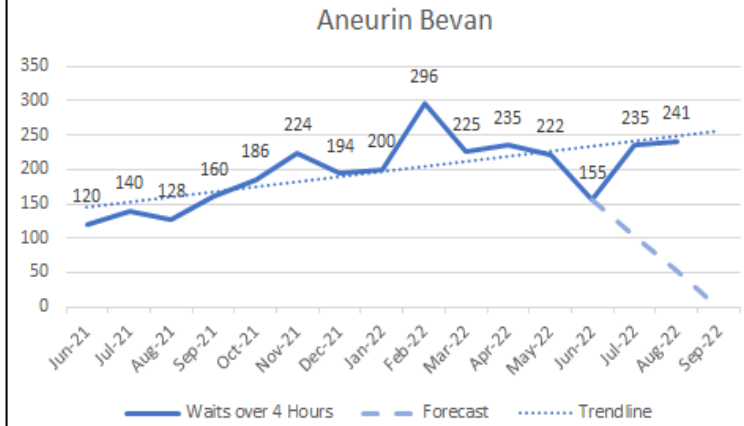
Target Failure Assurance

- Over 9% of people waiting 12+ hours at ED across ABUHB, with 19% of people waiting 12+ hours at ED in the Grange in August. A total of 1437 patients were waiting in ED over 12 hours with all of these at the Grange site.
- These high numbers remain a concern and need to understand HB recovery plan.
- Impact can be seen in ambulance amber response times which have increased considerably to a mean of 2hrs 28 mins in September. This was 1hr 30 mins in July 2022.

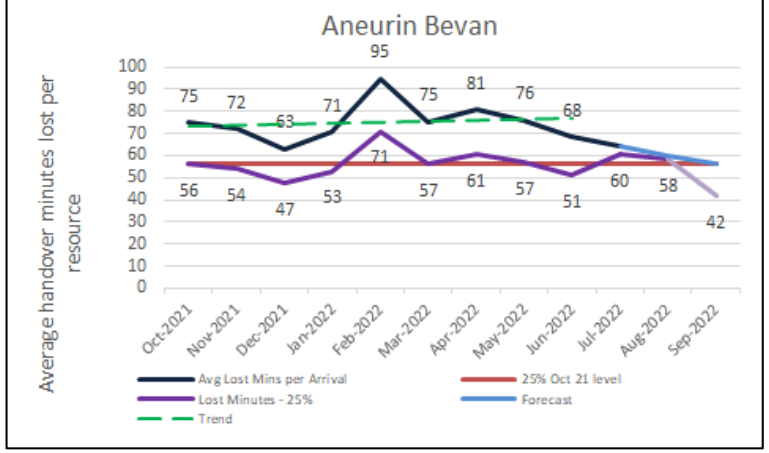


Urgent and Emergency Care

Wait over 4 Hours Trajectory (12 month)



Ambulance Handover Trajectory (Monthly)



The graph to the left shows the current level of ambulance waiting outside the Emergency Departments over 4-hours.

Based on the previous data from June 2021 the current trendline is showing an upwards trend.

After some initial improvements this has returned to a deteriorating trend.

Reduction Scale: 241

July – August 2022: 49.8% (122)
August – September 2022: 100% (0)

The graph to the left shows in red a 25% reduction based on a baseline of 80 minute lost per arrival in October 2021.

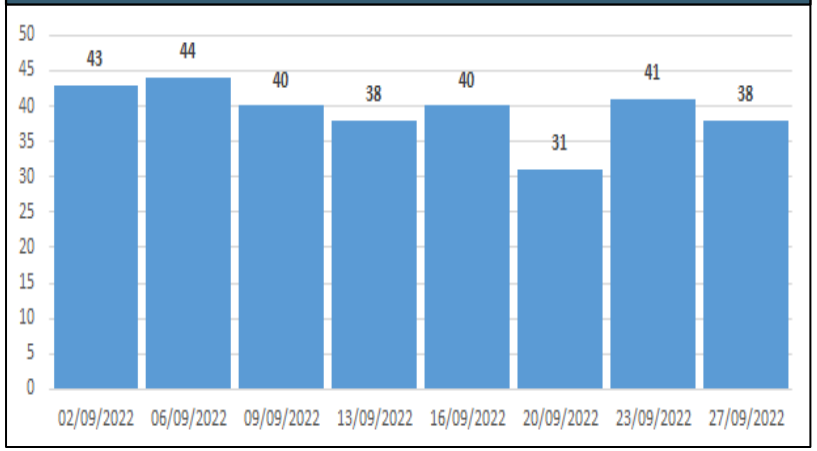
The dark blue line depicts the actual reported lost minutes or arrival reported by the Welsh Ambulance Service NHS Trust from October 2021 to June 2021.

The light blue line for July to September 2022 is a forecasted position to bring it to or below the original October 2021 baseline.

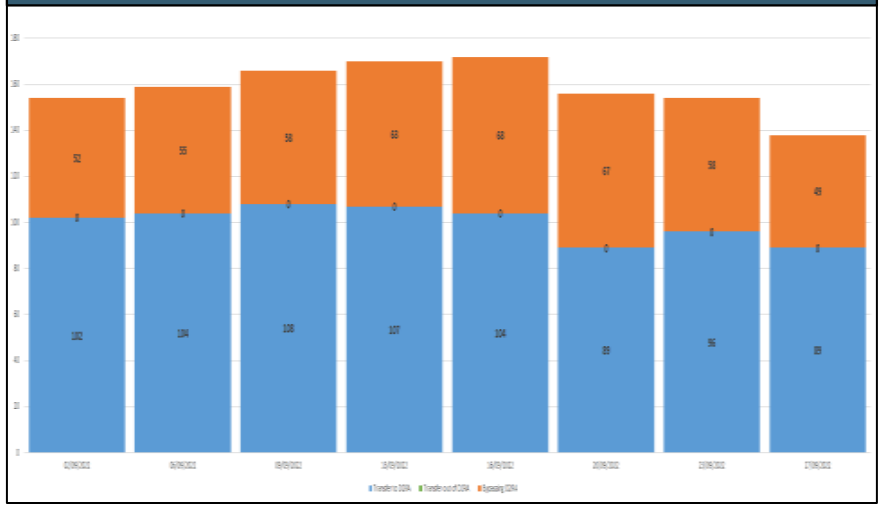
The middle purple line depicts the actual reported lost hours with a 25% reduction applied. The light purple line is a forecasted reduction for July to September 2022 to bring it to or below the original October 2021 baseline.

Pathways of Care Delays

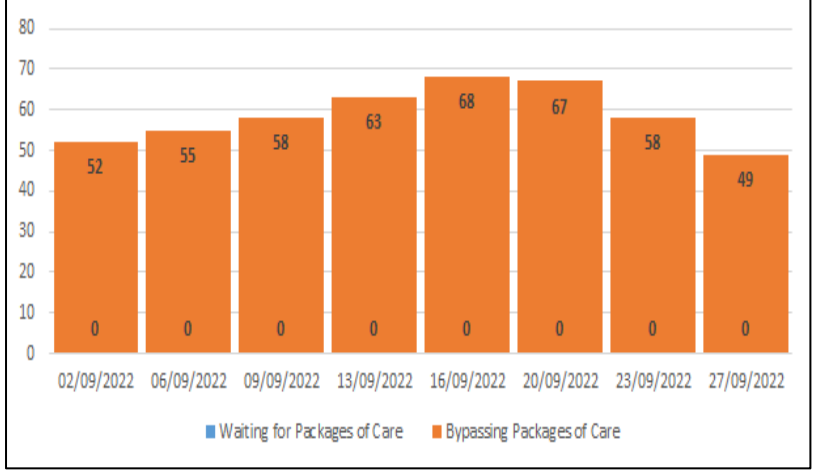
Number of patients waiting for discharge on Pathway 2 (to own home)



Total number of patients awaiting next stage of care

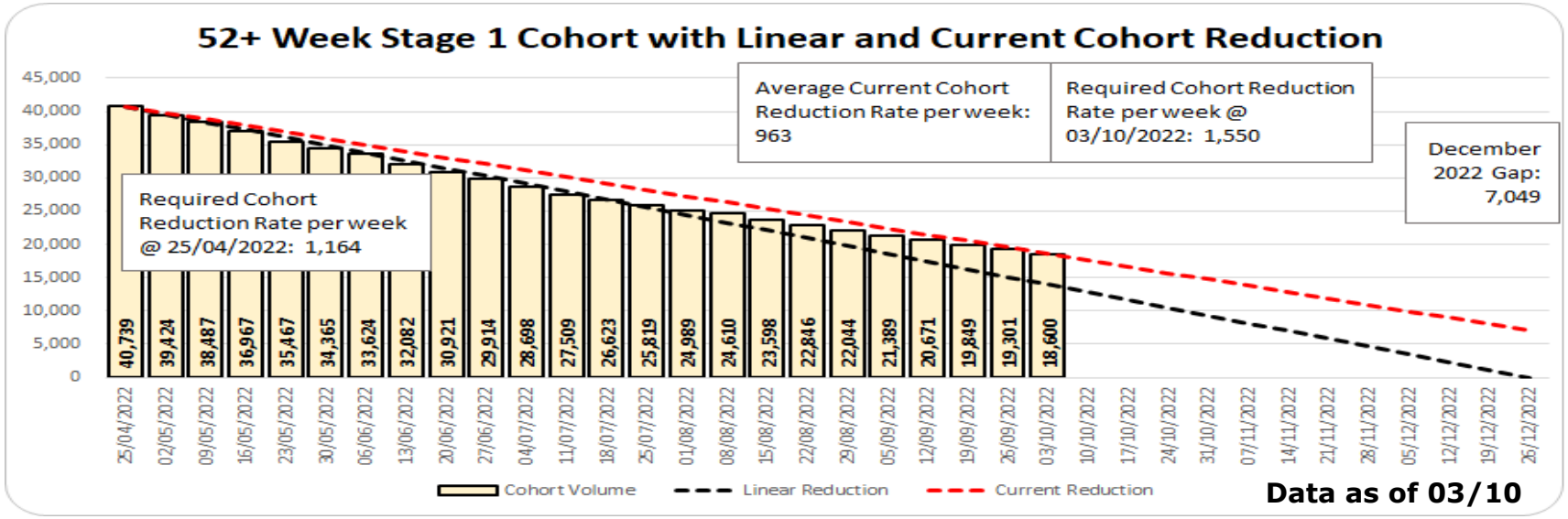


Number of people waiting for packages of care



- There has been a slight overall reduction in people awaiting next phase of care, with the number reducing from around 160 to around 140 over the month.
- There are currently no people reported as requiring a permanent care home placement, suggesting that the use of pathway 3 is in line with D2RA principles.
- There are a proportion of people waiting for ongoing domiciliary care, which is outside of D2RA process and reflected as such.

Planned Care Recovery – 52 Week Outpatient Milestone



52 week forecast has worsened to 7,049 overall for December 2022. Revised trajectories are being modelled by ABUHB and will be shared with DU.

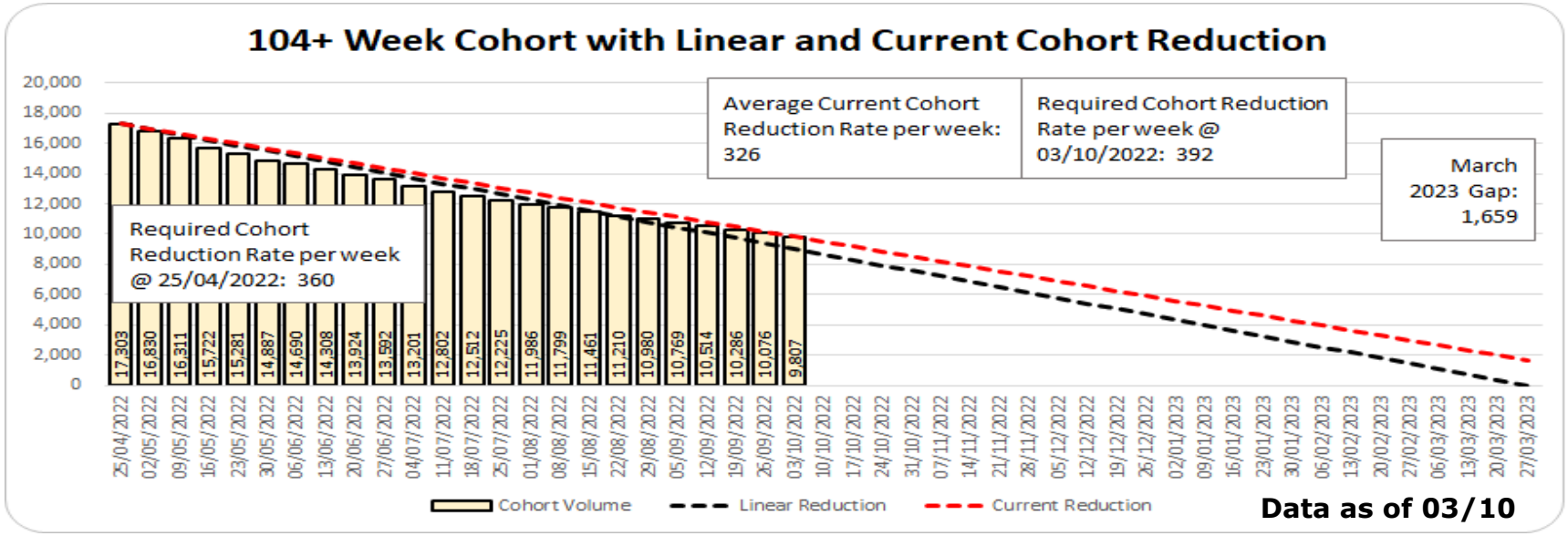
13% of the 52 week OP cohort are classified as clinically urgent.

The greatest volumes of patients by specialty within this cohort are:

ENT = 3,645
Orthopaedics = 3,233
Ophthalmology = 2,470
Urology = 1,090

Other specialties are expected to achieve the 52 week milestone.

Planned Care Recovery – 104 Week Wait (All Stages) Milestone



104 week forecast has worsened to 1,659 overall for December 2022. Revised trajectories are being modelled by ABUHB and will be shared with DU.

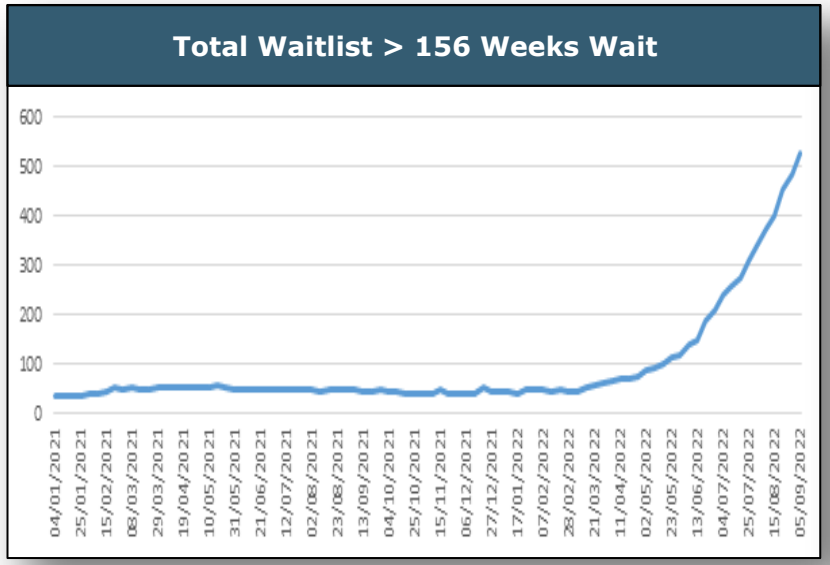
104 Waiting list has remained fairly static throughout August and September, however good progress was made with Ophthalmology

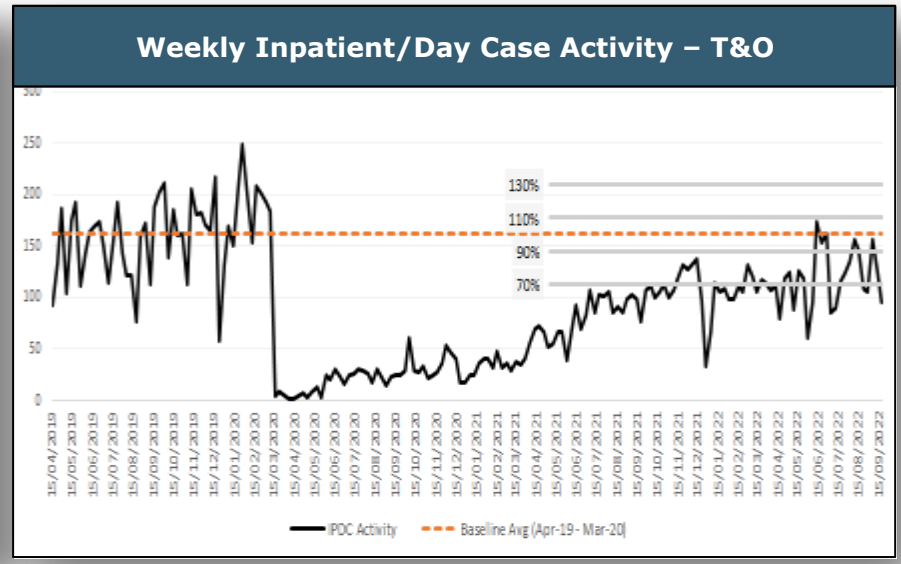
17% of the 104 week cohort are classified as clinically urgent

Most challenged areas:

- Orthopaedics Stage 1 & Stage 4
- ENT Stage 1 & Stage 4

Planned Care Recovery – >156 Week Wait Current Position





Challenge for ABUHB is to eliminate increasing Orthopaedic waits to improve the 156+ week position as it continues to rise. 12% of patients in this cohort classified as clinically urgent.

485 patients at stage 4 awaiting treatment, of which 406 are in Orthopaedics.

Activity data up until and including the w/c 19/09 shows an average activity of 76% over the previous 13 weeks vs pre pandemic activity.

HB has the potential to eliminate 156 week waits by March 2023, however subspecialty case mix is cited as a barrier to achieving this.

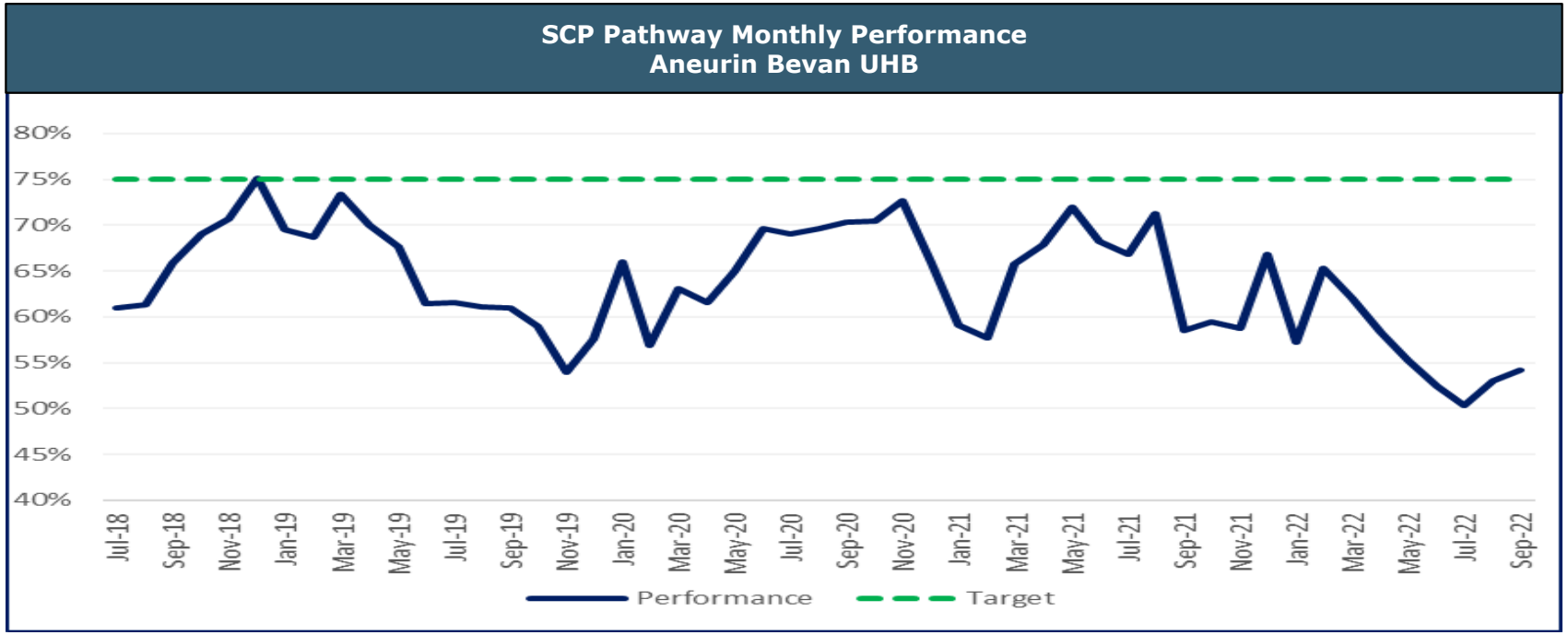
Planned Care Look Forward

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Number of patients waiting over 52 weeks for a new outpatient appointment	9,700	9,579	9,380	9,200	9,000	9,000	9,100	9,200	9,300	9,300	9,300	9,300

	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Number of patient wating more than 104 weeks for treatment	6,514	6,029	5,813	4,485	3,962	3,618	3,251	2,899	2,719	2,222	2,059	2,383

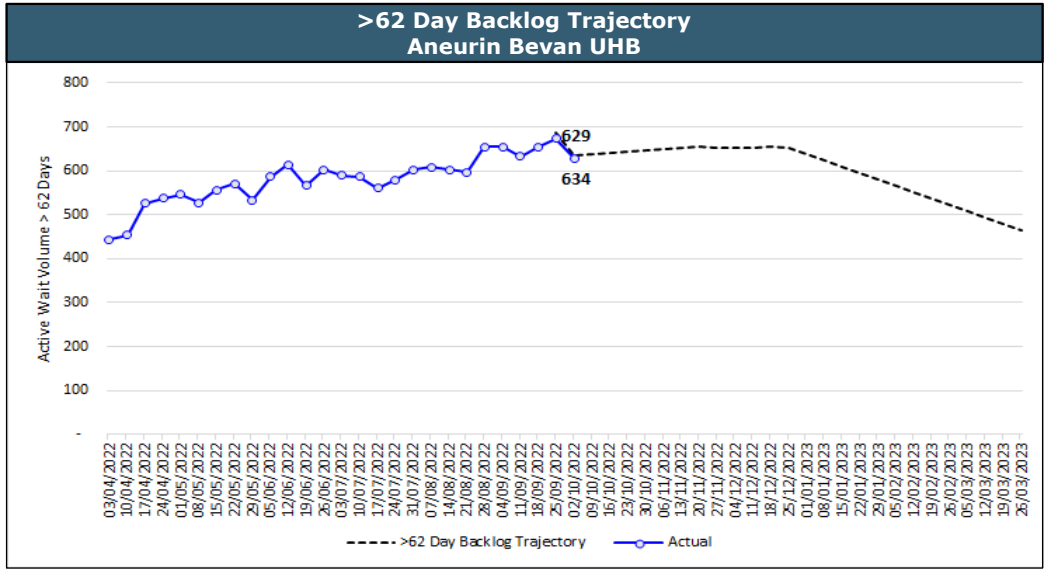
— Outpatient programme in place with plans in all specialties
— Roll out of SOS and PIFU Programmes
— All patients being contacted and validated
— Maintaining profile but risks in specific specialties
— Progress in clearing longest waits for treatments
— Remodelled theatre utilisation and implementing programme to create additional sessions
— Ambulatory Models to protect capacity
— Regional Programme in Place – taking forward Ophthalmology, Orthopaedics and Diagnostics

Cancer – 62 day Performance

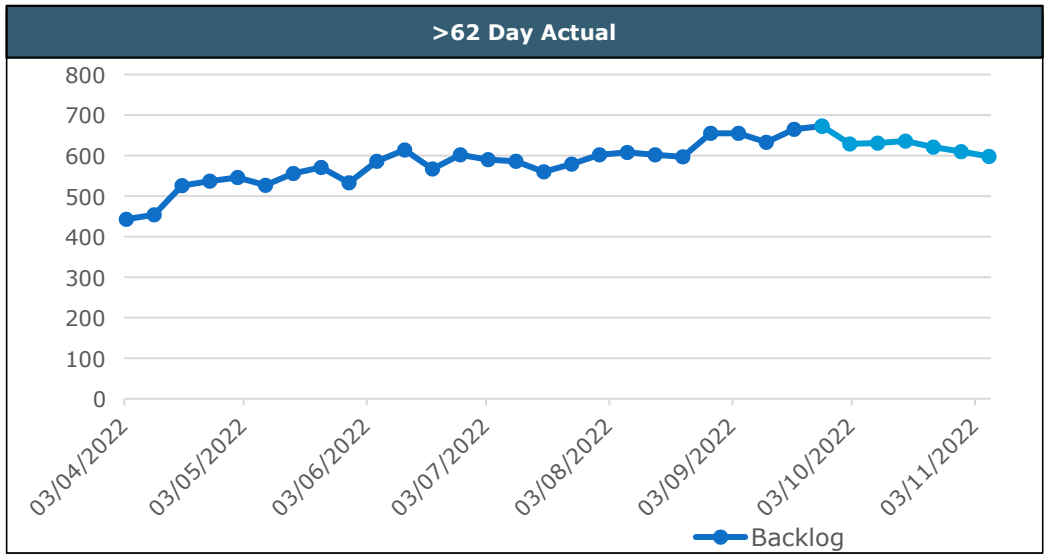


- Performance is on a 3 month improving trajectory. October is anticipate to be another small improvement.
- To achieve 75% still requires a 45% reduction in breach numbers.
- WG have dictated that reduction in cancer backlog is the top priority. This is the focus of all tumour sites which will naturally lead to an improvement in performance compliance.

Cancer – Backlog Recovery

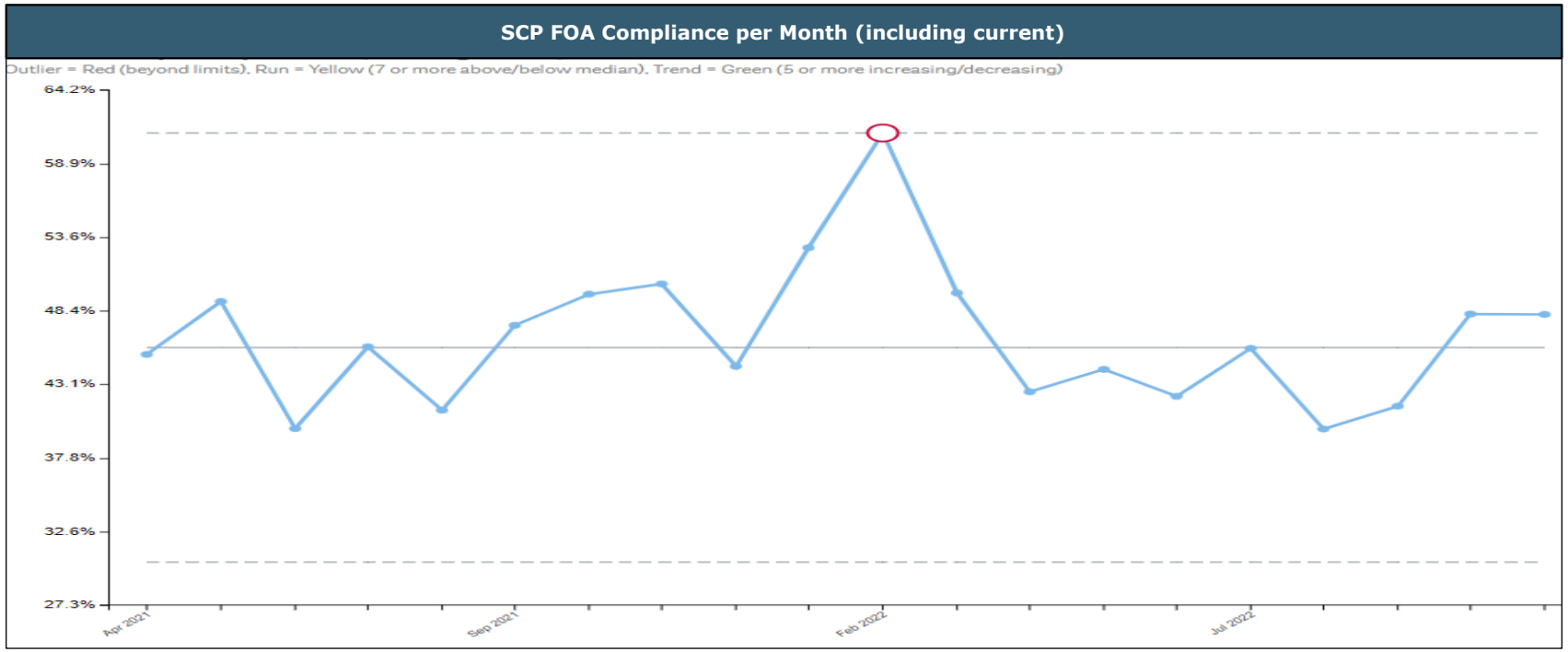


The recovery forecast presented at cancer summit projected a plateauing backlog until January when a reduction is anticipate.



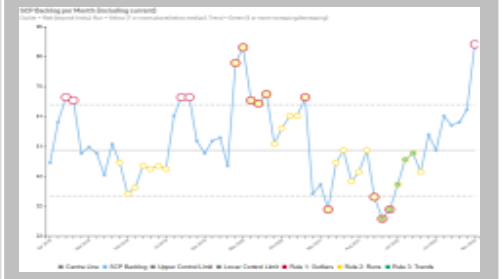
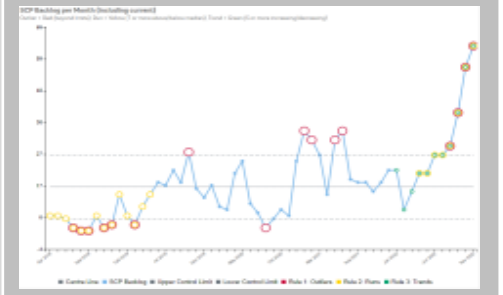
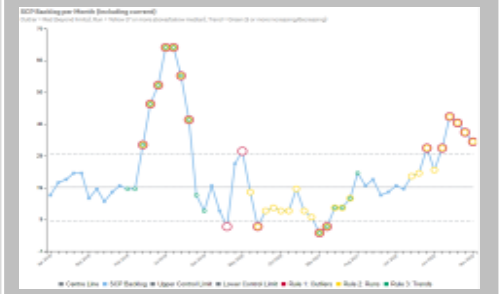
Current backlog figures suggest we are ahead of forecast with a slowly reducing backlog. Further reduction is at risk from Gynae and Breast.

Cancer Recovery Assumptions



- The backlog recovery has been modelled on improved access to first appointment.
- The forecasting used an assumption that 75% of patients would be seen within 14 days by the end of November.
- Tumour sites have been supported using new demand and capacity functions to identify the additional capacity needed to achieve and maintain 14 days.
- Whilst early improvements were seen in October, November improvement has stalled due to annual leave, high referral rates and staffing challenges.

Recovery Challenges

Site	Challenge	Recovery forecast	
Gynaecology	Time to first appointment – additional capacity was delayed due to pay dispute.	Additional capacity has now been scheduled in November and waiting times are starting to come down. 14 day anticipated to be achieved by the new year. Backlog to reduce by February/March.	
Breast	Radiologist availability restricting diagnostic clinic capacity.	Additional Radiologist commencing in January with further mammographer in Feb/Mar. Performance anticipated to worsen through December with improvements seen in February.	
Dermatology	Pathology turnaround & delays to first clinic	Pathology outsourcing currently benefiting routine backlog. Unlikely to improve USC until at least Jan. Further reduction of waiting times to first biopsy being prioritised to mitigate pathology waits	

Questions

Aneurin Bevan University Health Board

Assurance Report on Contractual Arrangements for WAST Inter-Site Transfers

Executive Summary

The Welsh Ambulance Services NHS Trust (WAST) are commissioned to provide an Inter-Site transfer model to step-up emergency and deteriorating patients from the eLGH sites for specialist or critical care, and step-down patients for lower acuity ongoing care. This went live in November 2020 with the value of the service level agreement in year 1 being £4.4 million.

From a commissioning perspective, the provision of ambulances (including number and clinical skill set) for specific Inter-Site transfers to support the Clinical Futures Model is:

Vehicle Type	Skill Set	Number of Ambulances	Hours of Operation
Transfer Practitioner	Transfer Practitioner	1	24/7
999/EMS	Paramedic/Technician	1	12/7
Urgent Care	Urgent Care	9	24/7

Initial activity modelling suggested that the Inter-Site vehicles would undertake a total of 72 transfers per day (33 step-up and 39 step-down); daily activity has been lower than this. In summary, the capacity modelled for Inter-Site transfer activity is within the parameters of the resources available on a daily basis at an average of 38 per day (step-up and step-down combined) during the last three months. To summarise, the skill set and number of ambulances available has been and remains clinically safe to undertake the step-up and step-down transfers across the Health Board's sites.

It was acknowledged from an early point that WAST's 999/urgent triage system would not provide the detailed assessment of categories of transfer for the Inter-Site system. As such, Clinical colleagues from the Health Board and WAST designed a specific Adult Transfer Triage Tool (appendix 1) which assesses the clinical observations of a patient and identifies which level of clinician is required to safely transport the patient. This document was formally agreed and signed off by the Medical Directors of the Health Board and WAST respectively. This provides assurance that the Flow Centre is requesting the correct level of clinician to safely transfer our step-up and step-down patients appropriately.

The Inter-Site transfer model was jointly reviewed after six months by the Health Board and WAST which was facilitated by colleagues in the Emergency Ambulance Services

Committee (EASC) with a formal report submitted to both organisational Executive Teams (appendix 2).

The key findings did identify that:

'A safe and high quality patient service has been delivered to date with minimal, if any, harm to patients reported.'

The Health Board now has a triumvirate of Senior Managers and Clinicians supporting to ensure there is a robust challenge to the review working group which is now ongoing and implementing the recommendations following the evaluation. The Associate Director of Operations, Head of Transformational Change (Facilities) and a Consultant Anaesthetist provide the expertise for the Health Board on this group.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	✓

Executive Sponsor: Leanne Watkins, Director of Operations

Report Author: Steve Bonser, Head of Transformational Change (Facilities)

Report Received consideration and supported by :

Executive Team		**Committee of the Board [Committee Name]**	

Date of the Report: October 2022

Supplementary Papers Attached:
Appendix One: Adult Triage Transfer Tool
Appendix Two: Inter Hospital Transfer Service Evaluation
Appendix Three: Tier 2 Transport Services Performance & Monitoring Group ToR

Purpose of the Report

Provide the Patient Quality, Safety and Operational Committee (PQSOC) with an overview of how the Health Board's contractual arrangements for WAST Inter-Site Transfers operate. This report will identify the current position with the Inter-Site Transfer model across the Health Board's operational footprint.

Background and Context

Informal concerns have been raised about the effectiveness of the Inter-Site model and the mechanism to monitor the contractual requirements and activity of the model.

WAST provide monthly reporting on the key performance indicators with the Health Board's Putting Things Right team providing the qualitative aspect via a report on Datix submissions.

Assessment and Conclusion

Following extensive discussions with WAST and EASC, WAST were commissioned to provide an Inter-Site transfer model to step-up emergency and deteriorating patients from the eLGH sites for specialist or critical care, and step-down patients for lower acuity ongoing care. This went live in November 2020 with the value of the service level agreement in year 1 being £4.4 million.

There was a six-month review undertaken of the Inter-Site model which was facilitated by EASC with Health Board and WAST collaboration as part of the original SLA. The Health Board now has a triumvirate of Senior Managers and Clinicians supporting to ensure there is a robust challenge to the review working group which is now implementing the recommendations following the review. The Associate Director of Operations, Head of Transformational Change (Facilities) and a Consultant Anaesthetist provide the expertise on this group.

It should be noted that the original SLA has expired and a revised SLA is now required and is being drafted as part of a working group associated with implementing the recommendations of the six-month review. To ensure continuity, the Chief Ambulance Services Commissioner for EASC proposed that the existing SLA remain in place until the revised one is approved by the relative Executive Teams. Both Executive Teams agreed to this and work is ongoing to refresh the SLA ensuring that the Health Board's requirements are met.

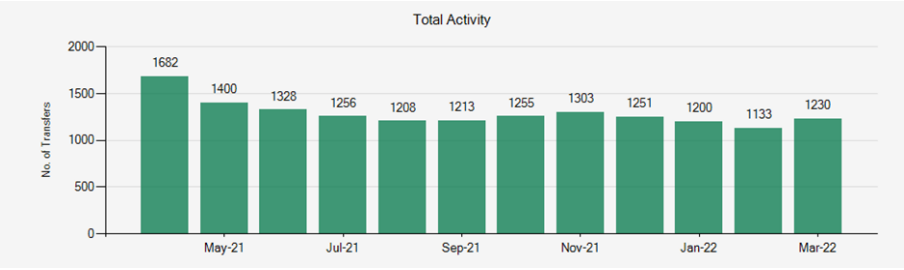
<u>Inter-Site Transfers</u>

From a commissioning perspective, the provision of ambulances for specific Inter-Site transfers to support the Clinical Futures Model is:

Vehicle Type	Skill Set	Number of Ambulances	Hours of Operation
Transfer Practitioner	Transfer Practitioner	1	24/7
999/EMS	Paramedic/Technician	1	12/7
Urgent Care	Urgent Care	9	24/7

There were a total of 15,498 Inter-Site transfers, 999 community responses and discharges undertaken by the Inter-Site transfer vehicles during the period April 2021 – March 2022. Initial modelling suggested that the Inter-Site vehicles would undertake a total of 72 transfers per day (33 step-up and 39 step-down). It should be noted that all activity has been managed within the original scope.

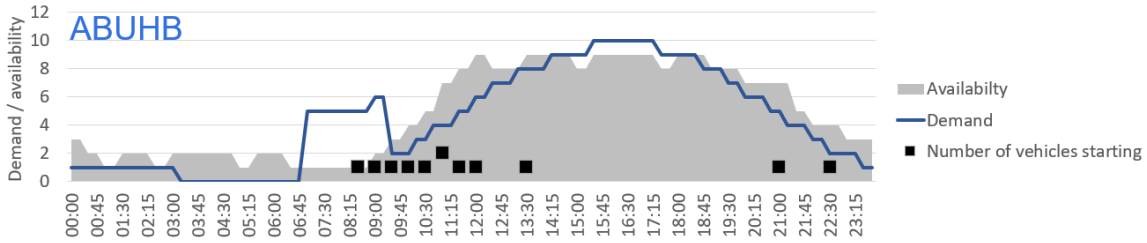
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Total Activity	1682	1400	1328	1256	1208	1213	1255	1303	1251	1200	1133	1230	15459



Activity Type	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Step Up	253	232	239	260	231	251	258	265	229	222	185	261	2886
Step Down	1100	886	831	745	719	712	717	776	733	627	645	653	9144
Step Across	95	77	50	56	47	68	128	89	106	166	131	85	1098
Discharge	198	170	150	142	141	133	123	126	131	130	133	153	1730
Community	36	35	58	53	70	49	29	47	52	55	39	78	601

Demand & Capacity

Further analysis of the Health Board's demand profile for Inter-Site transfers was undertaken by ABCi in March 2022 following concerns raised within the Health Board of the ability of the WAST Inter-Site Ambulance roster being able to match the required demand pattern. A collaborative approach was taken and as a consequence, WAST are adjusting their rosters to meet the required demand pattern as below. This will take effect from 3rd October 2022.



ABCi and the Health Board's leads for Inter-Site are confident that this roster will maximise efficiencies of the available vehicles and best meet the demand requirements. It should be noted that the Transfer Practitioner vehicle which operates 24/7 and the 999/EMS ambulance which operates 12/7 are not managed within the main Inter-Site roster but do assist with the demand when patient acuity dictates.

Inter-Site Transfer Triage

It was acknowledged from an early point that WAST's 999/urgent triage system would not provide the detailed assessment of categories of transfer for the Inter-Site system. As such, Clinical colleagues from the Health Board and WAST designed a specific Adult Transfer Triage Tool. This clinically focussed triage tool assesses the clinical observations of a patient and identifies which level of clinician is required to safely transport the patient. For robust governance, this document was formally agreed and signed off by the Medical Directors of the Health Board and WAST.

Deviation from the Inter-Site Model

There has been some deviation from the commissioned Inter-Site transfer model which has been instigated by the Health Board due to operational necessity. This was in part, due to the ongoing COVID-19 pandemic and the effect it had on WAST's ability to convey patients due to the restrictions in place due to nosocomial transmission.

Due to this and the way in which patient flow across our sites operates, the Health Board requested that a cohort of patients were classified as 'step-across' and were moved between other Health Board sites (i.e., County to YAB) and some discharges, primarily from GUH were facilitated to maintain and assist patient flow across a 24/7 period.

There were 2828 step-across transfers and discharges undertaken by the Inter-Site transfer ambulances in 2021-22; 18% of the total conveyances of the entire model.

Ongoing concerns continue to be raised surrounding the inappropriate use of the Inter-Site vehicles by WAST. This includes:

- Deploying to amber 1 and green category 999 community calls; the formal agreement is that they should only be deployed to red category 999 community calls.
- Utilisation as a patient conveying resource; the formal agreement is that they should be used in a first responder capacity only and not convey.
- Utilisation and deploying to 999 community calls in neighbouring Health Board areas.
- Redeploying to a red category 999 community call when already deployed to a step-up transfer within the Health Board's operational area.

Dialogue is ongoing between the Health Board and WAST over the aforementioned concerns with an expectation that this will be resolved as part of the renegotiated SLA.

Executive support is also being provided in a consistent manner by the Director of Operations, Medical Director and Chief Executive to ensure any escalation of matters that cannot be resolved are supported at an Executive level.

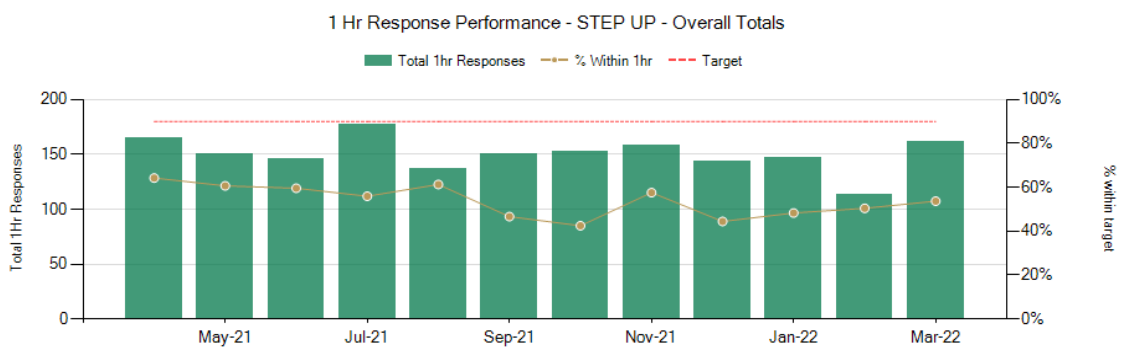
<u>Inter-Site Performance</u>

One hour step-up performance from our eLGHs was a significant concern when the Inter-Site model was being developed. This cohort of patients are generally the deteriorating patient on wards or those that will inappropriately attend an eLGH and be unable to be cared for at the required level.

One hour step-up performance for the last financial year has been reported as 53.9% vs. the 90% standard as per the agreed KPI.

Response Performance - 1 Hour - Step Up

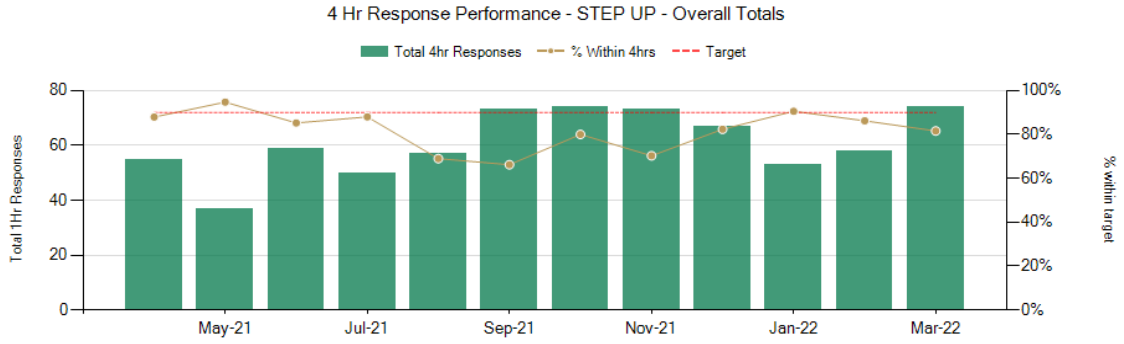
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Transfer Ambulance													
1hr Responses	92	79	67	118	78	93	72	83	83	84	64	105	1018
% within Target	*73.9%*	*77.2%*	*73.1%*	*66.9%*	*76.9%*	*51.6%*	*59.7%*	*66.3%*	*47.0%*	*44.0%*	*59.4%*	*61.9%*	*63.1%*
Emergency Ambulance													
1hr Responses	42	33	44	44	36	34	44	39	39	34	32	27	448
% within Target	*33.3%*	*15.2%*	*34.1%*	*20.5%*	*22.2%*	*8.8%*	*6.8%*	*20.5%*	*17.9%*	*44.1%*	*12.5%*	*14.8%*	*21.2%*
Transfer Practitioner													
1hr Responses	30	37	35	12	22	22	32	29	21	28	15	30	313
% within Target	*76.7%*	*67.6%*	*65.7%*	*75.0%*	*68.2%*	*81.8%*	*56.3%*	*82.8%*	*81.0%*	*67.9%*	*93.3%*	*60.0%*	*71.2%*
Other													
1hr Responses	1	1		3	1	1	5	7	1	1	2		23
% within Target	*100.0%*	*0.0%*	*#DIV/0!*	*66.7%*	*100.0%*	*100.0%*	*20.0%*	*57.1%*	*100.0%*	*0.0%*	*50.0%*	*#DIV/0!*	*52.2%*
All Resources													
1hr Responses	165	150	146	177	137	150	153	158	144	147	113	162	1802
% within Target	*64.2%*	*60.7%*	*59.6%*	*55.9%*	*61.3%*	*46.7%*	*42.5%*	*57.6%*	*44.4%*	*48.3%*	*50.4%*	*53.7%*	*53.9%*



Four-hour step-up performance for the last financial year has been reported as 80.8% vs. the 90% standard as per the agreed KPI.

Response Performance - 4 Hour - Step Up

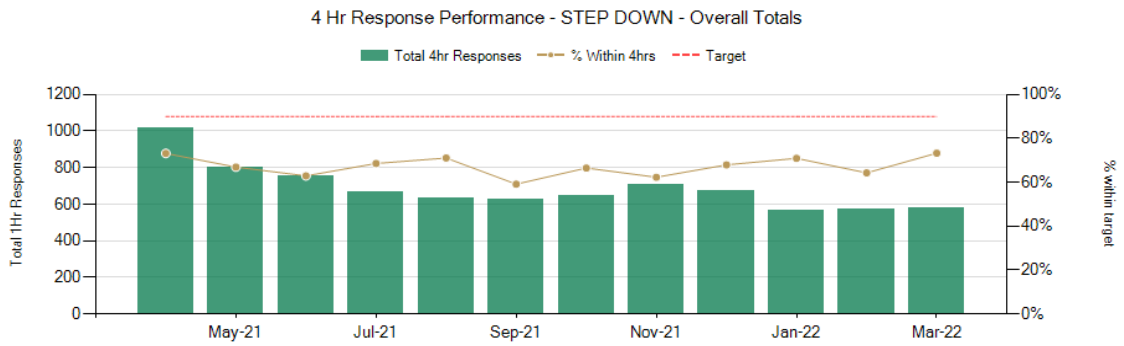
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Transfer Ambulance													
4hr Responses	47	33	49	45	51	69	70	61	61	44	56	67	653
% within Target	93.6%	97.0%	85.7%	86.7%	68.6%	68.1%	80.0%	70.5%	83.6%	90.9%	85.7%	85.1%	81.8%
Transfer Practitioner													
4hr Responses		2	6		3			7	1	4			23
% within Target	#DIV/0!	100.0%	100.0%	#DIV/0!	66.7%	#DIV/0!	#DIV/0!	57.1%	0.0%	75.0%	#DIV/0!	#DIV/0!	73.9%
NEPTS Resource													
4hr Responses	8	2	4	5	3	4	4	5	5	5	2	7	54
% within Target	63.6%	66.7%	66.7%	100.0%	75.0%	40.0%	80.0%	83.3%	83.3%	100.0%	100.0%	55.6%	73.1%
All Responses													
4hr Responses	55	37	59	50	57	73	74	73	67	53	58	74	730
% within Target	87.9%	94.7%	85.2%	88.0%	69.0%	66.2%	80.0%	70.3%	82.4%	90.6%	86.2%	81.6%	80.8%



Four-hour step-down transfers were planned to be generated from GUH back to our eLGHs. Four-hour step-down performance for the last financial year has been reported as 67.1% vs. the 90% standard as per the agreed KPI.

Response Performance - 4 Hour - Step Down

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	TOTAL
Transfer Ambulance													
4hr Responses	409	303	265	190	176	207	191	218	209	171	219	202	2760
% within Target	78.0%	84.5%	69.8%	72.1%	74.4%	56.0%	66.0%	61.0%	60.3%	71.9%	62.1%	75.2%	70.3%
Transfer Practitioner													
4hr Responses	12	19	11		7	6	1	24	7	12			99
% within Target	100.0%	100.0%	63.6%	#DIV/0!	42.9%	100.0%	100.0%	62.5%	71.4%	66.7%	#DIV/0!	#DIV/0!	76.8%
Emergency Ambulance													
4hr Responses	2	1		3		2	2	1	1	1	1		14
% within Target	0.0%	100.0%	#DIV/0!	100.0%	#DIV/0!	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	71.4%
NEPTS Resource													
4hr Responses	595	478	478	472	451	411	451	462	458	380	356	377	5369
% within Target	69.9%	58.4%	60.6%	67.5%	70.5%	60.0%	66.5%	62.6%	70.4%	70.7%	65.1%	72.5%	65.9%
All Responses													
4hr Responses	1018	801	754	665	634	626	645	705	675	564	576	579	8242
% within Target	73.2%	67.0%	63.0%	68.6%	71.1%	59.2%	66.5%	62.3%	68.0%	70.9%	64.3%	73.3%	67.1%



Hours lost (calculated from notification to handover within 15 minutes of arrival at hospital with a standard of 100% within 15 minutes) during 2021-2022 were shown as 2274.44 lost hours for the inter-site transfer vehicles; an average of 6.2 lost hours per day.

Monitoring Performance & Contract Requirements

Inter-Site performance is monitored from both a quantitative and qualitative aspect. From a quantitative perspective, WAST provide a monthly report which shows activity and performance for each key performance indicator as agreed as part of the SLA and service specification. This is collated into a monthly report that is shared with the Director of Operations and the Associate Director of Operations. It is also presented at the Quality and Patient Safety Operational Group (QPSOG) on a bi-monthly basis for assurance of monitoring and transparency.

The Health Board now has a triumvirate of Senior Managers and Clinicians supporting the monitoring of the Inter-Site transport model to ensure there is a robust challenge to the review and working group which is now ongoing and implementing the recommendations following the evaluation. The Associate Director of Operations, Head of Transformational Change (Facilities) and a Consultant Anaesthetist provide the expertise for the Health Board on this group.

Incident Reporting

From an incident reporting perspective, the Putting Things Right team have confirmed that there have been zero Serious Incidents reported that refer to the Inter-Site Transfer model.

During the period April – September 2022, there were three Datix submissions which relate to the Inter-Site Model. The first, in April relates to the triage, pre-transport of a patient, the second in May related to a conflict in deploying the Transfer Practitioner vehicle and the final one in September related to the unavailability of resources due to existing commitments on other calls. These have also been discussed with WAST colleagues outside of the Datix process as part of the ongoing liaison with respect to the contract.

A monthly report is also provided by the Health Board's Putting Things Right team which highlights any Datix submissions that relate to ambulance activity and generally from a qualitative perspective. This is reviewed monthly by the Head of Transformational Change (Facilities) and discussed at the monthly Tier 2 Ambulance Services Monitoring Group meeting between WAST and a cross-section of colleagues from across the Health Board's operational Divisions. The Tier 2 meeting has an agreed Terms of Reference (appendix 3)

that was agreed by the Executive Team and is reviewed annually to ensure it remains fit for purpose.

This meeting is minuted with a clear action log that ensures any required actions are allocated and subsequently monitored by the group and chair. Whilst attendance at this key meeting has been sporadic for some attendees, the focus of the group has remained within the scope of the Terms of Reference providing a robust challenge where required.

Patient Experience

The Health Board, led by the Assistant Director of Nursing (Corporate Services) and supported by the Head of Transformational Change and other Health Board colleagues have been working with WAST since July 2022 to support the conducting of a patient experience survey for the Inter-Site Transfer model.

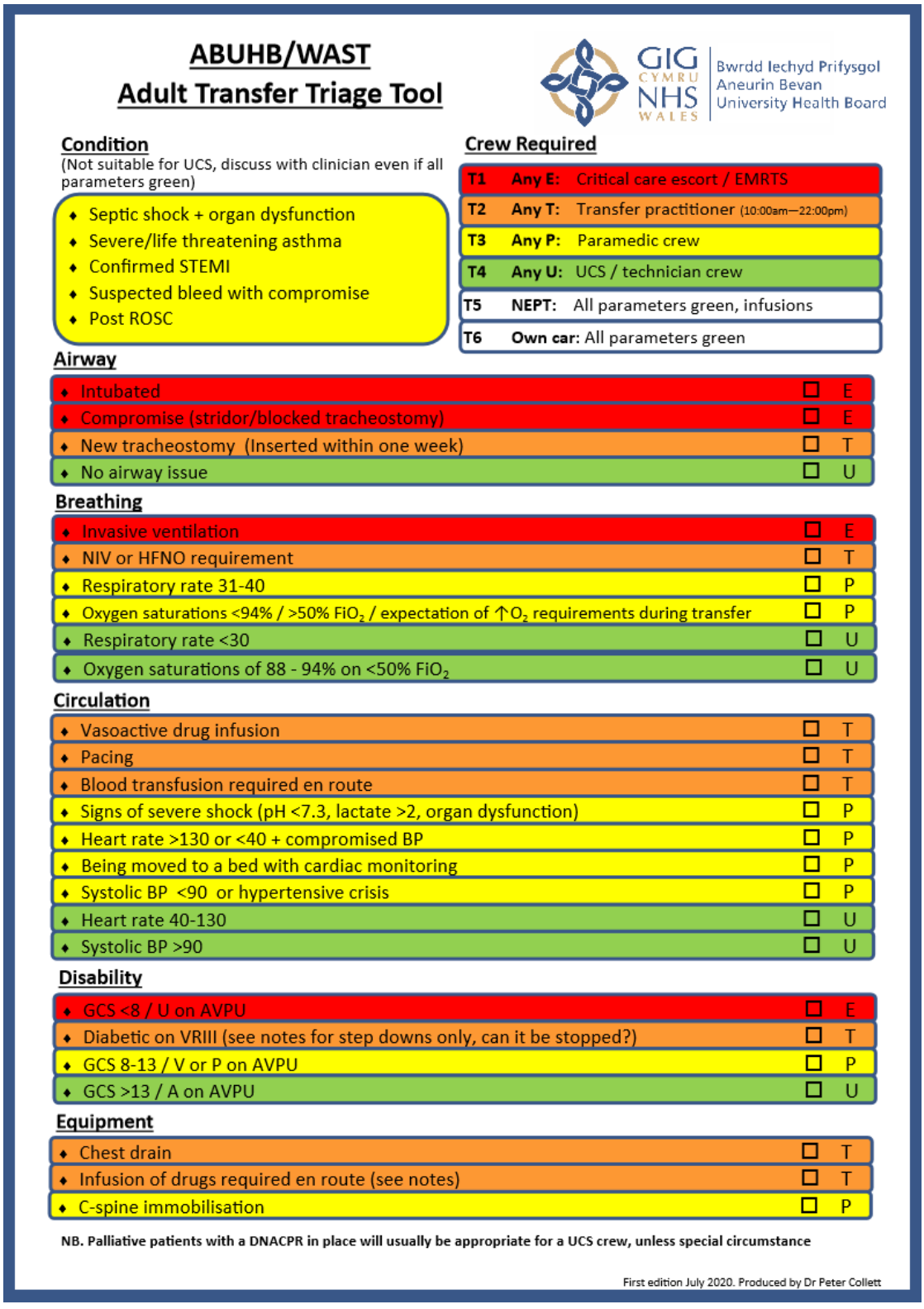
An initial meeting was held in September 2022 with a further meeting planned for October to finalise the scope and survey with a planned implementation in November. The CHC has also been informed of this approach and are willing to support both organisations in ensuring this does capture the patient experience accurately and concisely.

Recommendation
The Committee is asked to note the contents of the paper for assurance purposes.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	All schemes referred to in the report have bespoke financial support and governance.
Quality, Safety and Patient Experience Assessment	This highlight report is focussed on improving performance, quality and safety for ambulance service users.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Supports the Clinical Futures Programme. Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement – Many quality improvement initiatives, including transport provision are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety, including utilisation of ambulances based transport services will prevent patient harm within our services.
Glossary of New Terms	DAG – Delivery Assurance Group EASC – Emergency Ambulance Services Committee EMS – Emergency Medical Services NEPTS – Non-Emergency Patient Transport Service
Public Interest	Report has been written for the public domain.

Appendix 1



ABUHB/WAST
Adult Transfer Triage Tool

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Condition
(Not suitable for UCS, discuss with clinician even if all parameters green)

- Septic shock + organ dysfunction
- Severe/life threatening asthma
- Confirmed STEMI
- Suspected bleed with compromise
- Post ROSC

Crew Required

T1	**Any E:**	Critical care escort / EMRTS
T2	**Any T:**	Transfer practitioner (10:00am—22:00pm)
T3	**Any P:**	Paramedic crew
T4	**Any U:**	UCS / technician crew
T5	**NEPT:**	All parameters green, infusions
T6	**Own car:**	All parameters green

Airway

Intubated	☐ E
Compromise (stridor/blocked tracheostomy)	☐ E
New tracheostomy (Inserted within one week)	☐ T
No airway issue	☐ U

Breathing

Invasive ventilation	☐ E
NIV or HFNO requirement	☐ T
Respiratory rate 31-40	☐ P
Oxygen saturations <94% / >50% FiO_2 / expectation of ↑O_2 requirements during transfer	☐ P
Respiratory rate <30	☐ U
Oxygen saturations of 88 - 94% on <50% FiO_2	☐ U

Circulation

Vasoactive drug infusion	☐ T
Pacing	☐ T
Blood transfusion required en route	☐ T
Signs of severe shock (pH <7.3, lactate >2, organ dysfunction)	☐ P
Heart rate >130 or <40 + compromised BP	☐ P
Being moved to a bed with cardiac monitoring	☐ P
Systolic BP <90 or hypertensive crisis	☐ P
Heart rate 40-130	☐ U
Systolic BP >90	☐ U

Disability

GCS <8 / U on AVPU	☐ E
Diabetic on VRIII (see notes for step downs only, can it be stopped?)	☐ T
GCS 8-13 / V or P on AVPU	☐ P
GCS >13 / A on AVPU	☐ U

Equipment

Chest drain	☐ T
Infusion of drugs required en route (see notes)	☐ T
C-spine immobilisation	☐ P

NB. Palliative patients with a DNACPR in place will usually be appropriate for a UCS crew, unless special circumstance

First edition July 2020. Produced by Dr Peter Collett

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

THE GRANGE UNIVERSITY HOSPITAL
INTER HOSPITAL TRANSFER SERVICE EVALUATION

PREPARED BY: PHILL TAYLOR - HEAD OF COMMISSIONING AND PERFORMANCE
JULY 2021

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In November 2020, Aneurin Bevan University Health Board (ABUHB) opened the Grange University Hospital (GUH) as part of the health board's future health care model "Clinical Futures". GUH would provide centralised specialist and critical care services for the population of ABUHB, with lower acuity care, including minor injury and assessment units provided by three enhanced local general hospitals (ELGH), supported by a network of community hospitals.

Centralising services required a safe, reliable and responsive transport system to "step up" emergency and deteriorating patients from ELGH sites for specialist or critical care and "step down" patients for lower acuity ongoing care. The ability to transfer patients between sites when it is needed and ensure patient flow, are critical success factors for the new Clinical Futures Model of care.

In order to support the delivery of the Clinical Futures Model, the Welsh Ambulance Services NHS Trust (WAST), via the Chief Ambulance Service Commissioner (CASC) was commissioned by ABUHB to provide an Inter Hospital Transfer Service.

As part of the services commissioning arrangements, an evaluation of the service would be completed following the first 6 months of service delivery. The Inter Hospital Transfer Service evaluation has been undertaken by the Emergency Ambulance Services Committee (EASC) Team.

Key Findings

- Establishing the Inter Hospital Transfer Service during the Covid19 pandemic to support the advanced opening of the GUH was a significant achievement
- The overall demand for the service was significantly less than expected due to the health boards operating model having to adapt and respond to the Covid19 pandemic and current requirements of the health board's population
- The level of transfer ambulance resources were appropriate given that the service modelling was developed using higher demand profiles
- Performance measures have not been achieved due to the challenges experienced by ABUHB and WAST in responding to the requirements of the population during the Covid19 pandemic
- The Transfer Triage Tool is supported as an effective and safe tool for the clinical triaging of patients requiring inter hospital transfer
- A safe and high quality patient service has been delivered to date with minimal, if any, harm to patients reported
- Initial mechanical and build quality issues with the new transfer ambulances have been overcome
- Challenges remain with booking and communications systems which require improvements in order to make better use of the available resource, improve quality for patients and the performance of the service overall

Recommendations

Strategy / Operating Model

- Establish a forum for senior/strategic decision makers across organisations to lead on future service development
- Undertake a review of the future clinical profile of patients and service model
- Revise the overall Inter Hospital Transfer Service booking system to ensure improved efficiency
- Undertake a review of the communication processes and infrastructure across all health board and WAST systems
- Explore the expansion of the transfer practitioner role to undertake paediatric transfers
- Deliver an alternate ambulance vehicle that meets the requirements of the transfer practitioner function
- Consider options for the future accommodation of discharge activity

Workforce

- Develop an alternative solution for emergency ambulance transfers that improves timeliness of response
- Review and implement revised rosters for the transfer ambulance resources against the actual demand profile
- Explore the benefits of extending the hours of operation of the transfer practitioner resource
- Undertake an exercise to refresh all health board and WAST staff on the purpose of the Inter Hospital Transfer Service

Process

- Review opportunities to enhance the utilisation and process within the transfer & discharge lounge

Technology

- Explore the options to manage all transfer ambulance resources via one Computer aided dispatch (CAD) system

Management Information

- Explore the opportunities to enhance the level of reporting data available

PURPOSE

In November 2020, ABUHB's care system changed with the opening of the GUH and the implementation of the Clinical Futures Model.

In order to support the delivery of the Clinical Futures Model, WAST was commissioned by ABUHB to provide an Inter Hospital Transfer Service to transport patients between hospital sites.

The purpose of this evaluation was to assess the effectiveness and value for money of the GUH Inter Hospital Transfer Service.

BACKGROUND

ABUHB future health care system was due to change in March 2021. Emergency medicine and critical care along with some other specialist services including paediatrics, were to be centralised at the GUH. Three ELGHs; Royal Gwent Hospital (RGH), Nevil Hall Hospital (NHH) and Ysbyty Ystrad Fawr (YYF), would provide lower acuity care, including minor injury and assessment units, supported by a network of community hospitals.

Centralising services required a safe, reliable and responsive transport system to step up emergency and deteriorating patients from ELGH sites for specialist or critical care, and step down patients for lower acuity ongoing care. The ability to transfer patients between sites when needed and ensuring patient flow, were critical success factors for the new Clinical Futures Model of care.

In July 2019, a service model and transport specification were developed by the ABUHB.

Following the development of the service model and transport specification, ABUHB explored options for the commissioning and delivery of a dedicated inter hospital transfer service. This included an external procurement option, however following wider discussions with stakeholders, it was agreed to work with WAST to deliver the service.

Following the submission of ABUHBs inter hospital transfer requirements, WAST responded with an inter hospital transport solution (March 2020) describing four options developed using simulation software (Optima). ABUHBs inter hospital transfer requirements specified a requirement for a paramedic led blue light step up transfer service and a non-emergency patient transport services (NEPTS) led step down transfer service.

Four options proposed by the Welsh Ambulance Services NHS Trust

	Option 1	Option 2	Option 3	Option 4
	Fully ring fenced tier of additional Emergency Ambulances, staffed by Paramedics	Absorb all additional workload within the existing EMS service	Four tiered pool of ring fenced resources, (ABUHB Hybrid Model)	Some activity undertaken by EMS, and remaining activity delivered by a two tier pool of vehicles WAST Proposed Model
Vehicles / crews required				
Emergency Ambulance 24/7	6	4	3	
Unscheduled Care Service 24/7			3	3
Emergency Ambulance 12/7	6	4	4	1
Unscheduled Care Service 12/7			3	7
NEPTS 12/7			3	
Total	**12**	**7**	**16**	**11**
Workforce required				
Band 6 Paramedic	66	40	43	14
Bank 6 Emergency Medical Techician	42	26	23	2
Band 3 Unscheduled Care Service / NEPTS			48	68
Total	**108**	**66**	**114**	**84**

Note: Following the agreement of option 4, further discussions took place regarding the staff make up and service structure. A revised option 4 was delivered within the original financial envelope.

The presented options reflected ABUHBs original requirements based on a comprehensive analysis and clinical discussion on patient data. Of the four options presented to ABUHB, WASTs preferred option, was Option 4. Option 4 provided dedicated non-blue light Urgent Care Service (UCS) led step up and step down service with access to blue light paramedic resources for emergency step up transfers.

WAST presented a view that Option 4 was a more efficient, clinically appropriate, prudent, and value for money option for the ABUHBs additional transfer needs. Following wider consultation between ABUHB and WAST, Option 4 was agreed to be taken forward. This option recognised challenges with recruiting the requested numbers of paramedics and timescales associated with providing blue light driver training to new UCS staff. This option was also based on a clinical view from WAST on the transport requirements for patients and consideration of existing polices for inter hospital transfers.

During the period of design and in response to the Covid19 pandemic, the opening of the GUH was brought forward to November 2020. The advancement of the opening of the GUH was a key factor in the final design and delivery of the Inter Hospital Transfer Service.

On the 15 July 2020, ABUHB officially notified WAST that they wished to commission WAST to provide the Inter Hospital Transfer Service, Option 4. This option was agreed as being a 12-month transitionary arrangement until actual demand and resource requirements could inform future commissioning arrangements.

EVALUATION

Scope of Evaluation

The purpose of this evaluation was to assess the effectiveness and value for money of the GUH Inter Hospital Transfer Service. The evaluation would measure outcomes against the established Commissioning Agreement and Service Specification.

In addition, the evaluation will consider the delivery and effectiveness of systems that support the transfer service, including the function of the Flow Centre, Flow Desk and WASTs Ambulance Liaison Officer (ALO).

To note, the author acknowledges the role of the Flow Centre in providing a pre-hospital streaming function but the evaluation will not comment on this function as it is not directly aligned to the Inter Hospital Transfer Service.

Evaluation Limitation

This evaluation was not intended to assess the ABUHB Clinical Futures Model as a whole but will recognise key areas that impact on the delivery of the Inter Hospital Transfer Service.

The author also recognises the impact the Covid19 pandemic has had on the development and delivery of the Clinical Futures Model and the Inter Hospital Transfer Service.

Evaluation Methodology

The evaluation aims to respond to four key questions by analysing data under four categories; Service Model, Performance, Patient Quality and Safety and Resource Quality and Availability. To respond to the four key questions the evaluation has reviewed the following information.

- Factual quantitative narrative review of the service, activity, performance of the service using the modelled/forecast position vs actual.
    - The quantitative data analysis would analyse data from ABUHB and WAST data recording systems against the four evaluation categories.
- Qualitative discussion on the effectiveness of each component and the overall model.
    - The qualitative review would analyse feedback from an ABUHB and WAST staff survey. The survey would independently capture feedback against the four evaluation categories from two groups of staff; staff responsible for the direct service delivery of the Inter Hospital Transfer Service and staff indirectly responsible for the delivery of the Inter Hospital Transfer Service.
- A literature review of existing reports and documents aligned to the development and delivery of the Inter Hospital Transfer Service.
- Verbal feedback from key stakeholders to verify information obtained.

Key Evaluation Questions

The evaluation will conclude with recommendations aligned to the four key questions:

1. Is the transfer service meeting the actual transport requirements of the GUH Inter Hospital Transfer system?

2. Is the transfer service meeting the performance requirements aligned to the established Commissioning Agreement and Service Specification?

3. Is the transfer service delivering a high quality, safe and effective service for the ABUHB Clinical Futures Model?

4. Are the supporting systems meeting the requirements of the transfer service?

SERVICE SCOPE

GUH was a brand new Specialist Critical Centre based in Llanfrechfa near Newport. The hospital would have 560 beds (when fully operational) including trolleys and cots and provide treatment and care for those needing complex specialist or critical care to the circa 600,000 populations of ABUHB and South Powys areas.

All major emergency patients would be taken to GUH. There would be a 24/7 Emergency Department and Assessment Unit alongside a broad range of diagnostic services, operating theatres, consultant led obstetric unit and a dedicated paediatrics assessment service. There would be a helipad on the site to enable emergency cases to be transferred swiftly.

In addition to the emergency cases, there would be a requirement to transfer patients from GUH to an ELGH to receive step down ongoing care.

With the reconfiguration of ABUHB services and a change in acuity on the ELGH sites, there was a recognised need that some patients would require transfer to the GUH from the ELGHs due to deterioration of condition or due to self-presenting to the wrong site.

The purpose of the service was to provide safe, timely and appropriate inter hospital transfers to support the implementation of the Clinical Futures Model.

The scope of the service was planned to provide transfers between the GUH and three ELGHs, with transfer requests being managed via a dedicated Flow Centre that was integrated within WASTs Clinical Contact Centre (CCC), allowing both organisations to view all health board ambulance activity and effectively manage resources and patient flow.

It was acknowledged that there would be circumstances where clinical agreement would determine that transfers outside this scope would be undertaken where this was in the best interest of the patient or supported wider system flow improvements.

Patients would be clinically triaged and categorised by the Flow Centre using a bespoke Transfer Triage Tool (TTT) developed by ABUHB and WAST clinical teams. The patient's categorisation against the TTT would align the patient to the correct ambulance resource type.

Transfer Categorisation

The service primarily provided inter hospital transfers; described as step up and step down transfers between the GUH and ELGHs

Step up - ensuring that patients with emergency care or specialist treatment needs that can only be provided at GUH are transferred in a timely manner from the ELGHs. This included:

- Patients who self-presented to one of the ELGHs and required an emergency transfer to GUH Emergency Department, or
- Patients who were inpatients within an ELGH and deteriorated on a ward requiring an emergency transfer to GUH Emergency Department, or
- Patients who were inpatients within an ELGH and required transferring to GUH for planned specialist treatment

Step down – to transfer patients from GUH who required ongoing care in ELGHs in a timely manner to maintain flow.

DEMAND MODELLING

ABUHB Clinical Futures service modelling indicated that there would be 12,045 step up transfers per annum and 14,235 step down transfers per annum between GUH and the 3 ABUHB ELGHs.

Step Up Transfers from RGH, NHH and YYF to GUH	Transfers Per Day	Transfers Per Annum
Self-Presenters at MIUs	30	10,950
Ward / Unit deteriorations	3	1,095
Total	33	12,045

Step Down Transfers from GUH to RGH, NHH and YYF	Transfers Per Day	Transfers Per Annum
Total	39	14,235

Agreed key performance indicators (KPIs) and service model assumptions were established, which were used by WAST to model (using Optima) the level of resources required against the modelled demand.

The agreed KPIs and assumptions would be:

- Step up transfers would be conveyed within 1 hour
- Step down transfers would be conveyed within 4 hours
- 90% performance against response time targets
- 30 minute pick up and drop off

A clinical review by ABUHB and WAST was undertaken of all modelled patient transfer activity, with activity clinically aligned to each transfer categorisation and ambulance resource requirement.

Step Up Transfers from RGH, NHH and YYF to GUH	Provided by	Resource Type	Step up/down	Transfers per day	Transfers per annum
Emergency Response	• EMS core resource • Triaged as per clinical model	1 EA 12/7	Step Up	10	3,650
<60 Minutes	• Dedicated Transfer Practitioner	1 Blue Light 12/7	Step up and Step down	5.87	2,143
	• Provided by dedicated pool	3 UCS 24/7 & 2 UCS 12/7	Step up	18.94	6,913
< 4 Hours	-	4 UCS 12/7	Step down	37.19	13,574
Total additional transfers per day	-	4 UCS 12/7	Step down	72.02	26,280

Service Level Agreement

The Service Level Agreement (SLA) set out the joint roles and responsibilities in the establishment and delivery of an inter hospital patient transport service which formed an essential part of the Clinical Futures Model.

The SLA for the Inter Hospital Transfer Service was developed by ABUHB in conjunction with the WAST and the CASC.

The SLA and service specification was developed alongside the development of the Inter Hospital Transfer Service, due to timescales. Therefore, the agreed SLA between ABUHB and WAST, included additional overarching principles and assumptions alongside the original service modelling KPIs and assumptions.

Agreed overarching principles and assumptions included in the SLA:

- 30 minutes drop off and 30 minutes pick up time on scene
- Patients collected and dropped off at the appropriate location to help meet the required standard
- One patient per vehicle conveyance, in line with service modelling parameters

For transfers being undertaken within the original modelling:

- 90% of transfers with patients within 60 minutes of transfer call for a step up transfer
- 4 hours response time for step down
- Where transfers were undertaken outside the scope of the service or beyond the modelled assumptions, performance targets would not be applied, however they should receive a timely response in line with the patient's needs. Please note that all activity has been included in performance reports as the impact of incorporating differing activity into the service impacts across the service.
- Step up transfers carried out by Transfer Ambulances and 1 x12hr EA vehicle within EMS service
- Step down transfers can be provided by Transfer Ambulances
- Transfer Ambulances may need to respond to red community calls if there is no other resource available therefore cannot be 'ring fenced' – acknowledges ring fencing is not efficient use of resource.
- Clinician to clinician discussions enabled to support (ABUHB –WAST)

Key assumptions within SLA, included:

- Some step up transfers would require an immediate ambulance response and a highly skilled crew which would be carried out by the emergency services fleet; paramedic level resource. A modelling assumption based on a clinical review by WAST was made that this applied to about 10 out of 33 step up transfers (30%) per day
- A dedicated pool of transfer ambulances would undertake the remaining 23 out of 33 step up transfers (70%) per day. Modelling suggested that approximately five of these were planned to be undertaken by the transfer practitioner and dedicated vehicle. They would also do half of the 39 step down transfers per day (19.5 per day, or 50%)
- Modelling suggested that a dedicated step down fleet would do the remaining 19.5 step down transfers per day (50%)
- In periods of low activity expectations were that vehicles within this SLA may be used for discharge purposes, subject to an operational decision making mechanism
- Where transfers outside the primary scope of the agreement impacted on the delivery of the service, due consideration would be given to this when evaluating performance delivery. The draft modelling from Optima on the impact of the introduction of additional activity has indicated the impact on performance achievement

SERVICE MODEL

The commissioned service was designed to facilitate 72 transfers (33 step up transfers & 39 step down transfers) per day, utilising dedicated transfer resources and accessing a pool of emergency service ambulances.

The initial service design, which informed the service modelling was developed with the view that it would be a responsive service. The service was designed on the performance principles that step up transfers, transfer practitioner transfers and emergency transfers would be conveyed within 1 hour of a booking being made with WAST, with step down transfers being conveyed within 4 hours of a booking being made with WAST.

The initial operational model considered by ABUHB focused on the utilisation of a range of planned and unscheduled resources. As the operational model evolved, collaborative work was undertaken to encompass a pre-planned model for planned care transfers, supported by a responsive model for unscheduled care transfers.

Step down patients who were inpatients within the health care system and step down patients who presented overnight at the emergency department, and required transfer to an ELGH the following morning, could be pre-planned.

Following the implementation of the service, new categories of patients started to be conveyed by the service. In response to these additional categories of patients, additional performance principles for 1 and 4 hours were aligned to all transfer practitioner and UCS step up and step down transfers.

Step up, step down and transfer practitioner transfer bookings would be made via the Flow Centre with emergency transfers made directly with WASTs CCC.

Flow Centre

The function of the Flow Centre was to effectively manage the transfer and flow of patients between the GUH and ELGH sites. The Flow Centre team were to be embedded alongside Welsh Ambulance Services staff, who were responsible for the coordination and dispatching of resources to patients.

The Flow Centre was to be established within the WAST’s Regional Headquarters at Vantage Point House in Cwmbran.

Transfer request bookings would be placed with the Flow Centre by hospital sites. Once patients were identified as suitable for transfer by the hospital, a booking for the patient would be placed with the Flow Centre by the hospital who also confirm the bed availability. The Flow Centre would then place the patient information on to the health board system and then place a booking with WAST.

Following a GUH clinician to Flow Centre clinician conversation, step up patients requiring specialist treatment at GUH would be booked via the Flow Centre. The escalation of the deteriorating patient would be verbally completed via a Situation – Background – Assessment – Recommendation (SBAR) process. An SBAR document would be generated at the point of identifying the deteriorating patient. The SBAR would form the basis of the handover documentation.

Step up emergency transfers being booked directly with WAST via the 999 Health Care Professional line (999 HCP line).

Step down patients from GUH would be assessed as fit to be stepped down and transferred to the ELGH by a senior clinician against a step down assessment criteria. The rationale for the decision to step down and the ongoing treatment plan would be documented within the clinical documentation.

Step down patients would be identified the day before transfer and numbers reported to the GUH flow team or site manager. Same day transfers would be identified following morning senior reviews and included in the transfer figures for that day.

On the morning of transfer the nurse in charge of the ward would confirm if the patient was fit for transfer by checking all parameters are unchanged for the patient. The patient would be deemed as fit for transfer by 08:00 on the day of transfer and notification being provided to the Flow Centre.

Opportunities for stepping patients up earlier, proactive monitoring of patients across ELGH sites, Treatment Escalation Plans and Core Site Safety, all contribute to the prudent utilisation of the transfer practitioner role. The interface between the Flow Centre and the Flow Desk for safe and efficient identification and allocation of appropriate resource, will be essential to the success of the transfer process.

Flow Desk

The Flow Desk would be established by WAST to provide a dedicated 24/7 coordination point, responsible for the management and dispatch of transfer ambulance resources.

To manage the requirements of the step up step down resources, the resources would be operated by two separate WAST teams with the WAST CCC.

EMS call takers and dispatchers would manage the 24/7 step up transfer ambulance resources, with a NEPTS day controller managing the step-down transfer ambulance resources between 08:00 and 20:00.

For step up transfers, the Flow Centre would contact the Flow Desk via phone to place a step up booking, where the dispatcher would then allocate the booking to a resource. For step down transfers, the Flow Centre would directly place a transfer booking into the NEPTS computer aided dispatch (CAD) system, Cleric.

Transfer & Discharge Lounge

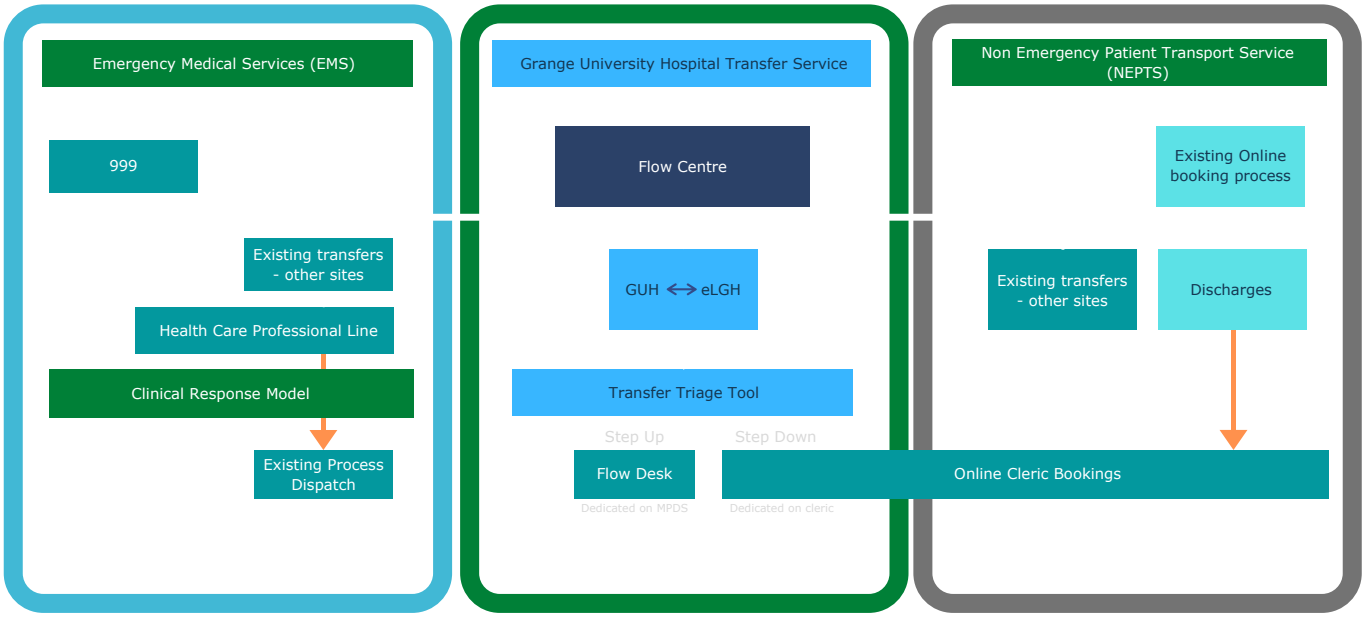
Onsite WAST Ambulance Liaison Officers (ALO) would be based within the dedicated transfer & discharge lounges, alongside the hospital transfer and discharge team, to assist in the delivery of the service.

On day of transfer, the hospital flow team would confirm the time of patients transfer and move the patient to the transfer & discharge lounge or agreed place by internal transfer team. The transfer lounge or agreed place would provide ongoing care for the patient until their allocated transport arrives to take them to the receiving hospital.

On arrival at the receiving hospital the patient would be taken to the transfer & discharge lounge or agreed place by the transferring crew. An internal transfer team would then transfer the patient to the receiving ward when the bed is available.

Inter Hospital Transfer Service Model

The development of the Inter Hospital Transfer Service created a hybrid model, utilising new and existing routes and resources for the transfer of patients throughout the health board.



Resource Requirements

The demand modelling and clinical review of patients' conditions requiring emergency and planned transfers between hospitals, was used to identify the appropriate ambulance resource for transfer of each patient group. It was established that 56 of the 72 transfers per day, would be step up and step down transfers requiring a 1 or 4 hour response and could be safely transferred utilising an Urgent Care Service (UCS) resource. 10 emergency transfers per day required an emergency ambulance transfer.

6 step up transfers per day were identified as unplanned and requiring a specialists clinically qualified member of staff than UCS but did not require an emergency ambulance response. The health board also required access to a dedicated blue light resource that could be prioritised by the health board in order to respond to the 6 unplanned step up transfers. To meet the health board's requirements and to meet the needs of the unplanned step up patients, a hybrid transfer resource was developed, in the form of a transfer practitioner resource.

The demand modelling and clinical review also established the length of operating hours for the transfer resources and the requirements for dedicated and non-dedicated transfer resources. It was established that UCS resources would be required to be dedicated operating 24/7, the transfer practitioner would be a dedicated resource operating 12/7 and emergency transfers could be accommodated via an additional 12/7 emergency ambulance resource pooled alongside existing emergency ambulance resources.

All transfer resources would be managed via the WAST's CCC, with a dedicated Flow Desk to manage the dedicated transfer resources. Emergency transfer resources would be accessed via the existing 999 HCP line. All non-emergency transfer bookings would be placed with the Flow Desk via the Flow Centre.

Workforce

Urgent Care Services (UCS)

UCS is a non-emergency crew that is trained and equipped to care for and transport urgent and non-urgent patients who require basic care, including monitoring of observations and providing pain relief for low levels of pain.

Emergency Ambulance Resource

An emergency ambulance resource operated by a paramedic and emergency medical technicians (EMTs) equipped to respond to emergency patients who required enhanced emergency care.

Transfer Practitioner Model

The ability to influence the prioritisation and allocation of transfer vehicles was an essential requirement of the inter hospital transfer model for ABUHB. The transfer practitioner resource was developed to ensure the safe and timely ward to ward transfer of deteriorating patients. The transfer practitioner resource provided additional assurance to ABUHB senior clinicians and a resilience within the health board during the transitional first year period, following the opening of the GUH.

The transfer practitioner would work closely with the transfer ambulance crew member to move patients safely between sites. In clinically exceptional circumstances this may include appropriate tertiary step ups, accepting that it would have an impact on service availability. The vehicle and driver would stay with the transfer practitioner. Senior clinical support is provided by an Intensive Treatment Unit (ITU) Consultant. Paediatric and obstetric transfers are excluded from the transfer practitioner model during the transitional year but will be re-assessed for future requirements.

Position	Established WTE
Manager	1.0
Team Leaders	7.0
Paramedics	3.0
Emergency Medical Technician	2.0
Urgent Care Service	68.0

Position	Established WTE
Transfer Practitioner	2.0
Control	15.8
Ambulance Liaison Officer	1.0
Resource Coordinator	1.0

Estates

The Inter Hospital Transfer Service modelling was based on the operating model that transfer vehicles would be based at and respond from the ELGH and GUH hospital sites.

Vehicles

A range of resource levels were modelled by WAST and concluded that in order to meet response times as required - including those that require a 60 minute response and those that require a 1-4 hour response – and a 30 minute drop off and 30 minute pick up time, a total of 10 vehicles with 3 relief vehicles of the following vehicle types would be required (based on 33 step ups and 29 step downs).

Vehicle Specification

A vehicle options appraisal was undertaken by WAST in June 2020 to review the vehicle tender documents and vehicle specification set out by ABUHB for the Inter Hospital Transfer Service. The specification was reviewed by fleet, clinical and operational teams, considering key factors that would directly impact on service delivery. The normal design, build and full implementation of an ambulance vehicle is between 9 and 12 months. At the stage of the options appraisal the GUH hospital was planned to open in 5 months. The nature of Inter Hospital Transfer Service required the development of a bespoke vehicle, with additional adaptions for the transfer practitioner vehicle, with both being able to operate at a fully laden weight of less than 3.5 ton.

Vehicles under 3.5 ton are able to be operated on a B category (car) driving license. For vehicles over 3.5 ton, individuals are legally required to hold a category C1 driving license. For individuals who passed their driving test prior to the 1 January 1997, they would automatically hold a category C1 license due to historical driving rights. For the purposes of recruitment, this would mean that people under the age of 40 at the time of recruitment would not automatically hold a driving license unless they completed the C1 category training. The license is held by the individual and is undertaken on a personal basis. The length of time to complete the training is dependent on the individual and can exceed a cost of £1,000 to complete. It is acknowledged that the challenges regarding C1 driving licenses are a national issue for all ambulance services.

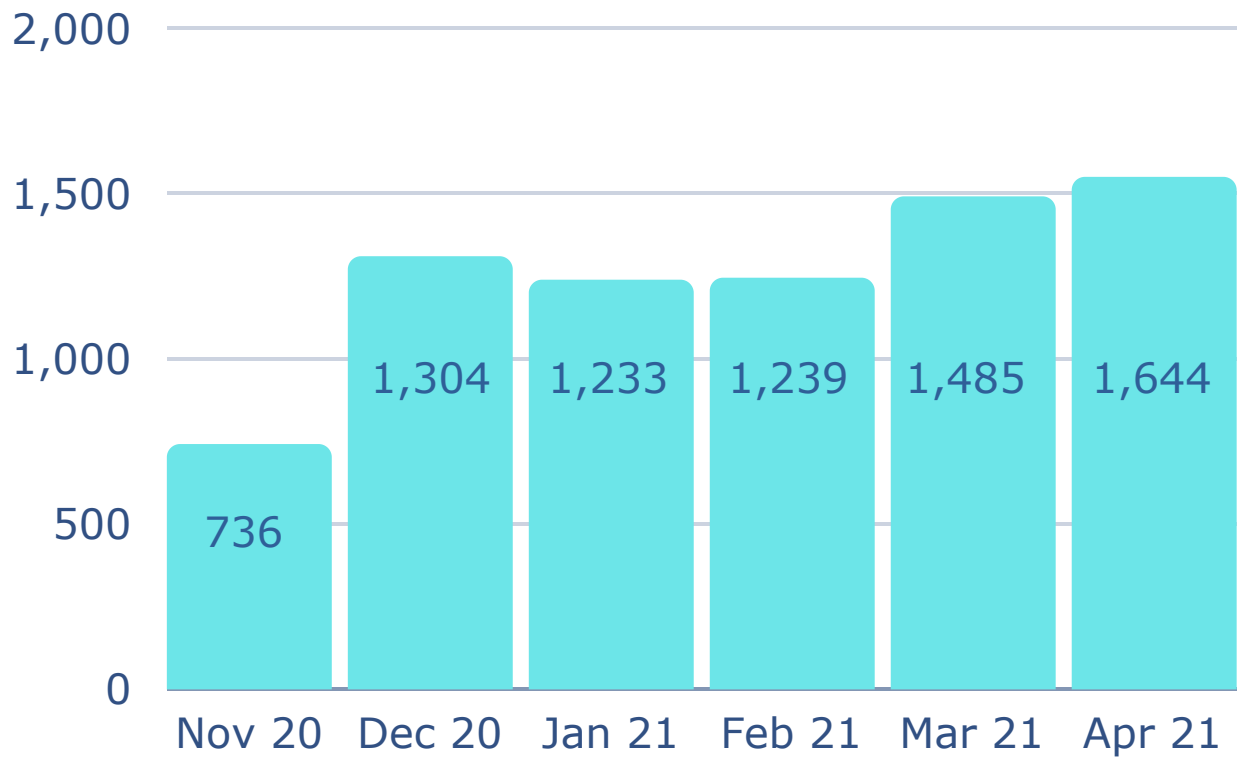
Due to the requirement to recruit 68 new UCS members of staff, it was established that if the new transfers ambulances exceed 3.5 ton and required a C1 category driving license, there was a high probability that WAST would not be able to recruit a sufficient amount of staff. This would therefore compromise the ability to support ABUHB in providing a safe Inter Hospital Transfer Service to effectively deliver the Clinical Futures Model.

Resource Requirements

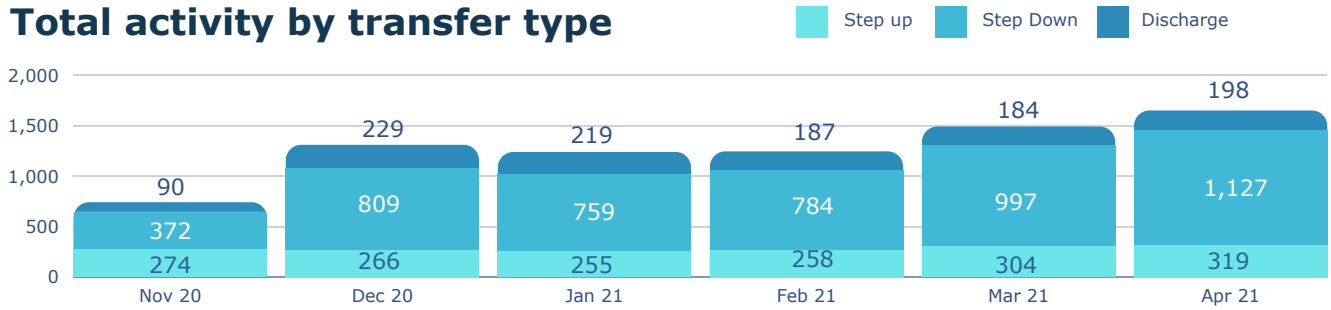
Vehicle type	Resourced by	Vehicle numbers	Estimated transfers by day	Vehicle Operational Hours	Handover times	Response Times
Emergency Response	3 x Band 6 Paramedics 2 x Band 4 EMTs	1	10 step up	12 hours 7 days	30 minutes	As per national clinical response model
Transfer Ambulance (Transfer Practitioner Vehicle)	1 x ABUHB staff member 1 of 68 Band 3 staff covering 10 transfer vehicles	1	1.8 step up 4.1 step down	12 hours 7 days	30 minutes	Dedicated vehicle 1-4 hours dependent on TTT
Transfer Ambulance	68 Band 3 staff covering 10 transfer vehicles	6	9.5 step up 18.6 step down	12 hours 7 days	30 minutes	1-4 hours dependent on TTT category
Transfer Ambulance	68 Band 3 staff covering 10 transfer vehicles	3	9.5 step up 18.6 step down	12 hours 7 days	30 minutes	1-4 hours dependent on TTT category

PERFORMANCE DATA

Activity



Total activity by transfer type

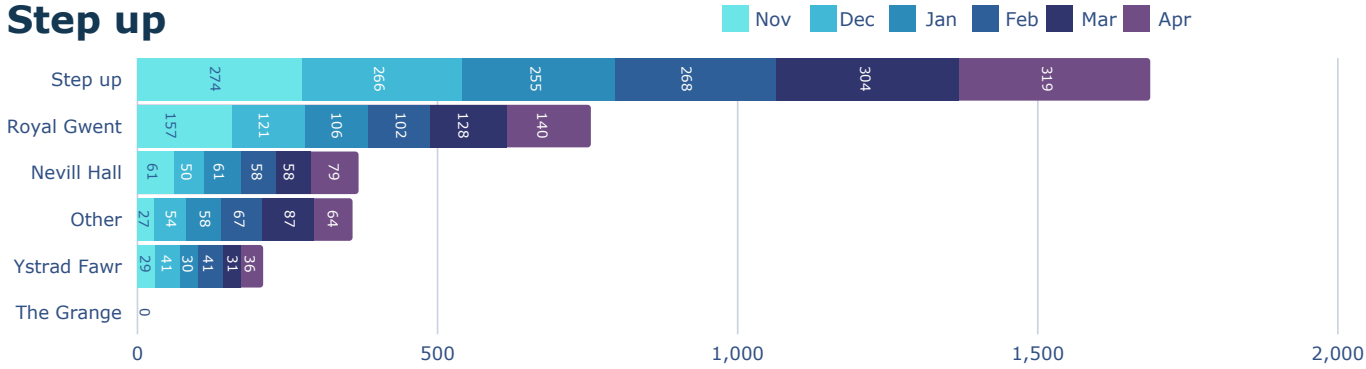


Performance Summary

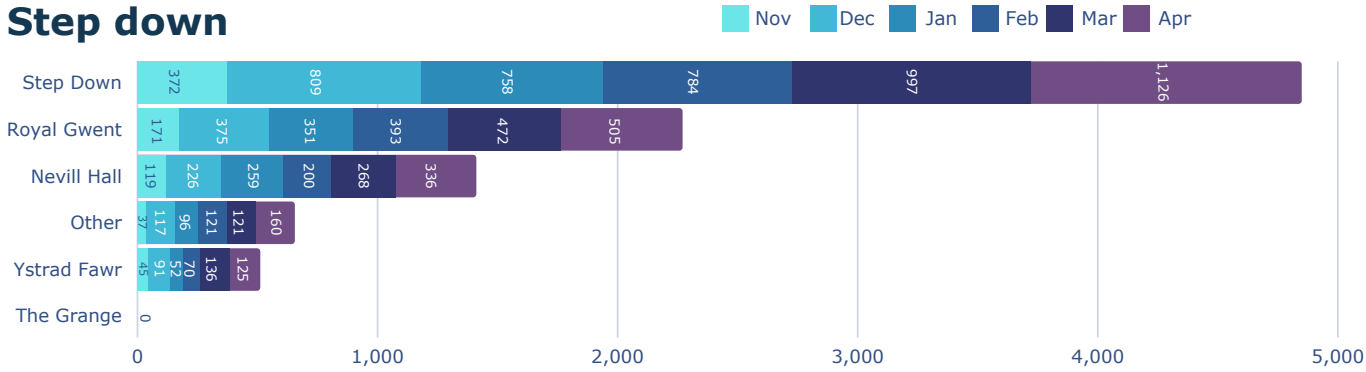
- Overall service demand continuing to increase
- Step down demand increasing and close to modelling demand levels
- Step up demand remains consistent and below modelled demand levels
- Discharge demand was not included in the original modelling

Activity by Site

Step up



Step down



Performance Summary

- Step down activity is 63% of overall demand
- 45% of step up patients originate from the Royal Gwent Hospital
- 21% of step up activity originates from health care sites that were not included within the original service modelling
- 13% of step down activity is transferred to a health care site that was not included within the original service modelling

Modelling

Commissioned resource activity against modelled activity

Resource Type	Transfer Type	Response	Modelled Per Day	Actual per day (avg)	Model Difference
Emergency Ambulance	Step Up	999 as per MPDS	10	1.40	-8.6
	Step Down		n/a	0.29	+0.29
Transfer Practitioner	Step Up	<1 hr	4.06	1.07	-2.99
	Step Down		1.81	0.37	-1.44
	Step Up	<4 hrs	n/a	0.17	+0.17
	Step Down		n/a	0.40	+0.40
Transfer Ambulance	Step Up	<1 hr	19	3.1	-15.9
	Step Down		n/a	0.53	+0.53
	Step Up	<4 hrs	n/a	3.17	-3.17
	Step Down		37	36.4	-0.6
	Step Across	n/a	n/a	2.5	-2.5
	Discharges	n/a	n/a	7.6	-7.6
Total		**n/a**	**72**	**57**	**-15**

Performance Summary

- Emergency ambulance transfer demand 83% lower than originally modelled
- Transfer Practitioner transfer demand 75% lower than originally modelled
- Transfer ambulance step up demand 81% lower than originally modelled
- Transfer ambulance step down demand equal to original modelled demand
- New categories of transfer added (Transfer Type)

Conveyance and Handover

Hospital Handover Times

Hospital	0-15mins	15-30mins	30-45mins	45-60mins	60-120mins	120-180mins	180+	Total
Brecon War Memorial Hospital	1	1	-	-	-	-	-	2
Bristol Heart Institute	-	1	1	-	-	2	-	4
Bristol Royal Hospital for Children	-	1	-	-	-	-	-	1
Bristol Royal Infirmary	-	-	1	-	-	-	-	1
Bronglais General Hospital	-	-	-	-	1	-	-	1
Bronllys Hospital	-	-	-	-	-	-	1	1
Charing Cross Hospital	-	-	-	1	-	-	-	1
Chepstow Community Hospital	15	3	1	-	-	-	-	19
Children's Hospital of Wales	8	10	1	-	-	-	-	19
County Hospital (Pontypool)	31	6	3	2	-	-	-	42
GP Surgery	1	-	-	-	-	-	-	1
Glangwilli General Hospital	3	1	1	-	1	-	-	6
Grange University Hospital	326	358	212	135	212	82	105	1,430
Homerton University Hospital	-	1	-	-	-	-	-	1
Llandough Hospital	14	16	3	2	1	-	-	36
Monnow Vale Health Facility	1	-	-	-	-	-	-	1
Morriston Hospital	18	6	1	-	1	-	-	25
Nevill Hall Hospital	223	189	70	30	16	3	1	523
Prince Charles Hospital	2	3	2	-	1	-	-	8
Prince Phillip Hospital	1	-	-	-	-	-	-	1
Princess of Wales Hospital	2	1	1	-	-	-	-	4
Queen Elizabeth Hospital	1	1	2	1	-	-	-	5
Rhymney Integrated Care Centre	1	-	-	-	-	-	-	1
Rookwood Hospital	1	2	-	-	-	-	-	3
Royal Brompton Hospital	-	-	-	1	-	-	-	1
Royal Gwent Hospital	610	273	73	16	18	6	-	996
Royal United Hospital	1	-	-	-	-	-	-	1
Singleton Hospital	1	1	-	-	2	1	-	5
Southmead Hospital	-	2	1	1	-	-	-	4
St Cadocs Hospital	7	6	1	-	-	-	-	14
St David's Hospice Care	-	1	-	-	-	-	-	1
St Michaels Hospital	1	-	-	1	-	-	-	2
St Peters Hospital	1	-	-	-	-	-	-	1
St Woolos Hospital	44	10	-	-	-	-	-	54
The New Barry Hospital	1	-	-	-	-	-	-	1
University Hospital of Wales	43	56	42	20	12	2	-	175
Velindre Hospital	-	2	-	-	-	-	-	2
Ysbyty Aneurin Bevan	57	31	6	1	1	-	-	96
Ysbyty Tre Cwm	2	1	-	-	-	-	-	3
Ysbyty Ystrad Fawr	82	76	21	5	5	-	-	189
Total	**1,499**	**1,058**	**443**	**216**	**271**	**96**	**107**	**3,690**

Performance Summary

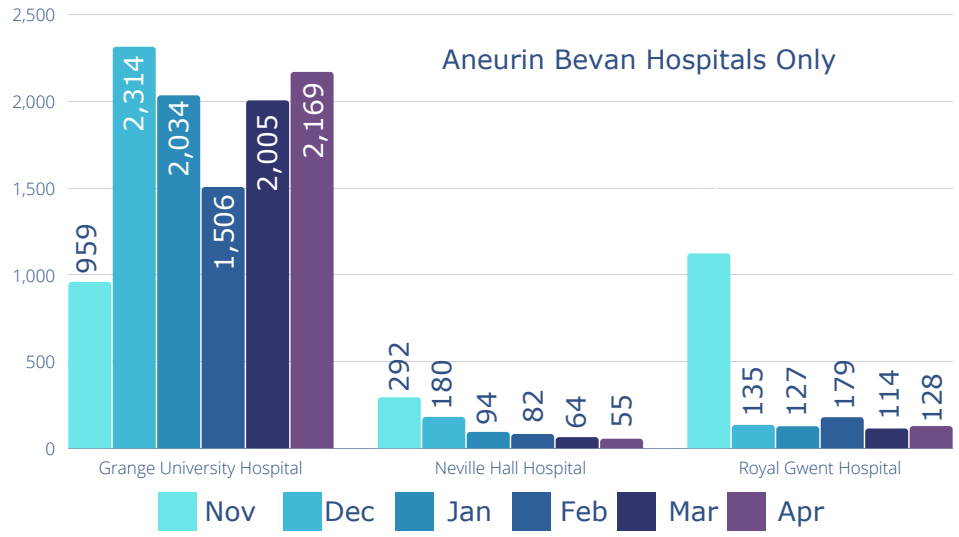
- 48% of patients at GUH are handed over within 30 minutes of arrival or departure
- 89% of patients at RGH are handed over within 30 minutes of arrival or departure

Lost Hours

Hospital handover lost hours - intersite transfer service

Hospital	November	December	January	February	March	April	Total
Grange University Hospital	84.31	194.96	194.56	140.33	142.85	137.31	894.32
Morriston Hospital	-	-	0.05	0.34	0.14	0.24	0.77
Prince Charles Hospital	-	-	0.23	-	-	-	0.23
Princess of Wales Hospital	-	-	-	-	-	0.27	0.27
Royal Gwent Hospital	0.40	-	-	-	-	-	0.40
University Hospital of Wales	3.12	5.76	5.15	5.32	6.14	4.85	30.34
Total	**87.82**	**200.72**	**199.99**	**145.99**	**149.13**	**142.67**	**926.32**

Lost hours - 999 response



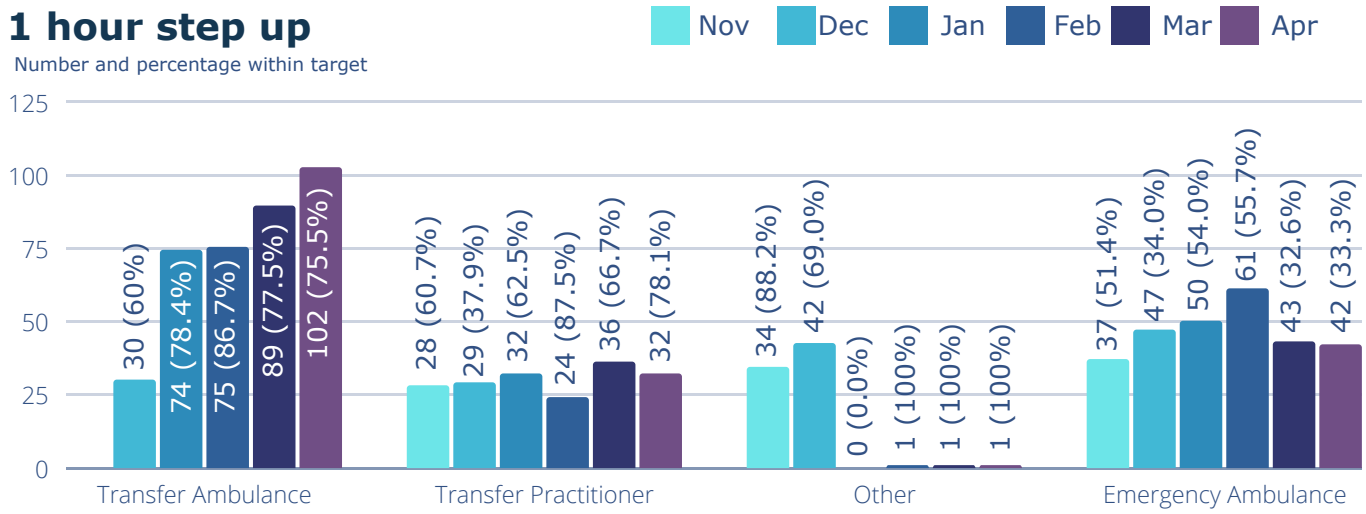
Performance Summary

- 5 hours 30 minutes are lost per day, with transfer ambulances waiting longer than the agreed 30 minutes to handover patients
- 70 hours of emergency ambulance resources are lost per day due to handover delays at Emergency Departments

Step Up / Down

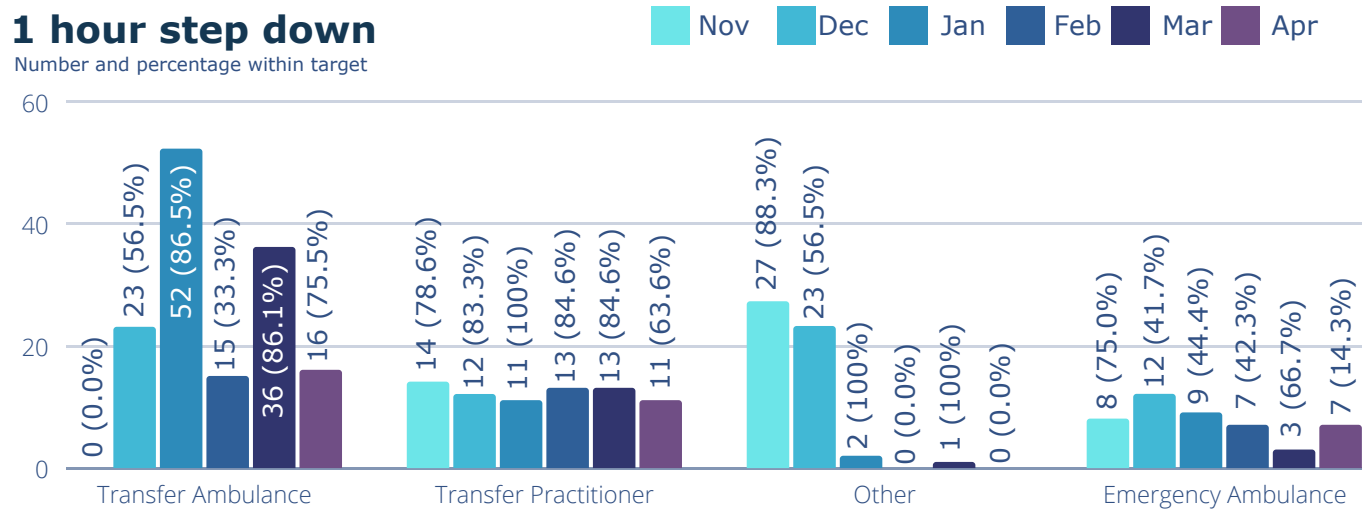
1 hour step up

Number and percentage within target



1 hour step down

Number and percentage within target



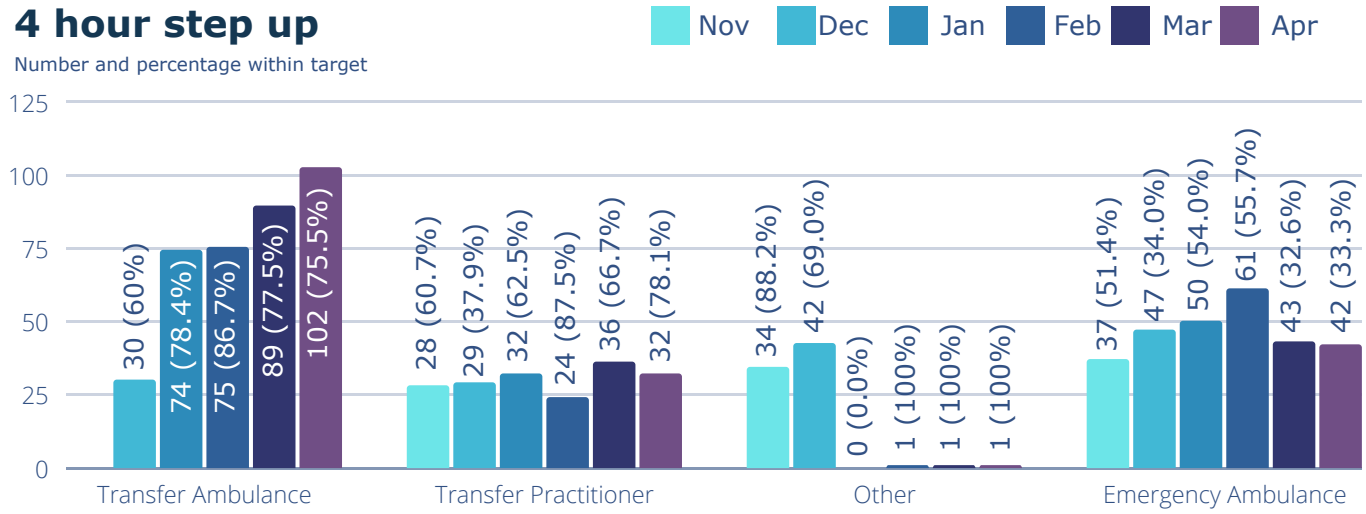
Performance Summary

- Transfer ambulance performance exceeding 75%
- Emergency ambulance transfer performance 49% for 1 hour transfers
- Monthly transfer practitioner resource performance varies between 60% and 100%, with demand remaining consistent

Step Up / Down

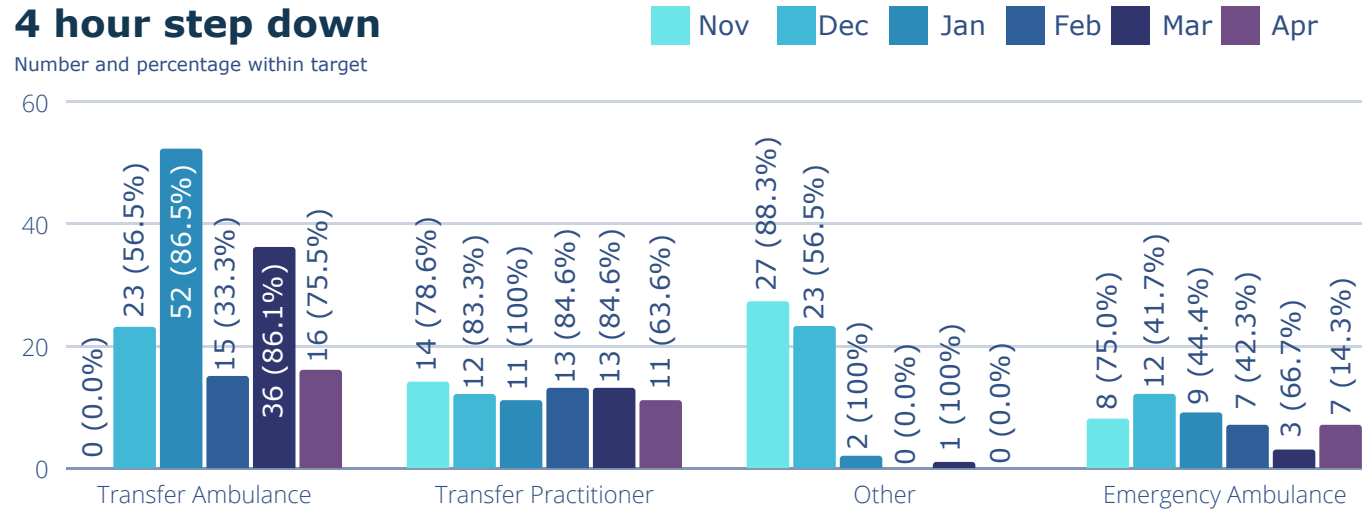
4 hour step up

Number and percentage within target



4 hour step down

Number and percentage within target

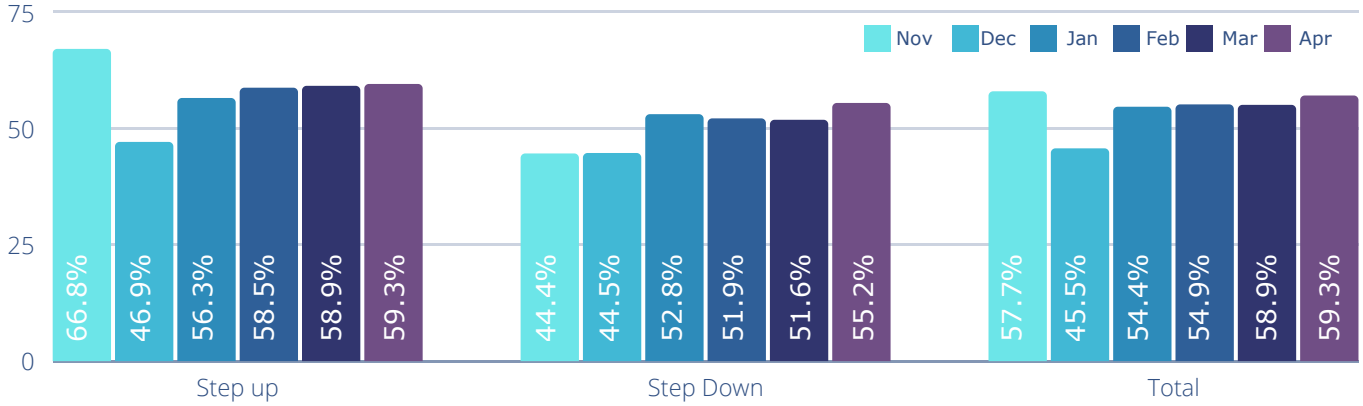


Performance Summary

- Growing demand for 4 hour step up transfers
- 4 hour step up performance is 89.6%
- Growing demand for 4 hour step down transfers
- 38.8% increase in 4 hour step down demand between Jan 21 and Apr 21
- 4 hour step down performance is 81.8%. (Not all private ambulance performance data was captured)

Pickup

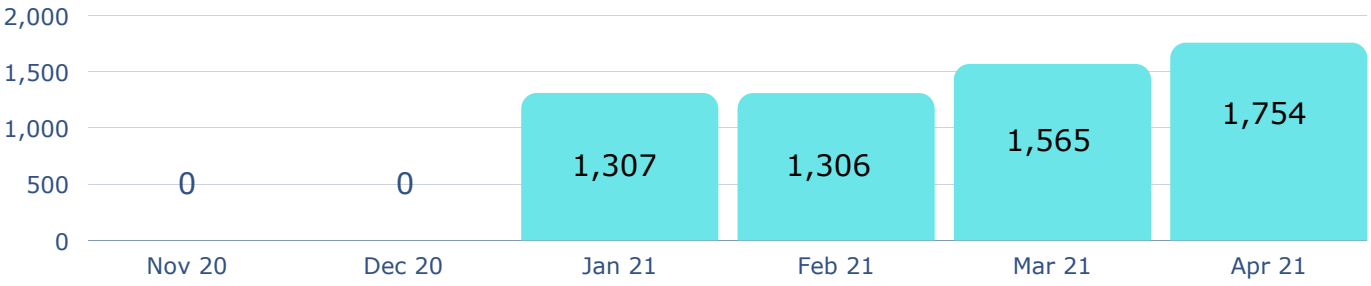
The percentage of patients picked up within 30 minutes of appointment time



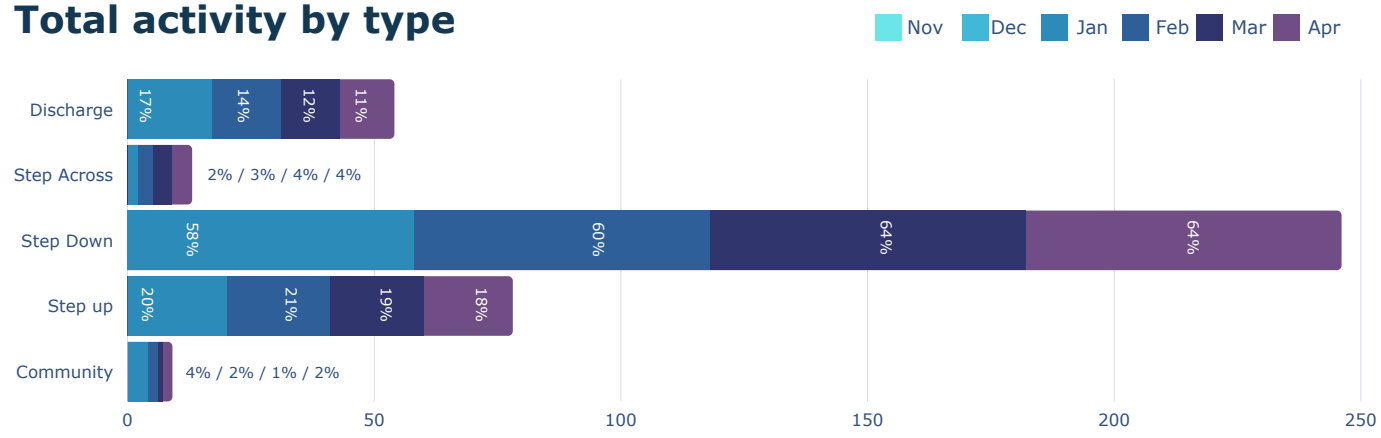
Performance Summary

- Performance improvements alongside increasing demand
- 58.25% performance for step up patients picked up within 30 minutes of their planned time
- 52.87% performance for step down patients picked within 30 minutes of their planned time

Transfers

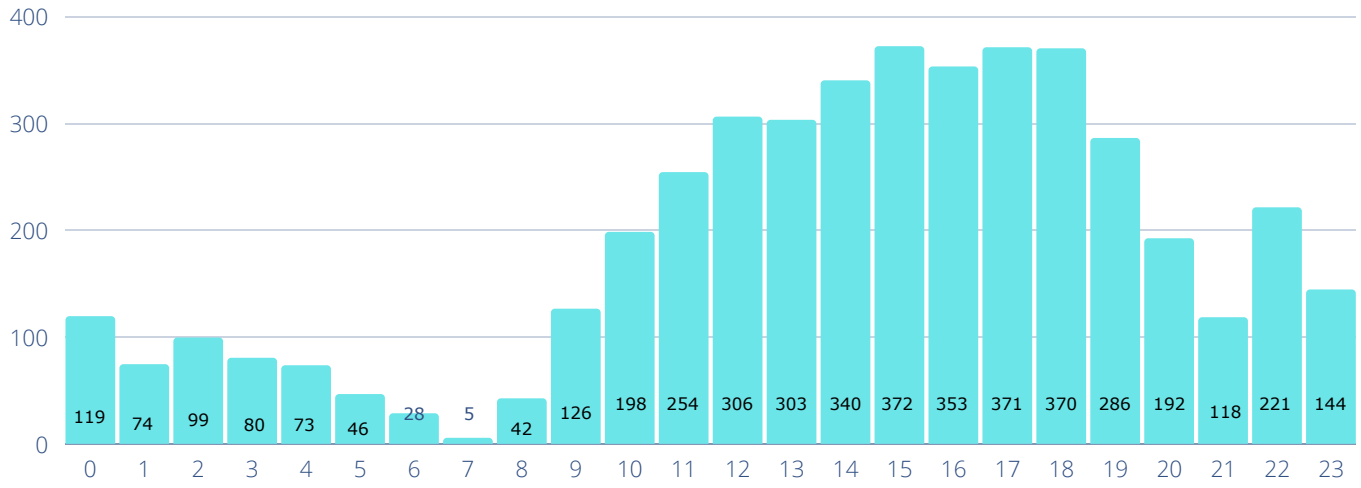


Total activity by type

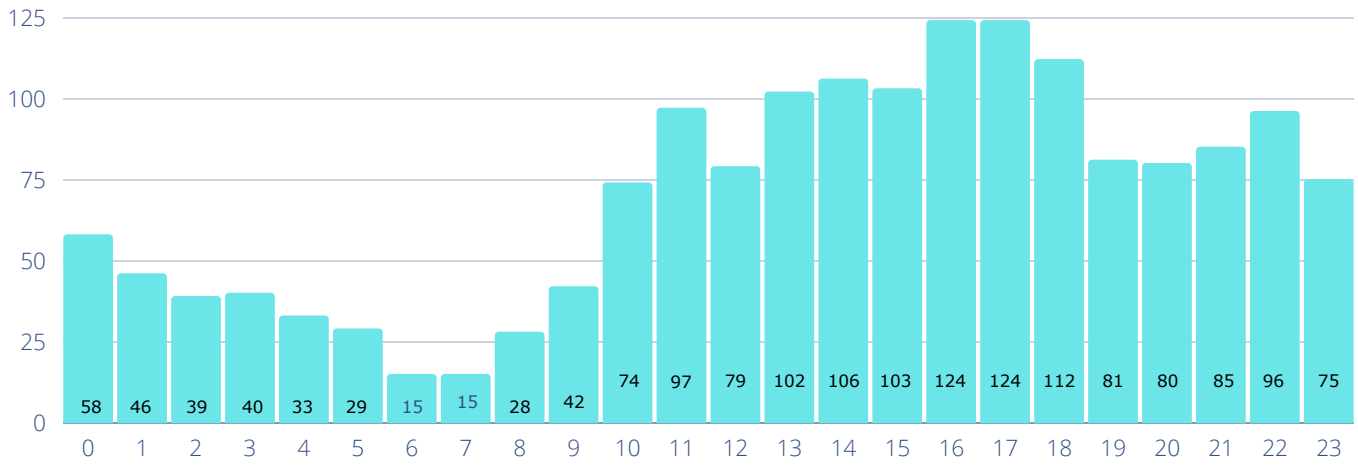


Hour by hour

Destination hospital: Step down by hour



Destination hospital: Step up by hour



Performance Summary

- Peak service demand between 1500 and 1800
- Lowest service demand between 0600 and 0800
- Demand variable across 24 hour operating period
- Variable demand pattern has been consistent over reporting period

QUALITY AND SAFETY

Community Response - Number of Responses

Calls attended by transfer resources where incident location was not a hospital

DATE	RED	AMBER 1	AMBER 2	Total
January 21	21	4	2	27
February 21	16	1	1	18
March 21	15	1	1	17
April 21	21	3	5	29
Total	**73**	**9**	**9**	**91**

Time From Allocation To Clear

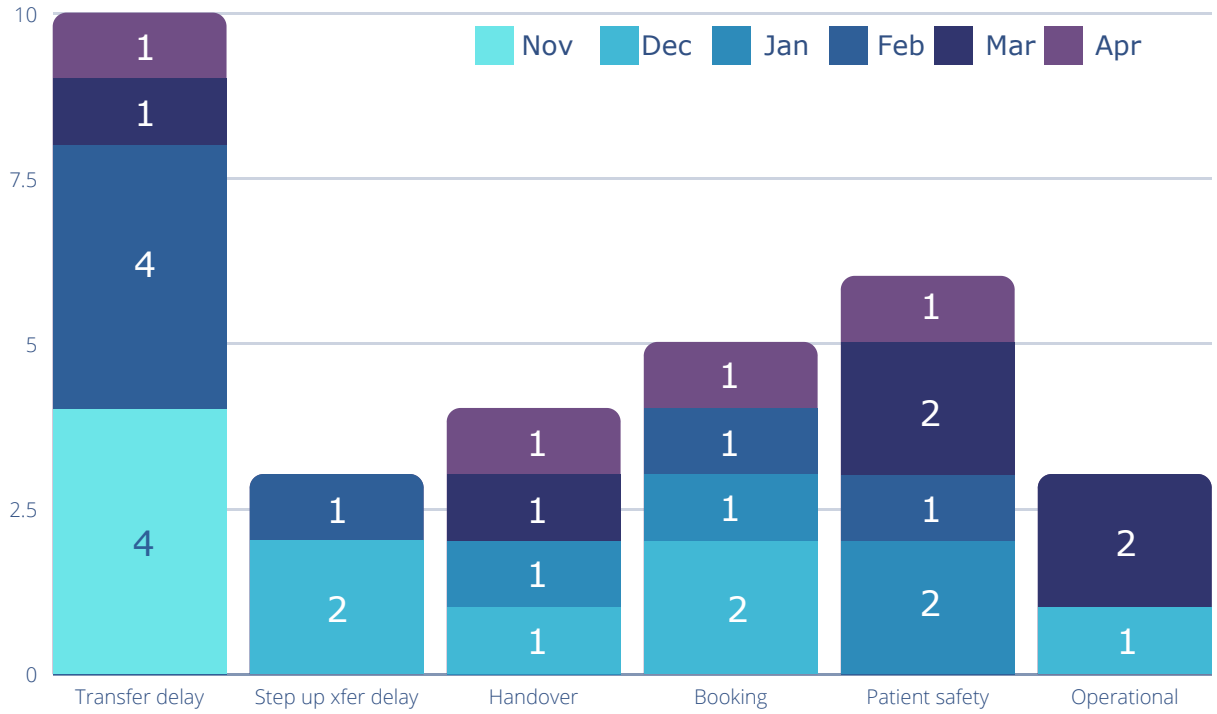
DATE	RED	AMBER 1	AMBER 2	Total	Service Hours based on rotas	% of Service Time
January 21	26:16:20	08:25:44	5:55:50	40:37:54	4743:00:00	0.86%
February 21	17:01:35	0:10:52	1:44:55	18:57:22	4284:00:00	0.44%
March 21	17:28:52	1:32:13	1:45:54	20:46:59	4743:00:00	0.44%
April 21	16:38:49	7:25:03	10:01:05	34:04:57	4590:00:00	0.74%
Total	**77:25:36**	**17:33:52**	**19:27:44**	**114:27:12**	**18360:00:00**	**0.62%**

Performance Summary

- Community response demand not included in original modelling.
- Manual allocation of resources to community response.
- Transfer practitioner and step up resources only allocated to community response calls.
- Additional Amber 1 and Amber 2 activity to be validated.
- 114.27 hours (0.62%) of transfer ambulance resources have been allocated to community response.

Datix Totals by Month

Hospital	Emergency Transfer Delay		Step Up Transfer Delay		Handover		Booking Process		Patient Safety		Operational	
	ABUHB	WAST	ABUHB	WAST	ABUHB	WAST	ABUHB	WAST	ABUHB	WAST	ABUHB	WAST
November 2020	4	0	0	0	0	0	0	0	0	0	0	0
December 2020	0	0	2	0	1	0	2	0	0	0	1	0
January 2021	0	0	0	0	0	1	0	1	1	1	0	0
February 2021	4	0	0	1	0	0	0	1	0	1	0	0
March 2021	0	1	0	0	0	1	0	0	0	2	0	2
April 2021	1	0	0	0	1	0	1	8	0	1	0	0



Performance Summary

- 14 (64%) of Datix incidents recorded relate to difficulties and delays in accessing an emergency ambulance transfer
- No Datix incidents relating to patient harm during transfer
- Datix incidents relating to delays and patient risk align to concerns within the booking process and operating model

Resource Availability

Workforce	Staff in post January 2021		Staff in post end of April 2021		Notes
	Established WTE	In Post	In Post	Gaps	
Manager	1.0	1.0	1.0	0	
Paramedics	3.0	3.0	3.0	0	
EMT	2.0	2.0	2.0	0	
Team Leaders	7.0	4.0	6.0	1.0	
UCS	66.0	63.0	62.0	4.0	Recruitment & training underway. Turnover expected and planned for. No impact on UHP.
UCS - Transfer Practitioner	2	2	2	0	
Control	15.8	15.8	15.8	0	
Liaison	1.0	1.0	1.0	0	
Resource	1.0	1.0	1.0	0	

Performance Summary

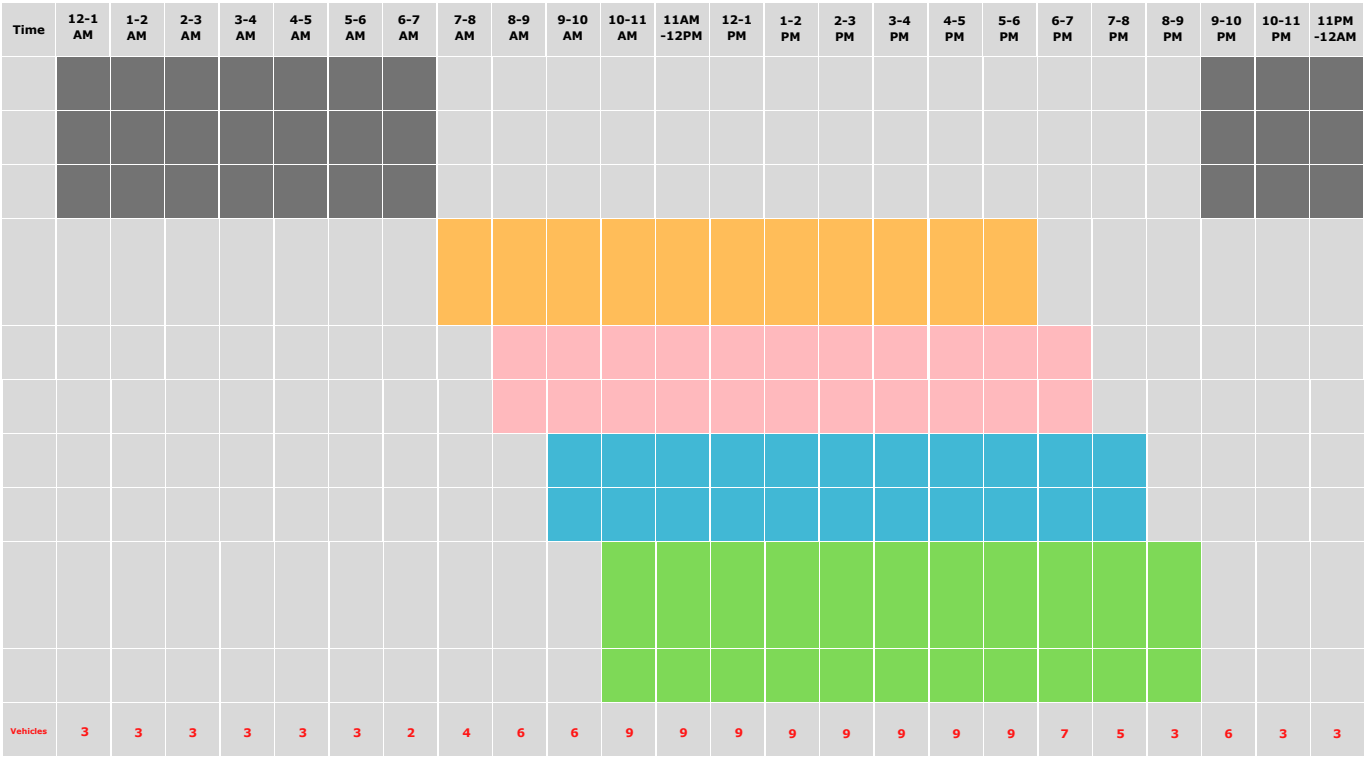
- Effective recruitment of Inter Hospital Transfer Service staff
- 68 WTE positions were funded against original modelling: 66 UCS transfer ambulance staff and 2 UCS transfer practitioner ambulance staff

Utilisation and Rota

% booked on the day	Booked Previous Day*	% Aborted Journey	% Cancelled Journey	% of escorts
98.1%	1.9%	9.8%	0.4%	0.6%

* The figures above only relate to crews on the NEPTS CAD system due to the differences in the reporting between WAST systems as there are no pre-planned functionality on the EMS CAD. This could mean the percentage booked on the day overall may be higher.

Rota



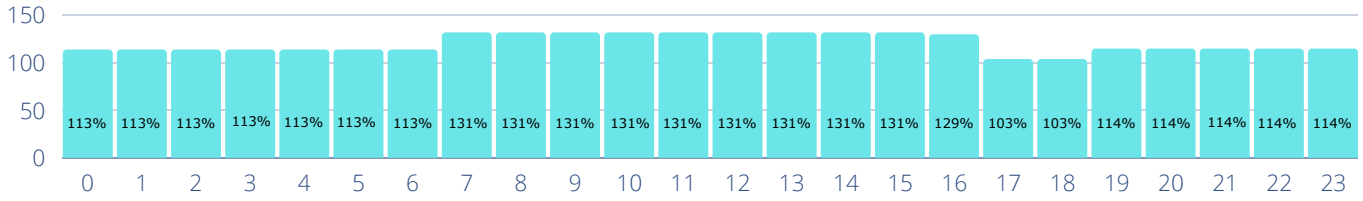
Performance Summary

- 1.9% of transfers are booked the day prior to travel
- 9.8% of transfers are cancelled on the day of travel
- Resource availability within operational rota aligned to modelled demand
- Jan 21 to Apr 21 average UHP – CCC Allocator 111%, UCS 107% , TP vehicle 101%

Unit Hour Production

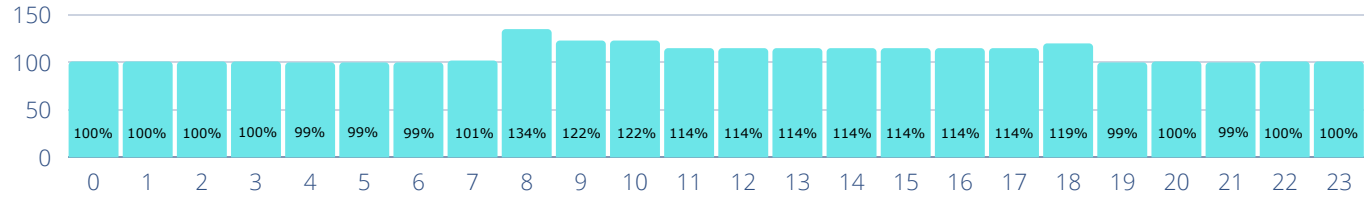
Allocator | Hour by hour - April 2021

Expected	Actual	Daily Percentage
103	124	120%



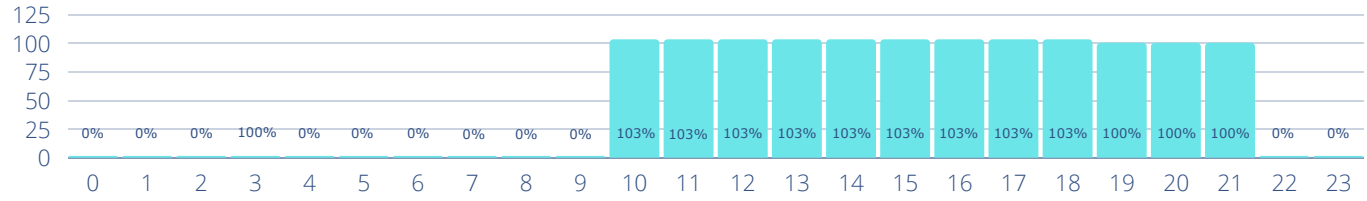
UCS | Hour by hour - April 2021

Expected	Actual	Daily Percentage
497	554	112%



TP Vehicle | Hour by hour - April 2021

Expected	Actual	Daily Percentage
51	53	102%



QUESTIONNAIRE RESPONSES

Overview

There were a total of 19 responses received

89%

of responders were in a direct service delivery role

11%

of responders were in an indirect service delivery role

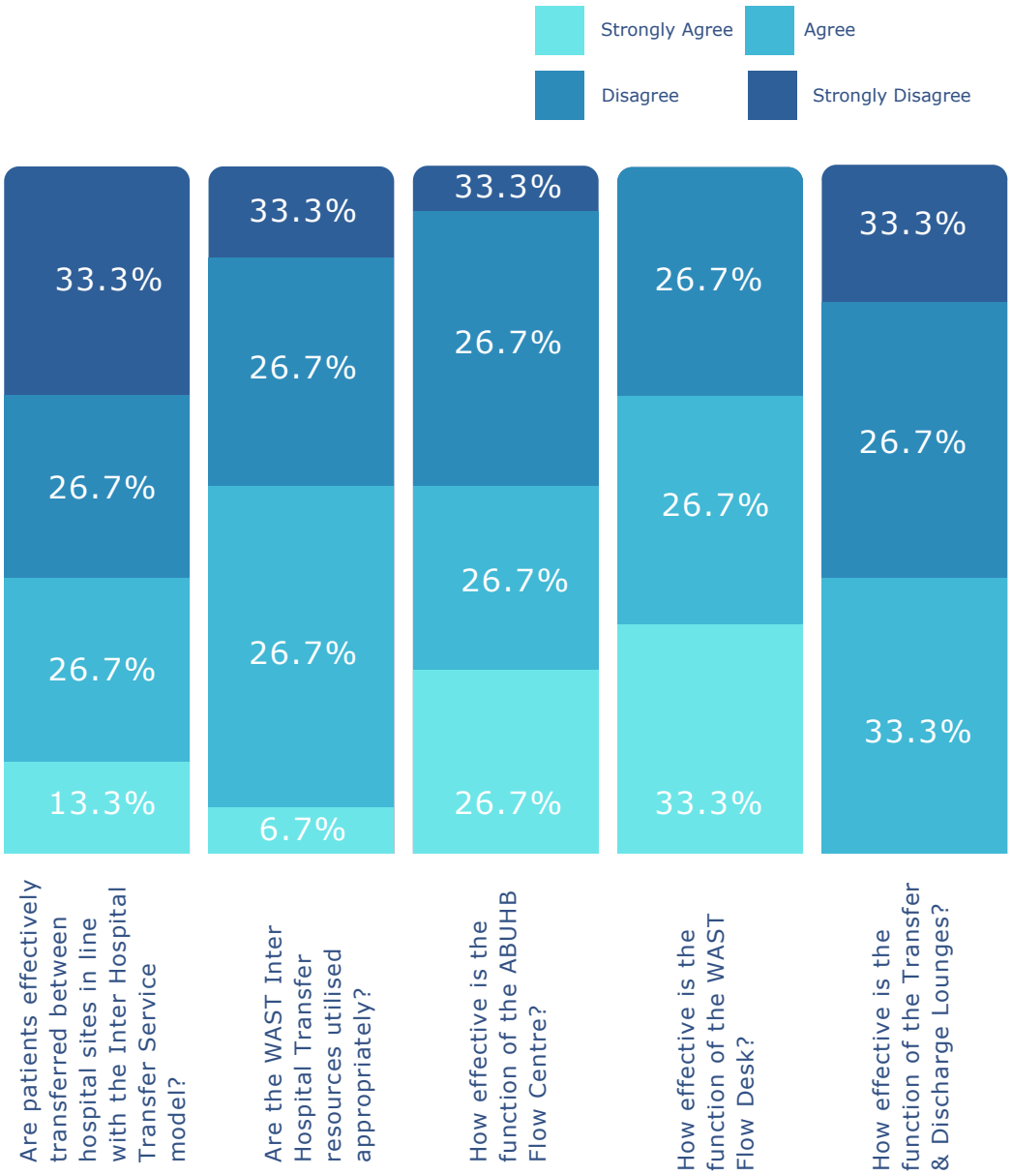
61%

of responders were employed by the Welsh Ambulance Services NHS Trust

39%

of responders were employed by Aneurin Bevan University Local Health Board

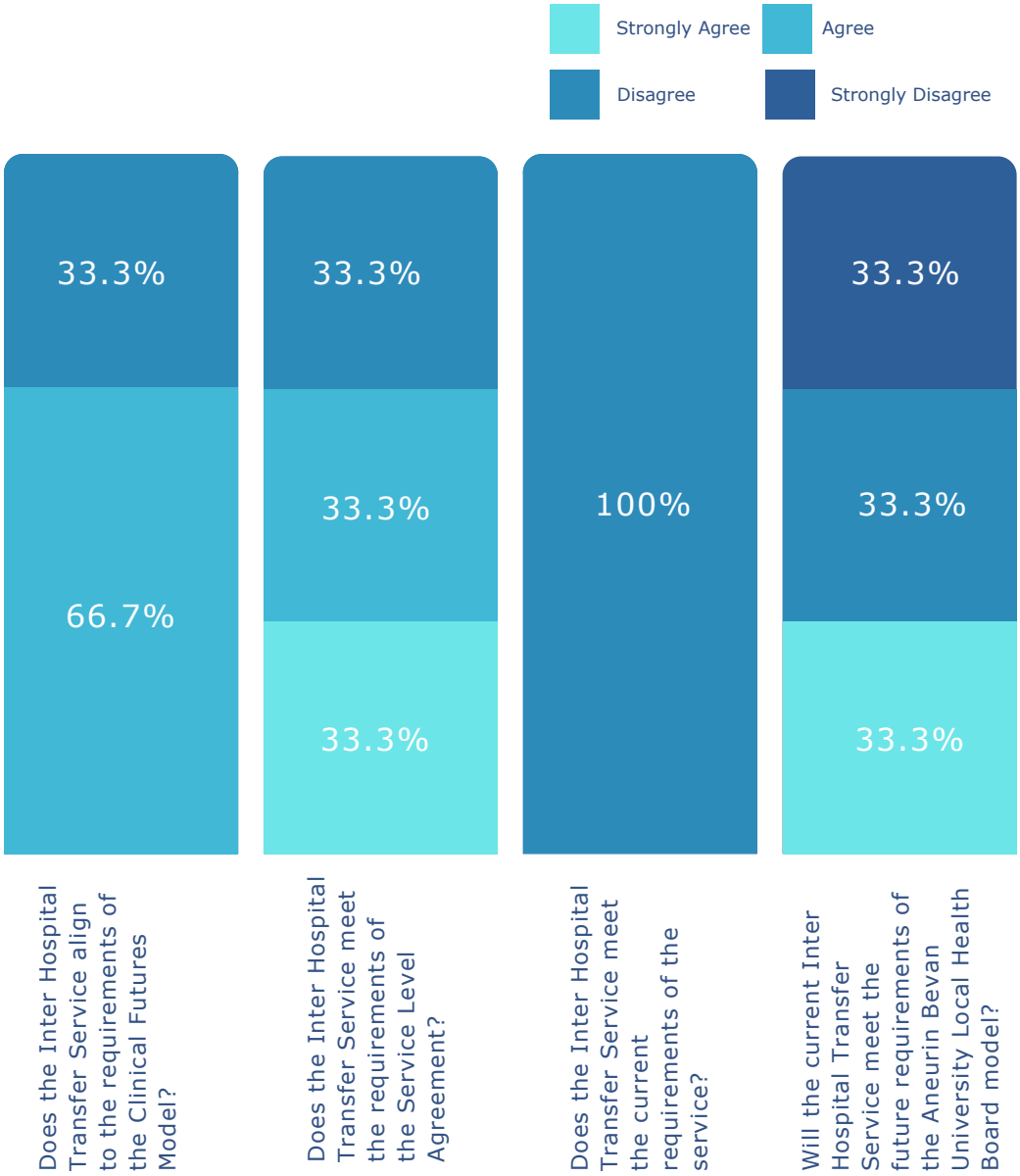
Direct Service Delivery



Response Summary

- Ineffective communication systems
- Inconsistencies in systems and processes
- Inconsistencies in service delivery
- Inconsistencies in patient flow
- Extension to transfer practitioner operating hours
- Transfer practitioner are not currently but, have the ambition and capability to convey paediatrics

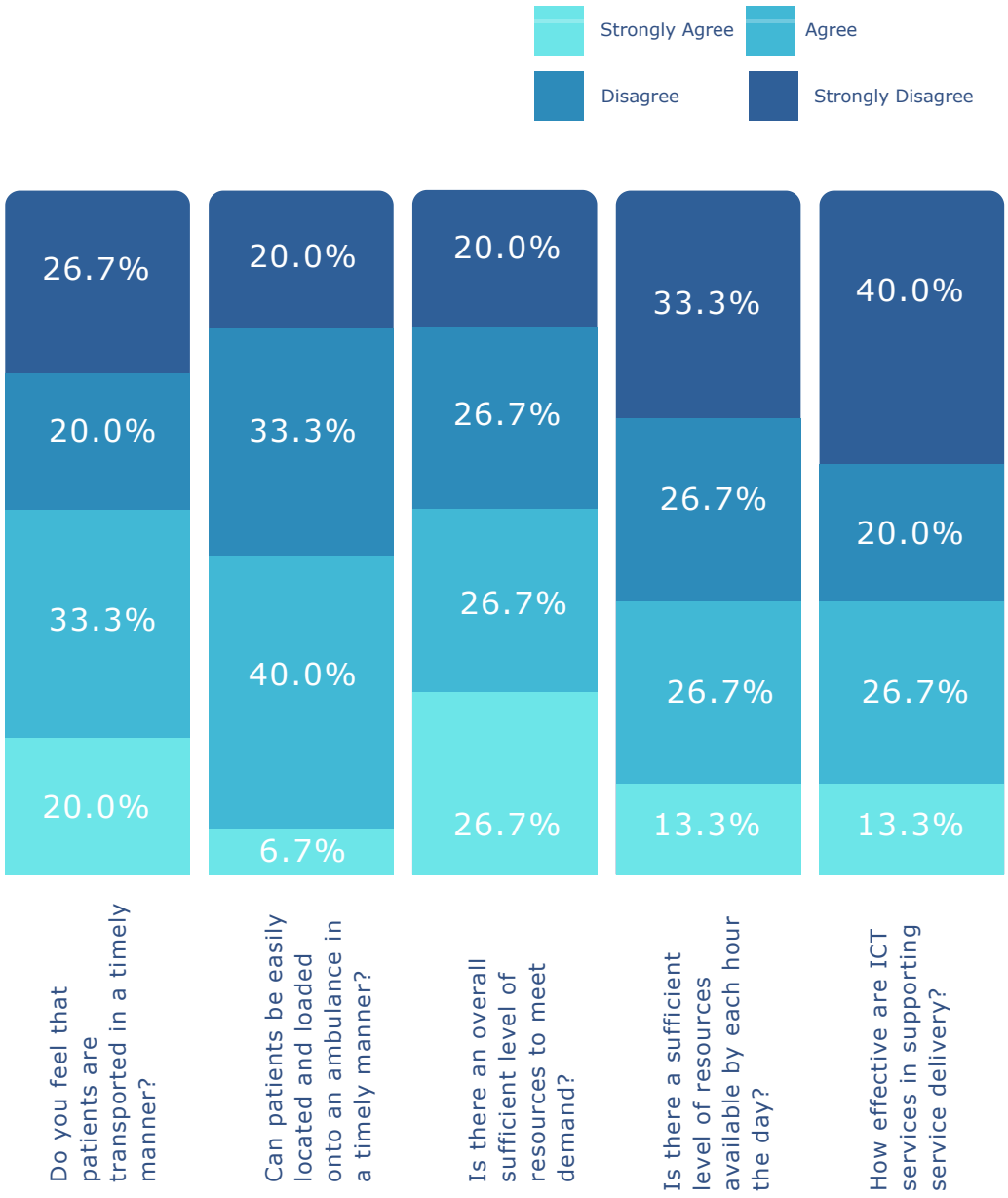
Indirect Service Delivery



Response Summary

- Great linkage between organisations to manage all resources
- Clinical Futures Model not fully implemented
- Review of current resource levels against future requirements

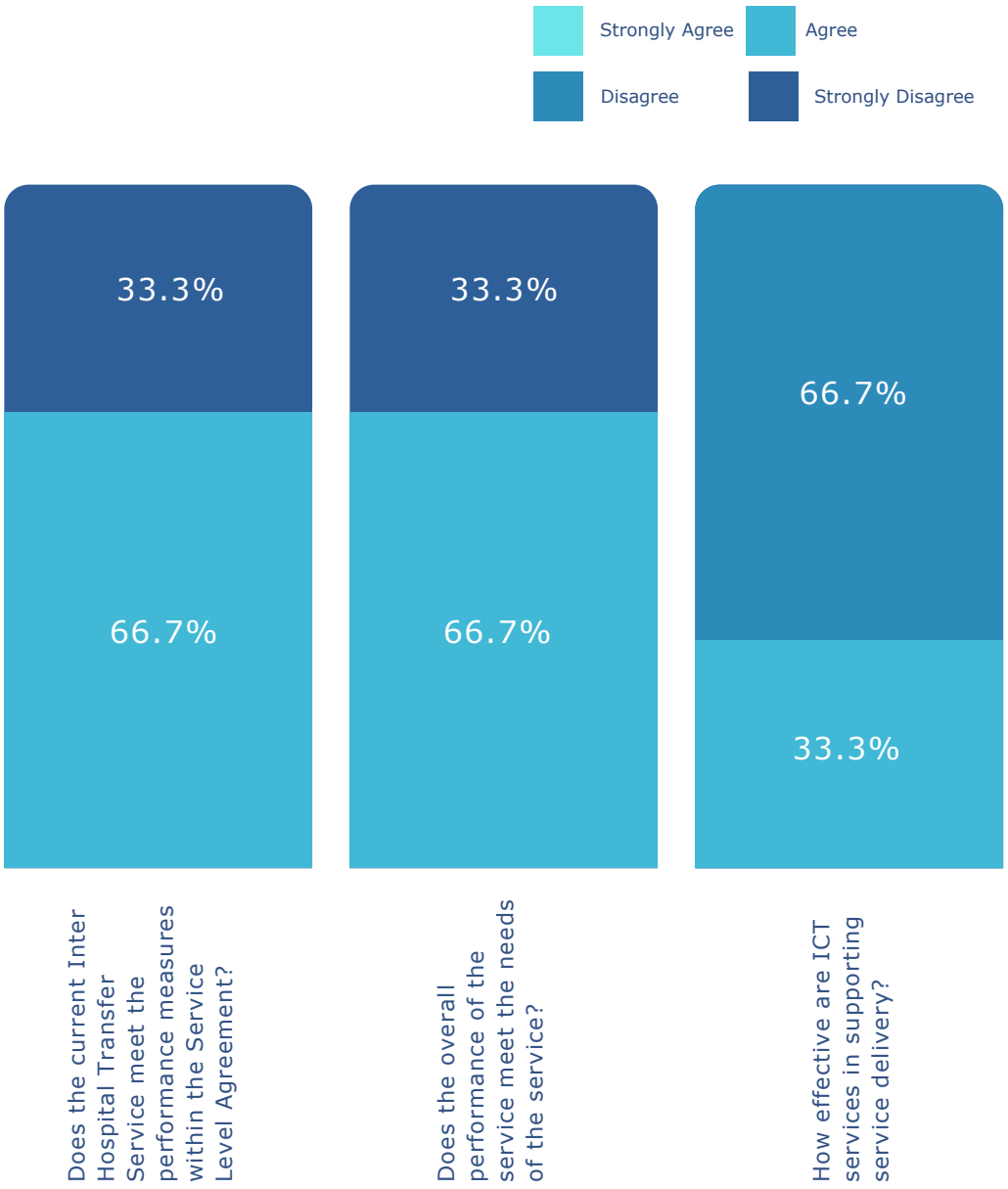
Direct Service Delivery



Response Summary

- Difficulties accessing emergency transfer resources
- Repetition in systems and processes
- Utilise one CAD system
- Hospital communication systems and infrastructure ineffective
- Align resources to demand

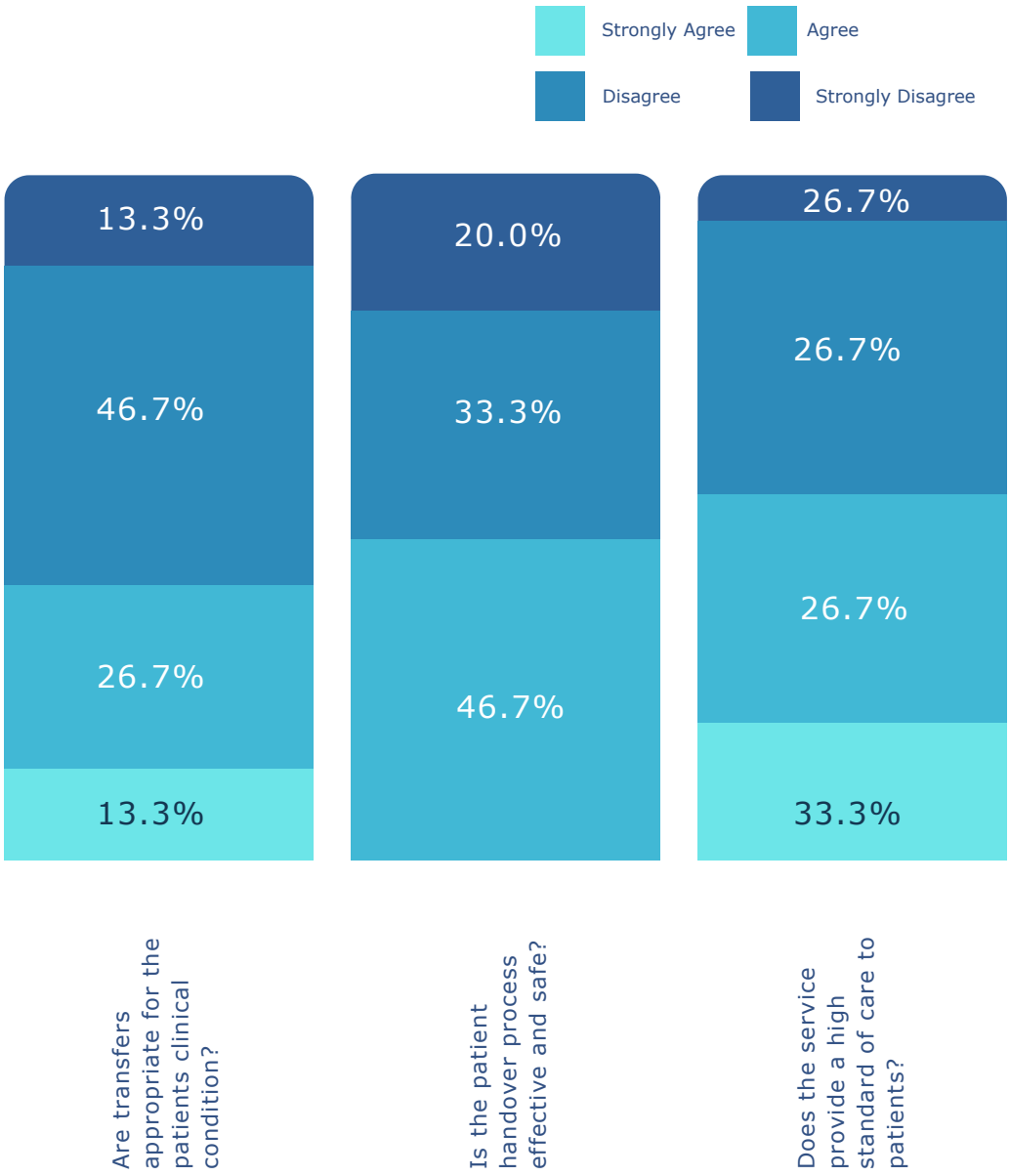
Indirect Service Delivery



Response Summary

- Joint review of whole system
- Review joint strategic and management structure

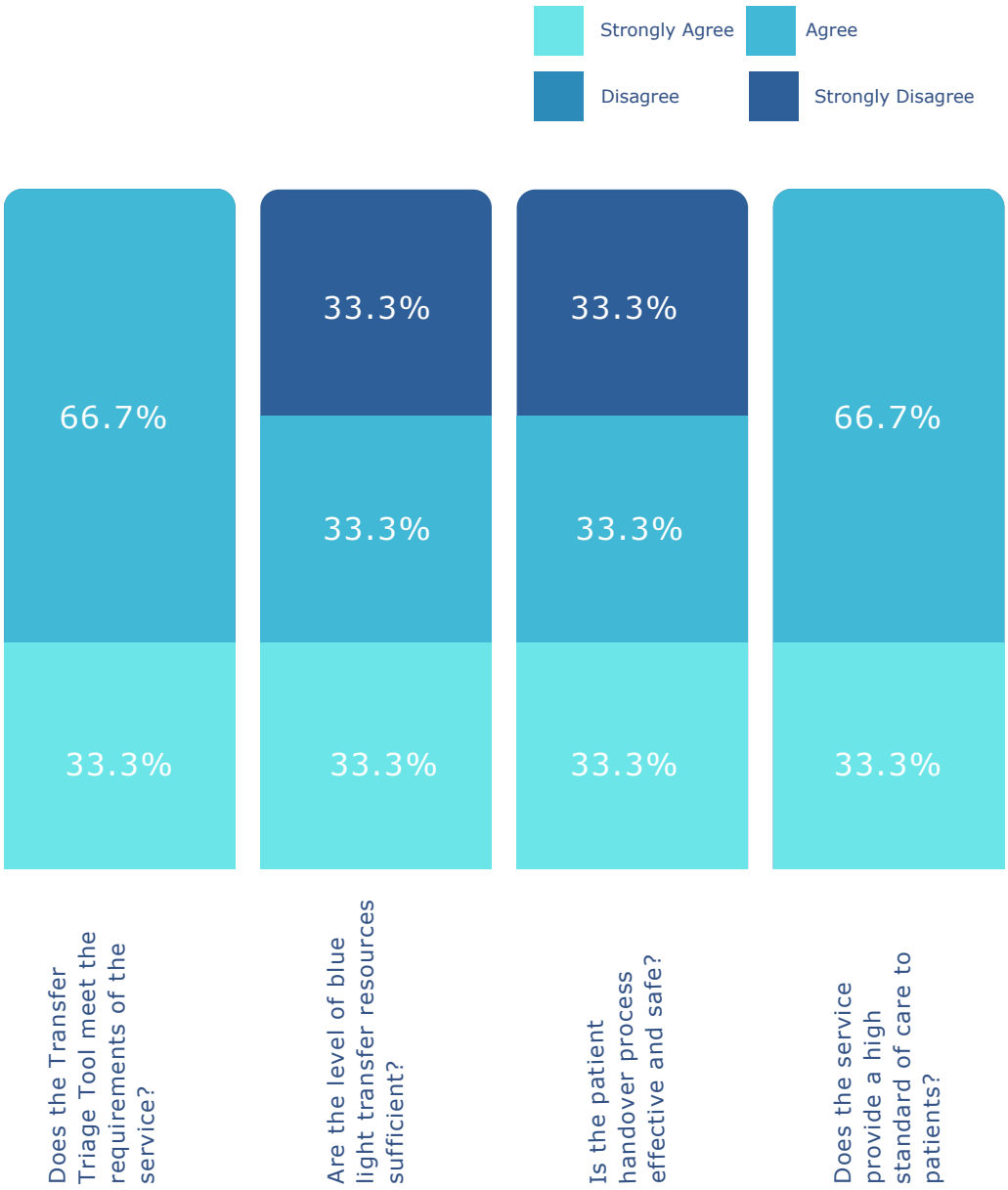
Direct Service Delivery



Response Summary

- Function, flow and care within discharge & transfer lounge
- Delays at hospital sites, patients becoming readmitted
- Patients frequently moved between sites
- Step down transfers being undertaken through the night

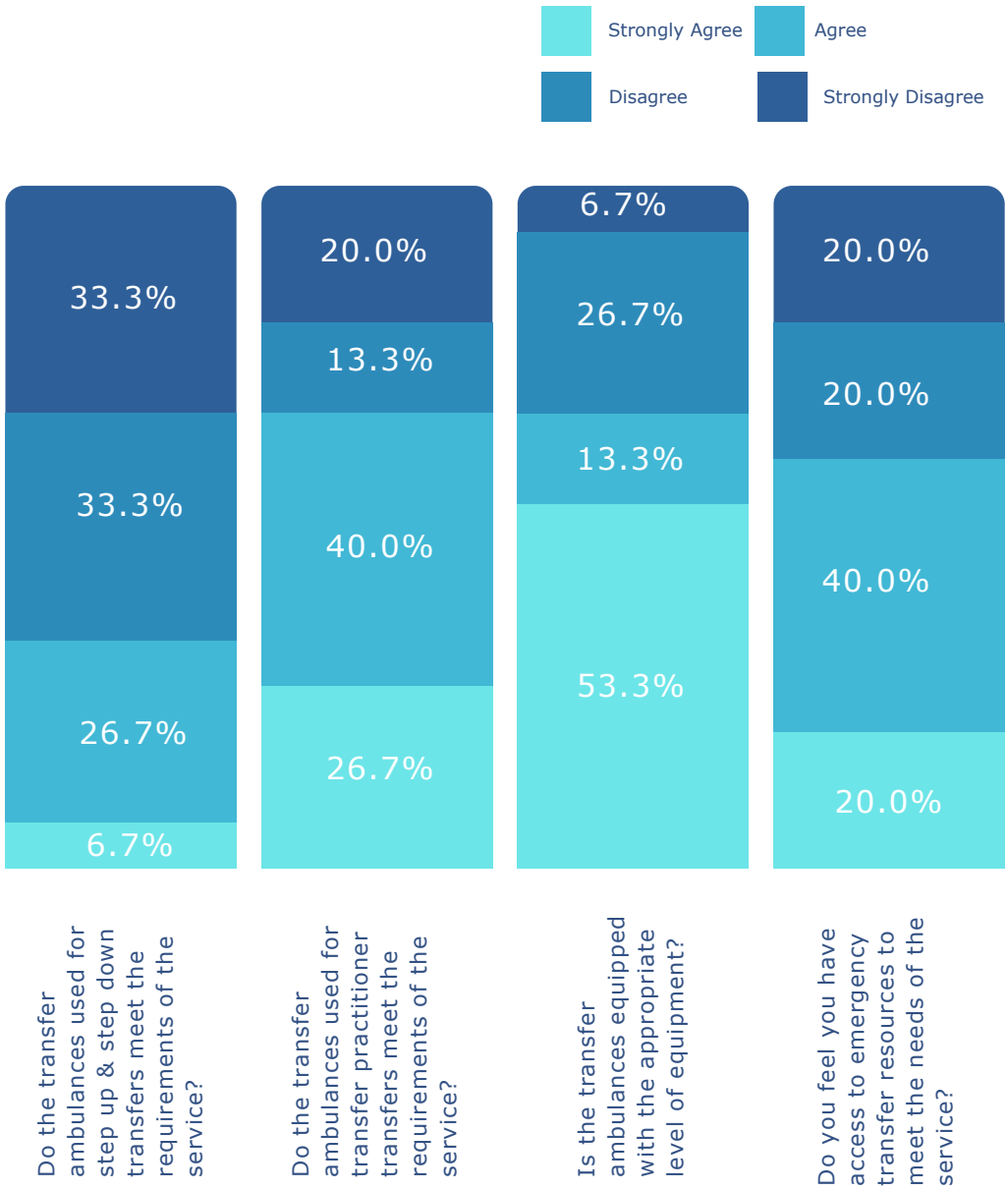
Indirect Service Delivery



Response Summary

- Variation in the understanding of the operation and purpose of the service
- Greater communication and learning from incidents and joint investigations

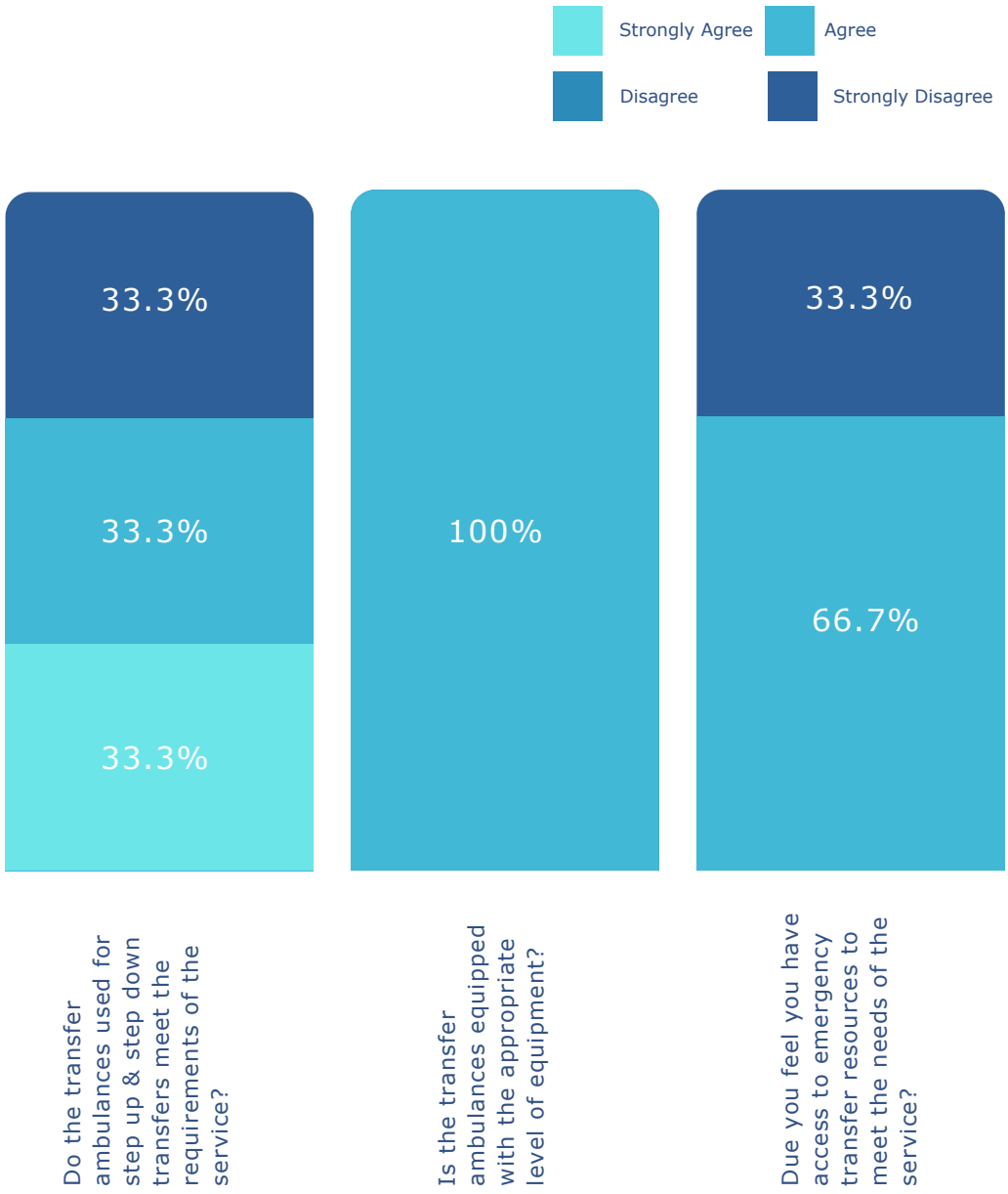
Direct Service Delivery



Response Summary

- Identify an alternate transfer practitioner vehicle
- Realign operational roster to demand
- UCS resources unable to support transfer practitioner requirements out of hours

Indirect Service Delivery



Response Summary

- No transfer practitioner resource overnight. Transfer practitioner transfers have to been undertaken by EMS. Delays in accessing EMS resources to undertake transfers
- EMS community response handover delays at emergency departments are impacting on resource availability
- Expect to see increased demand once the Clinical Futures Model is fully operational

ANALYSIS SUMMARY

Model

Clinical Futures Model

The GUH opened ahead of schedule in November 2020 to respond to the Covid19 pandemic and winter season pressures. With an initial change to the focus of health care services being delivered by the GUH following its initial opening, ABUHB had to adjust to the health care requirements of the population and take a phased approach to full implementation of the Clinical Futures Model.

The Inter Hospital Transfer Service was developed to reflect the requirements of the full implementation of the Clinical Futures Model. Due to the challenges associated with the full implementation of the model, there was variation in how the Inter Hospital Transfer Service aligned to the current health board operating model.

A number of proactive steps have been taken by both ABUHB and WAST to realign processes and resources to reflect the current requirements of the health board, providing the timely and safe transfer of patients between health board sites.

Service Design

The work to design the Inter Hospital Transfer Service initially started prior to the Covid19 pandemic, alongside the design work for the operational delivery of the Clinical Futures Model. The core design and operational delivery work for the Inter Hospital Transfer Service was undertaken during the Covid19 pandemic, whilst both ABUHB and WAST were under significant operational pressures.

During the design period and first 6 months of operation, the original concept and design of the Inter Hospital Transfer Service has evolved to meet the demands of the health board's operational model. It is acknowledged that the changes to the original service design have been taken in order to respond to the requirements of the health board and to provide the highest level of care to patients.

It should be recognised that both ABUHB and WAST teams developed and delivered the Inter Hospital Transfer Service, within a reduced timeframe, during the Covid19 pandemic, whilst also managing substantial changes to the whole health board emergency and unscheduled care systems. Both organisations should be commended for their achievements in delivering the service as they have, during a period of unprecedented challenge.

Key Finding: Establishing the Inter Hospital Transfer Service during the Covid19 pandemic to support the advanced opening of the GUH was a significant achievement

Service Level Agreement

Due to the condensed timescales the SLA and service specification was developed alongside the development of the Inter Hospital Transfer Service. The service specification is reflective of the period of development and the planned operating model. As the health board operating model responds to the changes of the population, it is acknowledged that the Inter Hospital Transfer Service may need to evolve to reflect the live environment. Therefore, service delivery outcomes may not directly align to the established SLA and may require future updating.

Flow Centre

The Flow Centre has been established within the WAST's Regional Headquarters at Vantage Point House, Cwmbran. Due to IT, communication and capacity requirements of the Flow Centre, it was unable to be located alongside WAST staff responsible for the dispatching of ambulance resources. A Flow Desk was established within WAST's CCC, with WAST staff dedicated to the coordination and dispatching of ambulance resources. The Flow Centre communicates with the Flow Desk via telephone and email.

Both health board and WAST teams have responded well to the development and implementation of a system to support the delivery of a new operating model, in difficult circumstances within a limited timescale.

Evidence gathered indicates that due to communication difficulties between the hospital sites, Flow Centre and Flow Desk and the requirement to use multiple bookings systems, there is an increased risk of errors being made within the booking process, resulting in delays, reduced patient flow and reduced patient care.

Flow Desk

The Inter Hospital Transfer Service resources are managed by two independent control teams within WAST's CCC, in order to accommodate the requirements and agreed principles of the Inter Hospital Transfer Service.

The health board operating model stated that all step down and pre-planned step up transfers would be identified and booked for transferring the day prior to travel, with emergency step up transfers being booked on the day. It was agreed between organisations that step up and transfer practitioner resources would also be able to respond to the community for "Red Calls". In order to dispatch transfer resources, transfer resources would need to align to the EMS CAD system, C3.

Data indicates that 98.1%* of all step up and step down patients are booked on the day with step down patients being transferred 24/7, outside of core times. The variation between the operating model and the designed operating model, has seen challenges in managing step down resources 24/7 and the ability to effectively plan and fully utilise transfer resources.

With two independent teams utilising two non-integrated CAD systems, the control teams have found difficulties in managing and transferring resources between teams in order to actively response to live demand. It is recognised that there are complexities within the booking system and there could be opportunities for quality and efficiency improvements, enhancing the overall service.

Transfer & Discharge Lounge

The level of resources required to deliver the Inter Hospital Transfer Service was established utilising modelling data, which was developed using the identified demand and needs established by ABUHB, supported by required performance indicators and operating principles. The safe and timely management of patients arriving at or leaving a hospital site is an essential requirement in order to maximise resource utilisation. A performance indicator for the handover of transfer patients was set at 30 minutes.

The designed health board operating model was developed with the principles that key hospital sites would operate a transfer & discharge lounge, supported by a portering team, where patients leaving a hospital site would be located prior to being collected by an ambulance. The transfer & discharge lounge would be staffed during hours of operation by a dedicated nursing team. In addition to the dedicated nursing team, a dedicated WAST ALO would be located within the GUH transfer & discharge lounge during the core hours of operation to support with coordination of step down transfers and discharges.

Information indicates that the GUH transfer & discharge lounge has and continues to experience difficulties following the initial opening of the GUH site. The implementation of the new operating model with a new transfer & discharge team, required further development to raise service delivery standards.

* The figures above only relate to crews on the NEPTS CAD system due to the differences in the reporting between WAST systems as there are no pre-planned functionality on the EMS CAD. This could mean the percentage booked on the day overall may be higher.

Portering teams have not been introduced in any sites, with many patients not being present with the transfer & discharge lounge or at an agreed at the time of travel. Ambulance staff are having to collect patients directly from hospital wards, where patients are not always ready to travel.

Due to capacity issues within GUH, the transfer & discharge lounge is being used as an overflow area for the hospital, detracting from the lounges intended purpose and ability to operate effectively.

There have been a range of improvements made to date to develop standard operating procedures and implement consistency in service delivery, improving overall patient care. Performance against the 30 minute performance target has slightly improved month on month since the service commenced, with overall health board performance at 59.3%.

The Inter Hospital Transfer Service modelling was based on the operating model that transfer vehicles would be based at and respond from the ELGH and GUH hospital sites.

Through the service development phase, ABUHB offered WAST access to health board staff welfare facilities at hospital sites. It was identified that hospital sites could not fully accommodate the capacity and workforce welfare requirements of WAST. Discussions took place between ABUHB and WAST to identify a joint solution to the estates matter.

A short term option for the period of 8 months (December 2020 to August 2021) was agreed between organisations, with the whole dedicated transfer team being located at the health board's Llanfrechfa Grange Recreational Hall adjacent to the GUH. Funding from within the Inter Hospital Transfer Service budget was allocated to adapt the site, in order to meet the essential requirements of WAST.

The agreed longer term estates solution was that WAST would identify an alternate site or sites within the vicinity of GUH. WAST identified a suitable alternate site located in Cwmbran. WAST have commenced work to commission the site.

The ABUHB operating model required transfer resources to be based at hospital sites. This model would therefore only require minimal one off investment in existing estates in order to accommodate the Inter Hospital Transfer Service. Due to the challenges with accommodating the requirements of WAST and the Inter Hospital Transfer Service, dialogue continues between organisations regarding the longer term funding of estates to accommodate the Inter Hospital Transfer Service.

Performance

Demand

Demand against all transfer categories has continued to increase since the service commenced in November 2020. Overall service demand compared to modelled demand has been lower. This reduction in demand is attributed to the Covid19 pandemic, which has delayed the full implementation of the health board's operating model. The modelled demand identified 72 transfers per day. Actual average demand is at 57 transfers per day.

The 57 transfers per day include an average of 7.6 discharge journeys (per day) that were not included in the original modelling. The original Inter Hospital Transfer Model was not developed to accommodate patients being discharged home. Discharge activity would be accommodated by existing and additional dedicated discharge resources. Due to the overall reduction in demand, the health board took the active steps to fully utilise the transfer resources to support discharge demand.

Additionally, the Inter Hospital Transfer Service is seeing a growing and unpredicted demand for 'step across' transfers, where patients require transferring between two hospital sites that are not aligned to GUH, e.g. ELGH to community hospital. Of the 57 transfers per day, there are an average of 2.5 step across transfers per day.

Step down transfer demand has increased since November 2020 and is the part of the Inter Hospital Transfer Service that is most aligned to the original modelled demand. The average number of daily step down transfers has been 36.81 transfers per day, compared to the modelled average step down transfer demand of 38.81.

Due to the delay in the full implementation, step up demand is the category of transfer that has seen the area of greatest reduction against modelled demand. The modelled step up demand identified 33 transfers per day (30 incorrect attendance at MIUs', 3 deteriorating inpatients). The actual average demand is 11 step up transfers per day.

Emergency ambulance transfers and transfer practitioner transfers are also lower than originally modelled. Emergency ambulance transfers were modelled at 10 transfers per day. The actual average demand is 1.69 emergency transfers per day. Transfer practitioner transfers were modelled at 6 per day, with actual average demand at 2 per day.

Of the 10 dedicated transfer resources (5 step up, 4 step down, 1 transfer practitioner) per day, the 5 step up and 1 transfer practitioner resource are utilised to respond to the Red Calls within the community.

Resources are manually dispatched to Red Calls via WAST Control. Between January 2021 and April 2021, the 6 resources have responded to an average of 21 Red Calls per month, averaging 0.15 Red Calls per day. The average time allocation to clear is 1 hour 5 minutes.

Additionally, the 6 dedicated resources have attended 11 Amber 1 Calls and 9 Amber 2 Calls. Further validation of this demand is required but information indicates that the transfer practitioner resource has been utilised to support to emergency transfers, some of which would have been allocated to a pooled emergency ambulance resource.

There has been a noticeable level of demand aligned to hospital sites that were not factored into the original design and modelling for the Inter Hospital Transfer Service. The original model was designed around the transfer of patients between 3 ELGHs and GUH.

Data indicates that 357 (21%) of step up transfers have originated from sites other than the 3 ELGHs, with 652 (13%) of step down transfers being transferred to sites other than the 3 ELGHs.

Overall, monthly activity has continued to rise but demand is still below the modelled levels. The service has evolved to support areas of demand that were not originally planned for. The differing activity could impact on the overall numbers of transfers that can be completed and performance outcomes. If the services overall demand continues to rise, the priorities of the transfer service may need to be considered.

Performance

The performance target for conveyance for the Inter Hospital Transfer Service is that 90% of patients will transferred either within 1 hour or 4 hours from the time of booking, dependant on their transfer category.

The performance target for the handover of patients for the Inter Hospital Transfer Service is that all patients will be handed over and the transfer ambulance becoming mobile, within 30 minutes of the crews arrival.

There were no performance indicators for the level of demand by hour of the day, but following assumptions were made:

- there would be a continuous flow of step-up and step-down patients throughout the course of the day
- step-down transfers would only take place during the hours of 0800 and 2000
- cancelled/aborted journeys would not be a factor in a co-ordinated system

Key Finding: The overall demand for the service was significantly less than expected due to the health boards operating model having to adapt and respond to the Covid19 pandemic and current requirements of the population of the health board's

1 Hour Response

Response time performance:

Step Up Transfers - Transfer Ambulance 77.6%, Transfer Practitioner 65.2%, Emergency Ambulance Transfer 44.3%

Step Down Transfers - Transfer Ambulance 81%, Transfer Practitioner 82.4%, Emergency Ambulance Transfer 45.7% (1 hour step down transfers were not part of the original service expectations and require further review).

4 Hour Response

Response time performance:

Step Up Transfers - Transfer Ambulance 90.09%, Transfer Practitioner 100%, Emergency Ambulance Transfer 100% (4 hour step up transfers were not part of the original service expectations and require further review).

Step Down Transfers - Transfer Ambulance 88.7%, Transfer Practitioner 93.6%, Emergency Ambulance Transfer 81.3%.

Handover

The SLA includes a 30 minute handover performance target for patients arriving or departing a hospital site. The 90% handover performance target is applied to step up patients arriving at GUH and step down patients arriving at ELGHs. The overall handover performance against the 30 minute performance target is 54%, with step up transfers at 57.8% and step down transfers at 51%.

Evidence indicates that there are two key areas that impact on the services ability to deliver the 90% performance target. One area is that patients are not ready for transfer and not located within the transfer & discharge lounges or at an appropriate place. Transfer crews are having to identify and return patients directly to hospital wards. The second area relates to handover delays at hospital sites, where patients are having to wait on an ambulance prior to be accepted by the receiving hospital site. Data shows that on average 159.44 hours per month / 5.3 hours per day, are lost due to transfer ambulances being delayed in handing over patients at hospital sites.

Hour of Travel

The health boards model of operation envisaged a continuous stream of patients being transferred daily throughout the health board system. Step down demand would be present between 0800 and 2000, with step up demand being 24/7. Evidence suggests that patient flow is not balanced throughout the course of the day and that transfer demand increases throughout the day, with the highest level of demand existing between 1600 and 1900, causing a bottle neck in the system.

Pre-planned

The concept that patients requiring transfer would be pre-planned prior to travel can be a key factor in ensuring effective resource management. Data indicates that 98.1%* of all transfer patients are booked on the day.

This principle of pre-planning transfers, along with the modelling assumption that the hour of travel could be controlled, were key factors that were included in the development of the transfer ambulance operational roster, establishing the level of resources required by hour of the day.

Cancellations and Aborts

Service modelling did not include a predicted level of cancellation/abort activity. Cancellations are identified as journeys being cancelled 24 hours prior to travel with aborts classed as on the day cancellations. Data indicates that 9.8% of all transfer activity is aborted, with 0.4% being cancelled*.

The Inter Hospital Transfer Service has not been able to achieve the established 90% performance target for 1 and 4 hour transfers, nor handover of patients within 30 minutes.

Key finding: Performance measures have not been achieved due to the challenges experienced by ABUHB and WAST in responding to the requirements of the population during the Covid19 pandemic

* The figures above only relate to crews on the NEPTS CAD system due to the differences in the reporting between WAST systems as there are no pre-planned functionality on the EMS CAD. This could mean the percentage booked on the day overall may be higher.

The key challenges impacting on service performance in these areas relates to volatility and variability within the system, causing demand to significantly increase later into the day and exceed the level of resources available at that time period. It is acknowledged within the service modelling, that in order to meet high performance targets, resources need to be available a high percentage of the time. With limited pre-planning and high utilisation at later periods of the day, the dedicated resources are not utilised optimally. Not achieving optimal utilisation may impact of the service's ability to meet the performance targets within the SLA.

The effective utilisation of resources is also impacted by resources being delayed at hospital sites and aborted journeys. As identified within the service model analysis, effective communication between sites and a robust and streamlined booking process could positively contribute to the Inter Hospital Transfer Services overall performance. Differing activity also impacts, discharges, step across etc.

Resource Availability and Utilisation

To deliver the requirements of the Inter Hospital Transfer Service, WAST were required to recruit and train 68 new UCS members of staff, in addition to 3 paramedics, 2 EMT's, 15 CCC staff, 1 ALO, 1 Resource Coordinator and 8 management team members. WASTs ability to recruit and train the 68 new operational staff with a limited timescale during the Covid19 pandemic was a significant challenge which was effectively overcome.

The effective recruitment exercise ensured all commissioned resources were delivered within the agreed timescales. Additionally, WASTs proposal to recruit all UCS staff instead of a mixture of UCS and NEPTS staff, meant that the service could provide greater efficiencies to the health board by extending the level of clinical resources available within the same financial envelope.

To deliver the Inter Hospital Transfer Service, 98.8 whole time equivalent (WTE) positions in operational and non-operational roles were identified through the service design process. Of the 98.8 WTE, 68 WTE were operational UCS staff. 66 new UCS staff were recruited to provide the transfer ambulance element of the service, with WAST undertaking an internal recruitment exercises to recruit the 2 WTE staff to deliver the transfer practitioner service.

In April 2021, there were 91.8 WTE in post. The 5 WTE shortfalls were in operational roles due to individuals moving within the organisation. Ongoing recruitment plans are in place to backfill vacant positions. With an effective relief capacity being built into the operational and CCC rotas, both operational and CCC unit hour production (UHP) have continuously exceeded 100% since the service commenced. This has been a significant achievement and ensured a continuously high level of resources availability.

When GUH opened in November 2020 and the Inter Hospital Transfer Service commenced, private ambulance providers were utilised to deliver the service until the new WAST service went live. Due to the level of risk with the new operating model, the health board requested a dedicated interim blue light resource. This resource was provided by a private provider.

Reviewing the blue light utilisation of the dedicated resource indicated that the requirement to utilise blue lights was limited. Transfers aligned to the employed skill set of the private provider staff (UCS), could safely be undertaken in a timely manner without the requirement to continuously operate under blue lights.

For patients requiring an emergency transfer from ELGHs to GUH, a pooled paramedic/EMT emergency ambulance resource was commissioned. The funding aligned to this resource commissioned a pooled resource 12 hours per day, 7 days a week, to undertake 10 emergency transfers per day. Evidence indicates that the pooled resource has undertaken 1.69 emergency transfers per day. The level of emergency transfer demand is lower than originally planned. There is also evidence to suggest that due to emergency ambulance resource availability, the transfer practitioner resource has undertaken some emergency transfers that would have been undertaken by an emergency resource if available.

Datix incidents reported by the health board and WAST, show that the highest number of Datix incidents submitted (14) regarding a single concern, related to delays in accessing an emergency transfer resource. Of the 0.15 emergency transfers undertaken daily, average performance against the 1 hour response target is 44.3%. The Inter Hospital Transfer Service questionnaire asked individuals if they felt that there was sufficient access to emergency transfer resources. 100% of respondents stated that they did not feel that here was a sufficient access to emergency transfer resources.

Evidence indicates that WAST UHP has been delivered to the agreed level for the commissioned service. One of the key contributing factors to low emergency ambulance availability relates to handover delays at emergency departments. Within ABUHB, an average of 70 hours are lost every day due to handover delays at emergency departments. Evidence would suggest that the level of handover delays is significantly impacting on the ability to access a pooled emergency transfer resource.

The transfer practitioner resource has also seen a reduced level of demand from the original planning model. The resource was originally modelled to undertake 6 transfers per day. On average the service undertakes 2 transfers per day, not including responses to red calls within the community. Although resource utilisation is low, the level of resource availability is higher and therefore, performance against the resource is enhanced. The health board has expressed a view that extending the transfer practitioner resource from 12/7 to 24/7 and undertaking paediatric transfers would enhance the health board’s ability to access a dedicated clinically suitable resource 24/7, improving patient outcomes.

Since the WAST Inter Hospital Transfer Service went live in December 2020, the dedicated UCS service has continuously produced 100% resource availability aligned to the agreed roster. Data indicates that the utilisation of these resources across the day is variable due to the flow of patients throughout the health board system. Average performance against the UCS resources exceeds 77% across all transfer performance targets but average performance is reduced by low performance at times of peak demand.

In February 2020, the Inter Hospital Transfer Service began undertaking discharge activity, conveying patients from a hospital to a home address. The nature of this activity means that these journeys can take considerably longer than a hospital transfer. On average a discharge journey can take 2 hours, where a hospital transfer can take 30 minutes. The increased journey time for discharges has the ability to impact on resource availability and utilisation. 3 Datix incidents have been submitted for failed discharges due to concerns regarding discharge process and the potential risk to patient care.

In additional to discharges it should be noted that new step across activity that has been undertaken by the service has impacted on performance due to longer journeys. To accommodate the current model of operation and to improve resource utilisation, joint work is required to realign patient flows as far as possible, alongside a review of the transfer ambulance rosters.

Information Communication Technology

Across ABUHB and the WAST, there are multiple information and communication technology (ICT) systems that support the coordination and care of patients. In order to manage a patient through the Inter Hospital Transfer Service, patients have to be manually triaged to identify the correct ambulance resource, before personal information is manually inputted into health board and WAST booking systems. The duplication and manual input of personal information raises the potential risk of administrative errors.

The Flow Centre and WAST Control team were unable to be embedded within the same operating environment as originally envisaged. Due to technical and estates limitations, compromises were made with teams being located within separate environments but within the same building.

These limitations could be viewed as having an impact on the health board's ability to view all WAST resources in a live environment and their ability to actively prioritise patients. In overcoming the physical and technical constraints of the model, both the Flow Centre and Control Teams have established a positive relationships with good communication channels between teams and remote access to systems has been achieved.

Key finding: The level of transfer ambulance resources were appropriate given that the service modelling was developed using higher demand profiles

Evidence indicates that there are ongoing communication challenges when the Flow Centre or Flow Desk are trying to communicate with hospital sites and communication on site. There are reported difficulties with obtaining a response from hospital wards with regards to a patient's booking, confirmation of bed allocation and effectiveness of hospital mobile communications systems.

The inability to effectively communicate in a robust and timely manner has impacted the performance of the service and quality of service patients receive. Since November 2020 there have been 16 Datix incidents reported regarding errors made during the Inter Hospital Transfer Service booking process. The Datix incidents relate to incorrect booking information or failed communication between hospital sites and the Flow Centre or Flow Desk.

A performance data report against key performance metrics has been developed by WAST and is reported to the health board and CASC on a monthly basis. It is acknowledged that due to the pace in which the service was established and requirement to capture data from multiple reporting systems, without commonality, further work is required to capture this data in order to assist with further service development.

The Inter Hospital Transfer Service, along with wider ambulance service performance is reviewed at a monthly Tier 2 meeting. Feedback suggests that this meeting provides a forum to review performance but does not have the ability to fully support wider operational and strategic development.

In addition to the overall performance reporting, further improvement work and service evaluations may be required to develop and implement changes to the overall model. Future improvement work will need to be managed via a dedicated joint senior strategic and operational forum.

Key finding: Challenges remain with booking and communications systems which require improvements in order to make better use of the available resource, improve quality for patients and the performance of the service overall

Finance

Revenue Performance 2020/21

The overall performance of the revenue in 2020/21 was £494k below plan for the SLA. The main drivers for this were lower than expected costs in the following areas:

- Training and on-boarding costs (£330k)
- Vehicle fuel, maintenance and operating costs (£112k) and
- Estates costs (£32k)

Additionally, within the operations outturn, there was slightly higher use of private providers than expected (£46k) which was offset by slightly lower than expect staff and relief costs (£75k).

Capital Performance 2020/21

2020/21		
Plan	Actual	Variance
£1,150	£1,444	£294

Capital spend was £294k over plan for the 2020/21 financial year to provide 11 vehicles as required by the SLA. The forecast capital spend in 2021/22 has reduced as a result of this in order to remain in line with the overall plan.

Financial Breakdown

Table 1: WAST Revenue Outturn 2020/21 compare to Service Level Agreement Plan

Figures in £k

CCC			SLA Plan	Actual Outturn	Variance
Staff	**Grade**	**WTE**	**2020/21 Plan**	**2020/21**	**2020/21**
EMS Allocators	5	6.4	117		
EMS Call Takers	3	6.4	81	234	37
NEPTS Liaison	3	1.0	10		
NEPTS Call Takers	3	3.0	38	38	-10
		16.8	**245**	**272**	**27**
Uniform costs			2		-2
Onboarding costs			7		-7
Contingency / mgmt overheads			8		-8
Sub Total CCC			**262**	**272**	**10**

Operations			SLA Plan	Actual Outturn	Variance
Staff	**Grade**	**WTE**	**2020/21 Plan**	**2020/21**	**2020/21**
Manager	7	1.0	21	27	6
Paramedics	6	3.0	68	161	93
EMT	4	2.0	29		-29
OTL	4	7.0	101	60	-41
UCS	3	68.0	856	817	-39
Resource Coordinator	4	1.0	13	14	1
		82.0	**1,087**	**1,079**	**-8**
Relief - UCS & NEPTS Type Vehicles			49		-49
Relief - EMS Vehicle			25		-25
Uniform			20	20	0
Onboarding (inc. Licence and ICT costs)			31		-31
Training			376	75	-301
Travel and Subs				6	6
Vehicle Fuel and Maintenance			129	73	-56
Vehicle Operating Costs			56		-56
Estates and Miscellaneous			75	43	-32
Private providers			356	402	46
Sub Total Operations			**2,203**	**1,698**	**-505**
Total			**2,464**	**1,970**	**-494**

Patient Safety and Quality

Transfer Triage Tool

To provide an Inter Hospital Transfer Service to complement the requirements of the Clinical Futures Model, both organisations were required to develop and implement new and alternate ways of triaging and conveying patients, all underpinned with the highest levels of quality and safety in mind.

To support the clinical assessment and triaging of patients, requiring transfer between hospital sites, a TTT was developed by health board and WAST clinical teams. The TTT allows Flow Centre staff to appropriately triage a patient requiring transfer and book that patients transfer with the correct resource.

Evidence indicates that the current TTT is an effective tool that has the ability to effectively triage patients aligned to the Inter Hospital Transfer Service. 100% of people who completed the Inter Hospital Transfer Service Questionnaire either agreed or strongly agreed that the TTT met the requirements of the service.

When establishing the level of clinical resources required to operate the Inter Hospital Transfer Service, a clinical case review was undertaken with health and WAST clinical teams. The review assessed the type of clinical resource required to safely manage the 72 patient transfers per day. In April 2021, a secondary review was undertaken to evaluate the actual clinical demand of patients against the type of clinical resources provided. The evaluation indicated that for the 72 transfers per day, the type of clinical resources was appropriate for the clinical demands of the service.

Evidence indicates that the 9 UCS step up and step down resources are able to safety manage the clinical requirements of the patients they convey. Access to ambulance resources with blue light capability was a key consideration when developing the service. Although the dedicated transfer ambulances are equipped with blue lights, the staff are not trained to operate an ambulance under blue lights. A range of factors were present in the decision not to train staff to operate the transfer ambulances under blue lights. The timescales associated with delivering blue light training to all 68 staff, would have significantly delayed the go live of the Inter Hospital Transfer Service and impact on the health boards ability to deliver a safe operating model.

In response to the health board’s concern regarding the transfer ambulances not being able to operate under blue lights, a literature review and real world scenario were undertaken. The outcomes of the review indicated that in relation the requirements of the Inter Hospital Transfer Service, the health board operating model and the patient care, the ability to operate under blue lights would have limited benefits.

The dedicated transfer practitioner ambulance, introduced to transfer patients with a higher clinical requirement, is an adapted version of the 9 transfer ambulances and is operated by a blue light qualified WAST member of staff and an ABUHB transfer practitioner.

The dedicated transfer practitioner resource operates 12 hours per day, 7 days a week. Activity undertaken by this resource is low compared to original modelling but it is acknowledged that the transfer practitioner resource has been utilised to convey other patients requiring transfer.

The ability to easily access a dedicated resource with a high clinical skill set and blue light capability, has benefited patients and the overall model, as the resource has been used to convey patients who would have had to wait a longer period of time due to delays in accessing an emergency ambulance.

Evidence suggests that there is scope to enhance the transfer practitioner resource by expanding the skill set of the transfer practitioner to undertake paediatric transfers. Currently paediatric transfers are only undertaken by an emergency ambulance due to the clinical training of the staff. Due to delays with accessing an emergency ambulance transfer, it is felt by enhancing the skill set of the transfer practitioner, paediatric transfers can be undertaken in a timelier manner improving the quality of care to paediatric patients. Evidence also indicates that there is a strong opinion that the dedicated transfer practitioner resource operating hours should be extended.

Key finding: The Transfer Triage Tool is supported as an effective and safe tool for the clinical triaging of patients requiring inter hospital transfer

Handover process

As outlined in the performance summary, handover delays have impacted on the service's ability to meet established performance targets. These handover delays also impact on the level of care and safety provided to patients, particularly patients who are being stepped up from ELGHs and may be of deteriorating health. 3 Datix incidents have been reported where delays in the handover process have contributed to a patient's deteriorating health.

Standards of Care

Acknowledging the challenges presented to both ABUHB and the WAST during the Covid19 pandemic, both organisations have continued in their approach to deliver the highest standards of care to patients with the development and implementation of the Inter Hospital Transfer Service.

Evidence indicates that there have been high standards of care provided by the operational element of the Inter Hospital Transfer Service, with staff providing a safe and clinically focused environment when transferring patients. There are no reported Datix incidents relating to the standards of care provided to patients by WAST staff.

Reported Datix incidents relating to standards of care are aligned to process issues (Analysis Summary Section 1), access to emergency transfer resources (Analysis Summary Section 2) and handover delays (Analysis Summary Section 2).

Key finding: A safe and high quality patient service has been delivered to date with minimal, if any, harm to patients reported

Resource Quality and Performance

Transfer Ambulance

The design, development and implementation of the new bespoke transfer ambulance fleet was undertaken whilst managing non-conventional constraints. The timescales and vehicle weight limits, due to driving licences, were significant factors in the outcome of the transfer ambulances produced to deliver the Inter Hospital Transfer Service.

The ability to design, build and implement the new transfer ambulances prior to opening of GUH was not viable and therefore private and alternate WAST vehicles were utilised short term to support the initial opening period of GUH. Once the new transfer ambulances were put into operation, there were a range of manufacture and coach builder defects that required resolving.

Again, alternate WAST vehicles were utilised to offset any reduction in the dedicated resources. The two transfer practitioner ambulances used the same base vehicle as the 11 UCS transfer ambulances but with reduced rear seating to accommodate the weight of additional equipment. The base vehicle (Renault Master) used for the transfer ambulances are fitted with vehicle speed limiters, limiting the top speed of the vehicle to 62mph.

For the 11 UCS transfer vehicles evidence indicates that although some concerns have been raised regarding the vehicles top speed, there is no evidence to support that this has had an impact on the patients' clinical conditions, nor impacted on service performance.

The transfer practitioner vehicles are required to undertake transfers where patients have a higher clinical requirement and may need to be transferred under blue light conditions, over longer distances. Due to this requirement, evidence indicates that the ability to operate at higher road speeds could impact on a patient's clinical outcome. In response to this WAST increased the speed limiter so the vehicle could reach 70mph if required. It is also noted that due to the engine capacity of the Renault Master vehicle, the vehicle's general acceleration is less than that of a Mercedes Sprinter, which is the base vehicle for an emergency ambulance. Feedback suggests that overall, the Mercedes Sprinter offers greater acceleration and speed.

Since the implementation of the service, there has been an identified requirement for the transfer practitioner vehicle to convey the ITU trolley. Due to the weight of the ITU trolley and additional equipment required to be carried on the vehicle, the overall weight being carried by the Renault Master transfer practitioner vehicle could surpass the legal operating weight of the vehicle. To offset this issue, a decommissioned Mercedes Sprinter emergency ambulance is currently being utilised as the transfer practitioner vehicle. This vehicle requires a C1 category driving licence.

The current WAST staff who operate the transfer practitioner vehicle are qualified with a C1 category driving licence and are trained to operate under blue light conditions. Although there were a range of challenges aligned to the design, build and implementation of the GUH 11 UCS transfer vehicles, overall the ambulance resources provided have met the requirements of the service.

The two transfer practitioner vehicles were developed in line with the requirements of the service but compromises were made due to vehicle operating weights and driver licence restrictions. Due to the emerging issues, there's a requirement to consider the long-term requirements of the transfer practitioner vehicle and identify the most suitable to deliver the service.

With regards to overall vehicle availability, WAST have provided a high level of vehicle availability. Where there have been vehicle shortfalls due to delays and defects, this has been offset by WAST by utilising other vehicles within their fleet.

It is acknowledged that the transfer practitioner brings additional equipment on board the vehicle when required. With regards to the standard equipment fitted to all transfer vehicles, 100% of respondents to the Inter Hospital Transfer Service questionnaire stated that vehicles are appropriately equipped for the requirements of the service.

Key finding: Initial mechanical and build quality issues with the new transfer ambulances have been overcome

Key Findings

- Establishing the Inter Hospital Transfer Service during the Covid19 pandemic to support the advanced opening of the GUH was a significant achievement
- The overall demand for the service was significantly less than expected due to the health boards operating model having to adapt and respond to the Covid19 pandemic and current requirements of the health board's population
- The level of transfer ambulance resources were appropriate given that the service modelling was developed using higher demand profiles
- Performance measures have not been achieved due to the challenges experienced by ABUHB and WAST in responding to the requirements of the population during the Covid19 pandemic
- The Transfer Triage Tool is supported as an effective and safe tool for the clinical triaging of patients requiring inter hospital transfer
- A safe and high quality patient service has been delivered to date with minimal, if any, harm to patients reported
- Initial mechanical and build quality issues with the new transfer ambulances have been overcome
- Challenges remain with booking and communications systems which require improvements in order to make better use of the available resource, improve quality for patients and the performance of the service overall

KEY EVALUATION QUESTIONS

1. Is the Transfer Service meeting the actual transport requirements of the ABUHB Inter Hospital Transfer system?

Overall the Inter Hospital Transfer Service is meeting the actual requirements of the current ABUHB operating model. Evidence indicates that enhancements in service delivery could be achieved by realigning dedicated transfer ambulance resources to the flow of demand; improve access to emergency ambulance transfer resources and review the current transfer booking and coordination process.

2. Is the Transfer Service meeting the performance requirements aligned to the established Commissioning Agreement and Service Specification?

The Inter Hospital Transfer Service is not meeting all of the performance requirements aligned to the Commissioning Agreement and Service Specification. The ABUHB operating model has had to respond to the challenges of the Covid19 pandemic and the requirements of the population it serves. Variation in the current requirements of the ABUHB operating model compared to the designed model, is contributing to the Inter Hospital Transfer Service's ability to meet the established performance requirements.

3. Is the Transfer Service delivering a high quality, safe and effective service for the ABUHB Clinical Futures model?

Evidence indicates that the Inter Hospital Transfer Service ambulance resources provide a high quality and clinically safe environment for patients. The effectiveness of the resources is determined by operating processes and system flow. Enhancing system flow and operating processes could aid in improving the operational effectiveness of the ambulance transfer resources.

4. Are the supporting systems meeting the requirements of the transfer service?

The supporting ICT systems are providing both organisations with the functionality to deliver a inter hospital transfer service to patients. In order to enhance the overall level of service delivery, a review of the supporting ICT systems and operating processes would be required.

RECOMMENDATIONS

Strategy / Operating Model

- Establish a forum for senior/strategic decision makers across organisations to lead on future service development
- Undertake a review of the future clinical profile of patients and service model
- Revise the overall Inter Hospital Transfer Service booking system to ensure improved efficiency
- Undertake a review of the communication processes and infrastructure across all health board and WAST systems
- Explore the expansion of the transfer practitioner role to undertake paediatric transfers
- Deliver an alternate ambulance vehicle that meets the requirements of the transfer practitioner function
- Consider options for the future accommodation of discharge activity

Workforce

- Develop an alternative solution for emergency ambulance transfers that improves timeliness of response
- Review and implement revised rosters for the transfer ambulance resources against the actual demand profile
- Explore the benefits of extending the hours of operation of the transfer practitioner resource
- Undertake an exercise to refresh all health board and WAST staff on the purpose of the Inter Hospital Transfer Service

Process

- Review opportunities to enhance the utilisation and process within the transfer & discharge lounge

Technology

- Explore the options to manage all transfer ambulance resources via one Computer aided dispatch (CAD) system

Management Information

- Explore the opportunities to enhance the level of reporting data available

ACKNOWLEDGEMENTS

For further information on the work of the Emergency Ambulance Services Committee, National Collaborative Commissioning Unit or any other details contained within this evaluation please contact:

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This reported was designed and produced by NCCU Corporate Services

Tier 2 Transport Services Performance & Monitoring Group

Terms of Reference

Purpose

The purpose of the Tier 2 Transport Services Performance & Monitoring Group is to monitor the performance and quality delivery of the Emergency Medical Service (EMS) ambulance service, the Non-Emergency Patient Transport Service (NEPTS) and the Inter-Site Transfer Service provided by WAST for the Aneurin Bevan University Health Board (the Health Board) in a single Performance and Monitoring meeting.

The Group will provide assurance to the Board in relation to the Health Board's arrangements for transport and make recommendations to the Health Board's Executive Team and wider Health Board to ensure that transport provision is safe, effective, sustainable and acceptable for the people of Gwent in line with agreed commissioning intentions.

Terms of Reference

1. To review and consider any outcomes of the NEPTS Modernisation Programme.

2. To receive report and review Key Performance Indicator (KPI) data which should include data provided from National Ambulance Quality Indicators (AQI) for EMS and current KPIs for NEPTS and the Inter-Site Transfer Service. This should also include patient safety and quality information appertaining to all three contracts

3. Receive reports from Tier 3 Transport Services Performance & Monitoring Meetings

4. To agree the priorities for future service delivery and consider the revision to the SLA and costing model (Inter-Site Transfer Service)

Membership

Membership will be Health Board wide to ensure all relevant areas are covered:

- Chair – Head of Transformational Change, Facilities
- Senior WAST Representative(s)
- EASC / NCCU Representative
- Unscheduled Care Division Representative
- Scheduled Care Division Representative
- Family & Therapies Division Representative
- Community Division Representative

- Senior Finance Representative
- Estates & Facilities Division Representative

Meeting Function

Papers

Notes will be made at each meeting and circulated within five working days of a meeting being held.

Papers for each meeting will be circulated electronically three working days before each meeting.

Agenda

The agenda will be set by the Chair of the Group. Any member of the group can raise an agenda item via the Chair.

Quorum

Three substantive members must be present to ensure the quorum of the Group, one of whom should be the Meeting Chair.

Reporting

The Group will provide a monthly report to the Health Board via the Quality and Safety Operational Group. KPI information for EMS and NEPTS will be supplied by the National Collaborative Commissioning Unit and directly by WAST to an agreed set of metrics for the Inter-Site Transfer Service.

Co-Option

Additional members will be co-opted to attend as necessary and as determined by the substantive members of the meeting.

Frequency of Meetings

Meetings are to be held monthly with location to be confirmed in advance.

Review

These Terms of Reference and operating arrangements shall be reviewed annually by the Group with reference to the Board.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 6th December 2022 Agenda Item: 4.3

Aneurin Bevan University Health Board

Improvement Plan based upon Findings of the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust (The Ockenden Review)

Executive Summary

On 30 March 2022, the final report from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust (SaTH) was published. This follows the first report from the inquiry, published in December 2020 which set out local actions for learning as well as immediate and essential actions to improve quality, safety and service user experience. The second, and final report, identifies several new themes intended for wider sharing across NHS England.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
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Executive Sponsor: Jenny Winslade – Executive Director of Nursing

Report Author: Linda Alexander – Deputy Director of Nursing

Report Received consideration and supported by :

Executive Team	✓	**Committee of the Board [Committee Name]**	

Date of the Report: 25 November 2022

Supplementary Papers Attached: Aneurin Bevan University Health Board Maternity & Neonatal Services Improvement Plan

Purpose of the Report

On 13 May 2022, the Chief Nursing Officer for Wales wrote to Health Boards requesting the completion of an internal self-assessment, using a standardised tool, to be returned to Welsh Government by the 27th May 2022 (Appendix 1). The tool extrapolated relevant learning from the HIW review of Maternity Services, Cwm Taf Morgannwg University Health Board (CTMUHB) maternity report & the final Ockenden Report.

The Health Board returned its response on time however due to the short turnaround given to complete, it was acknowledged further work would be required in relation to collating the evidence to support the assurance provided. It was recognised that the collation of evidence may change the initial RAG rating provided.

This work has since been completed, to note, the initial assessment submitted to Welsh Government identified 4 amber this increased to 13 following a thorough review and collation of all relevant evidence.

Background and Context

Maternity and Neonatal services across the United Kingdom have, for many years, been subject to increasing scrutiny, with a series of commissioned high profile reviews published including:

- The Morecombe Bay Investigation (Kirkup Report) 2015
- Royal College of Obstetricians and Gynaecologists Review of Maternity Services at Cwm Taf Health Board (April 2019);
- Health Inspectorate Wales (HIW) Phase One of its National Review of Maternity Services in Wales (November 2020);
- CTMUHB Independent Maternity Services Oversight Panel Thematic Stillbirth Category Report (October 2021);
- CTMUHB Neonatal Deep Dive Review (February 2022).

Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust chaired by Donna Ockenden (March 2022).

Assessment and Conclusion

Following the much-anticipated publication of the final Ockenden Report, the CNO commissioned the development of an assessment tool for use by all Health Boards, to determine local progress against a range of recommendations.

An Executive-led exercise was conducted in Aneurin Bevan University Health Board to complete the self-assessment involving key stakeholders within the Family & Therapies Division, to include: the Divisional Director, General Manager and Head of Midwifery (the triumvirate) together with senior representatives from Neonates, Obstetrics, Anaesthetics, Midwifery and Workforce and OD.

Based on the questions posed within the tool, and following collation of all evidence to support each recommendation, ABUHB identified no red areas, 13 amber areas with the rest rated green. A number of actions/recommendations were not rated, either because they did not apply to the service i.e., level 3 neonatal unit or require a wider national response.

It is important to note that a key for the RAG rating was not provided by Welsh Government and nor was the approach to the completion of the self-assessment prescribed.

Following submission from all Health Boards a national improvement is now in development which will be monitored via the ABUHB Maternity & Neonatal Assurance Group, with oversight via the Patient Quality, Safety & Outcomes Committee (PQSOC).

Whilst awaiting a National steer ABUHB has developed a local improvement plan (Appendix 1) to address all amber areas within the Assessment, Assurance and Exception Reporting

Tool. Important to note, 2 areas require input from a national perspective in order to progress.

Recommendation
The Committee is asked to: • Note the comprehensive work undertaken to evidence the RAG rating against the national reporting tool. • Note the progress made within the Division against the RAG rating within the local improvement plan.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework.
Financial Assessment, including Value for Money	No financial impact.
Quality, Safety and Patient Experience Assessment	A notable impact for women, babies and families which has a local, regional and national impact.
Equality and Diversity Impact Assessment (including child impact assessment)	An equality and diversity impact assessment has not been conducted for the self-assessment tool.
Health and Care Standards	Staying Healthy Safe Care Effective Care Dignified Care Timely Care Individual Care Staff & Resources
Link to Integrated Medium Term Plan/Corporate Objectives	Links to priority 1: every child has the best start in life
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Aligned to the well-being goals: a healthier Wales.
Glossary of New Terms	ABUHB – Aneurin Bevan University Health Board OD – Organisational Development CTMUHB – Cwm Taf Morgannwg University Health Board HIW – Health Inspectorate Wales SaTH - Shrewsbury and Telford Hospitals NHS Trust CNO – Chief Nursing Officer for Wales

Public Interest	Written for public domain. No public identifiable information contained within.

ABUHB Maternity and Neonatal Services Improvement Plan

1) SAFE AND EFFECTIVE CARE

Maternity care provision has seen growing levels of complexity over the last decade with rising rates of obesity and chronic medical conditions. To ensure that services are sustainable and provide the best care it is imperative that women and families are cared for within the most appropriate pathways and by the professionals who best meet their needs.

Recommendation		Service Comment	Service Action	Responsible Officer	Timescale
1.	Patient safety specialist should be in post at each health board.	Several senior roles where safety, quality and experience are integral. Currently, ABUHB do not have designated safety specialists in the Family & Therapies Division. WG – PHW Improvement Cymru have funded local safety champion in each HB. 0.6 maternity & 0.4 neonatal services seconded for 6 months advert closed on TRAC. Interviews planned for September 2022.	Appointed safety specialist 6-month secondment with remit to scope phase 1 of mat/neo safety programme. Utilising the framework for IHI safe reliable care they will examine culture, leadership and learning systems. The findings will be reported into the safety project with improvement Cymru. Commenced 13th November 2022	Head of Midwifery	February 2023

Recommendation		Service Comment	Service Action	Responsible Officer	Timescale
2.	Health Boards should appoint a dedicated Lead Midwife and Lead Obstetrician for fetal surveillance who will run regular fetal surveillance meetings, cascade training and lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	A Lead obstetrician has dedicated time to support fetal surveillance via fortnightly fetal surveillance (CTG) meetings. Champion midwives in place – fetal surveillance midwife post advertised to ensure weekly CTG meetings are in place. Obstetric Labour Ward Lead leads on review of cases of adverse outcome involving poor FHR interpretation and practice. Cases shared with All Wales morbidity group. Twice yearly STAN study in place.	Lead obstetrician in post Maternity services has appointed a lead midwife for fetal surveillance 0.4WTE. Midwife commenced in post 6th November 2022	Head of Midwifery	October 2022
3.	External clinical specialist opinion from outside the Health Board, must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This should include the use of the PMRT where applicable.	NB. Not mandated. Internal reviews occur with referral to external specialists, as required. Previous Independent commissioned reviews have been undertaken in relation to neonatal deaths in MLU services, a clear framework for commissioning across Wales is required. The Network perinatal group comprising of clinical risk leads, consultants with an interest in governance with network leadership conclude that an all-Wales national framework to ensure standardised process to incident investigation, resulting in a consistent and structured approach to reviews must be undertaken. Network T&F group to progress.	Awaiting outcome of All Wales national framework All Wales Morbidity and mortality reviews in place for neonatal death and neonatal brain injury supported by mat/neonatal network	Maternity/ Neonatal Network HOMAG	April 2023

Recommendation		Service Comment	Service Action	Responsible Officer	Timescale
4.	Regional integration of maternal mental health services should be considered.	NB. Currently not a regional approach, however the All Wales perinatal Network has developed the following:- 10 pathways based on the need to provide the 'Right Care at the Right time and by the Right People'. Women would have the same access to care where ever they live. These pathways cover 5 levels of need and provide a framework that support clinicians in their decision making: Level 1: (Blue) is our universal offer for everyone Level 2: (Green) Watchful Waiting Level 3: (Yellow) Active Listening/ Emotional Wellbeing Visits Level 4: (Orange) When a mental health assessment and referral to the GP is needed Level 5: (Red) Which covers referral into the Specialist PNMH Teams and MBU	Across Wales every perinatal team has a specialist midwife to link and develop services, offer training and support. The specialist Midwives also work collectively, and run a forum to discuss service development, share data and knowledge, which may include specialist speakers, every 3 months. This has included supporting the digital improvements across Wales. In addition, the Wales Perinatal and Infant Mental Health Curricular Framework and Training Plan, and the Perinatal & Infant Mental health, which will include 7 online modules, is currently being trialed within specialist teams before being rolled out in 2023.	All Wales perinatal Network	April 2023

		Currently adopting an Ask, Assess & Act approach, utilising the same questions and screening tools across Wales (EDPS and GAD 7). The Perinatal Mental Health Service is pan-Gwent. This multi-disciplinary team provides care and treatment for women who are pregnant or postnatal and are at risk of or are affected by mental illness. The team includes a consultant psychiatrist, psychologists, mental health nurses, specialised midwife, occupational therapist and administrative staff. Woman can access practical and emotional support, a range of psychological interventions including Mindfulness and Acceptance and Commitment Therapy groups; advice on local services and information; care planning. Referral is through midwives / GP. The multidisciplinary perinatal mental health team have clear criteria for referral of women. ABUHB perinatal mental health team are developing 'Perinatal Champion' roles in midwifery which evolved from the two year project on birth trauma. This role			

		would involve increasing the knowledge and awareness of perinatal mental health presentations, interventions and being a link with the team and with colleagues who might need advice on perinatal mental health. The service has recently expanded its commitment to support women through the training of 6 midwives to undertake REWIND therapy with women diagnosed with PTSD. There is currently no reginal integration of maternal mental health services – this is being reviewed on a national basis.			
5.	Postnatal care must include systems in place to ensure a consultant review of all readmissions within 14 hours of readmission, including daily review of unwell postnatal women regardless of clinical setting.	Requirement is fully met during weekdays. Not entirely met on weekends due to 9:00am-5:00pm resident Consultant presence. 75 hours of consultant presence on the labour ward. DATIX requirement for Postnatal readmission care reviewed as part of MDT risk and governance process.	All women are triaged on admission/ readmission. Escalation to on call consultant out of hours as required. Senior registrar available and rostered for Triage.	Clinical Director	Review April 2023

2) SKILLED MULTI-PROFESSIONAL TEAMS					
Professional groups who work together must develop strong inter-professional working skills to ensure that they share clear aims, language and culture in order to deliver safe and effective care. Multi-professional training should be a standard part of professionals' continuous professional development, both in routine and emergency situations					
Recommendation		**Service Comment**	**Service Action**	**Responsible Officer**	**Timescale**
6.	Midwives responsible for coordinating labour ward must attend a funded and nationally recognised labour ward coordinator education module. This must be a specialist post with an accompanying Job Description	RCM LW leadership programme supported - Compliant but to note there is currently no education module available in Wales. Ongoing work with HEIW to explore training and education. Ongoing work with HEIW to ensure a funded education module. ABUHB has a clear job description for the labour ward coordinator which is seen as a specialised role. The roster supports 3 LWC in attendance per shift. Forms part of work plan action HOMAG.	ABUHB maternity services have met (Sept 22) with HEIW to discuss and influence plans for funded education programme for LWC.	Head of Midwifery	April 2023
7.	Health Boards must train a core team of midwives to deliver high dependency maternity care, sufficient in numbers to ensure one midwife is available each shift.	NB. A Competency Framework is currently in development to further strengthen role and skills of co-ordinators. There is high dependency care training as part of PROMPT which is mandated.	Final draft of competency framework out for consultation. Review in clinical effectiveness group November 2022. This will be reviewed monitored via and the	Head of Midwifery	January 2023

		We have developed a critical care guideline and care pathway/HDU booklet. Regular MDT (minimum 3x per day).	Clinical effectiveness Group		
8.	Ensure the Medical Director has effective oversight and management of the consultant body by making sure they are: • available and responsive to the needs of the service • urgently reviewing and agreeing job plans to ensure the service needs are met • clarifying SPA activity • ensuring the most unwell women are seen initially by a consultant and all women are seen by a consultant within 12 hours.	There is a robust process in place for consultant job planning to ensure the needs of the service are met. SPA and direct clinical care are agreed in order clear objectives can be met. Consultant cover weekdays is 12 hours, weekend cover is 9-5pm, with on call consultant cover out of hours.	Compliant with the exception of women being seen within 12 hours on weekends due to availability and rota. All women are triaged on admission/readmission by a Senior Registrar with escalation to on call consultant available at all times out of hours. Senior registrar available and rostered for Triage.	Clinical Director	Review April 2023
9.	Ensure obstetric consultant cover is achieved in all clinical areas when required by: • Reviewing the clinical timetables to ensure 12-hour cover per day on Labour ward is achieved, • Undertake a series of visits to units where extended consultant	A robust process in place for consultant job planning to ensure the needs of the service are met	Resident consultant 12 hour cover available weekdays and 9-5 pm on weekends. On call consultant cover is available outside of these hours.	Clinical Director	Review April 2023

	Labour ward presence has been implemented • Ensure the consultant on-call for the labour ward has ownership of all patients in the maternity unit for the period of call. (This must involve the antenatal ward round being performed by the consultant)				
10.	Investment in neonatal nursing staff, part matron part improvement. Nurse in charge to be supernumerary, ANNP should be expanded to ensure career progression. Nurse consultant roles to be explored. AHP in line with national recommendations including an expansion of pharmacy services.	AHP and pharmacy services business cases have been produced with a focus on expanding current provision. The Health Board is currently commencing work to ensure alignment to the All Wales Neonatal standards. Registered nurse staffing in line with BAPM standards. Band 8a in post to support service improvement and management of clinical areas. Nurse in charge supernumerary. ANNP's have career progression most on Tier 1 but can extend to Tier 2. Across Wales Neonatal nurse consultant post limited.	Neonatal Workforce Standards/Quality Metrics currently under review which proves a framework for the planning and delivery of effective neonatal care and mechanisms of assessing the quality and safety of services.	Paediatric Neonatal Divisional Nurse	December 2022

3) SUSTAINABLE SERVICES AND WORKFORCE PLANNING					
Maternity services in Wales should provide equity across health boards to ensure all women and families have individualised care appropriate to their needs. This will require key resources to ensure sustainable future delivery of services.					
Recommendation		**Service Comment**	**Service Action**	**Responsible Officer**	**Timescale**
11.	Multiyear workforce planning process in place, incorporating the whole perinatal team	Workforce planning embedded within the Division and supported by workforce business partner. Workforce planning forms part of IMTP and is shared at MSAG, Maternity assurance.	Meetings progressed with workforce business partner to develop multiyear workforce plan.	Family & Therapies Business Partner	April 2023
12.	A strategy is in place to support a succession planning programme for the maternity workforce and develop future leaders and senior managers. This must include a gap analysis of all leadership and management posts in midwifery and obstetric	NB. There is strong CPD for the MDT but not necessarily a strategy for maternity in terms of leadership development and succession planning. Divisional Workforce meetings in place in collaboration with workforce business partner and review of gap analysis to be undertaken.	Meetings progressed with workforce business partner to develop and review gap analysis. Support for staff to undertake Leadership Academy within ABUHB. Working with RCM and HEIW to progress CPD and leadership opportunities.	Family & Therapies Business Partner/ Head of Midwifery	March 2023
13.	Obstetric anaesthesia staffing guidance to include:	There is a full commitment for staffing obstetric anaesthesia within maternity services, with allocated sessions and full	Review of PROMPT data reports 90% compliance for anaesthetic consultants.	Clinical Director/ Lead Anaesthetic Consultant	Completed

	• The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave. • The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity. • The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments. • Participation by anaesthetists in the maternity multidisciplinary ward rounds	participation in handover, MDT rounds and faculty for PROMPT. The Elective Caesarean list is performed within an elective scheduled care pathway in main theatres, with dedicated staffing.	Awaiting evidence from service re obstetric anaesthetic staffing.		

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Hospital Inspection Report (Unannounced)

The Emergency Department, The Grange University Hospital, Aneurin Bevan University Health Board

Inspection date: 1 – 3 August 2022

Publication date: 10 November 2022

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of the Emergency Department at The Grange University Hospital, Aneurin Bevan University Health Board between 1 – 3 August 2022. The following areas were reviewed during this inspection:

- Ambulance Bay and waiting Room
- Triage
- Resuscitation (resus) - This department has 8 resuscitation bays for those patients who were critically ill
- Majors – This is an area containing 20 bays for patients to have their assessments, care and treatments
- Assessment & Sub Wait - This area has a dedicated ECG room and 4 cubicles to assist with assessments and care of the patients in the waiting room. This area also includes an area outside the majors office where patients need to be monitored and they sit on chairs, to await a bed space or discharge and is referred to in this report as the rapid assessment unit (RAU)
- Covid Assessment Zone (CAZ) - Patients were streamed to the appropriate triage area from outside the department depending on their answer to set COVID-19 related questions. The patients who entered via the COVID entrance would be triaged in the A1 Corridor outside the Children's Emergency Assessment Unit (CEAU).

Our team, for the inspection comprised of two HIW Inspectors, three clinical peer reviewers and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Patients were happy with the way that staff interacted with them and were complimentary about the staff dedication and care provided. However, patients were critical of waiting times. We observed all staff striving to deliver good quality, safe and effective care to patients, within very busy units. During the inspection we found that some patients had been waiting on uncomfortable chairs and in the back of an ambulance for over 15 hours.

The waiting area was very small and cramped and unfit for purpose. Staff acknowledged this and told us they needed a bigger waiting area. A large portacabin style building has been built in the area immediately to the front of the CEAU. This was marked as a possible building for another waiting room. However, it is not operational and in its current location would present a significant risk to patient safety if not staffed and monitored sufficiently.

Until the flow of patients into and through the ED can be improved, the health board may find it difficult to address a number of our concerns.

We saw staff speaking with patients and their relatives in a polite, professional and dignified manner. However, we found that the dignity of some patients was affected by either lengthy waits within the department or as a result of where and how patients had been accommodated whilst awaiting further review or treatment. Staff made active efforts to move patients to more appropriate areas of the department where possible.

This is what we recommend the service can improve:

- Manage the overcrowding in the waiting room and the RAU that are not conducive to providing dignified care
- Ensure that there is an area available to facilitate red release calls at all times
- Not requiring patients to wait on chairs overnight in the RAU

- Continue to put processes in place as part of a system wide solution to poor flow and overcrowding at the ED waiting rooms

- Regularly review patients in ambulances, the waiting room and the RAU to ensure that patients receive appropriate and timely pain relief and treatment.

This is what the service did well:

- Patients and their carers that we spoke with were mainly complimentary of the care overall with positive comments on staff

- Staff were observed trying to maintain the best dignified care they could to patients

- Staff were seen to be discreet in communicating personal information with patients

- There were large flow diagrams displayed showing the patient journey through the department, in both Welsh and English.

Safe and Effective Care

Overall summary:

We were not assured that all the processes and systems in place were sufficient to ensure that patients consistently received an acceptable standard of safe and effective care. This was despite all the efforts of staff who were working hard, under pressure from the number of patients presenting at the ED.

We had a number of immediate concerns relating to the safe care of patients, and these were dealt with under our immediate assurance process.

Patient notes we checked were clear and easy to navigate, with a structured rapid assessment pathway. There were aspects of medicines management which were noted as positive.

Immediate assurances:

HIW highlighted the following serious issues which required immediate action by the health board to prevent significant harm to patients, members of the public and staff. Please note this list is not exhaustive and full details are contained in Appendix B:

- The risk of cross contamination in the area known as the COVID corridor
- The resuscitation equipment had not always been checked daily
- The resuscitation trolley contained two ampoules of out-of-date medication. These were immediately replaced
- The temperatures of medication fridges had not been regularly checked
- The controlled drugs register had not been checked on a daily basis
- There were several areas of the department where substances which could be harmful to health were freely accessible to patients and members of the public, these included medication and prescription pads.

This is what we recommend the service can improve:

- Staff awareness of the Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances
- Give due consideration to staff comments in relation to the lack of availability of some equipment
- Give due consideration to staff comments in relation to the manning and risk associated with patients in the waiting room and the RAU.

This is what the service did well:

- The nurses in the RAU area, who were also responsible for the waiting room had very good oversight of patients
- Patients we spoke with praised those involved, including staff and the Red Cross volunteers for the care and nutrition provided
- Medication charts were completed correctly and medicines administered within time limits
- Nursing and medical documentation was comprehensive and easy to locate and understand
- The patient safety at a glance board allowed good oversight information of the whole waiting room and RAU

- Staff working hard to mitigate risks associated with holding people on hard chairs in the RAU and waiting room.

Quality of Management and Leadership

Overall summary:

We spoke with a cross-section of staff working in the ED. Many told us that they were struggling with the high demands of the department and they could not provide the care to patients they deserved in a timely manner. Staff felt supported by their line managers.

Senior managers were aware of the issues in the department and trying to put arrangements in place to manage this situation. However, the department was experiencing high demands on the service.

We were assured that there was a supportive culture in place which promoted accountability and patient care and that the management and leadership was focused and robust.

This is what we recommend the service can improve:

- Implementing a robust process to ensure the impact of the workload on staff wellbeing is managed
- Continue with its efforts to recruit permanent staff
- Action is taken to improve compliance with staff appraisals.

This is what the service did well:

- The department was well led with clear lines of responsibility and systems in place to monitor and respond to service needs
- We noted that triage staff were resilient and worked hard in a difficult working environment balancing the risk to patients in the waiting room and in the ambulance bay
- The nurse in charge was clearly identifiable and visible in all areas. Staff told us that the senior staff in ED were supportive and visible

- Mandatory training records provided showed that compliance was generally good

- Staff told us of the monthly wellbeing sessions that were in place that had received good feedback.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

HIW issued both paper and online questionnaires to obtain patient views on the Emergency Department (ED) at The Grange University Hospital. In total, we received 11 responses. Patient comments included the following:

> *"Staff were clearly doing their best but up against it and under-staffed and clear lack of beds for number of patients."*

> *"Overall, very disappointed [waiting time] post-surgery severe pain and waiting on cold bench for fourteen hours"*

> *"Friendly staff"*

> *"Just very, very good."*

Responses from patients about their care were mixed, including negative comments about waiting times and PPE, but positive comments about staff. The main issues raised by patients, attracting the most negative comments, were waiting times at the ED and patient checks. Over half the respondents said they had waited for more than four hours before receiving treatment or being referred on. In addition, only a quarter said staff checked on them while they were waiting.

A total of six respondents rated the service they received as 'very good' or 'good', but five rated it as 'poor' or 'very poor'. We asked patients how the setting could improve the service it provides. They told us:

> *"Waiting over sixteen hours with a prolapsed disc and suspected stroke…not very comfortable chair…no bed…stuck in a busy hallway in chair with very little offer of pain relief."*

> *"Have a bigger waiting room, some patients were sitting outside."*

> *"Using PPE correctly using hand gel/washing, more monitoring of patients while waiting."*

Staff Feedback

HIW issued an online survey to obtain staff views on the ED. In total, we received 13 responses from staff at the setting. Responses and comments from staff were generally negative, with the main issues being:

- Lack of space and assessment areas which was impacting on patient safety
- Poor patient flow
- Inadequate staffing levels
- Lack of appropriate training.

Despite this, around two-thirds of staff who responded were satisfied with the quality of care they gave to patients and would recommend their organisation as a place to work.

Positively, all but one member of staff had received an appraisal, annual review or development review of their work within the last 12 months and the majority felt able to make suggestions to improve the work of their team. All staff also believed that patients were adequately informed and were involved in decisions about their care.

Staying Healthy

Health Protection and Improvement

There was information displayed highlighting the appropriate use of the ED and signposting to other services. These were seen on the COVID-19 screening portacabins and in several areas throughout the ED. Posters were also displayed explaining that the hospital was a smoke-free environment. This also extended to the use of vapour or e-cigarettes. We witnessed patients smoking outside the main reception and from the numbers of cigarettes butts on the floor, this area had clearly been used as a smoking area.

Dignified care

Dignified care

Staff were observed trying to maintain the best dignified care they could to patients in an unsuitable and noisy environment in parts of the ED. These overcrowded and gridlocked areas were not conducive to providing dignified care as patients were sat near each other on chairs overnight that did not provide adequate rest and personal care for the patients.

We spoke with 12 patients during the inspection, generally they were very satisfied with the care, but they were frustrated and sometimes angry with the waiting times. The majority were very complimentary about the staff working in the department and in the ambulances. They said they were kind, respectful and helpful. Whilst many patients were unhappy with the waiting times for care and treatment, they recognised that this was not the fault of the staff.

All patients bar one who completed the questionnaire agreed that staff treated them with dignity and respect and that measures were taken to protect their privacy during assessment or treatment.

We observed staff speaking to patients with respect and kindness, and one patient commented on how kind staff were and that they would go ‘above and beyond’ what was required.

Patients in beds or trolleys looked generally comfortable, those in chairs in the RAU and the waiting room looked less comfortable and, in some cases, looked very uncomfortable.

Patients’ dignity could not be maintained in the RAU. Chairs were placed very close together with clinical interventions taking place such as venepuncture and intra-venous (IV) drug administration. They were visible to not just the nursing staff but the whole of majors and anyone passing through. Curtains and doors were closed in majors and resus when delivering personal care.

We noted one particular positive incident of note where an agitated patient in a cubicle was being monitored and supported by a team of security officers. The staff were careful to maintain the privacy and dignity of the patient by not being too intrusive whilst supervising their safety.

We also noted bereavement support being delivered in a timely way and undertaken in a sensitive and compassionate manner. Bereavement information seen was comprehensive including access to support services and a practical guide.

We asked staff in their questionnaire about maintaining patient dignity, whilst five of the eleven staff who answered this question agreed that patients' privacy and dignity was maintained, six disagreed.

Communicating effectively

Staff were seen to be discreet in communicating personal information with patients as well as being kind and considerate to patients and their family and carers. Curtains were drawn when necessary for patients in cubicles. However, maintaining confidentiality in the RAU could be difficult to achieve due to the lack of space.

We observed most staff speaking with patients about their care and treatment in a way that they understood. One of the conversations we heard involved a nurse on triage explaining the waiting time and arranging an appointment with urgent care and primary care as an alternative treatment plan. Patients were moved to private rooms for their examination and assessment by medical staff.

The patient safety at a glance board behind the wall in the RAU facilitated good communication between staff as patient information was recorded and easily available. The board assisted in maintaining safety in a busy overcrowded area. The details on the board included when observations were next due, as well as information on bloods, electro-cardiographs (ECG), X-ray and treatments given or next due.

Patients we spoke with had mixed comments about how staff communicated with them. Five patients were positive or did not have issues. One had poor eyesight and staff were aware they needed to keep their drink topped up frequently. Almost all patients we spoke with said that the staff listened to them and took the time to explain their care and treatment in a way that they could understand.

We asked patients a series of questions about their experiences relating to their healthcare. A total of eight patients who answered the question agreed that staff listened to them, but two disagreed. Of the nine patients who answered the question, six agreed they were involved as much as they wanted to be in decisions about their healthcare. Seven of the nine patients agreed they were provided enough information to help them understand their healthcare.

We noted two members of staff wearing the Welsh speaking logo, to make patients aware that they could speak to them in Welsh. However, we did not see any evidence of staff being able to make an 'Active Offer'.

There was a voice activated communication system used within the hospital that staff were able to wear on a lanyard.

We were advised by staff that there was a working hearing loop in reception and the additional speaker on the reception desk was used when needed. However, they stated that the microphone in the desk was still not working properly.

In resus we observed a number of medical rounds and both medical and nursing staff were always discreet in their communications about personal information. Patients were also spoken to by medical staff at level that allowed the patient to understand their care and treatment. It was noticeable that staff, although busy, took the time to ensure patients understood what they said and that this was given in a reassuring way. We also observed a member of medical staff repeating information to a patient to ensure that the patient understood the conversation. Of the staff who answered this question, nine agreed that sufficient information was provided to patients but two disagreed.

Patient information

There were large flow diagrams displayed showing the patient journey through the department, in both Welsh and English. There were also permanent smaller bilingual signs describing where the patient was in the department and explaining what the area was, for example explaining the triage process in simple terms for patients.

Directions to the ED were clearly displayed outside the hospital. Once inside each unit, there were signs directing patients to the toilets, exits and also the emergency exits.

Timely care

Timely Access

Most patients we spoke with were happy with the care and treatment they received. Those who had entered the ED via the waiting room felt that the waiting times were far too long. They said that the chairs were uncomfortable, and not knowing how much longer they would be waiting created anxiety and frustration. All patients acknowledged that it was not the fault of the staff, whom patients were very positive about, but criticised what they believed to be the policies and management of emergency healthcare services locally. Those who were admitted by ambulance were very pleased with the treatment they had received, both in the ambulance and after entering the ED. This was also the case when they had been waiting in the ambulance for a lengthy period.

In the survey, four patients who answered this question arrived by ambulance. Of these, two said that, on arrival at the hospital, they waited in the ambulance for less than 15 minutes before being admitted into the ED. The other two patients waited between 15 and 30 minutes. All the patients who answered said that they were regularly checked on by hospital staff whilst waiting in the ambulance, and both said they felt safe and cared for whilst in the ambulance.

On the afternoon of our arrival at the hospital, there were 14 ambulances waiting in the ambulance bay and we were told there were major delays in offloading with average offload times being over four hours. This included one patient who had been waiting 18 hours due to an infection control risk.

Care of patients on ambulances was the joint responsibility of hospital staff and the Welsh Ambulance Service Trust (WAST) staff. Paramedics were responsible for patient observations and reporting to hospital staff if the patient deteriorated or if WAST staff had concerns regarding clinical progress. Then the triage nurse and Hospital Ambulance Liaison Officer (HALO) would be informed to possibly expedite offload to a more appropriate area. We noted a close liaison between the deployed HALO, the triage nurse and the nurse in charge of the ED, regarding patient care.

Patients would either be triaged on board the ambulances or offloaded and triaged in the ambulance triage area. They would then be returned to the ambulance or admitted to the department where possible. Ideally patients would be offloaded to the triage area in order to be turned for a full skin inspection and assessment. Triage staff reported that it was difficult to complete a full skin assessment and continence check on an ambulance trolley.

In our opinion there had been significant and multiple long waits for patients to be offloaded from an ambulance. The clinical risks were mitigated by triage assessment and if the patient required urgent attention they would be offloaded, where possible, to a more clinically appropriate area. Red calls and pre alerts were accommodated by managing patients within both the resus and majors areas of the department.

There was a new policy in place relating to releasing ambulances for red calls in operation at the ED. Normally a designated cubicle was allocated as an empty area to expedite quick offloads to release crews for red calls. However, the cubicle was frequently occupied, due to the lack of space within the department and red release calls were noted as not taking place on two occasions during the inspection as there was no safe area to offload the patient.

We observed one of the four site meetings (these occur at 9am, 12pm, 3pm and 6pm) where the relevant staff provide information to the operations and urgent care team. At the meeting the number of attendances and other statistics were discussed for the ED, medical assessment unit and surgical assessment unit and then clinical priorities and clinical safety concerns were discussed. This aimed to assist in the patient movement and any transfers needed could be managed. Additionally, they would look at patients who had been sitting in chairs for long periods and put actions in to address those issues. The aim being to move patients out of these areas into speciality areas.

We also spoke with staff relating to the management and flow of patients. We were told that the main issue related to medically fit patients occupying beds throughout the health board who could not be discharged. This was due to a number of factors including because there were not appropriate care packages in place outside the hospitals to care for the patients and they therefore could not be discharged. If these patients were able to be discharged, this could then create more space for patients to be discharged from the ED into other wards and hospitals.

Whilst we did hear reception staff advising patients that there was a delay, they did not tell patients how long this was, as it varied depending on the acuity of the patient. On the previous inspection, dated the 1-3 November 2021, we noted that there was not a system in place to inform patients of the average waiting time for patients at the ED. The health board stated that the Royal College of Emergency Medicine did not support systems to display waiting times and that the health board supported this. In reply to our recommendation to introduce an electronic waiting time board the health board stated that they were working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine. This is due to be in place by October 2022.

We were supplied with the 12 month ED metrics as at 2 August 2022. These showed the following:

- Length of stay on ambulance - On average, 40.7% of ambulance handovers are over 1 hour, and 5.1% of ambulance handovers are over 6 hours

- Time from arrival to triage - The average time from arrival to triage was 36 minutes

- Length of stay in waiting room - From arrival to first being seen by a clinician averaged 2.3 hours

- Length of stay in ED - The overall average time that patients spent in ED was 7.4 hours. This varied from on average 6.4 hours for those patients not admitted to 10.7 hours for those admitted

- Waiting time breaches – Over the last six months, the overall compliance against the 4-hour ED performance target averaged 42.3%, against the 12 hour ED performance target this averaged at 83.8%

- ED Never Events - Over the last six months there has been an average of 100 patients a week waiting over 16 hours in the ED.

Significant multiple ambulance offload breaches were observed throughout the inspection, with poor flow observed into, and out of, the department. Patient harm due to delayed treatment of pressure area care and dignity was at an increased risk when elderly / vulnerable patients were delayed on ambulances for a significant amount of time.

Individual care

Planning care to promote independence

The ED workload was not always conducive to encourage patients to mobilise. However, we saw physiotherapists and occupational therapy staff on the ward encouraging patients to move. Some staff in majors reported that the high acuity of patients did not give staff time to mobilise patients as often as they would like. The ED is designed for short term stays, although several elderly patients were in the department for over 24 hours.

The electronic patient record Symphony included a blue forget me not symbol when a patient had a diagnosis of dementia. Additionally, the symbol was used on the manual board in the rapid assessment area to identify patients with dementia. We were told that the unit had recently acquired equipment such as board games for patients with dementia.

Of the patients who answered the question, five agreed that they had access to toilet / washroom facilities but two disagreed. There were a number of toilets for patients in the waiting room and in majors.

All 11 staff who answered the question agreed patients and/or their relatives were involved in decisions about their care. Eight staff said they were satisfied with the quality of care they gave to patients and three disagreed. A staff member commented:

"Completely accept that this is a national problem with flow but it is the biggest patient safety concern as there is good evidence that patients come to harm. We don't really need a bigger waiting area as most of those patients need to be on a trolley or the assessment area waiting areas. A nice analogy - If the bath is full and overflowing… don't make a bigger bath… sort out the plug hole please "I do believe all the staff in ED provide the best care they can do to all our patients, however when we're short staffed and at maximum capacity we really struggle."

People's rights

There was level access to the department with further parking now available nearer to the ED so that older relatives did not have to walk as far to accompany their relatives in the ED.

Most people were satisfied with the level to which their friends and family were involved in their care. Most people were not interested in making a complaint because, they either did not want too as they were satisfied with their care even if they had waited a long time, or because they felt if made no difference.

Staff we spoke with confirmed that patients' spiritual needs had been considered and that there was access to pastoral and religious support. They also said that for those religions requiring certain foods and not allowing certain types of treatment that would be document and provided. Staff we spoke with said, regarding equality and diversity in the organisation, that all patients were treated according to their clinical need. They all said that they were aware of the importance of individual needs and rights. Equality and diversity awareness was part of the mandatory training requirements for staff. Staff were also aware of individual requirements of various religious faiths, including after death.

Visitors were now allowed in the ED and there was open visiting. Visitors were able to provide assistance and were involved in patient care at the request of the patient. We noted in resus instances where relatives were encouraged, wherever appropriate, to assist with hydration under the supervision of the nursing staff. Visitors and relatives were discouraged from accompanying patients into the waiting room due to a lack of space and some relatives were noted sitting on chairs outside the waiting room. Relatives of patients in resus were also encouraged to be present, if they wished, when certain treatments were given.

We noted there were specific and suitable places for patients to meet with family and friends in private. Some of the bays in resus had now been converted into confined cubicles with doors, this also allowed space for end-of-life care to be

given appropriately. These cubicles allowed more peace and quiet for the patients. The lights in these resus cubicles could also be dimmed.

All patients who answered said they were assessed by healthcare staff. This ranged from three patients assessed immediately, four within 30 minutes of arrival and four said they waited more than 30 minutes to be assessed.

We asked patients how long they had to wait in total at the ED before receiving treatment or being referred on, five answered that they waited less than two hours, but two waited over 12 hours. Patients commented:

> *"Was not seen until five hours after arriving."*

> *"Reduce waiting times ambulance availability."*

Only one of the eight patients who responded agreed that there was adequate seating in the waiting area and six disagreed. Two of the eight patients who responded to the question agreed that staff checked on them whilst they were waiting but six disagreed.

Listening and learning from feedback

We noted that the department gathered the views of patients and their carers through quick response (QR) codes that were displayed on posters in the department. Additionally, we noted that patients were signposted to relevant routes if they had a complaint to make, this including community health councils. The NHS Putting Things Right poster was also displayed prominently. Staff we spoke to in the department were also aware of the process for feedback and complaints. The audit of patient feedback for the last two days in July also showed that patient feedback on the care provided was generally very positive. One patient commented:

> *"Mixed feelings which included the news that I'd had a {condition} but staff have been superb. Very attentive, efficient, and very focus on getting things right in spite of being up against it resource wise."*

The information on how health boards had learned and improved on feedback received was not displayed within the department.

We spoke with the staff involved in registering and processing complaints and compliments in the hospital. The process was described and included telling the complainant in a timely manner and ensuring staff are made aware of the results of the investigation and any lessons learned. One patient said she they had

complained and only received a response from nursing staff after chasing. She was then told she needed to speak to someone in management about the complaint and someone would ring her, but no one had rung. The original complaint was made six months previously.

A total of 11 ED staff answered questions about patient experience measures.

- All bar one agreed patient experience feedback was collected within their department

- A total of eight of the 11 agreed that they received updates on patient experience feedback in their department but two disagreed

- Only six of the 11 agreed that feedback from patients was used to make informed decisions within their department, again two disagreed.

Delivery of Safe and Effective Care

Safe Care

Managing risk and promoting health and safety

At the previous inspection it was noted that there was limited visibility of the waiting room from the reception area and that the close circuit television (CCTV) in the waiting room was monitored on an ad hoc basis from a monitor in the RAU. Whilst the monitoring of this CCTV was still considered to be ad hoc, it was positive to note that additional cameras had been installed and there was also a monitor in the reception area.

The waiting area was very small, cramped and unfit for purpose. Patients told us that they had previously had to sit on the floor due to the lack of space, although this was not observed during the inspection. Staff acknowledged this and told us they needed a bigger waiting area. A large portacabin style building had been built in the area immediately in front of the children's emergency assessment unit, next to the ED. This was marked as a possible location for another waiting room. However, it was not operational and in its current location would present a significant risk to patient safety if not staffed and monitored sufficiently, as well as the potential of having two separate waiting rooms.

Patients in the waiting room, RAU and majors were observed as being monitored closely. Regular clinical observations were undertaken and any abnormalities in these were identified and escalated as required.

The nurses in the RAU area were responsible for the waiting room and had very good oversight. However, due to the nature of the department there could be in excess of 50 patients in the waiting room and up to ten patients in the RAU. As minor injury patients were redirected to MIUs, the majority of patients in the waiting area were physically or mentally unwell and would be classed as 'majors'. This was a significant risk and placed stress and risk on the staff members. They relayed their concerns during the inspection that the workload was very high due to this and that patients in the waiting area waiting for beds still needed interventions which the nurses would have to undertake.

We were told about the process to ensure risks and incidents were managed effectively. This included reporting incidents on DATIX and escalating issues at departmental or site level. Feedback from incidents was received by various methods including Whatsapp, nursing news and face to face. We were provided

with copies of the risk register and it was evident that this was regularly reviewed and managed. The risks contained in this register included capacity in the waiting room, using the CAZ as a thoroughfare, assessment capacity and holding patients on trolleys and on ambulances.

The environment in the majors and resus areas were considered to be safe. Beds were kept at the lowest levels with call bells to hand. Patients at risk were highlighted in red on the patient safety at a glance board. There was level access to the department with no trip hazards and equipment was stored away from the department when not is use. We also noted that even though there was some maintenance work occurring in the main corridor alongside the ED, there were warning signs and maintenance equipment was kept to one side leaving sufficient room for trolleys to pass. Security were also clearly visible throughout the department. The environment was clean and in a good state of repair with the floor and hard surfaces being cleaned regularly. However, the ED did not have enough room, facilities or staff for the number of patients coming into the ED.

There were several areas of the department where substances which could be harmful to health were freely accessible to patients and members of the public. These included storerooms, dirty utility areas, cleaning cupboards and fluid storage areas. This was highlighted to senior nursing staff who assured us that it would be addressed and made safe immediately. In particular we noted the following:

- Medication was left unattended on a countertop in Majors, this included opened packets of Doxycycline Capsules 100mg, Bisoprolol Fumarate 5mg, Sumatriptan 50mg and bags of medication from the pharmacy

- Tablets of bleach were noted in a storeroom that was left open along the main corridor toward the medical assessment unit

- Fluids were contained in unlocked cupboards within the Majors areas, with a sign including the contents of Potassium 40mmol, Glucose 10%, Hartmans and sodium chloride solutions

- A prescription pad was left unattended in Majors.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Preventing pressure and tissue damage

Pressure risk assessments were noted during our inspection, these included waterlow assessments, turn chart and body map being completed on patient records, once the patient was allocated a bed in majors. We did not note any waterlow assessments for patients sitting in the RAU. Pressure relieving mattresses were available and patients could be transferred onto air flow mattress depending on their risk.

The triage nurse completed the paper nursing care record with the waterlow score European Pressure Ulcer Advisory Panel (EPUAP) and body mapping tool on the initial triage assessment. Whilst we noted that skin bundles were completed intermittently, there was good evidence of skin inspection in notes overnight.

All WAST and nursing staff questioned. recognised the risk of developing pressure damage with long wait times to offload. Ambulance trolleys were not designed to relieve pressure and were not suitable for long patient lays. Several elderly patients were observed on ambulances trolleys for several hours. Staff attempted to mitigate the risk, but the long offload waits could contribute to patient harm. We noted an 80-year-old patient had been on an ambulance for over 13 hours during one morning of the inspection and a full comprehensive skin inspection had been carried out only once.

There was also considered to be a high risk of pressure damage when patients were sat in chairs for long periods Some elderly patients were observed to be on chairs for over 18 hours.

Falls prevention

Falls risk assessments were observed as being completed as appropriate and patients were encouraged to wear appropriate footwear when walking around the ED. Patients deemed at a high risk of falls were highlighted as such on the front sheet of the patient notes. We observed staff pass on risk of falls information on handovers and safety briefs.

We were told that all falls were recorded on Datix, the incident management system used in the NHS in Wales. However, agency staff we spoke with were unaware of the process to share lessons learned and action plans as a result of Datix entries.

Multidisciplinary teams (MDT), including physiotherapists and occupational therapists (OT) were observed in the ED on several occasions. Additionally, we saw

that physiotherapist and OTs carried out the relevant assessments prior to patients being deemed safe for discharge.

We checked a sample of patient records and noted that ED documentation included falls screening questions for all patients attending the ED. If the patient was deemed to be at risk of a fall, staff would complete an ED falls assessment tool. Documentation on this in majors was of a good standard. However, patients in the RAU, who were deemed as fit to sit did not have any assessments completed.

Infection prevention and control (IPC)

The way the department ensured that IPC was managed carefully and appropriately was examined. Overall, we noted good IPC practice throughout the department. Staff were in most cases seen to be wearing their masks properly and gowns and gloves were available with handwashing undertaken at appropriate points. There was also good access to sinks and hand gel. There were isolated instances noted of staff wearing watches and therefore not bare below the elbow. Staff were observed wearing appropriate personal protective equipment (PPE) when delivering personal care to patients.

We noted that social distancing for patients and staff was difficult if not impossible to maintain in the RAU. Additionally, whilst seats in the waiting room had red crosses on them to facilitate social distancing, patients were seen sitting on them and all seats in the waiting room were occupied for the majority of the inspection.

We were told that neutropenic patients would be placed in the cubicles with separate doors and bathrooms. Additionally, one of the cubicles in majors was a negative pressure room. None of these rooms were being used as isolation rooms at the time of the inspection.

Staff we spoke with also told us, that there had been an increase in the number of staff contracting COVID-19 recently. This was believed to be at the point when masks were not being used in the department due to the change in the legal requirements. We were told that as a result, all staff and patients now wore masks in all clinical areas.

We also spoke to senior staff involved in IPC. They spoke about the support and cover available to the ED on IPC. This included trying to introduce new initiatives and giving staff the tools to use in this area. IPC staff were also involved in a full regular annual rolling audit and surveillance using an electronic audit tool. The audit would be completed in various sections throughout the year. Any improvements needed would be discussed with the ward manager at the time and

the relevant action would be taken to rectify the issue. If this was then identified to be part of a trend, the IPC staff would ensure that daily monitoring would take place together with the relevant education and additional resources to support the area.

We saw that the 'one patient one day' themes for June 2022 included, out of 13 checks, cannula bundle not updated - six instances; waterlow not updated for over eight hours – five instances; and falls assessment not completed/updated – four instances. The same documents for July 2022 showed that an improvement had been made in these areas.

The IPC dashboard provided for July 2022, related to items such as healthcare acquired infections, hand hygiene, patient screening and infection prevention procedures and staff awareness. The majority of items were 'Green', such as new clostridium difficile (C.diff) infections in the last month and completing urethral catheter insertion and maintenance bundles. Some items were in 'Red' such as staff were not aware of their current compliance with screening, bundles, infection rates and audits. Information on the results of the audits and lessons learned were shared via email and 'nursing news'.

All patients, in the questionnaires indicated that, in their opinion, the setting was at least 'fairly clean'. However, only three of the patients agreed that, in their opinion, COVID-19 infection control measures were being followed where appropriate and five disagreed.

Staff responses showed that all bar one agreed that their organisation had implemented the necessary environmental changes. They all agreed that their organisation had implemented the necessary practice changes, that there has been a sufficient supply of PPE and that there were decontamination arrangements for equipment and relevant areas. All staff agreed there are appropriate infection prevention and control procedures in place.

We spoke with the domestic staff and they were aware of the requirements of deep cleaning. If specialist ultraviolet of hydrogen peroxide vapour cleaning was required, the supervisor would be contacted. However, we noted that the documentation in patient cubicles were not regularly completed to show that they had been cleaned in several cubicles. There was one cubicle, where the last check listed was 21 July 2022. During our visit we noted that the department was clean, with cleaners clearly visible throughout the day.

Patients were triaged for COVID-19 symptoms before entering the ED. Patients with symptoms of COVID-19 would be streamed down a corridor known as the COVID corridor. Approximately five metres down this corridor there was an area

with equipment for a patient to be briefly triaged and tested for COVID-19. The patients would then sit in soft chairs, with screens between each patient, along this corridor. At the end of the corridor, approximately 80 metres long, was the COVID-19 ward known as A1. There would normally be two members of staff on duty, one qualified nurse and one healthcare support worker. Staff would wear the appropriate PPE with patients (apron, mask and gloves).

We noted that staff from other areas, such as resus, the main ED or the paediatric area would pass through this area from time to time creating additional footfall and risk of cross infection. There was also an office next to where the patients would sit whilst being monitored before moving onto the COVID-19 ward A1, creating further footfall. We were also told that there would be occasions when accompanied patients from the CEAU, which was adjacent to the triage and testing area, would need to pass through this area to go to radiology.

There was a large sign on the entrance to this area to say that it was a COVID-19 area. There was no signage further down the corridor for staff coming from the other directions or at the bottom of the stairs again adjacent to the triage and testing area to inform staff not to enter.

This was also reported as an area requiring immediate assurance during the previous inspection, alongside the need for hand washing and printing facilities and the number of patients that needed to be monitored and tested. During this inspection we noted that a hand washing facility and printing facilities were in place and that the number of patients in this area had significantly reduced, with only one patient noted as being monitored at any one time during the inspection.

These issues were dealt with under HIW's immediate assurance process and are referred to in Appendix B of this report.

Nutrition and hydration

Patients we spoke with praised those involved, including staff and the Red Cross volunteers for the care and nutrition provided. All patients in majors were noted as having jugs of water and there was a water dispenser in the waiting room. Patients within the majors area were offered tea and coffee, patients in the RAU also had water provided. Staff we spoke with said that they were able to meet the nutrition and hydration needs of the patients. Meals were provided three times a day and sandwiches were available out of hours. However, meals were not provided to patients in the waiting room.

Staff we spoke with said that fluid balance charts were not regularly started for patients in the RAU. However, bed area fluid balance charts were completed when

patients were in cubicles. Additionally, we were told that the All Wales Nutrition Charts were not always used due to patients not being in the ED for a sufficient period of time. We also noted that not all intravenous (IV) fluids and oral fluid intake was recorded on the fluid balance charts. From the five records checked, nutrition charts were not completed for patients who had been in the department for over 16 hours. At the last inspection we recommended that nutrition and fluids were recorded appropriately on the relevant documentation. The health board replied that the "ED would ensure IV fluids were recorded on the All Wales Medication Charts. Fluid balance was recorded within the ED patient care record which is a mirror image of the All Wales Fluid Balance Chart. The All Wales Nutrition Chart has been introduced into ED."

We saw that the triage nurse and ambulance crews liaised with each other regarding feeding patients if not nil by mouth. Red Cross personnel were available to provide hot drinks and meals during the day. All staff and patients were complimentary about the Red Cross service and that it was a valuable service to maintain patient and staff welfare.

All patients who were eating seemed happy with their meals. Patients in ambulances were provided with sandwiches distributed by the Red Cross volunteers during the day. Overnight the feeding and hydration of patients was the responsibility of ambulance staff with sandwiches being available stored in fridges inside the ED. We also noticed drinks had been provided to ambulance staff to ensure they were kept hydrated.

The meals served appeared to be hot and looked appetising. Patients were seen to be helped to eat their meals and with hydration needs where required. In response to the question four of the eight patients agreed that they had adequate access to food and drink, three disagreed.

Medicines management

The systems in place to ensure that medicines were managed safely, administered correctly and used safely were reviewed. We viewed five medication charts in majors and all were completed correctly and medicines administered within time limits. All patients had oxygen prescribed appropriately when required. We were told that the pharmacists visited the department daily. The arrangements relating to administering medicines out of hours was described and this included completing a prescription form for patients to obtain medication from community pharmacists. The lack of ready access to medication out of hours could delay the discharge for certain patients.

All medication was observed to be administered and recorded contemporaneously and all patients were observed wearing patient identity bands. The good practice was noted that reception staff printed out name bands on booking in and placing them on patient notes prior to triage. However, we noted that pain scores were not completed for all patients. Paramedics we spoke with also stated that pain relief on ambulances could be significantly delayed. This would be when the triage nurse was under pressure and was waiting for a prescription or did not have sufficient time to come on board the ambulance to administer pain relief.

Due to pressures on staff and the acuity of patients, staff were often called away to deal with other patients when administering medicines to patients. Medication was observed as being left at the patients' bedside, but we did note that the nurse returned later to ensure that the patient had taken the medication. There continued to be difficulties in maintaining patient confidentiality when administering medication to patients in the RAU.

Staff were commended on ensuring that the medication administration record in the drug charts were recorded to a high standard. Staff were attentive and ensured patients received analgesia and other interventions as needed.

We considered the arrangements for the checking of the contents of resuscitation trollies in majors. There was a requirement to check the contents of the trollies daily to ensure the seal was intact and that the defibrillator, portable suction and portable oxygen cylinders were serviceable. The records in this area showed that during July 2022 checks had not taken place on 11 days for one trolley and 20 days for another trolley. This demonstrated that the resuscitation equipment had not always been checked daily.

We noted that the latest emergency drugs list and expiration dates relating to the medication in the trolley showed that all the contents were in date. We reviewed the contents of the resuscitation trolley and we found that two ampoules of Hydrocortisone Efcortesol 100mg in 1ml ampoules had passed their expiry date (June 2022). These were immediately replaced.

We checked the temperature checks of the fridges in majors containing medication, to ensure that they were within an acceptable temperature range for the storage of the medication. We noted that the temperatures had not been checked on 11 occasions during July 2022. There was also an error code flashing on one fridge.

Further, we checked the controlled drugs register in Majors to ensure that daily checks of the stocks of controlled drugs were being carried out. We noted that on five days during July 2022, checks had not been carried out.

HIW considers that the lack of regular checks meant that there was a risk to patient safety, as the resuscitation trollies in both units may not be sufficiently stocked, or equipment / medication may not be in-date and ready for use, in the event of a patient emergency. Additionally, the medication in the fridge may be not as effective as if they had been stored correctly and the controlled drugs may not be available or may have been misappropriated and the fact they were missing not identified in a timely manner.

The lack of these daily checks on the resuscitation trolley on every occasion had also been identified as an improvement needed on the previous inspection in November 2021. We were told by the Director of Nursing that as a result of this and a previous failing in another inspection within the health board, the health board issued an organisational-wide alert. This was to ensure that these checks were carried out daily and evidenced. The health board at the time stated they would be carrying out a health board wide audit to ensure compliance with these checks. However, despite any actions that were carried out, staff were still not checking the resuscitation trollies daily as evidenced by this inspection.

This issue was dealt with under HIW's immediate assurance process and is referred to in Appendix B of this report.

Safeguarding children and safeguarding adults at risk

The department used a safeguarding proforma at triage should the nurse have suspicions or safeguarding concerns at this stage. There were also safeguarding questions included in the patient notes that would be completed for patients in cubicles in majors. Although we did not inspection the paediatric area of the emergency department, patients aged 16 and over would normally be seen in the main ED.

We were told that patients assessed as at risk of self-harm would be allocated a member of staff to care for them on a one-to-one basis. There was a dedicated room for relevant patients that had been adapted with anti-ligature handles.

Staff we spoke with were aware of the systems and processes in place to ensure patients were safeguarded and kept safe from abuse. All staff were aware of the procedures that needed to be followed and who to seek advice from. We also spoke to senior staff involved in safeguarding, they described the high impact service for patients who attended the ED on a frequent basis to provide additional support to the patient.

The nurse in charge said that staff had also received additional bespoke training relating to patients who may need to be subject to a Deprivation of Liberty Safeguard (DOLS). There were also plans in place to provide training on adult slavery, child sexual exploitation and non-accidental injuries in the future to staff.

Blood management

All staff we spoke with were aware of the importance of blood transfusion safety and the potential risks of incorrect blood product transfusions. There were appropriate systems in place to monitor the safe and appropriate use of blood components and their products. Staff were also able to describe the patient identification and blood component checks at all stages of the transfusion process. There were no patients in the department with blood transfusions at the time of inspection.

Staff were fully aware of the importance of maintaining the cold chain for blood products and the time critical element of using blood within certain time limits when outside the cold chain. There had not been issues noted with the supply of blood and there was always a sufficient supply of O rhesus positive blood.

Whilst staff we spoke with were aware of the use of Datix to report adverse events, they were not aware of the Serious Hazards of Transfusion (SHOT) reporting system. This was also reported at the last inspection. The health board action plan stated that SHOT awareness formed part of the IV training package and that SHOT awareness was re-enforced via the nursing newsletter, a copy of which was seen at the inspection.

Medical devices, equipment and diagnostic systems

The equipment at the ED appeared to be new and in a good state of repair. The areas had all the equipment needed to meet the needs of the patients. Faults were reported and equipment that was taken out of circulation was removed from the patient facing areas to await removal to electrical and biomedical engineering (EBME). All commodes seen had been decontaminated and cleaned and were labelled after use.

Staff we spoke with including nurses, healthcare support workers and the ward assistants were all aware of the correct processes to ensure that the appropriate equipment within the department was accessible, stocked, used and maintained appropriately. However, we were told that at times of peak demand there may be a lack of blood pressure machines, monitoring equipment and tympanic thermometers.

Effective care

Safe and clinically effective care

Patients and their carers that we spoke with were mainly complimentary of the care overall with positive comments on staff.

We spoke to a number of staff in various areas of the ED. Staff confirmed they were aware of how to access the relevant clinical policies and procedures through the health board intranet. All staff questioned were also aware of patient safety notices and had read them in the last month, this included medical staff that we spoke with who stated that these were also highlighted at the medical handover.

There was clear evidence from information supplied that a number of different audits were undertaken in the department. These included one patient one day, uniform, wristband and hand hygiene audits. We also noted that risk assessments were being completed for all admissions. The results of these audits were not displayed in the department. However, we were told that the results of the audit would be discussed with the members of staff concerned and as a headline on the nursing newsletter.

Well established patient pathways were noted particularly for stroke and segment elevation myocardial infarction (STEMI). All staff we spoke with were aware of these and said they were used daily. This included medical staff that we spoke with, one of whom stated that the guidelines on the intranet were very good.

We spoke with three staff about access to the Nursing and Midwifery Council guidance for nurses and midwives and all were able to access these through the NMC website.

The ED was busy but calm, staff were busy but in control. Staff in the RAU were very knowledgeable around who was in the waiting room and department. Staff were clearly working hard to mitigate risks associated with holding people on hard chairs in the RAU and waiting room. However, the patient experience in these areas was poor. When speaking to staff who were manning the RAU, they said they felt deeply uncomfortable about the area known as the RAU and the risk in there and the waiting room. They advised that patients were accommodated there daily with very serious conditions and needed a bed to lie down.

Whilst patients in the RAU were deemed fit to sit according to the health board criteria, we question whether this was the case as we noted two instances where patients in our opinion had conditions that required a bed not a chair.

We asked the 12 staff who stated in the questionnaire that they were permanently based in the ED questions about various aspects of patient care, including how this was facilitated. Ten staff disagreed with the statement that the facilities within the ED were appropriate for them to carry out their specific tasks. Staff commented:

> *"Assessment not suitable environment. Waiting room too small. Poor flow means patients spend too long in the department."*

> *"There are a lot of good things but the main underlying issue of the whole dept is a lack of assessment space for the waiting room. This has a massive ripple effect through the dept and means even if we are fully staffed we can't work at full capacity."*

> *"The facilities are excellent and are adequate if we had flow of patients, but as we have no flow the department runs out of the waiting area and ambulance bay. You could keep building a bigger waiting area but most of those patients should be on a trolley or in an assessment area."*

Additionally, ten staff disagreed with the statement that the ED environment was appropriate in ensuring patients received the care they required at their 'point of attendance'. Staff commented:

> *"Flow through hospital means over crowding in the department. Assessment area not suitable. Not able to monitor patients in waiting room. Department disjointed with sub waiting area at the top of majors. Waiting room is too small."*

> *"The wait time is too long."*

> *"I feel like if you are really poorly you are in safe hands. But as I've said before it's a real issue not having enough space to do obs, ECGs and clinical assessments. The patients do get the care they require but not in good time."*

That being said, eight of the twelve staff agreed there was an adequate skill mix within the ED team with four disagreeing. The following comments were made about staff skill mix:

> *"Lots of junior staff due to experienced staff leaving."*

> *"We struggle to retain experienced nurses because the working conditions are so hard."*

"The ED team is very clicky, you are likely to get a promotion if you are friends with someone in management, regardless of your clinical experience. People new to the department are made to feel inadequate by other members of staff."

Staff answers in the questionnaire indicated that patients were not generally assessed within the 4-hour target, but they knew how to escalate when the department was close to capacity. The majority agreed that they were not able to meet the conflicting demands on their time at work and that there were not enough staff to enable them to do their job properly. Staff told us:

"When working in 'red' triage which is basically in a corridor. Often you are the only nurse in the area. You are expected to triage patients both walk ins and ambulances, transfer patients, do swabs for MAU if they have red patients, take patients for ECG within 10 mins of cardiac symptoms however machine is at the other end in a1. If you have other patients there and are on your own it's impossible to get everything done, even if you're lucky enough to have a HCA often the workload is too heavy. It is unsafe…"
"It is very rare for us to see and assess patients in the otherwise excellent clinical areas, because there is no flow. The majority of patients are seen in ambulances or in non-clinical spaces such as relatives rooms. Though we have some assessment rooms, this area is cramped, woefully inadequate and dangerous as access and egress is poor and the notes are liable to get mixed up. The nursing staff are hugely overburdened and highly stressed when working in this area. The root cause of this is poor flow."

Staff mainly agreed that they had adequate materials, supplies and equipment to do their work and they were able to access ICT systems they needed to provide good care and support for patients. Eight staff said they were able to make suggestions to improve the work of their team, but three disagreed.

We asked staff permanently based in the ED how the department could improve the service it provides. Staff suggested:

"Improvements in environment, bigger waiting room and subwaiting areas. Improvements on flow through hospital. Improved staffing. Visible senior management team to support staff."

"Shorten wait times. Make more room in assessment room."

"It's the whole system than need to be rethink, the hospital backdoor need to be looking after to allow patient flowing in the right direction in a manner time."

"… Flow. We do need adequate staff to meet demand which is higher than expected. We need no expected patients to come to the department and for referred patients to leave within an hour. We need a faster response from inpatient teams when referred and not made to feel we are inconvenience."
"1) Improved flow from ED into wards to allow newly arriving patients to be accommodated.
2) more senior management presence to encourage inpatient specialties to be more responsive to ED referrals
3) frailty team embedded within ED
4) re-design of assessment rooms and area surrounding to improve patient safety
5) co-location of MIU and urgent primary care on the GUH site. This could then be the sole 24/7 Minor injuries within ABUHB with all other MIU'S closed overnight. Would allow for better streaming of patients and reduce the ED queue.
6) improved communication with other sites/ teams. The vocera system is not functioning well and often delays patient care by taking multiple attempts to connect with other teams.."

Sepsis

We noted the process used to ensure that cases of sepsis were identified and managed in a safe and effective way. Patients would be assessed at triage and bloods would be sent from there. We were also told that WAST pre-alerted the ED if severe sepsis was identified and a space would be created in the resus area.

The sepsis six tool was used and the ED nursing documentation had the sepsis risk identified highlighted. There was a good awareness of sepsis amongst staff at all levels and all staff were aware of, and used, the sepsis six pathway. Some staff reported that the lack of capacity and space could sometimes delay commencement of treatment, but staff mitigated this delay by starting IV infusions whilst patients were sitting on chairs in the RAU.

We were also told that patients at risk of sepsis were given relevant information to take away with them.

Quality improvement, research and innovation

In addition to the nutrition and hydration services provided by the Red Cross we were also told that the Red Cross also maintain patient care needs and assisted nursing staff to attend to welfare needs of patients. They did this by ensuring safe discharge with transport and access to patients' homes. We were told this included providing a welcome pack to ensure patients had basic necessities such as milk, bread and other items when they returned home and that the heating was on if needed.

We were also told about initiatives in place by staff to instigate improvements to care such as the changes to the electro cardio graphs (ECG) process to also improve safety.

Record keeping

We viewed a total of ten patients records in detail and also a number of records as discussed elsewhere in this report.

In general, pain scores were routinely taken and appropriate analgesia in response to this was prescribed and administered. The records reviewed all showed that appropriate risk assessments were completed and actioned. In all, the nursing and medical documentation was comprehensive and easy to locate and understand.

Quality of Management and Leadership

Governance, Leadership and Accountability

The department was considered as being well led with clear lines of responsibility and systems in place to monitor and respond to service needs. Staff we spoke with were complimentary about the management of the department. The senior nurse and assistant divisional nurse were noted in the department in uniform and were seen supporting areas.

We were told that all incidents were reported on Datix and would be reviewed by the nurse in charge and then reviewed by the serious incident team if necessary. Depending on the severity of the incident the review could be carried out at corporate level. A senior clinician from ED would attend the serious incident meetings. Any action plans would be fed-back to staff, through various methods including the nursing newsletter, email, Whatsapp or to individual staff. Staff would report incidents and were aware of the list of incidents that should be reported.

A management structure was in place and senior staff described clear lines of reporting to the wider health board management team. Roles, responsibilities and lines of accountability were also described and clear. Senior staff we spoke with described the on-call system, with a senior nurse at work throughout the week providing onsite cover. There was an on-call consultant during the silent hours. Additionally, senior staff were able to describe the gold, silver and bronze on call out of hours arrangements, with managers available during the core hours. The inspection team saw evidence of good management throughout the areas inspected.

We noted that triage staff were resilient and worked hard in a difficult working environment and that they balanced the risk to patients in the waiting room and the risk in the ambulance well.

The flexible staffing business case was described and we were told that there were normally enough staff to flexibly move staff around the department. There was also a pool of nurses available for bank work.

There were a number of meetings noted with cross departmental working trying to address the flow. There were also safety huddles in the ED to discuss staffing and other issues. Whilst the inspection team questioned the number of meetings, the health board considered that these meetings were important. The department

were building diverse teams, building people together and there was a lot of negotiation around patient flow and patient perspective. There was challenge about the need for a meeting and trying to generate a whole system response.

One member of staff spoke about their part time course and the support they had been given by the charge nurse and that they thoroughly enjoyed the experience of working in the resus area. They were clearly motivated and wanted to learn.

There were a number of student nurses working in the ED and the department hoped that these students would want to work in the department once they qualified.

We noted good communication during the medical round and particular noted the way that one consultant was speaking to the patient at a level the patient could understand. Also, in general all staff were working well to a good standard.

The nurse in charge was clearly identifiable and visible in all areas. Staff told us that the senior staff in ED were supportive and visible. Good working practice were observed between doctors and nurses who worked collaboratively for the best interests of the patient.

Staff we spoke with were open and honest and knew what was happening, particularly in the RAU. They understood the risks with sitting patients and delays. They knew how to find the relevant information, they had access to information and who to go too.

A total of eleven staff answered questions about reporting incidents and concerns. Only five said they had seen errors, near misses or incidents that could have hurt staff. All relevant staff said that the last time they saw an error, near miss or incident that could have hurt staff or patients, they or a colleague reported it. They all agreed their organisation encouraged them to report errors, near misses or incidents and that their organisation treated staff who are involved in such incidents fairly. Also, they all agreed their organisation treated reports of errors, near misses or incidents confidentially. All bar one agreed that, when errors, near misses or incidents were reported, their organisation took action to ensure that this did not happen again. Again ten of the eleven who expressed an opinion agreed that they were given feedback about changes made in response to reported errors, near misses and incidents.

The majority of staff agreed that if they were concerned about unsafe practice, they would know how to report it and they would feel secure raising concerns about unsafe clinical practice, one said no. Additionally, eight out of twelve staff

said they were confident that their concerns would be addressed but two said they were not.

Workforce

Staffing

We reviewed how the department ensured that there were sufficient numbers of appropriately trained staff for the provision of safe and effective patient care. Whilst the Nurse Staffing Levels (Wales) Act 2016 did not apply to the ED there was a ratio and skill mix required within the ED establishment. We were told that the additional staff referred to in the previous inspection had now been recruited (just over 19 staff including two practice educators).

The off-duty rotas were checked and staffing levels were generally in order. However, it was noted that on some shifts up to 50% of agency staff were used. The department tried to use the same agency staff to ensure some continuity of care and that these staff were aware of how the department operated. However, on the day of our inspection, there were five nurses short on shift. This included one triage nurse short, leading to an increase in triage waiting times. The risks were mitigated with senior nurses relocating staff to higher demand area.

Staff felt pressured on most shifts and believed there were insufficient staff on most shifts for the volume of patients together with extended stays in the department. The ED was regularly full with little movement including elderly and vulnerable patients requiring an increased level of nursing care. However, staff remained flexible and were redeployed to other areas within the department when staffing and acuity was a problem in a specific area. Staff reported that the department had been in escalation on multiple occasions for several months and that this was now the normal state.

Regarding whether staff felt they had enough time to provide care safely, a number of band five nurses we spoke with said that the workload could be excessive and unrelenting, with the demands on the system being unsustainable. This included two members of staff saying they were close to burn out and considering other jobs and career options. Staff consider the staffing to be inadequate to deal with the increasing demand and acuity of patients.

We were told that there were a number of vacancies in the department, including 22 at band five level. There were also a number of healthcare support worker vacancies but very little interest had been generated for these posts. Additionally, we were told of three band five resignations recently. This has had a significant impact on the department and increased the need for bank and agency staff.

Training

Staff training was mainly online, but face to face training had started recently. There were a number of training rooms available at the hospital that could be booked for training. Staff we spoke with said that their training was up to date and that they had received additional training such as triage training. Mandatory training records provided showed that compliance was generally good with over 90% compliance for safeguarding and violence and aggression for example. The lowest being 73% for fire safety.

A total of 12 staff who completed the questionnaire said that were based permanently in the ED and answered questions about professional development. The majority agreed they have had full training on all areas within the department. Staff commented:

> *"Although I have been in the department a year in August, I do not think I have had adequate training for the role. This is my first hospital setting in my career and I do not feel I have received the right amount of training."*

> *"Bank staff don't get training."*

> *"I'm yet to receive paediatric."*

> *"I love my job and just want more training provided."*

A total of seven staff agreed that their competency-based learning objectives were signed off before they started practicing in all treatments and three said they had not. We asked if there was any other training staff would find useful. Staff told us:

> *"All training to be able to do my job."*

> *"European Trauma Course."*

All bar one member of staff agreed that their training, learning and development helped them do their job more effectively and helped them to stay up to date with professional requirements. Nine respondents agreed that their training, learning and development helped them to deliver a better patient experience, three disagreed.

Information supplied showed that only 65% of staff at band five had appraisals within the last 12 months. Management stated that they were always available for

a one to one. In the survey, eleven of the 12 respondents indicated that they had an annual review or appraisal within the last 12 months.

Support and Management arrangements

Staff we spoke with felt supported by management. Senior staff we spoke with also described the arrangements in place to support student nurses, including being allocated a placement supervisor and mentor. Newly qualified staff would work as supernumerary staff for their first three weeks in post and followed a structured induction from the practice educators. We were also told that each student was given a primary and associate practice assessor or supervisor on commencing their placement. Mentors of students also ensured that they received an adequate level of supervision as appropriate to their level and competency.

Senior staff believed that there was a positive culture in the department and staff were passionate about their job. They were frustrated because no matter how hard they worked, they were unable to solve the issues regarding patient flow and numbers of patients attending the unit.

Team meetings were arranged but there was no regularity to these meetings. The last all staff meeting being the end of May. Staff were kept informed through Whatsapp groups as well as the local nursing newsletter.

A total of 11 ED staff answered questions about the hospital / organisation in the questionnaire. All bar one agreed that their organisation encouraged teamwork and eight agreed they would recommend their organisation as a place to work and three disagreed. The replies to the other questions in this area were mainly not as positive:

- Partnership working with other departments was effective -eight disagreed
- Partnership working with outside organisations was effective - five disagreed
- Staff were supported to identify and solve problems - six disagreed
- The organisation took swift action to improve when necessary - seven disagreed
- Care of patients was their organisation's top priority -five disagreed
- If a friend or relative needed support, they would be happy with the standard of care provided by this hospital.

Again, 11 ED staff answered questions about their immediate manager / line manager. The responses in this area were generally more positive. Nine agreed that their immediate manager could be counted on to help with a difficult task at work and gave them clear feedback on their work. Seven agreed that their immediate manager asked for their opinion before making decisions that affect their work. Ten agreed that their immediate manager was supportive in a personal crisis.

Regarding senior management, 11 ED staff answered questions, again the responses were generally positive. Ten agreed they knew who the senior managers were, seven agreed that senior managers were visible, eight agreed that senior managers were committed to patient care. Nine agreed that communication between senior management and staff was effective and seven agreed that senior managers tried to involve staff in important decisions and acted on staff feedback. A member of staff commented:

> *"Overall, the team and physical environment is excellent at GUH, but the system is made inefficient by crowding- meaning patients are rarely in a clinical space when we go to see them. Crowding is also leading to an unsafe department where patients with serious pathologies are often kept in inappropriate areas- we have had several serious incidents as a direct result of this. The ED team have worked hard to make the dept as safe and efficient as possible. Further improvement now need board level Senior managers to step up, be more visible and more supportive in their approach. To improve things further requires significant change to be made outside of the ED, and a more system-wide approach."*

Wellbeing

Staff told us of the monthly wellbeing sessions that were in place that had received good feedback.

We asked a series of questions about health and wellbeing of staff in the questionnaire, 11 ED staff answered questions.

- Nine agreed that their job was not detrimental to their health
- Five agreed their organisation took positive action on health and wellbeing
- Eight agreed that they are offered full support in the event of challenging situations

- Eight agreed that their current working pattern / off duty allowed for a good work life balance

- Nine agreed that they were aware of the occupational health support available

Equality

From our conversations with staff, we considered that equality and diversity was promoted within the organisation. We were also told that consideration was given to allow staff to observe any prayer times and to take leave during any religious festivals as required. Staff we spoke with believed that all staff were treated equally and that patients were also treated equally. Staff gave examples of how equality rights of all patients were considered regardless.

All nine members of staff who answered indicated that they had not faced discrimination at work within the last 12 months. Nine members of staff agreed that their workplace was supportive of equality and diversity. Staff commented:

> "ED team are diverse and welcoming."
>
> *"I really like the staff in A&E. I find everyone very helpful and supportive…"*

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Emergency Department (ED), The Grange University Hospital

Date of inspection: 1 - 3 August 2022

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to reduce the risk of cross contamination in the area known as the COVID corridor.	Standard 2.4 Infection prevention and Control (IPC) and De-contamination	1) Point of care testing has been implemented to support rapid testing to ensure that Covid status of patients is identified.	Senior Nurse	Completed
		2) Staff have been reminded of the importance of appropriate usage of PPE.	Senior Nurse/IPAC	Completed
		3) Ensure a good supply of PPE is available at all times for patients and visitors.	Senior Nurse	Completed
		4) Daily checks of PPE trolleys in place to ensure adequate supplies of PPE.	Nurse in Charge	Completed
		5) Signage prominently displayed to ensure corridor is not utilised as a thoroughfare.	General Manager/IPAC	Completed

		6) Hand hygiene audits to be completed weekly to monitor compliance with effective hand hygiene and actions taken on compliance rates. These will be uploaded onto the Health and Care monitoring system.	Senior Nurse	Completed and will be ongoing
		7) Cleaning schedules to be monitored and reviewed weekly to ensure effective cleaning. Actions to be take in regards compliance rates.	Senior Nurse	Completed and will be ongoing
		8) All staff have been reminded of the importance of closing doors along the A1 corridor, to minimise the potential for cross contamination This will be further reinforced via site meetings.	Senior Nurse	Completed
		9) Standing agenda item on the weekly GUH Hospital Management Team meetings, to ensure this message is reinforced.	General Manager	Completed
		10) Communication to be sent out via the health board intranet to reinforce use of A1 corridor.	General Manager	Completed

		11) Current risk assessment reviewed and amended to reflect risk mitigations that are in place.	Senior Nurse	Completed
		The A1 (Covid) corridor is in use as an interim area for the assessment of Covid positive patients. The longer term plan is to utilise the portacabin that is located outside the emergency department - the risks of using the A1 corridor is recognised and as far as reasonable they are mitigated. This includes consideration of alternative areas within the emergency department which were not considered to be appropriate.		
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken to ensure that resuscitation equipment and medication is always available and safe to use in the event of a patient emergency within the emergency department and within all other wards and	Standard 2.6 Medicines Management and Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	12) Staff have been reminded of the necessity to ensure daily checks of resus trolleys are undertaken.	Senior Nurse	Completed
		13) Monthly resus trolley checks, as per ABUHB protocol, to be undertaken to include: breaking of seal, and drug expiry check.	Senior Nurse	Completed – review by 31 August 2022
		14) Internal Alert regarding resus trolley checks re-distributed to all areas within the Health Board.	Risk Manager	Completed

departments across the health board.		15) Further assurance being sought from Divisions in regards Health Board compliance.	Interim Director of Nursing	30 August 2022
		16) Daily Omnicell fridge temperature report for Majors and Resus emailed daily to ED Senior Nurse and Band 7 team.	Senior Nurse	Completed
		17) New 'ED safety checklist' commenced allocating checks based on role will be reviewed daily by Nurse in Charge. This also includes the requirement for appropriate CD checks as per ABUHB policy.	Senior Nurse	Completed
		18) Monthly safety checklists to be uploaded onto share point.	Senior Nurse	31 August 2022
The health board is required to provide HIW with details of the action taken to ensure medicines are managed safely and that substances that could cause a hazard to	Standard 2.6 Medicines Management and Standard 3.1 Safe and Clinically Effective Care	19) Nursing News has been displayed in the staff room reminding all staff of their responsibility to store medication and prescription pads in the Omnicell. It has been reinforced that no medication or prescription pads are to be left unattended at any time. To be discussed at team meetings.	Senior Nurse	Completed

health are appropriately secured.		20) Clinical director has been requested to remind all medical staff of the safe storge of prescription pads within the Omnicell.	Clinical Director	Completed
		21) Operation service manager has alerted all supervisors within GUH to the importance of ensuring all doors that lead into storage space areas are kept locked at all times to ensure the safe storage of substances.	General Manager / Operation Service Manager	Completed
		22) Flammable cupboard ordered to store substances in majors.	Senior Nurse	Completed
		23) High strength potassium solution removed from majors cupboard and now locked in storage cupboard.	Senior Nurse	Completed
		24) Locks to be fitted to intravenous storage cupboard in majors department. Request has been submitted.	Senior Nurse	31 August 2022
		25) Lead pharmacist has attended the emergency department to consider potential solutions and improvements.	Pharmacy	Completed

		26) Clinical areas to re-check compliance with patient safety notice.	Divisional Pharmacist / Senior Nurse	12 September 2022

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Sue Pearce**

Job role: **Divisional Nurse**

Date: **12 August 2022**

Appendix C - Improvement plan

Service: Emergency Department (ED), The Grange University Hospital

Date of inspection: 1 - 3 August 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the 'No Smoking' legislation is enforced.	Standard 1.1 Health Promotion, Protection and Improvement	x2 WTE Smoking Officers employed and currently undertaking their training. All staff are encouraged to advise patients and relatives regarding No Smoking Policy on site. As appropriate all patients admitted are offered Nicotine replacement and provided with the relevant Health Promotion advice.	Facilities Manager	October 2022
The health board must ensure that action is taken to promote the use of the Welsh language within the ED.	Standard 3.2 Communicating Effectively	Welsh & English signage in place across GUH site. Signage in ED reception promoting the 'active Offer' for patients wishing to receive information in Welsh. Welsh language training available to all staff. Translator available for any service user requesting to converse in Welsh if ED staff unavailable.	Head of Welsh Language Unit	Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Posters advertising translation service in place across department.		
The health board must ensure that waiting times are displayed in a prominent position within the waiting area.	Standard 3.2 Communicating Effectively	The ED is working towards a safe system to provide live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	Service Lead / Clinical Director / Senior Nurse	November 2022
The health board must ensure that the microphone in the reception desk is working correctly at all times.	Standard 3.2 Communicating Effectively	Reception staff have been reminded to escalate any concerns regarding the microphone to Works & Estates.	Service Lead	Completed
		Works & Estates aware to expedite any calls regarding microphone faults from the Emergency Department.		Completed
		The department is currently scoping alternative solutions to the current microphone system to improve communication between patients and staff.		December 2022
The health board must review the use of the area known as the RAU to ensure that patient dignity and privacy is promoted and maintained. This	Standard 4.1 Dignified Care	Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns.	Service Lead / Clinical Director / Senior Nurse	Completed
		ED escalation process is in place.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
includes maintaining patient confidentiality when administering medication to patients in the RAU.		Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required.		Completed
		All staff have been reminded of the importance of maintaining patient dignity and privacy in all areas of the department.		Completed
		All staff have been reminded of the importance of confidentiality when undertaking medication administration checks.		Completed
The health board is to provide details to HIW with the continuing actions taking place to manage the overcrowding in the waiting room and the RAU that are not conducive to providing safe and dignified care.	Standard 4.1 Dignified Care	The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times.	General Manager for Urgent Care / Director of Operations	Completed
		The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners).		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		ED escalation process is in place.		Completed
		Same Day Emergency Care Unit (SDEC) to pull appropriate patients direct from triage.		Completed /Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		December 2022
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		December 2022
The health board must ensure that there is an area available to facilitate red release calls at all times.	Standard 5.1 Timely Access	There is an agreed red release trolley space within the ED along with an agreed process for managing red release requests and escalation process to the hospital flow team.	General Manager for Urgent Care / Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing
		A dual-pin handover between Paramedic and Nurse has been established to maintain a focus on reducing lost hours and to expedite patient handovers.		Completed /Ongoing
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		ED Nurse in Charge (NIC) to alert Clinical Site Manager if a crew is held without a plan. The Clinical Site Manager to agree plans with ED NIC and reinforce plans at Site Meeting so that there is a wider specialty / system response to de-escalate the demand / pressures within the ED.		Completed
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		Completed
		If there is a crew delay of >1hr the Clinical Site Manager will authorise pre-empting of defined patients in ED to their specialty wards against the 'definite' discharge profile. This will then escalate to the 'potential' discharge profile when a crew is held for two hours and where there has been no plan confirmed.		Completed / Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Patients who have been identified for discharge will not be held on ambulances for tests / investigations. Patients will be brought into the hospital to undergo their tests and then moved to the Transfer Lounge whilst they await their results and transport home. The Health Board will use the WAST Launchpad demand data at every cross-site meeting to identify what is on the WAST Stack (WAST Community Demand and Acuity) to plan ahead, potentially pre-empting moves to make capacity for the demand expected. The aim is to clear 6 trolley spaces by 16:00hrs every day to support the late afternoon surge profile.		December 2022
The health board must ensure that patients are not required to wait on chairs overnight in the RAU.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. Please refer to actions above.	General Manager for Urgent Care / Director of Operations	Completed / Ongoing
The health board is to provide HIW with an update on the actions taken to continue to put processes in place to ensure a system wide solution to poor flow and overcrowding at the ED.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. An overarching Programme plan is under development including highlighting where other improvement and transformation work will impact on the 6 Goals measures.	General Manager for Urgent Care / Director of Operations	Completed / Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that regular reviews of patients in ambulances, waiting room and RAU are carried out to ensure that patients receive appropriate and timely pain relief and treatment.	Standard 5.1 Timely Access	There are agreed policies with the ED and WAST with roles and responsibilities outlined for patients held on ambulances. Staff have been reminded of the importance of ensuring patients receive the appropriate timely care, observations and medication in accordance with their presentation.	Clinical Director / Senior Nurse	Completed Completed
The health board must ensure that the information on how they have learned and improved on feedback received is prominently displayed within the department on a 'You said, We did' board or similar.	Standard 6.3 Listening and Learning from Feedback	'You said, we did' implemented as part of the commissioning of the Screening & Testing Unit. You said, we did system to be introduced wider across the ED.	Service Lead / Senior Nurse	Completed September 2022 December 2022
The health board must ensure that there is a robust process in place to ensure that staff are regularly reviewed to ensure that their stresses	Standard 2.1 Managing Risk and Promoting Health and Safety	Regular staff wellbeing sessions are available. There are x2 wellbeing Consultants and a Band 7 nurse in place.	Service Lead / Clinical Director / Senior Nurse / Divisional Nurse	Completed Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
as a result of the workload are managed.	Standard 7.1 Workforce	Open door availability to meet with Senior Nurse which has been reinforced through nursing news.		Completed
		Senior management team visible daily to allow staff the opportunity to raise concerns.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		Staff are reviewed annually via their PADR process during which wellbeing at work is discussed and any actions noted.		Completed
		Wellbeing services and resources are available to all staff.		Completed
		Debriefing sessions are in place for staff involved in critical incidents which may impact on wellbeing.		Completed
The health board is required to update HIW with the actions taken to further reduce the risk of pressure damage to	Standard 2.2 Preventing pressure and tissue damage	There are agreed policies with the ED and WAST with roles and responsibilities outlined.	Senior Nurse / Divisional Nurse	Completed
		Patients identified at risk will receive the appropriate pressure relieving devices.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
patients required to wait on ambulances.		The importance of pressure area care has been shared via the nursing news in ED.		Completed
		All pressure ulcer Datix's are reviewed by the ED Band 7's and appropriate actions implemented. Any involving WAST will be shared with WAST colleagues.		Completed
		Equipment is available for use based on patient risk assessment.		Completed
The health board must ensure that all areas are cleaned as required and that evidence of this cleaning is recorded and displayed in a prominent position.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The ED has dedicated domestic staff undertaking cleaning with formal records of cleaning completed.	Senior Nurse / Facilities Manager	Completed
		Monthly Synbiotix cleaning assessments undertaken by facility staff and shared with senior management (Last assessment was 96% undertaken on the 25 August 2022).		Completed
		Nursing cleaning schedules are in place for all areas across the ED and will be displayed in a prominent position ensuring completion.		Completed / Ongoing
The health board must continue to ensure that the relevant nutrition charts are completed for patients in the ED.	Standard 2,5 Nutrition and Hydration	Patients are assessed on their clinical presentation which includes eating and drinking.	Clinical Director / Senior Nurse	Completed / Ongoing
		The ED will ensure intravenous fluids are recorded on the All Wales medication charts.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart.		Completed
		Nutrition & Hydration Training is included within induction for new staff.		Completed
The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	Standard 2.8 Blood management	SHOT awareness forms part of the IV training package. SHOT awareness re-enforced via Nursing Newsletter. Any infusion incidents are reported on Datix. The blood transfusion service then report these incidents to SHOT.	Clinical Director / Senior Nurse	Completed / Ongoing
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the availability of equipment.	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	All staff have been reminded of the process for escalating concerns to the Nurse in Charge or Emergency Physician in Charge (EPIC).	Clinical Director / Senior Nurse / Band 7's / Assistant Divisional Nurse	Completed
		Staff are encouraged to raise concerns verbally to the NIC.		Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		Any equipment deficits as a result of delays in repair to be escalated to the EBME manager.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		A review of the medical equipment across ED has been undertaken and there is sufficient equipment to provide a safe service if all equipment operational.		Completed
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the manning and risk associated with patients in the waiting room and the RAU.	Standard 3.1 Safe and clinically effective care	Staff are encouraged to raise concerns verbally to a senior member of staff with confidence.	Clinical Director / Senior Nurse	Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. Please see actions above.		Completed
The health board must continue with its efforts to recruit permanent staff.	Standard 7.1 Workforce	The ED will continue to actively retain permanent staff and recruit new staff to the unit.	Clinical Director / Senior Nurse	Completed
		Streamlining events are in place to actively recruit newly qualified staff.		Completed
		Nursing and Health Care Support Worker posts to be advertised continuously.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Experienced Health Care Support Workers in the ED are supported to undertake their nurse training via the Flexible nursing route.		Completed
The health board must ensure that action is taken to improve compliance with staff appraisals.	Standard 7.1 Workforce	Improvement plan in place for annual appraisals.	Clinical Director / Senior Nurse	December 2022

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Sue Pearce**

Job role: **Divisional Nurse**

Date: **26 September 202**

Appendix C - Improvement plan

Service: **Emergency Department (ED), The Grange University Hospital**

Date of inspection: **1 - 3 August 2022**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that the 'No Smoking' legislation is enforced.	Standard 1.1 Health Promotion, Protection and Improvement	x2 WTE Smoking Officers employed and currently undertaking their training. All staff are encouraged to advise patients and relatives regarding No Smoking Policy on site. As appropriate all patients admitted are offered Nicotine replacement and provided with the relevant Health Promotion advice.	Facilities Manager	October 2022
The health board must ensure that action is taken to promote the use of the Welsh language within the ED.	Standard 3.2 Communicating Effectively	Welsh & English signage in place across GUH site. Signage in ED reception promoting the 'active Offer' for patients wishing to receive information in Welsh. Welsh language training available to all staff. Translator available for any service user requesting to converse in Welsh if ED staff unavailable. Posters advertising translation service in place across department.	Head of Welsh Language Unit	Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that waiting times are displayed in a prominent position within the waiting area.	Standard 3.2 Communicating Effectively	The ED is working towards a safe system to provide live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	Service Lead / Clinical Director / Senior Nurse	November 2022
The health board must ensure that the microphone in the reception desk is working correctly at all times.	Standard 3.2 Communicating Effectively	Reception staff have been reminded to escalate any concerns regarding the microphone to Works & Estates.	Service Lead	Completed
		Works & Estates aware to expedite any calls regarding microphone faults from the Emergency Department.		Completed
		The department is currently scoping alternative solutions to the current microphone system to improve communication between patients and staff.		December 2022
The health board must review the use of the area known as the RAU to ensure that patient dignity and privacy is promoted and maintained. This includes maintaining patient confidentiality when administering	Standard 4.1 Dignified Care	Fit to sit criteria in place and all patients in chairs are assessed with appropriate escalation to the site ops team in the event of concerns.	Service Lead / Clinical Director / Senior Nurse	Completed
		ED escalation process is in place.		Completed
		Staff have been reminded of the importance of maintaining patient privacy throughout the department. Private rooms are available if required.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
medication to patients in the RAU.		All staff have been reminded of the importance of maintaining patient dignity and privacy in all areas of the department.		Completed
		All staff have been reminded of the importance of confidentiality when undertaking medication administration checks.		Completed
The health board is to provide details to HIW with the continuing actions taking place to manage the overcrowding in the waiting room and the RAU that are not conducive to providing safe and dignified care.	Standard 4.1 Dignified Care	The ED medical staff rotas are matched to attendances to ensure the staffing is maximised at the busier times of the day to improve wait times.	General Manager for Urgent Care / Director of Operations	Completed
		The ED and assessment units have invested in alternative roles to support medical staff and reduce the wait to be seen time (Nurse Practitioner's / Physician Assistants / Acute Care Practitioners).		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		ED escalation process is in place.		Completed
		Same Day Emergency Care Unit (SDEC) to pull appropriate patients direct from triage.		Completed /Ongoing
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		December 2022
The health board must ensure that there is an area available to facilitate red release calls at all times.	Standard 5.1 Timely Access	There is an agreed red release trolley space within the ED along with an agreed process for managing red release requests and escalation process to the hospital flow team.	General Manager for Urgent Care / Service Lead / Clinical Director / Senior Nurse	Completed / Ongoing
		A dual-pin handover between Paramedic and Nurse has been established to maintain a focus on reducing lost hours and to expedite patient handovers.		Completed /Ongoing
		3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.		November 2022
		ED Nurse in Charge (NIC) to alert Clinical Site Manager if a crew is held without a plan. The Clinical Site Manager to agree plans with ED NIC and reinforce plans at Site Meeting so that there is a wider specialty / system response to de-escalate the demand / pressures within the ED.		Completed
		If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		If there is a crew delay of >1hr the Clinical Site Manager will authorise pre-empting of defined patients in ED to their specialty wards against the 'definite' discharge profile. This will then escalate to the 'potential' discharge profile when a crew is held for two hours and where there has been no plan confirmed.		Completed / Ongoing
		Patients who have been identified for discharge will not be held on ambulances for tests / investigations. Patients will be brought into the hospital to undergo their tests and then moved to the Transfer Lounge whilst they await their results and transport home. The Health Board will use the WAST Launchpad demand data at every cross-site meeting to identify what is on the WAST Stack (WAST Community Demand and Acuity) to plan ahead, potentially pre-empting moves to make capacity for the demand expected. The aim is to clear 6 trolley spaces by 16:00hrs every day to support the late afternoon surge profile.		December 2022
The health board must ensure that patients are not required to wait on chairs overnight in the RAU.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. *Please refer to actions above.*	General Manager for Urgent Care / Director of Operations	Completed / Ongoing

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is to provide HIW with an update on the actions taken to continue to put processes in place to ensure a system wide solution to poor flow and overcrowding at the ED.	Standard 5.1 Timely Access	There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. An overarching Programme plan is under development including highlighting where other improvement and transformation work will impact on the 6 Goals measures.	General Manager for Urgent Care / Director of Operations	Completed / Ongoing
The health board must ensure that regular reviews of patients in ambulances, waiting room and RAU are carried out to ensure that patients receive appropriate and timely pain relief and treatment.	Standard 5.1 Timely Access	There are agreed policies with the ED and WAST with roles and responsibilities outlined for patients held on ambulances. Staff have been reminded of the importance of ensuring patients receive the appropriate timely care, observations and medication in accordance with their presentation.	Clinical Director / Senior Nurse	Completed Completed
The health board must ensure that the information on how they have learned and improved on feedback received is prominently displayed within the department on a 'You said, We did' board or similar.	Standard 6.3 Listening and Learning from Feedback	'You said, we did' implemented as part of the commissioning of the Screening & Testing Unit. You said, we did system to be introduced wider across the ED.	Service Lead / Senior Nurse	Completed September 2022 December 2022
The health board must ensure that there is a	Standard 2.1	Regular staff wellbeing sessions are available.	Service Lead / Clinical Director /	Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
robust process in place to ensure that staff are regularly reviewed to ensure that their stresses as a result of the workload are managed.	Managing Risk and Promoting Health and Safety Standard 7.1 Workforce	There are x2 wellbeing Consultants and a Band 7 nurse in place.	Senior Nurse / Divisional Nurse	Completed
		Open door availability to meet with Senior Nurse which has been reinforced through nursing news.		Completed
		Senior management team visible daily to allow staff the opportunity to raise concerns.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas.		Ongoing
		Staff are reviewed annually via their PADR process during which wellbeing at work is discussed and any actions noted.		Completed
		Wellbeing services and resources are available to all staff.		Completed
		Debriefing sessions are in place for staff involved in critical incidents which may impact on wellbeing.		Completed
The health board is required to update HIW with the actions taken to further reduce the risk of pressure damage to	Standard 2.2 Preventing pressure and tissue damage	There are agreed policies with the ED and WAST with roles and responsibilities outlined.	Senior Nurse / Divisional Nurse	Completed
		Patients identified at risk will receive the appropriate pressure relieving devices.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
patients required to wait on ambulances.		The importance of pressure area care has been shared via the nursing news in ED.		Completed
		All pressure ulcer Datix's are reviewed by the ED Band 7's and appropriate actions implemented. Any involving WAST will be shared with WAST colleagues.		Completed
		Equipment is available for use based on patient risk assessment.		Completed
The health board must ensure that all areas are cleaned as required and that evidence of this cleaning is recorded and displayed in a prominent position.	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The ED has dedicated domestic staff undertaking cleaning with formal records of cleaning completed.	Senior Nurse / Facilities Manager	Completed
		Monthly Synbiotix cleaning assessments undertaken by facility staff and shared with senior management (Last assessment was 96% undertaken on the 25 August 2022).		Completed
		Nursing cleaning schedules are in place for all areas across the ED and will be displayed in a prominent position ensuring completion.		Completed / Ongoing
The health board must continue to ensure that the relevant nutrition charts are completed for patients in the ED.	Standard 2,5 Nutrition and Hydration	Patients are assessed on their clinical presentation which includes eating and drinking.	Clinical Director / Senior Nurse	Completed / Ongoing
		The ED will ensure intravenous fluids are recorded on the All Wales medication charts.		Completed
		Fluid balance is recorded within the ED Patient Care Record which is a mirror image of the All Wales Fluid Balance Chart.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Nutrition & Hydration Training is included within induction for new staff.		Completed
The Health Board must ensure that all staff are made aware of Serious Hazards of Transfusion (SHOT) and the importance of reporting any instances.	Standard 2.8 Blood management	SHOT awareness forms part of the IV training package. SHOT awareness re-enforced via Nursing Newsletter. Any infusion incidents are reported on Datix. The blood transfusion service then report these incidents to SHOT.	Clinical Director / Senior Nurse	Completed / Ongoing
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the availability of equipment.	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	All staff have been reminded of the process for escalating concerns to the Nurse in Charge or Emergency Physician in Charge (EPIC).	Clinical Director / Senior Nurse / Band 7's / Assistant Divisional Nurse	Completed
		Staff are encouraged to raise concerns verbally to the NIC.		Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		Any equipment deficits as a result of delays in repair to be escalated to the EBME manager.		Completed
		A review of the medical equipment across ED has been undertaken and there is sufficient equipment to provide a safe service if all equipment operational.		Completed

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide details of the action taken to respond and address the less favourable staff comments in relation to the manning and risk associated with patients in the waiting room and the RAU.	Standard 3.1 Safe and clinically effective care	Staff are encouraged to raise concerns verbally to a senior member of staff with confidence.	Clinical Director / Senior Nurse	Completed
		All concerns and actions will be discussed with staff members and timely feedback provided of actions taken.		Completed
		There is continued work across the Health Board to improve the flow of patients through the ED and assessment areas. *Please see actions above.*		Completed
The health board must continue with its efforts to recruit permanent staff.	Standard 7.1 Workforce	The ED will continue to actively retain permanent staff and recruit new staff to the unit.	Clinical Director / Senior Nurse	Completed
		Streamlining events are in place to actively recruit newly qualified staff.		Completed
		Nursing and Health Care Support Worker posts to be advertised continuously.		Completed
		Experienced Health Care Support Workers in the ED are supported to undertake their nurse training via the Flexible nursing route.		Completed
The health board must ensure that action is taken to improve compliance with staff appraisals.	Standard 7.1 Workforce	Improvement plan in place for annual appraisals.	Clinical Director / Senior Nurse	December 2022

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): Sue Pearce

Job role: Divisional Nurse

Date: 26 September 2022

Appendix C - Improvement plan

Service: Ysbyty Ystrad Fawr

Date of inspection: 05, 06 and 07 September 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The garden area of Ty Cyfannol should be cleaned, and individuals encouraged to maintain the area.	Health Protection and Improvement	Raised with Facilities Division. Meeting convened for w/c 14.11.2022 to clarify outdoor cleaning schedules for all MH & LD wards.	Senior Manager, Facilities	December 2022
The health board needs to provide a wider range of therapeutic and physical activities for patients on Ty Cyfannol, including activities outside of weekday working hours and opportunities to exercise. This issue was also a previous recommendation during our previous inspection of the ward in 2017.	Health Protection and Improvement	Prior to Covid, the ward had use of the Hydrotherapy Pool on the Hospital site. The Ward Manager has received confirmation that this can be reinstated in Dec/Jan, depending on the Covid situation.	Ward Manager	December 2022
		The Activities room on the ward is open 7 days a week until 9pm but can stay open longer depending on the demand and use. This is accessible to all patients.	Ward Manager	Ongoing from September 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		To liaise with the local Leisure Centre to enquire what is available for the patients on Ty Cyfannol throughout the 7-day week.	Ward Manager	November 2022
		Pet therapy to be re-instated once a month on the weekend.	Ward Manager	December 2022
		'Growing Spaces' (third sector organisation attends Ty Cyfannol three times per week to offer music, arts & crafts and gardening sessions on the ward.		Ongoing
		The lead for OT is arranging 'Music and Hospitals' to attend the ward regularly.	Professional Lead for OT	November 2022
		Continue to bid for OT Technicians to work out of hours and weekends on the Ward to support activities outside of core hours.		Ongoing
The health board must ensure that appropriate measures are put in place to protect the privacy of patients, by ensuring the patient bedroom vision panels are kept closed between patient observations.	Dignified care	All staff have been reminded to keep vision panels closed.	Ward Manager	COMPLETE
		Ward HEB walkarounds will include this standard as a regular check to monitor and improve compliance.	Lead Nurse/ Senior Nurse	December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board needs to consider gender segregation on the wards by ensuring that proper safeguards are put in place, and that care plans and risk assessments are completed accordingly.	Dignified care	Ty Cyfannol to continue to segregate corridors by sex, however mindful of supporting the needs of individuals who identify as gender-fluid/non-binary. Annwylfan to continue to collocate males and females as best as possible. People who have more acute needs will be located in a bedroom nearer the nursing station to enable better observation.	Ward Managers	Ongoing
		Division to liaise with other Divisions to share practice.	Head of Q&I	November 2022
		Standards for mixed occupancy wards to be discussed and agreed at Divisional QPS meeting.	Head of Q&I	November 2022
On Ty Cyfannol, the assisted toilet being used as a storage area should be cleared for the use of any patients who may need it.	Dignified care	This room officially changed use to a storage cupboard last year following correct Health Board procedures. The current sign to be replaced to reflect the change of use. There are a further 3 assisted toilets available on the ward for patients to use in addition to ensuite facilities in all bedrooms.	Ward Manager	November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The shower doors in the ECA of Ty Cyfannol should be replaced to ensure the privacy and dignity of patients.	Dignified care	The doors are magnetic and removable. They have now been re-connected to the door frame.	Ward Manager	COMPLETE
The health board must ensure that staff always consider and respect the privacy and dignity of patients when discussing patient matters.	Dignified care	All staff have been reminded that conversations involving patients must be held in private away from other patients and visitors to the unit. This will be formally discussed and noted in the Team Meeting.	Ward Manager	COMPLETE
We recommend that the health board implement a more individualised care process for patients to ensure that patients know who their allocated nurse is on a daily basis.	Communicating effectively	All staff have been reminded to inform patients on admission who their Named Nurse is.	Ward Manager	COMPLETE
		Personalised person-centred information boards to be installed by each bed where this information and other specific details can be displayed.	Ward Manager	Costings to be requested by December 2022
Up-to-date staff organisational boards should be displayed on the wards, for patient and visitor awareness.	Communicating effectively	Ty Cyfannol ward has ordered a replacement display board – awaiting delivery.	Ward Managers	COMPLETE
		Induction processes for new staff to both wards will include adding a photo/name to the board.		November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must ensure that patient personal details cannot be viewed from outside the nursing station on Annwylfan, to protect patient confidentiality.	Patient information	A new PSAG board with closing 'wings' has been ordered.	Senior Nurse	COMPLETE
The health board should ensure that information on making a complaint is displayed for patients and visitors on the wards.	Patient information	A 'Putting Things Right' poster is now displayed on Ty Cyfannol. Posters are also displayed in the reception area.	Ward Manager	COMPLETE
		Information added to carer and patient wall displays and now included in carer pack for Annwylfan.	Ward manager	COMPLETE
The health board should ensure that information on advocacy services is displayed for patients and visitors on the wards.	Patient information	An Advocacy Poster is now displayed on Ty Cyfannol. Posters are also displayed in the reception area. Information added to carer and patient wall displays and also now included in carer pack for Annwylfan.	Ward Managers	COMPLETE
The broken cupboard in the child visit room on Ty Cyfannol needs to be repaired.	People's rights	Works order requested for this to be repaired.	Ward Manager	COMPLETE
The health board should ensure that relevant policies are reviewed and kept up to date prior to their expiration date. This includes the	People's rights	Policy is currently being updated.	Health Board Equality, Diversity &	March 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Equality and Diversity Policy which expired in November 2021.			Inclusion Specialist	
The health board should implement a process for gathering and obtaining feedback from patients, carers and families on Annwylfan.	Listening and learning from feedback	The local Community Health Council conducts annual visits to the older adult mental health wards to independently seek feedback from patients and families. These are fed back with recommendations.	Lead Nurse OAMH	Ongoing
		Schedule and plan for obtaining feedback to be discussed at the next Directorate QPS meeting.	Lead Nurse, OAMH	December 2022
The health board must review the policy for the Assessment and Management of Environmental Ligature Risks within the Mental Health and Learning Disabilities Division. The review date expired on 31 January 2020.	Managing risk and promoting health and safety	This policy is complete and awaiting ratification by the MH/LD Division's QPS meeting before being ratified by the Health Board.	Head of Q&I	December 2022
The health board must remove or repair the Ty Cyfannol garden shelter which presents as a ligature risk, and include it in the ligature audit process.	Managing risk and promoting health and safety	Costings have been requested from the Health Board's Minor Works Department to replace the shelter – monies have been released via Capital funding to purchase. Awaiting costings.	Works and Estates	March 2023

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Ligature Risk Assessment has been completed which states the area must be observed every 15 minutes to monitor ligature risk. The area has been visited by the Health Board's Fire Officer – the shelter cannot be removed until a replacement has been sourced, as patients must have access to a smoking shelter. To remove would create a fire risk.	Service Improvement Manager, AMH	COMPLETE
We recommend a more secure and appropriate container is arranged for the ligature cutters inside the patient property cupboard on Ty Cyfannol.	Managing risk and promoting health and safety	The ward now keeps all cutters in a 'grab bag'/ secure container in various positions on the ward to allow emergency access.	Ward Manager	COMPLETE
		Siting of ligature cutters to be included in Assessment and Management of Environmental Ligature Risks within the Mental Health and Learning Disabilities Division.	Head of Q&I	December 2022
The health board should assess and undertake measures to improve the security of the doors on Ty Cyfannol, in light of recent patient breaches.	Managing risk and promoting health and safety	Re: second set of doors into the ward: This set of doors was installed recently to separate the ward from the Crisis Home Treatment Team corridor. They are an extra set of locked security doors built on top of underfloor heating, which	Service Improvement Manager (AMH)	December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		restricts them from being made more secure at the bottom. There is a further, main set of robust doors leading into the Home Treatment corridor and subsequently the ward. Signs are now displayed on the doors as a reminder, that they are securely closed before staff walk away. With regard to doors near the ECA, there is a green 'fire exit button' which opens the doors when pressed. The MH/LD Division is currently exploring potential solutions with Works & Estates that allows swift access in case of fire but that maintains the security of the doors. Another mitigation being explored is the potential for the doors to be alarmed. Anyone nursed in the ECA is nursed on level 3 (within eyesight) observations as a minimum thus mitigating the risk of absconding when the ECA is in use.		
The health board must provide entry cards for all staff working on the wards, to ensure the safety of staff and patients	Managing risk and promoting health and safety	Spare access cards to be made available on Ty Cyfannol Ward and signed back in after use.	Ward Manager	December 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		Annwylfan continue to ensure spare cards are available in the nursing office.		COMPLETE
The health board must ensure that all patient call bells can be reached by patients from their beds on Annwylfan.	Managing risk and promoting health and safety	Bed positioning in relation to bells to be reviewed in each bedroom.	Ward Manager/ Senior Nurse	December 2022
		Ward HEB walkarounds will include this standard as a regular check to monitor and improve compliance.		ONGOING
The Ty Cyfannol cleaning schedule should be kept up to date.	Infection prevention and control	Cleaning schedule is now being updated daily and the Clinical Band 6 Nurse is taking responsibility for compliance.	Band 6 Clinical Lead Nurse	COMPLETE
The health board needs to ensure that staff understand and are fully compliant with IPC training.	Infection prevention and control	Infection Prevention and Control training is mandatory for staff. Additionally, two staff members from Ty Cyfannol have completed additional IPC Training and are now IPC Champions on Ty Cyfannol.	Ward Manager	COMPLETE
The health board should introduce a more varied menu rotation for patients on Ty Cyfannol.	Nutrition and hydration	Facilities Division recently completed a Health Board-wide review of catering. This feedback has been escalated to facilities colleagues.	Head of Q&I	COMPLETE
The health board should ensure that the Malnutrition Universal Screening Tool is completed and	Nutrition and hydration	This is part of the admission pack and will be completed for each patient on admission.	Ward Manager	COMPLETE

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
regularly reviewed for all patients on Ty Cyfannol.		The Named Nurse will be responsible for reviewing and updating this as part of their checklist. If indicated, this will be included on the personalised person-centred information board to be installed by each patient bed.		
The health board must ensure that medication is always stored securely inside the clinic room and never left unattended on the wards.	Medicines management	Senior Nurse has reminded all registered nurses of their responsibilities with regard to medicines management.	Senior Nurse	COMPLETE
The health board ensure that controlled drugs are administered correctly on Ty Cyfannol, and that the frequency of stock checks is aligned with health board policy.	Medicines management	All staff have been reminded that the medication key and controlled drug keys must be held securely by 2 separate RMNs on shift.	Ward Manager and Band 6	COMPLETE
		The Controlled Drug Checks are being carried out weekly and have been added to a weekly check list.	Clinical Lead Nurse	COMPLETE
A copy of patient consent forms should be attached to MAR charts to assist in medication administration and ensure that medication is being legally prescribed.	Medicines management	The prescription charts are now kept in a different folder to ensure the 'consent to treat forms' are kept with the prescription charts.	Ward Manager	COMPLETE

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
Patients' legal status should be recorded in MAR charts on TY Cyfannol.	Medicines management	Medical colleagues have been reminded that patients' legal status must be recorded on MAR charts.	Clinical Director	COMPLETE
Patient consent should be recorded after a three-month period on Ty Cyfannol MAR charts.	Medicines management	Medical Colleagues have been reminded that consent to treatment forms should be reviewed after a 3 month period.	Clinical Director	COMPLETE
Patient photos should be attached to the MAR records to prevent medication errors on Annwylfan.	Medicines management	Photos now attached to MAR charts. This standard has been added to the ward weekly audit process.	Ward Manager	COMPLETE
The health board should ensure that staff fully understand the need for preventive measures before undertaking restrictive practices with patients.	Safe and clinically effective care	Understanding antecedents and de-escalation techniques is a significant part of PMVA training. PMVA compliance is now 100% for Ty Cyfannol and 94% for Annwylfan.	Ward Manager/ Training Department	COMPLETE
The health board should ensure that relevant policies are reviewed and kept up to date prior to their expiration date, including the Use of Restrictive Physical Intervention Policy which expired on 26 September 2019.	Safe and clinically effective care	This policy will be reviewed by the end of December 2022.	Head of Health & Safety	December 2022
		An interim guidance pertinent to Mental Health has been developed to be considered as an appendix for the Health Board's policy. To be considered at MH/LD Division's policy group of 17.11.2022 & QPSE meeting of 24.11.2022.	Head of Q&I	November 2022

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board must draft a structured policy regarding use of the ECA on both wards. We further recommend improvement in the documentation and daily records entries for patients who spend time in the ECAs so that a clear picture of their time spent on the ECA can be established.	Safe and clinically effective care	Seclusion & Segregation policy currently being drafted.	Head of Q&I	December 2022
		ECA guidelines to be included as appendices, to include required documentation to record ECA stays.	Directorate Clinical Teams	December 2022
We recommend that the health board ensure completion of the new nursing office on Ty Cyfannol.	Quality improvement, research and innovation	This is now open and being used as a nursing office.	Ward Manager	COMPLETE
The health board needs to improve the completion and filing of records on the wards, and ensure records are stored correctly during the transitional period to the new electronic file system.	Record keeping	All clinical records are now kept on WCCIS.	Ward Manager	COMPLETE
The health board should improve the structure of the Annwylfan ward round summary to ensure that details of every person present are captured for every ward round.	Record keeping	Summary sheet to be developed by newly formed Annwylfan ward Development Group.	Caerphilly Borough Older Adult Senior Management team	December 2022
Consent to treatment forms should be filed with the patient MAR charts on Ty Cyfannol.	Mental Health Act Monitoring	The prescription charts are now kept in a different folder to ensure the 'consent	Ward Manager and Band 6	COMPLETE

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
		to treat forms' are kept with the prescription charts. This will be monitored appropriately as part of the weekly checks by the Clinical Lead Band 6.	Clinical Lead Nurse	
The health board should ensure that Section 17 leave forms are signed by the patients and that patients are offered a copy.	Mental Health Act Monitoring	The ward will continue to ensure that patients are asked to sign the form and offered a copy via Ward Round. This will be noted in the Ward Round minutes.	Link Nurse and Responsible Clinician	COMPLETE
Photographs of detained patients undertaking Section 17 Leave should be kept on record.	Mental Health Act Monitoring	This is not currently Health Board policy. This will be discussed at the MH/LD Division's QPS meeting for decision.	Head of Q&I	November 2022
The health board should take steps to improve the completion of patient care notes on Ty Cyfannol.	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	WCCIS is now the primary care record for all patients.		COMPLETE
		Division to consider standards for clinical recording and training that might be required at Divisional QPS meeting.	Head of Q&I	November 2022
The Electronic Staff Record (ESR) system needs improvement so that an accurate staff training status can be obtained and reviewed, to ensure all staff are up to date with their training in order to provide safe care and treatment to the patient group. This was also a	Governance, Leadership and Accountability	This has been escalated to Workforce & Development within the HB for consideration at local and national level. In addition, training opportunities and compliance is monitored via the annual	Head of Workforce Information	COMPLETE

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
recommendation from our last inspection in 2017.		PADR process and in managerial 1:1 sessions		
The health board must ensure that bank and agency staff are compliant with mandatory training and that they can access the relevant information to perform their role on the wards.	Governance, Leadership and Accountability	A protocol has been developed by the WCCIS team to support bank/agency and other temporary staff can access the system.	WCCIS Implementation Team	COMPLETE
The health board should undertake robust measures to address the high level of agency staff use on Annwylfan.	Workforce	The Division has developed an action plan with the Older Adult Directorate team and HR Business Partner to address recruitment and retention on the ward. This is subject to monthly review with specific issues escalated when required.	Directorate Lead Nurse OAMH	COMPLETE

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Michelle Forkings**

Job role: **Divisional Nurse for Mental Health and Learning Disabilities**

Date: **15/11/2022**

Self-Assessment into Governance Arrangements at Her Majesty's Prison Usk and Prescoed following publication of HIW review of the Quality Governance Arrangements within Swansea Bay University Health Board

Summary

Health Inspectorate Wales (HIW) undertook a review of the Quality Governance Arrangements within Swansea Bay University Health Board, for the delivery of healthcare services to Her Majesty's Prison Swansea. HIW raised significant concerns relating to the Governance arrangements in place and as such issued a report containing 29 recommendations.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor: Jenny Winslade – Executive Director of Nursing	
Author(s): Primary Care & Community Divisional Senior Leadership Team Prison Partnership Board	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	
Date of the Report: 21 September 2022			
Supplementary Papers Attached: ABUHB Self-Assessment			

Situation

Following publication of the HIW report, Aneurin Bevan University Health Board undertook a self-assessment against these recommendations in relation to their own Governance arrangements within Her Majesty's Prison Usk and Prescoed.

The self-assessment provides assurance to the Health Board that appropriate current Governance arrangements are in place. It was identified that there were areas requiring strengthening which have been addressed within the action plan.

Background and Context

Health inspectorate Wales (HIW) undertook a Local Review of the Quality Governance Arrangements within Swansea Bay University Health Board, for the Delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea'. The report was published on Thursday 30 June 2022.

Previously, in 2017 and 2020, HIW accompanied Her Majesty's Inspectorate of Prisons on its inspections of HMP Swansea. Significant concerns were identified during both inspections. These were largely in relation to the overall governance arrangements that Swansea Bay University Health Board had in place for the provision and management of healthcare services at the prison, and gaps in the provision of some healthcare services and delays in accessing these services.

Consequently, as part of its 2021-2022 annual review, HIW decided to review the governance arrangements in place within the Health Board for the provision of healthcare services to HMP Swansea again. The purpose of the review was to assess the actions taken by the Health Board to address the issues highlighted by previous HMIP inspections.

Overall, HIW found that the quality governance arrangements in place at the health board did not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea. HIW identified a need to strengthen these arrangements and raise the profile of prison healthcare within the Health Board, to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively.

The report into the findings set out 29 recommendations for improvement. HIW's expectation is that each Health Board, that provides healthcare services to prison establishments in Wales, reviews the recommendations and provides assurance through local governance mechanisms.

Following receipt of the report, the Health Board has undertaken a self-assessment of the governance arrangements in place for Her Majesty's Prison Usk and Prescoed Prison Partnership Board. All 29 recommendations have been considered.

Assessment and Conclusion

An action plan has been developed for ABUHB (attached) and provides assurance that current processes are in place to meet the 29 recommendations. There are areas where action has been required to strengthen the Health Board compliance, namely:

1) Terms of Reference for Prison Partnership Board updated in July 2022.
2) Review of 'panic buttons' by the Health and Safety Team.
3) Public Health Wales to commence a Health and Social Care Needs Assessment in September 2022.
4) Mental Health Team to undertake a service needs analysis.

Recommendation

The Committee is asked to:

- Review and accept the action plan by way of assurance in regards current Governance arrangements for Her Majesty's Prison Usk and Prescoed.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of inspections, reviews and actions are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report is central to the safety and quality of care provided to patients and it provides a Six month update of HIW (Healthcare Inspectorate Wales) inspections, reports, and outstanding actions across the Health Board.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable to the purpose of this summary report.
Health and Care Standards	This report provides information around standard 2.1, 3.1, 3.2, 3.3, 3.5,4.2,5.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP. This report refers to the work of Healthcare Inspectorate Wales (HIW) in both their planned and unplanned work which is referenced in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation
	Integration – – The quality and patient safety improvements described work across directorates and divisions within the HB.
	Involvement – Many improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety described work across directorates and divisions within the HB.
	Prevention – Improving patient safety will prevent. Patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the Health Board.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Self-Assessment into Governance Arrangements at Her Majesty's Prison Usk and Prescoed following publication of HIW review of the Quality Governance Arrangements within Swansea Bay University Health Board

Recommendation 1

The health board and prison partnership board must consider how they gain assurance, that any reports or recommendations relating to prison healthcare published by both Welsh Government and Senedd committees, are identified, received, and disseminated to the appropriate individuals throughout the health board and prison. In addition, that action is taken to ensure appropriate membership and attendance of the Prison Health Oversight Group.

ABUHB Response	Action	Responsible Officer
As per the Prison Partnership Board Terms of Reference, any reports or recommendations relating to prison healthcare published by both Welsh Government and Senedd committees, are identified, received, and disseminated to the appropriate individuals throughout the health board and prison. Members of the Prison Health Oversight Group for Wales feedback to Prison Health Group who meet monthly and the Prison Health Improvement Network who meet quarterly.	Standard item on Prison Partnership Board agenda. Prison Partnership meet quarterly.	Prison Partnership Board Governor HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 2

The health board and prison partnership board must ensure that recommendations made in the report, Health and Social Care provision in the Adult Prison Estate in Wales, are reviewed and considered, and take action where necessary.

ABUHB Response	Action	Responsible Officer
The Prison Delivery Group meet quarterly, and membership includes Monmouthshire Integrated Services Social Care Lead. There is a Memorandum of Understanding between HMP Usk and Prescoed, Monmouthshire Social Care Services and Aneurin Bevan University Health Board (ABUHB), which states all agencies will cooperate and respond to relevant reports and recommendations.	Prison Delivery Group discuss and take the necessary action regarding the Health and Social Care Provision in the Adult Prison Estate in Wales Report. Any actions taken are fed back to the Prison Partnership Board.	Prison Delivery Group Prison Partnership Board Governor HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 3
The health board and PPB must ensure there are clear lines of reporting and escalation into the PPB terms of reference, to ensure robust governance arrangements are in place for the management of healthcare services at the prison.

ABUHB Response	Action	Responsible Officer
There are clear lines of reporting and escalation into the Prison Partnership Board terms of reference, to ensure robust governance arrangements are in place for the management of healthcare services at the prison.	Prison Partnership Board have clear lines of escalation routes available to them both via Her Majesty's Prison and Probation Service (HMPPS) and the Aneurin Bevan University Health Board Senior Leadership Team. The Prison Health and Social Care Oversight Group is an escalation route for any issues which cannot be resolved locally and is jointly chaired by Welsh Government and HMPPS in Wales.	ABUHB Prison Partnership Board Governor HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 4		
The health board and PPB must promptly address the outstanding recommendations made in the Tamlyn Cairns Partnership health needs assessment report and implement any actions and monitor as appropriate.		
ABUHB Response	**Action**	**Responsible Officer**
The health board and Prison Partnership Board promptly address recommendations made when the health needs assessment reports are published and implement any actions and monitor as appropriate.	Latest health needs assessment undertaken by Public Health Wales in 2018. The recommendations were logged, and an action plan commenced and reviewed until all actions completed.	ABUHB Prison Partnership Board Head of Healthcare HMP Usk and Prescoed

Report on an unannounced inspection of HMP Usk and HMP and YOI Precoed by HM Chief Inspector of Prisons 14-25 June 2021 (justiceinspectorates.gov.uk)

Recommendation 5		
The Health Board must ensure that it has a clear strategy and plan for the commissioning and delivery of healthcare services, and for the wellbeing and improvement of prisoner health.		
ABUHB Response	**Action**	**Responsible Officer**
The Health Board has a clear strategy and plan for the commissioning and delivery of healthcare services, and for the wellbeing and improvement of prisoner health.	GDS – Contract ends 30th April 2023. The Health Board will review the current service specification with a view to tender in Autumn 2022. The Health Board will also consider additionality due to the increase in prisoners scheduled for HMP Prescoed from April 2023. The Health Board continues to capture prisoner feedback on service delivery/accessibility via questionnaires. In addition, prisoners that access dental care services also have an ACORN (Assessment of clinical oral risk and needs) assessment carried out to determine the	General Medical Services Contracting Team Primary and Community Care

The following services are commissioned and accessible for HMP Usk and Prescoed prisoners: • General Dental Services (GDS) • General Medical Services (GMS) • General Optometric Services (GOS) Contract delivery is monitored monthly.	prisoner's oral health needs. This in turn informs the dentist of the treatment the prisoner requires and the frequency of their return. Prison wait times are also considered against primary care wait times. GMS and GOS contracts end on 31st March 2024. The Health Board will review the current service specifications in 2023/24 with a view to tender in Autumn 2023. However, prior to this tender, the Health Board will consider additionality due to the increase in prisoners scheduled for HMP Prescoed from April 2023. The Health Board continues to capture prisoner feedback on service delivery/accessibility via questionnaires. In addition, prison wait times are also considered against primary care wait times.	

Recommendation 6		
The Prison Partnership Agreement must be reviewed and updated promptly by the health board and HM Prison Service. This must reflect current arrangements for commissioning and accountability for the delivery of healthcare services at HMP Swansea.		
ABUHB Response	**Action**	**Responsible Officer**
The Prison Partnership Agreement reflects current arrangements for commissioning and accountability for the delivery of healthcare services at HMP Usk and Prescoed. There are also a number of sub documents related to accountability and commissioning in terms of Memorandums of Understanding and Service delivery agreements.	The Prison Partnership Agreement has been reviewed and updated by the health board and Her Majesty's Prison Service in July 2022.	ABUHB Prison Partnership Board Governor HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 7		
The health board must ensure quality and safety matters arising from HMP Swansea are defined, reported, and escalated appropriately through the governance framework. In doing so, it must: a) Ensure that the appropriate groups within the quality and safety governance framework scrutinise and monitor actions taken to address recommendations made in all external inspection reports. b) Ensure that all outstanding recommendations made within the HMIP Scrutiny Visit reports, CHC report, and DIC report recommendations, are considered robustly, and any actions taken should have regular review to ensure appropriate and timely actions are implemented.		
ABUHB Response	**Action**	**Responsible Officer**
The Primary Care and Community division has an established Divisional Quality and Patient Safety (QPS) group that provides the division-wide forum for monitoring, advising, benchmarking, and ensuring appropriate escalation regarding the division's quality and safety performance and its reporting mechanisms through to the ABUHB QPS Operational group meeting. Its main purpose is to provide an overarching clinical governance and decision-making body through representation of senior staff and corporate representation which define, develop, and standardise the frameworks, systems and processes required to ensure consistency and commonality across the division to ensure the delivery of the quality and patient safety agenda and effective communication throughout its key areas of responsibility. The group is responsible for the development and implementation for a shared evidence directory to support the annual self-assessment for Health and Care Standards for the division that in turn informs the corporate Health	The response to the recommendations outlined in this report will be on the agenda for discussion at the next divisional QPS and assurances sought from the Prison directorate team for appropriate and timely completion of actions outlined. The group will consider the outcomes of recommendations made within the HMIP Scrutiny Visit reports, Community Health Council reports, and Death In Custody report recommendations, determining their relevance to service provisions and ensure dissemination and raising awareness amongst teams and services. The group will consider if any of the risks identified within these reports	Prison Partnership Board Quality and Patient Safety Team ABUHB

and Care standards group and the Annual Quality statement. The group monitors and reviews the division-wide integrated risk register that incorporates both corporate and clinical risks identified within borough, service and directorate risk registers. The group coordinates the divisional representation which feeds into all ABUHB Quality and Patient safety forums to ensure that the ABUHB QPS agenda is recognised and implemented throughout the division.	need to be included on the Prison Directorate integrated risk register The group will address the key patient quality and safety components within these reports that are specifically relevant to primary care and community services for health provision within prisons.	

Recommendation 8		
The health board must ensure adequate arrangements to identify, escalate, record, manage, and mitigate risks in relation to healthcare services at HMP Swansea.		
ABUHB Response	**Action**	**Responsible Officer**
The health board has adequate arrangements to identify, escalate, record, manage, and mitigate risks in relation to healthcare services at HMP Usk and Prescoed.	Update relating to HMP Usk and Prescoed is fed back into ABUHB Divisional Sitrep 5 days a week Monday- Friday. Verbal Update provided twice weekly into Divisional Bronze Group. Risks fed into quarterly QPS and HMPPS risk register. HMP Usk and Prescoed Business Continuity Plan in place and reviewed annually.	Head of Healthcare HMP Usk and Prescoed

Recommendation 9		
The health board must improve visibility and oversight of clinical audit, and ensure this activity is reported to relevant governance groups for monitoring and scrutiny for prison healthcare services.		
ABUHB Response	**Action**	**Responsible Officer**
The health board has visibility and oversight of clinical audit, and ensures this activity is reported to relevant governance groups for monitoring and scrutiny for prison healthcare services.	All prisoners are in receipt of GMS healthcare provision funded by ABUHB. Prisoners have their healthcare needs manged as per Local and National standard practice e.g. National Institute of Clinical Excellence. GMS service work in close liaison with the prison healthcare team and undertake clinical audits of chronic disease management and medicines use.	Head of Healthcare HMP Usk and Prescoed

Recommendation 10		
The health board and prison must consider how it can address the issue identified around staff safety, and the availability of 'panic alarms' within the healthcare environments at the prison.		
ABUHB Response	**Action**	**Responsible Officer**
There are 'panic buttons' situated in each room at HMP Usk and Prescoed healthcare setting. Members of the healthcare team carry radios when on duty and follow the ABUHB Lone Worker Policy. Healthcare staff also have access to panic alert button on computer keyboards. All new staff are inducted on how to maintain personal safety.	Healthcare will request review of 'panic buttons' by Health and Safety team to ensure correctly placed.	Head of Healthcare HMP Usk and Prescoed

Recommendation 11		
The health board and prison must review and update the memorandum of understanding to ensure that there is clarity around responsibility and accountability for repair of premises and healthcare equipment.		
ABUHB Response	**Action**	**Responsible Officer**
There are currently defined expectations on the Governor of an establishment in relation to maintenance of the site. Responsibility for healthcare equipment is defined as the responsibility of ABUHB	Discussed at Prison Partnership Board and agreed that HMPPS have responsibility for the estate and personal and physical security measures and ABUHB are responsible for any healthcare equipment and joint decisions will be made as required on an individual basis.	Prison Partnership Board Governor HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 12		
The health board should review the clinical pathways used to deliver care to the prison population to ensure they are appropriate to the secure environment. Consideration should be given to the variety of patient needs, and to ensure appropriate and up to date guidance is available to both substantive and temporary healthcare staff.		
ABUHB Response	**Action**	**Responsible Officer**
Clinical pathways used to deliver care to the prison population are appropriate to the secure environment. Consideration has been given to the variety of patient needs and ensures appropriate and up to date guidance is available to both substantive and temporary healthcare staff.	Pathways are adapted to the prison environment e.g. Palliative Care Pathway has been developed involving multi-agencies and tailored to the category C and D prison estate. Healthcare staff follow Local and National clinical pathways for healthcare e.g. NICE. Local clinical pathways are available for all staff via the health board intranet.	Head of Healthcare HMP Usk and Prescoed

	Diabetic Nurse Specialists attends monthly to review prisoners with more complex need.	

Recommendation 13		
The health board and prison should consider commissioning a further health needs assessment to establish what clinical pathways should be in place at the prison.		
ABUHB Response	**Action**	**Responsible Officer**
Full Health and Social Care Needs Assessment undertaken in 2018 by Public Health Wales to determine if current needs for health and social care were being met. Action plan was implemented to reflect recommendations and actions completed. The inspection by Her Majesty's Inspection of Prisons (HMIP) in 2021 highlighted a Health and Social Care Needs Assessment should be undertaken every 3 years and may benefit focusing on specific areas rather than the whole prison.	Public Health Wales have agreed to commence a Health and Social Care Needs Assessment in September 2022 and focus on reviewing the needs of the older prisoner.	Head of Healthcare HMP Usk and Prescoed Public Health Consultant

Recommendation 14
The health board must explore how individual health records can be accessed by GPs working within the prison, to ensure timely and an up-to-date history of patients is available, and to also provide timely health care and prescribing for prison residents.

ABUHB Response	Action	Responsible Officer
The health board have arrangements for individual health records to be accessed by GPs working within the prison, to ensure timely and an up-to-date history of patients is available, and to also provide timely health care and prescribing for prison residents.	Note summaries are requested from own GP surgeries. Prison GP's have remote access when not on site and access to Welsh Clinical Portal. Information for those patients from out of area is requested for via healthcare administrator. Prisoner signs consent for copies of previous GP records to be obtained. Any information requested is recorded on electronic medical notes or scanned into records.	Head of Healthcare HMP Usk and Prescoed

Recommendation 15
The health board should take steps to consider and monitor the service provided by the dental provider 'Time for Teeth', to ensure its contractual obligations are meeting the needs of the prison residents.

ABUHB Response	Action	Responsible Officer
Prior to Covid 19 pandemic, the Health Board undertook face to face annual contract reviews with the provider. Since the start of the Covid 19 pandemic, the Health Board regularly engages with the provider on a virtual basis.	'Time for Teeth' report monthly to the Health Board; number of prisoners seen, wait times etc. The Health Board also monitor contract delivery via COMPASS/eDEN, the reporting tool used for all practices/providers delivering NHS dental services.	General Medical Services Contracting Team Primary and Community Care

Recommendation 16		
The health board must consider the impact on the prison population as a result of the prolonged period without access to eye care services, and how it can mitigate against the risk of this occurring in the future.		
ABUHB Response	**Action**	**Responsible Officer**
There has been little disruption to eye care services within ABUHB. All prisoners can access urgent eye care and where waiting times have slightly increased, additional clinics have been scheduled.	Where an urgent eye appointment is required and the prison provider is not on site, prisoners can access urgent eye care via local opticians. In addition, where a prisoner has been seen by the prison provider and new spectacles are required an online order can be requested.	General Medical Services Contracting Team Primary and Community Care

Recommendation 17		
The health board must take appropriate action to address any issues arising as part of the implementation of the new electronic pharmacy system, and to ensure all staff are adequately trained, and that appropriate support is always available to staff if required.		
ABUHB Response	**Action**	**Responsible Officer**
Not Applicable - HMP Usk and Prescoed healthcare do not have an electronic pharmacy system.	N/A	Senior Pharmacy Lead HMP Usk and Prescoed

Recommendation 18
The health board must ensure that the pharmacy team based at the prison are made aware of the latest HMIP report findings, and that any actions set by the health board as a result are shared with them to ensure improvement.

ABUHB Response	Action	Responsible Officer
The health board ensures that the pharmacy team based at the prison are made aware of any report findings, and any actions set by the health board as a result are shared with them to ensure improvement.	Pharmacy team briefings include discussions relating to the prison team. Any concerns are escalated to the Clinical Director of Pharmacy. External reports are included in the Prison Medicines Group agenda.	Senior Pharmacy Lead HMP Usk and Prescoed

Recommendation 19
The health board must undertake a prompt review of its governance arrangements to ensure it is compliant with all medication licensing requirements.

ABUHB Response	Action	Responsible Officer
The health board is compliant with all medication licensing requirements.	HMP Usk and Prescoed supply all prescription medicines via WP10 prescribing.	Senior Pharmacy Lead HMP Usk and Prescoed

Recommendation 20
The health board must provide HIW with an update regarding the progress of the CD license application, and when it has been granted.

ABUHB Response	Action	Responsible Officer
HMP Usk and HMP Prescoed do not stock Control Drugs.	All Control Drugs for patients following palliative pathway will be prescribed on a named patient basis via WP10s.	Senior Pharmacy Lead HMP Usk and Prescoed

Recommendation 21		
The health board must review the current staffing establishment of MHIRT to ensure the resources available meet the demand of mental health services, in both HMP Swansea and HMP Parc.		
ABUHB Response	**Action**	**Responsible Officer**
ABUHB forensic mental health provide an in-reach service to meet and review current service need within HMP Usk and Prescoed. Current establishment is 0.5 WTE x 2 (job share) Currently there is reduced staffing to 0.5 WTE and a short term plan has been put in place to ensure that there is minimal disruption to services and to target current waiting lists in the prisons whilst the vacancy is being advertised.	A meeting is being arranged to discuss the ongoing needs of residents and ensure that support/therapies reflect the long-term service need and identify ongoing staffing requirement within the prison. 0.5 WTE vacancy to be advertised and support provided by staff located within the Criminal Justice Service team.	Senior Nurse Prison Mental Health Services

Recommendation 22		
The health board must consider how the performance of its MHIRT service is monitored, to ensure it is meeting the needs of the HMP Swansea residents. In addition, it should consider how it can obtain regular patient feedback from the prison's residents in order to shape service provision.		
ABUHB Response	**Action**	**Responsible Officer**
Mental Health in Reach Team has considered how the performance of its service is monitored, to ensure it is meeting the needs of the	Complete waiting list scoping exercise to establish length of time between time of referral to time of assessment and time of assessment to time of treatment.	Senior Nurse Prison Mental Health Services

residents in HMP Usk and Prescoed.	To commence completion of feedback forms in relation to service needs when completing initial assessments. Complete a service needs analysis regarding service outcomes and evaluate to ensure that needs are met. Escalate any deficits within the analysis. Identify any training needs for staff.	

Recommendation 23		
The health board must consider how a strengthened approach can be implemented for health promotion within the prison, with a view to promoting the health of prisoners and addressing health inequalities.		
ABUHB Response	**Action**	**Responsible Officer**
The health board has a strong approach to health promotion within the prison, with a view to promoting the health of prisoners and addressing health inequalities	Health promotion boards are displayed in the reception areas of the Healthcare department. Staff make use of any interaction to empower the prisoners and follow 'Making every contact count' principle and 5 ways to wellbeing. Joint Health promotion days are held with HMPPS. Nursing students are encouraged to undertake a display focusing on seasonal health promotion topics e.g., Movember, Sun awareness, Influenza. Healthcare team have a Health Care Support Worker who is a trained Wellbeing advisor.	Head of Healthcare HMP Usk and Prescoed

Recommendation 24		
The health board PPB must consider: a) The disparities between staff groups and prisoner perceptions of prison healthcare services and consider whether key information is appropriately transported through its quality framework. b) How it can obtain and learn from regular prison staff (non-healthcare) and prisoner (patient) feedback, in relation to services available and that provided to HMP Swansea, and act accordingly on the feedback.		
ABUHB Response	**Action**	**Responsible Officer**
There are no known disparities between staff groups and prisoner perceptions of prison healthcare services at HMP Usk and Prescoed. It has not been noted in any previous inspection or report at the establishments.	HMPPS carries out quarterly assurance processes which focus on the HMIP Expectations. Governor of HMP Usk and Prescoed will ensure the assurance team consider this as part of their assurance work and feedback to the Prison Partnership Board.	Head of Healthcare HMP Usk and Prescoed Governor HMP Usk and Prescoed

Recommendation 25		
The health board must review the adequacy of the prison healthcare nursing establishment, to ensure it is sufficient to meet the current level of demand for health care services in HMP Swansea.		
ABUHB Response	**Action**	**Responsible Officer**
Healthcare is open 8-16.30 Monday-Friday and is managed by a senior nurse who is responsible for 9.8 WTE staff who rotate between the two sites HMP Usk and Prescoed.	Staff recruitment and retention is very good with most staff employed in the department for 6 years or longer. Healthcare are currently scoping nursing staffing as there will be an increased operational capacity of 80 men at HMP Prescoed from April 2023.	Head of Healthcare HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 26		
The health board must consider how it can obtain regular patient experience feedback from the prison residents at HMP Swansea, and to consider these findings in line with how this is considered regarding people within the health board's other communities.		
ABUHB Response	**Action**	**Responsible Officer**
General healthcare satisfaction survey last undertaken 2021. HMIP survey recorded 95% prisoner satisfaction during inspection in 2021. Dental and optometry patient experience feedback currently in progress. Following nominations from the residents at HMP Usk and Prescoed the healthcare team were given the ABUHB 'Patient's Choice' recognition award.	Feedback on patient experience is fed into Prison Partnership Board, Quality and Patient Safety group and Senior Leadership Team. Recommendations for improvement discussed and actioned as appropriate.	Head of Healthcare HMP Usk and Prescoed Head of Nursing Primary Care

Recommendation 27
The health board must ensure that its prison healthcare staff are recording prisoner concerns as highlighted within the HMP Swansea Healthcare Complaints Pathway. In addition, that these are accurately reported to the PPB for monitoring and action planning as appropriate.

ABUHB Response	Action	Responsible Officer
Prisoners can raise concerns/ complaints using the HMPPS Comp 1 form – prisoner formal complaint	Comp 1 healthcare concerns/complaints are formally logged with HMPPS/Healthcare and require a response within 7 days. All concerns/complaints are logged, responses scanned to patient records and reported into Prison Delivery Group meetings for any required actioning.	Head of Healthcare HMP Usk and Prescoed Governor HMP Usk and Prescoed

Recommendation 28		
The health board must ensure the prison residents have access to information relating to NHS Wales Putting Things Right process and are provided with information on how to raise a concern regarding healthcare.		
ABUHB Response	**Action**	**Responsible Officer**
A tailored version of the health board's Putting Things Right documentation has been implemented.	Putting Things Right documentation and leaflets are on display in the reception area of healthcare and have confidential envelopes attached.	Head of Healthcare HMP Usk and Prescoed

Recommendation 29		
The health board must inform HIW how it will work with the Prison Governor to share the findings of our review with the prison residents. This must also consider how the report's recommendations will be responded to.		
ABUHB Response	**Action**	**Responsible Officer**
Not applicable to HMP Usk and Prescoed.	However, should any information require sharing to prisoners then it would be displayed as a Notice to Prisoners (NTP) across both sites.	Head of Healthcare HMP Usk and Prescoed

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality Safety and Outcomes Committee Tuesday 18th October 2022 Agenda Item:4.6.5

HEALTH INSPECTORATE WALES' REVIEWS: AN UPDATE ON CURRENT POSITION

Executive Summary

This report is to update the Patient Quality, Safety & Outcomes Committee (PQSOC) of the progress with the delivery of recommendations and outstanding actions from HIW inspections conducted across Aneurin Bevan University Health Board.

Purpose: **Patient Quality, Safety and Outcomes Committee is asked to:**	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information and Discuss	✓
Executive Sponsor: Jennifer Winslade – Executive Director of Nursing	
Author: Tracey Partridge-Wilson – Assistant Director of Nursing	
Report Received consideration and supported by:	

Executive Team		**Sub-Committee**	
Date of the Report: 18 October 2022			

Supplementary Papers Attached:

- Health Inspectorate Wales Review: Update on outstanding actions

Situation

The PQSOC will be aware that there has been substantial focus on the effective internal management of HIW reviews and self-assessments, as well as an increase in oversight and control. Throughout this period, attention and concentration has been consistent, indicating a positive position in terms of the completion of recommendations and actions completed.

Background and Context

The Executive Director of Nursing (EDON) has delegated lead responsibility for HIW relationships, co-ordinating inspections, maintaining a corporate tracker, monitoring compliance with improvement plans, and managing constraints.

A robust organisational process is in place to ensure coordinated support during a HIW inspection. A database is maintained, which includes all HIW correspondence, dates for submission of evidence, action plans and evaluation dates. The corporate nursing team review every draft report prior to submission to HIW, through the objective portal.

When correspondence is received from HIW it is managed as per the below:

- As soon as correspondence comes into the CEO office from HIW it is immediately sent to the Assistant Director of Nursing, Quality and Safety and the Corporate Nursing Assistant, copied into the EDON.
- Through Corporate Nursing, the correspondence is reviewed and directed appropriately, providing the receiving teams with clear instructions as to the expectations and deadlines.

All correspondence is entered on the HIW database, with a flagging mechanism to ensure deadlines are achieved.

Assessment and Conclusion

Current Position within ABUHB

ABUHB have been compliant with all deadlines set by HIW, with timely submission of information, despite often challenging timescales.

The Assistant Director of Nursing (ADoN) meets regularly with key stakeholders in the Divisions to review all HIW inspections and progress. The ADoN is also working with Divisions to ensure their responses to HIW are succinct, addressing the recommendations made, as well as encouraging a robust approach to evidence collation and recording.

The current position with inspections and recommendations can be seen in the below table, extracted from the Tracker. There are 3 immediate improvement actions outstanding and a total of 27 actions outstanding following the recommendations from the inspection reports.

Hospital/Ward/Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	Number of Immediate Improvements actions identified by ABUHB	Number of immediate improvement actions outstanding	No. of Recommendations identified by HIW	Total No. of ABUHB Actions Identified	Total No. of Actions Outstanding
Maindiff Court CMHT	Scheduled 15-16 /11/22	**Self-assessment to be submitted by 17/10/22**						
Ty Cyfannol & Annwylfan Wards	5-7/09/22	Yes	3	7	**3**	Overall report and action plan awaited		
Twyn Glas, Caerphilly	20/04/2021					2	2	**1**
National Review of Mental Health Crisis Prevention in the Community	2020					19	26	**6**
ED, Grange University Hospital (unannounced)	1-3/11/21	Yes	12	23	**0**	58	87	**5**
ED, Grange University Hospital (unannounced)	1-3/08/22	Yes	3	26	**0**	20	75	**12**
HIW local review for the Delivery of Healthcare Services to HMP Swansea	Report issued 29/06/22					29	Primary Care & Community Divison completed a self-assesment & provided assurance to the Health Board	
Review of Healthcare Services for Young People	Report issued 11/09/20					37	69	**1**
Patient Discharge from Hospital to General Practice	2018					12	24	**2**
National Review - Patient Flow (Stroke) Pathway	Review between Feb-June 2022					Report and action plan awaited		
				TOTAL OUTSTANDING	**3**		**TOTAL OUTSTANDING**	**27**

The following information describes what reviews have happened and what inspections are scheduled. It also refers to improvement actions completed since the previous PQSOC report in March 2022.

Inspections undertaken since March 2022:

1. Ty Cyfannol and Annwylfan Wards - 5th–7th September 2022
2. Emergency Department, GUH – 1st–3rd August 2022
3. ABUHB self-assessment against Local Review for the Delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea – report received 29/06/22

Inspections scheduled:

1. CMHT, Maindiff Court Hospital – 15th–16th November 2022

Improvements plans – actions complete:

1. Diagnostic Imaging Department, GUH – 16th–17th November 2021 (23 actions previously outstanding)
2. Nuclear Medicine, RGH – 2nd–3rd February 2021 (11 actions previously outstanding)
3. Adferiad Ward, SCH – 13th–14th September 2021 (8 actions previously outstanding)

Actions outstanding (in date):

Immediate assurances = 3
Improvement plan = 27

Actions due in September 2022:

Immediate assurances = 0
Improvement plan = 3

Recommendations
The PQSOC are asked to: • **Note:** the progress and position with implementation against all recommendations and actions; • **Note:** The ongoing strategy for managing HIW correspondence and ensuring adherence to deadlines.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of inspections, reviews and actions are a key element of the Health Boards assurance framework.

Financial Assessment, including Value for Money	Direct or indirect impact on finance.
Quality, Safety and Patient Experience Assessment	This report is central to the safety and quality of care provided to patients and it provides a Six month update of HIW (Healthcare Inspectorate Wales) inspections, reports, and outstanding actions across the Health Board.
Equality and Diversity Impact Assessment (including child impact assessment)	Not applicable to the purpose of this summary report.
Health and Care Standards	This report provides information around standard 2.1, 3.1, 3.2, 3.3, 3.5,4.2,5.1, 6.3 and 7.1
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP. This report refers to the work of Healthcare Inspectorate Wales (HIW) in both their planned and unplanned work which is referenced in the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation
	Integration – – The quality and patient safety improvements described work across directorates and divisions within the HB.
	Involvement – Many improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The quality and patient safety described work across directorates and divisions within the HB.
	Prevention – Improving patient safety will prevent. Patient harm within our services.
Glossary of New Terms	Included in the report
Public Interest	Report has been written for the Health Board.

Health Inspectorate Wales' Reviews: An update on current position – September 2022

Mental Health & LD Division								
Hospital/ Ward/Area	**Date of Inspection**	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Maindiff Court CMHT	15-16/11/22	Self-assessment to be submitted to HIW by 17/10/22						
Ty Cyfannol & Annwylfan Wards	5-7/09/22	✓	3	7	**3**	Overall report and action plan awaited		

Outstanding Actions		
Ensure that all staff on Ty Cyfannol and Annwylfan are compliant with PMVA training	Training for staff on both wards has been expedited to ensure that staff will have completed a foundation or refresher course (according to their need) by the end of October 2022 (this excludes staff who are medically exempt/pregnant, or absent for a long/indefinite period e.g., long term sickness/maternity leave).	End of October 2022
Ensure the 'Use of Restrictive Physical Intervention' policy is reviewed to provide clear guidance to staff.	A draft of the updated Health Board policy will be completed by end of December 2022.	End of December 2022
	In the interim, guidance for the Division of MH & LD will be drafted and circulated.	End October 2022

Twyn Glas	**20/04/21**	N/A	2	2	**1**

Outstanding Actions			
The health board should ensure all items on the environmental audit are given suitable timescales and actioned appropriately.	The LD Directorate will review the environmental audit and ensure that all items on the audit are given suitable timescales and actioned appropriately.	End June 2021	**<u>Update September 2022</u>** Arjo confirmed baths will be delivered and installed February 2023.

National Review of Mental Health Crisis Prevention in the Community	**Report received 09/03/22**	/A	19	26	**6**

Outstanding Actions			
Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.	Mental Health & Learning Disability (MH & LD) Division will ensure that anyone who has been assessed by or is open to the in-patient unit, Community Mental Health Team (CMHT), Crisis Resolution Home Treatment Team (CRHTT) or Crisis Liaison Team (CLT) will be given deterioration advice and have a crisis plan. This may be part of a Community Treatment Plan or a 'crisis card' or similar if not open to services.	October 2022	In development.

Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.	MH & LD Division will work with Primary Care & Community (PC&C) Division to develop a process to ensure that people access assessment and monitoring pertinent to their needs. Inpatient wards will also review audit findings of physical health screenings upon admission.	September 2022	Ongoing Exploring with Executive Director of PC&MH the right forum to discuss & monitor these actions. Structures now developed to support physical health audit.
Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.	People who access the MH service in crisis will be clear about what follow up is planned for them (if any) by whom, and how to seek further support if required. The Gwent Mental Health Delivery Group meeting will progress this agenda.	September 2022	Yet to be actioned as Delivery Group has been restructured. To be shared at next meeting in November 2022.
To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.	The MH & LD Division is committed to the development of a single Point of Contact (POC) as part of its 'Whole Person, Whole System' crisis development. A test of change has been designed which will be tested from Autumn 2022. When the Primary Care Mental Health Specialist Services (PCMHSS) or CLT / CRHTTT deems a referral to CMHT is necessary (or vice versa) this should be made directly to the appropriate team, with GP notified (as opposed to GPs being required to make the referral).	November 2022	Ongoing - on track for completion in November.
Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.	The Health Board's 'Whole Person, Whole System' steering group will consider existing referral pathways and identify where these might require strengthening.	September 2022	Ongoing - considered as part of new 111 service. Test of change on track for November 2022.

Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.	The MH & LD Division is committed to the development of a single POC as part of its 'Whole Person, Whole System' crisis development. A test of change has been designed which will be tested from Autumn 2022.	November 2022	Ongoing - on track to launch test of change in November 2022.

Unscheduled Care								
Hospital/Ward/Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Emergency Department, GUH	1-3/11/21	✓	12	23	0	58	87	**5**

Outstanding Actions		
Introduce an electronic waiting time board	1. The ED is working towards an automated display of live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	November 2022
Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms.	2. There is continued work across the Health Board to improve the flow of patients through the ED and assessment units, via the Urgent Care Transformation Programme.	October 2022
Further arrangements are put in place to ensure that all patients are made to feel that they can access the right healthcare at the right time.	3. Right Place Right Time is part of the ongoing transformation work led by Director of Operations and Director of Primary Care & Community, through 6 Goals workstream.	October 2022

The Health Board is to inform HIW of the actions it has taken to address the recommendation made in the HIW Review relating to improving patient flow.	4. The Health Board will provide HIW with an update on flow improvements.	November 2022
Clinical supervision is completed annually.	5. The Health Board is currently reviewing a new model for Clinical Supervision.	October 2022

Hospital/Ward/Area	Date of Inspection	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Emergency Department, GUH	1-3/08/22	✓	3	26	0	20	75	**12**

Outstanding Actions		
The health board must ensure that the 'No Smoking' legislation is enforced.	1. x2 WTE Smoking Officers employed and currently undertaking their training. 2. All staff are encouraged to advise patients and relatives regarding No Smoking Policy on site. 3. As appropriate all patients admitted are offered Nicotine replacement and provided with the relevant Health Promotion advice.	October 2022
The health board must ensure that waiting times are displayed in a prominent position within the waiting area.	4. The ED is working towards a safe system to provide live waiting times for triage and wait to be seen by a clinician in keeping with accepted good practice as recommended by the Royal College of Emergency Medicine.	November 2022
The health board must ensure that the microphone in the reception desk is working correctly at all times.	5. The department is currently scoping alternative solutions to the current microphone system to improve communication between patients and staff.	December 2022

The health board is to provide details to HIW with the continuing actions taking place to manage the overcrowding in the waiting room and the RAU that are not conducive to providing safe and dignified care.	6. 3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.	December 2022
	7. If the above plans do not materialise the ED NIC will advise the Clinical Site Manager so that a revised plan can be established and implemented.	December 2022
The health board must ensure that there is an area available to facilitate red release calls at all times.	8. 3 to 5 moves per hour will be provided by the Operations Team to both ED and the Assessment Units (AMU and SAU). These decisions will be monitored and recorded at every site meeting.	November 2022
	9. Patients who have been identified for discharge will not be held on ambulances for tests / investigations. Patients will be brought into the hospital to undergo their tests and then moved to the Transfer Lounge whilst they await their results and transport home.	December 2022
	10. The Health Board will use the WAST Launchpad demand data at every cross-site meeting to identify what is on the WAST Stack (WAST Community Demand and Acuity) to plan ahead, potentially pre-empting moves to make capacity for the demand expected. The aim is to clear 6 trolley spaces by 16:00hrs every day to support the late afternoon surge profile.	
The health board must ensure that the information on how they have learned and improved on feedback received is prominently displayed within the department on a 'You said, We did' board or similar.	11. You said, we did system to be introduced wider across the ED.	December 2022
The health board must ensure that action is taken to improve compliance with staff appraisals.	12. Improvement plan in place for annual appraisals.	December 2022

Primary Care & Community Division								
Hospital/Ward/ Area	**Date of Inspection**	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
HIW Local Review for the Delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea	Report issued 29/06/22	N/A				29	Primary Care & Community Division completed a self-assessment & provided assurance to the Health Board	

Family & Therapies Division								
Hospital/Ward/ Area	**Date of Inspection**	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Review of Healthcare Services for Young People	Report issued 11/09/20					37	69	**1**

Outstanding Actions			
Health boards and service providers must ensure environments protect the safety and wellbeing of young people. There must be robust systems in place to monitor risks within the environment and ensure maintenance work is conducted in a timely way.	A quiet/breakout room for young people to be furnished with input from younger people.	June 2022	**Update September 2022** Unit was used for another function during Covid-19; however funding has been secured and approved. Plans extended to December 2022.

Corporate Services								
Hospital/Ward/ Area	**Date of Inspection**	Immediate Improvement Notice Received	Number of Immediate Improvements Identified	No. of immediate actions identified by ABUHB	No. of actions outstanding	No of recommendations identified in Improvement Plan	No. of actions identified by ABUHB	Total No. of actions outstanding
Diagnostic Imaging Department	16-17/11/21	N/A				26	30	0 (23 reported in March '22)
Nuclear Medicine	2-3/02/21	N/A				27	27	0 (11 reported in March '22)
Stroke	Feb-June 2022	N/A				Nothing received to date		
Patient Discharge from Hospital to General Practice	2018	N/A				12	24	**2**

Outstanding Actions			
NHS Wales healthcare organisations need to audit and monitor compliance with their own policy timeframes and Health and Care Standard 2.6 regarding the provision of to take out (TTO) medication.	• % of TTOs prescribed and available for pharmacy to dispense within 24 hours of the discharge date. • % of TTOs dispensed within one hour of the estimated discharge time. • A 'live' TTO stream to be developed to alert pharmacy that a prescription has been written and is available for dispensing.	Pharmacy Manager Head of Transformation	**<u>Update September 2022</u>** Pharmacy have worked with informatics to pull a live data stream from the ABUHB Clinical workstation. This relies on a member of the team pulling the data to update the live stream. This has not improved the waiting time for discharges. Therefore, the process now ensures clear communication between flow coordinators, nurses and pharmacy to improve discharge waiting times. The following measures can be pulled manually by pharmacy and working with informatics to review the reporting: • % of TTOs prescribed and available for pharmacy to dispense within 24 hours of the discharge date. • % of TTOs dispensed within one hour of the estimated discharge time.

• NHS Wales should specify a target date by which discharge summaries and clinical letters issued to general practices are issued via direct electronic transmission. • Timeframes and next steps regarding the rollout and implementation of e-discharge across all NHS Wales healthcare organisations. • NHS Wales healthcare organisations should actively pursue the implementation of e-discharge information. Any new e-discharge system needs to be monitored continually to measure its effectiveness.	All other WCCIS community and therapy services will be live by 2021.	Assistant Director of Digital Programmes	**<u>Update September 2022</u>** 'Go live' in ABUHB for Community and Therapy Services continues to be delayed and implementation dates have been realigned to the adjusted National Programme Plan.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Healthcare Inspectorate Wales
Annual Report 2021-2022

Healthcare Inspectorate Wales (HIW) is the independent inspectorate of the NHS and regulator of independent healthcare in Wales.

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Goal

To encourage improvement in healthcare by doing the right work at the right time in the right place; ensuring what we do is communicated well and makes a difference.

Through our work we aim to:

Provide assurance

Provide an independent view on the quality of care.

Promote improvement

Encourage improvement through reporting and sharing of good practice.

Influence policy and standards

Use what we find to influence policy, standards and practice.

Page 4

Foreword

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life

Page 7-12

Priority 1

To maximise the impact of our work to support improvement in healthcare

Page 15-62

Priority 2

To take action when standards are not met

NHS Health Boards and NHS Trusts

Page 64-65

Priority 3

To be more visible

Collaboration and joint working with other organisations is an integral part of the way in which we work

Page 66

Priority 4

To develop our people and our organisation to do the best job possible

Although the last year has been one of significant change, we have continued to invest in the development HIW

Foreword

Alun Jones
Chief Executive

“I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.”

Welcome to our Annual Report for 2021-2022, a year which continued to be unpredictable and with significant ongoing challenges in both healthcare, and daily life.

Healthcare services continued to be under intense pressure from the impact of the COVID-19 pandemic and our role has been crucial in supporting the delivery of safe healthcare for the people of Wales. Our core purpose of checking the quality and safety of healthcare services did not change, and we continued to adapt our processes and approach to work in response to the ongoing unprecedented situation.

The report sets out our key findings from the regulation, inspection and review of healthcare services in Wales. It outlines how we carried out our functions and the number of inspections and quality checks we undertook across Wales.

Change and flexibility have been key features of life since March 2020 and as an organisation we have learned much about how and where our work can add value to the healthcare improvement agenda. Through this report we will offer an insight into our work over the 12-month period, outlining how we adapted and used our resources most effectively to deliver our work and support improvement. This involved continuing with quality checks which we introduced earlier in the pandemic and enabled us to gain assurance remotely. We worked collaboratively with others to harness insight and understanding, building on lessons learnt. We also used new styles of reporting which enabled us to share our findings quickly to enable healthcare services to take improvement action more quickly.

In a year which has seen healthcare services work hard on recovery from the early days of the pandemic, to restore services which had been paused, whilst continuing to deal with emerging variants, outbreaks and further peaks of COVID-19, we have seen significant turbulence. I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.

Senior managers leading services have demonstrated tenacity and ability to continue innovating and supporting their organisations. Staff working on the front line have continued to demonstrate their compassion and resilience, as once again, patients have told us of their positive experiences of staff despite highly challenging circumstances.

It is clear that there remain many challenges ahead, for services, for the staff who work within them and for the people of Wales whilst the gargantuan task of service recovery continues. For healthcare organisations, it will be staff who will be the key to the success of this recovery. Supporting staff wellbeing, continuing to invest in training and support services for them and continuing to innovate within existing service delivery will be key to the effective recovery of staff and services from the fatigue brought on by the pandemic.

The year in question reflects a time when we worked on the commitments we made in our one year Strategy and Operational plan. We made good progress in meeting the achievements we set out to deliver. I am proud to have continued leading the organisation through this time, working daily alongside a team of professional and committed staff who work hard to support the organisation as we deliver our vision of improving healthcare for the people of Wales.

In March 2022, we published our new and ambitious strategy, and we are fully committed over the next three years, to implementing and delivering our new priorities which further our aim to drive improvement in healthcare.
We will continue to use our role to encourage improvement in healthcare, building on the best of what we have done to date to deliver the greatest impact.

If you have any questions, comments, ideas or feedback on our work, please do get in touch with us – we would love to hear from you.

Alun Jones
Chief Executive, Healthcare Inspectorate Wales

Overview

Our 2021-2022 Strategic Priorities:

1. To maximise the impact of our work to support improvement in healthcare
2. To take action when standards are not met
3. To be more visible
4. To develop our people and our organisation to do the best job possible

For HIW, as for many healthcare services and organisations, it was a year of continued and significant change, where we had to adapt to ensure that we continued to check that people in Wales were receiving good quality healthcare. We introduced new ways of working to ensure we discharged our statutory functions, whilst being as flexible and adaptable as possible to ensure we did not add undue burden to a system already under significant pressure following the COVID-19 pandemic.

We continued with a full range of assurance and inspection activities, building on our enhanced ways of working, allowing us take action where standards were not met but to also support a broader recovery of healthcare services. During the year, we kept our activity under regular review to ensure that we targeted our resources most effectively. We operated responsively, with our work underpinned by our strategic priorities. This report describes our progress against these priorities as we aim to drive improvement and promote quality in healthcare services across Wales.

To maximise the impact of our work to support improvement in healthcare

HIW has an ongoing programme of national and local reviews which helps us to evaluate how healthcare services in Wales are delivered.

Local reviews are pieces of work which explore an aspect of one organisation or region, whilst **national reviews** explore healthcare services across Wales.

National and Local Reviews

COVID-19 National Review - How healthcare services across Wales met the needs of people and maintained their safety during the pandemic

The purpose of our COVID-19 review was to understand how healthcare services across Wales met the needs of people and maintained their safety during the pandemic. We also considered how services managed their environments of care, infection prevention and control measures, and how the physical and mental well-being of staff was supported.

A key theme to have emerged from our review was the need for healthcare services to further strengthen their infection prevention and control arrangements to mitigate the risk of cross infection or further outbreaks of COVID-19. In addition, the arrangements for supporting and maintaining the physical and mental well-being of staff required attention and focus as healthcare services continued through the recovery phase of the pandemic. However, in general, our review found the quality of care being provided across Wales was good and was delivered by hugely committed and dedicated groups of staff.

National Review of Mental Health Crisis Prevention in the Community

The focus of our review was to understand the adequacy of the measures in place across Wales, to help mental health crisis being prevented in the community, through timely and appropriate care. We considered the experiences of people who accessed care and treatment to support their mental health and prevent crisis. In addition, whether the services provided were safe and effective, and how healthcare teams worked collaboratively throughout the community to help prevent mental health crisis. Furthermore, we explored how third sector organisations support this.

Our review found challenges across Wales inhibiting the ability of people to access timely support for their mental health, which could increase the risk to their safety (or to others) and may result in hospital admission.

Key findings included inefficiencies in process, particularly for direct referrals where patients were caught in a cycle of continually accessing GP services to re-commence the referral process. This resulted in individuals experiencing lengthy waiting times and a lack of support for their mental health. HIW's review urged health boards to consider how they can address this gap in provision, strengthening the engagement between GPs and other primary and community care services and secondary mental health services. The review did find healthcare staff were committed and dedicated to providing support and care to people with mental health needs.

HIW noted several positive initiatives across Wales, including the implementation of a single point of access. Where this was in place, it ensured that specialist mental health professionals were available to provide clinical triage, onward referral, and effective signposting to individuals in crisis. HIW made a recommendation that health boards must ensure that single point of access services are implemented across Wales and are accessible to all those experiencing mental health crisis.

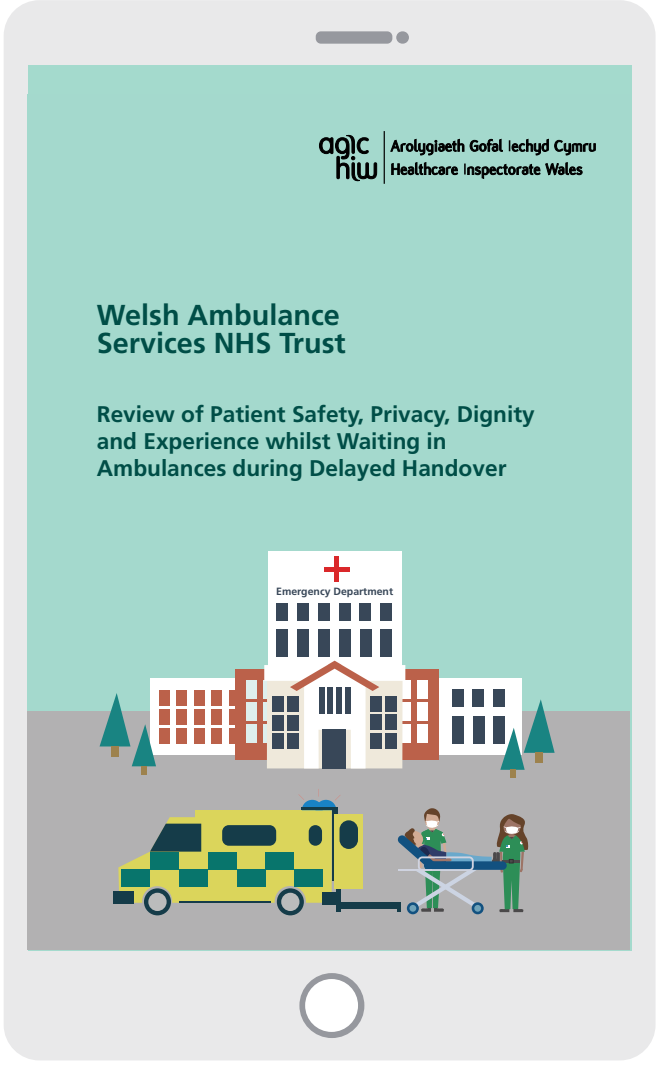
Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances During Delayed Handover

Our review found that the issue of prolonged handover delays is a regular occurrence with ambulance wait times outside Emergency Departments (EDs) across Wales. The delays and variations in process between and within health boards was having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, and dignified care to patients.

Whilst there are expectations and guidance for NHS Wales to follow, and a clear will to meet these guidelines, there are substantial challenges to achieve timely patient handover across Wales which inhibit efforts to consistently achieve these. The challenges are indicative of the wider patient flow issues across all hospitals. Our review team found some inconsistencies and a lack of clarity between the Welsh Ambulance Services NHS Trust (WAST) and ED staff about responsibility for patient care, until transfer of care to health board teams. These types of inconsistencies were increasing risk and having a detrimental impact on patient care and safety.

Patients were generally positive about their experiences and provided good feedback about ambulance crews and ED staff, however, this should not detract from the issues associated with delayed handover.

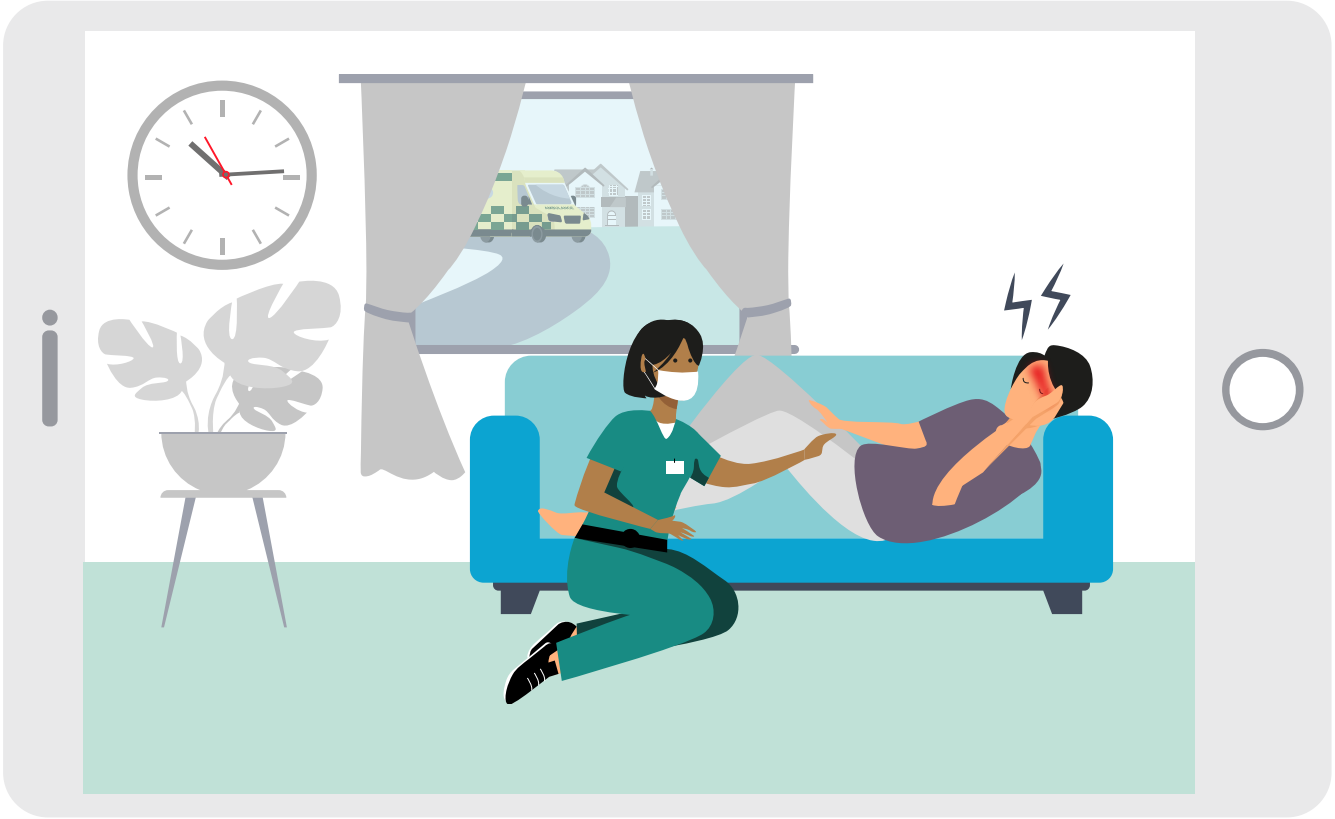
A significant amount of work is already underway across NHS Wales to tackle these issues. Progress has been made in some areas, and improvement work is ongoing between WAST, health boards and Welsh Government to meet these challenges.



Current Ongoing Reviews

National Review of Patient Flow (Stroke Pathway)

Ineffective and inefficient patient flow can have a significant impact on the quality and safety of patient care. As a result, we decided to undertake a national review of Patient Flow. In order to assess the impact of patient flow challenges on the quality and safety of patients awaiting assessment and treatment, we elected to focus our review on the stroke pathway. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.



The planning of the review commenced in autumn 2021, and the field work began in March 2022. Throughout our review we will consider how NHS Wales addresses peoples' access to acute care at the right time and if care is received in the right place, by people with the right skills, through to timely discharge from hospital services. We want to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway. We aim to publish the review report during winter 2022-2023.

Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board

We made the decision to undertake this review following our assessment of a range of information sources which indicated significant concerns around mental health services within Cwm Taf Morgannwg University Health Board (CTMUHB). We commenced the review in January 2022 which will progress into late summer and the report will be published later in 2022. The focus of the review is to explore the quality and safety of discharge arrangements of adult patients from inpatient mental health units, back into the community.

Local Review of the Quality Governance Arrangements in Place within Swansea Bay University Health Board (SBUHB) for the delivery of Healthcare Services to Her Majesty's Prison (HMP) Swansea

We decided to undertake a review of the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea.

The review assessed the actions taken by the health board to address the issues highlighted following previous inspections by Her Majesty's Inspectorate of Prisons, which we contributed to, and how effective the health board's quality governance arrangements are regarding prison healthcare. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the population of HMP Swansea.

We identified a need to strengthen these arrangements and raise the profile of prison healthcare within the health board to ensure that the quality of prison healthcare is designed, delivered, and monitored effectively. The review report details our findings and recommendations for improvement within several areas of the health board and Prison Partnership Board.

HIW recommended that prison healthcare, including the quality of the service, needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.
HIW asked the health board and Prison Partnership Board to carefully consider the findings from this review and act upon the recommendations set out within the report.

HIW continue to work with the health board to ensure improvements are made in a timely manner and will monitor the progress made. The report was circulated to other health boards to share lessons learnt, and to consider the findings against their own quality governance arrangements.

Joint Inspection of Child Protection Arrangements (JICPA)

During 2021, we worked jointly with four other inspectorates on a second pilot review of child protection arrangements. The review was undertaken in the Neath Port Talbot local authority which is situated within Swansea Bay University Health Board. It was led by Care Inspectorate Wales (CIW), and included HIW, Estyn, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Service and Her Majesty's Inspectorate of Probation.

The focus of the review was to explore the arrangements in place for the multi-agency response to children at risk of criminal and sexual exploitation. On completion of the review, we identified several key strengths across the multi-agency partnership in relation to processes, structures and relationships which helped to facilitate effective partnership working where a child was at risk of exploitation. We also identified areas for improvement throughout the review, which included the need to strengthen contextual safeguarding, and the need to reduce the waiting times for Children and Adolescent Mental Health Services (CAMHS) assessment following referral.

In the last quarter of 2021-2022, HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue the JICPA work, to enable us to review processes within a further four local authorities across Wales. As part of the plan, we would complete work in six further local authorities and evaluate all JICPA reviews undertaken to produce a national report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023.

To take action when standards are not met

We are responsible for inspecting, reviewing, and investigating NHS services and independent healthcare services throughout Wales. We inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. When through our work we find this is not the case, we will take action so that health boards and their services know where they need to make improvements.

Service of Concern process introduced for NHS Bodies in Wales

One of the key priorities set out within our strategic plan was to take action when standards are not met. In line with this priority and wishing to increase transparency about how we discharge our role in providing assurance to the public regarding the quality and safety of healthcare services, we introduced a Service of Concern process for the NHS in November 2021.

This process is used when we identify significant service failures, or when there is an accumulation of concerns about a service or setting. The intention of the process is to support improvement and learning, both for the service in question, and across NHS services more broadly. Our escalation and enforcement process for independent healthcare currently utilises such a process.

The process may lead us to make a Service Requiring Significant Improvement designation. This enables us to plan and deliver future activities necessary to gain assurance about the quality and safety of care by a service. We then work with the health board and services to ensure improvements and effective actions are made in a timely manner. We will then consider and review whether the service can be de-escalated and removed from the process.

This process enables a range of stakeholders including health boards to take the rapid action necessary to ensure safe and effective care can be provided to people. The Service of Concern process has strengthened the action we take to drive improvement when services fall significantly short of the required standard. Examples of our use of this process are outlined later within this report.

Use of HIW's legal powers

In February 2022 following a criminal investigation relating to an unregistered service, HIW issued a caution for a breach of section 11 of the Care Standards Act 2000.

As the regulator of independent healthcare services in Wales, HIW is committed to taking action when standards are not met. In order to ensure that patients receive safe effective care the use of legal powers on this occasion highlights how HIW will take action when a healthcare provider does not comply with the regulatory requirements.

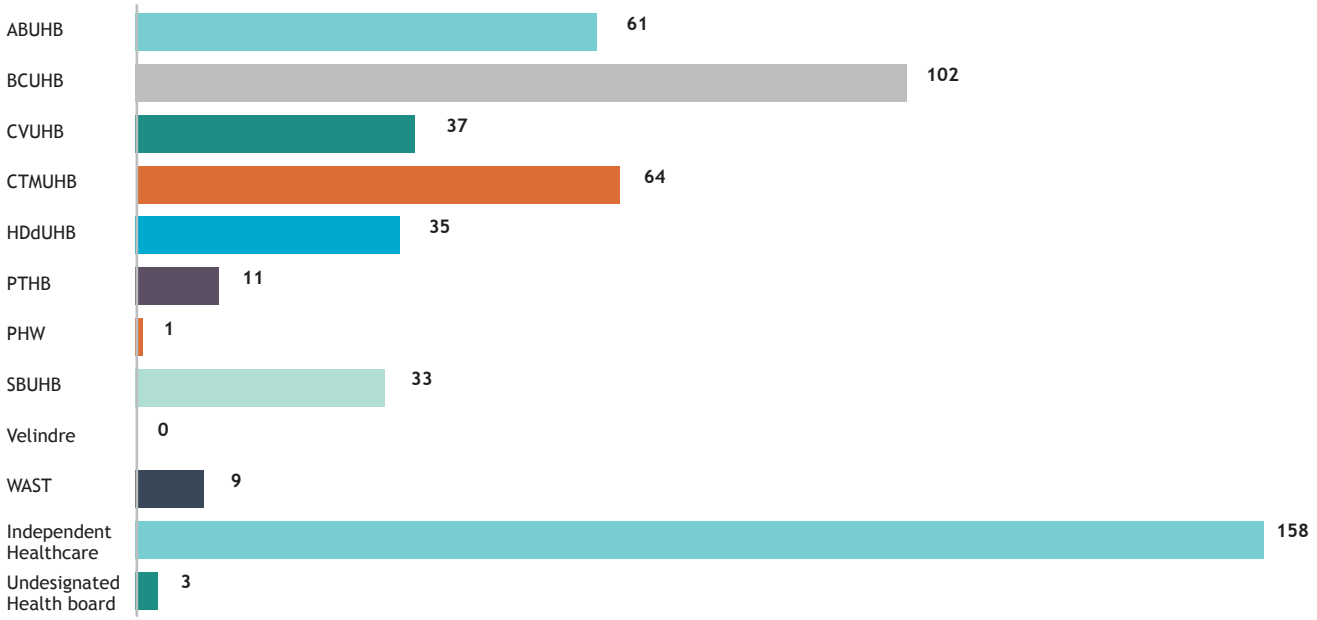
Concerns

The concerns we receive continue to be an invaluable source of intelligence to the organisation and their importance cannot be underestimated. Some of the onsite inspection work we undertook during 2021-2022 was as a direct result of concerns that had been raised with us. In addition to the evidence we have gathered directly from our inspection and Quality Check activity, we have also sought assurance from healthcare organisations in relation to concerns received.

In total, we received 514 concerns from April 2021 to March 2022. This represents an increase of eighty compared to the previous year. Of note, however, is that HIW is seeing a sustained increase in numbers of concerns being raised since the start of the COVID-19 pandemic.

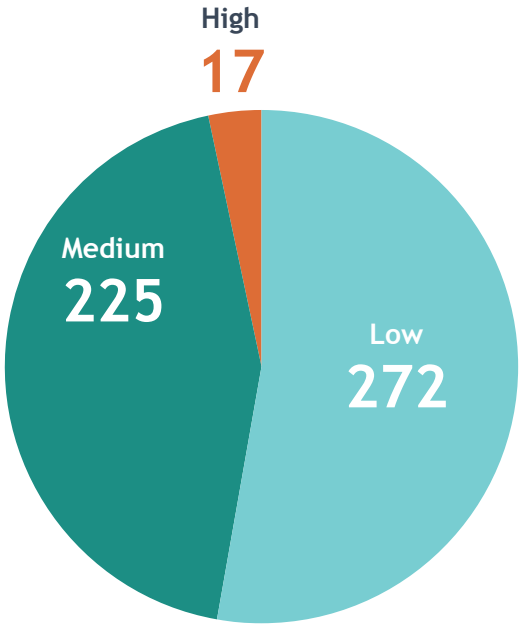
We have seen a **40% increase** in the number of concerns being raised since the 2019-2020 year.

Location of concerns



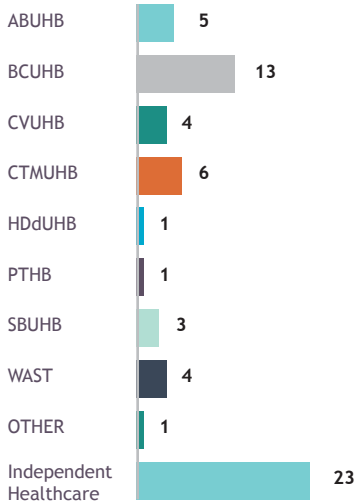
Concerns, Whistleblowing and Safeguarding

Risk levels of concerns received



- High-risk concerns require immediate action and response within 2 working days, either by HIW or other agency.
- Medium-risk concerns may require more direct HIW input, and responses should be actioned within 5 working days.
- Low-risk concerns are those concerns that are generally dealt with by way of signposting towards Putting Things Right or the respective local complaints process for independent health providers and responses should be actioned within 7 working days.

Whistleblowing Concerns



Whistleblowing Concerns

25 received for **2019-2020**

100 received for **2020-2021**

61 received for **2021-2022**

In total, we received 17 high risk concerns in 2021-2022. All high-risk concerns were evaluated, actioned and escalated and assurances requested from health boards / trusts or independent healthcare settings. Where appropriate we also contacted the local safeguarding team and shared any safeguarding concerns that we may have identified. At times we have also had to share information with the emergency services such as the police due to the nature of concerns raised or due to concerns over a person's well-being.

Concerns were received from a range of individuals including, patients, their families, friends, staff, and allied health professionals. It is important to note that of 61 concerns received from whistle-blowers, 37 were in relation to NHS health boards / trusts and 24 were in relation to independent healthcare settings. Common themes identified from concerns received were mainly in relation to two key areas. The first group of concerns were in relation to clinical assessments and treatment. The second group of concerns related to infrastructure, staffing, and facilities.

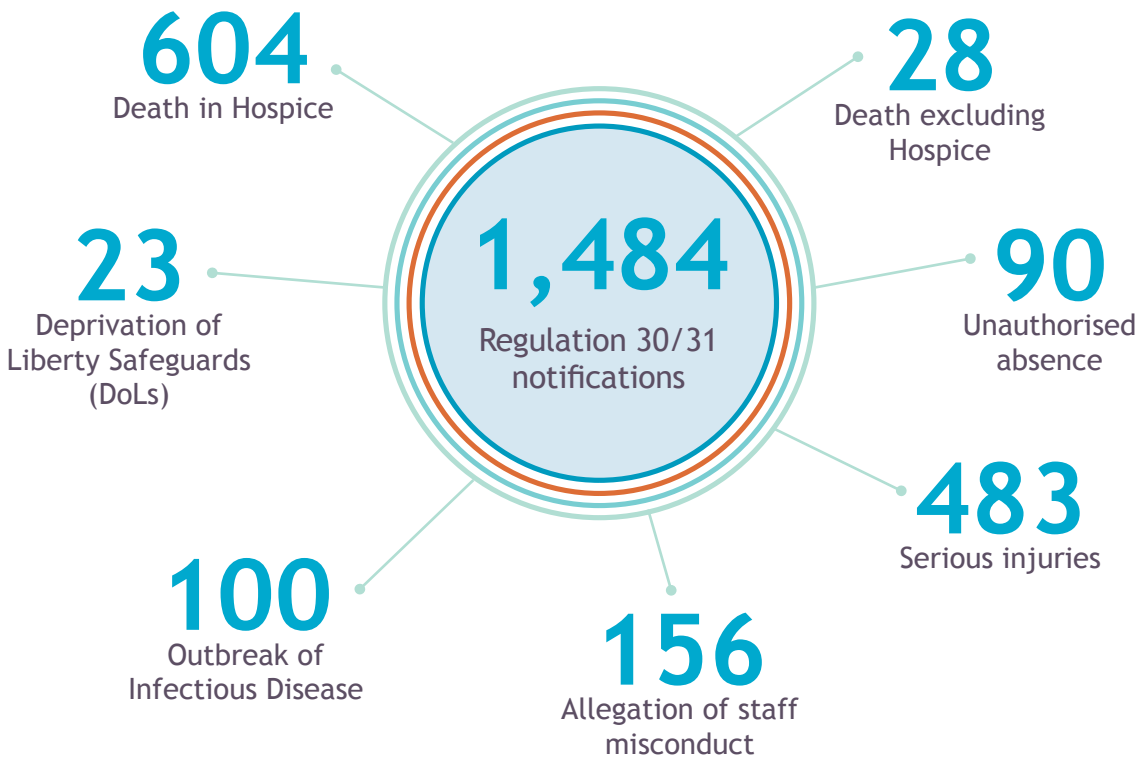
In total we received 404 safeguarding referrals from local authorities.

Local authorities and the police are the statutory lead for all safeguarding referrals and the final decision on action is made by them. HIW is invited to initial strategy meetings where we can have an input into any potential actions that are taken. We also review all referrals that are submitted, and the information is shared internally with relationship managers for intelligence. Relationship managers are the first point of contact for HIW staff and health boards/ trusts. They also take the lead in determining the inspection and assurance activity within each health board. If there is a need for further action, we write out to the health boards / trusts or independent healthcare setting and request assurance or a regulatory notification where applicable.

Regulatory Notifications

Independent healthcare providers are required to inform us of significant events and developments in their service submitting notifications against Regulation 30/31 of the Independent Healthcare (Wales) Regulations 2011.

In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications is as follows:



This is a **36% increase** in the number of notifications we received, compared to 2020-2021. The number of serious injuries reported within independent healthcare services has increased significantly by **72%** over the last year.

During 2021-2022 we received 156 Regulation 25 notifications (The Private Dentistry (Wales) Regulations 2017).

They are as follows:

All notifications are reviewed by a case manager when they are submitted and then reviewed weekly by the Investigation team. For every notification submitted we request follow up information to provide reassurance that the incident has been handled appropriately and that the setting has attempted to mitigate the risk of similar incidents happening again. When similar themes are noted, we refer the information to the enforcement team and the escalation and enforcement pathway starts.

Death in Custody Reviews

It is the responsibility of the Prisons and Probation Ombudsman (PPO) to undertake an investigation of every death that occurs in a prison or approved premises in Wales. HIW supports these investigations by undertaking a clinical review of all deaths within a Welsh prison or approved premises. This collaboration has been formally outlined within a Memorandum of Understanding between the PPO and HIW. A link to the agreement can be found on our website.

The purpose of our clinical reviews is to critically examine and evaluate the quality of healthcare services provided to prisoners during their time within a prison or approved premises.

From 1 April 2021 to 31 March 2022, we were commissioned by the PPO to undertake 15 clinical reviews. This is one less compared to 2020-2021. These clinical reviews were conducted at four out of the six prisons located in Wales. No clinical reviews were undertaken in relation to HMP Prescoed or HMP Usk.

The table below identifies the number of reviews and their locations:

Location	Total
HMP Parc	7
HMP Berwyn	2
HMP Cardiff	5
HMP Swansea	1

Overall, our death in custody reviews highlighted that the care provided to prisoners in Wales was equitable with the expected level of care a person in the community would receive. Access to GPs, nursing staff and allied health professionals was deemed sufficient in the vast majority of our reviews.

In all of our clinical reviews we identified the need for improvement and highlighted good practice. There were two key areas highlighted for improvement, these were the need to ensure comprehensive and detailed documentation was completed for all patients and improvement in relation to the timely undertaking of investigations such as blood tests and x-rays.

Good record keeping is a fundamental part of delivering safe and effective patient care. An accurate documented record that details all aspects of the patient's care and treatment is fundamental as it contributes to the dissemination of information amongst different care practitioners involved in the patient's treatment or care. A specific area of documentation that was identified as needing improvement was the recording of physical observations as part of patient assessments. These observations provide a significant insight into a patient's state of health and can alert practitioners to the clinical deterioration of an individual.

It was acknowledged that on some occasions, delays were experienced by prisoners in obtaining blood tests and x-rays. Numerous factors were identified which can impact on the timeliness of these investigations being undertaken, such as transport and the availability of specific staff. In addition, vulnerabilities were identified in alerting healthcare staff when a prisoner had not attended an appointment. The importance of recognising these missed appointments need to be clearly embedded in policies and procedures and escalated accordingly to ensure individuals receive the required investigations.

Our clinical reviews highlighted that healthcare professionals working in prisons were motivated, dedicated and committed. Evidence showed that staff endeavoured to provide high levels of holistic care and treatment to their patients. HIW's findings following a review into the effectiveness of Swansea Bay University Health Board's quality governance arrangements for the provision and oversight of healthcare services in HMP Swansea did provide a differing perspective. Our review concluded that the health board's quality governance arrangements do not adequately support the delivery of good quality, safe and effective healthcare services to the prison population. We identified a need to raise the profile of prison healthcare within the health board to ensure that the quality healthcare is designed, delivered, and monitored effectively. HIW recommended that prison healthcare needs to feature more prominently on the health board's quality agenda, so that safe, effective care can be provided to the prison residents.

NHS Assurance and Inspection Findings

We continued to deliver a blended approach to assurance and inspection via onsite inspections and remote Quality Checks. There was ongoing work to develop and enhance current methodologies, which are the tools used to undertake inspection and assurance work. All methodologies continued to include a specific focus on COVID-19.

Hospitals

COVID-19 continued to impact the way in which we inspected and sought assurance of NHS hospitals throughout 2021-2022. During Winter 2021, rates of COVID-19 transmission continued to increase, including the emergence of the Omicron variant. It was important that we took a cautious approach to reduce burden on the services most affected. We therefore cancelled all routine NHS onsite inspection work throughout December and January. We still undertook onsite inspection work where we considered there to be a high risk to patient safety as a result of specific issues that we were aware of and was not possible to gain assurance remotely. All other work during this period we conducted remotely. In February 2022, we resumed all our routine NHS onsite inspections following the move to alert level 0 across Wales and the general decreasing trend in rates of COVID-19. We provided 24 hours' notice for inspections to elective, scheduled care areas where the flow of patients is planned, and COVID-19 precautions are structured around patients who are being admitted for planned surgery, or where there are patients with compromised immunity due to the treatment they are receiving and in maternity services. This allowed our inspection teams to communicate with NHS staff and for arrangements to be put in place so that the inspection could be undertaken safely. We continued to conduct unannounced inspections (no notice provided) of clinical areas within unscheduled care areas.

During this period, we undertook:

Of the eight onsite inspections we completed, two of those were categorised as a 'green' pathway[1].

Our onsite inspections and Quality Checks covered a variety of different types of hospital wards including emergency departments, maternity, oncology, cardiac, paediatric units, step down facilities and one minor injury unit.

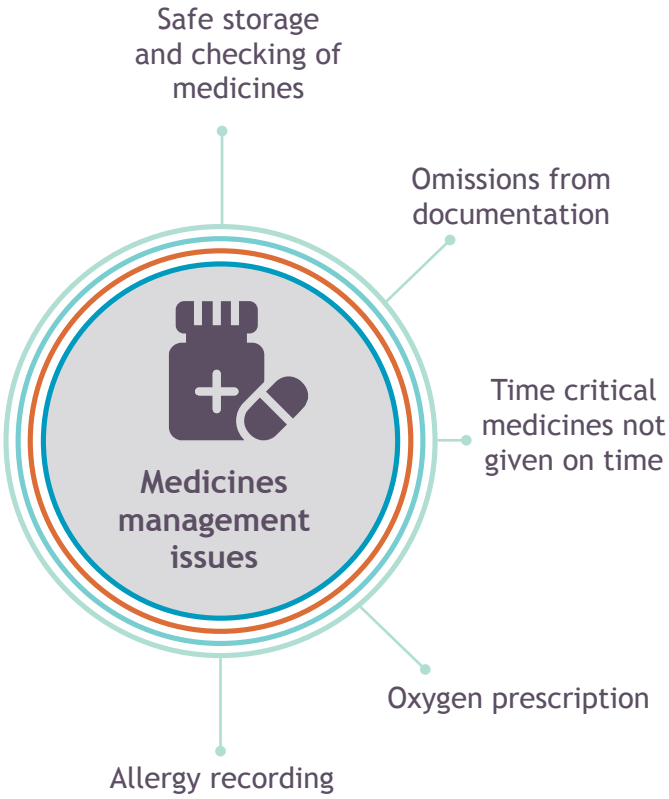
It was clear, from work carried out throughout the year, that there was significant and sustained pressure on the emergency care system, and that this directly impacted patient care. Through our inspection and assurance work we identified a clear difference between scheduled and unscheduled care. We identified many more areas requiring improvement within unscheduled care compared to scheduled care. In particular, scheduled care areas, such as oncology and cardiac wards, where the staff have more control over admission and can provide more patient centred care had fewer areas for improvement.

Although responses we received to our staff questionnaires indicated low staff morale, particularly related to challenges around staffing numbers and high demand for services, this did not generally seem to impact on the experience patients had of staff. Patients told us staff were kind and compassionate.

Our inspections continued to note low levels of compliance with mandatory training for staff. Mandatory training plays a key role in ensuring staff can provide safe and effective care to patients.

[1]The Green Pathway is the term given to COVID-free areas of a hospital. Within the pathway there are specific pathways such as surgical pathways. Measures taken can include patients being assessed as having no current risk of COVID and patients booked for surgery may be asked to self-isolate in their homes.

Medicines management continues to be a concern for HIW, as we identified issues across all of our hospital inspections in relation to:



Through our work we experience many clinical areas. We encounter patients who receive their care within and from services, and when visiting is possible, we also meet relatives, carers and others involved in their lives away from healthcare. We also encounter the staff working within services day to day; therapy staff whose work takes them to departments to support with specific issues, housekeeping staff whose input supports the smooth running of departments, and managers and senior leaders who provide the governance and leadership that is needed daily to ensure services achieve and maintain standards, and where necessary, improve. We have observed services at times of significant pressure, and the staff within them working relentlessly to deliver care. We have seen services at times when pressure is not significant, but staff still working hard to deliver care. We acknowledge the challenge and stress that sustained high pressure can cause. The case studies below demonstrate the way in which we continued to focus on patient safety in 2021-2022, challenging services and health boards to look for different ways of doing things when outcomes for patients could be improved.

Case Study - Inspection of the Emergency Department, Prince Charles Hospital, Cwm Taf Morgannwg University Health Board

In the following case study, we have focussed on the findings and outcome of an inspection we carried out of the Emergency Department (ED) in Prince Charles Hospital. This example of our work illustrates a department working under significant pressures leading to issues with patient safety. What happened next was an example of a health board working responsively and constructively to tackle the issues our work highlighted. By responding in this way, early progress was made in improving patient safety and outcomes for patients.

During our inspection in September 2021, we found that the ED, as the front door to a wider healthcare system, was experiencing a period of heightened pressure due to high demand on services. Patient flow throughout the hospital was clearly an issue.

We acknowledged that this was a very challenging and stressful environment for staff, who continued to work above and beyond in exceptional and challenging conditions.

The inspection revealed extensive issues in relation to patient safety, meaning that we could not be assured that patients in attendance at the ED were receiving safe care. These concerns related to inadequate infection prevention and control arrangements, ineffective arrangements for the segregation of COVID-19 patients, inappropriate or incorrect usage of Personal Protective Equipment, and numerous environmental factors impacting on the ability of staff to provide safe and dignified care. The department and GP assessment unit were significantly overcrowded to a level where this affected patients' dignity and safety. The paediatric area was not sufficiently staffed, and the environment was not conducive to safe and dignified care. Patients were not always monitored at a frequency which would identify deterioration and changes in their condition. Our discussions with staff also revealed concerns about their well-being, due to the environment that they were working within.

We used our Immediate Assurance process, where we formally write to a health board immediately after the inspection, to outline the urgent remedial actions that were needed to ensure patient safety. Our full inspection report identified the longer-term improvements that were required.

Key staff at the health board were positive in their response to our feedback, and in our subsequent engagement, with a clear commitment to addressing the issues highlighted. The health board's responses included a comprehensive set of actions, with much progress already made at the time our report was published.

Due to the significance of the issues found in the inspection, we undertook a follow-up inspection in January 2022.

At the time of the follow-up inspection, we found that the ED continued to experience a period of heightened pressure due to high demand on services. Once again, we acknowledged that this remained a very challenging and stressful environment for some staff, who continued to work above and beyond in exceptional and challenging conditions. Whilst some areas still needed attention, there were no urgent patient safety issues.

There was a clear commitment to addressing the issues highlighted in the initial inspection and we found that the health board had made significant progress in addressing most of the improvements raised in a sustainable way, rather than quick fixes to issues which cannot be maintained. The rapid and positive outcome achieved within this example is of note, with this being achieved through a constructive and supportive style adopted by senior leaders in supporting staff in the department. Staff felt there was a shared responsibility for improvement. Our work provided an insight into challenges at the department, and this will support the health board in continuing to improve delivery of care provided by the ED. The outcome of our work and the effort from the health board was improved patient safety in the department.

Case Study - Enhanced Quality Check Ysbyty Glan Clwyd, Betsi Cadwaladr University Heath Board

In May 2022, we identified the Emergency Department (ED) at Ysbyty Glan Clwyd, Betsi Cadwaladr University Health Board as a Service Requiring Significant Improvement.

This designation was based on an accumulation of evidence where HIW identified specific risks following a No Surprises Notification in January 2022, concerning potential unsafe discharge from the ED. A patient was unfortunately found deceased after discharge. Following insufficient assurances from the health board in response to HIW's initial correspondence, HIW undertook an in-depth review of the case notes of the patient involved. This review highlighted a number of concerns and significant patient safety concerns. This was fed back to the health board and assurance and actions were provided to HIW that safe care and treatment was being provided at this time.

HIW subsequently completed an enhanced Quality Check of the department in March 2022. Quality Checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas: infection prevention and control, governance (specifically around staffing) and the environment of care.

Due to the issues noted in January 2022, we expanded our usual methodology to seek assurance on how the health board ensures patients are cared for, and discharged, safely.

Our work identified numerous patient safety issues. We issued an Immediate Assurance letter, where we write to the health board immediately after the Quality Check, outlining urgent remedial actions to ensure patient safety.

Whilst the health board responded positively with a detailed action plan, the severity of the issues identified led HIW to remain concerned about wider patient safety at the department. Consequently, we undertook a full onsite inspection in May 2022 to inspect the full environment of care, and ensure the actions set out in the health board's response to the March Quality Check were completed and sustained.

Our onsite inspection identified further significant patient safety issues. We also identified areas where the health board's actions in response to the March Quality Check had been ineffective. We escalated our concerns to senior staff at the health board during the inspection, as well as at our standard feedback meeting at the end of the inspection. We received verbal assurances from the health board on actions that would ensure patient safety, and we issued a further Immediate Assurance letter on 9 May 2022.

Having considered the findings and evidence gathered since January 2022, HIW determined that the health board had not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care, with particular concern regarding the poor standard of nursing documentation. Our May 2022 onsite inspection highlighted that the health board had not demonstrated improvement to an acceptable standard in response to the Immediate Assurance issues identified during the March 2022 Quality Check. Furthermore, the May 2022 inspection identified several additional areas of concern relating to patient safety. As a result, we were concerned there was a risk to the safety of patients seeking care at the Emergency Department in Ysbyty Glan Clwyd.

The designation of Ysbyty Glan Clwyd Emergency Department as a Service Requiring Significant Improvement enabled HIW to plan and deliver any future activities necessary to gain assurance about the quality and safety of care in the service. This process considers the timing of any follow up activity, to enable HIW to decide whether the service can be de-escalated and removed from this process.

General Practice

We continued to use Quality Checks to seek assurance on the quality of care being provided by GP practices during 2021-2022. Our Quality Checks continued with a specific focus on COVID-19. During this period, we undertook 25 Quality Checks of GP practices across health boards in Wales.

It was positive to note from our assurance work that there was good evidence of GP practices using their membership of a cluster[2] to support the provision of patient care and sharing of ideas and good practice between GP practices. We noted that most GP practices had made significant changes to their practice environments to ensure that they were safe for patients and could be easily cleaned in response to the challenges of the COVID-19 pandemic.

However, it was disappointing to discover that at some GP practices there was a lack of cleaning policies and full cleaning schedules. We also noted a lack of completed risk assessments at some practices for home visits, practice staff and the environment. Policies and risk assessments are management tools which help to ensure that all staff are aware of what is expected of them, they can be used to help outline and ensure safe practice and they can help to maintain consistency in standards and support improvements in quality. Where these tools are absent or are not kept up to date it indicates a weakness in management practices, and this is of concern. GP practices and primary care leaders within health boards should ensure there are processes and systems in place to support effective management of these services.

We identified a theme through our activity and intelligence relating to the accessibility and availability of face-to-face appointments. This showed that although practices were doing their best to recover services affected by the pandemic, issues of access still persisted. People told us that they could not always get appointments when they needed them and found it difficult in some areas to access practices by phone. We also found that an element of digital exclusion has continued, with some people unable to access services in an equal way due to a focus on online and telephone consultations. We found that practices had continued to respond well to the challenges of the pandemic. This included releasing staff to provide vital support to vaccination programs and clinics. A number of areas had developed innovative approaches to manage consultations and meet the demands of their communities. As a result, we have redesigned our methodology for GP inspections and introduced new peer reviewers to this process. This will ensure that HIW keeps pace with the developments in this sector.

[2] A cluster is a group of GP surgeries working together to pool resources and share best practice in a bid to help patients remain fit and healthy, and to improve the way patients are cared for if they become unwell.

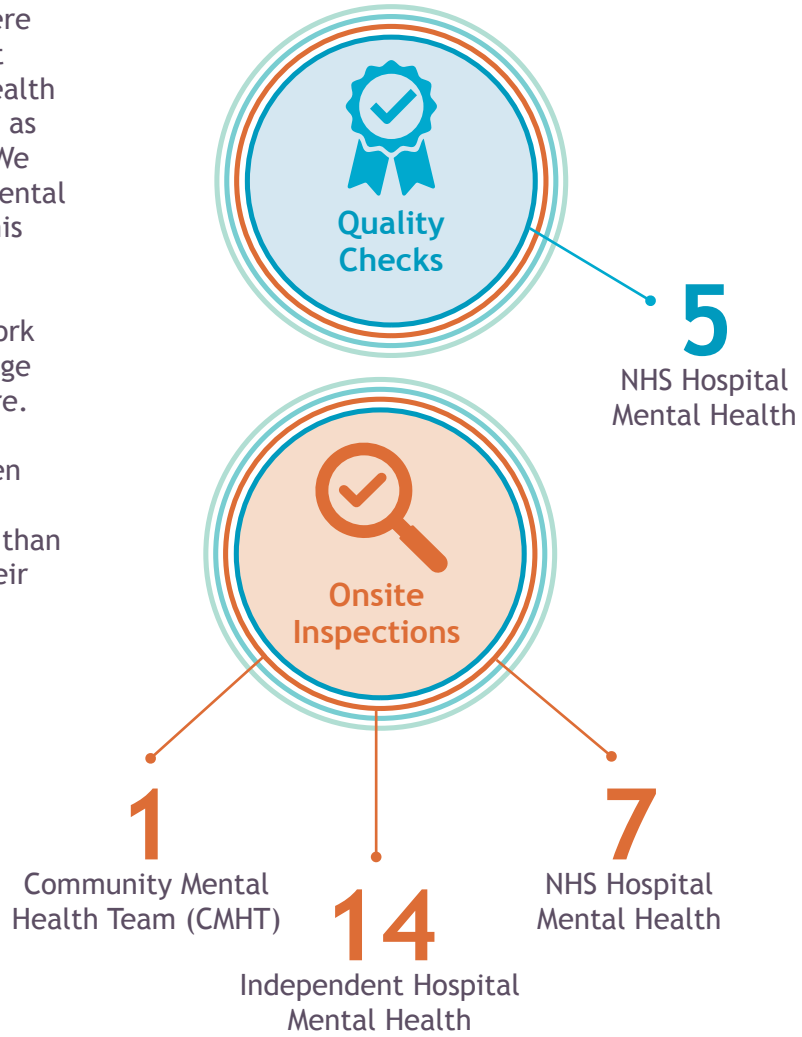
Mental Health

We look at how NHS mental health and independent mental health care services meet and comply with a range of professional standards and guidance, including the Mental Health Act 1983 and the Independent Healthcare (Wales) Regulations 2011.

The provision of mental health care during the pandemic has been challenging and complex for both the NHS and independent healthcare service providers. We continued to use a mix of remote Quality Checks and onsite inspections for our work to mental health care settings. This hybrid approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was high and to conduct our work onsite when either the COVID-19 risk was lower, or where the risk to patient safety was of significant concern. Our Review Service for Mental Health (RSMH) continued during this time, as well as our concerns and notifications processes. We also continued to respond to patients in mental health settings who contacted us during this period.

Over the past 12 months, our assurance work evidenced several key themes across a range of settings in relation to mental health care. Mental health is challenging and complex and inspections highlighted staff were often required to intervene to manage patient behaviours and ensure their safety, rather than provide care and treatment bespoke to their needs.

During 2021-2022 we undertook:



Inspections also highlighted instances of:

- Mandatory training for staff not being completed or up to date
- Poor medication management including incomplete administration charts and medication being stored incorrectly
- Risks being identified and subsequently not addressed in a timely manner or not addressed at all
- An over reliance on agency staff and repeat periods of inadequate resourcing
- Care and treatment plans not being monitored and regularly updated
- A lack of governance oversight including collaborative working and sharing information for future improvement.

In most cases we found that staff working in services providing mental health care and treatment, treated patients with kindness and respect. We also saw that most services continued to work well to adapt to the changing needs presented by the pandemic. Patients were receiving compassionate care in most cases which promoted their independence and autonomy. We also saw that in some cases the recovery from the pandemic was going well, with improvements on previous inspections noted.

During 2021-2022 we inspected two out of the three children and adolescent mental health units in Wales, Tŷ Llidiard in Bridgend, and Hillview Hospital in Ebbw Vale.

Learning Disability

HIW undertook eight Quality Checks and five inspections of facilities providing learning disability services. In most cases, we found that patients accessing care in these facilities were receiving person centred and compassionate care and treatment. Tailored care plans were in place and allowed staff and patients to work towards common goals for the benefit of patients. We saw that staff interacted with patients in a kind and compassionate manner and worked hard to meet patient needs. However, we did find that staffing numbers were not always at a level which met patient needs. We also saw that the COVID-19 pandemic had negatively affected the promotion of independence in some of these settings. We saw in one case that there were significant issues relating to the environment, governance and safety of the unit. As a result, an Immediate Assurance letter was issued, and significant improvements were implemented by the Hywel Dda University Health Board.

The Second Opinion Appointed Doctor (SOAD) Service

HIW operates the SOAD service for Wales, and we appoint registered medical practitioners to approve some forms of treatment. The role of the SOADs is to safeguard the rights of patients who are detained under the Mental Health Act and either do not consent or are considered incapable of consenting to treatment (section 58 and 58A type treatments). Individual SOADs come to their own opinion about the degree and nature of an individual patient's mental disorder and whether the patient has capacity to consent.

They must be satisfied that the patient's views and rights have been taken into consideration. After careful consideration of the patient and approved clinician's views, a SOAD has the right to change the proposed treatment. For example, a SOAD may decide to authorise only part of the proposed treatment or limit the number of electroconvulsive therapies (ECTs) given.

The SOADs have a responsibility to ensure the proposed treatment is in the best interest of the patient. The appropriate approved clinician should make a referral to HIW for a SOAD opinion relating to:

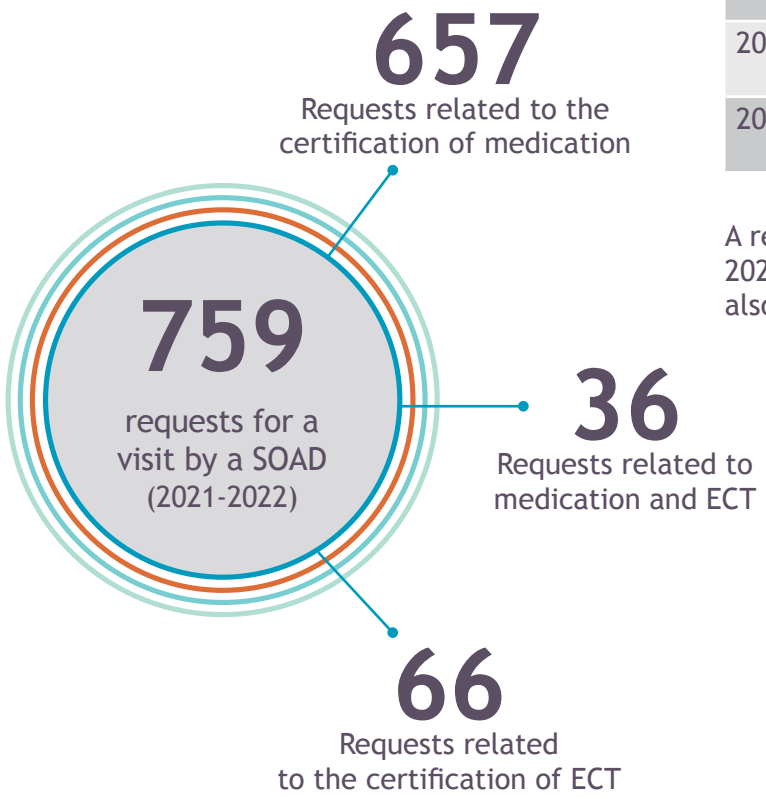
- liable to be detained patients on Community Treatment Orders (CTO) (Section 17A) who lack the capacity to proposed treatment or who do not consent for Part 4A patients
- serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (Section 57)
- detained patients of any age who do not consent or lack the capacity to consent to Section 58 type treatments (section 58)
- patients under eighteen years of age, whether detained or informal, for whom Electroconvulsive Therapy (ECT) is proposed, when the patient is consenting having the competency to do so (Section 58A), and
- detained patients of any age who lack the capacity to consent to electroconvulsive therapy (ECT) (Section 58A).

Due to the ongoing COVID-19 pandemic and health and safety concerns regarding on site visits for the SOADs, in 2020-2021 we operated a temporary COVID-19 safe methodology for the SOAD service, wherein onsite hospital visits were temporarily suspended and replaced with teleconference or telephone call appointments. As we move to a post-pandemic operating model, the SOAD service now operates a hybrid methodology where onsite visits, where safe and practicable, are carried out, however, remote certification is still also utilised enabling the efficiencies gained from the remote methodology to continue, whilst ensuring patients safety and rights are prioritised.

We continue to work with Mental Health Act administrators in health boards and independent providers to ensure that patients get timely access to a SOAD and that the process is as smooth as possible to ensure that the rights of patients are protected. We attended the Mental Health Act Administrators annual forum and engaged with stakeholders directly to support understanding of our hybrid methodology.

In Wales during 2021-2022, there were 759 requests for a visit by a SOAD. This figure is a slight drop from the previous year, although it remains broadly consistent with figures from previous years.

These were:



The following table provides a breakdown of requests per year:

Requests for visits by a SOAD in 2021-2022

Year	Medication	ECT	Both	Total
2019-2020	855	50	27	932
2020-2021	869	60	27	956
2021-2022	657	66	36	759

A regular programme of training is provided to all SOADs to encourage best practice. In the year 2021-2022 training which focussed on depression treatment and medications was provided. SOADs also attended a session in winter 2022 focussing on Legal Updates to the Mental Health Act 1983.

Review of Treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the Mental Health Act Administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the sixth consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are reviewed by our lead SOAD for Wales on a monthly basis.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continue to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3 form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting.

[3] The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008 are the principle regulations dealing with the exercise of compulsory powers in respect of persons liable to be detained in hospital or under guardianship, together with community patients, under the Mental Health Act 1983.
The Regulations prescribe the forms that are to be used in the exercise of powers under the Act, and these are set out in Schedule 1 of the Regulations. These Regulations (and the prescribed forms) came into force on 3 November 2008 and include CO forms.

Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)

HIW is responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). The regulations are intended to protect people from hazards associated with ionising radiation. Our inspection approach checks that services are compliant with these (IR(ME)R) regulations and looks at whether care and treatment is being provided in line with the Welsh Government's Health and Care Standards.

During 2021-2022 HIW completed seven IR(ME)R inspections, covering the three modalities of medical exposures. Six of these inspections covered the NHS and one covered independent hospitals.

HIW was assisted in these inspections by a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. All the inspections were undertaken onsite. As part of the process, we asked providers to undertake a full self-assessment and then we held discussions with staff about the content of the self-assessments and the supplementary evidence provided to support the self-assessment. Whilst onsite we also reviewed clinical and other relevant records as well as observing the environment in which services were delivered. We also requested patient and staff feedback through online surveys. The QR code to access the survey was displayed on posters in the services we inspected, and we promoted the surveys through our social media channels. Paper copies of the patient survey are also provided in advance of the inspection to the setting to accommodate patients who are unable to access the online survey. HIW received 273 completed patient questionnaires and 214 staff questionnaires covering these seven inspections.

Feedback from patients was overwhelmingly positive with patients confirming that they had been treated with dignity and respect and had been helped to understand the risks and benefits of the procedure they were receiving. During our IR(ME)R assurance activity we continued to meet experienced and committed teams of professionals, with a good team working ethos. Overall, staff we spoke with demonstrated a good awareness of their responsibilities under IR(ME)R and we were assured that examinations at all sites inspected were undertaken safely.

Medical Physics Experts (MPEs) are qualified staff who are able to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine, and radiotherapy. We noted that the relationships between the various IR(ME)R locations inspected and the MPEs was good, whether this was provided as part of a service level agreement with another health board or by staff employed directly by the health board.

Some common themes have emerged across our IR(ME)R inspections this year. They are summarised as follows:

Employer's Procedures - on several occasions we identified that these did not provide enough detail and did not reflect the actual agreed practices staff described to us. We also saw examples where procedures were not up to date and had not been reviewed. Therefore, whilst staff could describe safe practises to us, we could not be assured that the written procedures would provide new, locum or agency staff with the required level of information to guide them in performing their relevant roles. Examples of common areas where detail was lacking in Employer's Procedures included:

- **The information supplied in the self-assessment form contained additional information which should be included in the employer's procedures to explain the process in more detail.**
- **Pregnancy employer's procedures and relevant documents did not always reflect the terminology used in IR(ME)R 2017. Also, pregnancy enquiry EPs were a common area where agreed practise described by staff was not reflected accurately in the employer's procedures itself.**

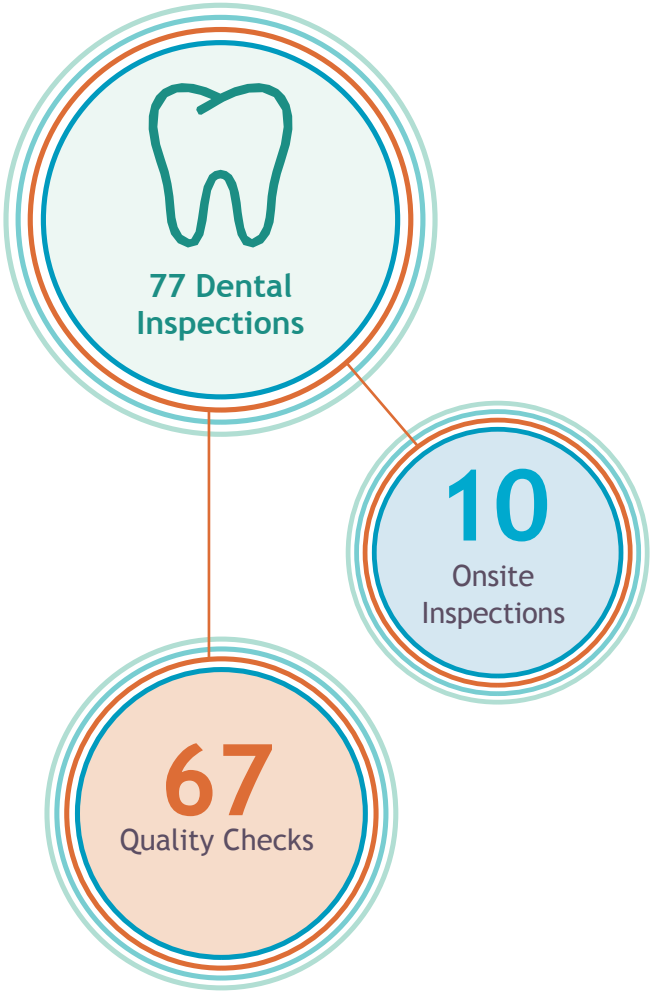
Entitlement - is the process of defining the roles and tasks that individuals, referred to as duty holders, are allowed to undertake. We identified that duty holders had not always been formally notified of their entitlement and scope of practice under IR(ME)R.

Clinical audit - is a key component of improving patient care through identifying areas for improvement and to promote effective use of resources and enhance clinical services. Audits should also highlight any discrepancies between actual practice and standards. Some instances were noted where the difference between IR(ME)R audit and clinical audits was not fully understood and as a result clinical audits had not been completed.

Staff Capacity - in most cases staff told us that they felt supported by senior management and the wider organisation. However, they did tell us that they struggled in terms of capacity to undertake all relevant tasks required as part of their duty holder roles. This may have been evident in the number of recommendations made in relation to mandatory training levels being low and appraisals not being completed in a timely manner.

We identified recommendations for improvement relating to collecting feedback from patients and informing staff of the results of this feedback. In most cases this was due to the COVID-19 pandemic which had reduced the collection of feedback. It is hoped that the process of collecting feedback would return to pre-pandemic levels in 2022-2023.

Dental Practices



Earlier in the pandemic, dental practices worked under a Red Alert which was issued by the Chief Dental Officer for Wales and which prevented them from undertaking any Aerosol Generating Procedures (AGPs). Enhanced cleaning and the requirement for time in between patients, led to a much more limited dental care provision than pre-pandemic. In summer of 2020 dental practices were able to increase the treatment they could provide and during 2021–2022 we saw them steadily increase service provision, working to recover back towards pre-pandemic levels.

During the year we undertook 77 pieces of assurance work across dental practices across Wales. Due to COVID-19 risk levels, we conducted most of this work remotely, and undertook ten onsite inspections where the level of risk to patient safety could not be explored remotely.

In three Quality Checks we had concerns which meant we needed to ask the practices to take immediate action to reduce risks to patient safety; we did this either via our Immediate Assurance process or issuing a Non-Compliance Notice, dependant on whether the practice provided NHS dental treatment, private dental treatment or a mixture of both. In one instance, a health and safety assessment had been correctly carried out by the practice, but the findings had not subsequently been acted on, leaving outstanding areas of health and safety concern. In the other two instances we found that there were inadequate seals to either flooring or to the flooring and worksurfaces in clinical decontamination rooms. Appropriately sealed floors and worksurfaces are necessary to reduce the risk of contamination and to support good standards of infection prevention and control.

Overall, we found evidence that dental practices had effective COVID-19 procedures in place to reduce the risk of virus transmission. This included social distancing, fallow time (settle time in between patients which is necessary for reducing levels of circulating air particles), and quick methods of communication with staff teams to ensure they received timely updates on COVID-19 procedures.

We also found evidence that many dental practices had considered the Welsh language needs of the patient population and were able to provide bilingual information to patients and a bilingual service where possible.

We were also pleased to note the efforts made by some practices to support and accommodate patients with additional needs to receive their treatment. One practice, 'MyDentist' in Wrexham told us that they held dedicated sessions, twice per year, for patients diagnosed with autism to receive treatment in a calming environment. Extra time was set aside for each appointment, lights are dimmed, and the radio volume lowered. We were also told that there were sensory toys, light blocking glasses and ear defenders available for patients to use.

Bryant Dental Practice also told us that during the pandemic, the practice utilised the 'Attend Anywhere' service and remote triage to reach patients who were too nervous to attend the practice due to COVID-19. We were also told that protected appointment slots are made available for vulnerable or at-risk patients at the start or end of each day.

We did find some common areas for improvement through our work. The majority of dental practices needed to improve their documentation recording staff training and ensure that all staff completed mandatory training sessions. We recognise that training has been challenging to source at times during the pandemic, but practices must continue to prioritise this as up to date training supports with quality and patient safety.

We found some areas of management and governance which needed strengthening:

- **A number of practices did not have a system which ensured all risk assessments were being kept up to date. We noted that some fire risk assessments were out of date. Risk assessments are an important management tool which helps to keep patients and staff safe and should be reviewed and updated regularly to reduce risks.**

- **Some dental practices did not have an up-to-date Infection Prevention and Control policy to work from. Whilst we acknowledge there have been some frequent updates to infection control advice over the course of the pandemic, correct IPC procedures (which should be governed through a policy) are crucial for maintaining patient safety.**

- **We also found numerous examples of practices not undertaking audits of their work. Audits offer an opportunity to review the consistency.**

Practices should ensure they take account of the above findings, considering whether they can apply any of this learning to their service to improve the quality and safety of care and treatment that is provided.

Independent Healthcare

Acute Hospitals

Due to the impact of NHS waiting times, independent healthcare is being utilised by patients now more than ever. After exclusively making use of remote Quality Checks throughout 2020-2021, it was important for our inspectors to return to onsite visits of independent hospitals to ensure patients received safe and effective care.

During 2021-2022 we completed four onsite inspections of Independent Hospitals.

Overall, our inspections found that safe and effective care is being provided to patients. Most patients who participated in the inspection expressed satisfaction with the care and treatment received.

Patients told us that staff were kind and caring and we observed good interactions between staff and patients, with staff supporting patients in a calm, dignified and respectful manner.

We found that the staff teams were committed to providing patients with safe and effective care and patients' care needs had been assessed by staff and monitored to promote patient well-being and safety.

The hospitals we inspected were clean and tidy and arrangements were in place to reduce cross infection. This is of high importance as during the time of our inspections, COVID-19 was still prevalent. However, even our most positive of inspections identified issues in medicines management procedures, for example, daily controlled drugs checklists not fully completed. We also noted issues with medications security, storage, and temperature checks.

We found good management and leadership in the hospitals with staff commenting positively on the support that they received from the management team. There was a clear multi-disciplinary approach to provisions of care across all three inspections.

Hospices

Hospices provide care to adults, young people and children who have a terminal illness or a long-term condition that cannot be cured. Due to the vulnerability of the patients, it is imperative that hospices have policies and procedures in place to protected patients from COVID-19.

During the year we completed:

Overall, our assurance and inspection work of hospices throughout the year was positive with evidence that services provided safe and effective care.

Adults

We noted the interaction between staff and patients was good and it was evidence that family members were engaged and involved in their relative's care. There were good examples of multi-disciplinary working to improve provisions of care.

Staff emphasised the importance of maintaining visiting as far as possible for the well-being of patients and their relatives, particularly for patients in their last days of life. Staff described how this was achieved in a timely and effective manner in line with public health guidance at that time. This included initially restricting visiting numbers and COVID-19 testing for relatives before visiting.

We did find some common areas for improvement through our work:

- Environmental risk assessments and action plans were not always complete.
- Low levels of completed mandatory training.

Young People and Children

During our inspection we observed staff being kind and respectful to children. We saw staff making efforts to protect children's privacy and dignity when providing assistance with personal care needs. We viewed staff communicating with children in a calm, friendly and cheerful manner. Staff were observed communicating with children in an encouraging and inclusive manner.

The multi-disciplinary team provided patients with individualised care according to their assessed needs. There were robust processes in place for referring changes in patients' needs to other professionals such as tissue viability nurses, speech and language therapists and dieticians.

Children who completed the online survey told us that they were involved in the planning and provision of their own care. Parents/guardians told us that they were being consulted and encouraged to ask questions and make decisions around care provision.

Treatment using a Class 3B/4 laser or Intense Pulsed Light (IPL)

The 2021-2022 year saw many registered lasers and IPL providers re-open their services to patients following a period of closure due to the COVID-19 pandemic.

[4] https://gov.wales/sites/default/files/publications/2019-07/the-national-minimum-standards-for-independent-health-care-services-in-wales-2011-no-16.pdf

Once these services reopened, we returned to seeking assurance that laser and IPL services were safe for patients through our Quality Checks.

During this period, we conducted 15 Quality Checks and one onsite inspection of laser and IPL registered providers across Wales.

The themes from our work during this time are set out below and providers should use these as learning points, considering whether they can make any improvements based on what we have found and recommended.

Registered laser and IPL services provided us with good evidence of COVID-19 procedures, such as social distancing arrangements for patients and staff in waiting areas. Many services also had comprehensive COVID-19 risk assessments in place. It was reassuring to find that many of the services had taken time during their period of closure to understand the COVID-19 regulations and put safe practices in place to reduce the transmission of COVID-19. We found that nearly all providers ensured that a face-to-face consultation was carried out on prospective patients prior to the start of any treatment. They also ensured consent was obtained from patients ahead of treatment taking place.

During our Quality Checks we discovered that not all providers had an up-to-date safeguarding policy. Safeguarding policies and procedures which are accurate and up to date are an important means of supporting safe practices. We also noted that not all providers had a valid set of local rules that refer to the current IPL device in place. Local rules are set by the Laser Protections Adviser (LPA) which outline the safe and correct use of the laser machine. Providers must have a contract in place with an LPA to be able to provide laser treatments safely and legally.

Many providers were required to update their Infection and Prevention Control Policy. By ensuring the policy is up to date, providers can be assured that staff and patients are protected infectious diseases and infections.

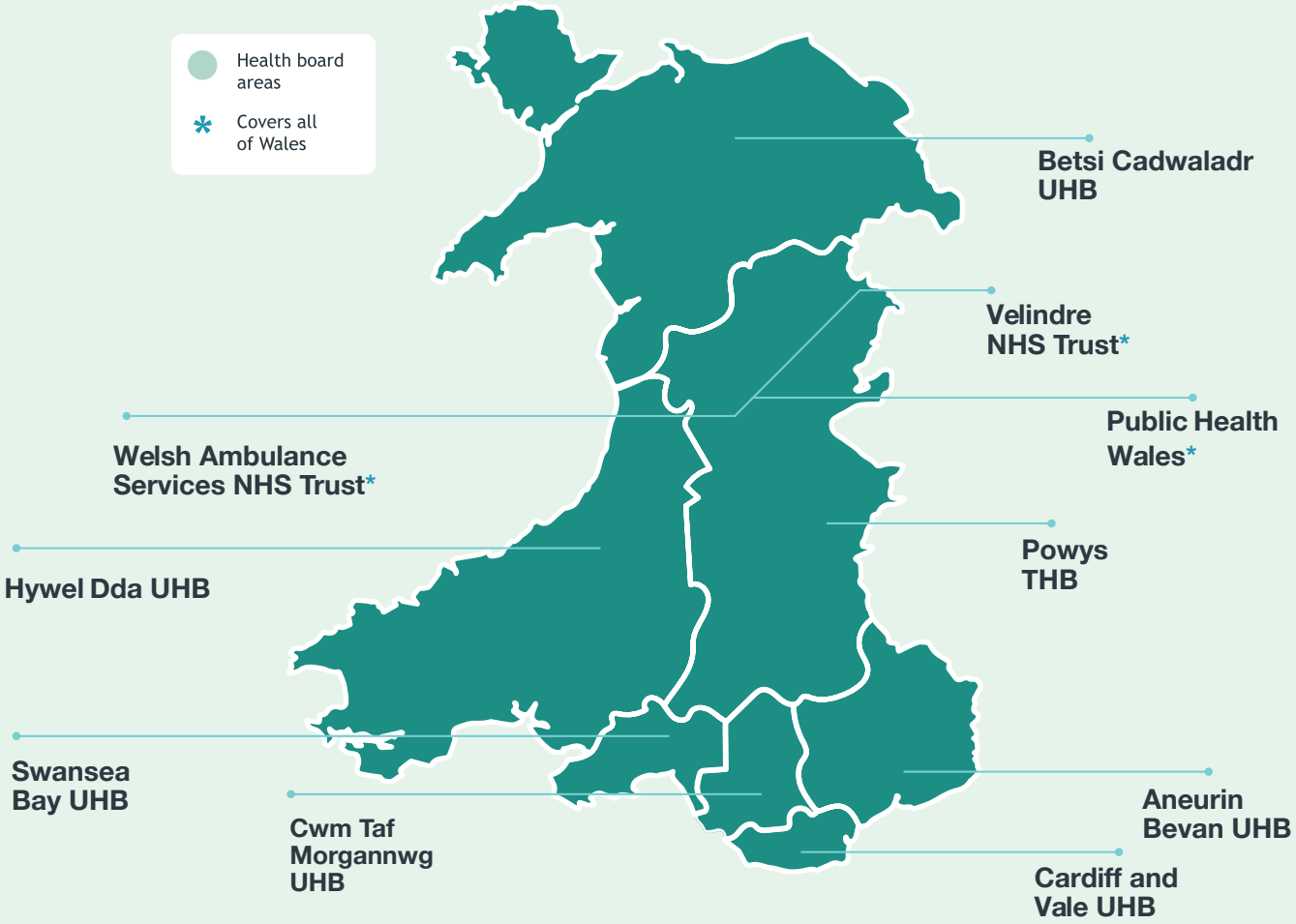
Nearly half of the providers did not have a policy in place which outlined how the service would approach the need to communicate and provide information in Welsh should the patient request it. Standard 18 of the National Minimum Standards of Independent Health Care Services in Wales[4] states that services should comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and address all language and communication needs.

NHS Health Boards and NHS Trusts

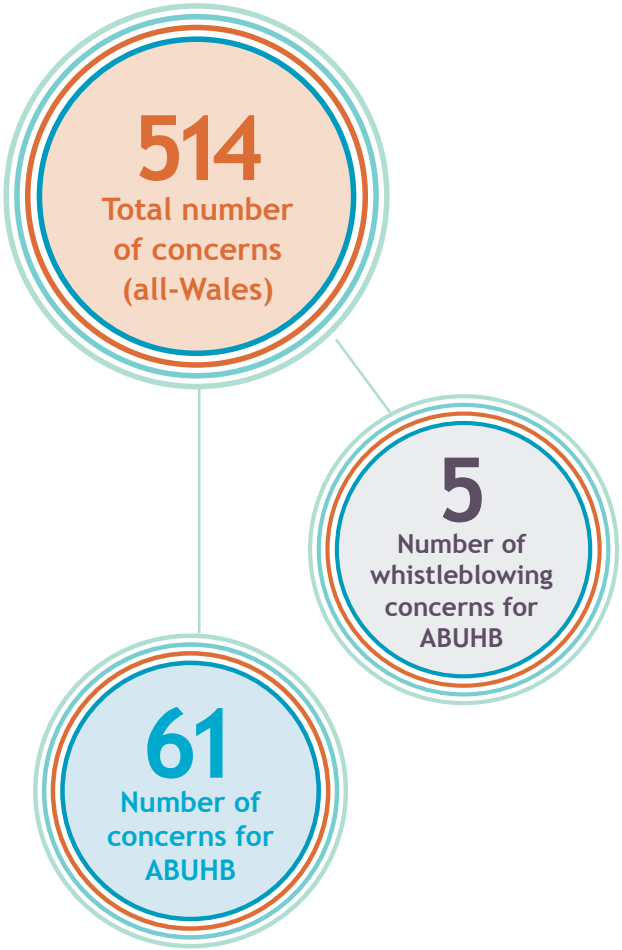
The period covered by this report, 1 April 2021 - 31 March 2022, continued to present healthcare services, and health boards with unique pressures and challenges.

This year they have faced not just the challenge of dealing with COVID-19 itself, but the added challenge of recovering services, tackling long waiting lists and demand for services as a result of many being paused in the initial pandemic response.

Across Wales we noted some common areas of concern through our work; in general, these were pressures associated with recovery of services, waiting times for treatment and significant issues with patient flow in hospitals, and notable pressure and demand on children's services, mental health services and primary care.



Aneurin Bevan University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	5
Hospital	2
Learning Disability	1
Community Hospital	1

Onsite	3
Hospital	2
IRMER	1
Mental Health Hospital	1

Within Aneurin Bevan University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Aneurin Bevan University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and in specific service areas where there have been particular challenges.

Changes made to governance structures during the pandemic have been carried forward due to the beneficial impact the health board found these had. We noted that engagement with senior leaders continued to be positive and considered that communication between the health board and HIW had shown improvement.

The health board has been proactive in sharing the learning from our assurance and inspection work across its services and has also proactively worked to deliver and embed actions for improvement that we have recommended through our work. The health board has kept us up to date on its progress on a regular basis.

A challenge for the health board throughout this time has been the newly opened Grange hospital. We undertook an onsite inspection to the emergency department and found several issues, some of which required immediate attention to improve patient safety. Staff who responded to our questionnaire told us about feeling pressured and struggling to cope with high levels of demand. High levels of demand for emergency department treatment have been seen across Wales, but this coupled with a new department, new building and new team pose an additional challenge and we urged the health board to continue with the positive input to support the department as it matures as a service.

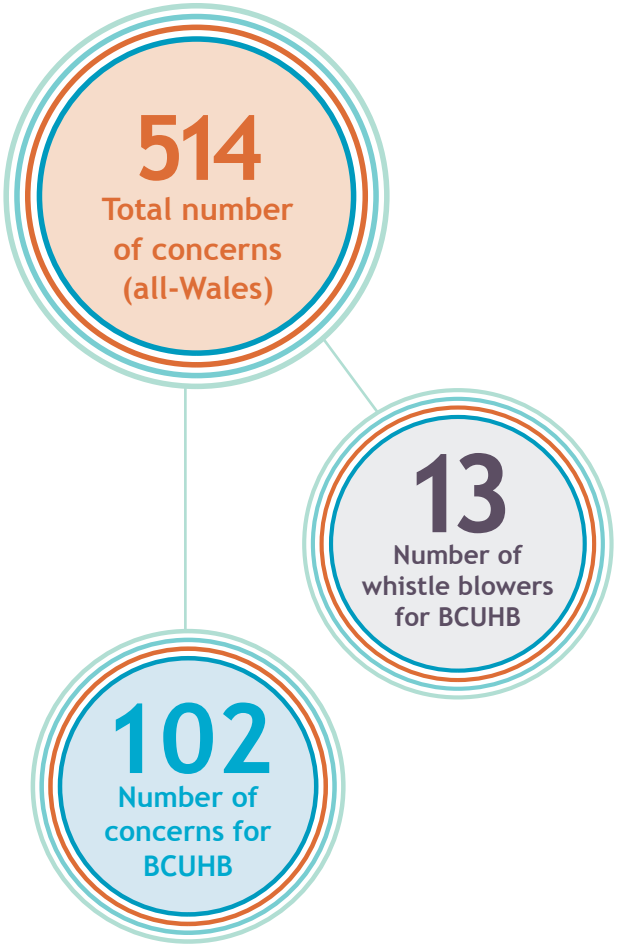
In many of our Quality Checks, our findings were positive, in particular around access to PPE, with minimal improvements required in any area. However, we were disappointed to note that compliance rates with mandatory training continued to need improvement.

During this period, we noted the health board working hard to maintain service delivery in the face of some substantial staffing challenges. At times, emergency actions have needed to be taken, such as temporarily pausing some services until staffing levels were safe again. Recruitment drives and promoting positive working cultures across services will need to be areas of focus for the health board as it continues to tackle this challenge.

The concerns we received the most for Aneurin Bevan UHB related to:

- **Clinical Assessment**
- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**

Betsi Cadwaladr University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	7
GP	3
Hospital	2
Learning Disability	2

Onsite	4
Mental Health Hospital	2
IRMER	1
Learning Disability	1

Within Betsi Cadwaladr University Health Board, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.
During the period in question, the health board had recently come under the leadership of a new Chief Executive, Jo Whitehead, who was appointed in January 2021. We noted positive evidence of change at this most senior level through open dialogue and a commitment to working together with us and other partners to help bring about change and improvement in services throughout the health board.

We noted that the culture in many areas across the health board still required work to ensure that staff feel empowered to challenge issues and raise concerns. It is critical that the health board continue to work on this area, empowering staff and developing a culture where staff feel confident to raise concerns and constructively challenge.

As a result of ongoing concern about standards of care in mental health inpatient services at the health board we conducted two onsite inspections to the Hergest unit. We were concerned to find issues relating to staffing levels and significant staff fatigue, and infection prevention and control during our inspection work to Hergest.

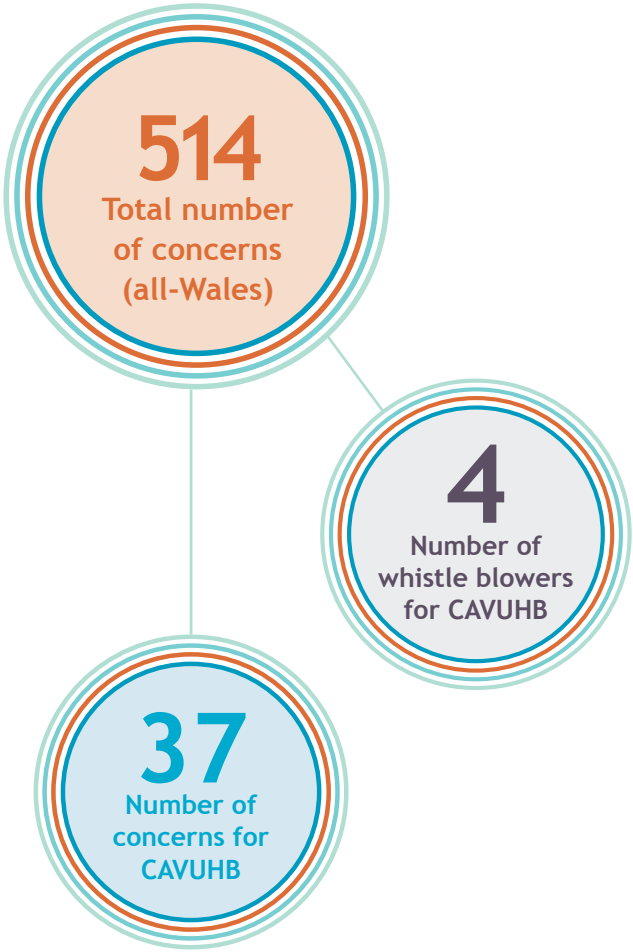
The health board responded constructively to the challenges we raised as a result of this work, but continued input from the health board will be necessary to bring about and sustain the level of improvement needed in this service. We will continue to monitor the progress made against the specific recommendations we made following our inspection to Hergest and will consider how the learning is shared to other services across the health board.

Poor record keeping was also an area of concern emerging through our ongoing work and monitoring of the health board. As a result of this emerging trend, we specifically focussed on record keeping in work within the health board during this year. We undertook an offsite Quality Check of the emergency department at Ysbyty Glan Clwyd in March 2022, with a significant focus on the evidence drawn from patient record keeping. We found a high level of risk to patient safety through this work and requested the health board take immediate action to reduce the risk. The outcome and findings of this work have contributed to the overall view of this specific service as an emergency department in Wales. We will continue to monitor the progress the health board makes in this specific department and how the learning is shared and used to shape improvement across their services.

The concerns we received the most for Betsi Cadwaladr UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Whistleblowing**
- **Clinical Assessment**

Cardiff and Vale University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	6
GP	5
Hospital	1

Onsite	3
Hospital	1
IRMER	1

Within Cardiff and Vale University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care provided by the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Through our assurance work, we did not identify any significant concerns during the year. However, we noted a significant increase in demand for services, as the health board began recovery form the pandemic. This was also evident within the University Hospital for Wales Emergency Unit, which saw a rapid rise in demand at a time where additional measures were required to help maintain adequate infection prevention and control. The health board is undertaking a significant amount of work to improve the infrastructure, environment, and processes to manage this. We also noted significant pressure within the health board's Mental Health services including Child and Adolescent Mental Health Services (CAMHS).

This includes the timely compliance with referral, assessments, and treatment times. However, the health board has made progress with some improvements already in these areas.

Bed availability within inpatient CAMHS units nationally, is at a premium. Challenges remain in the health board, with its ability access CAHMS inpatient services in other localities.

As a result, where children and adolescents require inpatient treatment, and beds are not available in a specialist unit, some patients require admission to general paediatric areas, with the support of registered mental health nurses, and at times, older adolescents have been admitted to the adult inpatient services located in Hafan Y Coed. The challenge for the health board will be to sustain and continue improvements in this area, particularly when the demand for CAMHS services remains high. We will continue to monitor our findings for the past year throughout the 2022-2023 inspection year. This will include undertaking planned and reactive inspection and assurance work as necessary, maintaining our relationship manager communication with the health board and partner organisations and through our engagement with service users and staff. This will enable us to check that healthcare services are provided in a way which maximises the health and well-being of people who use services within the health board's hospitals and its community services.

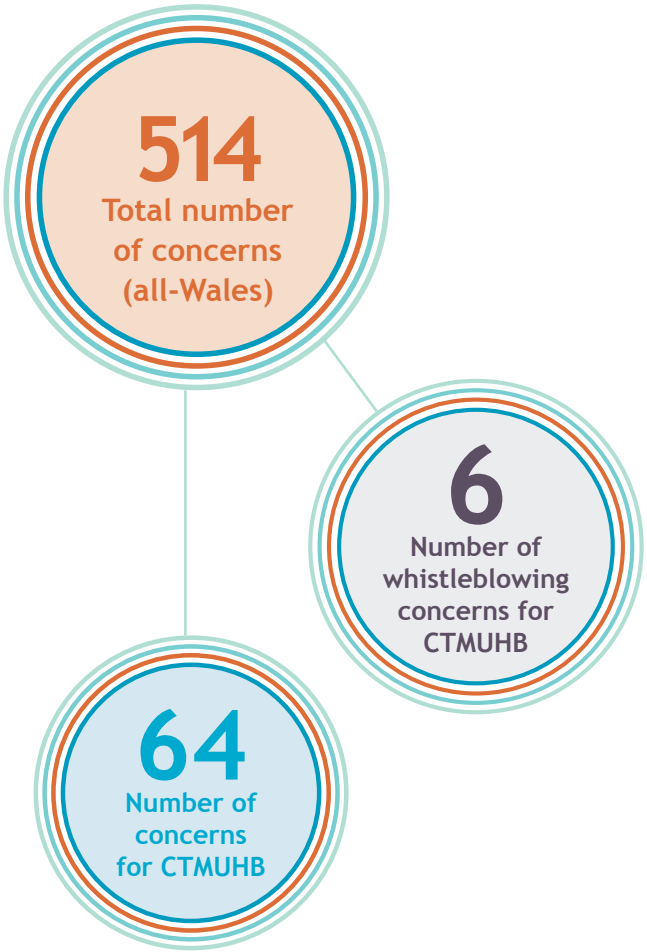
Throughout the year, we identified that the health board teams have continued to work tirelessly during several significant challenges which remain as a result of the pandemic. These challenges include an increase in staff absences and vacancies, stretched services and the resulting impact these challenges can have on staff well-being and patient safety. The health board has been proactive in supporting its staff, with a plan in place to support their health and well-being.

Our engagement with the executive team has continued to be positive and constructive, both to HIW and the health board. There has been number of changes within the executive team which included the appointment of a new Chief Executive, and the recruitment process in place to obtain additional key executives, which included the Executive Director of Nursing, Medical Director, and Chief Operating Officer. We endeavour to maintain our positive relationships with the executive team and other senior leaders.

The concerns we received the most for Cardiff and Vale UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Mental Health Act**
- **Clinical Assessment**

Cwm Taf Morgannwg University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	9
GP	3
Mental Health Hospital	3
Learning Disability	2
Hospital	1

Onsite	5
Hospital	3
IRMER	1
Mental Health Hospital	1

Within Cwm Taf Morgannwg University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

Overall, we found that the health board was continuing to make progress against the joint Audit Wales and HIW review of governance conducted in 2019. Both organisations jointly followed this up during 2020, reporting in May 2021. We found that there was a greater strategic focus on quality, safety and risk than had been previously found. However, we noted that it was too early to fully assess the effectiveness of the improvements and consequently we will be undertaking a further follow-up review during 2022-2023.

As a result of growing concern about the Emergency Department in Prince Charles Hospital, we carried out an unannounced inspection of the unit. We had significant concerns about patient safety and the potential high levels of risk to patients because of our findings. We were pleased that the health board responded very positively to our findings, noting their openness and willingness to work on tackling and addressing the issues we had highlighted through our work. We returned to the department unannounced four months later to consider their progress and could see several improvement initiatives in place which were already beginning to make a difference. We noted, however, that there were still areas which needed more work and urged the health board to maintain the momentum behind the improvement.

A challenge for Cwm Taf Morgannwg University Health Board will be around sustaining these improvements. Some of the issues we identified indicated that the culture at the department needed to be addressed. Where there are cultural issues, the challenge of maintaining the impetus and embedding changes may be greater. In a health board that has previously faced challenges with quality governance, it was positive to note the beginnings of change and the progress made by the health board to improve and sustain those improvements. The work done on improving the culture, values and behaviours across the organisation is a positive step for the whole health board but one that will need continued focus to make sustainable change.

The concerns we received the most for Cwm Taf Morgannwg UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Hywel Dda University Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	2
Mental Health Hospital	2
Learning Disability	2
Hospital	2

Onsite	3
Hospital	2
IRMER	1

Within Hywel Dda University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Hywel Dda University Health Board working hard through difficult times to recover services following the early restrictions of the pandemic. Through our engagement with senior leaders in the health board and observing at quality and safety meetings, it has been evident that quality is clearly embedded in their approach to leading the health board, and we have seen a strong focus on a learning culture.

Difficulty in recruiting qualified staff continues to be a challenge for the health board, although there had been an increase in numbers of applicants for roles as healthcare support workers. The health board has continued

to tackle recruitment challenges through initiatives such as the use of an apprenticeship scheme, which enables people to work and gain healthcare qualifications. Resilience across their services has been fragile at times due to the staffing issues and compounded by the rurality and geographical spread of the health board and their hospitals. We note that senior leaders continue to plan and work proactively in an attempt to develop sustainable services for the future.

We carried out an offsite Quality Check of one of the health board's inpatient learning disability services and had significant concerns about the safety of the environment and the day-to-day management of risks in a service which was caring for vulnerable patients. The health board responded very quickly and constructively to the issues we identified and sped up their intention to discharge the patients to alternative placements. This action meant the service was empty and the health board did not admit any further patients for the remainder of the year while they worked to tackle the numerous service delivery issues that were present. We will continue to closely monitor the progress and re-opening of this service through our work and will consider further intervention and escalation if necessary. Through our partnership working with the Community Health Council (CHC), we were made aware of reports of poor patient experience within maternity services provided by the health board. The CHC ran a survey asking for experiences of maternity services within the health board. The results were mixed and saw several negative responses from patients. We engaged with the health board and have monitored their initial response to the issues; the challenge for them will be to fully embed the changes and maintain the momentum behind the improvements. We will continue to engage with the CHC to understand whether the patient experience within these services is improving and will consider future assurance work to check on the improvements in service delivery that have been made because of these interventions.

The concerns we received the most for Hywel Dda UHB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Self-harming behaviour**

Powys Teaching Health Board

Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	2
GP	2

Onsite	3
Hospital	1
CMHT	1

Within Powys Teaching Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period there have been several changes to senior leadership and management within the health board. This includes staff leaving, retiring, and undertaking secondments elsewhere within the organisation. Due to the level of recruitment, this is an area which may take time to stabilise, but it has been positive to note that the executive team is focusing on supporting and embedding leadership changes as a priority in support of their workforce and the continued delivery of frontline patient care.

There has been continued positive engagement with the leadership team, including regular and ongoing meetings with the Director of Nursing and Medical Director throughout the year.

Powys Teaching Health Board commissions a significant proportion of its services from providers in both England and Wales. There are arrangements in place to monitor the performance of the providers used to deliver services to Powys patients via a Commissioning Assurance Framework. However, some of the performance data was paused earlier in the COVID-19 pandemic, therefore this monitoring arrangement has not been fully functional throughout the year. As some services are provided by other health boards and trusts, the restarting of services has been variable, leading to a potential inconsistency and impact on Powys residents.

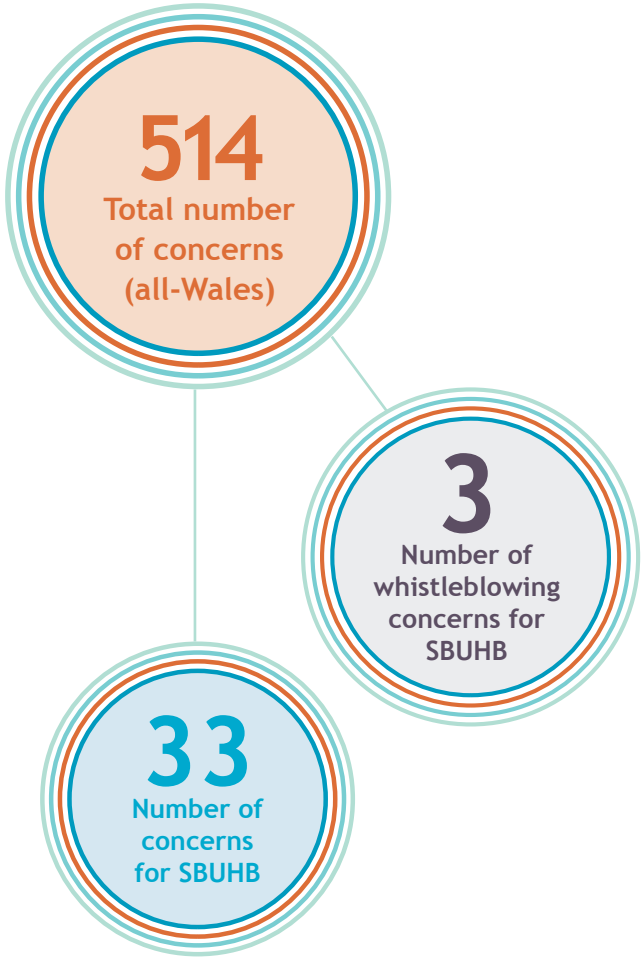
The health board has been monitoring this closely, reporting issues openly at quality, safety, and performance forums. We will continue to engage with the health board on this to ensure we remain up to date on this complex situation, and we will consider future work to better understand commissioning arrangements.

We undertook an onsite inspection to the mental health ward at Bronllys Hospital and identified that there had been limited improvements to some of the recommendations we had made at an inspection we carried out there in 2019. The lack of progress seemed to be particularly around the buildings and maintenance issues that we had identified. We urged the health board to improve their oversight of this area and make progress on these actions. Since then, it has been pleasing to observe updates provided by the health board to their quality and safety committee regarding the overall progress made against HIW recommendations and their subsequent completion.

The concerns we received the most for Powys THB related to:

- **Infrastructure (Staff facilities and the environment)**
- **Treatment / Procedure**
- **Clinical Assessment**

Swansea Bay University Health Board



Below is a breakdown of quality checks and onsite inspections that took place within the health board

Quality Checks	8
GP	5
Hospital	2
Learning Disability	1

Onsite	4
Learning Disability	1
Mental Health Hospital	1
IRMER	1
HMP	1

Within Swansea Bay University Health Board, during the 2021-2022 period, our work to seek assurance on the safety and quality of care within the health board comprised of a mix of Quality Checks and onsite inspections, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the health board developed over this time is a culmination of all the above sources of evidence.

During this period, we have seen evidence of Swansea Bay University Health Board working hard through difficult times to resolve the issues that have arisen from the pandemic and also in specific service areas where there have been particular challenges.

There have been changes in the executive team over a number of years, however, the health board has made new executive appointments, including a new CEO and Executive Nurse Director. We also note the positive impact of stability in the executive team will require time to achieve and will continue to monitor progress through our work.

As a result of negative findings from a previous HIW inspection to Morriston Hospital Emergency Department in January 2020, we undertook an offsite Quality Check to check on progress and to consider how the department was responding to the ongoing challenges of the pandemic. We found that there had been improvements made but a significant demand for emergency care and lack of capacity elsewhere in the hospital due to the high number of inpatients was continuing to be a challenge. We were concerned to find that the training data being maintained by the department was not up to date so we could not be assured that there was an appropriate number of trained staff covering the area. The health board responded positively to this challenge and was able to assure us of sufficient numbers of trained staff by providing additional evidence. Whilst this is one specific example, we noted that demand and capacity challenges were present in other areas, these can present immediate challenges and divert the focus away from longer term improvement work.We were pleased to see that the health board was continuing to look for solutions to demand and capacity issues, such as dedicating the Neath Port Talbot site for planned and elective surgical procedures, supporting a better flow of patients at acute sites and to ensure continued attempts to reduce lengthy waiting lists. We recognise this is an ongoing challenge for the health board which will need to support and maintain the resilience of its workforce to meet continued high demand.

We also carried out a review of the governance arrangements in place by the health board in the provision of healthcare services to the prison population in HMP Swansea. This review was as a result of previous concerns raised by Her Majesty's Inspectorate of Prisons (HMIP) regarding the prison. The evidence we gathered pointed to gaps in oversight by the health board and processes that were not robust enough to ensure an effective service was being provided. The health board responded constructively and positively to our findings on this and will need to continue working on the recommended actions in order to create and sustain improvement.

The concerns we received the most for Swansea Bay UHB related to:

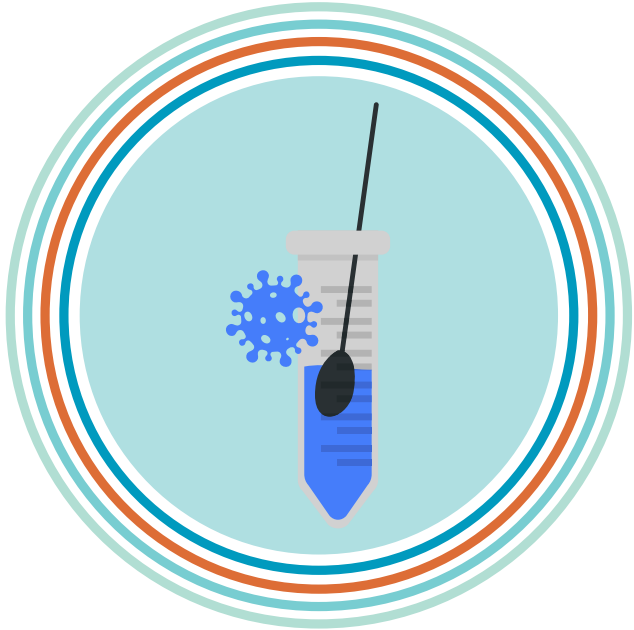
- **Infrastructure (Staff facilities and the environment)**
- **Safeguarding**
- **Clinical Assessment**

Public Health Wales

Within Public Health Wales, during the 2021–2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of consideration of the themes and trends arising from concerns, attendance at quality and safety meetings, engagement with the senior executive team, monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

During this period, we observed Public Health Wales providing an important contribution to the ongoing surveillance of COVID-19 rates and communication of this to the public. Health Improvement programmes demonstrated innovation to delivering services remotely. Valued work was undertaken to support schools and businesses look after the emotional and mental well-being of pupils and staff as the nation came out of the pandemic. The delivery of vital public health screening services provided by the trust continued to be impacted by the COVID-19 pandemic. We saw evidence of services working to overcome these challenges in line with agreed recovery plans. Dedicated resource has been invested to tackle demand for each service and find solutions to the loss of community facilities which were used to host clinics pre-pandemic.

We recognised improvements with the recovery of services such as bowel and cervical screening and activities operating at pre-pandemic capacities for services such as breast screening and abdominal aortic aneurysm screening. We have noted the trust has an open and constructive culture amongst their staff and senior leaders which is positive as they continue working post-COVID-19. Through our work and engagement with the trust we will continue to monitor these areas which have been a particular challenge and will consider undertaking assurance work to further investigate issues as appropriate.

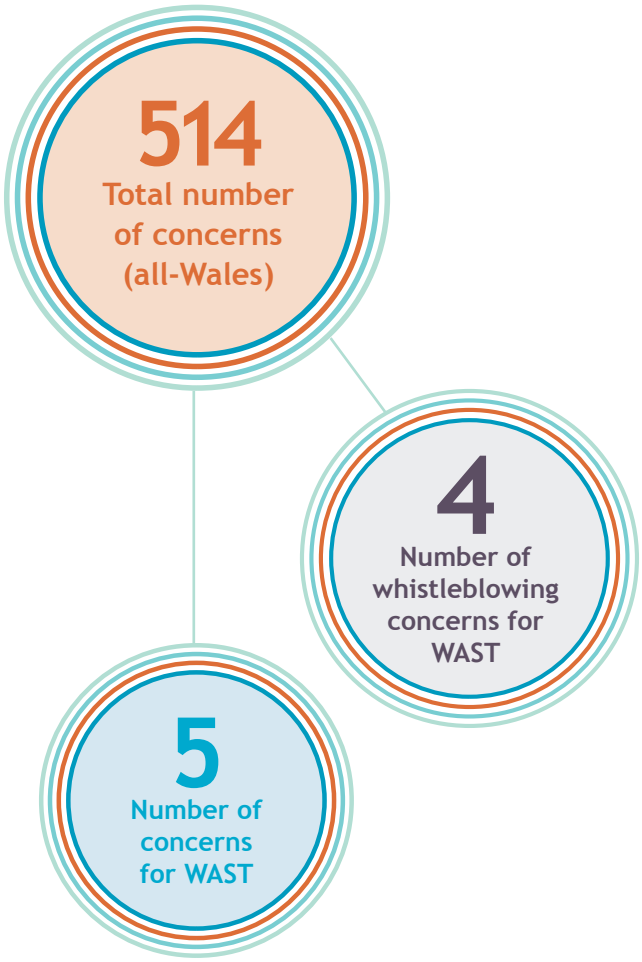


Velindre University NHS Trust

Our work to seek assurance on the safety and quality of care within Velindre University NHS Trust during the 2021–2022 period comprised of an offsite Quality Check of the inpatient service and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)].The view of the trust developed over this time is a culmination of all the above sources of evidence.

We saw evidence of Velindre University NHS Trust working very hard to maintain the services they provide through specialist cancer inpatient and outpatient services, and also across Wales through the Welsh Blood Service. COVID-19 remained the biggest risk to service delivery with staff absences, capacity reductions and increasing patient numbers impacting on the trusts ability to reduce waiting times for treatment and services such as radiotherapy. Attempts to undertake HIW assurance work at the trust were hindered by an increase in infections in early 2022. This work will now take place in 2022-2023 and will provide us with a sense of how services are recovering from the pandemic.

We noted the efforts of the Welsh Blood Service to build and sustain blood stocks throughout the pandemic. We noted evidence of the organisation continuing to plan for future service requirements and monitored progress with the Transforming Cancer Service Programme. We have seen transparent and constructive challenge taking place by independent members on all aspects of the trust at committee meetings.
Engagement between HIW and the executive team for the trust remains positive and constructive, with a welcome for the scrutiny we are able to provide.



Welsh Ambulance Services NHS Trust

During the 2021-2022 period, our work to seek assurance on the safety and quality of care within the trust comprised of the final part of our local review exploring the impact of patients being delayed on the back of ambulances, consideration of the themes and trends presented by concerns and whistleblowing reports received directly by us, and monitoring of data sets and intelligence shared with us from partner organisations who make up our National Healthcare Summit members [Healthcare Summit | Healthcare Inspectorate Wales (hiw.org.uk)]. The view of the trust developed over this time is a culmination of all the above sources of evidence.

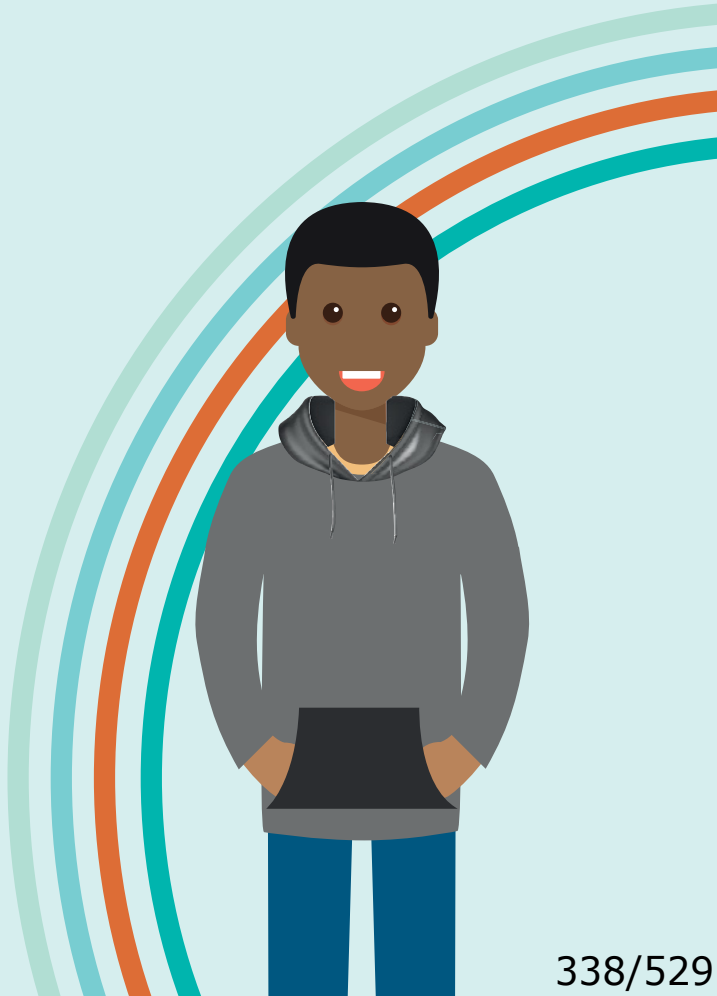
During this period, we noted the trust working through highly challenging times to provide their services and expertise across all parts of Wales.

Throughout the year the trust has been very open and honest with HIW, responding promptly to requests for information and data. We observed good levels of scrutiny and challenge at quality and safety meetings and have been assured that senior leaders seem to clearly recognise the issues they are facing and are committed to improvement. However, we also noted ongoing issues in service delivery despite this commitment to improvement.

Staffing has been a particular and significant challenge for the trust as it continues to see COVID-19 related absences impacting their workforce. Military personnel were brought in to support on community response vehicles and whilst this may have provided a temporary solution, once this resource is no longer available, the trust will need to continue to find solutions to their workforce challenge. We realise that this will not be simple to resolve and we will continue to monitor the trust's approach to service design and workforce planning through our work.

Our local review of patient experience whilst waiting in the back of ambulances found a number of examples where delays in handover had impacted extremely negatively on patients, but also on the ambulance staff providing their care. Staff told us that they were frustrated to find themselves waiting for long periods of time, sometimes entire shifts, waiting outside a hospital to transfer a patient and felt demoralised at not being able to provide care to patients in need of their help within the community. Whilst patients reported being cared for well by the ambulance staff who looked after them, they did not report positively about the length of time spent in the ambulance environment.

We made several recommendations through our review which we recognised were a substantial challenge to the trust and wider NHS system, however, to improve patient safety and tackle the impact on staff well-being, these recommendations must be acted on. The challenge for the trust will be the need to collaborate with health boards across Wales, all of whom have their own unique features and challenges. Supporting the well-being of ambulance staff who provide direct patient care and have direct contact with patients as call handlers will need to be of the utmost priority to the trust as it continues working on the recommendations and through this challenging time.



To be more visible

Collaboration and Engagement

Collaboration and joint working with other organisations are an integral part of the way in which we work. This year we continued to build on the strong relationships we have in place with our partners, once again acknowledging the additional insight this provided and the positive impact on our work that this gave us.

Collaboration

We continued to work with partners to explore how we can share data and intelligence. This included hosting two Healthcare Summits, in May and November 2021.

The summits were attended by the key regulatory and improvement bodies for healthcare in Wales. We agreed a collective view on the key national issues and risks across Wales, for example access to Child and Adolescent Mental Health Services (CAMHS). We shared these concerns, on behalf of all partners, with the NHS Wales Chief Executive. The purpose of this was to help us better understand what improvement action is underway at a national level. This forum continued to be a rich and valuable source of information and route for information sharing. We also started working with partners to develop a new mechanism, for members of the Healthcare Summit to share emerging serious patient safety risks and concerns across the sector. The work to develop this new mechanism will continue into 2022-2023.

During the year we continued to work closely with our partner, Care Inspectorate Wales (CIW).

In March 2022 we jointly published our report into the use of Deprivation of Liberty Safeguards (DoLS) in Wales. The safeguards apply to people over the age of 18 in hospitals or care homes, who cannot consent to treatment or care. We worked alongside CIW again, plus Her Majesty's Inspectorates of Probation (HMIP) and of Constabulary and Fire Services (HMICFRS), as well as Estyn, the education and training inspectorate for Wales to review the child protection arrangements in place in the Neath Port Talbot area.

We also work closely with Audit Wales, and in May 2021 we published a report providing detail on the progress made by Cwm Taf Morgannwg University Health Board in addressing the recommendations from our 2019 joint review into their governance arrangements. HIW's clinical team has been actively working in collaboration with training providers and professional organisations to support training delivered by the General Medical Council and to pre-registration nursing students. This supports greater awareness and understanding of the role of HIW in Wales. The clinical team has also been sharing good practice we have identified through our inspection work by signposting health board teams to the services they can approach to learn from.

Engagement

Speaking and listening to people who use healthcare services and who work within healthcare services is of the highest priority to us. By doing this, we can better understand what matters to people and can gain a greater understanding of the culture within a service and insight into the experience patients receive.

During our inspection and review work we ask patients to tell us about the care they receive by completing a short survey, and when we are able to speak to patients in person during onsite visits, we gather views directly. This year, for example, we used a short engaging video on social media to help explain our National Review of Patient Flow and to encourage people to tell us about their personal experience, or the experience of their loved ones if they have been treated for a stroke. In January 2022, we launched a refreshed area on our website, keeping all our surveys in one place and making it easier for people to find out what active work we have ongoing, and provide their comments. Work on our 2022-2025 strategy was a key focus during the year and as part of this we undertook two large scale online surveys open to stakeholders and the public. We used these surveys to help shape our future direction through the increased understanding the responses gave us about the impact of our work on people and services.

In February 2022, we increased our social media presence and launched on LinkedIn. We recognised this as an important additional avenue for engagement with healthcare professionals. We have continued to use Twitter and Facebook to engage widely with social media users about our work, encouraging people to click through to our website where they can find out more about our work and role in Wales. Across our digital platforms we have seen an increase in engagement with a higher number of impressions and a wider reach of our content.

We also developed a new methodology for onsite inspections of Mental Health Units. One important change in this area is the implementation of a process to use questionnaires for patients, staff, friends, and family members. This will increase our engagement with people who use mental health services and those who work within them.

In response to previous feedback from the public that our reports can be hard to understand, we concluded a project to implement a new reporting style for onsite inspections. This new approach was implemented in April 2022 and involves publishing a public summary and a full detailed report for the setting. We also reviewed how we report to remove unnecessary duplication and make the reports easier to read. The outcome of this will be reports that are easier to understand and engage with.

To develop our people and our organisation to do the best job possible

Internal Update

Although the last year has been one of significant change, we have continued to invest in the development of HIW and its people in order to ensure we monitor and check that people in Wales are receiving good quality healthcare. We introduced many new ways of working to continue to fulfil our organisational functions, whilst being flexible to any emerging risks. People are at the heart of what we do, and it is important we strive to share lessons learnt, reflect on what has worked well and take forward this learning to continuously improve.

We listened to and supported the well-being of our people to enable them and our organisation to do the best possible job and keep our communities safe and well. Our Corporate Service department developed a bespoke Learning and Development programme for our staff, tailoring unique opportunities to enable our workforce to build on vital skills. Following the launch and implementation of our internal Well-being Strategy our staff survey scores have shown clear signs of improvement across our key themes including inclusion, leadership and change.

We have also recruited to several new roles including Mental Health Act and peer reviewers to strengthen our access to clinical expertise alongside developing a professional pathway f or all our HIW inspectors. Over the past 12 months we have recruited a number of peer reviewers with experience in specialised nursing roles including stroke and child and adolescent mental health.

We implemented a new Customer Relationship Management system in March 2022. The new system replaced many of our existing spreadsheets and documentation. The system has been successfully rolled out and allows our staff to use data and information more effectively and efficiently to strengthen our ability to generate intelligence and insight. We have continued to work with partners to explore how we can share data and intelligence. This includes early collaborative work to develop a new process for healthcare organisations and partners in Wales to share serious patient safety risks and concerns across the sector.
We have held regular staff forums to discuss lessons learnt, areas of improvement and empower our workforce to have their say. The forum and anonymous staff suggestion box are monitored and fed back to senior leadership, where ideas, concerns and proposals are reviewed and actioned.

Commitment Matrix

The following table is a list of the objectives HIW set itself for 2021-2022, together with details of how we met the objective.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 1		
Process applications to register, or changes to registration, in a timely manner. Ensure all applicants can demonstrate they meet relevant regulation and minimum standards.	Registration applications determined within 12 weeks of full and complete submission.	The following registration work was completed during 2021-2022 **Independent Healthcare Services** • 44 New Registrations • 28 Changes of Registered Managers • 12 Changes of Responsible Individuals • 22 Variations of HIW Registration Conditions **Private Dental Practices** • 14 New Registrations • 37 Changes of Registered Managers • 12 Changes of Responsible Individuals • 1 Variation of HIW Registration Conditions

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 2		
Conduct a programme of visits to suspected unregistered providers as required. Deliver a programme of assurance and inspection work on independent settings in line with our frequency rules. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of visits undertaken. Number of Quality Checks undertaken. Number of reports published four weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where urgent action is required, following assurance working the independent sector, the service will be issued with a Non-Compliance Notice within two days.	We carried out three visits to unregistered providers. We carried out 91 Quality Checks of independent services. We carried out 34 onsite inspections of independent services. We published 91 Quality Checks during 2021-2022. 75 of these were published within four weeks. We published 34 onsite inspections reports during 2021-2022. 28 of these were published within three months following the inspection. We issued 16 Non-Compliance Notices.

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
Ensure that concerns and Regulation 30/31 notifications are dealt with in a timely and professional manner.	Number of concerns received. Number of Regulation 30/31 notifications received. Analysis of source and action taken.	During 2021-2022 we received 144 concerns from the public or staff. We also received 16 concerns in relation to unregistered providers or settings that do not require registration with HIW. All concerns are reviewed and evaluated on a weekly basis and inform decisions about our inspection activities and priorities. Independent healthcare providers are required to inform us of significant events and developments in their service. These Regulation 30/31 notifications continue to be managed in line with our process and dealt with effectively. In total we received 1,484 Regulation 30/31 notifications. A breakdown of the notifications are as follows: • Death in Hospice – 604 • Death excluding Hospice -28 • Unauthorised absence – 90 • Serious injuries – 483 • Allegation of staff misconduct – 156 • Outbreak of Infectious Disease – 100 • Deprivation of Liberty Safeguards (DoLs) – 23

What we said	Measured by	Outcome
Regulating independent healthcare		
Deliverable 3		
		In total we received 156 Regulation 25 (The Private Dentistry (Wales) Regulations 2017) notifications during 2021-2022. They are as follows: • Serious injuries – 8 • Outbreak of an Infectious Disease – 147 • Allegation of staff misconduct – 1 • Death of a patient – 0 All notifications were evaluated, and additional assurances were sought where necessary.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 4		
Deliver a programme of assurance and inspection work in the NHS across all settings informed by analysis of risk and how our resources are best deployed. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety.	Number of Quality Checks undertaken. Number of reports published five weeks following Quality Check. Number of full inspections undertaken. Number of reports published three months following an inspection. Where immediate assurance is required following an NHS assurance process, letters will be issued to the Chief Executive of the organisation within two days.	We carried out the following Quality Checks and inspections: **Quality Checks** 25 GP 10 NHS Hospital 5 NHS Mental Health Hospitals 8 Learning Disability 1 Step Down Community Hospital **Onsite Inspections** 8 NHS Hospitals 7 NHS Mental Health Hospitals 5 Learning Disability 6 IR(ME)R We published 49 Quality Checks during 2021-2022. 26 of these were published within four weeks. We published 23 onsite inspection reports during 2021-2022. 17 of these were published within three months following the inspection. We issued 12 out of 14 Immediate Assurance letters within two days of inspection/Quality Check.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 5		
Continue our programme of reviews including: • Mental health crisis prevention in the community. • Medicines management review. • Focused local reviews; one of these will be a local review of WAST. That will consider thesafety, dignity, well-being and overall experience of patients whilst waiting in ambulances at hospital emergency departments. • COVID-19: Themes and learning from our work. Undertake follow-up work on previously published local or national reviews, including: • Phase one of our National Review of Maternity Services. • Review of Patient Discharge from hospital to GP Practices. • Review of Integrated Care: Focus on Falls. • Substance Misuse Services in Wales. • WAST – Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centers. • PHW – Assessment of how the breast screening process is managed in a timely manner for women who have an abnormal screening mammogram.	Analysis, production and publication of the review. Publication of terms of reference for these reviews. Commence programme of follow up work.	During the year we published: • COVID-19 National Review • National Review of Mental Health Crisis Prevention in the Community • Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover We also completed our local review of Governance Arrangements at Swansea Bay University Health Board for the Provision of Healthcare services to Her Majesty's Prison Swansea. We started work on our National Review of Patient Flow (Stroke Pathway) and Local Review of Discharge Arrangements for Adult Patients from Inpatient Mental Health Services in Cwm Taf Morgannwg University Health Board.

What we said	Measured by	Outcome
Inspecting the NHS		
Deliverable 6		
Conduct a high-level review of each NHS body through: • Further development of the Relationship Management function. • Producing an annual statement for each health board and NHS trust.	Publication of health board and NHS trust annual statements.	As part of our 2021-2022 annual report, we have undertaken a high level review of each NHS health board and trust. We have produced a statement for each health board and trust, and these can be found in the *'To take action when standards are not met'* section of this report.

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 7		
Undertake a programme of assurance and inspection work on NHS, independent mental health and learning disability settings. Continue to plan and deliver the rest of our work programme in areas where we believe there is the highest level of risk to patient safety. Undertake a minimum of one piece of Learning Disability assurance work in each Health Board area in this inspection year.	Number of assurance and inspection activities undertaken.	During 2021-2022, we undertook the following assurance and inspection work across NHS, independent mental health and learning disability settings: **Quality Checks** • 5 NHS Mental Health Hospitals • 8 Learning Disability **Inspections** • 14 Independent Mental Health Hospitals • 7 NHS Mental Health Hospitals • 5 Learning Disability

What we said	Measured by	Outcome
Our work in mental health		
Deliverable 8		
Provide a Second Opinion Appointed Doctor service for approximately 1000 SOAD requests.	Publication of Key Performance Indicators.	The SOAD services undertook 759 case reviews. These were: • 657 – Medication • 66 – ECT • 36 – Medication and ECT

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 9		
Publish reports from all our assurance activity in accordance with our performance standards.	Publication of reports according to our Publication Schedule. Publication of HIW performance against targets. Publication of Annual Report for 2020-2021.	We published 140 Quality Checks during 2021-2022. 101 of these were published within four weeks. We published 57 inspection reports during 2021-2022. 45 of these were published within three months following the inspection.

What we said	Measured by	Outcome
Sharing what we find		
Deliverable 10		
To actively share our findings and recommendations with stakeholders, service providers and the public to influence and drive improvements in healthcare. In particular in relation to: • Hospital Assurance activity • GP Practices • Dental Practices • Mental Health Act Annual Monitoring Report • Deprivation of Liberty Safeguards (DOLS) • IR(ME)R • Lasers • HIW Annual Report	Publication and dissemination of our findings in a number of ways including: Learning bulletins distributed. Case studies of good practice distributed. Improved website content.	We held regular workshops with Community Health Councils and quarterly summits key stakeholders for the NHS and independent healthcare sector. We issued 19 newsletters throughout the year ranging from updates and guidance to dental practices, winter update to stakeholders, and monthly newsletters. We have supported improvements to our website in 2021-2022 including: • created a new surveys section on our website. • created a new social media feature on our website. • Made regular improvements to the functionality of the website to provide a better user experience including engaging features, streamlined navigation tools and the use of branded imagery.

What we said	Measured by	Outcome
Working with others		
Deliverable 11		
Continue our joint inspection work with UK agencies. Details to be agreed on a quarterly basis.	Number of inspections undertaken.	We carried out 15 death in custody investigations. We undertook two prison inspections with HMI Prisons and HMI Probation.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
Continue working with other agencies on inspections and influencing best practice. Our five planned reviews with other Inspection Wales and Her Majesty's Inspectorate services are: • Review of Health Board and Trust Quality Governance arrangements (Governance reviews with Audit Wales).	Participation in joint work. Consolidation of the key findings and emerging themes from our joint work, and consider how these can inform our future work programmes.	CIW had involvement in design of work through our stakeholder group for our Mental Health Crisis review. We continued to work with Audit Wales to review Health Board and Trust Quality Governance arrangements. We undertook a JICPA second pilot review with all relevant agencies of child protection arrangements.

What we said	Measured by	Outcome
Working with others		
Deliverable 12		
• CIW providing support to our Mental Health Crisis Prevention review. • Joint Inspectorate of Child Protection Arrangements (JICPA) review (with CIW, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, Her Majesty's Inspectorate of Probation (HMI Probation) and Estyn). • Supporting HMI Probation with their joint thematic inspection of community-based drug treatment and recovery work with probation service users (for intelligence to support our Mental Health Crisis Prevention review). • Supporting HMI Prisons with their inspections of prison services in Wales. • Work with the Welsh Government, Care Inspectorate Wales and other stakeholders to review the effectiveness of Regional Partnership Board joint working.		HIW, CIW and Estyn submitted a joint business case to Welsh Government to secure additional funding to continue our JICPA work, to enable us to review processes within a further four local authorities across Wales. Within the plan, we would conclude the work undertaken in six local authorities and will evaluate all JICPA reviews undertaken to produce a national picture within a report, which would be published in summer 2024 once all work is complete. A provisional agreement is now in place for the funding early in quarter one of 2022-2023. HIW continued to work closely with CIW and Welsh Government to undertake work with and assess the effectiveness of the regional partnership boards. Our newly appointed Director of Strategy and Engagement will be leading this work through work with the partnership boards and providing regular updates to our review steering board.

Our priorities for 2022-2025

Healthcare exists for people and communities, and the work we carry out looks at whether it meets the needs of a community and whether it is of a good quality. Where we find inequalities in healthcare provision, where a service is not designed for the needs of the community it serves, we will challenge this.

Equality and diversity is embedded in the work we do and we consider how healthcare services reach those who face the greatest barriers to accessing quality healthcare.

Our responsibilities in relation to mental health span both the NHS and the independent sector. HIW also works with other review and inspectorate bodies to consider the quality of healthcare delivered in non-healthcare settings such as prisons.

As we head into the next three years we will be working to our new strategy.

Our goal is:

To be a trusted voice which influences and drives improvement in healthcare.

These priorities will help us to consider whether healthcare meets the needs of a community and whether it is of a good quality. Equality and diversity will be core to the work we do and our strategy supports us to consider how healthcare services reach those who face the greatest barriers to access, and poorest outcomes in health.

Our Resources

For 2021-2022 we had a budget of approximately £4.3m. Although the pandemic impacted our ability to deliver a full programme of onsite activity, we continued to make use of our new method for gaining assurance offsite, known as a Quality Check, where appropriate. We strengthened this approach during 2021-2022 following an evaluation of its effectiveness and suitability for its use beyond the pandemic. However, we continued to respond to emerging in-year intelligence which gave us immediate cause for concern or where the risk to patient safety was such that onsite activity was the most appropriate method for gaining assurance.

We have posts equivalent to approximately 83 full-time equivalent staff. We currently have a panel of over 200 specialist peer reviewers with backgrounds including specialist and general nurses, GPs, dentists, anaesthetists, and GP practice managers. We also have specialists in Mental Health Act Administration and a panel of psychiatrists who provide our Second Opinion Appointed Doctor (SOAD) service. We have over 30 Patient Experience Reviewers and Experts by Experience.

The table shows the number of full or part time posts in each team within HIW during 2021-2022.

Team	Whole time posts
Senior Executive	3
Inspection, Regulation and Concerns	39
Partnerships, Intelligence, and Methodology	14
Strategy, Policy and Communication	5
Clinical advice (including SOAD service)	4
Corporate Services (including business support)	18
Total	83

Finance

The table shows how we used the financial resources available to us in the last financial year to deliver our 2021-2022 Operational Plan.

	£000's
HIW Total Budget	**£4,376,000**

Expenditure	£000's
Staff costs	**3,882,624**
Travel and Subsistence	**13,150**
Learning & Development	**18,883**
Non staff costs	**45,944**
Translation	**59,939**
Reviewer costs	**414,358**
ICT Change Program costs	**333,816**
ICT Non CRM costs	**15,102**
Depreciation of assets	**13,866**
Total expenditure (a) £	**4,797,682**

Income	£000's
Independent healthcare	**311,790**
Private dental registrations	**241,900**
Total income (b) £	**553,690**
Total Net Expenditure (a-b) £	**4,243,992**

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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Chief Executives and Chairs
NHS Health Boards and Trusts Wales
Via Email

23 September 2022

Dear Chief Executive and Chair

EMBARGO: Healthcare Inspectorate Wales (HIW) 2021-2021 Annual Report - Publication

I would like to inform you that HIW will be publishing its latest annual report at 00:01 on Wednesday 28 September. You will find an embargoed copy of our report attached.

Our annual report summarises the findings from all our activities during 2021-2022, including our inspection and assurance work. This annual report also sees us scrutinise our own performance as an organisation against our strategic priorities. I would like to take this opportunity to thank you for your continued collaboration with the organisation during the year in question, our positive relationships continue to be extremely important to me in developing the organisation so that it can have the greatest impact.

Overall, we have found the quality of care provided across Wales over the past year has been of a good standard. Through our work we found healthcare services continue to be under sustained pressure from the impact of the COVID-19 pandemic. Healthcare services are continuing to work hard on recovery to restore services which had been paused, whilst continuing to deal with emerging variants and outbreaks. I once again commend the strength and resilience shown by staff working at all levels within healthcare services, who continue to deliver care and treatment in the best way they can, despite the many challenges they face daily.

Your HIW Relationship Manager will discuss with you the findings that specifically relate to your health board or trust, and will have made arrangements with you to present the findings to the Board. However, should you wish to follow up on anything contained within the report then please do get in touch with either them or me directly.

If you have any questions, comments, ideas or feedback on our work in general, please do get in touch with us – we would love to hear from you.

Yours sincerely

Alun Jones
Chief Executive
Healthcare Inspectorate Wales

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GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 6th December 2022 Agenda Item: 4.8

National Clinical Audit Activity Report

Executive Summary

The National Clinical Audit (NCA) programme ensures results are published and discussed at Clinical Standards and Effectiveness Group (CSEG). Minutes are attached for the audits presented at CSEG in September (2022), namely:

- National Paediatric Diabetes Audit (NPDA) results 2020/21 along with the details of the Diabetes Quality Programme Self-Assessment
- National Heart Failure Audit (NHFA)

The November SEG meeting will include presentations from:

- National Clinical Audit of Psychosis (NCAP)
- National Cardiac Audit Programme (NICOR) – called 'The Heart in Lockdown' report published in June 2022. This focuses on the impact of cardiovascular services during the first year of the COVID-19 pandemic. NICOR comprises six domains, (two not relevant in ABUHB), each concerned with a particular cardiovascular disease area or treatment, individual reports are published:
    - The Myocardial Ischaemia National Audit Project (MINAP)
    - The National Audit of Percutaneous Coronary Interventions (NAPCI)
    - The National Heart Failure Audit (NHFA)
    - The National Audit of Cardiac Rhythm Management (NACRM)

ABUHB have not participated in the National Audit of Dementia (NAD) - Memory Assessment Services Spotlight Audit 2021. However, round five of the National Audit of Dementia is currently underway across the Health Board.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	X
Note the Report for Information Only	
Executive Sponsor: Dr James Calvert, Medical Director	
Report Author: Joanne Stimpson / Leeanne Lewis	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 05/10/2022			

Supplementary Papers Attached:

- Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 24th September 2022 at 14:00-16:00
- AMaT roll out
- Clinical Audit Strategy

Purpose of the Report

National Clinical Audit (NCA) demonstrates healthcare is being provided in line with national standards and guidance. It provides assurance to an organisation and enables learning. It reassures patients, knowing the performance of services are being measured and monitored. The findings from NCAs produces recommendations that enable patient safety and quality to be improved. The findings and action plan from audit reports are presented to the Clinical Standards and Effectiveness Group. The results and actions are presented to the Patient, Quality and Safety Outcomes Committee as part of the assurances processes required by Welsh Government to be taken internally by all Welsh Health Boards.

Background and Context

The National Clinical Audit and Outcome Review Plan (NCAORP) is published by Welsh Government annually. Publishing of NCAORP ceased during the Covid-19 pandemic. NCAORP confirms the list of National Clinical Audits that require mandatory participation by the Health Board. It specifies how findings from audits and reviews should be used to measure and drive forward improvements in healthcare in Wales.

Welsh Health Boards and Trusts are required to ensure sufficient resources to undertake participation in all audits, reviews and national registries. To ensure completion of the full audit cycle the Health Board's findings and recommendations from audit must link directly into the quality improvement programme and inform changes to improve patient care and outcomes.

In order to ensure maximum benefit is derived from the clinical audit programme Health Boards and Trusts should:

- Ensure the necessary resources, governance and organisational structures are in place to support complete engagement in audits, reviews and national registries included in the annual Plan.
- Appoint a Clinical Lead to act as a champion and point of contact for every National Clinical Audit and Outcome Review which the Health Board is participating in.
- Ensure Divisional Triumvirates are sighted on all relevant documents as well as the Clinical Lead.
- Ensure there is a formally recognised process for reviewing the organisations performance when reports are published. This review should include consideration of improvements (planned and delivered) and an escalation process to ensure the Board is made aware when issues around participation, improvement and risk identification against recommendation are identified.
- Have clear lines of communication which ensures full Board engagement in the consideration of audit results and review of findings and, where required, the change process to ensure improvements in the quality and safety of services take place.

- Facilitate the wider use of data from audit and national registries to be used as supporting information for medical revalidation and peer review.
- Ensure learning from audit and review is shared across the organisation and communicated to staff and patients.

Assessment and Conclusion

Audit is a vital part of healthcare, helping to improve patient care, manage risk, and to comply with Welsh Government reporting requirements. The audit process can be time-consuming, labour-intensive, and often slow to deliver results. Clinical audit is mandatory and must be a priority for directorates. The updated Clinical Audit Strategy is due to be published and provides the Strategic Direction for clinical audit for the Health Board. The strategy sets out the Health Board's commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.

To facilitate effective participation in audit, clinical teams need to dedicate time to support the clinical audit strategy. For positive audit results that meet targets or are within the recommended WG parameters we should acknowledge and celebrate success amongst teams. For results that deviate from national targets or are outliers with other Health Boards or Trusts, a detailed action plan is needed to document how the directorate will improve results or outcomes.

The purchase of the web-based system AMaT (Audit Management and Tracking) will make auditing easier, faster, and more effective. Key benefits include simple management of audits, easy management of reaudits, visibility of noncompliance and areas of focus for future improvement projects. The QPS team will work in collaboration with Clinical Audit leads to utilise AMaT to its full capabilities. This will allow tracking of results and an action plan to be produced with measurable improvements within a specified timeframe. Using AMaT Clinical Directors will be empowered to undertake audits more effectively and enable presentation of data as a dashboard system and easy-to-read graphical presentations. This will improve engagement with the clinical directors, QPS audit team and CSEG.

ABUHB is in the process of training staff to use AMaT, currently 90 users are registered. All National Clinical Audits are to be registered. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with relevant documentation uploaded and allocated an audit lead. The Clinical Lead is the audit mentor for the specialty of the NCA. Defined objectives are identified and are time specific for the audit period. AMaT can also have NICE guidance and local guidance added, if appropriate. There are currently 35 audits registered in the Clinical Audit area on AMaT. See Appendix for more information.

With the introduction of AMaT, there will be positive engagement for participation in audit. Audit should be mandatory and non-performance must be challenged. AMaT will facilitate clinical audit and provide an oversight of the data. This will improve accountability for clinical audits, developing a clear action plan and allow tracking of actions, providing assurance to the Committee and Board.

Going forward there will be a standardised approach to reporting audit findings. These will be reported under:

- Areas where good practice has been identified
- Areas of where practice requires improvement
- Actions to be taken - using SMART objectives

Recommendation
The committee is asked to acknowledge that we are working towards implementing the Clinical Audit Strategy. Work is underway to train staff to use AMaT. Use of the database will provide assurance that each of the National Clinical Audits has been undertaken. A clear action plan will be developed and owned by the Directorate, working with the QPS team and CSEG.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight clinical risks in the system. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	Advice will be obtained from the Workforce and OD Directorate about how the Impact Assessment is carried out for this report.
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 –	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.

5 ways of working	**Integration** – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain.

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held on Thursday, 24th September 2022 at 14:00-16:00, via Microsoft Teams

In attendance:
Dr Leo Pinto - Asst Medical Director for Clinical Effectiveness (Chair)
Joanne Stimpson - Quality & Patient Safety Lead for NCA
Anita Goff - Lead Nurse H&C Standards, Quality & Patient Safety
Grace Hargreaves - Assistant Risk Manager, Risk Management
Tom Morgan Jones - Divisional Director SC & Consultant Anaesthetist
Caroline Rowlands - Deputy Head of Nursing, QPS and Nurse Education
Susan Dinsdale – Asst Divisional Nurse – Family & Therapies
Jonathan Sims - Clinical Director of Pharmacy
Tom Grace - MCA Lead / Head - Deprivation of Liberty Safeguarding
Sarah Cadman - Head of Quality & Improvement, MH&LD
Guests:
James Stevens - Cardiology Clinical IT Manager
Davida Hawkes – Consultant Paediatrician
Linda Edmunds – Consultant Nurse, Cardiac Rehabilitation

Apologies:
Emily Knight - Clinical Effectiveness and Formulary Pharmacist

CSEG 2409/01 Welcome and Introductions
The Chair welcomed everyone to the meeting.

The Group was happy for the meeting to be recorded via Microsoft Teams.

Apologies for Absence
As above.

Declarations of Interest
There were no declarations made of potential conflicts of interest by those attending the meeting.

Draft Minutes of the Meeting held on 23rd June 2022

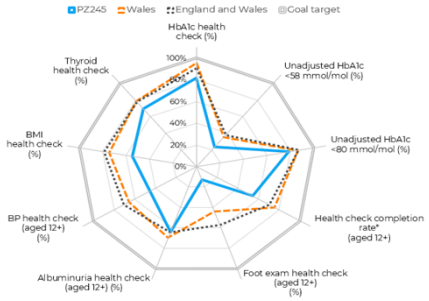
The draft minutes of the meeting held on 23rd June 2022 were considered by the group and agreed as an accurate record and outstanding actions discussed.

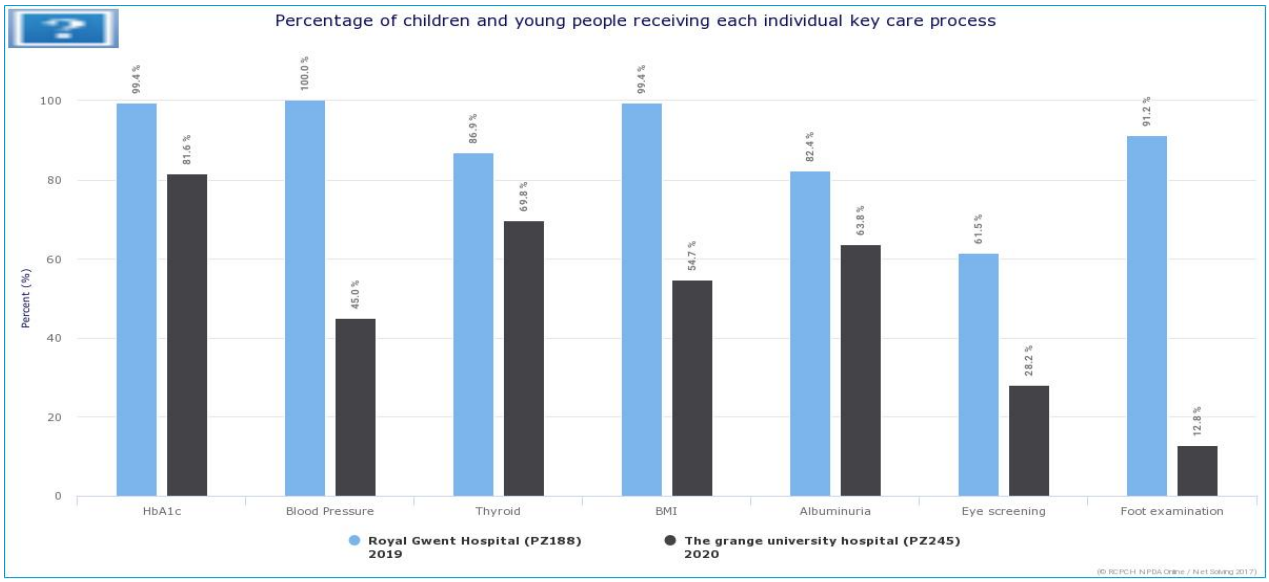
CSEG 2409/02 National Paediatric Diabetes Audit (NPDA) results 2020/21

Dr Davida Hawkes, Consultant Paediatrician and Clinical Lead for the Paediatric Diabetes Service presented the results of the 2020/2021 report stating that the HB has always been one of the better performing units in Wales, however pre-covid results were disappointing as were the results for certain elements of this audit period. Data has already been submitted for 2021/2022. Dr Hawkes informed the group of the context of the audit and the importance of accurate data recording. This was the first reporting of single unit data for GUH, previously reporting NHH and RGH, the comparison is made to RGH having much of the activity.

The 6 Key health checks are:

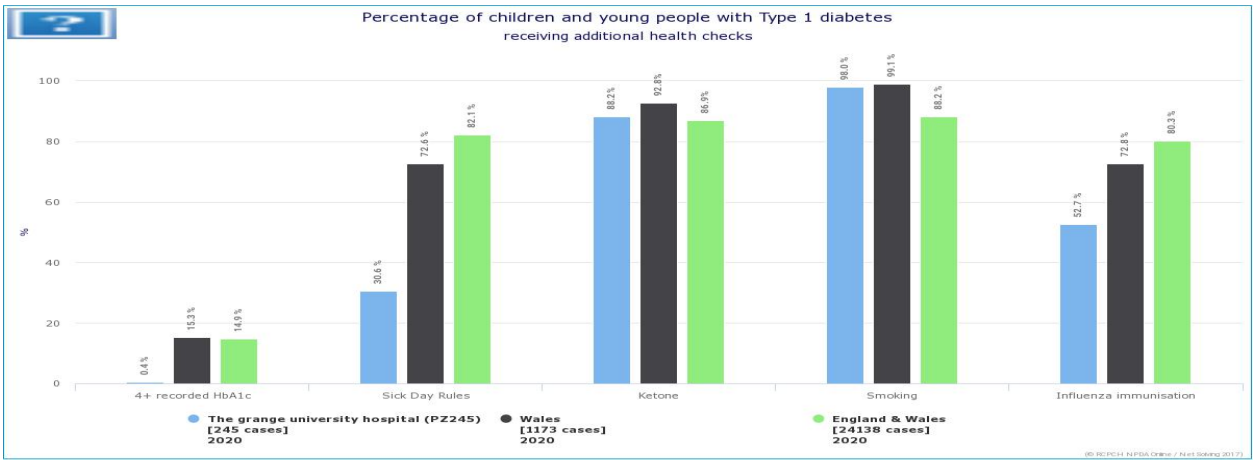
1. HbA1c
2. Blood Pressure
3. Thyroid function
4. BMI
5. Albuminuria
6. Foot examination



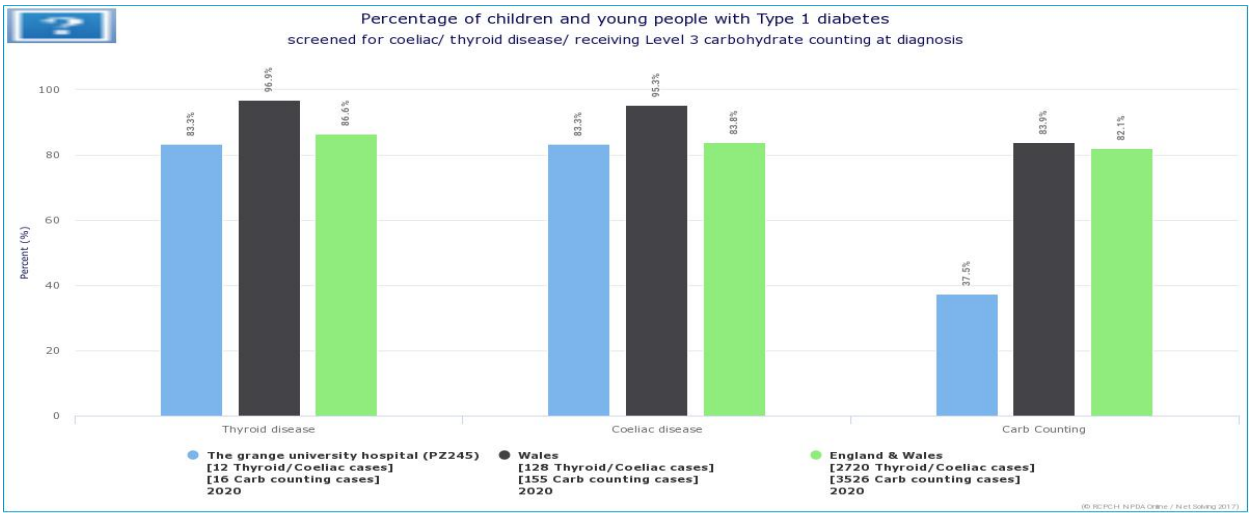


The graph above demonstrates the reduction in performance from 2019 to 2020 for ABUHB for the above key health checks. Undoubtedly this is due to not seeing children Face to Face (F2F) which remains a problem within the service and holds a significant risk.

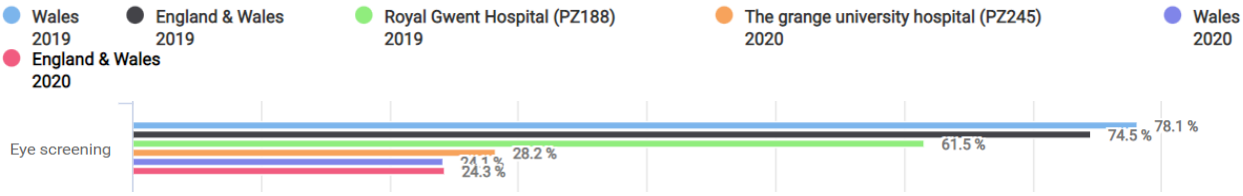
Children and Young people with T1D should have at least 4 HbA1c recorded, which below demonstrates that ABUHB are 0.4% compared to Wales 15.3% and UK rate of 14.9%, this is linked with not seeing the patients F2F.
The Sick Day Rules is affected by data entry and should be 100% so discussions are required with the team, all children have Ketone monitors, and the smoking status is completed by the nurses and the Influenza Immunisation is on the clinic letters so this should also be 100%.



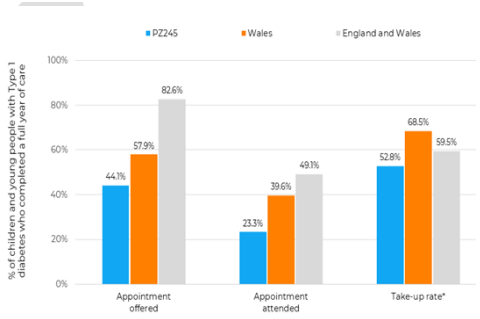
Thyroid and Celiac Disease blood screening has been worked on by community nurses, however our performance has reduced from the previous year (2019 100% for both measures) and behind the Welsh standard for 2020.
Carb Counting is a data entry deficit as all children carb count from diagnosis.

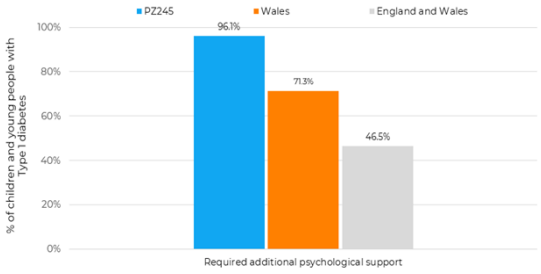


The data below shows Eye Screening was drastically reduced during 2020 and outside of ABUHB control as managed by the Diabetic Retinopathy Screening Service who halted screening during the pandemic.



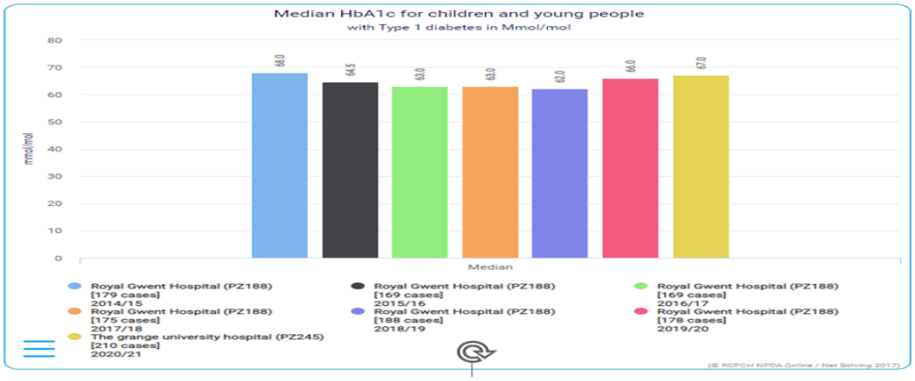
The % of children and young people with Type 1 diabetes with a complete year of care who were offered an additional dietetic appointment, who attended an additional dietetic appointment, and the proportion who were offered and subsequently attended an appointment (take-up rate) ABUHB are lower than Wales and UK.



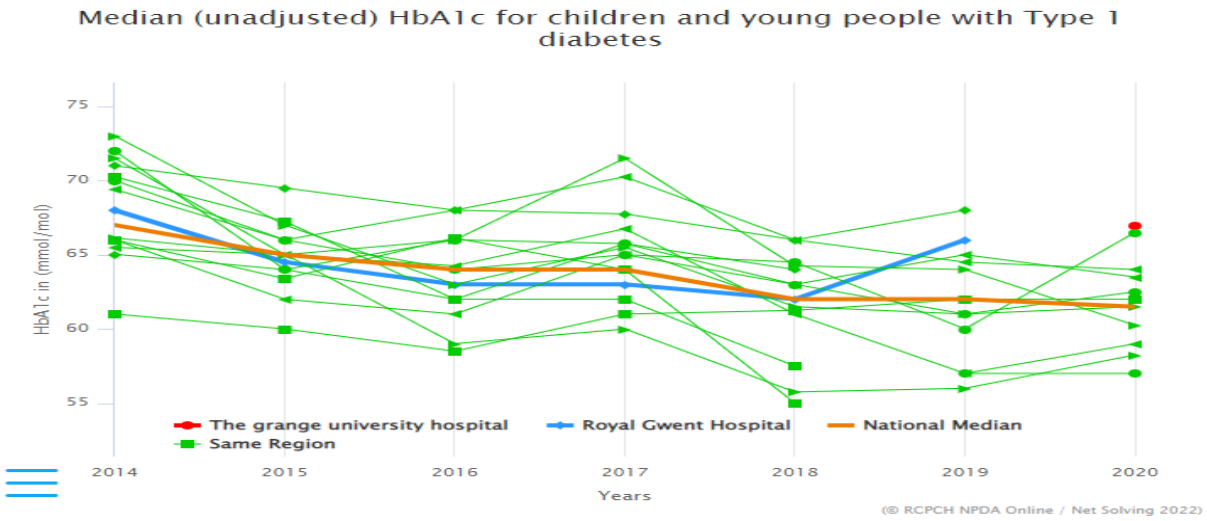


19.1% of Children and young people in GUH were recorded as having a psychological screening assessment, of those 96.1% were recorded as requiring additional support, however this is impacted by the psychologists not being available.

The NPDA recommends tracking year-on-year unit level HbA1c results using the median, as this is less affected by extreme high or low values and since local case mix is unlikely to vary significantly between audit years.



Each year the figures have progressively reduced however due to some mitigating factors, consultant absence and gaps in Dietetic, nursing and psychology so never having a complete MDT. There have also been problems with the booking centre, a lot of children were lost to follow up and the move to virtual clinics which worked well in the early days of the pandemic with all family members at home, however when work and school returned the virtual clinic didn't work. During the pandemic there were drive though clinics set up in various locations, due to the easy of driving through, it was time consuming, however these have stopped for unknown reasons.



The trajectory for GUH compared to other organisations in the region, is disappointing compared to the National median.

NPDA tech spotlight report published in 2019 showed use of an insulin pump to be associated with lower HbA1c and a correlation with children using Continuous Glucose Monitoring (CGM). ABUHB colleagues have put a business case forward to improve funding of insulin pumps and to enhance the nursing and dietetic staffing, across Paediatrics and adults care, which was approved but funding the business case has not yet been possible.

Data quality is an issue, and most data items are available on internal systems and is very time consuming.

T2D is a much lower level across the UK and in ABUHB and we have a Wales working group and a UK group to work on improving care for CYP with T2D alongside weight management. Within ABUHB the T2D children now have a dedicated clinic for appropriate management and planning for better engagement with the patients/families.

It has been reported that there are worse outcomes for children in the most deprived areas and lower numbers of CYP using the technology (pumps and CGM) in deprived populations. ABUHB are keen to address these areas however funding remains an issue.

Key points:

- ABUHB has a slightly higher rate (0.3%) of T1D in CYP than Wales and 2.1% higher than the UK
- Key health checks performance for ABUHB has deteriorated from 2019 to 2020 as has Wales compared to the UK however the performance across the UK has seen the same reduction in performance
- CYP receiving a complete year of 4 or more HbA1c measurements for 2019 was underperforming compared to the Wales and UK and this has seen a further decrease for 2020
- Other additional health care checks are being completed however data entry is affecting the results
- More CYP are being assessed as requiring additional psychological support
- Median HbA1c year-on-year for ABUHB has deteriorated since 2019

Actions:

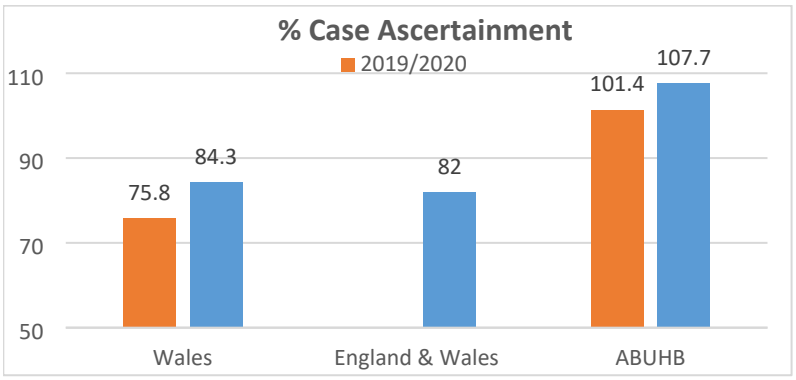
- Reinstate Face to Face clinics
- Offer technologies to all children as per NICE Guideline and this will need HB funding for the Insulin Pump business case that was approved in 2021.
- Look to complete data on a quarterly basis
- Increase staffing levels, including Psychology, Dietetics and Nursing

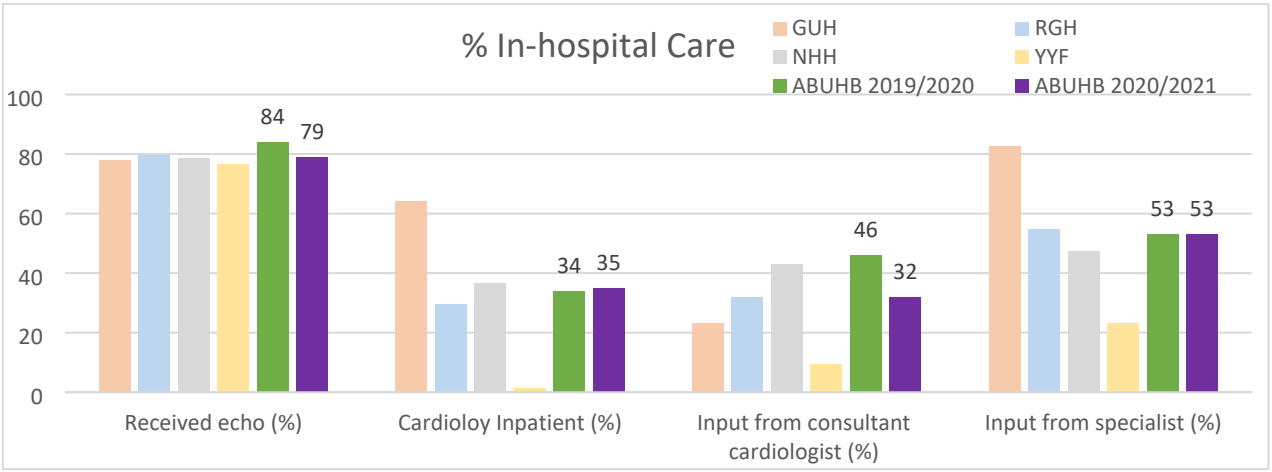
CSEG 2309/03 - National Heart Failure Audit (NHFA) 2020/2021

Linda Edmunds, Consultant Nurse, Cardiac rehabilitation presented the NHFA which is part of the National Cardiac Audit Programme (NCAP). This incorporates Acute and Chronic Heart Failure. Over the last few years, the data input has improved drastically, up to about 97% in the most recent entry. Clear prompt diagnosis and receiving specialist care is vital and the follow up of these patients within 2 weeks of discharge, and the medication being accurate and incorporating cardiac rehab after discharge.

Key points:

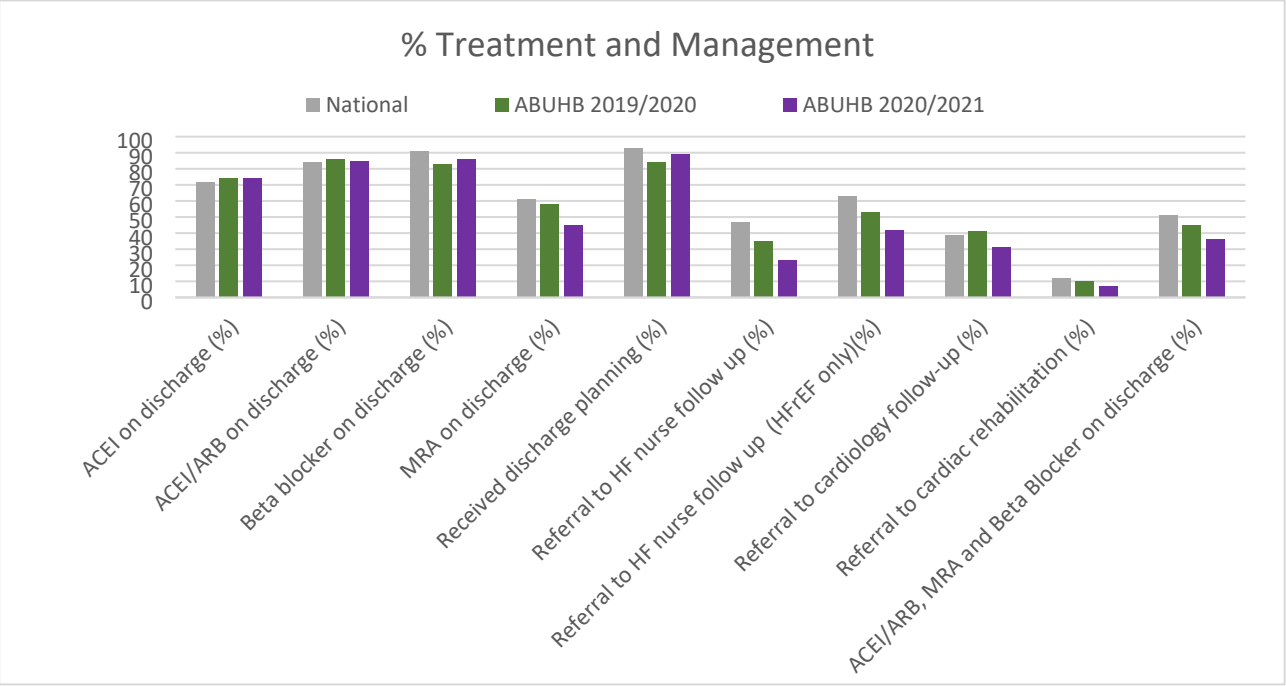
- Heart Failure admissions nationally have reduced however numbers have risen in ABUHB from 662 in 2019/20 to 678 in 2020/21





- Nationally patients diagnosed with Echocardiography is 85% with ABUHB 79% for 2020/2021 compared to 84% for the previous year
- Input by a Consultant Cardiologist for ABUHB is 32% however increases to 53% when expanded to input from any specialist, although significantly underperforming compared to the national rate
- 34% of patients in 19/20 were Cardiology Inpatients compared to 35% in 2020/2021
- Across ABUHB GUH is performing well at 48.8% compared to the national level of 51% for patient discharged on all 3 disease -modifying drugs, however overall ABUHB is underperforming at 36%
- Referral to Cardiology Follow up has reduced from 41% to 31% for ABUHB which is at 39% nationally
- Cardiac rehabilitation is 12% nationally, with ABUHB sites lower than this, although NHH was 13.3% for 2020/21, GUH was 3.9% and RGH 5%
- Only recently have patients been referred to the inpatient Heart Failure Nurse specialists, previously referral was not made until time of discharge

- Specialist Care for ABUHB has remained at 53% compared to 65% nationally



Actions: (Based on recommendations from NICOR)

- Commencement an inpatient heart failure nurse service to ensure echocardiography is performed within 48 hours to provide diagnosis to aid accurate treatment – one site initially for roll out once taken onboard any learning
- High risk cardiac patients have access to the cardiology ward – right treatment at the right place
- Pathway of care to ensure patients are seen by the heart failure team with a dedicate Consultant cardiologist lead
- Seeing patient face to face in the ward area ensure that patients are being discharged on the correct medications
- Follow up pathways providing a 2-week appointment at the point of discharge
- Improved access to cardiac rehabilitation

Next meeting Thursday 24th November 2022 @ 14:00 – 16:00

PQSOC - National Clinical Audit Activity Report

- **AMaT Update**

Following publication of each National Clinical Audit the audit will be registered on AMaT with an identified Lead. The Clinical Lead in conjunction with the Divisional Triumvirate will review the reports and develop an action plan to address any requisite improvements, within AMAT.

Both the results and action plan will be presented to the ABUHB Clinical Standards and Effectiveness Group which reports to Quality and Patients Safety Operational group, a subgroup of PQSOC.

- **AMaT roll out plan.**

There are 3 user levels within AMaT, which the QPS team are the Super Users and across the HB there are 7 administrators to date with 90 Users registered.

There are currently 3 areas within AMaT being rolled out across ABUHB. All National Clinical Audit are to be registered to the Clinical Audit & Improvement Area. The Clinical Audit Strategy states that all NCA's will be registered on AMaT with all relevant documentation uploaded and allocated an audit lead which is the main contributor to the audit. Audit mentors should the Clinical Lead for the specialty of the NCA. Rationales and objectives are identified along with date ranges for the audit period and NICE guidance or local guidance if appropriate can be added. Governance issues can be detailed if relevant and each audit can be linked to a suitable audit meeting.

Currently there are 35 audits registered in the Clinical Audit area as detailed below. Abandoned audits must give a valid reason why they are abandoned (duplicate in these cases)

Total number of projects	35	100%
Total number of open projects	35	100%
Number of open projects with no results	30	86%
Number of open projects with results	5	14%
Number of open overdue projects (no action plans)	20	57%
Total number of open projects (with action plans)	2	6%
Number of open overdue projects (with action plans)	1	3%
Number of closed projects	0	0%
Number of abandoned projects	2	N/A

Prepared by Joanne Stimpson

Divisions were requested to identify and register 2 audits in July 2022, with implementation in August 2022. Due to resource issues this has not been completed for all areas.

There are currently 9 audits registered within the Ward, Area & Service Projects element of AMaT which is where ethe majority of the HB audits will be managed. With 3 audits currently being completed. This area will provide each audit with a dashboard of the score question results and the option to export all data for further data analysis.

There are several projects currently beginning the processes, such as Treatment Escalation Plans which ABUHB have hosted and managed the project on an All-Wales basis and is due to share the AMaT proforma for use across Wales. The Weekly Stroke Thrombolysis audit is about to embark on using AMaT to capture the data and target information.

Action plans can be created for all target area within an audit and can be attributed to allocated to an audit participant with dates actions are to be completed.

Currently the QPS Team are working with many areas across the HB to progress the use of AMaT for all audits undertaken by all staff. Medical students are also being registered to be able to carry out audits within the specialties.

Aneurin Bevan University Health Board

Clinical Audit Strategy 2022-2025

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 1 | Issue date: 21 September 2022
Approved by: Clinical Standards & Policy Group | Review by date: 20 September 2025
Owner: Patient Safety & Quality Department | Ref Number: ABUHB/Clinical/1092

Contents:

1. Introduction/Overview

Looking forward to our future - Our Strategic Direction: 2022-25 sets out the vision for clinical audit for the Health Board. The vision is to be recognised as the best healthcare provider in our class, consistently performing within the top 10% nationally. The mission is to safeguard the health and well-being of the population we serve and to abide by our Health Board values.

The values we aim to show are:

OUR VALUES:

Clinical audit is one tool in the wider quality improvement strategy aimed at providing assurance of delivery best practice. This strategy sets out the principles of when clinical audit should be used and will clarify how the development of the clinical audit plan can be achieved, placing patients first. The application of the strategic direction to clinical audit is described in this strategy, contributing to the range of quality improvement activities and governance arrangements of the Health Board.

What is Clinical Audit?
The National Institute for Health and Clinical Excellence (NICE) describe clinical audit as:

> "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery" (NICE 2002)

2. Statement

ABUHB is committed to delivering safe and effective care to the population of Gwent. Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks.

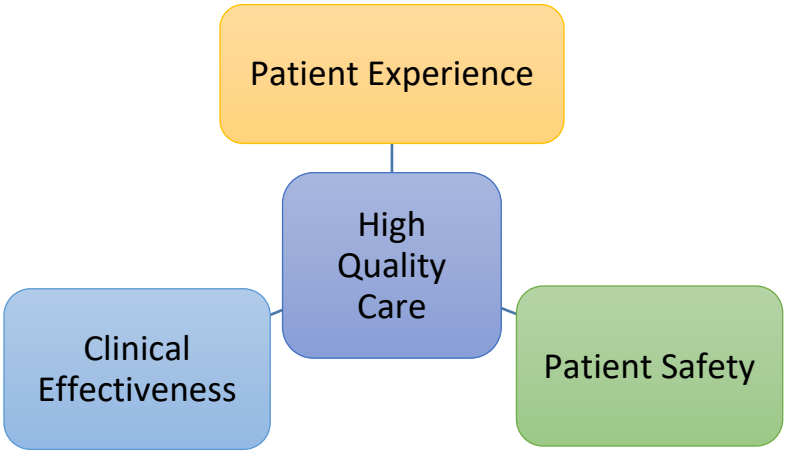
When carried out in accordance with best practice standards, clinical audit:

- Provides assurance of compliance with clinical standards
- Identifies and minimises risk, waste and variation
- Improves the quality of care and patient outcomes

ABUHB has adopted a policy on the governance and practice of clinical audit which applies to all staff

3. Aims/Purpose

- This strategy sets out the Health Boards commitment to quality and effectiveness through the application of clinical audit to support delivery of: High quality, patient safety, patient experience and clinical effectiveness.



- Cost-effective clinical services to ensure that care is both sustainable and effective
- National Audit engagement at a local level.
- The Trust Quality Account as part of the Trust Annual Report.
- Compliance to regulatory requirements from NHS Improvement and the Care Quality Commission.
- Reports on the compliance with clinical standards that can be used for assurance.

- Quality improvement as part of the national and local Commissioning for Quality and Innovation (CQUIN) targets and local Clinical Commissioning Group initiatives.
- Quality improvement projects and local audits that are aligned to the Trusts priorities for improving care.
- Demonstrable NICE compliance and best practice evidence implementation.

4. Objectives

Achieving the objectives set out in this strategy will ensure that the Health Board Clinical Audit Policy is implemented and effective, resulting in sustained improvements and the delivery of safe care.

The Health Board has Four Priorities:

- There is scrutiny of national clinical audit performance with robust development, monitoring, and progression of Improvement plans
- Divisions to identify clinical audits that allow scrutiny and assurance associated with quality and safety risk
- Trainees are supported to participate in meaningful clinical audits that support clinical governance
- Groups and committees across the Health Board will commission clinical audit to support effective assurance where no other evidence is available.

5. Scope

Our strategy is relevant to:

- The Board
- Divisional Management Teams
- Clinical Directors
- Chairs of Health Board groups and committees
- Clinical Audit Leads
- Education Leads

6. Roles and Responsibilities

Responsibility for the implementation of this strategy is with the Divisional Triumvirate, Clinical Leads and Clinical Directors and presented to the Clinical Standards Effectives Group.

7. Main Body

Priority 1
There is scrutiny of national clinical audit performance with robust development and monitoring of improvement plans

The National Clinical Audit and Outcome Review Plan is a comprehensive programme of clinical audit that allows the Health Board to bench mark their delivery of care associated with a broad range of evidence-based guidance against health organisations across the UK. The National Audit plan can be accessed here .

To ensure an effective and robust approach to considering national audit outcomes and implementing the requisite improvements a systematic approach to the governance of these audits is required.

- On Publication of each national audit the national report and local results will be uploaded to AMaT and the Divisional Triumvirate and the Clinical Lead will be notified of the publication.
- On Publication, all national clinical audits will be reviewed by the Division in partnership with the Clinical Director and Clinical Audit Lead
- An action plan will be developed by the Divisional Triumvirate in partnership with the Clinical Director to support the requisite improvements and uploaded onto AMaT.
- The national audit results and Improvement will be presented to the Clinical Standards and Effectiveness Group within two months of publication by an individual agreed between the Divisional triumvirate and the Clinical Director
- The Divisions will ensure the necessary scrutiny and monitoring of National Audit improvement plans in a Quality and Patient Safety Forum
- All associated risk will be reviewed and where appropriate recorded on the Divisional risk register

Priority 2
Divisions will identify clinical audits that allow scrutiny and assurance associated with quality and safety risk

Quality is the endeavour of continuously, reliably, and sustainably meeting customer, patient, or service user needs. This definition places quality at the centre of the health service and as the organisational strategy, not merely a component of the strategy. The Duty of Quality

applies to all health service functions in Wales and applies to both clinical and non-clinical functions and the people that deliver those functions.

NHS organisations will be required to ensure that they are routinely using data and information about quality at every layer of the organisation as part of their Quality Management Systems and clinical audit will be an important tool in supporting this function.

Divisional Triumvirates will be required to develop a programme of Clinical Audit that support governance and assurance aligned to the quality and safety priorities of the Division. The quality and safety priorities will include:

- Nationally reportable Incidents
- Patient safety incident themes
- Clinical outcomes
- New Evidence Based Guidance including NICE
- Themes from mortality reviews and M&M

Each Division will be required to present an overview and update of their clinical audit plans at each Clinical Standards and Effectiveness Groups meeting.

- All clinical audits will be registered on AMaT and will have an identified lead.
- All Clinical audits will be monitored at an appropriate and pre-defined quality and safety forum.
- All results will be reported on AMaT
- Where required all actions plans will be recorded on AMaT
- The Divisional Triumvirate will have oversight of all clinical audits and their results and will ensure that the required actions plans are progressed and monitored.
- Clinical Audit will be a standing agenda item on Divisional Quality and Patient Safety Group agendas
- Divisions will be asked to produce a report on a bi-annual basis detailing clinical audit activity, results and improvements and present this at the Clinical Standards and Effectiveness Group.

Priority 3
Trainees are supported to participate in meaningful clinical audits that support clinical governance

Where trainees are required to undertake clinical audit as part of their ongoing development, the Directorate and Division have a responsibility to ensure that the necessary arrangements are in place to ensure that they have oversight of these projects, that the results are considered and

that were necessary action plans are developed to support the requisite improvements.

Trainees should be supported to undertake meaningful clinical audits that support quality and safety priorities and are involved in the resulting quality improvement.

- All clinical audits undertaken by trainees should be agreed by a clinical supervisor and should contribute to the Divisional Quality and safety priorities
- All clinical audits must be registered on AMaT with the audit supervisor specified.
- All audit results must be uploaded to AMaT if the data is not collected directly onto the AMaT system
- All results will be reviewed by the clinical supervisor
- Where required an action plan will be developed with the support of the Clinical Director with oversight from the Divisional Triumvirate and uploaded to AMaT
- All clinical audits and action plans will be monitored at an appropriate and pre-defined quality and safety forum.
- All trainees must receive the appropriate acknowledgement of their participation in clinical audit and will be provided with a certificate of participation generated through AMaT.

Priority 4
Groups and Committees across the Health Board will commission clinical audit to support effective assurance as required.

Clinical governance is the systems, processes, and behaviours by which organisations lead, direct and control their functions to achieve organisational objectives, safety, and quality of service, and in which they relate to patients and carers, the wider community, and partner organisations

The Health Board Quality Assurance Framework Structure comprises a range of groups, each of which forms an essential element of the overall system and controls that are in place within the Health Board; their purpose is to mitigate and manage risk which may occur regarding the achievement of ABUHB strategic objectives and priorities as set out in the Health Board's Integrated Medium-Term Plan.

The groups ultimately report to the Patient Quality Safety and Outcomes Committee, a sub-committee of the Board.

- The Quality Assurance Framework support the delivery of a quality management system including
- Quality Planning – the Health Board priorities and plans for the delivery of high quality and safe services

- Quality Improvement – The systematic process to implement the improvements required within our services
- Quality Control – The processes in place to ensure that the care being delivered
    - Every group that forms part of the quality assurance framework will review the evidence available to support its function in overseeing the quality-of-care provision
    - Consideration will be given to implementing clinical audit where no existing evidence is available
    - Clinical audit should be considered to provide evidence of improvements here required.
    - Clinical audit will be implemented to meet mandated national requirements e.g., DNACPR audits

8. Resources

Welsh Health Boards and Trusts are required to ensure sufficient resources are available to undertake participation in all audits, reviews and national registries. Undertaking Clinical audit is mandatory and should be incorporated into existing job plans.

9. Training

Training on how to use AMaT will be carried out by the Corporate QPS team. This will involve training sessions that will be delivered virtually by AMaT and organised by the QPS team. The following training plan will be implemented throughout ABUHB.

Recommendation	Action	Responsible group / Individual	Completion Date
Priority 1	All Clinical Directors, Directorate and Divisional Management Teams, Senior Nurses, Clinical Governance and Quality and Safety Leads will register with AMaT	Divisional Triumvirates	July 2022
	All national audit reports and local data will be disseminated to the Divisions using AMaT	Quality and Patient Safety Team	July 2022
	National audit action plans developed to address requisite improvements will be saved, monitored on AMaT	Divisional Triumvirates	August 2022
	All audits and Improvement plans will be presented at the Clinical Standards and Effectiveness Group	Divisional Triumvirate and Clinical audit lead	September 2022
Priority 2	Divisions will register two local clinical audits on AMaT that address a current Divisional quality and safety priority	Divisional Triumvirates	July 2022
	Implement the two registered audits and record the results on AMaT and present the outcomes of these	Divisional Triumvirates	August 2022

	audits at a Divisional Quality and Patient Safety meeting		
	Present overview of local audit activity in Clinical Standards and Effectiveness Groups	Divisional Triumvirates	September 2022
Priority 3	Provide each cohort of Medical Trainees with registration and training information for AMaT	Medical Education	August 2022
	All clinical supervisors to register with AMaT	Divisional Triumvirates	July 2022
	All clinical audits undertaken by medical trainees to be registered on AMaT and results to be uploaded to AMaT	Directorate Management Teams	From August 2022
	All clinical audits completed by medical trainees to be presented at a clinical audit meeting or quality and patient safety meetings	Directorate Management teams	From August 2022
	All medical Trainees to be issued with a certificate to evidence their involvement in the clinical audit	Directorate Management teams	August 2022
Priority 4	All groups and committees that form part of the ABUHB Quality Assurance Framework should review the evidence available to them to identify gaps in assurance and consider commissioning clinical audits to address these gaps.	Chairs of ABUHB groups and Committees	October 2022

10. Implementation

Clinical Directorates should ensure that all relevant staff are aware of the Policy, especially those who are involved with Clinical Audit.

There will be standardised approach to reporting audit findings. These will be reported under the headings

- Areas where good practice has been identified
- Areas of where practice requires improvement

- Actions to be taken - using SMART objectives

11. Equality

The policy does not require an Equality Assessment Impact Assessment (EqIA).

Adherence to this policy will identify opportunities to replicate or improve equitable health-care delivery across Aneurin Bevan University Health Board.

12. Audit

This policy will be subject to the formal auditing process to ensure it is fit for purpose, has been implemented effectively and to assess compliance.

13. Review

This policy will be reviewed every three years, or sooner should the author or legal requirements deem it to be relevant or required.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Patient Quality, Safety & Outcomes Committee Tuesday 6th December 2022 Agenda Item: 4.8

Aneurin Bevan University Health Board

Learning From Deaths

Executive Summary

Data collated for this report demonstrates that:

- ABUHB Risk adjusted Mortality Index (RAMI) is 98.
- Data since the opening of the GUH shows a significant improvement in the Health Boards Risk Adjusted Mortality Data over time.
- 30-day inpatient stroke mortality is 9.388%, the lowest in Wales.
- 30-day MI inpatient mortality has improved significantly compared to last year and is now 3.744%.
- The recruitment of a new post is underway to appoint a Senior Information Manager, who will work on the CHKS database and support data for clinical outcomes. This will provide more analysis of mortality data and allow a deep dive approach for learning from death for specific conditions. This post will work collaboratively with Information and QPS. The aim will be to provide clinicians with more accessible information to help them manage their services.
- Since the Medical Examiner (ME) service started in January 2021 there have been a total of 665 ME reviews. This is 13% of all in-patient deaths.
- The Mortality Review Screening Panel meets weekly and is undertaking a thematic review of ME reported cases to date. Learning will be disseminated in a newsletter to enable organisational learning from the ME reviews.
- The Mortality Review Group will also be revising and updating the terms of reference for the Mortality Screening Panel Group and undertake a trial of exclusive Datix system use for all Mortality Screening Panel work.
- The Group will be considering approaches and strategies by which improvements can be made to the feedback mechanism, with particular attention to cases which have been directed from panel review for a mortality and morbidity review (M&M) and for cases which were escalated to SI status.
- Elective and non-elective 30-day mortality continues to remain low and is comparable to the Welsh average.
- Robust process are in place to review hospital acquired thrombosis.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	x
Receive the Report for Assurance/Compliance	x
Note the Report for Information Only	
Executive Sponsor: Dr James Calvert Medical Director	
Report Author: Leeanne Lewis – Assistant Director of Quality and Patient Safety	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Committee Name]**	Sub-Committee
Date of the Report: 6th December 2022			
Supplementary Papers Attached: Nil			

Purpose of the Report

For the last twenty months the Health Board has convened a weekly Mortality Screening Panel to review and investigate referrals made by the Medical Examiner. Emerging themes have been combined with information from clinical coded data, and national audits to support learning from death and will be reported to the committee on a bi annual basis in the future.

Health Organisations across Wales use a number of measures to consider mortality. The Risk Adjusted Mortality Index (RAMI) adjusts for individual patient risk factors and co morbidities and therefore allows comparison between organisations. The accuracy of RAMI is dependent on the completion and accuracy of clinical coding, (January 2021 – August 2022 8.99% of ABUHB finished consultant episodes were uncoded).

In 2014 Professor Palmer published an independent review of the use of RAMI and the extent to which it provides valid data and recommended a blended approach that considers numerous sources of information, in addition to RAMI, including that from mortality reviews, national bench-marking and national audit. Palmer advocates a number of approaches to understand performance, this ensures assurance and quality improvement around death, not sole reliance on aggregated retrospective data (e.g. RAMI).

Background and Context

There was a statutory requirement for an independent review of all deaths in Wales by a Medical Examiner (ME) service by summer 2022. There has been a phased approach across the Health Board to implement this system since November 2020 with inpatient deaths in YYF, GUH and RGH now subject to independent scrutiny by the ME. The Primary Care Division have recognised in their IMTP that ME reviews will need to take place, but the implementation date has not been confirmed by the ME service. The timescale has not been confirmed for when these numbers will increase and additional cases will be reviewed.

The themes addressed throughout the paper have been collated from a number of sources, including data derived through clinical coded activity, national audit, ABUHB universal mortality reviews and ME reviews.

Medical Examiner

All mortality cases referred to the Health Board by the ME are subject to an initial review (level 1) to establish if they are already being investigated through an established process including Putting Things Right, to avoid duplication.

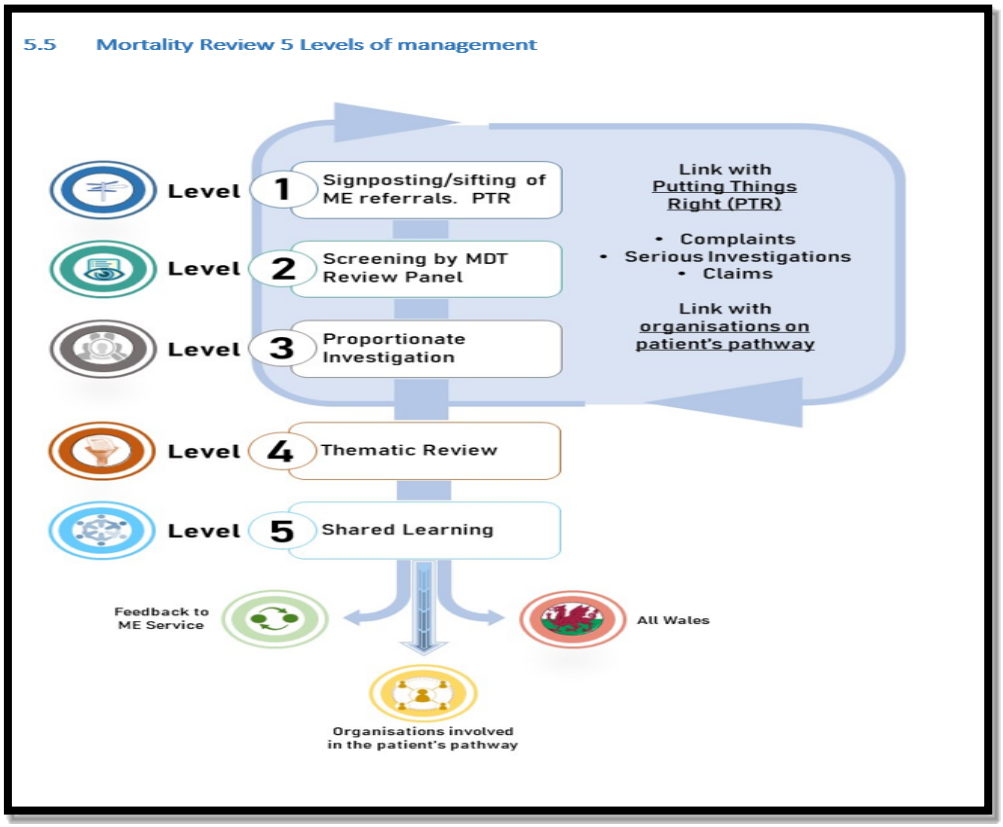
The ME system provides external, independent scrutiny of the quality-of-care delivery and reports back episodes of patient for the Health Board to investigate further.

All referrals subject to a Level 2 mortality review are considered by a multidisciplinary panel with cross divisional representation. The panel establishes if further investigation is required and sets out the terms of reference for the investigation and agrees who should be commissioned to undertake this.

These reviews can include issues being raised at mortality and morbidity (M&M) meetings, referral for investigation under PTR processes, consideration at the ABUHB Falls Review Panel, Infection prevention and Control review and hospital acquired thrombosis review.

The National Mortality Framework illustrated in figure 1, describes 5 levels of mortality management.

Figure 1



The next stage of this work is to pull together qualitative data and develop a process to spread organisational learning. A process is underway to consider how to triangulate data from all sources. There is a new post being funded by Information and QPS. This will allow the QPS team to scrutinise clinical outcome data. When this is successfully recruited, we will be in a position to look at developing a mortality dashboard.

Review of the Mortality Screening Panel Group membership will ensure there is divisional representation to support the Learning from Death agenda. Standardised agenda templates and reporting requirements within Divisional and Speciality Morbidity and Mortality and Governance meeting require development in collaboration with the QPS leads and Clinical Directors for all specialities.

There will also be a trial of a new, dedicated, Datix system for Mortality Screening Panel work. The Group will also undertake a gap analysis in order to ascertain how the Mortality screening panel delivers when compared with the All-Wales Mortality framework expectations. The Group will consider approaches and strategies by which improvements can be made to the feedback mechanism, with particular attention to cases which have been directed from panel review for an M&M and for cases which were escalated to SI status.

Previous data showed just over 25% of cases reviewed by the ME service are referred back to the Health Board to consider further review and investigation. A further 27% of cases

are referred to HM Coroner. There is some variation in the proportion of reviews that are forwarded for level 2 reviews between health boards in Wales, however there is significant variation in the numbers of cases being reviewed in each Health Board, with some organisations having relatively small numbers of cases reviewed at present.

Since the ME service started in January 2021 there have been a total of 665 ME reviews. This is 13% of all in-patient deaths (Total 5128). From April 2021 to March 2022, this was also 13% (2685 in-patient deaths and 360 ME reviews).

Assessment and Conclusion

RAMI

The Risk Adjusted Mortality Index (RAMI) is a statistical tool which estimates the probability of death for all admitted patients, taking into account factors such as age, sex, diagnoses, procedure, clinical grouping and admission type.

Where the predicted mortality rate equates to the actual mortality rate, RAMI will be reported as 100, where actual mortality exceeds the predicted rate, RAMI will be reported as a figure exceeding 100.

Figures two to four illustrates the ABUHB RAMI compared to Welsh peers until October 2022 and demonstrates a comparable mortality rate. Our current RAMI is 98, meaning that, after adjusting for the acuity of our patient population, our patients are 2% less likely to die than would be expected. This rate is below that of other health boards in Wales for the past 20 months.

Figure 2 Risk Adjusted Mortality Index

ABUHB Blue **Wales Green**

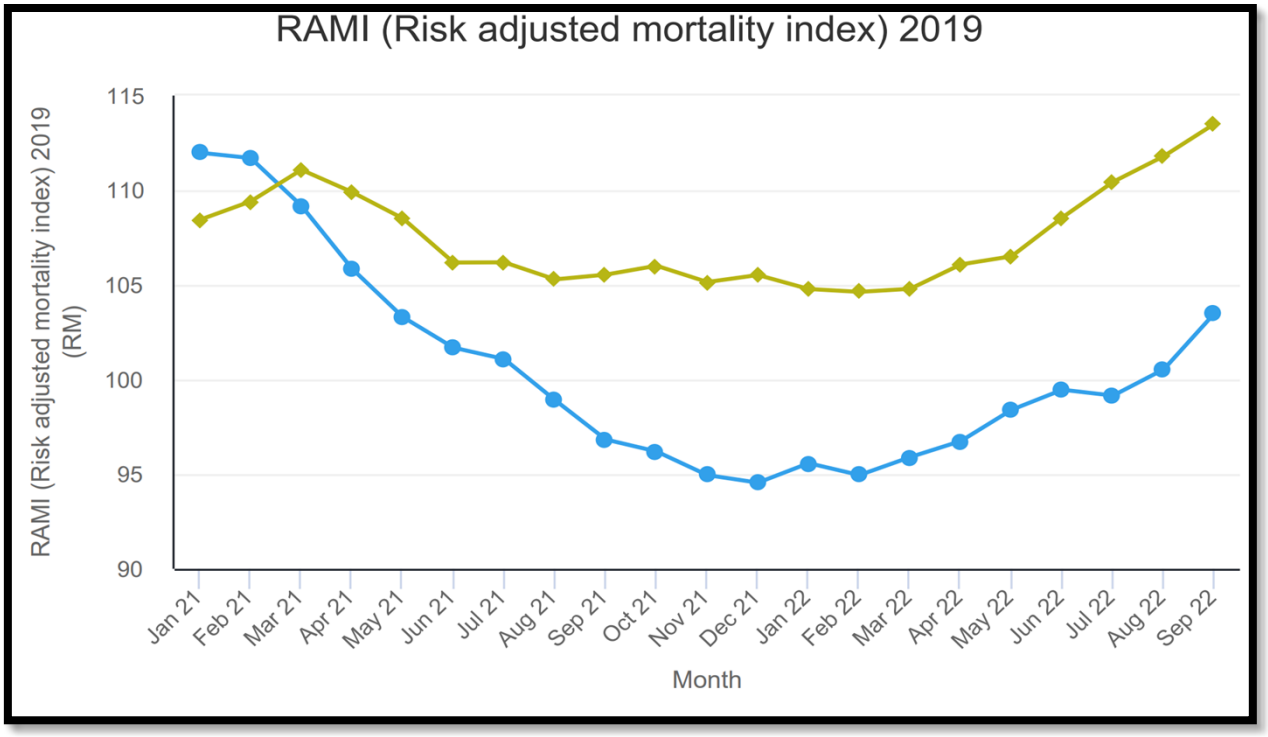


Figure 3 Funnel plot showing RAMI compared to other Welsh Health Boards

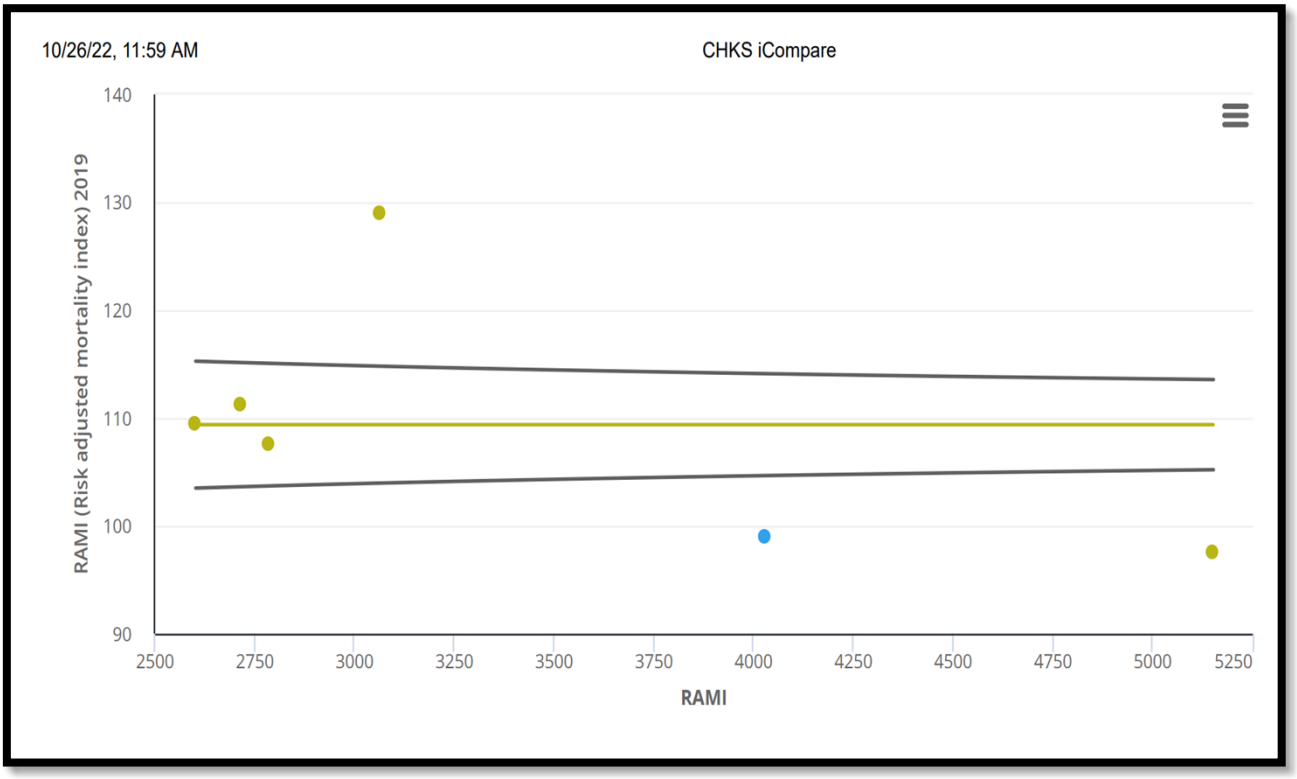
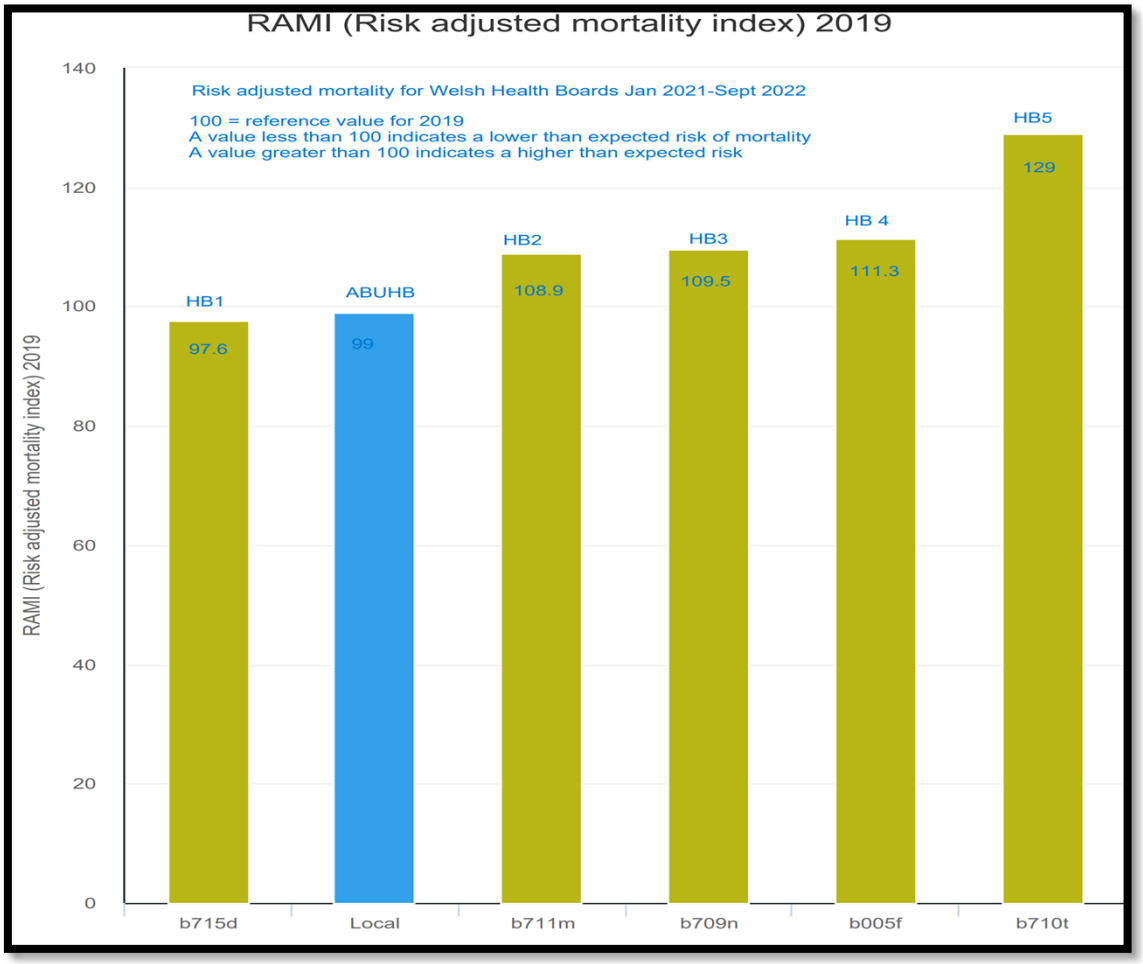


Figure 4 Bar chart showing RAMI compared to other Welsh Health Boards



Since the opening of the GUH our data shows a significant improvement in the Health Boards Risk Adjusted Mortality Data over time. This compares favourably with other large complex organisations in Wales and elsewhere in the UK. Prior to GUH opening we used to track routinely over 100 and our outcomes were comparable to that of other Welsh Health Board's.

All-Cause Mortality

Figure five illustrates ABUHB all-cause mortality – combined inpatient and community deaths. The chart compares ABUHB mortality since January 2020 compared with the Health Board 5-year average and also compares it to the All-Wales mortality rate for the same period and the All Wales 5-year average. Figure six illustrates mortality rate by hospital site within ABUHB.

Where Welsh and ABUHB mortality rates have risen above the 5 year average this correlates with deaths in patients who have been diagnosed with Covid, defined as patients who had any Covid-19 identified in their inpatient notes or included anywhere in the death certificate. Excess mortality (above the 5-year average) was significantly reduced in the most recent wave of covid when compared with wave 1 and 2. Figure six shows all-cause mortality by ABUHB hospital site.

Figure 5 All- Cause mortality

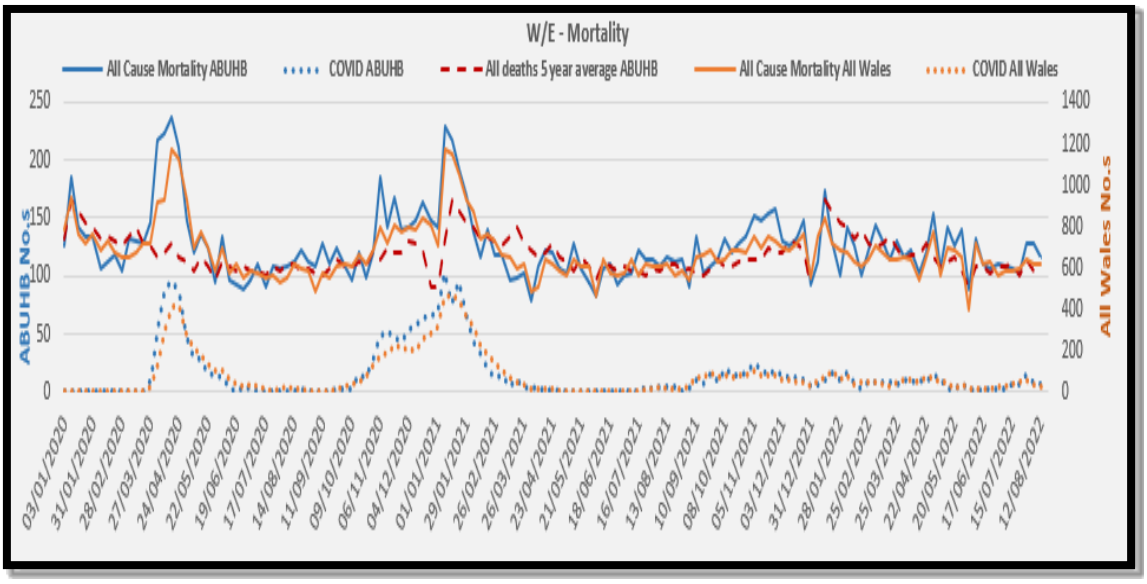
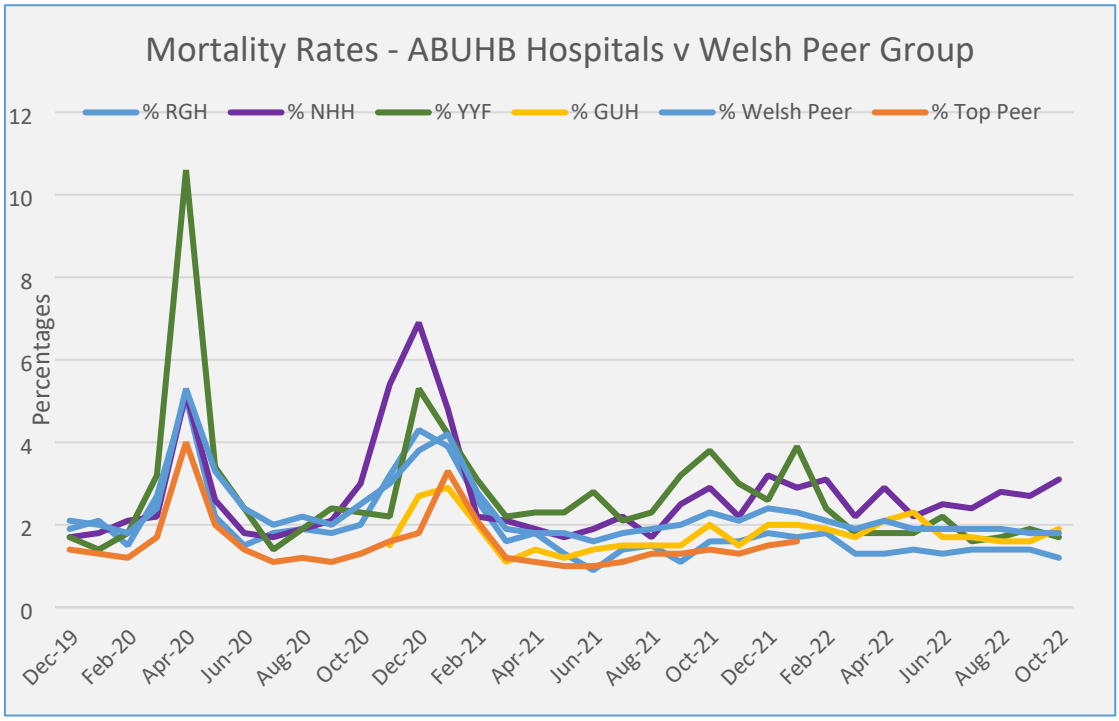


Figure 6 – Mortality Rates by ABUHB Hospitals

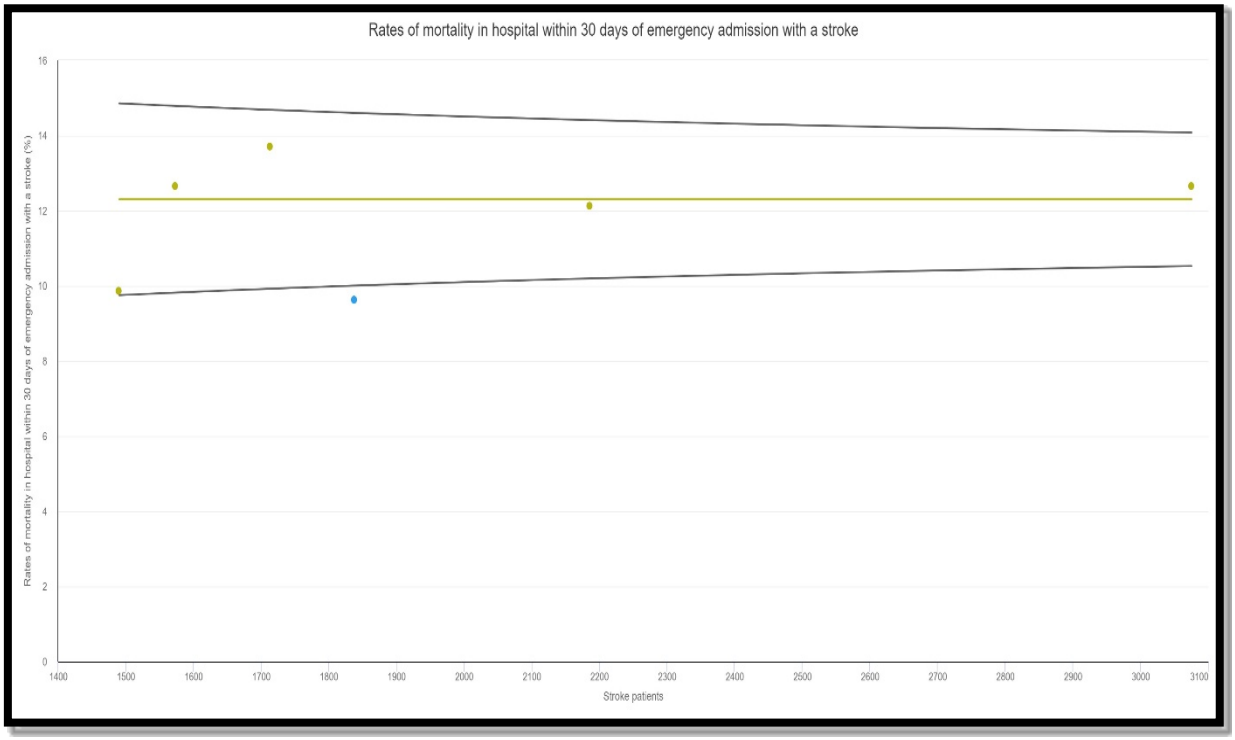


Condition Specific Mortality

Stroke

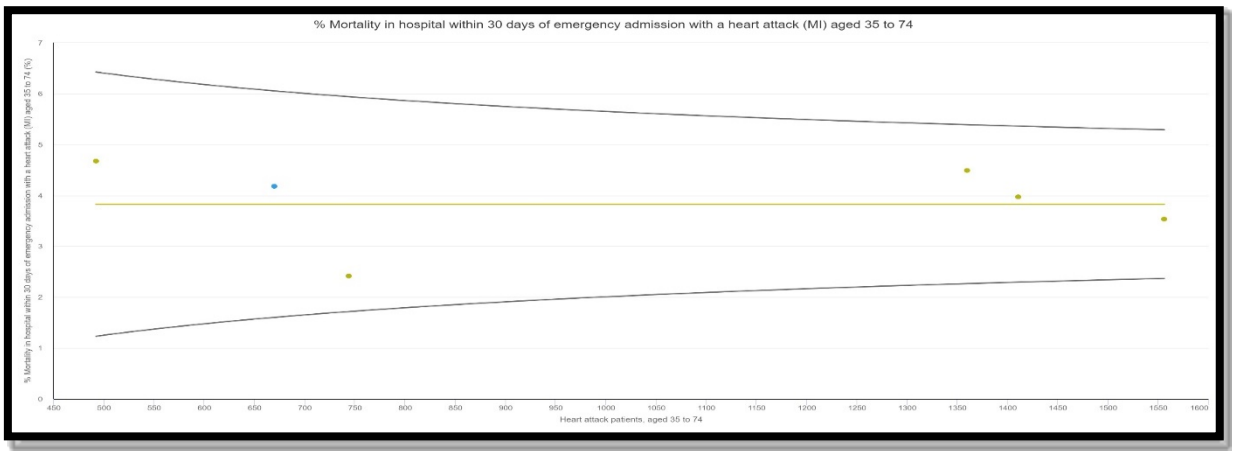
ABUHB 30-day inpatient mortality following admission with a stroke is 9.388% below the national mean and the lowest mortality rate for any Health Board in Wales (peer range 9.981% to 13.415%) for the period October 2021-October 2022.

Figure 7: 30 Day Inpatient Mortality following a Stroke (Jan 21-Oct 22)



Myocardial Infarction (MI)

Figure 8: 30 Day Inpatient Mortality following An MI (age 35-74) (Jan 21-Oct 22)



ABUHB MI mortality in October 2022 was 3.774%, a decrease of 24.78% compared to last year, which is now closer to the peer mean of 3.385%. Figure ten shows the actual numbers of MI associated deaths per site since October 2020. December 2019. A previous thematic review of MI cases reported to PQSOC in December 2021 identified that the majority of deaths were in patients who experienced an out of hospital cardiac arrest or patients who had significant comorbidities and were diagnosed with a non-ST elevation MI.

Figure 9 ABUHB MI mortality rates

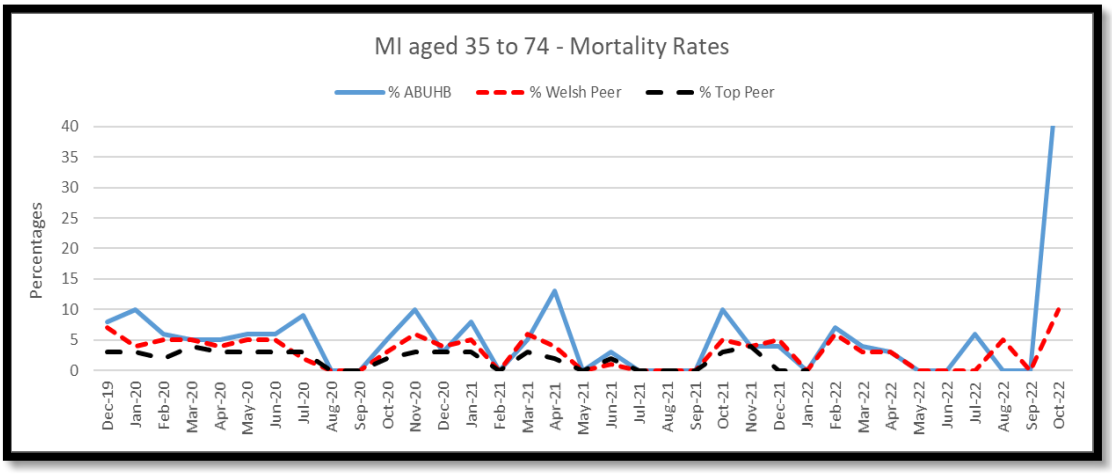
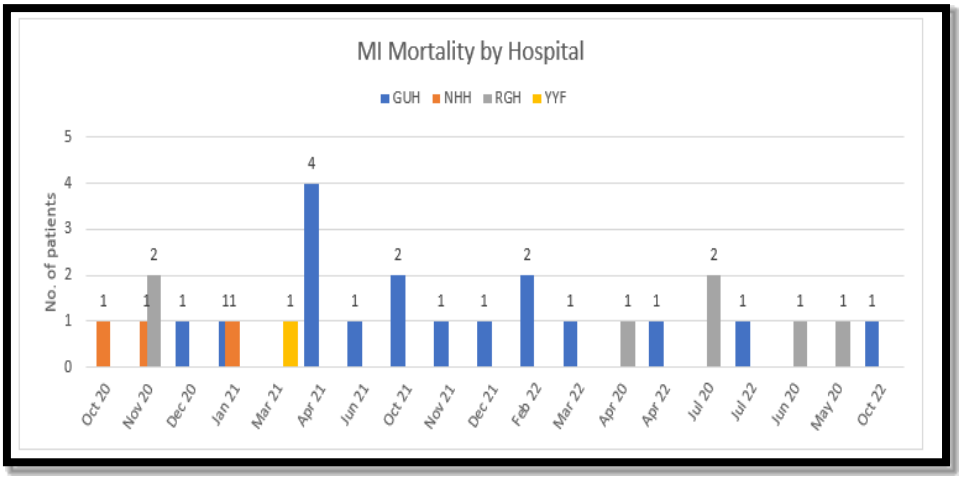


Figure 10 ABUHB MI deaths per site



Hip Fracture

Figure eleven illustrates the ABUHB mortality rate compared with Welsh health Organisations, with a rate of 4.854% for October 2021-October 2022, while figure twelve illustrates hip fracture mortality since January 2020.

Figure 11: 30-day inpatient Mortality post Hip Fracture

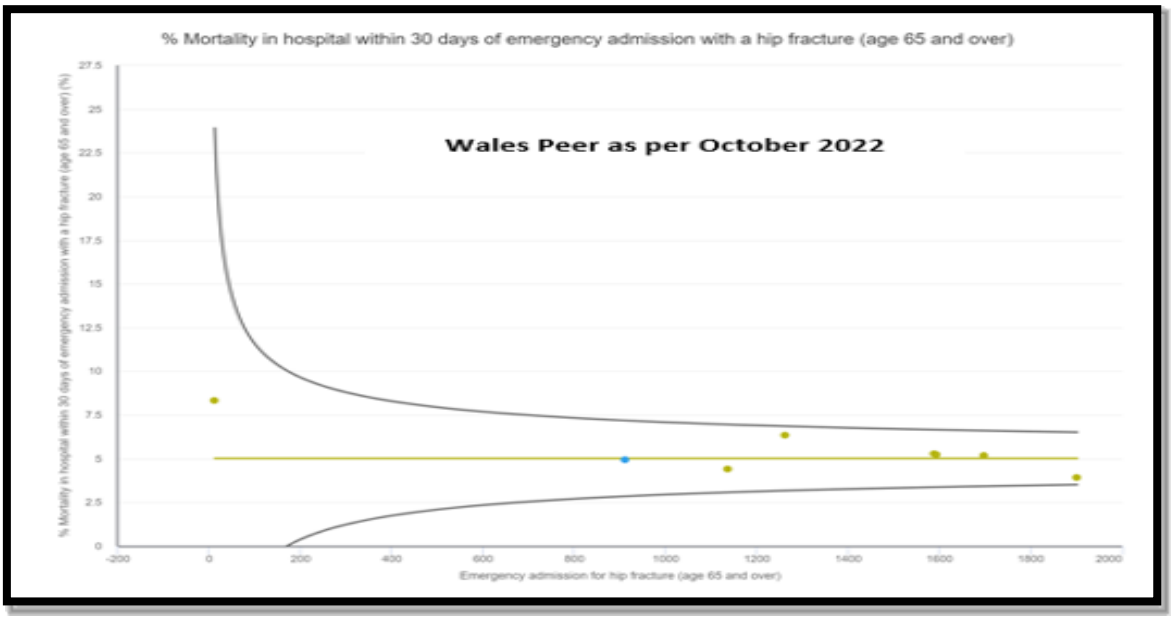
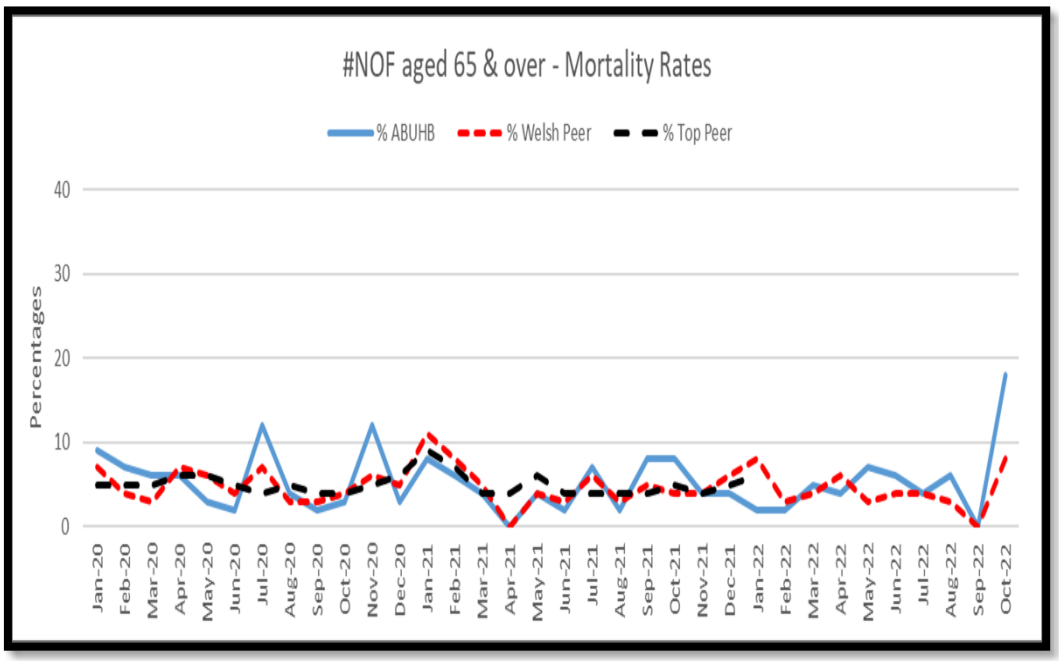


Figure 12 ABUHB Adjusted Mortality – Hip Fracture (NHFD)



Medical Examiner

Reasons for Medical Examiner referral vary but figure thirteen demonstrates the commonly recurring words in the reason for referral as identified through a thematic analysis of all referrals. The most common concerns highlighted by the ME relate to communication and the trend remains unchanged for the previous learning from death report in December 2021. The ME referrals are scrutinised and result in a follow up action which can be seen in Table 1.

Figure 13 Reasons for Referral (Jan 22- Oct 22)

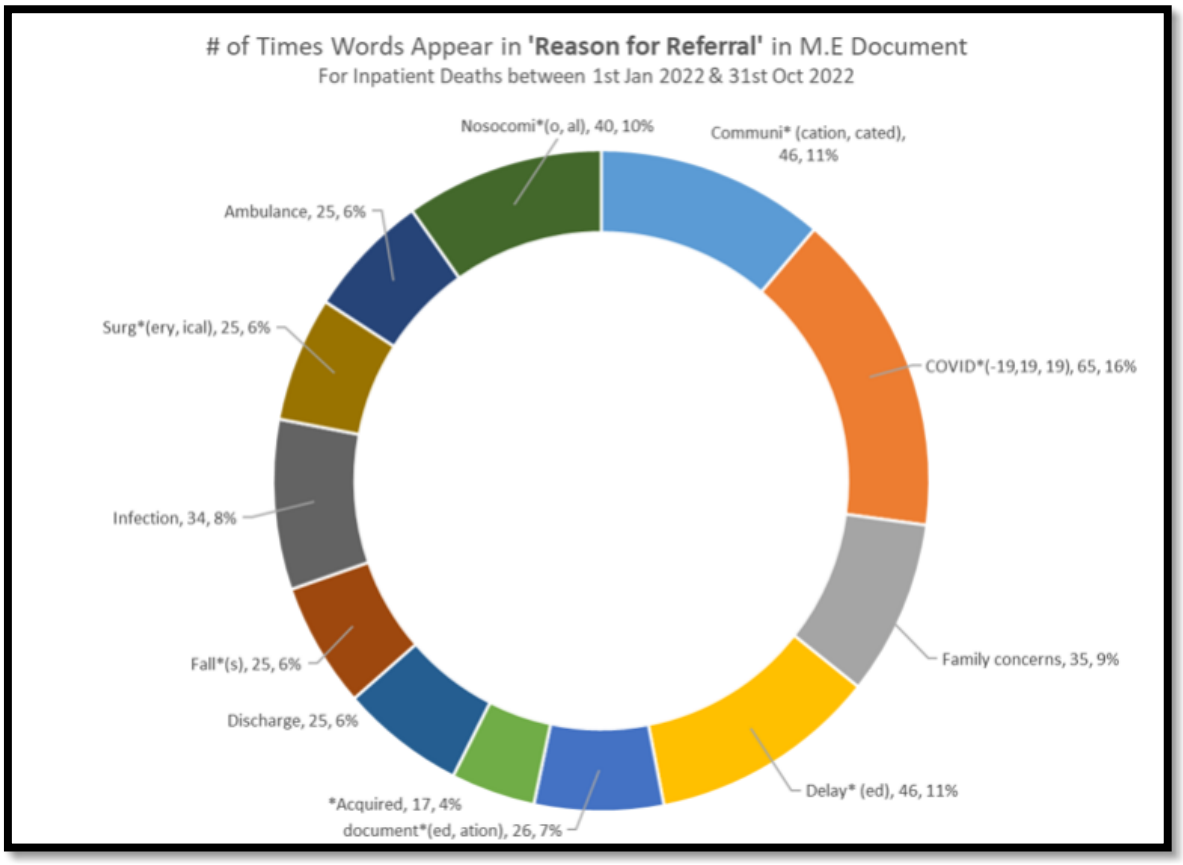
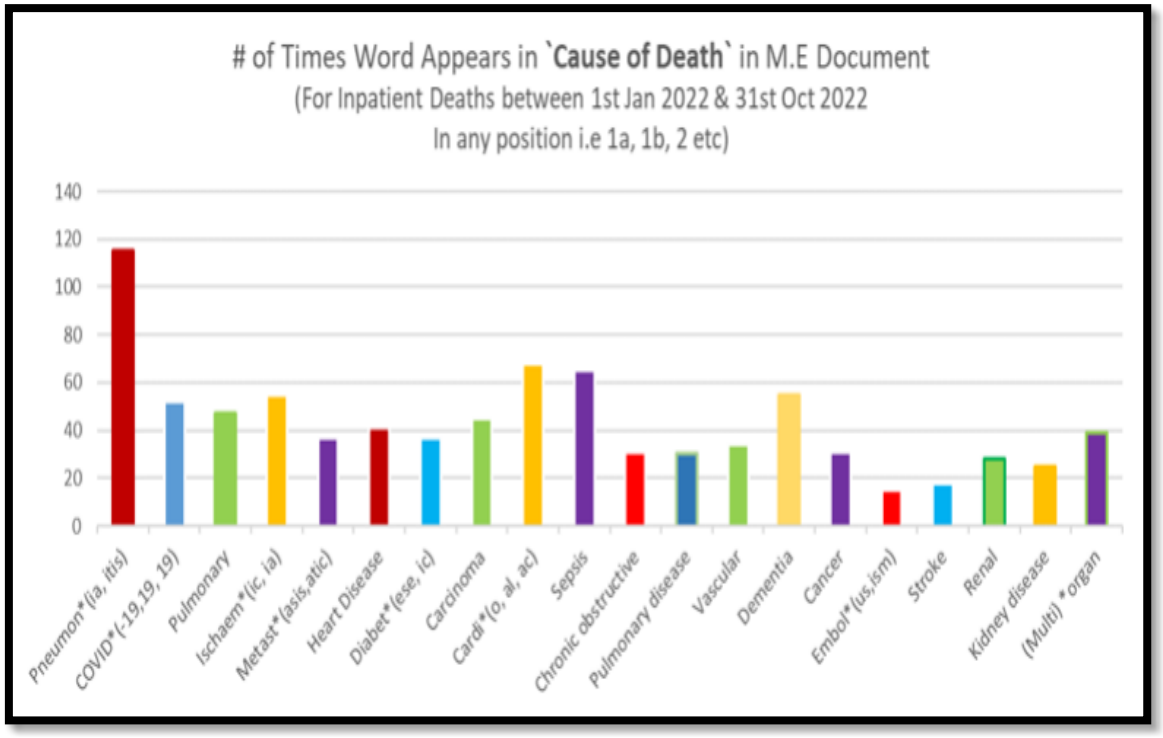


Table 1 Actions from ME reviews (Jan 22 – Oct 22)

Total Nº of ABUHB Inpatient Deaths 1st Jan 22 – Oct 22	2,318	
Total ME Referrals Nº	372	16%
No Further Action Nº	42	11%
Referred to…		
IP&C	63	17%
Putting Things Right	60	16%
QPS lead	3	1%
Significant Learning Event	1	0%
M&M	50	13%
Awareness	18	5%
SI*	30	8%
Clinical Review	51	14%
Concise Review	1	0%
Divisional Review	2	1%
ME referred to Coroner	118	32%

Figure fourteen illustrates a thematic review of the agreed cause of death recorded in ME referrals. Pneumonia, Pneumonitis, Covid, Sepsis and Pulmonary remain the most commonly recurring words in the cause of death in referrals from the Medical Examiner.

Figure 14 Cause of Death.



The Medical Examiners considers a number of factors in each mortality review undertaken. These include:

- Recent interventional procedure following which death was not expected as the outcome?
- Was the death due to a pre-existing condition or the known chronic condition?
- Was there a major change in diagnosis or development of an additional condition?
- Delay in recognition of deterioration, diagnosis and or treatment?
- Incorrect diagnosis or treatment?
- Failure of communication and or documentation?
- Did the patient fall and sustain any injuries during the last illness or acute admission?
- Did pressure ulcers develop during the last illness or acute admission?
- Did the patient develop an infection during last illness or acute admission?
- Was the patient admitted to ITU/HDU?
- Was there a complication of treatment?
- Was there a clinically significant change in blood results without expected course of illness?
- Is there any indication of concerns from family or carers about the care this patient received?
- Is there any evidence of documented concerns about this patient's care raised by other health professionals?
- Was the patient under any safeguarding order or state custody (e.g. DOLS,POVA,MHA)?

Following consideration at the ABUHB Mortality Review Panel the Mortality and Morbidity groups have been asked to consider a number of specific questions relating to individual ME referrals including considering the communication with the patient and family of the of risk and benefit of the procedures. The outcome of the reviews are pending and will be reported in the next Learning from Death report.

Falls

Work to reduce incidents of inpatient falls has contributed to a significant reduction in the numbers of inpatients falls per 1000 occupied bed days since May 2021 as illustrated in figure fifteen. All inpatient falls that result in a fracture are considered at the inpatient Falls Review Panel to identify and share learning. An All-Wales inpatient falls network was established in 2022 to support national learning including a review of the evidence relating to falls sensors to understand the efficacy of this equipment and to standardise the use nationally.

The recent implementation of a community Falls Network will support quality improvement work designed to reduce community incidents of falls and harm. Over the past few years, the Health Board has undertaken pathway redesign and a number of improvements which have resulted in a reduced number of fracture neck of femur 30-day mortality rate.

The ME routinely reviews all mortality cases to establish if the patient had fallen during their inpatient care or if they were admitted following a fall in their residential setting.

For the period September 2020-22 the mean average for numbers of falls per month was 278. With the exception of January 2022, the numbers of falls incident have in the main remained below this value.
For the given 24-month period:

- 67% of the months were below the mean average value
- 29% of the months were above the mean average value
- 6% were aligned to 7 falls per month.

Figure 15 Inpatient falls

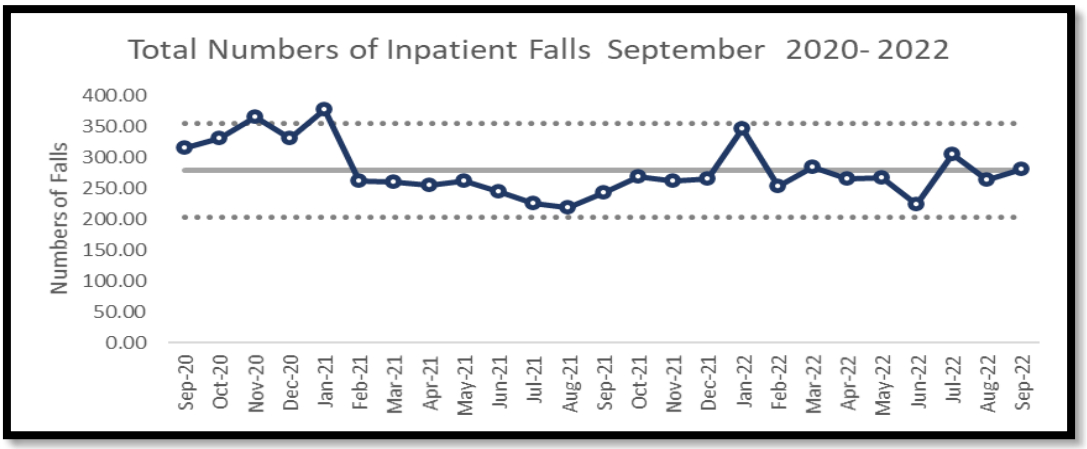


Figure 16- Number of falls by 1000 occupied bed days

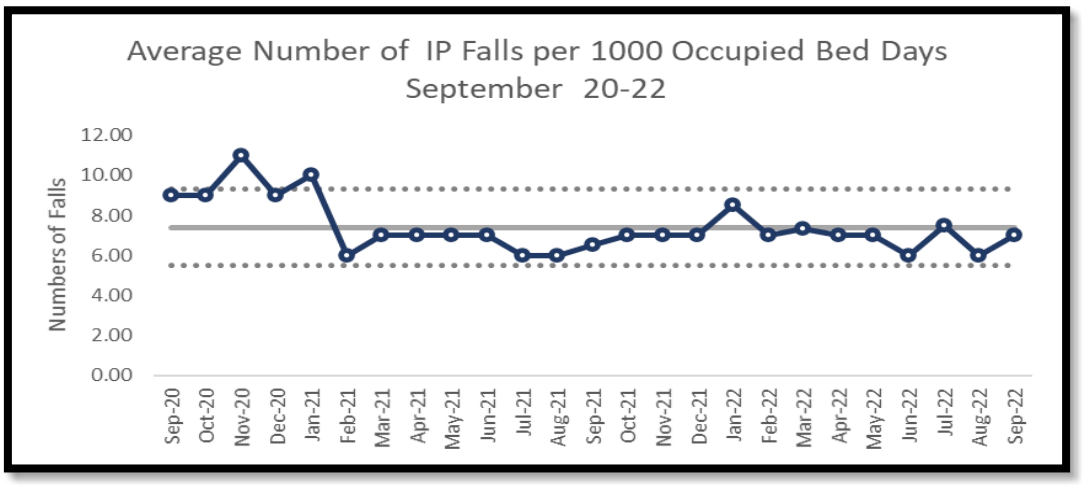
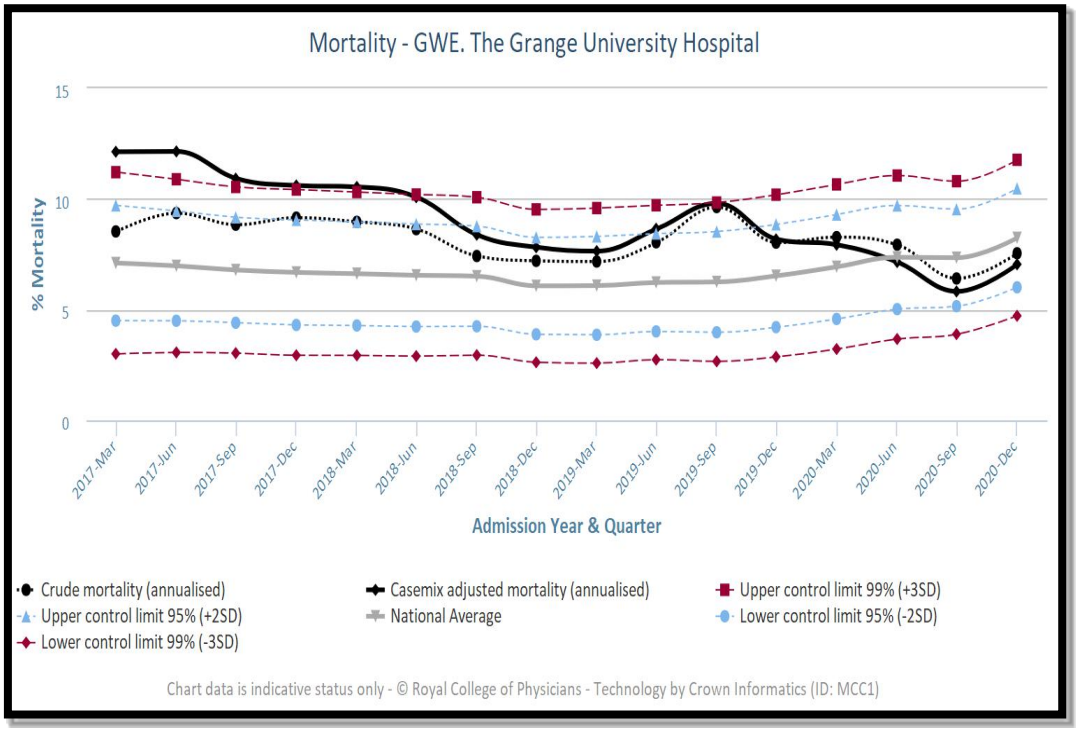


Figure 17- Adjusted mortality – Hip fracture (NHFD)



The national mean rate of falls is 6.6 per 1000 occupied days (OBDs) with an ABUHB mean average value of 6.85 as in February 2022.

Over the past 12 months the Inpatient Falls Policy has been revised and a new multi factorial risk assessment introduced. Falls prevention training has been made available to all hospital nursing staff and all inpatient falls that result in a fracture are presented at the falls review panel to support learning. Themes emerging from the review panel included compliance with accurate risk assessment and re assessment and challenges in enhanced care due to staffing pressure. A meaningful activity pilot is underway to support a revised approach to providing enhanced care.

Thrombosis

Thrombosis occurrence increases with age. Other risk factors include endogenous causes, such as cancer, obesity and clotting disorders while exogenous causes included hospitalisation, immobility and trauma. Hospital Acquires Thrombosis (HAT) are defined as venous thromboembolisms (VTE) that occur within 90 days of a hospital admission, the risk of them occurring can be mitigated by appropriate VTE risk assessment and prescribing of VTE prophylaxis.

ABUHB has a robust process in place to identify and review all HAT to establish if the occurrence was avoidable.

Figure eighteen demonstrates that since June 2020 only three HATs have been identified as potentially avoidable and Figure nineteen illustrates the areas of occurrence of HAT and the two clinical areas where avoidable HAT have been noted. A standardised approach to provide feedback to clinicians and specialities is being agreed through the ABUHB Thrombosis committee.

Figure 18 HAT data Apr 20- Jun 22

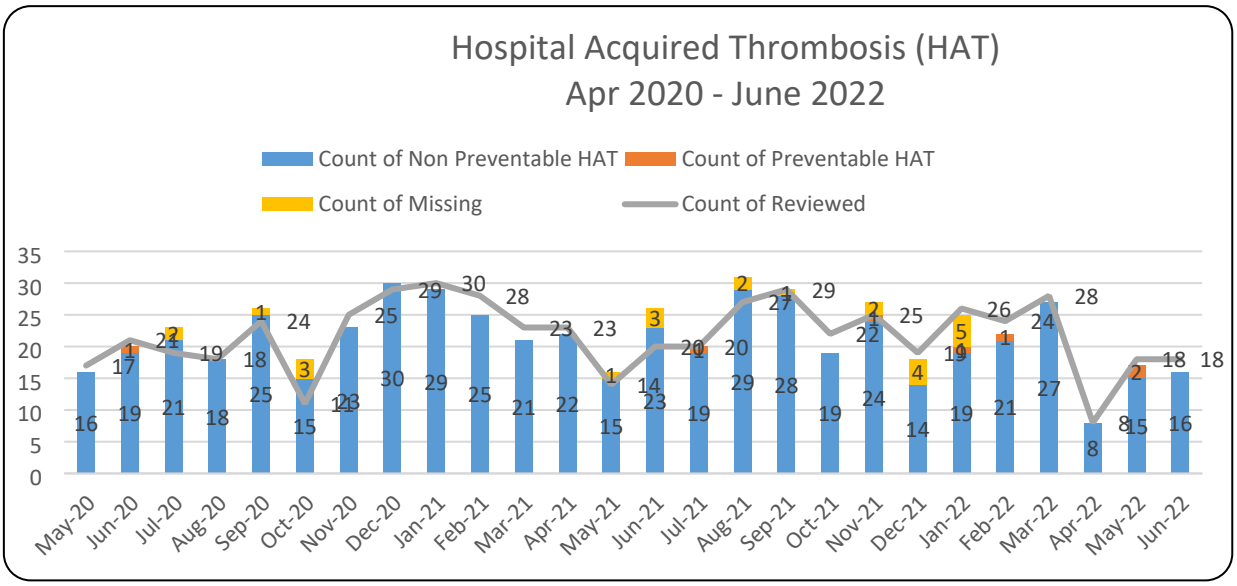


Figure 19 HAT data per speciality

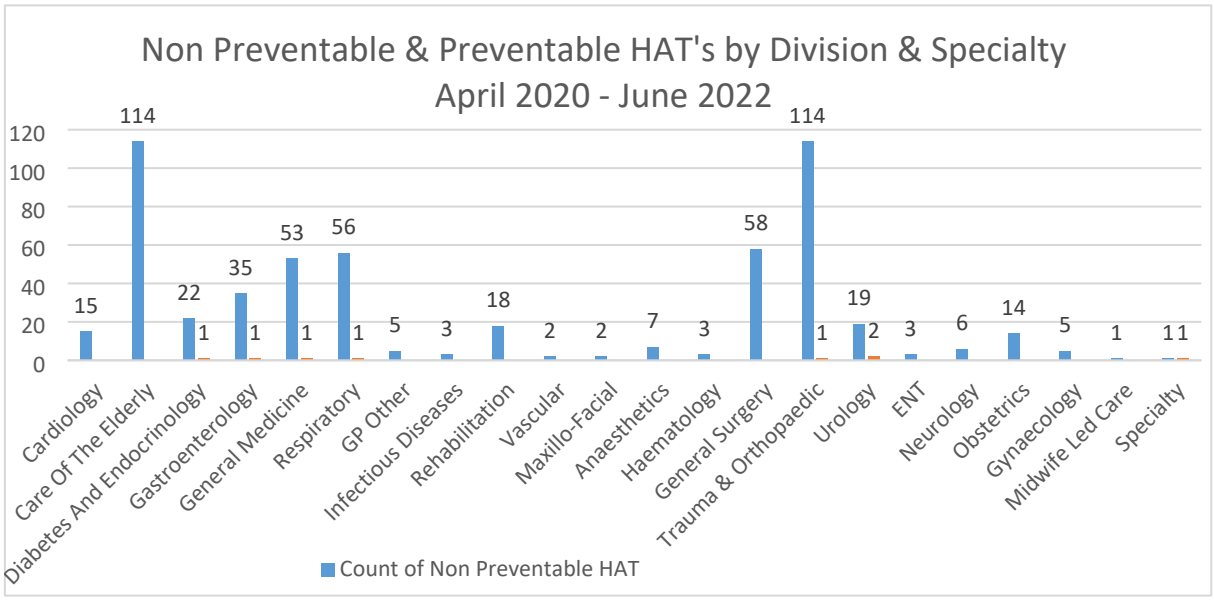
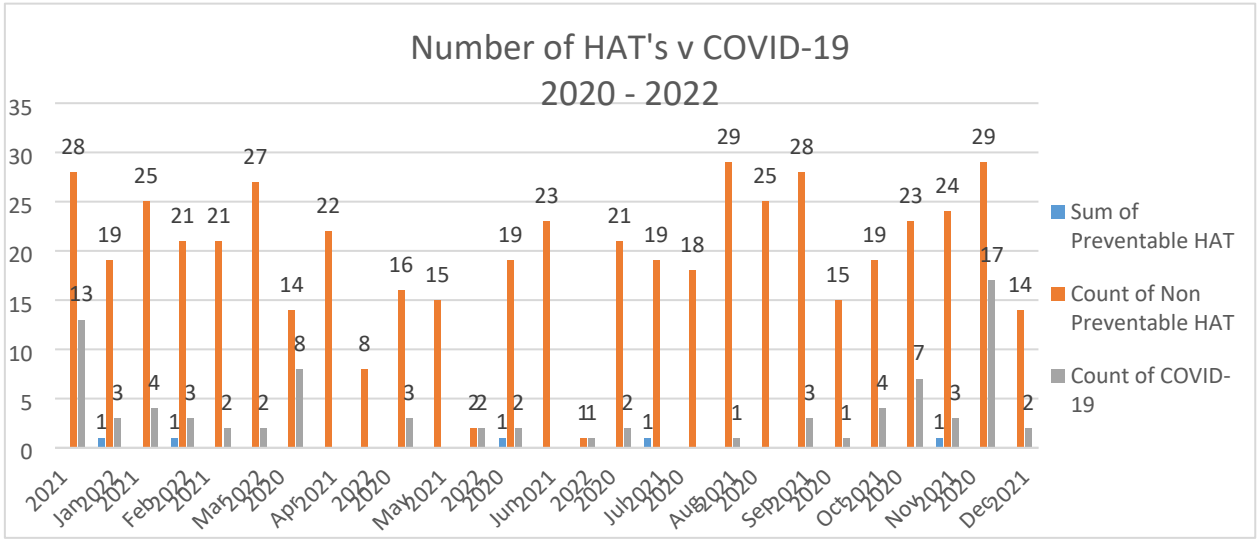


Figure twenty illustrates the occurrence of HAT associated with Covid.

Figure 20 HAT associated with COVID



National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit (NELA) identified Royal Gwent Hospital as a mortality rate outlier in 2019-2020 with an adjusted mortality rate of 14.4% compared to a mortality rate of 9.5% in NHH and 8.7% nationally. NELA reports now reflect the opening of GUH and relocation of surgery to this site. There has been an ongoing programme of improvement focusing on increasing the presence of consultant anaesthetists and surgeons in theatres, reducing delays to theatre and improving multi-disciplinary decision making around post-operative admission to ITU. This data has been presented by the anaesthetists and recent NELA Mortality and Morbidity reviews have been undertaken as well as a review of NELA performance results. Whilst there has been

NELA produce Exponentially Weighted Moving Average (EWMA) mortality charts to provide near real-time 30 day unadjusted in-hospital mortality. The EWMA chart displays the expected range of mortality given the hospitals case mix, and the hospital's actual mortality. The unadjusted data in Figure twenty-one shows the mortality since GUH opened. A wider time frame of data is available from RGH and NHH pre GUH opening (see Figures 22).

Figure 21 Real Time ABUHB NELA Mortality (EWMA) since GUH opened

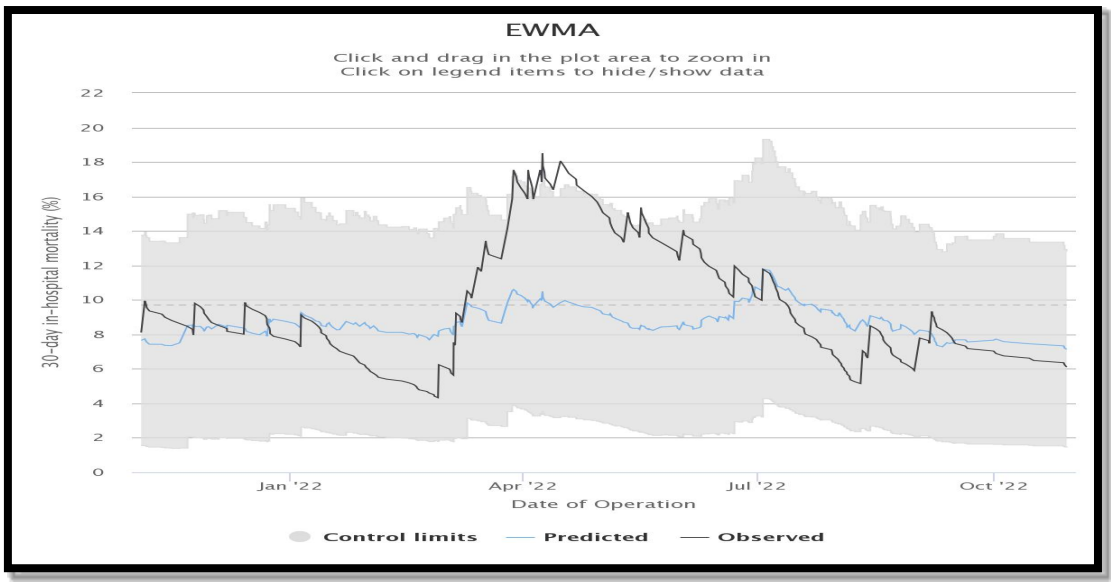
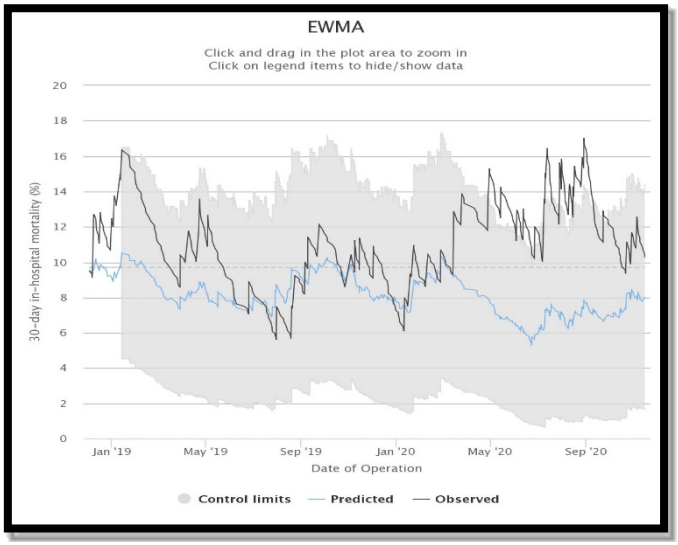
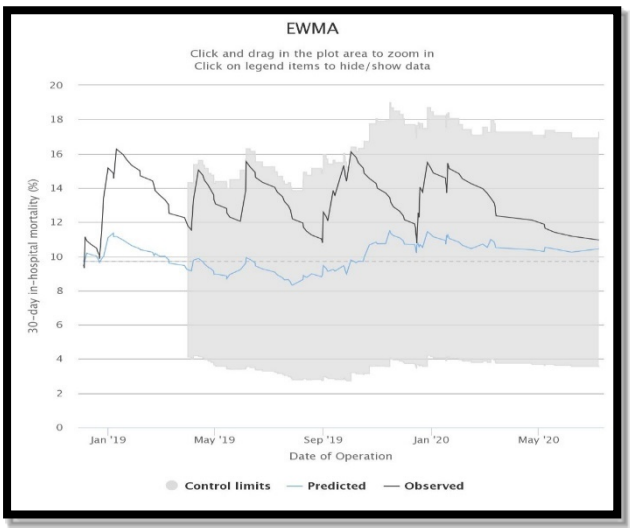


Figure 22 Real Time ABUHB NELA Mortality (EWMA) for RGH (left) and NHH (right)





The critical care lead for NELA in ABUHB has presented the data to the anaesthetics directorate and is working collaboratively with the NELA leads in anaesthetics, surgery, emergency medicine (EM) and COTE to capture own specialty views on this matter.

The sharp rise in the mortality rate as illustrated on the EWMA chart was due to 12 deaths out of 48 cases over a 6-week period in March and April 2022. An alert from NELA was issued at the time and all of these cases were reviewed by the NELA leads. Most of these patients were high risk, and some patients underwent a palliative procedure for metastatic cancer. A review demonstrated that overall, there were no concerns in care identified. The NELA group feel the team is generally functioning well within a new hospital set up.

There have been significant improvements in the pathway for these patients with the addition of Emergency Department and Perioperative Older Persons Surgical service (POPS) leads for NELA patients. However, our admission rates to critical care for high-risk patients remains well below the national average. It is believed that more post laparotomy patients need to be accepted onto critical care. This is not always possible due to a lack of capacity, which may result in a delay in the ability to discharge patients to the wards due to a lack of beds. The flow of these patients through critical needs to be reviewed as there is an understandable reluctance taking a patient of borderline risk with an anticipated stay on the unit that is for two weeks.

The number of cases for emergency laparotomies over the past few months is being scrutinised following the increase in the EWMA graph. The cases are being reviewed at M&M. There is an active M&M programme for the NELA patients that is attended by all the NELA leads. All of the NELA patients over 65 have their notes reviewed by a Clinician, who has confirmed there have not been any concerning patterns of care that contribute to death from a medical perspective. It is felt that most of the deaths relate to non-surviving pathology. It is believed that the vast majority of patients going to theatre are going appropriately. The documentation in notes shows evidence of considered and thoughtful decision making, both on the ward and within M&M meetings.

A number of actions points have been identified from those M&Ms that has been put to the CDs in anaesthetics, critical care and surgery. The specialty leads will follow up on action points assigned to individuals.

Our best achievements on NELA in AB:

- Improved access to geriatric physician for older +/- frailer patients following their emergency laparotomy (ABUHB is one of the best performing centres in the UK).
- Emergency medicine (EM) lead on NELA pathway improvements (AB is one of the few trusts nationally that manage to have an EM lead on NELA – the forthcoming national report will dwell into the lack of EM engagement in NELA, so we are well ahead of the game).

We have managed to do well on these:

- Improved risk stratification of patients identified for emergency laparotomy
- Consultant supervision in theatres for high-risk NELA patients (>5%)

Challenges and how we could improve include:

- Tripartite discussions peri-operative (preferably pre-operative) between anaesthetics, surgery and critical care consultants
- Improved admissions to critical care for all high-risk emergency laparotomy patients

Whilst trying to achieve all the 6-step bundle, this will not make us have the lowest mortality in the UK, but the group are reassured that the patients had their best possible care. There is an appreciation that whilst we are still way off target to achieve the elements contained with the bundle that has been implemented elsewhere.

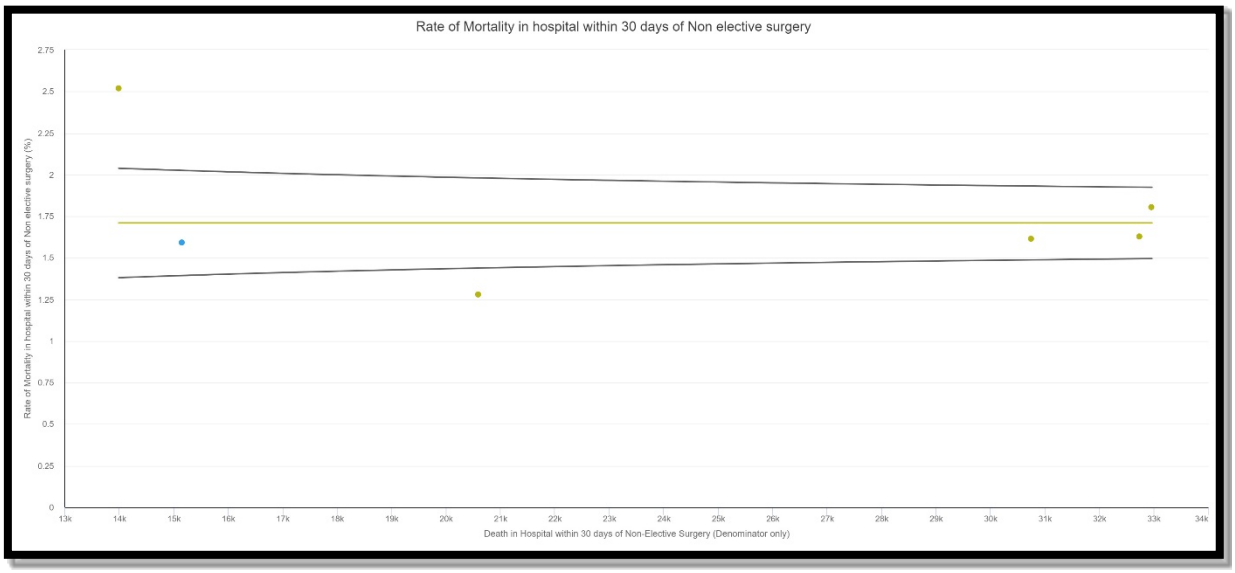
To continue to provide assurance around this:

- The Quality and Patient Safety reports will continue to monitor and report data from the NELA report and continue to build the momentum within the Health Board.
- The group have requested the need for an Executive Lead (or a nominated deputy) to help implement the standards and processes of care, and recommendations from the NELA leads in the Health Board. With the number of National Clinical Audits (NCAs) requiring participation it is not possible to have an Executive Lead for all NCAs. However, if audit results are presented to the Clinical Standards Effective Group (CSEG) this meeting is chaired by the Deputy Medical Director and attended by the Assistant Director for Quality and Patient Safety who would help support and help facilitate the recommendations for improvements in NELA results. Audit results from this group are taken to the Patient Safety and Quality Outcome Committee (PSQOC) which has Board oversight.
- Ensure there are regular meetings or to develop a forum with Execs (or deputy) and the NELA leads that ensures data is discussed continuously, including improvements acknowledged and an action plan for looking at outcomes and reports. With reporting of audit finding to CSEG, this will allow successes to be recognised and challenges to be documented with ongoing actions. This Group would ensure that concerning audit findings or unmanaged risks are escalated to Board via PQSOC and will ensure these risks are placed on Directorate or Divisional risk registers.

Non elective Surgery Mortality

30-day mortality associated with non-elective procedures is recorded as a percentage of total surgical cases and is illustrated in the Figure twenty-two compared with Welsh Health Organisations. ABUHB performance is 1.64% for October 2021- October 2022 2022 compared with the Welsh peer average of 1.487%.

Figure 22 Non elective 30-day inpatient mortality



Elective Surgery Mortality

Figure twenty-three illustrates the ABUHB performance relating to 30-day inpatient associated with elective procedures. ABUHB have a 0.0842% 30-day inpatient post elective surgery mortality rate for October 2021 – October, a decrease of 5.095% compared to last year.

Figure 23 Elective Surgery 30-day Inpatient Mortality compared to peers (Jan 20- Aug 22)

ABUHB Blue **Wales Green**

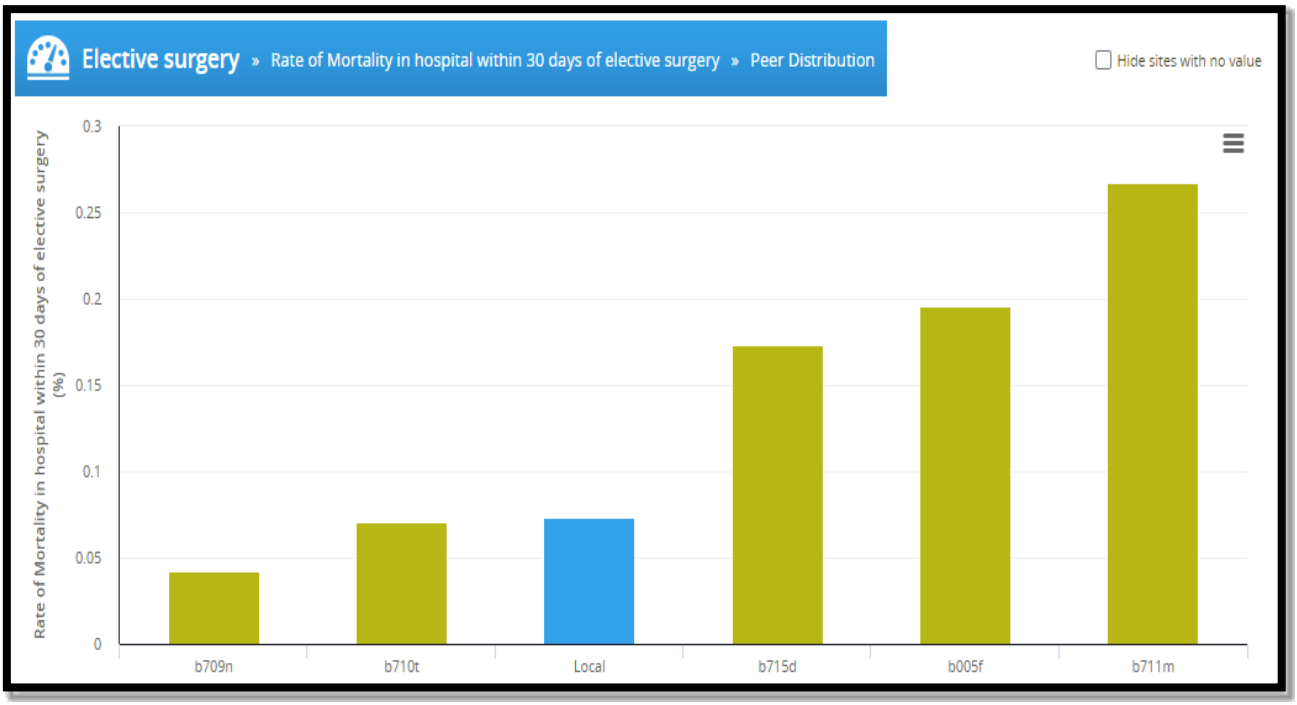
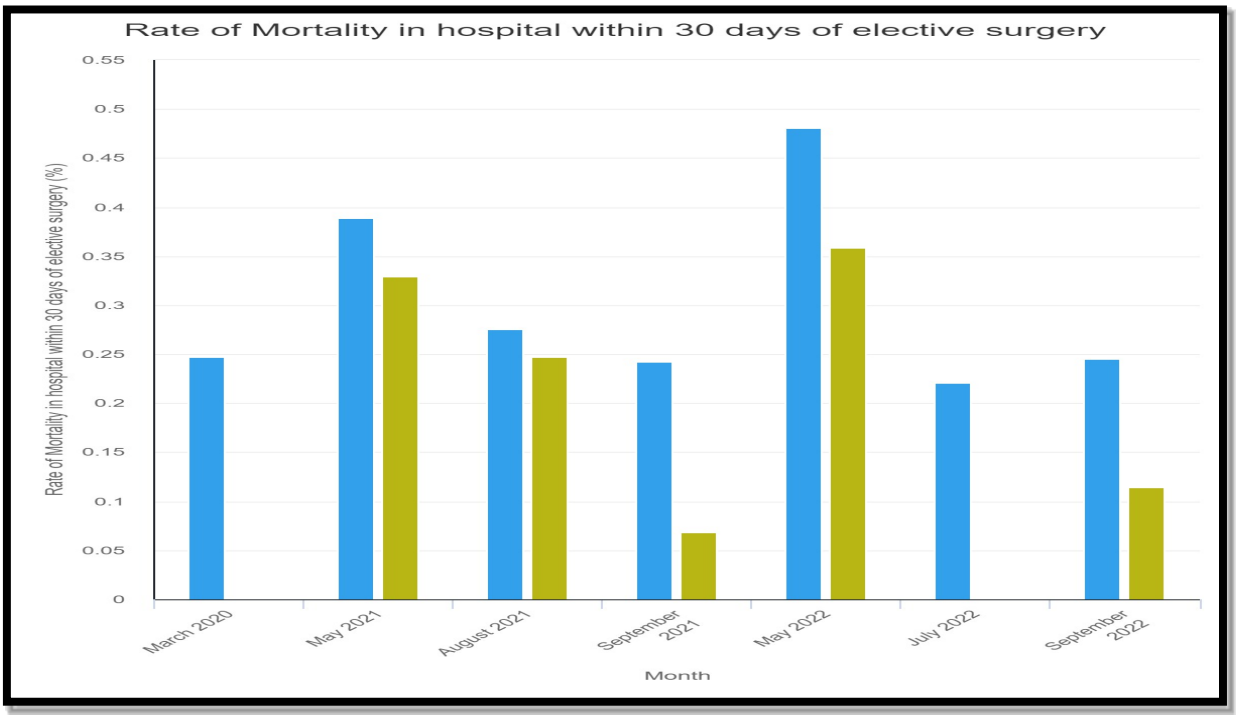


Figure 24 Rate of mortality within 30 days of elective surgery



Recommendation
The Committee are asked to: **NOTE** the assurance provided by the Health Board process to review and scrutinise care inpatient mortality **Discuss** the learning and improvements that are being implemented where required **Discuss** the format of future reports

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report reviews high level data in order to highlight learning from death. The quality improvement initiatives in this report are being undertaken to improve patient safety and therefore reduce the risk of harm to our Patients. Improved patient safety also reduced the risk of litigation Issues are part of Divisional risk registers where they are seen as a particular risk for the Division and a number of areas are also included within the Covid and Corporate Risk Registers.
Financial Assessment, including Value for Money	*Some issues highlighted within the report will require additional resources to support further improvement. These will be subject to individual business cases which will contain the full financial assessment. In many cases, improving the quality will reduce harm to patients and/or waste, but this will also be highlighted in the business cases.*
Quality, Safety and Patient Experience Assessment	The report is focussed on improving quality and safety and therefore the overall patient experience.
Equality and Diversity Impact Assessment (including child impact assessment)	NA
Health and Care Standards	Health and Care Standards form the quality framework for healthcare services in Wales. The issues focussed on in the report are therefore all within the Health and Care Standards themes, particularly safe care, effective care and dignified care. Many of the themes reported in the paper have been discussed and presented at ABUHB groups that from part of the quality assurance framework
Link to Integrated Medium Term Plan/Corporate Objectives	Quality and Safety is a section of the IMTP and the quality improvements highlighted here are within the Plan.
The Well-being of Future Generations (Wales) Act 2015 –	**Long Term –** Improving the safety and quality of the services will help meet the long term needs of the population and the organisation.

5 ways of working	**Integration** – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – Increasingly, as we develop care in the community, the quality and patient safety improvements described work across acute, community and primary care.
	Prevention – Improving patient safety will prevent patient harm within our services.
Glossary of New Terms	
Public Interest	Report has been written for the public domain

Patient Quality & Safety Outcomes Committee

Health and Safety Assurance Report

Health and Safety Governance

Accountability

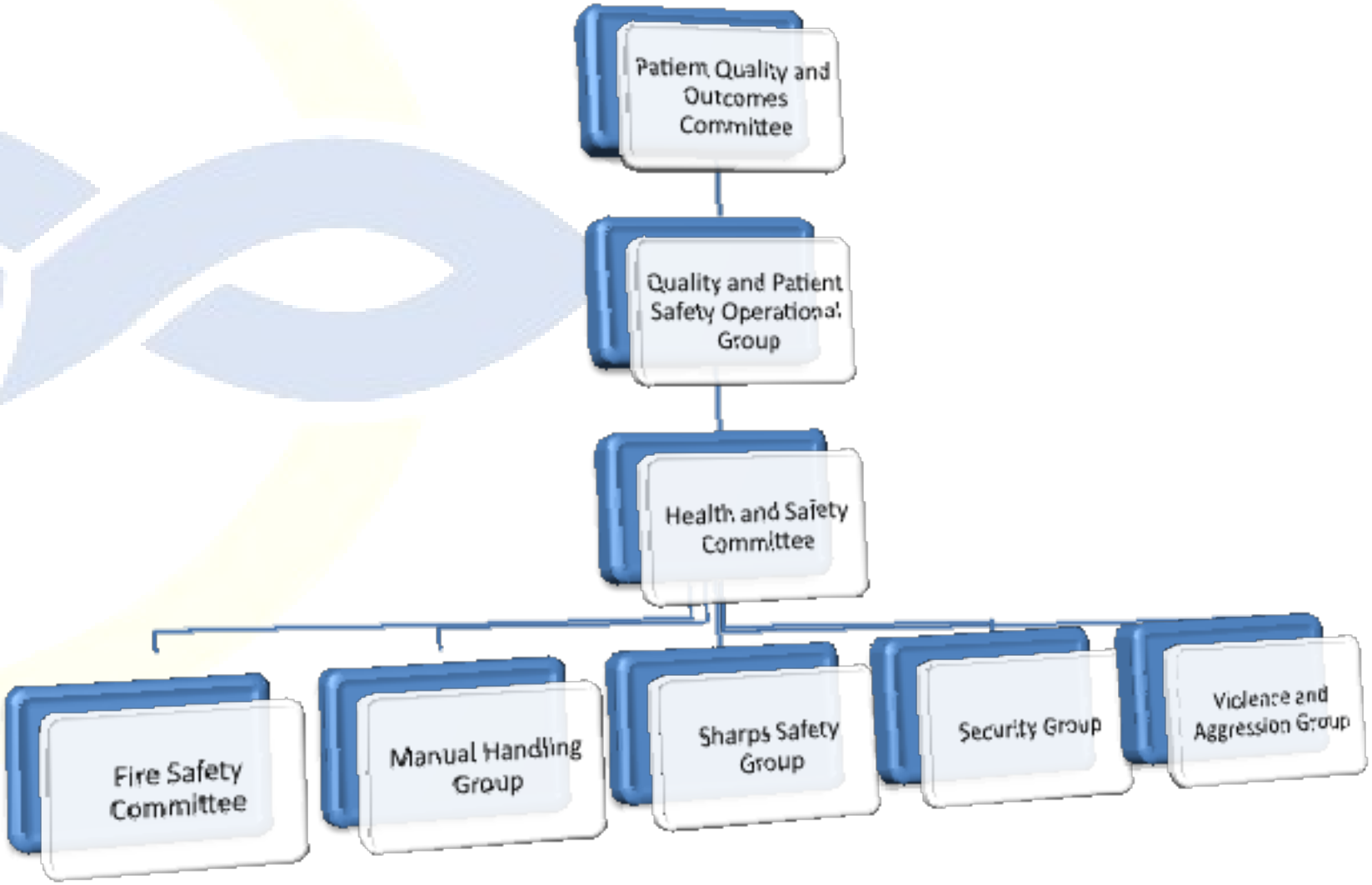
The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Therapies & Health Science.

Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties. The Committee receives reports from the subgroups and ratifies policies.

The Health and Safety Committee is accountable to the Quality and Patient Safety Operational Group, which is in turn, responsible to the Patient Quality and Safety Outcomes Committee.

Health and Safety Governance



Health and Safety Governance

Health and Safety Policies

Numerous health and safety policies have been developed to outline the Health Boards plans to achieve compliance with the relevant health and safety legislation and/or standards.

An objective for 2022/23 is to ensure all organisational health and safety policies are reviewed and updated as appropriate.

Health and Safety Governance

Audit and Assurance

There has been no Internal Audits on health and safety in 2021/22. However, recommendations from previous Internal Audits conducted in 2019/20, which elicited a 'limited assurance' response, are still being monitored. The recommendations relate to **health and safety workplace inspections** and **quality of risk assessments**.

The plan to revitalise the health and safety auditing process was severely impacted by the demands placed on the Corporate Health and Safety Department by the Covid-19 Pandemic.

Regular and robust audit programme will be revitalised in 2023, this is supported by the recruitment of a Health and Safety Advisor who has designated responsibility for monitoring compliance with health and safety standards, complimenting managerial controls.

Health and Safety Governance

Audit and Assurance *(continued)*

There has been engagement with the Divisions to actively review and update risks recorded on the risk module on the Datix system. This will support the programme to improve the quality and management of risk assessments. The Corporate Health and Safety Department are working collaboratively with the Corporate Governance Team to deliver the education programme for risk assessment within the Health Board.

The Health and Safety Legislative Assurance Framework identifies compliance with health and safety statutory instruments. The document is subject to the annual review, by the Corporate Health and Safety Department and Business Leads, in 2023.

Health, Safety and Fire Enforcement

The Health Board has not been subject to any enforcement activity during recent years.

However, there has been engagement with the Health and Safety Executive with notification of contraventions issued. These have been subject to fee for intervention (FFI).

What is FFI? If you are found to be in material breach of health and safety law, you will have to pay for the time it takes us to identify the breach and help you put things right. This includes investigating and taking enforcement action and is called fee for intervention. The FFI hourly rate is currently £163.

South Wales Fire & Rescue Service continue to monitor Health Board compliance with fire safety legislation as part of a planned audit programme.

Risk Management and Risk Reporting

H&S High / Extreme High Risks

The Corporate Health & Safety Department are supporting the review / audit of all Health & Safety Risks recorded on the Datix system with a risk rating of High or Extreme High (12+).

The review will consist of both desktop and or formal review with the goal of improving the accuracy of recorded risks and identifying further mitigation to ensure all reasonably practicable steps have been taken to mitigate the associated risks.

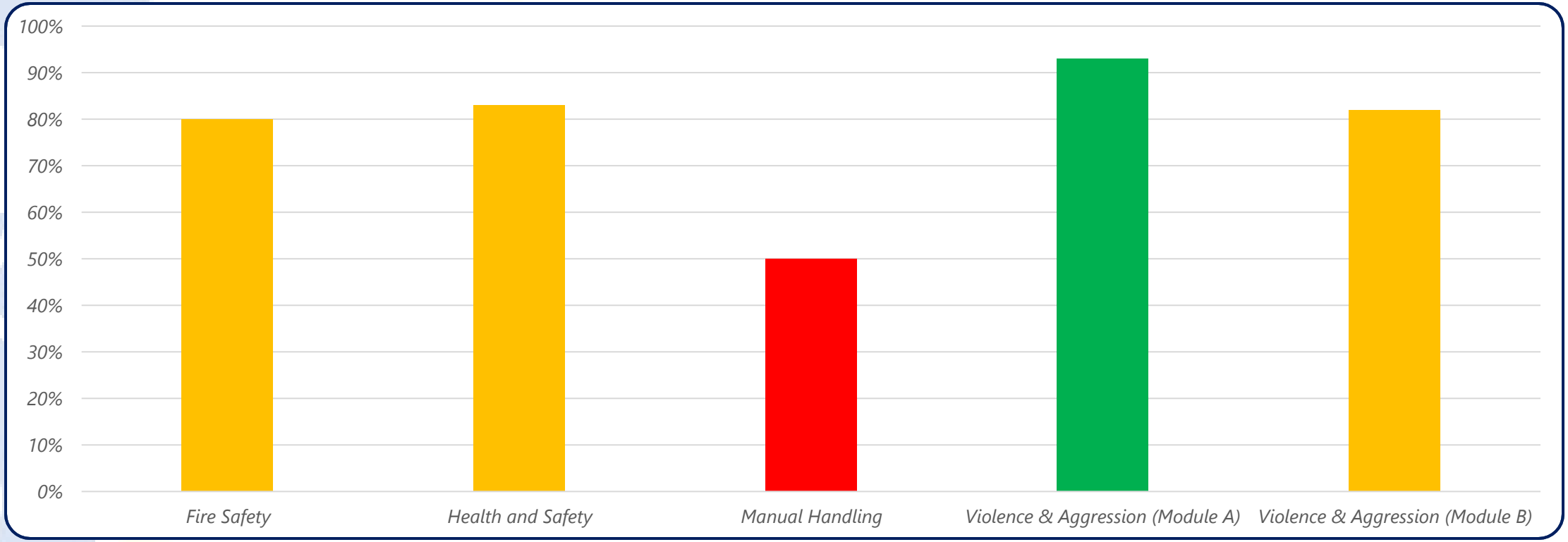
Risk Assessors

A review is being conducted of risk assessors (previously known as Competent Persons) across the Health Board to identify gaps.

A revised programme of risk assessment training will be rolled out early in 2023 to support the risk management strategy.

Health and Safety Statutory & Mandatory Training

The below chart illustrates the current health and safety statutory & mandatory training compliance

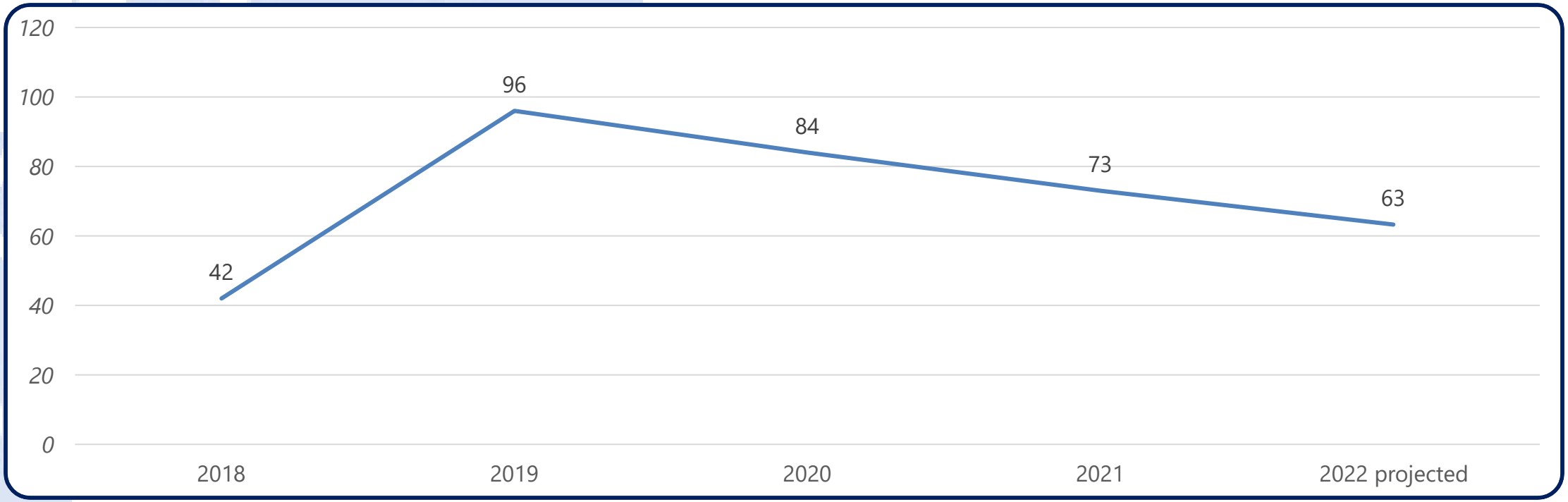


This data has been extracted from ESR and is accurate at end of October 2022

Health and Safety Incident Reporting

RIDDOR reportable Incidents

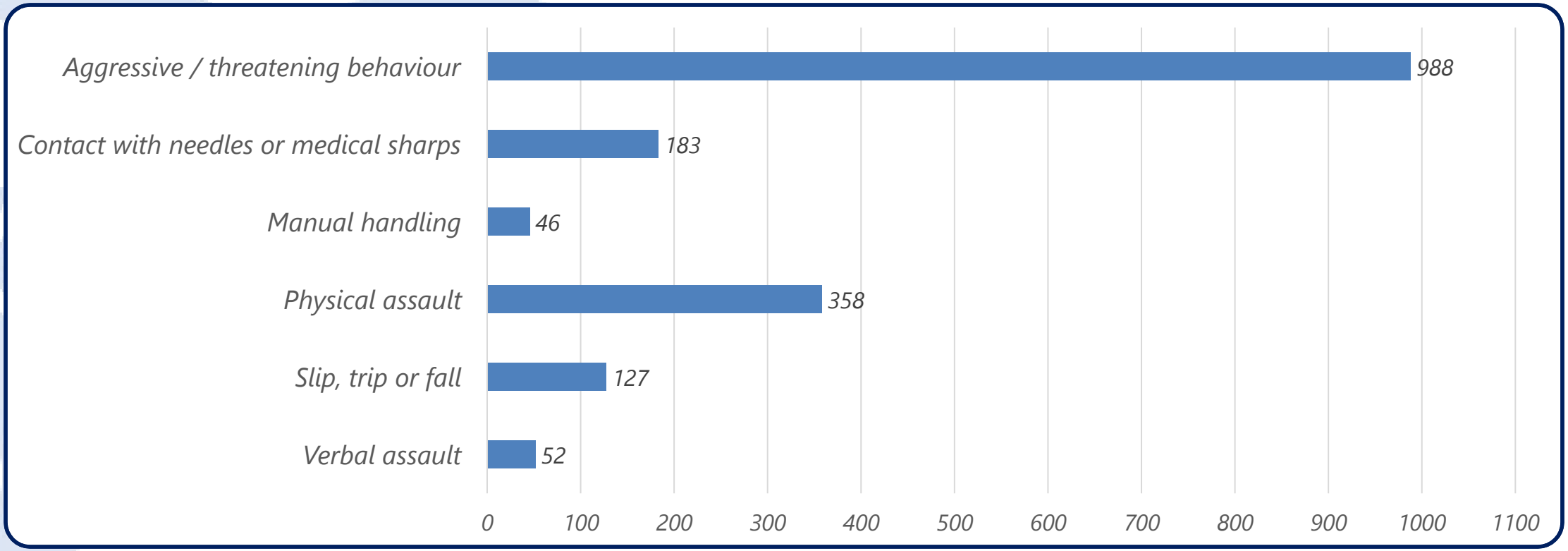
The chart below illustrates the number of RIDDOR reportable incident referred to the HSE over the past 5 years



Health and Safety Incident Reporting

Staff Incidents

The chart below illustrates the top five staff incident type reported since January 2022



Health and Safety Update

H&S Environmental Audits / Inspections - Corporate Health & Safety will be recommencing the monitoring programme with the focus on the environment. As RGH and NHH have had significant changes during the pandemic these will be targeted initially. The findings will be recorded on AMaT to enable evidence of improvement and to analyse data.

HSE Inspection – HSE inspection of Containment level 3 facility (CL3) in Microbiology on Thursday 3 October 2022. The inspector has indicated there will be a letter recommending some improvements (**not a formal improvement notice**).

Fire Safety Update

Fire Alarm Systems – Welsh Government Estates Funding Advisory Board (EFAB) bids have been prepared to replace the fire alarm systems at Royal Gwent Hospital and St Cadocs Hospital.

Fire Safety Training – the Fire Safety Team are currently reviewing the training strategy within the Health Board. The revised strategy, including training needs analysis will target the highest risk areas i.e. patient care areas.

Fire Wardens – there are currently in excess of 500 fire wardens trained across the Health Board. The Fire Safety Team are reviewing the activity of the wardens to establish if they are conducting the proactive monthly checks required for the role.

Fire Doors – following recent visits by the South Wales Fire & Rescue Service it has been highlighted that fire doors are being wedged or left open. To raise awareness of the importance of fire doors a health and safety information sheet has been circulated

Manual Handling Update

Training Programme for 2023 – a programme of manual handling training for 2023 will be published end of November / beginning of December. The programme has been developed following an analysis of workforce data and foundation training is planned to meet the turnover of staff in the highest risk areas.

Manual handling updates – the All Wales Manual Handling Passport identifies that updates are required no more than 3 yearly. Within the Health Board the current standard is every 2 years. The Manual Handling Team are currently reviewing a move to increasing the update to 3 yearly. Although this would significantly improve compliance the focus must be on competence of the individual to complete the task.

Inanimate Load Handing – A review is being conducted to establish the requirements for "low risk" staff/areas to complete manual handling training (modules A & B).

Violence & Aggression / Security Update

Guidance on Management of Unacceptable Communications – guidance has been developed to support staff on the actions to took when dealing with unacceptable communications

Security Management Review – the Health Board commissioned Security Experts to review the security arrangements across five sites. The review is currently being analysed and the findings will be shared with the relevant site management groups. Meetings are planned to review the Security Strategy for the Health Board

Aneurin Bevan University Health Board

Health Board Committee Update Report

Name of Group:	Quality and Patient Safety Operational Group (QPSOG)
Chair of Group:	Peter Carr, Executive Director of Therapies and Health Science
Reporting to:	Patient Quality, Safety and Outcomes Committee
Reporting Period:	From the meetings held 14th September and 9th November 2022 (held by Teams)

Summary of Key Matters Considered by QPSOG:

Divisional Risk Registers/Concerns
The Divisional Quality and Patient Safety Leads were given the opportunity to escalate Divisional risks and concerns related to quality and patient safety.

The improvement in the rate of hospital falls was noted, especially in the community hospitals. It was agreed to investigate and monitor a recent increase in hospital falls at Chepstow Hospital and in the mental health units.

All Divisions noted the continued risk associated the increasing reliance on temporary staff (nursing and medical). It was noted that the risk of sustaining the community hospital surge capacity beds has reduced following an agreement to progress permanent recruitment of staff.

All the Divisional risks and concerns raised are included in the Divisional risk registers with information detailing the mitigation action being taken. The QPSOG was assured that the appropriate action is in place at Divisional level to address and mitigate the current risks to ensure the quality and safety of services. No risks were escalated for additional assistance from the QPSOG.

Quality, Patient Safety and Experience Report
A verbal report was presented and comments invited ahead of the formal report being prepared for presentation to the PQSOC meeting in December 2022.

Patient Dining Review
The group received an update on the patient dining review which has been completed in response to concerns about the Health Board's compliance with the national catering standards. The report and associated action plan will be presented to the Executive Team, inadvance of it being presented to the PQSOC in December (along with a broader update on the Nutrition & Hydration standards).

Corporate Health and Safety
The group received an update on key developments related to all functions of corporate health and safety

COVID Investigation
The group received an update on the COVID investigation

Neonatal Assurance Action Plan
The Family & Therapy Directorate informed the meeting of an incident involving a suspected drug error from medication borrowed from ITU with an extremely premature baby. The baby sadly died and this is now a police incident, as a result there is no outcome at the moment. Investigations found there was high demand on the unit with over commissioned beds. An action plan has been developed and learning shared. An audit has since been undertaken by Pharmacy regarding the management and safe storage of medication and a number of issues were picked up: medication borrowed should have been returned, it was found that medication was left on the workstation and not locked away in the Omnicell. Drugs cabinets have now been procured and fixed to a wall. A SOP has also been developed regarding the storage of medicine and borrowing medication from another department, this is complete and ratified. A structured education programme for MDTs is under development. It was noted that all Divisions must complete an annual storage of medicines audit.

Safe Care Collaborative
The group received an update on the Safe Care Collaborative which is taking place with Improvement Cymru and the Institute for Health Care Improvement. The collaborative will run from March 2022 until March 2024. The collaborative will address the leadership, culture and learning systems in the organisation.

Gentamicin Dosing
The Scheduled Care Division shared the document they had created for use in non-patient facing areas, which describes the event, outcome and learning from the use of gentamicin. This was commended as a good example of shared learning in the organisation.

HIW Visit of ED

The group were updated that there had been real progress with the improvement action plan. 3 improvement recommendations were identified with 26 actions and another 20 recommendations resulted in 75 actions. Overall excellent progress with actions. **HIW Unannounced Visit to YYF - Anwylfan & Ty Cafanol Wards** The group were updated that 3 improvement notices were received with 7 actions. The management response is in progress with the completed actions. The report will be shared with the group at the next meeting along with the SBAR after it has been to PQSOC.
Matters Requiring QPSC Level Consideration:
• Quality, Patient Safety and Experience Report (scheduled for PQSOC meeting in December 2022) • Progress Report on Standard 2.5 / Nutrition and Hydration, including the patient dining review (scheduled for PQSOC meeting in Feb 2023)
Key Risks and Issues/Matters of Concern
There were no key risks or matters of concern to note other than those already noted above.
Date of Next QPSOG Meeting: 18th January 2023

Highlight Report

Group Name:	**ABUHB Children's Rights & Participation Forum**		
Group Aim:	The Forum is led by the Family & Therapy Division on behalf of Aneurin Bevan University Health Board on the area of children's rights and participation**.** This is the key children's rights and participation forum for Aneurin Bevan University Health Board. The group will inform and drive a children's rights approach, placing the UNCRC at the core of planning and service delivery, influencing the integration of children's rights into every aspect of decision-making, policy and practice.		
Date Completed:	15 August 2022	**Date of last meeting**	12 August 2022
Completed By:	Dr Kavitha Pasunuru (Chair) Sian Thomas Consultant Nurse Child Health Rebecca Stanton, Head of Transformation Programme		
Distribution List:	Patient Quality		
Summary:	A varied agenda for the August Forum that included: – Group membership and consistent attendance. – Mapping and Scoping Children's Rights across ABUHB. – Ideas around how we can extend engagement and reach (possibly through Social Media). – Healthier Together Website and links to support our Families and Children living in Poverty. – Ongoing feedback around Young People supporting Recruitment processes. – Coproduction work and ongoing developments. – NEST/NYTH National Framework. – Discussion around the work of the Children's Commissioner and the planned survey rollout in the autumn term.		

Group Membership
Review of group membership to ensure a broad range of attendees. It was also suggested that people identify a deputy to cover AL and absence. In addition, it was agreed to record sessions to enable others to watch back if they couldn't make the meeting.

Mapping and Scoping
Discussion around the Mapping and scoping exercise to understand the activity happening across ABUHB, and explore opportunities of connectivity. There is a desire within the group to eventually bring in a young person rep onto the forum, and supporting them to chair. Ideas were discussed on how we might establish a Young inspectors Programme to support our 'Rights Way' approach (aligned with the Children's Commissioner Office) and a template to be circulated to establish a baseline position. Ideas were circulated around how we reach out to young people through Social Media, and it was felt a useful next step would be to invite communications team to our next meeting to plan our approach.

Healthier Together Website and connecting up services
Marion Schmitt, a Paediatrician, joined us to present regarding Healthier Together Website and the links we could make with both her and the Website. Marion asked for ideas from the group on how we could responsibly share data to ensure that Children living in poverty could access the maximum support available to them. A rich discussion developed about how we could make links between the Health Board and Local Authorities to ensure this could happen. A suggestion was put forward relating to the NHS app, and how we need to link things with the app for ease of families trying to navigate support.

Youth Engagement
Feedback was given relating to all the current activity happening in the coproduction space; Kavitha and Rebecca fed back about the parent group they are running to support the redesign of a Neurodevelopmental Pathway, Rebecca is engaging with the Regional Youth Forum to develop a Mental Health Campaign alongside ABUHB comms team, and Rebecca is engaging with Coleg Gwent around Mental Health resources.

NEST Framework
We discussed how this group fits in with the NEST framework and the alignment that is currently taking place across the Health and Partnership landscape.

AOB
Feedback was given around the recent Children's Commissioner's Office engagement exercise, a survey will be published for young people in the Autumn, and partners can contribute to the questions that we might like to ask. It was felt this could link in with the earlier agenda item around mapping to ensure we aren't duplicating. A request has been made to the office about developing a youth summit for young people across Wales, and the group had plenty of suggestions and ideas about how we can further increase our engagement with young people whilst upholding the rights of Children and Young People.

Comment from Chair / Items for Escalation
Looking at rolling out the mapping baseline by end of this month to start collating data.

Reporting Committee	**Quality Patient Safety Committee (QPSC)**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**25 October 2022**

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

1.0 Patient Story

The committee heard a patient video/story from a couple who had accessed neonatal intensive care for their two children. The family were very complimentary of the service they received both from the tertiary and local unit focusing on the importance of communication and bringing care as close to home as soon as possible. The family were thanked for sharing their story and how the issues they raised can feed into the current work being undertaken re cot configuration.

2.0 Welsh Kidney Network (WKN)

QPS members were advised of 3 high risks on the WKN risk register. One risk referred to the introduction by Welsh Government of a Quality Statement for kidney disease and the capacity of the WKN as currently configured to ensure delivery of all components of the Statement. They noted that further clarity is being sought from Welsh Government regarding the role of the WKN in this regard. Two further high risk relate to vascular access capacity at BCUHB and dialysis capacity at Ysbyty Glan Clwyd. Members were informed of actions being undertaken to mitigate these risks. A Peer Review on vascular access has recently been undertaken at BCUHB. The report and subsequent action plan is in the process of being completed. The actions are intended to address the vascular access capacity issue. With regard to dialysis capacity, members noted that this facility is independent sector provided and discussion are ongoing with the provider and the HB regarding options to increase capacity. Members noted that patients access to dialysis is not being compromised whilst these discussions conclude.

Members were also informed that a governance review of the WKN had recently been completed, an action plan was being developed and this would be brought to the Joint Committee in January 2023. They were also appraised of the recent Annual Audit Day held by the Network which was well attended and an informative learning event.

3.0 Commissioning Team and Network 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 & Blood**

The risk register for the commissioning team was presented to the committee. There was one new risk relating to the management of outreach clinics delivered by St Helen's & Knowsley NHS Trust on two sites in Betsi Cadwalader University Health Board. Assurance and progress were provided against the two services that are in escalation and further information is provided in the summary of services in the escalation table, which is attached.

- **Cardiac**

The risk to bariatric services remain unchanged; however conversations with an alternative provider remain ongoing. WHSSC is still awaiting the Royal College of Surgeons' report for Swansea Bay University Health Board. The committee requested that this was escalated if not received shortly.

- **Neurosciences**

A neurosciences update was received by the committee. Members noted that the risk that patients were being prevented access to the Thrombectomy services in North Bristol, due to the current 3D biotronics-imaging platform not meeting the current Welsh Government cyber security credentials was now resolved and had subsequently been closed by the Commissioning team in October 2022. The risk relating to neurosurgery in South Wales had also been lowered, due to an improvement in both theatre and bed capacity and will be monitored over the coming months. The committee was informed that the Community Health Council (CHC) had undertaken a positive visit to the spinal unit in Llandough Hospital and the report would be published shortly. The quality team would follow this up with CVUHB.

- **Women & Children**

The committee was updated re the risks and, in particular, the risk regarding Paediatric surgery and noted the ongoing work being undertaken. Information had been requested from the Health Board and options regarding outsourcing were continuing to be explored and a detailed recovery paper was due to go to Joint Committee on the 8th November 2022.

It was noted that there is now a Commissioning Assurance Group meeting for each specialised paediatric service at CHfW. There is a rolling monthly schedule, to capture every service. Within the Quality agenda, work is currently being undertaken to address how assurance is reported with the aim of creating a dashboard to gain assurance for each specialised service.

The committee received a progress update on Paediatric neurology and pathology, noting an improved position and the work that was ongoing to secure a longer term sustainable position.

- **Mental Health & Vulnerable Groups**

The committee received a report on any Quality and Patient Safety issues for services relating to the Mental Health & Vulnerable Groups Commissioning Team portfolio. This included a summary of the services in escalation which contained a progress update on the work being undertaken in Tŷy Llidiard.

Members were provided with an update regarding service on Eating Disorders. Following the end of the contract with Cotswold House on 31st August 2022, arrangements have been made to secure beds with the Priory Group for Welsh patients. These arrangements are in place until January 2023, in the first instance, with options to extend this arrangement. In the interim, options are being scoped and considered to inform an options appraisal exercise for long term sustainable options for eating disorder services, through the Specialised Services Strategy for Mental Health, and a medium term solution to stabilise services for the next 3-5 years.

In July 2022, in response to the recommendations of the Cass Review Interim Report, NHS England took the decision to de-commission the Tavistock and Portman NHS Foundation Trust and introduce two early adopter providers from Spring 2023. The committee was assured that WHSSC are involved in the NHS England programme work and noted that the interim service specification has been released for a 45-day consultation. An update paper on GIDS has been submitted to Corporate Directors Group Board and Management Group for information.

The committee was pleased to note that NHS England has provisionally allocated £5m capital funding to the North West Mother Baby Unit scheme at Chester. It is expected that the provider, Cheshire & Wirral Partnership Trust, will develop a full business case for submission to NHS England in next 3 months.

The Committee noted the work that the Commissioning Team was undertaking and felt it would be helpful to receive a deep dive and invite the newly appointed Director of Mental Health to present the work at the next meeting. The Secure Services review was also outstanding and would therefore be an opportune time to fully understand how the strands will fit in the Mental Health Strategy going forward.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

A detailed report was received by the committee. Reassurance was received regarding the substantial work that had been undertaken and it was pleasing to note that the risk had reduced since the last report. A query was raised regarding the invoicing position, which would be addressed outside of the meeting and reported in the next report if there were ongoing concerns or had an impact on quality and patient safety issues.

4.0 Other Reports Received

Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. The status of each service in escalation remains unchanged. However, the Cardiac services are making good progress and it is hoped that WHSSC will be in a position to de-escalate these over the next few months. The North Wales Adolescent Unit is also waiting for the NCCU review and should also be in a position to be de-escalated. The template for reporting would alter from next year in line with the work presented at the Development Day.

- **CRAF Risk Assurance Framework**

Members were provided with an updated positon regarding the WHSSC CRAF and noted the proposed engagement work to support the IPFR risk. Members noted the risk workshop that had taken place on September 20th and the SWOT analysis undertaken on each risk to support the process of review and updating.

- **Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update**

The committee received the report and agreed that any inspections undertaken by the CHC would be included in the future.

- **Incident and Concerns report**

An update report was noted and received by the committee for assurance. There have been 10 new incidents reported to WHSSC over the period July 2022 to end September 2022.

- **Development Day summary report**

A second Development Day was held on the 16th September 2022. Committee members received a summary from each of the sessions and a copy of the presentations. Six out of the seven Health Boards were represented and positive comments were received regarding the content of the day. An evaluation of the day had been circulated and will be used to consider the content for forthcoming days and any improvements that could be made.

- **WHSSC Quality Unit Final Internal Audit Report**

A copy of the Final Internal Audit report, undertaken in June 2022, was received by the Committee. Substantial assurance was received with one matter requiring management attention:

  - There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

The agreed management plan has been accepted and a discussion was initiated at the Development Day. It was agreed that the report would to be considered by the All Wales Health Board Chairs QPS Committee and future auditing of compliance would be monitored through that group. Assurance was received that Health Boards do already have reporting systems in place to address the issue. A copy of the report is attached.

- **Quality Newsletter**

A copy of the second Quality Newsletter was received by the committee and is an Appendix to this report

5.0 Items for information:

Members received a number of documents for information only:

- Chair's Report and Escalation Summary to Joint Committee 6 September 2022,
- Welsh Risk Pool and Legal & Risk Services Annual Review
- QPSC Distribution List; and
- QPSC Forward Work Plan.

Key risks and issues/matters of concern and any mitigating actions

Key risks are highlighted in the narrative above.

Summary of services in Escalation (Appendix 1 attached)
WHSSC Quality Unit Final Internal Audit Report (Appendix 2 attached)
Quality Newsletter (Appendix 3 attached)

Matters requiring Committee level consideration and/or approval The committee requested that the findings of the Quality Internal Audit Report were noted and considered by the Health Boards.	
Matters referred to other Committees As above	
Confirmed minutes for the meeting are available upon request	
Date of next scheduled meeting:	23 January 2023 at 13.00hrs

Appendix 1

SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Bed panel data submitted electronically • NCCU undertook Annual Review on 29th June 2022 report yet to be published. • Escalation status will be considered thereafter.	⟺

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, Exec Lead identified from Health Board. Last escalation meeting 11th October • Improvement Board established to oversee delivery of an integrated improvement plan • Emergency SOP has been fully implemented • Majority of posts recruited to or start dates agreed. • Candidate withdrew from Physician Associate post and further advertisement to be progressed. • Psychologist/Family Therapist post interviews scheduled for w/c 17th October • JD under development for Psychology Assistant post with recruitment to progress following the appointment of the Family Therapist • Improved leadership evident via escalation meetings	⟷

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• Last escalation meeting was held on 01/09/22 • Next meeting is on 09/11/22 • Consultant Psychiatrist Interviews are on 1st November and will be followed by Clinical Lead appointment • Recommendation will be made to CDGB on November 7th that service is de-escalated to level 2 if all outstanding issues are addressed at next escalation meeting	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 18.10.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Continued six weekly meetings in place to receive and monitor against the improvement plan. • The service was de-escalated on delivery of the immediate actions required by the GIRFT recommendations (per	

					March update), but has remained in level 3 whilst the impact of these actions is ascertained. • The escalation level was discussed again in October 2022 and significant progress towards the GIRFT benchmarks was noted. • WHSSC is waiting for the final report of the recent Royal College of Surgeons of England (RCS England) Invited Service Review to be submitted, with the Health Board's response, after which the potential for further de-escalation and revised monitoring arrangements will be considered in line with the Escalation Framework.	

July 2021 (original escalation) April 2022 (escalated from 2-3)	Cardiac Surgery	C&VUHB	3	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB had previously agreed a programme of improvement work to address the recommendations set out in the GIRFT report. • In view of a failure to provide the requested GIRFT improvement plan and HEIW report, the service was re-escalated in April 2022. • The service has now provided both GIRFT improvement plan and HEIW report (and action plan), and WHSSC has developed de-escalation criteria based on the GIRFT recommendations and action plans. • The de-escalation criteria will be discussed at the next escalation meeting. • Level 3 meetings were held in June and July, and a meeting was scheduled for September, but this was postponed due to staff availability. • In view of the following meeting being scheduled for November, an updated action plan was requested	

					(due for submission 11 October 2022)	
Date of Escalation	**Service**	**Provider**	**Level of Escalation**	**Reason for Escalation**	**Current Position 19.10.2022**	**Movement from last month**
November 2021	Adult burns	SBUHB	3	At the time of initial escalation, the burns service at SBUHB was unable to provide major burns level care due to staffing issues in burns ITU. An interim model was put in place allowing the service to reopen in February 2002. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model	• Escalation monitoring meetings held on 12th August and 27th September 2022. • The current timeline for completion of the capital works to enablerelocation of burns ITU togeneral ITU at Morriston Hospital is the end of 2023. • The next escalation monitoring meeting is arranged for 1st December 2022.	⟷

February 2022	PETIC	Cardiff University	3	• Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. • Recent suspension of population of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotape production failures. • Failure to produce a business case of sufficient quality in a timely manner for replacement of the scanner.	• PETIC is taking forward the agreed actions with regard to increasing management capacity within the service and clarifying the governance arrangements for the service. • The next escalation monitoring meeting is arranged for 5th December.	

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Welsh Health Specialised Services Commissioning NEWSLETTER

2nd Edition, Autumn 2022

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

South Wales Neonatal Units

This is the 2nd edition of the Quality newsletter from the Welsh Health Specialised Services team in Wales. Our plan is for these to be published on a quarterly basis to supplement reports and data already provided through different forums into Welsh Health Boards.

This Newsletter is available in Welsh on request. Mae'r Cylchlythyr hwn ar gael yn Gymraeg ar gais.

This gives an overview of some of the work we are involved with, and presents some of the highlights from a commissioning perspective. The services commissioned from Welsh Health Specialised Services Committee (WHSSC) are provided both in Wales and in England this will only provide a snapshot of our work.

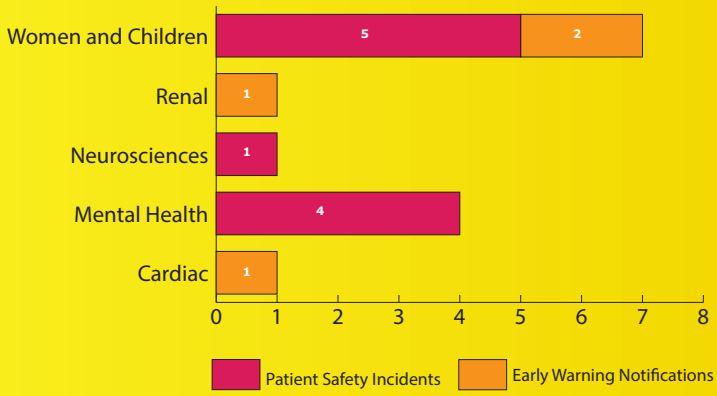
GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Contents

Reporting for the Last Quarter

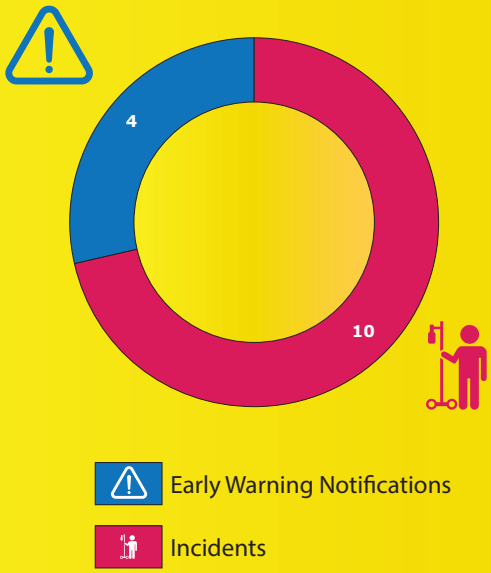
WHSSC do not investigate incidents but are responsible for supporting the investigations into these alongside the monitoring and reporting to the Health Boards. WHSSC are responsible for ensuring the delivery of safe services and ensure that trends or themes arising from concerns have actions plans which are are completed and support learning. WHSSC facilitates the continued monitoring of commissioned services and work with providers when issues arise.

Type by Commissioning Team



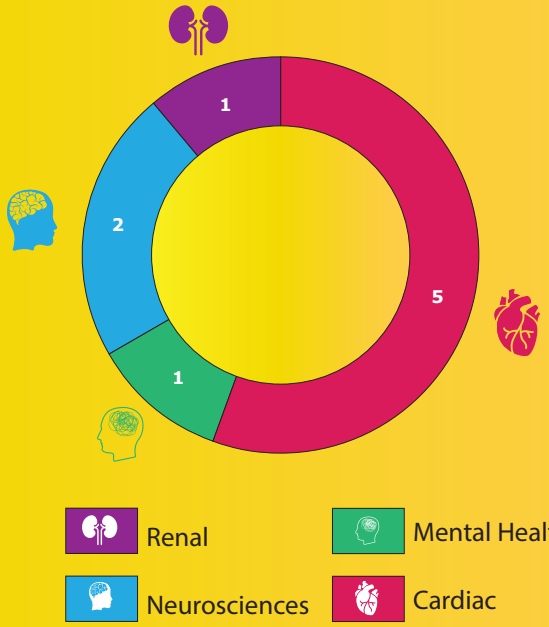
Patient Safety Incidents and Early Warning Notifications

Between March to July 2022, there were **10** Patient Safety Incidents and **4** Early Warning Notifications logged:



Patient Safety Incidents

Between March to July 2022, there were **9** Patient Safety Incidents closed:



Concerns raised with WHSSC may involve a direct response from the organisation or involve a joint response with the commissioning Health Board or WHSSC may need to ask the Health Board to respond directly.

Concerns

Incidents

Putting Things Right

Complaints

Update from the Patient Care Team IPFR (Individual Patient Funding Request)

The Patient Care Team receives and manages individual patient funding requests for healthcare that falls outside of agreed range of services.

An overview of IPFRs processed in Quarter 1 2022-23:

	Number of Requests discussed as Chairs Actions	Number of Requests discussed by All Wales IPFR Panel
April 2022	16	-
May 2022	7	14
June 2022	2	10

Welsh Gender Service

The Welsh Gender Service published their first ever Newsletter in Spring 2022 and a Summer edition is to follow. For now though, please see the Spring edition here:

Welsh Gender Service: Spring Edition Newsletter April 2022

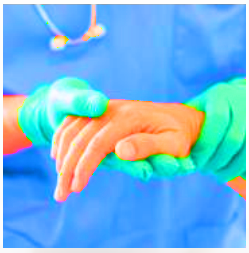
April and June 2022 Patient Safety Updates

Patient Safety Update: 5 April 2022

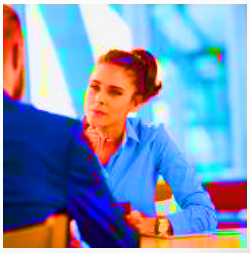
Patient Safety Update: 28 June 2022

Quality and Patient Safety Development Day

WHSSC will be holding a Quality and Patient Safety Development Day on 26th September 2022. Quality Clinical Colleagues and Independent member from across Welsh Health Boards will be in attendance. The day will feature data systems presentations from NHS England, the data team in WHSSC and presentations from the Delivery Unit team and NWSPP. A recap and feedback from the day will be provided in the next newsletter!



Patient Safety Incidents



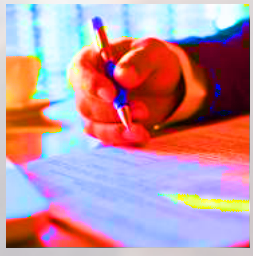
Listening

Never Events

Reassurance

Reporting

Learning



Compliance

Quality

Culture

Assurance

Feedback

Experience

Improving

Developing

Innovation

Ty Llidiard Co-production Event

Ty Llidiard have recently hosted a co-production event that involved young people, their carers and the staff based at Ty Llidiard. The event focused on the four C's: Compassionate, Calm, Confident and Caring.

Through consultation with Staff and the Young People who use Ty Llidiard, Scarlett Design came up with 4 potential design proposals with examples of how we would like to use them to create an internal and external philosophy and identity.

TŶ LLIDIARD
CARING · COMPASSIONATE
CALM · CONFIDENT

The day was split into 3 sessions:-

- ✓ Former service users and their families along with external stakeholders.
- ✓ The young people who were admitted at the time.
- ✓ The Ty Llidiard staff.

Over 70 people attended on the day with another 50 giving feedback electronically and by using the feedback forms and box that was left in the Ty Llidiard foyer for 6 weeks after.

The main themes to come from the young people were reducing boredom through engagement and activities and from the staff it was around communication and support.

Over 100 people voted on the visual identity / logo with nearly 70% voting on this design. The next steps are to use the agreed logo on uniforms, signage and on the exterior of Ty Llidiard. Positive feedback was received from the Director General of Health & Social Services/Chief Executive NHS Wales.

North Wales Adolescent Unit

There are positive developments for Children & Young People (CYP) who are being treated for Eating Disorders (ED) within the service. Over time, there has been a recognition that, the needs of young people admitted to Kestrel ward with an eating disorder have changed. Historically, Kestrel ward had a high proportion of admissions associated with Anorexia Nervosa (AN).

Across North Wales, there has been an increase in young people presenting with complex presentations around eating who require intervention. This is in line with the referrals and presentations seen within the inpatient context.

Kestrel ward have historically followed a weight restoration model for eating disorders, there has been no formal review of the ED pathway completed within the last decade. The recognised change in presentation of CYP has driven the change of pathway from one of weight restoration to a pathway with a stronger focus on Young People engagement. The inpatient ward is committed to developing an Autism friendly environment working alongside the National Autistic Society (NAS). The journey to accreditation with NAS has begun with the first meeting taking place in August 2022. Following a review of the environment, the NAS advisor was able to make suggestions as to what could be developed to ensure that the service could improve meeting the needs of CYP with a diagnoses of Autism Spectrum Disorder. The development of the environment is clinically led by the nursing team and operationally partnered by the broader MDT.

The service has welcomed a new role this year, the Patient Liaison Officer role was developed following a trend in concerns noted by CYP & families that recognised how communication between the service and families was not as effective as it could be.

The liaison officer has taken an active role in enhancing parts of the admission pathway including the information that is distributed to CYP & families pre admission, this includes the development of an North Wales Adolescent Service (NWAS) specific website.

There is a strong emphasis on what the role is and how this can support the CYP & family journey. In addition, the liaison officer is also closely linked to the regional Betsi Cadwaladr University Health Board (BCUHB) Child and Adolescent Mental Health Services (CAMHS) patient experience leads who have developed an action plan for improved patient experience in practice.

The liaison officer supported the children's charter events held by the CAMHS BCUHB patient experience leads, building on the existing principles of CYP engagement and enhancing the focus of patient centred care.

The development of the Advanced Nurse Practitioner (ANP) pathway is now complete, the service currently has 4 ANP trainees with a 5th joining in December, all of which are in the final phase of their academic studies, during their training phase the trainees are undertaking advanced level nursing tasks under supervision to ensure that they able to meet all 4 pillars of their advanced level training.

Ty Llewellyn Medium Secure Unit

A meeting with the quality team in WHSSC took place with Ty Llewellyn Medium Secure Men's Adult Mental Health Unit in July 2022. An update was provided on the progression of the environmental, workforce and quality developments which have been underway to support a more therapeutic environment and clear recognition of physical health monitoring in mental health patients.

These have included the development of a more robust handover, physical health check monitoring, NEWS training and access to medical cover 24 hours 7 days a week and a policy to support individual therapeutic monitoring.

Staff sessions on physical health checks have included further training around sepsis management and the recognition and monitoring of side effects which may occur following the long term use of medications.

A culture of openness and transparency is continuously being encouraged and supported.

Outcome measure training is being facilitated for some of the staff and there are some further developments within the unit to capture patient experience, which will be shared once completed.

Moondance Awards

The Moondance Cancer Awards 2022 held on June 16th to celebrate 'brilliant people across NHS Wales and its partners who maintained, and innovated, cancer services despite the extraordinary circumstances of the last two years'.

Among the lucky shortlist of delegates eagerly awaiting the results were colleagues from the All Wales Positron Emission Tomography (PET) Advisory Group who submitted an application to the 'Achievement: Working Together' category and All Wales Genomics Oncology Group (AWGOG), All Wales Medical Genomics Services (AWMGS) and Velindre Cancer Centre (VCC) who submitted a co-application to the 'Innovation in Treatment' category.

Presiding over judging of the innovation category were an esteemed panel of judges including UK Medical Director of the Telemedicine Clinic, Cancer Clinical Director for Wales Prof Tom Crosby, CEO of Tenovus Judi Rhys MBE and Prof Neil Mortensen, President of the Royal College of Surgeons.

The judges were reportedly *"delighted and humbled by the number and quality of submissions received".*

WHSSC staff enjoying the Moondance Awards, from left to right: Professor Iolo Doull, Dr Andrew Champion and Sarah McAllister. Dr Champion and Sarah McAllister were part of the shortlisted All Wales PET Advisory Group!

Upon declaring the winning result to the AWMGS/AWGOG/VCC application, the judges noted the formidable achievements of each of the following three initiatives commissioned via WHSCC:

1. The DPYD gene testing pilot in collaboration with VCC saw Wales become the first UK nation to routinely offer DPYD pharmacogenetic screening for cancer patients in receipt of certain types of chemotherapy
2. The All Wales Genetics Oncology Group (AWGOG) since its formation has published timely clinical guidance on NTRK gene and FGFR2 gene fusion diagnostic testing for cancer treatment following NICE recommendations
3. Cymru Service for Genomic Oncology Diagnosis (CYSGODI) launched in 2021 offer high-quality oncology precision medicine services using next generation sequencing technology to screen for targeted genes in a tumour and haematological malignancy.

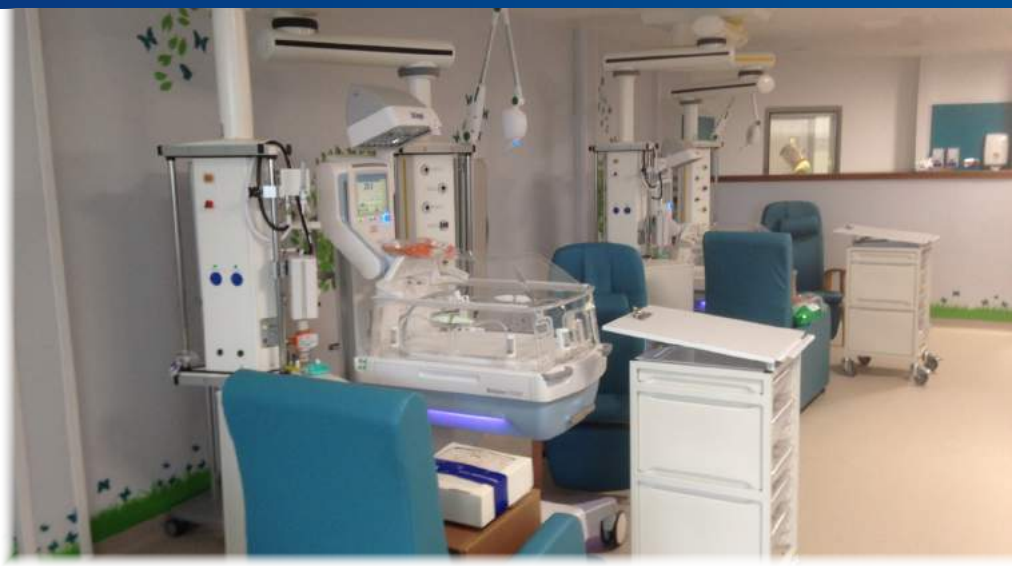
A huge congratulations to The All Wales Genomics Oncology Group for winning the Innovation in Treatment Award and also to The All Wales PET Advisory Group for being shortlisted in the Working Together category!

South Wales Neonatal Units

The WHSSC Quality team are undertaking scheduled neonatal visits within South Wales. The face to face meetings are intended to strengthen relationships and to develop an understanding of the role of the quality team within commissioning. WHSSC are responsible for commissioning the ITU and HDU cots in South Wales.

This is alongside supporting the importance of reporting and data collection in light of publications such as the Independent Maternity Services Oversight Panel (IMSOP) and Ockenden report and an awareness that the services have had a great deal of activity and had a number of workforce pressures. During the visits, the units have been encouraged to share evidence of Quality Improvement, good practice alongside areas of concern including workforce plans and recruitment.

Discussions have also included capturing patient experience and signposting to the Health Board team to support facilitation of this.



During the visits there was evidence of inspiring innovations to benefit patients, families and the staff and we have asked that this be continuously shared with WHSSC.

Alongside some workforce initiatives to utilise some of the current vacancies more successfully into advanced practice role development and Band 4 role development. To date the team have visited Hywel Dda University Health Board (HDUHB), Cwm Taf Morgannwg University Health Board (CTMUHB), Swansea Bay University Health Board (SBUHB) and Cardiff and Vale University Health Board (CVUHB).

HDUHB

HDUHB provided the WHSSC Quality team with the opportunity to visit the new unit and to meet with the neonatal team. It was evident moving into a better environment and managing the care of neonates within the new facility had a positive impact on the team.

CTMUHB

Very positive visit to the team in CTMUHB, it provided the opportunity to understand how the team have worked to address the issues identified by Independent Maternity Safety and Oversight Panel. There was evidence of practice development and support for the clinical team alongside the rotation of staff into different clinical areas and support to work with the regional Centres.

SBUHB

The Team have recently had nurses join them from overseas and are in the process of supporting their development with specific clinical programs. These have included the development of Objective Structured Clinical Examinations to enable a smooth transition into the workforce and to meet the NMC requirements. During the visit alongside meeting the Neonatal Intensive Care Unit (NICU) team the Quality team met with the midwifery team who demonstrated the work which had been undertaken with a Neonatologist and maternity to enable the Transitional care model to be better utilised to support a model of more rapid step down from Special Care Baby Unit (SCBU).

CVUHB

The NICU visit provided the Quality team with an opportunity to understand how the Operational Team are continuously addressing the daily priorities of managing the ever changing clinical picture. This was demonstrated through their facilitation of a twice daily huddle and their reporting to the Clinical Board. The clinical team welcomed an opportunity to share their concerns regarding workforce, repatriation and training issues.

These included the difficulties of sometimes having families who had become dependent on the regional Centres and their concerns about being repatriated back to their local health boards, due to a perceived lack of understanding on how their particular specialist needs would be met. This concern was highlighted form both a family perspective and the clinical teams perspective. The clinical team raised concern around local skill and knowledge in relation to managing some of the more complex surgical cases.

There had been recent recruitment event with some success at external recruitment. A number of nursing vacancies exist within the team and there is a plan to support student streamlining with over recruitment into some of these vacancies.

Maternity and Neonatal Safety Summit

Sue Tranka, Chief Nursing Officer for Wales has launched the Maternity and Neonatal Safety Support Programme to improve safety, experience and outcomes for mothers and babies in Wales. Maternity and neonatal champions will be appointed to every health board in Wales to improve the quality of services and to support the Maternity Five Year Vision.

The Programme aims to create national standards to ensure that all pregnant individuals, babies and their families will experience safe, high quality health care along with influencing their decisions regarding the care they receive.

The Maternity and Neonatal Safety Summit was held in August 2022 and was well attended both in person and remotely. There was engagement from the participants, who were encouraged to submit online questions to the presenting panel. This identified collaborative themes amongst the audience and facilitated an opportunity to network in person.

Welsh Pharmacy **Awards 2022**

The Blueteq High Cost Drugs (HCD) software programme was procured for NHS Wales by the WHSSC and the Welsh Government via the Advanced Therapies Wales Board, to support the implementation of Advanced Therapy Medicinal Products (ATMPs) and other HCDs commissioned by WHSSC. A Blueteq Project Working Group piloted the system in May 2021. In January 2022, the system went live for all WHSSC commissioned HCDs.

This new system allows NHS Wales to audit the initiation of complex HCDs in line with evidence based health technology appraisal recommendations, to support clinical data collection and evaluation and to strengthen financial governance.

A Blueteq form is created for all WHSSC commissioned National Institute for Health and Care Excellence (NICE) Technology Appraisals, Highly Specialised Technologies and All Wales Medicines Strategy Group approved medicines by the WHSSC Medical team in collaboration with Welsh clinical experts.

The implementation of Blueteq ensures equitable and timely access to specialised HCDs for eligible patients across Wales. The Blueteq project has been shortlisted as a finalist in the Welsh Pharmacy Awards 2022, which is a fantastic achievement.

Well done team!

Quick Round up of Commissioning Teams

Mental Health

5 year strategy being developed and well underway with excellent engagement and support from the Welsh Clinical Teams.

Women and Chidren's

Paediatric Strategy is gaining momentum and out for consultation.

Neurosciences and long term condition

All Wales strategy to improve outcomes and experience of patients receiving specialised rehabilitation is underway.

Cancer and Blood

Thoracic and Inherited Bleeding Disorder Service Improvement and Innovation Day to be organised. ENETS won a Patient Experience award and will be hosting a celebration event on 13th October.

Cardiac

Cystic Fibrosis Service Improvement and Innovation Day scheduled for 11th November 2022.

Intestinal Failure

Ongoing work being undertaken with the recently formed Intestinal Failure commissioning team and as a result of the Intestinal Failure review and Service Improvement and Innovation Day.

Recognition of significant events, thank you's and useful links

Adele Roberts, Head of Quality at WHSSC, receives a special parcel from a patient who was supported through the NHS England Gender pathway:

Lieutenant Colonel

On behalf of the whole military in Wales I am very grateful for the enhance patient care the systems providers and for the friendly, flexible and efficient way it is administered by you and Catherine. Patients enjoy fantastic care from the providers in Wales. The options for select-ed individuals to be seen quickly in order to make them fit for duty and progress their care is transformational…….This support to the military in Wales is envied by my colleagues in other parts of the UK

Ministry of Defence (MOD)

A thank you from a Lieutenant Colonel with the MOD was received into WHSSC by the Director of Finance Stuart Davies and Catherine Dew IPFR manager.

Useful Links

- Welsh Health Specialised Services Committee

Public Health Wales - 30 month implementation evaluation for NIPT (Non-invasive Prenatal Testing) evaluation

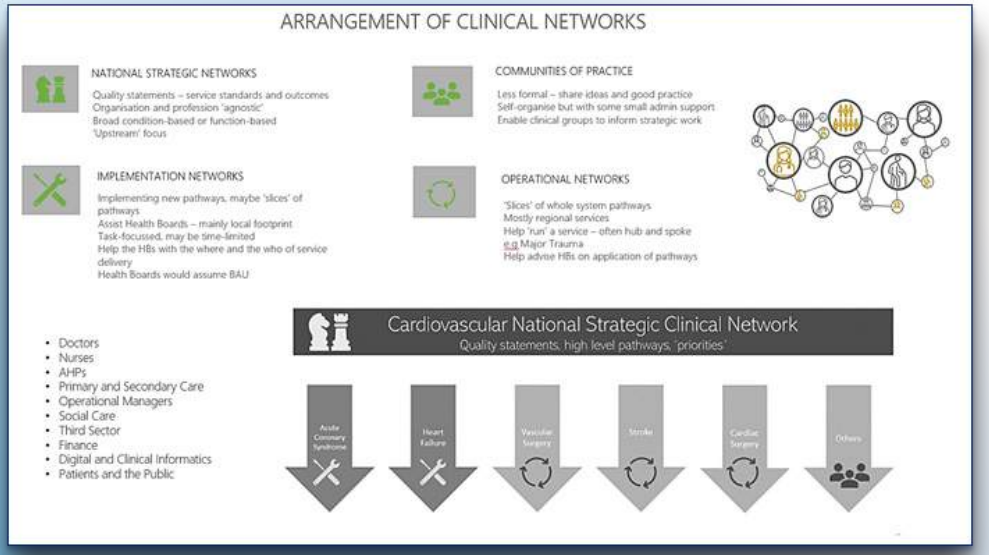
WHSSC commission NIPT and were informed by Public Health Wales of the evaluation findings from the first 30 months following the implementation of this as a contingent test as part of the antenatal Screening programme in Wales were formally published in the May edition of Prenatal Diagnosis, a peer reviewed journal.

Implementation of non-invasive prenatal testing within a national UK antenatal screening programme: Impact on women's choices - Bowden - 2022 - Prenatal Diagnosis - Wiley Online Library

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Clinical Network Programme

As part of the strategy work WHSSC has been working closely with the Clinical Network Programme and whilst the names and arrangements of networks in the diagram below are still under discussion we felt it would be helpful to share as part of the stakeholder engagement that has been undertaken over the past year. The Clinical Networks Programme is part of the National Clinical Framework implementation within the NHS Executive.



NETS

South Wales Neuroendocrine Cancer Service has received a Centre of Excellence Accreditation with ENETS (European Neuroendocrine Tumour Society) – a massive congratulations to Dr Mohid Khan:

ENETSCoE
ASSURING QUALITY SINCE 2009

DR Mohid Khan, Cardiff and Vale University Health Board

A well-done from Dr Sian Lewis, Managing Director for WHSSC the neurosciences commissioning team received substantial assurance form the Audit and Assurance team and to the pharmacy team Eleri Schiavone, Dr Andy Champion and Professor Iolo Doull on reaching the pharmacy finalist awards.

"Well done team we are proud of you!"

PDF **ENETS Audit Checklist/ Report Cardiff**

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

Welsh Health Services Specialised Commissioning

NEWSLETTER

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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Committee

whssc.nhs.wales

Autumn 2022

For queries or detail on any aspect within this Newsletter, contact Adele Roberts, Head of Patient Safety and Quality or Leanne Amos, Quality Administration Support Officer.

Email: Adele.Roberts@wales.nhs.uk / Leanne.Amos@wales.nhs.uk

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Designed by NHS Wales Shared Services Partnership Communications

Quality Assurance Reporting
Final Internal Audit Report

October 2022

Welsh Health Specialised Services Committee

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Contents

Review reference:	CTMUHB-2223-32
Report status:	Final
Fieldwork commencement:	13 July 2022
Fieldwork completion:	9 September 2022
Draft report issued:	15 September 2022
Management response received:	4 October 2022
Final report issued:	6 October 2022
Auditors:	Lucy Jugessur, Internal Audit Manager Emma Samways, Deputy Head of Internal Audit
Executive sign-off:	Carole Bell, Director Nursing Quality
Committee:	Audit & Risk Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To evaluate and determine the adequacy of the systems and controls in place within WHSSC in relation to quality assurance reporting.

Overview

We have issued substantial assurance on this area.

There was one matter requiring management attention:

- There was limited evidence to suggest that Health Boards are submitting the WHSSC Quality and Patient Safety Chair's report to their own quality committee meetings for scrutiny and assurance.

Report Opinion

Substantial

Few matters require attention and are compliance or advisory in nature.

Low impact on residual risk exposure

Assurance summary[1]

Objectives		Assurance
1	Roles and responsibilities of the Quality and Commissioning teams	Substantial
2	Processes and mechanisms to allow the Quality and Commissioning teams to co-ordinate the quality monitoring	Substantial
3	Effective quality assurance reporting arrangements in place	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Monitoring of WHSSC quality matters in Health Board committee meetings	3	Operation	Medium

1. Introduction

1.1 Our review of quality assurance reporting within the Welsh Health Specialised Services Committee (WHSSC) was completed in line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 WHSSC is responsible for the joint planning of specialised services on behalf of the Local Health Boards in Wales. Their strategic aim is to ensure that there is equitable access to safe, effective and sustainable specialised services, as close to patients' home as possible, within available resources. The quality of care and experience that patients and their families receive is central to the commissioning of specialised services. The specialised services commissioned by WHSSC are managed though five programme commissioning teams and include areas such as mental health, cancer & blood and neurosciences.

1.3 In 2014 a WHSSC Quality Framework was developed to provide an infrastructure around quality assurance. The framework has since been revised and renamed the Commissioning Assurance Framework (CAF) to encompass components necessary to provide assurance. A quality team was set up in 2019 to strengthen the focus of quality monitoring, improvement and reporting. The quality team have a pivotal role in the co-ordination of quality monitoring, interventions and reporting across the commissioned services. In turn, relevant quality information is required by health boards from WHSSC so they can meet their responsibilities to deliver high quality, safe healthcare services for all their citizens.

1.4 The risks considered in this review were:

- Serious concerns and performance related issues are not identified meaning remedial action cannot be taken.
- WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

1.5 We focussed on the role performed by the Quality function, and not the CAF as a whole.

2. Detailed Audit Findings

Objective 1: The role and responsibilities of the Quality team and the Commissioning service teams in relation to quality monitoring and reporting have been captured.

2.1 The CAF identifies that the Quality team was appointed in 2019 to "strengthen the focus on quality monitoring and improvement". It further details their role in the co-ordination of quality monitoring and interventions within commissioned services.

2.2 The Quality team comprises of a small number of staff, with each providing support to a number of commissioning teams. Their role is integral in the Commissioning teams and they provide quality information from internal and external reports and visits to the service providers, on matters such as infection control, serious untoward incidents (SUIs) and patient experience. Our testing has not identified

any concerns with the current set up of the team, though should the remit of their work expand in the future, the current resource and set up of having a shared quality lead overseeing a few commissioning teams may need to be reviewed.

2.3 The Quality team do not carry out the investigations into complaints and SUIs, this is undertaken by the service provider. However, the team link in with the provider and ensure that investigations are carried out in a timely manner, that responses address the issues of concern, and that lessons learnt are shared and themes are considered. They will also advise the Health Board who are commissioning the service of any complaints or SUIs.

2.4 The Quality team have been involved in re-introducing Service Improvement & Innovation Days (previously called Audit and outcome days). The days are to "support and strengthen the reporting of patient outcomes and experience, sharing of best practice and benchmarking across commissioned services". At the time of our audit, four improvement days had been hosted for Intestinal Failure, Sarcoma, Gender and Traumatic Stress Wales (TSW) Services, and there were key learnings and actions taken from the events.

2.5 The Quality team have recently produced a quarterly Quality Newsletter. The newsletter is to highlight some of the work that the team are involved with from a commissioning perspective and includes an update on the Service Innovation & Improvement Days, data about the number of incidents and complaints and short updates in relation to each of the Commissioning Teams.

Conclusion:

2.6 The roles and responsibilities of the Quality team members within the Commissioning teams is clearly set out. The Quality team have embedded quality monitoring and quality reporting within the commissioning services. The team have progressed since they were established, ensuring that quality and quality monitoring is a key priority in all commissioning teams. We have provided a Substantial assurance rating for this objective.

Objective 2: Processes and mechanisms are in place that allow the Quality and Commissioning teams to co-ordinate the quality monitoring and interventions within commissioning teams to enable reporting.

2.7 There are service specifications and Service Level Agreements (SLAs) in place for each of the services commissioned and these are monitored through SLA meetings with the provider. Prior to the meeting, the quality team review any available data on the services of the provider. During the meetings updates are provided on the services being commissioned and issues are discussed including actions to resolve the issue.

2.8 The WHSCC Quality team also meet with the health boards to discuss the services that WHSSC have commissioned on their behalf. These meetings allow the health boards to feedback concerns they may have, and for WHSSC to update the health boards about the commissioned services.

2.9 Where quality issues are identified with a service provided, an escalation process is in place that allows for enhanced monitoring to ensure issues are resolved as

soon as possible. The Corporate Directors Group Board are responsible for placing services in escalation. The escalation steps are aligned to a tiered approach:

- Level 1 – Enhanced monitoring. This is for any quality or performance concerns that have been identified and will be reviewed by the Commissioning Team.
- Level 2 – Escalated Intervention – For services where Level 1 Enhanced Monitoring identifies the need to further investigation/ intervention.
- Level 3 – Escalated Measures – Evidence that the action plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified.
- Level 4 – Decommissioning / Outsourcing – Services that have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage.

2.10 WHSSC are in the process of enhancing the process by developing an 'Escalation on a page' document. We understand that this will provide greater detail on the escalation status, highlighting a trajectory showing movements within the escalation level, to allow for more granular monitoring.

2.11 We reviewed the quality monitoring arrangements for Adult Gender Services and Cardiac Services, to ensure that there were appropriate processes in place and in line with the CAF. Both services had specifications in place, albeit one was in draft, which detailed the quality indicators and key performance indicators for the provider. There was evidence of meetings with the provider to discuss the services. Both commissioning teams for these services reported into the WHSSC Quality Patient Safety Committee (QPSC) and detailed reviews undertaken by other external functions and services that were in escalation. They also reported actions that had been taken since the previous review and the current position.

Conclusion:

2.12 There are appropriate processes and mechanisms in place that allow the Quality and Commissioning teams to review the providers and services in place. Where there have been issues with a service, an escalation process was in place. We have provided a Substantial assurance rating for this objective.

Objective 3: Effective quality assurance reporting arrangements are in place.

2.13 The CAF details the required quality reporting mechanisms. We confirmed that the QPSC receive consistent update reports from the Commissioning teams including information on services in escalation and any actions taken, quality visits and meetings undertaken, details of serious incidents, safeguarding concerns, complaints and compliments.

2.14 Following each QPSC meeting, a Chair's report is produced. We reviewed the minutes and papers of the WHSS Joint Committee and confirmed the Chair's report of the QPSC was presented at each Joint Committee meeting. A 'Services in Escalation' report was also provided detailing the current position of these services.

2.15 The QPSC Chair's report is also issued to health boards for inclusion on the agenda of their respective quality committees. Our review of a sample of Health Board quality committee meetings identified that for some of the health boards' Chair's report was not always presented to the committee. **(Matter Arising 1)** We acknowledge the Independent Members and officers from health boards sit on the WHSS committees and are therefore made aware of quality matters. However, the regular inclusion of the Chair's report in health board committee papers ensures that the information contained in the reports is available for review and scrutiny by a wider audience, including the public.

2.16 Our review of the minutes and papers from the QPSC identified a number of other quality update reports including:

- Reports that had been undertaken by Health Inspectorate Wales (HIW) and Care Quality Commission (CQC) on the commissioned services.
- An update report and action plan on one of the services within Mental Health & Vulnerable Groups that was at escalation level 4.
- Information in relation to the recent QPSC development day. The day consisted of an update on the CAF and how the Quality team are able to obtain assurance through areas such as SLAs, Service Specifications and performance & escalation.

2.17 We also saw a copy of the QPSC annual report which is provided to health boards. The report provided an update of the areas that were reported to the Joint Committee in the Chair's report, which included updates on the commissioned services.

Conclusion:

2.18 We recognise that there are sufficient quality assurance reporting arrangements on the commissioned services within WHSSC. However, the onward reporting of the quality of commissioned services is not always evident within the health boards. We have provided a Reasonable assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Monitoring of WHSSC quality matters in Health Board committee meetings (Operation)	**Potential Impact**
The Quality and Patient Safety Committee (QPSC) Chair's report provides an update from each of the Commissioning Teams and a summary of services that are in escalation. Chair's reports from each QPSC are presented at the Joint Committee meetings and are forwarded onto the health boards for inclusion within the papers of their respective Quality Committee meetings. We reviewed the papers of the last four quality committees for four health boards and found: • In one health board the Chair's report was an agenda item on three out of four of their quality committee meetings. • In two health boards the Chair's report was an agenda item on only one of their four meetings. • One health board did not appear to have the Chair's report as an agenda item at any of the quality committee meetings that we reviewed.	WHSSC is unable to provide assurance to health boards on the quality of care it commissions on their behalf.

	Recommendation	**Priority**
1.1	We acknowledge that the action of including Chair's reports on health board quality committee agendas is outside of WHSSC's control. However, WHSSC should liaise with health boards to communicate to them the importance of their committees being sighted on this information in order to scrutinise, and gain assurance from it, on behalf of their local population. WHSSC should work with the health board officers and Independent Members who sit on WHSSC committees to facilitate this.	**Medium**

	Agreed Management Action	Target Date	Responsible Officer
1.1	Consider the draft report in QPS Development Day.	26/10/2022	Director of Nursing & Quality
	Present Final report and Management Action Plan to WHSSC QPS Committee.	25/12/2022	Director of Nursing & Quality
	Appendix report to QPS Chairs report for submission and consideration by WHSSC Joint Committee.	8/11/2022	Chair WHSSC QPS Committee
	Report to be considered by All Wales Health Board Chairs QPS Committee.	Nov 2022	Chair WHSSC QPS Committee
	Future auditing of compliance to be monitored by the above committee.	Ongoing	All Wales Chairs QPS Committee

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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Children's Community Nursing Service – Children & Young People's Continuing Care

Final Internal Audit Report

September 2022

Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Committee:	Audit, Risk and Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose

To consider the robustness of Children and Young People's Continuing Care (CYP CC) governance arrangements within the Aneurin Bevan University Health Board's (the Health Board) Children's Community Nursing Service (the CCNS, part of the Family & Therapies Division).

We focused on mechanisms for ensuring the quality and safety of the Children and Young People's Continuing Care delivered.

Overview

The review was requested by the Health Board in response to Operation Jasmine (Adult Complex Care) and parent/carer concerns raised at other Health Boards regarding CCNS-led CYP CC.

We found that the CCNS is a well-managed service with robust governance, accountability and risk management mechanisms in place.

The CCNS (and wider Division) faces some key challenges in the delivery of CYP CC which we wish to bring to the Audit Committee's attention:

- significant vacancies (national shortage); and
- challenges to working with LAs due to lack of clarity in national guidance.

These matters are being managed by the CCNS and Division and have been escalated within the Health Board and to Welsh Government. See paragraphs 2.13-2.17 / 2.29-2.33 and recommendation 3 in Appendix A.

Our full findings are set out in section 2. All recommendations and management actions are included in Appendix A. Appendix B sets out observations which management may wish to consider further.

Report Classification[1]

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1	Governance and Management	Substantial
2	Risk Management	Substantial
3	Partnership Working	Reasonable
4	Concerns and Escalation	Substantial
5	Reporting and Scrutiny	Reasonable
6	Resource and Staff	Reasonable*
7	Training and Support	Substantial
8	Policy and Procedure	Substantial
9	Quality of Individual Patient Care	Reasonable

** Whilst we have provided reasonable assurance over this objective, the CCNS vacancies and national staffing shortages present a significant current challenge and longer-term risk to the sustainability of CCNS CYP CC.*

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
3	Managing resource and partnership working risks	6	Operation	High

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion. Report classification and recommendation priority rating definitions can be found here.

1. Introduction

1.1 Following the conclusion of the Gwent Coroners Inquests associated with Operation Jasmine, Aneurin Bevan University Health Board (the 'Health Board') undertook an internal reflection exercise – for assurance purposes – regarding its governance arrangements for Adults Continuing NHS Healthcare (CHC).

1.2 In 2021/22, we reviewed the arrangements for commissioning CHC and Section 117 care for adults with mental health (MH) or learning disability (LD) needs.

1.3 Due to Operation Jasmine and the outcome of a children's continuing care review at Cardiff and Vale University Health Board and Swansea Bay University Health Board, the Health Board requested that we review its quality governance arrangements for the provision of CYP CC through its CCNS.

1.4 The overarching objective of the review was to consider the robustness of CYP CC governance arrangements within the CCNS, focusing on mechanisms for ensuring the quality and safety of the CYP CC delivered.

1.5 An overview of the CCNS is set out on page 5.

Limitations of Scope

1.6 The review excluded:

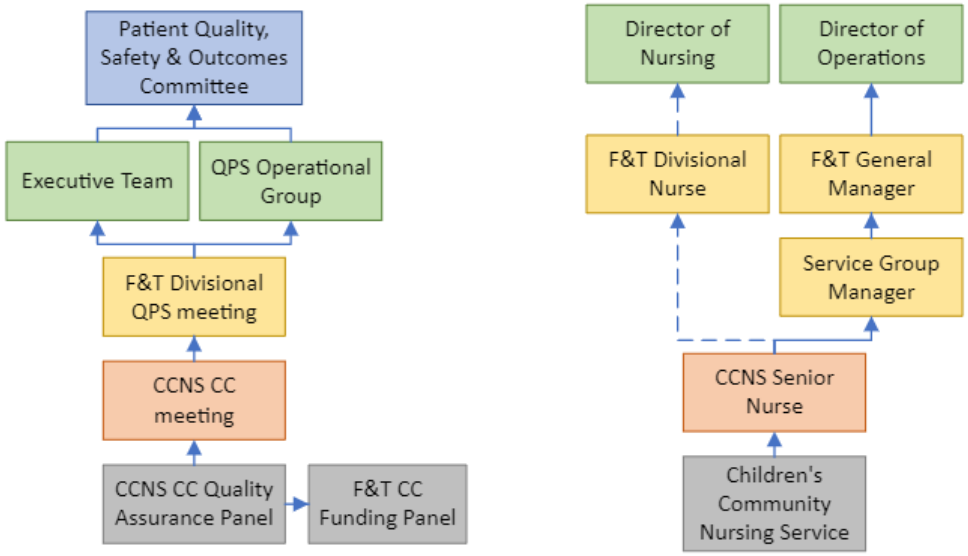
- CHC commissioning for adults and for individuals with MH/LD needs;
- transition of CYP CC patients to adult services; and
- CYP CC activities within Children & Adolescents Mental Health Service (CAMHS) and Children & Adolescents Learning Disabilities Service (CALDS).

Associated Risks

1.7 The key risk considered in this review was failure to identify and address inadequate care arrangements, potentially leading to poor patient / family experience or patient harm, failure to comply with relevant legislation or financial or reputational damage.

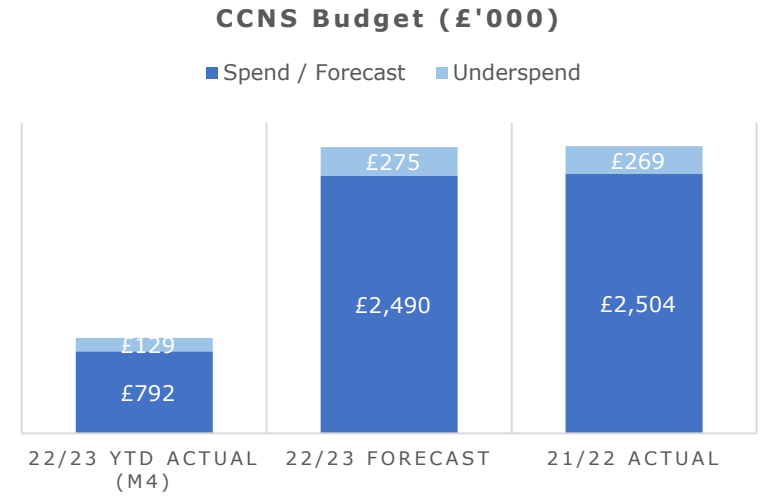
Children's Community Nursing Service at a Glance

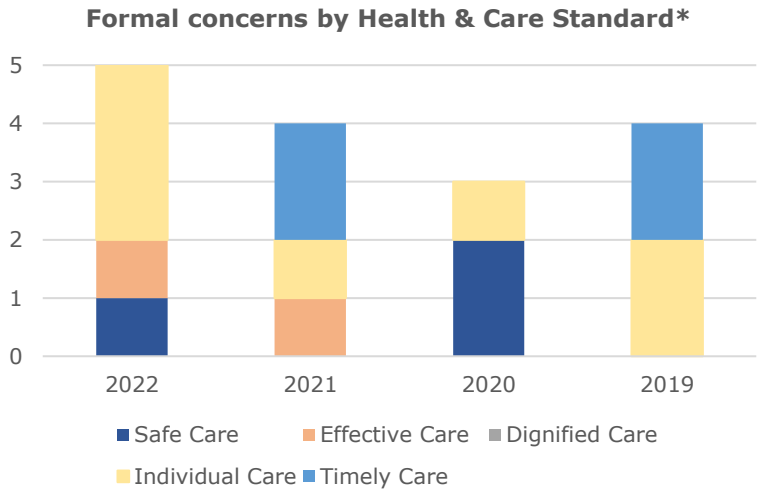
Governance, accountability and reporting structure:



Services provided by the CCNS:
- Children & Young People's Continuing Care (in scope)
- Specialist Schools (out of scope)
- Outpatient Clinics (out of scope)
- Care Closer to Home (out of scope)

CCNS staff	64 individuals
Compliance:	
- PADR	91.94%
- Statutory & Mandatory training	91.64%





* Formal concerns raised under the Putting Things Right or the Procedure for NHS staff to raise concerns processes. Also includes Children's Centres, which are not managed by the CCNS.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	-	2	3	5
Operating Effectiveness	1	-	1	2
Total	1	2	4	7

2.2 Our detailed audit findings are set out below. All recommendations and management actions are detailed in Appendix A.

2.3 Our recommendations may also be relevant to CYP CC activities within CAMHS and CALDS. Therefore, the Division should consider the report in this light.

Audit Objective 1: CYP CC Governance and Management

2.4 CCNS priorities are identified within the Division's top priorities within the 2022/23 Integrated Medium Term Plan.

2.5 The CCNS has a clear line management, accountability and escalation structure.

2.6 There are identified forums for discussing CYP CC matters, with clear escalation routes to the Board.

Conclusion:

2.7 No matters were identified for reporting. Therefore, we have provided **substantial assurance** over this audit objective.

Audit Objective 2: CYP CC Risk Management

2.8 CYP CC risks within the CCNS are being managed and monitored by the Senior Nurse within Datix.

2.9 The CCNS team meeting provides a forum for discussion around risk.

2.10 Risks are escalated from the CCNS through the Divisional reporting structures. The most significant CCNS risk – vacancies and recruitment – has been escalated to the Executive Team.

2.11 The Senior Nurse has reviewed the target risk scores in line with what is achievable for the Service. However, they are not in line with the Health Board's risk appetite, and it is not clear if the Division or Health Board has reviewed and approved this. See recommendation 1 (low priority).

Conclusion:

2.12 Whilst a low priority recommendation has been raised concerning target risks scores, our work confirmed that CCNS risks (including CYP CC related ones) are well managed. Therefore, we have provided **substantial assurance** over this audit objective.

Audit Objective 3: CYP CC Partnership Working

2.13 There are several forums through which CYP CC partnership working between the CCNS, CAMHS, CALDS and LAs takes place.

2.14 The CCNS and wider Division is engaging with LAs to streamline CYP CC processes and ensure consistency in practice and decision-making.

2.15 Recent examples of working in partnership to improve processes include:

- recent decision to pilot a joint CYP CC assessment process; and
- development of joint CYP CC training.

2.16 Some partnership working mechanisms have only recently been implemented or are in pilot stage. See recommendation 2 (low priority).

2.17 The Division is aware that there remain key challenges to be worked through with the LAs, some of which depend on decisions being taken by Welsh Government (i.e., lack of clarity in guidance on what constitutes health care vs social care). The Division is taking action to address these challenges through the forums and mechanisms identified. See recommendation 3 (note: whilst this is a high priority recommendation, we consider it to have a medium priority impact on this audit objective).

Conclusion:

2.18 Whilst there remain key challenges to partnership working, the Division is proactive in engaging the LAs in CYP CC assessments and service improvement. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: CYP CC Concerns and Escalation

2.19 The CCNS follows the Health Board's concerns and escalation processes, including Putting Things Right, Safeguarding and procedures to raise concerns.

2.20 CCNS concerns and incidents are being managed and monitored by the Senior Nurse within Datix.

2.21 Significant concerns and incidents are escalated by the CCNS to the Divisional QPS meeting.

2.22 The Division also monitors concerns and incidents through its 'Closing the Loop' (CTL) report.

Conclusion:

2.23 No matters were identified for reporting. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 5: CYP CC Reporting and Scrutiny

2.24 The CCNS team meets regularly to discuss key matters, including CYP CC.

2.25 The CCNS reports by exception to the Divisional QPS meeting via the Division's standard template.

2.26 The Division's CTL report covers QPS matters at a service level reported by Health & Care Standard.

2.27 Reporting is by exception only, there is no balanced performance report or supporting metrics. See recommendation 4 (medium priority).

Conclusion:

2.28 Noting the above, we have provided **reasonable assurance** over this audit objective.

Audit objective 6: CYP CC Resource and Staff

2.29 The CCNS Senior Nurse has undertaken demand and capacity analysis for the Service, including consideration of CYP CC.

2.30 The CCNS is facing significant challenges regarding staffing, vacancies and recruitment. The Service and wider Division are taking action to manage challenges to the extent possible, including:

- consideration of workforce restructuring for more effective use of the resource available;
- introducing a Band 4 Healthcare Support Worker role to attract and retain staff;
- as a last resort, commissioning CYP CC from Ty Hafan (although this presents other challenges – see section 2.2).

2.31 The staffing challenges are predominantly due to a national shortage of staff in this specialist area. This has been escalated to the Welsh Government.

2.32 This situation is exacerbated by the training requirements to deliver CYP CC packages – it can take up to 18 months to train healthcare support workers due to its complexity.

2.33 We were informed that some services provided by the CCNS are unfunded, which also impacts upon delivery of funded services, including CYP CC.

2.34 See recommendation 3 (high priority).

Conclusion:

2.35 The CCNS and wider Division are acting within their powers to manage the situation concerning CCNS vacancies and national staffing shortages. However, the current challenges remain significant and present a longer-term risk to the sustainability of CCNS CYP CC. Further Health Board support may be required in this area going forward. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 7: CYP CC Training and Support

2.36 The CCNS has a well-developed framework for ensuring staff are trained and regularly assessed.

2.37 The Service has a Practice Educator who oversees and delivers the training.

2.38 There is a mandatory CYP CC training module within ESR. Practical CYP CC training is currently delivered on an ad hoc basis.

2.39 Compliance with PADRs and Statutory & Mandatory training is monitored at a Divisional level.

2.40 The CCNS is currently heavily reliant upon agency staff to deliver CYP CC. It has implemented monthly monitoring to monitor the quality of care delivered by agency staff.

2.41 The CCNS does not currently have an overarching training and development strategy (we were informed the Practice Educator would like to develop one) or a programme of ongoing practical CYP CC training.

2.42 Staffing issues (noted in paragraphs 2.30-2.33) are impacting upon staff wellbeing and have created challenges in training delivery and attendance.

2.43 See recommendation 5 (low priority).

Conclusion:

2.44 The CCNS has good training and support mechanisms in place for CYP CC and our low priority recommendation relates to enhancing these mechanisms. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 8: CYP CC Policy and Procedure

2.45 The Division has a CYP CC Policy (the Policy) with supporting procedures / templates covering CC activities across the CCNS, CAMHS and CALDS. This has been developed through the Division's Continuing Care Development Group, which includes representation from the LAs.

2.46 We identified areas where the Policy could be further strengthened. See recommendation 6 (low priority).

Conclusion:

2.47 Noting the above, we have provided **substantial assurance** over this audit objective.

Audit objective 9: CYP CC Quality of Individual Patient Care

2.48 The patient assessment and review processes are clearly set out in the CYP CC Policy and are in line with the national CYP CC guidance.

2.49 The LA and Education are engaged in the decision-making process

2.50 The CCNS Continuing Care (CC) Manager undertakes a compliance quality assurance (QA) review to ensure compliance with the Policy.

2.51 In our testing on five of the 16 CCNS CYP CC patients, we reviewed evidence that key aspects of the process had been complied with (see Appendix D for details of the testing undertaken). No exceptions were noted.

2.52 Patient / family / carer experience is covered in the monthly visits that CCNS Nurses make to each patient's home. The CCNS is also working with the Health Board's Value Based Healthcare team to develop patient experience metrics and mechanisms to effectively capture and monitor these.

2.53 There are no QA mechanisms over:

- CYP CC assessments / reviews;
- care delivered by the CCNS team; and
- care delivered by external providers (respite and commissioned CC, the latter being new to the CCNS).

2.54 There are some mitigating controls that reduce the related risk, including the agency package review process (paragraph 2.40), the monthly visits to each patient's home and the compliance QA process.

2.55 Additionally, the CCNS has 'proactive' quality controls in the level of training and support provided to its staff (paragraphs 2.36-2.39).

2.56 See recommendation 7 (medium priority).

Conclusion:

2.57 The CCNS needs to strengthen its approach to quality assuring there CYP CC delivered. Therefore, we have provided **reasonable assurance** over this audit objective.

3. Observations for Management Consideration

Staff Survey

3.1 We undertook a survey of CCNS staff involved in the management and delivery of CYP CC. 64 staff members were surveyed; 16 responses were received. The full results along with our analysis have been provided separately to Divisional and CCNS management.

3.2 The survey responses have been incorporated into the recommendations and observations for consideration in Appendices A and B, respectively.

3.3 Survey summary with RAG rated responses:

Question Area	RAG	Comments	Appendix ref
Respondents		Survey had a small number of respondents, only one of which was a HCSW.	B.2
Policy / procedure		No significant concerns identified, although staff need to be updated on the new CYP CC Policy and Procedures and reminded of their location.	A.6
Training / support		Responses highlighted the impact of resource issues on training delivery and attendance.	A.5
PADR / competencies		Concerns that respondents had not had their competencies recently assessed.	A.5
Concerns		Two respondents felt concerns may be heard but not acted upon.	B.2
Culture		No significant concerns identified, although a small number of respondents felt the CCNS is not valued by the wider Division.	B.2

Other observations

3.4 Throughout the course of our fieldwork, we also identified further observations for management consideration, including:

- an area where the Health Board could provide further support in response to the staffing challenges experienced by the CCNS – point 3 in Appendix B; and
- observations for strengthening efficiencies at the CCNS Quality Assurance and Divisional CYP CC Funding Panels – point 4.

3.5 All observations for management consideration are set out in Appendix B.

Appendix A: Recommendations and Management Actions

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
1	2.11	**Risk Target Scores (O)**	Non-compliance with Risk Management Framework.	Acceptance of target risk scores outside the tolerance levels should be made at an appropriate level and clearly documented in the risk register.	**Low**	1) Risk Register to be reviewed in light of service development and transformation opportunities. 2) Tolerance levels of risk for the service will be mitigated as far as possible within this workstream, clearly identified and understood with required transformation changes supported by both Division and Executive team. 3) Ongoing monitoring and scrutiny at Division/Executive on 2 monthly basis **Responsibility: Assistant Divisional Nurse / Division Lead QPS** **Target Date 30/09/22**
2	2.16	**Monitoring partnership working (D)**	Duplication of effort. Ineffective partnership working.	Implement robust communication mechanisms between the various partnership working forums (e.g., CC Development Group, Regional Integrated Complex Needs Panel, etc). Monitor the effectiveness of these forums and any new joint processes implemented.	**Low**	1) Strengthen partnership working with partners in addressing the reduction programme connected with the Welsh Government not for profit/eliminate agenda 2) Clarity of terms of reference for stages of Continuing Care Process to be agreed and communicated clearly with partners 3) Education strategy regarding Children's Continuing Care for multiagency teams to be finalised and implemented 4) Task and finish group to agree initial joint assessment process pre referral to Children's Continuing Care and inform eligibility checklist and determine what is an "unmet health need" 5) A monitoring and review process to be established to ensure ongoing effectiveness of forums. **Responsibility: Assistant Divisional Nurse/ Division Lead for QPS** **Target Date 30/11/22**

[2] C = Control Design: a gap in the design of the system or process giving rise to increased risk; O = Operating Effectiveness: non-compliance(s) with the laid down system / process giving rise to increased risk.
[3] Recommendation priority rating definitions can be found here.

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
3	2.17 2.30 - 2.34	**Managing resource and partnership working risks (O)**	Inability to manage significant risks. Potential risk to service sustainability.	Close Health Board monitoring of the key risks facing the CCNS to ensure: • appropriate action continues to be taken; and • support is provided to the CCNS as required – see point 3 in Appendix B.	**High**	1) Engagement with families and staff in a review of service models – utilising co-production and with a compassionate leadership lens explore options of "out of family home" models of care, which may meet needs of child/young person more effectively, optimise management of scarce resources and support retention of staff. 2) Workforce review to identify skill mixed workforce resource required to deliver safe service across the various lines of commissioned service e.g. Continuing Care, Special Schools, Children's Out Patients, Clinical/Care closer to home 3) Business Case/Service Review to establish options of further efficiency and priority with the identification of discrete financial budget lines to meet assessed and agreed service priorities 4) Developing new roles/skill mix within the Children's Community Nursing Service to enhance service provision 5) Partnership Board/Welsh Government recommendation required to determine the prudent delivery of care described as ancillary and incidental care needs, and multi-agency responsibilities in its delivery. This will aid the alignment of Value-Based health care and Value-Based social care **Responsibility: General Manager / Executive Team** **Target Date 31/3/23**
4	2.27	**Performance report (D)**	Poor performance not promptly identified. Missed opportunities to share positive news.	Incorporate the use of the recently developed All Wales CCN Senior Nurse forum KPIs for CCNS within the performance monitoring process. Regular monitoring of the performance report within the CCNS with annual (minimum) reporting to the Division.	**Medium**	1) RL Datix to be utilised further to capture compliments as an initial step to provide more balance. 2) Key Performance Indicators for the Children's Community Nursing Service is being looked at within the All Wales Forum. Once finalised, these will be implemented locally and reported to Division two-monthly in line with QPS framework with appropriately agreed action plans supported 3) CIVICA has recently been commissioned by the UHB and will support the development of a dashboard to analyse service user feedback, key performance indicators and Quality outcome measures. **Responsibility: Assistant Service Manager** **Target Date 31/12/22**

	Para.	Title (D/O[2])	Risk / Potential Impact	Recommendation	Priority[3]	Agreed Management Action
5	2.41 – 2.43 3.3	**CCNS Training Strategy and training programme (D)**	Staff may not be adequately trained. Poor quality CYP CC.	Develop a CCNS Training Strategy to bring together and provide oversight for existing training activities. Implement a sustainable rolling programme of practical CYP CC training. Monitor the impact of the resource issues on training and competencies to ensure they are not adversely affected.	**Low**	1) Ongoing comprehensive training programme has re-commenced and is monitored for compliance. Compliance of training programme is currently affected by safe staffing needs – Division will continue to monitor expected improved compliance with mitigated workforce challenges 2) Compliance to be reviewed two monthly as per QPS framework and to allow for implementation of follow up actions. Reported to Divisional Management Team **Responsibility Senior Nurse & Practice Educator** **Target Date 30/11/22**
6	2.46 3.3	**CYP CC Policy and Procedure (D)**	Non-compliance with policy, procedure, laws or regulations.	Include links to the following within the CYP CC Policy to provide full clarity on requirements: • relevant laws and regulations; • relevant Health Board policies and procedures, e.g., those relating to escalation and concerns; and • relevant local processes not already reference, e.g., local procedures to support implementation of Health Board escalation and concerns. Include all roles and responsibilities and reporting lines for completeness, even though they follow the Divisional structure. Inform CCNS staff of recent updates to the CYP CC Policy and where the Policy is stored.	**Low**	1) Suite of policies and procedures have been undergoing review to ensure they are updated and make reference to concurrent local and UHB Policy as well as the wider National Policy and Legislation 2) Policies and procedures, guidelines, standards to be registered on the Intranet A-Z Policies and Procedures, and the Children's community nursing staff pages of Healthier Together Website for ease of access for the wider team 3) Terms of Reference updated and awaiting final Division approval/sign off. 4) Updated Continuing Care Policy **Responsibility: Division Director / Chair for CCC Panel** **Target Date 30/11/22**

7	2.53 – 2.56	**Quality assurance over CYP CC delivered (D)**	Non-compliance with policy, procedure, laws or regulations. Poor quality CYP CC which is not identified or addressed.	Develop quality assurance mechanisms to assess the quality of: • CYP CC assessments; • care delivered by the CCNS team; and • care delivered by external providers (respite and commissioned CYP CC). Incorporate the QA mechanisms into the CYP CC Policy.	**Medium**	1) Quality Assurance mechanisms have been under review and considered through the multiagency CC development group. This to be finalised and rolled out across services 2) CC policy will reflect clearly the mechanisms used for assurance **Responsibility Assistant Divisional Nurse / Division Lead for QPS** **Target Date: 30/11/22**

Appendix B: Observations for Management Consideration

	Para.	Matters for Consideration
1	3.4	The CCNS has recently begun discussing significant concerns at the CCNS Quality Assurance Panel as necessary. The CCNS may wish to update the Quality Assurance Panel terms of reference to reflect this.
2	3.3	The CCNS staff survey (summarised in section 3, full results provided to Divisional and CCNS management) highlighted some areas that management may wish to investigate further: • **Staff engagement:** The survey had a small number of respondents, only one of which was a HCSW. Do all team members feel engaged? Do they feel their voice would be heard? Are the current communication and engagement mechanisms effective? • **Vacancy issues impacting on staff wellbeing:** Discussions with CCNS staff and free text responses to the survey indicated the CCNS vacancy issues is having a knock-on impact on staff wellbeing, including: – uncertainty in working patterns due to frequent shift changes to cover illness and/or vacancies; – delivery and attendance of training is affected by the need to cover shifts (also addressed in recommendation 6); and – the feeling that there is little support when it is very busy. Are the current communication and engagement mechanisms effective in communicating the action being taken to manage this issue? Do staff feel they have a voice and that their concerns around wellbeing are being heard? Are they empowered to suggest or make changes which may improve their working environment or wellbeing at work? • **Concerns:** Based on our work, we saw concerns being acted upon and addressed. However, two respondents felt that concerns were heard but not acted upon. Is this isolated to these two staff members, or is it a wider feeling in the team who didn't respond? Is it because concerns haven't been acted upon, or is it that there is a lack of communication on action being taken? • **Culture:** Two respondents felt the CCNS is not valued by the wider Division. No explanations were provided. Is this isolated to these two staff members, or is it a wider feeling in the team who didn't respond? What is it that makes them feel this way and is there anything that needs to be addressed? This may be linked to the staff engagement point above. Some of these points may link back to the first point about staff engagement. The Division / CCNS may wish to use mechanisms such as focus groups, coffee mornings, staff feedback forms, etc to help support and improve staff engagement.

	Para.	Matters for Consideration
3	3.4	In response to the resourcing issue, the CCNS would like to trial delivery of CYP CC from a Health Board or similar property. We understand this approach to be less demanding on resource whilst providing respite away from the patients' homes We were informed this was trialled previously, with mixed success. Patients and families appeared to like this approach, but the location of the property used was not suitable for the service being delivered (the property was used due to it being vacant). Given the current resource challenges, the Health Board should consider if it is prudent to invest in such a trial in a more suitable location.
4	3.4	We attended the July 2022 CCNS Quality Assurance and Divisional CYP CC Funding Panels and identified the following points the CCNS may wish to consider: • both meetings overran – could the meetings be run more efficiently? Or should meeting invites be adjusted and flexed to allow for appropriate discussions and enable attendees to appropriately manage time? • information was missing for some patients, so decisions could not be made – is the compliance QA process identifying all that it should be? Is there a need for further education / guidance for referrers or process improvement to prevent this situation? • no representation from respite services (Ty Hafan) or Adult Complex Care (a child in transition to adult services was discussed) – would it be beneficial to have such representation at the meetings? • the Funding Panel agreed funding without considering the cost – whilst we appreciate eligibility is the driver as to whether the patient receives CYP CC, lack of awareness of the cost of packages may mean the decisions made by the Funding Panel do not represent value for money. The Division may wish to consider how it evidences consideration of value for money in funding decisions.

Appendix C: Terms of Reference

Scope	To consider the robustness of CYP CC governance arrangements within the Children's Community Nursing Service (part of the Family & Therapies Division), focusing on mechanisms for ensuring the quality and safety of the Continuing Care delivered. Areas of consideration: 1. CYP CC governance and management. 2. CYP CC risk management. 3. Partnership working with Local Authorities. 4. Triggers for service concerns and collating, analysing and reporting evidence, including escalation of concerns. 5. Reporting and scrutiny. 6. Resource and staff. 7. Training and support. 8. CYP CC policies and procedures, including mechanisms to ensure relevant legislation[4] is considered, addressed and complied with. 9. Regular assessment of CYP in receipt of Continuing Care, including: a. review of CC eligibility and Individual Care Plans in line with CYP CC guidance; b. demonstration of adherence to the principles of children's rights and wellbeing set out within The United Nations Convention on the Rights of the Child; and c. mechanisms for assessing the quality of individual patient care.
Associated risks	Failure to identify and address inadequate care arrangements, potentially leading to: • poor patient / family experience or patient harm; • failure to comply with relevant legislation; or • financial or reputational damage.
Limitations to scope	• CC commissioning for: – adults; and – individuals with learning disabilities or mental health needs. • Transition of CYP CC patients to adult services. • CYP CC activities within the Children & Adolescents Mental Health Service and the Children & Adolescents Learning Disabilities Service.

[4] For example, the Welsh Government's Children and Young People's Continuing Care Guidance, The United Nations Convention on the Rights of the Child, Mental Health Act 1983 After-care Section 117, Social Services and Well-being (Wales) Act 2014 and Additional Learning Needs and Educational Tribunal (Wales) Act 2018.

Appendix D: What We Did

Our approach was to:

a. undertake a review of key documents;

b. perform testing on a sample of the Division's CYP CC patients across the areas of consideration identified in the brief (Appendix One); and

c. interview key staff involved in the CCNS CYP CC process within the F&T Division.

To achieve this, we undertook the following review activity:

Interviews with key Health Board staff:

- Director of Nursing (at the time of the review);
- Divisional Nurse;
- Assistant Divisional Nurse;
- CCNS Senior Nurse;
- CCNS CC Manager; and
- CCNS Practice Educator.

Analysis of survey issued to all staff involved in CYP CC within the CCNS.

Review of supporting documentation to evidence compliance for the most recent CCNS CYP CC eligibility review for a sample of five patients:

- first assessment or annual review form for presentation to Panel;
- Decision Support Tool, including verifying patient / family / carer views had been documented;
- multidisciplinary team minutes, including verifying attendance of LA and Education representatives where appropriate;
- compliance QA form – to verify the compliance review by the CC Manager and to check the CCNS care plans had been updated within the previous twelve months; and
- Quality Assurance and Funding Panel minutes for one patient where the case was more complex.

High-level review of:

- National guidance – Welsh Government's The Children and Young People's Continuing Care Guidance January 2020;
- Health Board CYP CC Policy and supporting local procedures;
- local CCNS documentation supporting implementation of Health Board concerns and escalation processes;
- relevant reports and minutes for:
  - CCNS Quality Assurance Panel;
  - Divisional CYP CC Funding Panel;
  - CCNS team meetings;
  - Divisional CC Development Group minutes;
  - Divisional Quality & Patient Safety meetings;
  - Regional Integrated Complex Care Panel;
- CCNS training materials and competency database; and
- CCNS data from Datix for incidents and concerns.

Observation of the following meetings:

- July 2022 CCNS Quality Assurance Panel; and
- July 2022 Divisional CYP CC Funding Panel.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

PUTTING THINGS RIGHT ANNUAL REPORT 2021/2022

Executive Summary

The Putting Things Right (PTR) Annual Report has been prepared in accordance with the PTR Regulations to provide an overview of 2021/2022 position in terms of how Aneurin Bevan University Health Board (ABUHB) has managed concerns, patient safety incidents, and Public Services Ombudsman for Wales (PSOW) cases during this reporting period.

It provides information on the progress, performance, challenges and successes as well as an overview of emerging themes and trends including lessons learnt.

Patient Quality, Safety and Outcomes Committee is asked to:	
Approve the Report	✓
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: Jenny Winslade – Executive Director of Nursing

Author: Tracey Partridge-Wilson – Assistant Director of Nursing

Report Received consideration and supported by:

Executive Team	✓	**Sub-Committee**	

Date of the Report: 3rd October 2022

Supplementary Papers Attached:

- PTR Annual Report 2021/2022

Background and Context

The Report was written with input from Legal Services and Divisional colleagues.

The report focuses on and describes the successes and challenges related to 'Putting Things Right' during 2021/2022. Complaints, compliments, serious incidents and PSOW cases, are all covered all of which are underpinned by the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Assessment

Successes

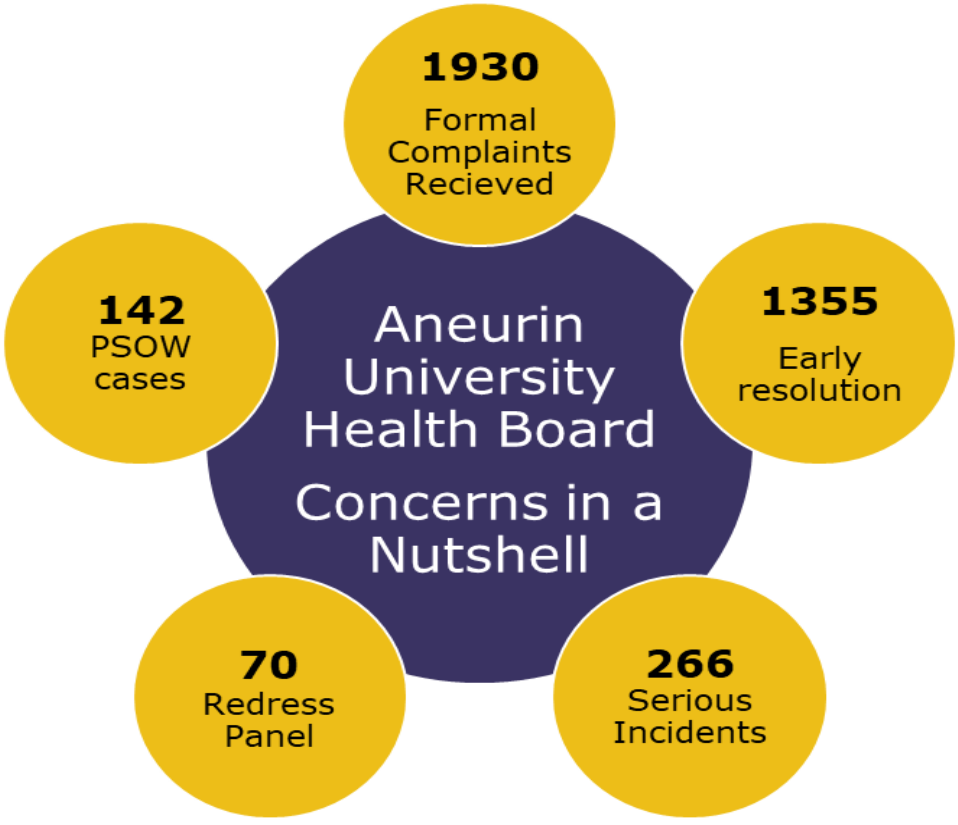
The implementation of RLDatix Feedback and Incident modules, as well as radical changes to policy and reporting of National reportable Incidents to the Delivery Unit, Investigation Officer Training has continued, along with PSOW facilitated sessions and an external company commissioned to provide Report Writing Sessions for senior staff in the organisation were highlighted as successes.

Funding was secured to transfer the concerns component of the Customer Management Centre to the Corporate PTR Team. This change is intended to improve the complainant's experience. Finally, relationships with key external stakeholders such as the PSOW office, Community Health Council (CHC) and Welsh Ambulance Services Trust (WAST) have continued to strengthen.

Challenges

Covid-19 recovery has continued to prove a challenge to the PTR agenda, combined organisationally by an increase in bank and agency staff. Although RLDatix is being embedded, delays in implementation and the use of two risk reporting systems have created challenges. Covid-19 has compromised the capacity to offer interactive training.

Performance and Learning



The report also includes qualitative and quantitative data on complaints and early resolution as well as performance, themes, and learning. Interactions with the Public Services Ombudsman for Wales are highlighted as are cases taken to Redress and most importantly learning. Compliments data is also included which provides staff with positive recognition. Performance has reduced for formal concerns from 69% to 57% however the proportion of those managed under early resolution concerns has positively increased from 25% to 41%. Due to Covid-19 constraints and the impact on operational pressures, some scheduled Learning Events have been postponed over the last year. With Covid-19 easing, it is hoped that these will be rescheduled for the coming year. Positively some Learning Events have taken place.

To summarise, the following are the five key priorities that will frame the PTR Annual Work Programme: **-**

1. To assist colleagues, as needed, in incorporating Care Aims.
2. Support organisational leads in the preparedness of the Introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
3. To support the Covid-19 Investigations Team in Covid concerns raised, ensuring consistency and alignment in responses provided to families.
4. Integrate new staff into the PTR Team by ensuring they have robust inductions, meaningful and timely PADR and individual development plans.
5. Collaborate with Divisional colleagues to improve complaint handling, including response quality and timeliness.

Conclusion

The year 2021/'22 has been a challenging year for ABUHB as the community it serves and beyond experienced the second year of the Covid-19 pandemic.

The Health Board has continued to use a "proportionate approach" to ensure the prompt handling of concerns/complaints/serious incidents and where possible de-escalation. However, there is room for improvement and the corporate team in collaboration with Divisional colleagues, will work to improve both the quality and timeliness of concern responses, resulting in fewer complainants contacting the PSOW. A work programme has been developed for focus during 2022/'23.

Recommendation

The Patient Quality, Safety & Outcomes Committee are asked to:

- **APPROVE** the Putting Things Right Annual Report 2021/2022.
- **NOTE** the five key priorities of the PTR Annual Work Programme.

Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	Links to relevant Quality, Patient Safety risks outlined within the Health Board's corporate risk profile.

Financial Assessment, including Value for Money	N/A
Quality, Safety and Patient Experience Assessment	Annual reports are central to patients' safety, experience and quality of care given.
Equality and Diversity Impact Assessment (including child impact assessment)	N/A
Health and Care Standards	The Annual Report provides information around standard 6.3.
Link to Integrated Medium Term Plan/Corporate Objectives	Quality, experince and Safety is a section of the IMTP and the quality improvements highlighted.
The Well-being of Future Generations (Wales) Act 2015 – **5 ways of working**	**Long Term –** Improving the experience safety and quality of the services will help meet the long term needs of the population and the organisation.
	Integration – The experience, quality and patient safety improvements described work across HB's
	Involvement – Many quality improvement initiatives are developed using feedback from the population using the service.
	Collaboration – The experience, quality and patient safety improvements described work across HB's
	Prevention – Improving patient experience, safety will prevent patient harm within our services.
Glossary of New Terms	**Nationally Reportable Patient Safety Incident –** *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.* Change from previous term of 'serious incident'.
Public Interest	Report has been written for the public domain.

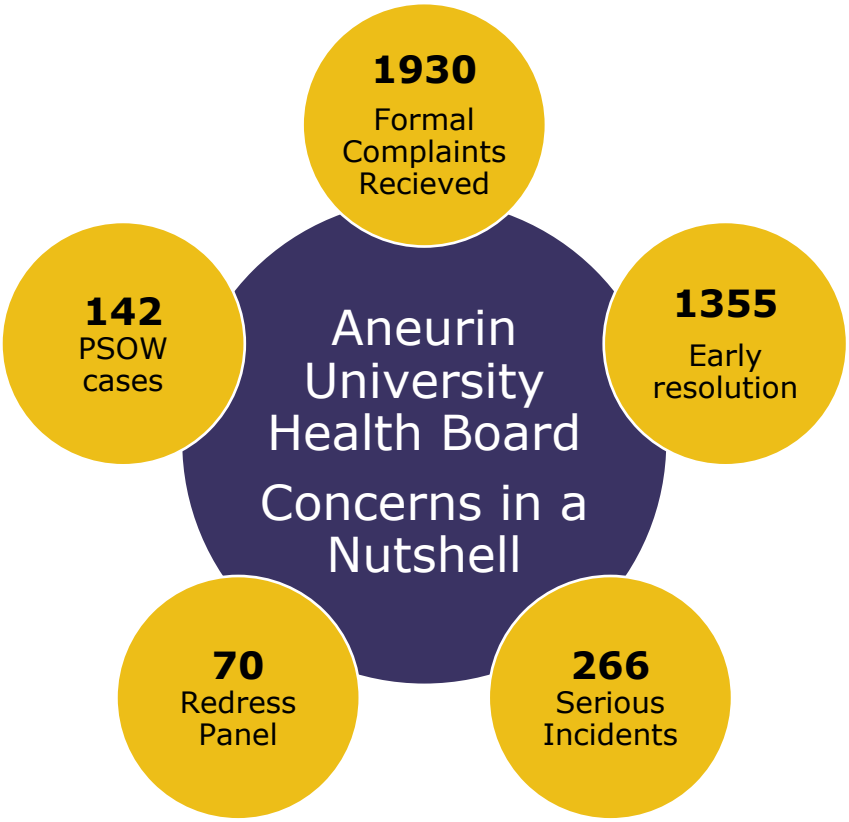
GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Putting Things Right Annual Report

2021-2022

Table of Contents



Introduction

Welcome to the Aneurin Bevan University Health Board's (ABUHB) Annual Putting Things Right Report. This report will cover the financial year, April 2021 to March 2022. The annual report demonstrates our ongoing commitment to the population of the Health Board, which covers Blaenau Gwent, Torfaen, Monmouthshire, Caerphilly, and Newport. This equates to around 600,000 children, young people, and adults.

The fundamental aim of "Putting Things Right" (PTR) is to be open and honest when dealing with concerns, with an emphasis on Learning. This is underpinned by the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) 2011. There are several goals, including the need to make it easier for people to raise concerns and to feel engaged and supported throughout the process. Fundamentally, they must be addressed in an open and honest manner, and organisations must demonstrate learning when things go wrong.

The pressures of Covid-19 have seen continued challenges for all departments of the NHS. The strategic focus of PTR has invested in the complaint experience. To ensure with the 'proportionate approach' to secure, where possible, rapid handling of concerns/ complaints/ serious incidents and de-escalation. To support this concept, a three-month 'Test of Change' was implemented from January to March 2022, with the goal of quickly managing concerns in the Primary Care and Community Division, assisting with compliance, and, most importantly, improving the complainant's experience.

It is important to note that this report will demonstrate the activity of the Health Board in a particularly unique year. 2021 saw the Covid-19 pandemic enter its second year, with Wales's experiencing restrictions and relaxations throughout the period. The Omicron variant also caused anxieties nationally, with responses required to address concerns regarding contagion. This has caused numerous organisational challenges and impacted on the availability of the workforce to attend training and learning events. The Health Board has also had to invest in the use of temporary staff, to fill gaps in sickness and increase workforce pressures. This has an increased risk as there is likely to be reduced awareness of ABUHB policies and processes amongst this staff group.

Governance Structure

There is a robust structure underpinning PTR, with executive leadership delegated to the Director of Nursing. Assurance is provided by exception reporting to the Quality and Patient Safety Operational Group, along with the Patient Quality Safety and Outcomes Committee. A review is also underway on the Quality Assurance Framework, which will align with the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

The above diagram illustrates the current corporate PTR structure. The Customer Management Centre's complaints component will be transferred to the Corporate PTR Team in May 2022. This will centralise calls and allow for more in-depth monitoring of themes and trends. More importantly, it will allow the corporate team to take action as "early resolution" where possible, ensuring a better experience for the complainant.

How did we do against 2020/21 goals?

The PTR Annual Report for 2020/21 set out a series of objectives for 2021/22. Table 1 provides a summary of the progress made against these, applying a RAG rating against achievement.

Table 1: Summary of Progress

Priorities for 2020/21		How did we do?	RAG Rating
Priority 1	Implementation of Patient Safety Incidents Policy *(due for launch on 14 June 2021)*	▪ A communication plan and implementation plan was developed to raise awareness of the new reporting process across the Health Board. ▪ A focused development session was scheduled for all Divisional QPS leads, led by the PTR team. ▪ A series of weekly Q&A drop-in sessions was coordinated and facilitated by the PTR team from 16th June onwards. ▪ National workshops have been held with Serious Incident team in attendance.	
Priority 2	Implementation of RLDatix *(due for launch in May 2021)*	▪ ABUHB Programme Board continue with fortnightly meetings and performance against the project plan. ▪ Weekly meeting with Welsh Risk Pool colleagues in preparation. ▪ Training sessions w/c 27th September for key Corporate and Divisional Teams. ▪ The planned RLDatix Claims, Redress and Feedback modules went live on the 1 October 2021. ▪ The incidents module went live in December 2021. An education programme and communication plan supported this.	
Priority 3	Preparedness for the Health and Social Care (Quality and Engagement) (Wales) Act	There are five workstreams in relation to the Duty of Quality: - ▪ Overarching principles and development of statutory guidance ▪ Quality Reporting Framework ▪ Health and Care Standards ▪ Communication and Engagement ▪ Education Along with an additional two, in relation to the Duty of Candour. National Workstream meetings took place Autumn 2022, with a public consultation scheduled for Spring 2022.	

Priorities for 2020/21		How did we do?	RAG Rating
Priority 4	Covid Claims agenda	▪ The Health Board (HB) are actively working with the Delivery Unit (DU) to ensure a consistent all Wales approach to the investigation of nosocomial Covid. ▪ A resource plan for the on-going management of Covid Claims is in-train. ▪ The HB have shared lessons learned from Covid and nosocomial transmission with the DU, which mirror other HB's in Wales. ▪ The HB are managing complaints that are Covid-associated with no cases submitted to WRP as yet. ▪ The Health Board continues to participate in ongoing national strategic meetings and discussions as to the investigation and management of Covid related concerns. The Health Board has participated in advice and training sessions delivered by NWSSP Legal & Risk Services. Covid claims received will be managed, on a case by case basis, in accordance with this national and legal advice and agreed all-Wales approach.	
Priority 5	Care Aims and progression of Organisational Learning	▪ Workshop took place in November to bring key stakeholders together agreeing a shared set of outcomes and to agree a framework for taking Care Aims/Shared Decision Making forward. ▪ Care aims will assist in influencing service improvement based on user feedback (complaints) – 'what matters to me'. ▪ Two team members from PTR undertook Digital Stories training - providing more opportunity for complainant's voices to be heard and shared, providing learning Health Board wide.	
Priority 6	Learning Framework	▪ A Learning Framework was drafted November 2021, due to vacancies and unprecedented sickness, progress has been limited.	
Priority 7	Improvement in SI Reporting and Performance	▪ Support provided to Divisions ensuring the provision of quality reports for HM Coroner and families. ▪ Compliance monitored, but not formally reported as numbers reported to the Delivery Unit have decreased with the introduction of new reporting criteria	
Priority 8	Mortality Reviews	▪ Mortality Referral Screening Panel established July 2021, which reports to the Mortality Review Group enabling emergent themes and trends to be identified. ▪ A learning from death framework is planned, which will pull together information from mortality reviews, Morbidity and Mortality National Audits and Inquests. ▪ Concerns and incidents are followed up as necessary and if required they are progressed via the PTR process.	
Priority 9	Newsletter	▪ Inaugural Newsletter was issued in October 2021.	

Successes and Challenges

Successes

1. Implementation of RLDatix Feedback and Incident Modules
In Quarter 3 RLDatix became operational. The Health and Safety Department provided extensive training attended by corporate and divisional employees. Comparative data showed the change did not affect reported rates, evidencing the training had allowed for a smooth transition. Aneurin Bevan University Health Board fosters a culture which encourages employees to voice their concerns, make suggestions, and challenge current practises without fear of being blamed or facing repercussions. The Datix statistics indicate that the new system is still being utilised by the workforce, but that users have encountered difficulties, which is to be expected when switching database management systems.

2. Implementation of the National Incident Reporting Modules
The way organisations were asked to report serious incidents underwent radical changes at a national level. A change in national policy and guidance led by the Delivery Unit in June 2021, resulted in a change in terminology and reporting criteria. Serious incidents are now referred to as "Nationally Reportable Incidents”. The Corporate PTR Team created a communication and implementation plan to ensure a smooth transition. The goal was to raise awareness of the new reporting process throughout the Divisions and Directorates. Focused development sessions, 7-minute briefings, and 'drop-in sessions' were used to accomplish this.

3. Funding Secured to Transfer the Concerns Component of the Customer Management Centre to the Corporate PTR Team
Concerns are received into the organisation through a variety of channels, including letter, email, Member Senedd (MS) route, Customer Management Centre, social media, and the Chief Executive. The telephone function will be managed centrally by the Corporate PTR team to improve the complainant experience. When possible, this will allow for prompt complaint handling and management under early resolution.

4. Successfully Recruited and Appointed into Team Vacancies
In preparedness for the transfer from the Customer Management Centre phone calls, staff have been recruited. This service will be taken over in May 2022. The structure has also been reviewed as a result of staff departures and retirements, with new roles created, facilitating skill mix.

5. Training
The Corporate PTR Team continued to develop and facilitate Investigating Officer training. They have also worked with the Public Services Ombudsman for Wales (PSOW), which has resulted in additional external training for Health Board staff. Recognizing the further need for complaint handling training, an external provider was enlisted to provide two days of bespoke training, which will be rolled out to all Divisions.

6. Partnership Working
PTR have continued to collaborate with key stakeholders to improve the patient experience. This includes quarterly meetings with the Community Health Council (CHC) and PSOW to foster open communication channels. In addition, regular monthly meetings with WAST have helped advance this important agenda and strengthen relationships.

Challenges

1. Sickness across the Corporate PTR Team
During this reporting period, there has been a significant amount of team sickness, both long-term and short-term. This has impeded corporate capacity and consequently performance.

2. Covid-19 Recovery
Continued organisational pressures have had an effect on concerns and incidents raised, as well as the inability to facilitate proactive events, such as Learning Events.

3. Increase in Bank and Agency Staff
This increase in use of temporary staff impacts on performance and management of concerns due to the transient nature of the workforce and lack of knowledge regarding policies and procedures.

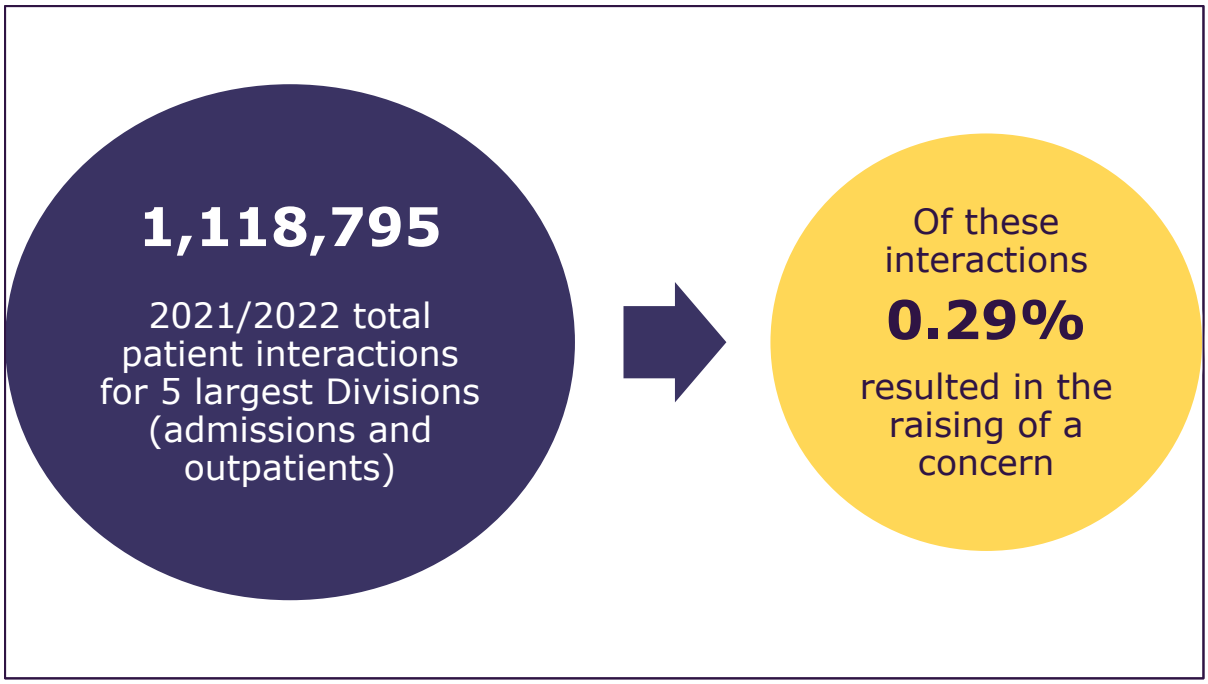
4. Virtual Training
Covid has compromised the capacity to offer interactive training. With restrictions lifting, it is anticipated this will resume its face-to-face format in September 2022, allowing for a more practical workshop approach. This will hopefully have a greater impact on learning, information retention and knowledge acquisition.

Concerns

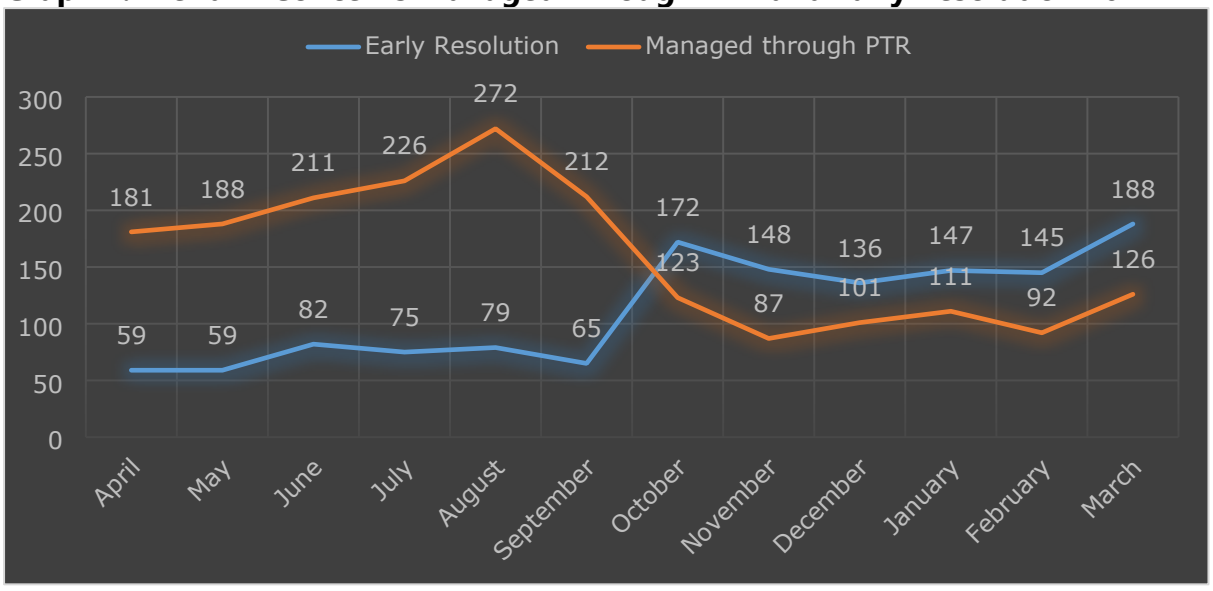
What is a concern?

A concern is when a patient or member of the public feels unhappy about any service provided by the NHS. Each and every concern raised deserves, and is entitled, to receive an appropriate and proportionate investigation and response.

As illustrated the percentage of concerns raised in comparison with volume of patient interactions is extremely low. This is even more remarkable as there was a 60% increase in interactions during this reporting year in comparison to 2020/21, which was 671,608.



Graph 1: Trend in Concerns Managed Through PTR and Early Resolution 2021-22

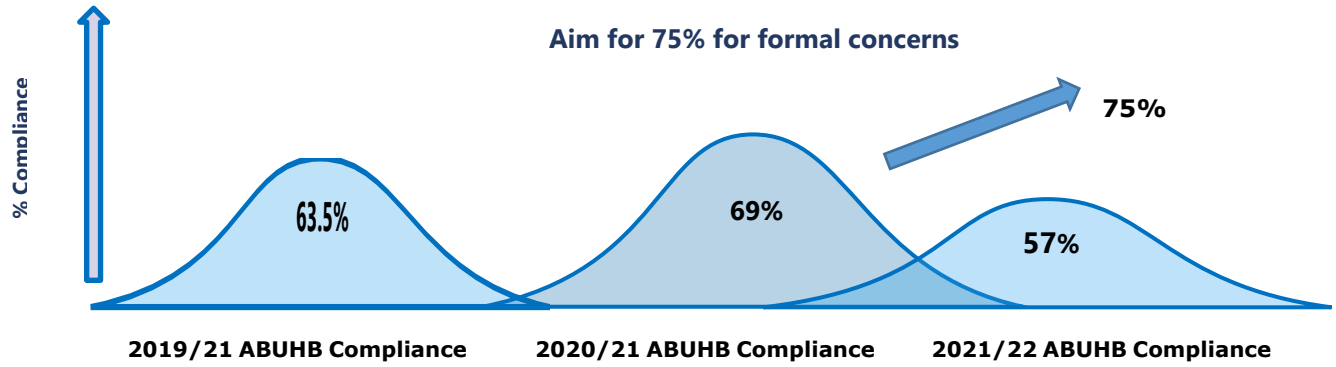


A data intersection from October 2021 illustrates the change in reporting and management of issues via the Early Resolution Pathway. Training and preparation enabled a switch in instantiations, which was maintained throughout the 'Test for Change' period. In 2021/22, a total of 3,285 concerns were received, compared to 2,224 in 2020/21. This represents a 68% rise.

Health Board Overall Compliance

In 2021/22, the Health Board received 3285 complaints, 1355 were resolved under early resolution. The following graph visually demonstrates the trend in overall performance for the last three years.

Graph 2: Trend in Compliance



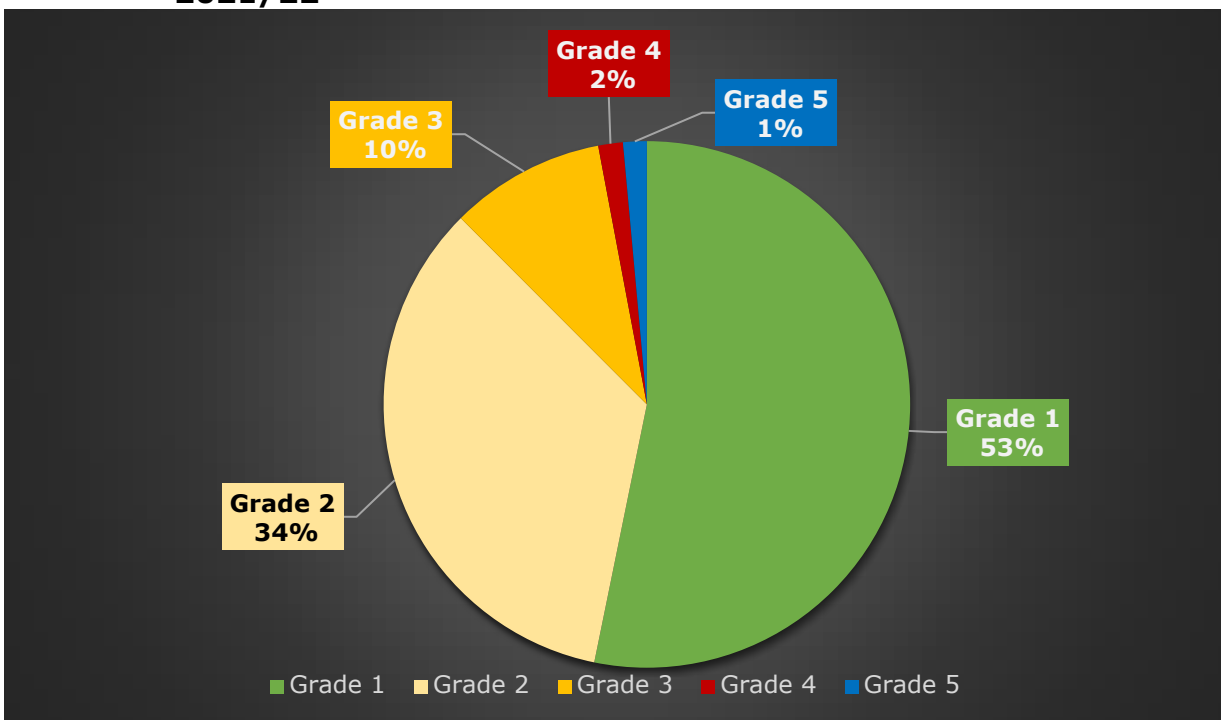
Performance has reduced for formal concerns from 69% to 57% however the proportion of those managed under early resolution concerns has positively increased from 25% to 41%. Supposition is that those concerns managed as formal concerns are representative of more complex concerns. Previously the Welsh Government target was 75% and over. This is no longer a target; however, it is a Health Board goal to achieve this.

When the organisation receives a complaint, it is graded accordingly. An explanation of grading is provided in the table below. Following an investigation, the majority of these are downgraded. Those graded 4 or higher are shared with the Divisional Triumvirate overseeing the area on first receipt, ensuring they are sighted early. Additionally Executive Team are notified of all grade 4/5 complaints via the weekly safety briefing.

Table 2: Level or Harm Grading in Complaints

Grade 1: No Harm	No harm.
Grade 2: Low Harm	Minor implications for patient safety, patient fall requiring treatment, minor treatment.
Grade 3: Moderate Harm	Semi-permanent injury or impairment of health or damage requiring intervention, re-admission, additional interventions.
Grade 4: Severe Harm	Semi-permanent harm leading to incapacity or disability, additional interventions, increased stay >15 days.
Grade 5: Catastrophic Harm	Unexpected death, multiple harm or irreversible health effects, avoidable loss of life.

Graph 3: Grading of Complaints upon receipt for the Financial Year 2021/22

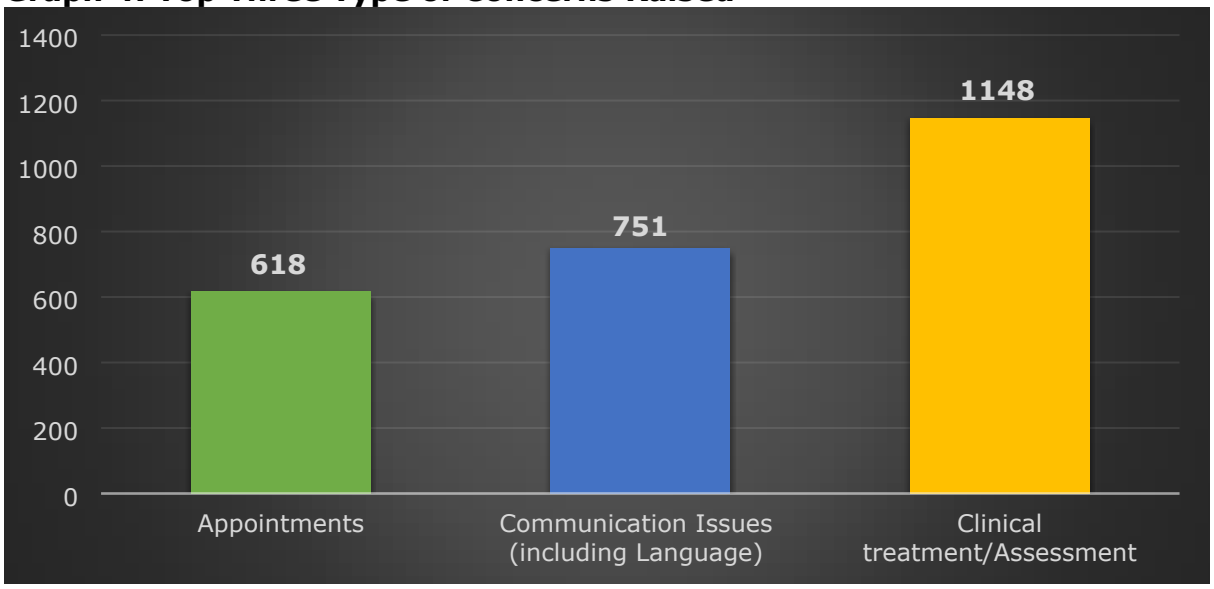


Graph 3 illustrates that a large proportion of concerns (97%) are graded as low, moderate, or having caused no harm upon receipt, with grades 4 and 5 accounting for 3% of the total received. These are frequently multifaceted and cross-cutting divisions and sometimes organisations.

Top Three Themes Raised in Concerns

The top three concerns consistently received are as follows.

Graph 4: Top Three Type of Concerns Raised



Concerns about hospital wait times, delays, and cancellations have increased impacted by Covid. Throughout the reporting period, these remained consistent. Residents of Gwent continue to express concern about wait times, with waiting lists times emerging as a recurring theme in reporting. The creation of a formal Planned Care Recovery Oversight Programme aims to assist patients; it intends to include health optimization for patients awaiting surgery and recovery. The Urgent Care Board is still concentrating on patient assessments and ambulance wait times.

A subsequent review of concerns resolved through 'early resolution' revealed that communication issues persist. This has increased anxiety among relatives who are unable to visit and contact their loved ones. During conversations with Switch Board leads, it was discovered that there was a significant increase in calls from relatives, particularly during times when families would have been visiting.

To address families' growing concerns, the Health Board agreed to two immediate measures to support relative communication:

1) Patient Liaison Officers (PLO's) were employed working 8am-8pm, 7 days a week at the 3 acute sites, linking in with the other hospitals. They act as a link between the relative and the wards. Relatives are encouraged to telephone the wards first and if no response to ring a dedicated telephone line.

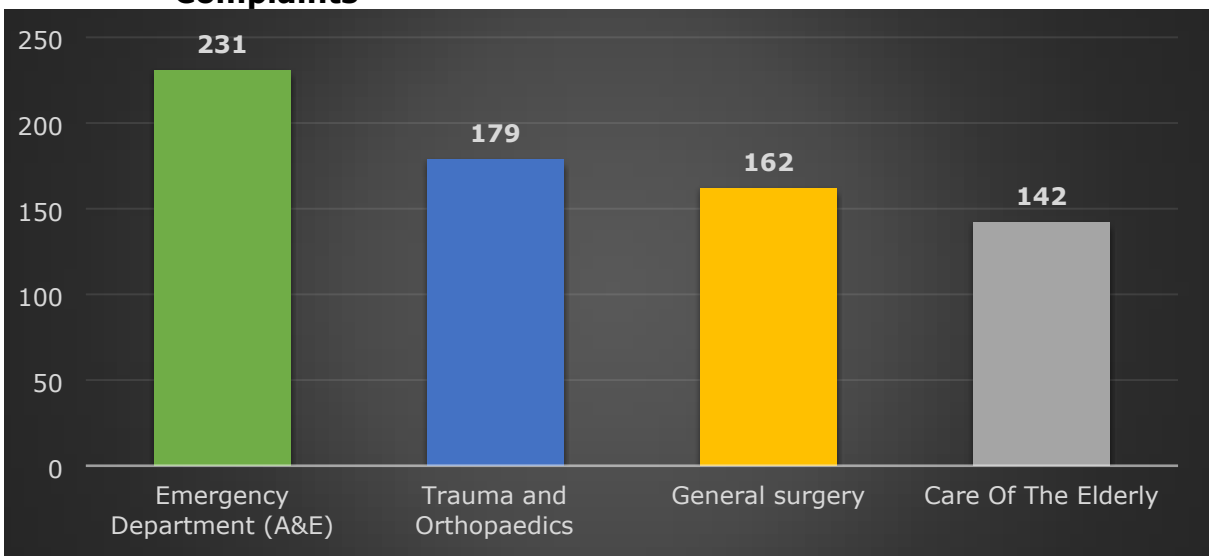
2) To support with increased calls during late afternoon/evenings, 30 additional hours at band 3 were secured to supplement the current Switchboard Team.

Calls taken by PLO's:	
January 2022	**432**
February 2022	**527**
March 2022	**1059**

Feedback from a patient's wife:

"I am not sure who the PLO was on Sunday 13th March, but I needed to ring to say how amazing they were. My husband had been brought into resus at the Grange seriously unwell and I didn't know if he would have made the night, I cannot thank the PLO enough for all the help she gave yesterday. On a positive note, my husband made it through the night and although not out of the woods yet, they are hoping to move him to a ward".

Graph 5: Top four specialities receiving the highest number of Formal Complaints



These are consistent with reporting in 2020/21, but there has been a change in position, for example, General Surgery was previously top, but has now been replaced by the Emergency Department.

Focused work has been undertaken to improve patient experience in ED, specifically in GUH, to include: -

Patient Liaison Officer Service
The Patient Liaison Officer Service is now fully established within the ED, with PLOs working Monday through Sunday from 8:00am to 8:00pm, answering patient relatives' inquiries. Callers appreciate the indication that they will be contacted again, and it breaks the cycle of calls going unanswered, which increases anxiety and distress and leads to more complaints.

Waiting and assessment areas in ED
Following the first year of operation of GUH, there are plans to review the Emergency Department at GUH, specifically the main wait area within the department, based on feedback from patients and a review of services by HIW. Immediate actions include the installation of plastic screens between chairs for social distancing and the presence of patient information/update screens in the main waiting area to improve communication.

Red Cross
Volunteers support the Emergency Department Wellbeing and Home Safe Service at Grange University Hospital, where they have been able to positively support patients both in and out of the department.

Improving Timeliness and Quality of Complaint Responses

Despite the fact that Covid-19 has continued to affect progress, there has been a constant organisational focus on improving response quality and turnaround time. The Corporate Team is frequently reviews processes to improve the timeliness of final responses.

Report Writing training via external providers has been commissioned, with sessions scheduled for April and May 2022.

Meetings with the Complaints Co-ordinator Network have continued virtually, as have weekly meetings with Divisional QPS leads and Corporate PTR Team. These are critical forums for ensuring effective communication and wider learning.

A small 'Test of Change' (ToC) was also proposed and implemented from January to March 2022. Following discussions at their mid-year annual review, the Senior Leadership Team in Primary Care and Community Division welcomed the opportunity to participate in a proposed 'Test of Change.'

Additional experienced investigating officers to manage complaints graded 1, 2, and 3 would help to create the pace, momentum, and traction needed to achieve the necessary improvements and a more sustainable position going forward.

Positively, the supporting team handled 31 complaints: 10 in Primary Care and Community Division, 20 in Urgent Care and Medicine, and 1 in Scheduled Care. Eleven (35%) were closed within one working day, nine (29%) within one week, two (6%) within two weeks, three (10%) within three weeks, and one (3%) within four weeks. Five complaints are still underway March 2022. Furthermore, feedback from the individuals working on the ToC project has been extremely positive.

It is anticipated that taking over the Customer Management phone calls in April 2022 will also expedite processes. The goal is to manage concerns using an early resolution approach whenever possible.

Learning from Concerns

Mental Health and Learning Disabilities Service Referrals

Patients' waiting times have been reduced as a result of the streamlining of referrals for adults in need of mental health support.

Primary Care Support to Families Following Bereavement

It was discovered that the support given by Primary Care to families after a loss fell short of the expected standard. As a result, care navigation training for all receptionists in general practices has been fully implemented, along with identification of GP Leads for specific cases when appropriate.

Appropriate and Efficient Discharge Planning

A number of measures have now been implemented across medicine to improve effective and efficient discharge planning for patients and to prevent delays. These are some examples:

- Redesign of 'Patient Status at a Glance Boards,' as well as standardisation throughout medicine. This includes developing a Standard Operating Procedure for daily Board Round meetings and Multi-Disciplinary Teams to ensure that discharge is addressed in all discussions.
- The introduction of an assessment booklet produced by Discharge Team. This includes gathering background information, contacting relatives, and setting the tone for discharge and the expectations that we can meet from the start.
- Collaborating with the Discharge Team to promote the 'What Matters To Me' conversation during admission and ensuring documentation to back this up.

Public Service Ombudsman for Wales (PSOW)

The number of complaints referred to PSOW indicates how the Health Board has responded to the complaints received. Our goal is to always respond to complaints in a timely, fair, and robust manner, and to address all issues raised at the local level whenever possible. When complainants are dissatisfied with the response they receive, they may refer their complaint to the PSOW. On occasions, the PSOW becomes involved while the complaint is still being handled by the Health Board, because of a lengthy delay in providing a response.

A proportion of complaints received by the PSOW office are Covid-19 related, due to the delay with treatment as a direct result of service reduction, the care and treatment provided to patients with Covid-19 and the frustration over the ever-changing visiting regulations imposed. At the height of the pandemic, the PSOW recognised the pressure the Health Board had been experiencing, liaising with the PTR team.

During 2021/22, quarterly meetings have been held with the PSOW Improvement Officer. Therapeutic working relationships have been maintained and efficient processes are in place to ensure, where possible, deadlines are met.

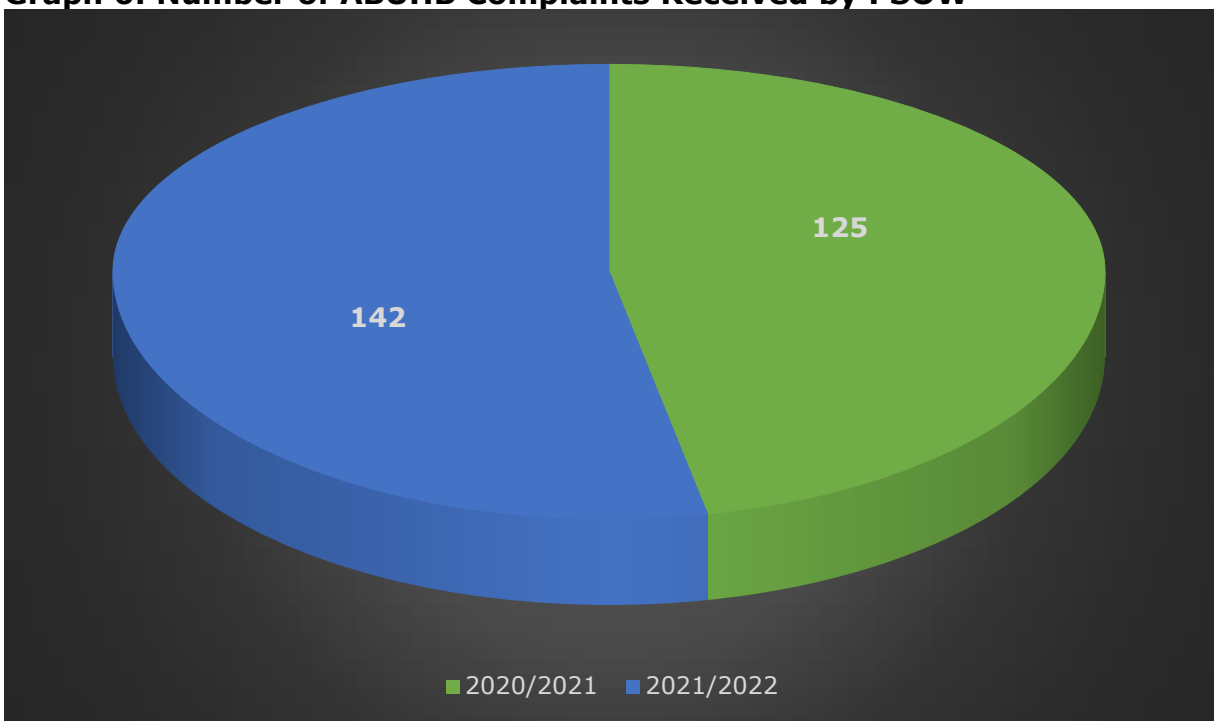
Positively the Health Board has not received any Public Interest Reports during this reporting period.

Number of Complaints received by PSOW

During 2021/22, the PSOW received 142 complaints. Of these, 37 were taken on as full investigations for the Heath Board and 35 cases were not considered for further investigation.

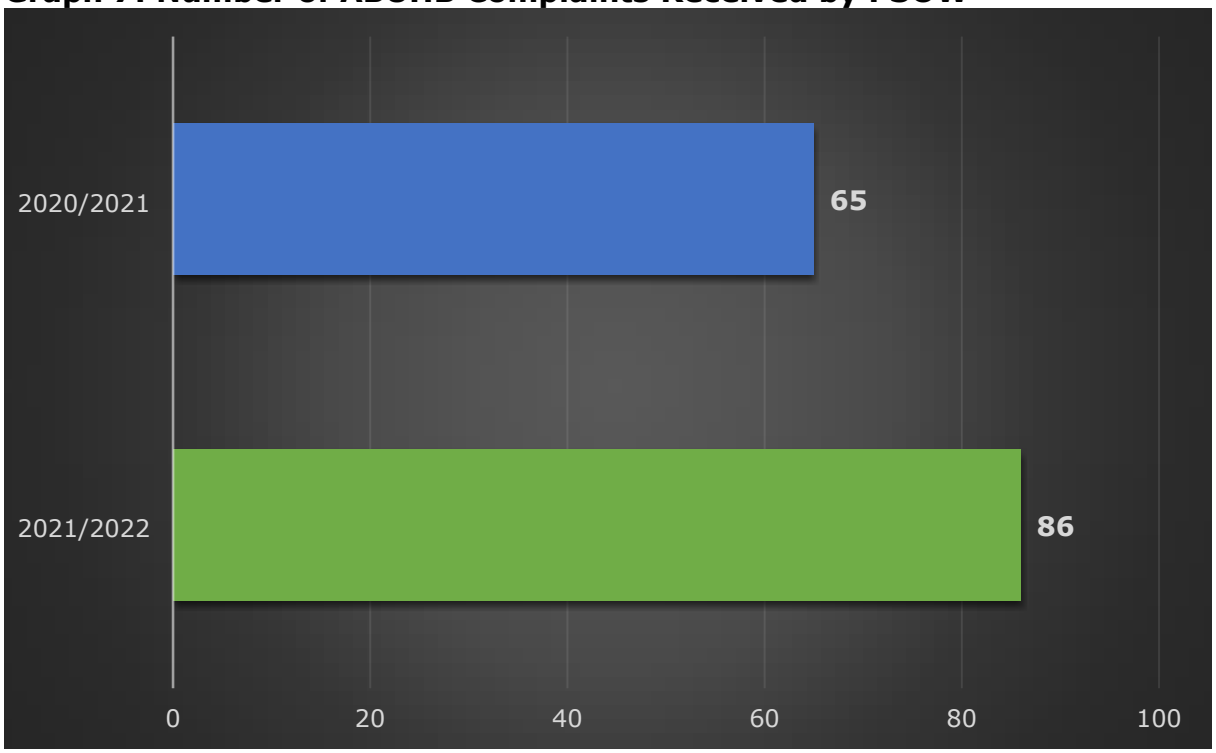
The following graph shows an increase in the number of complaints received by the PSOW for this reporting period.

Graph 6: Number of ABUHB Complaints Received by PSOW

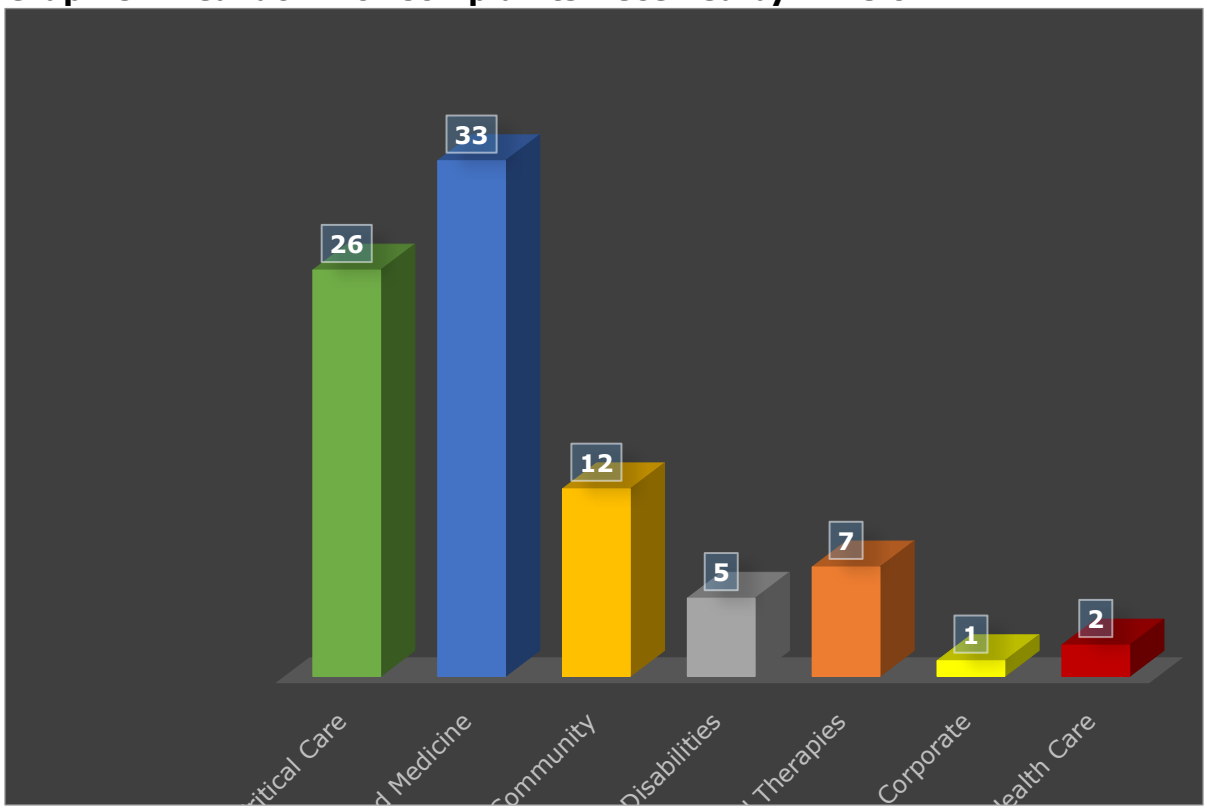


A total of 86 new complaints were received from the PSOW, an increase of 65, compared to 2020/21. This could be attributed to the impact of Covid-19 along with the increase in the number of complaints received.

Graph 7: Number of ABUHB Complaints Received by PSOW



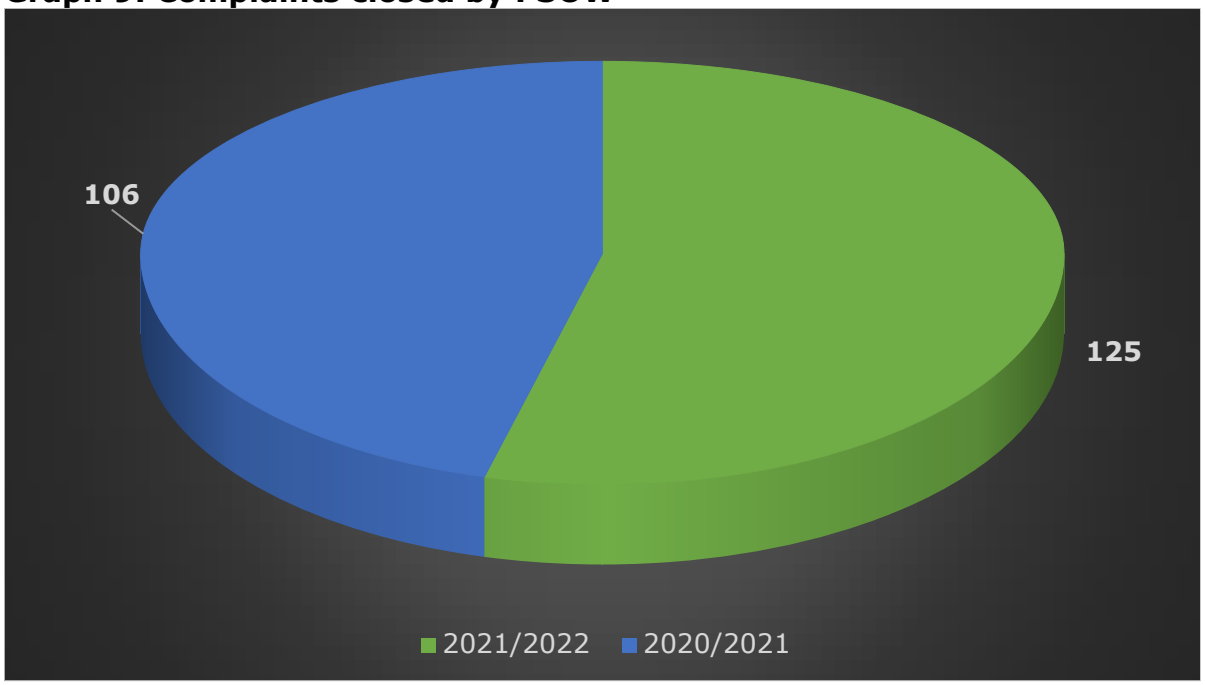
Graph 8: Breakdown of Complaints Received by Division



Complaints Closed by PSOW

As shown in the following graph, there has been a decrease in the number of complaints the PSOW closed in 2021/22.

Graph 9: Complaints closed by PSOW

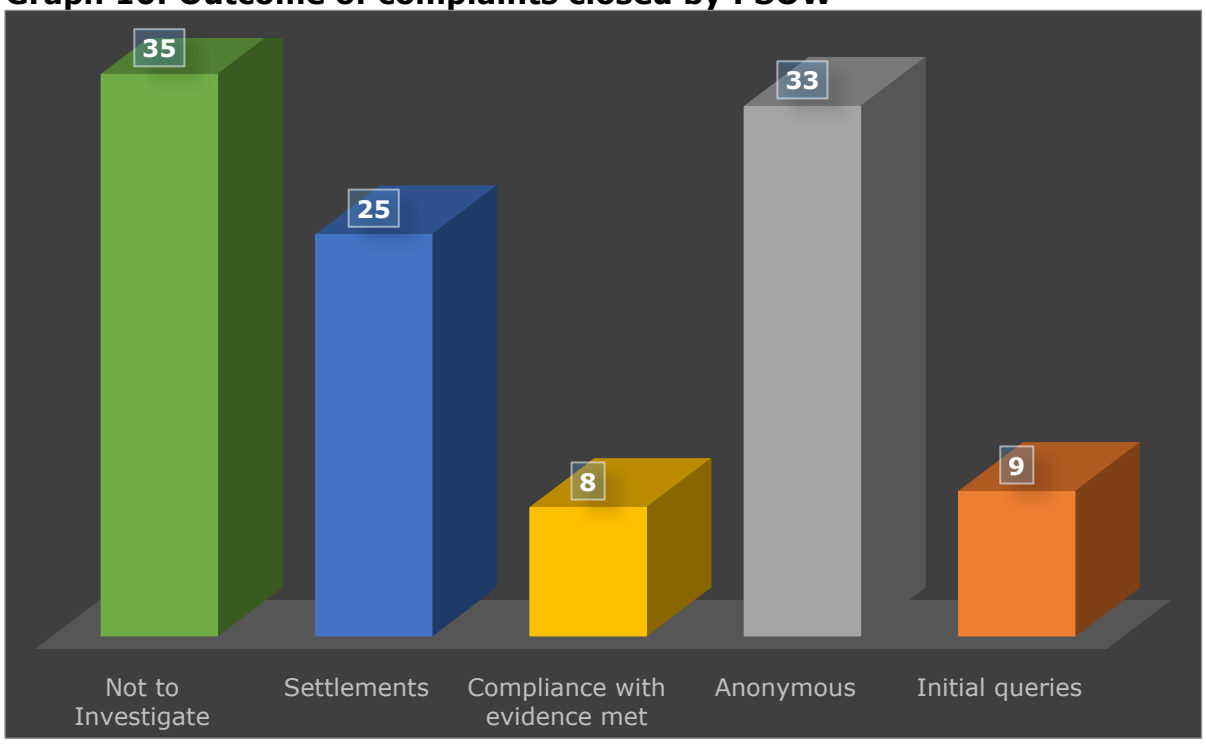


The intervention rate for 2021/2022 which includes the PSOW and the Health Board agreeing to settle the case rather than allow it to evolve into a full investigation and the number of Final Upheld Reports issued following an investigation was 28 and 14 respectively, which equates to 34%. This indicates a slight decrease, compared to 36% in 2020/2021.
The number of Final Upheld Reports received in 2021/2022, is likely to have been rolled over from the investigations that were undertaken in previous financial years.

The Health Board closed 110 cases in this reporting period, which includes complaints received by the Health Board in previous financial years, as well as those received in 2021/22 and also includes all the historic cases closed due to compliance being met from within previous Final Report recommendations.

Outcome of Complaints Closed by PSOW

Graph 10: Outcome of complaints closed by PSOW



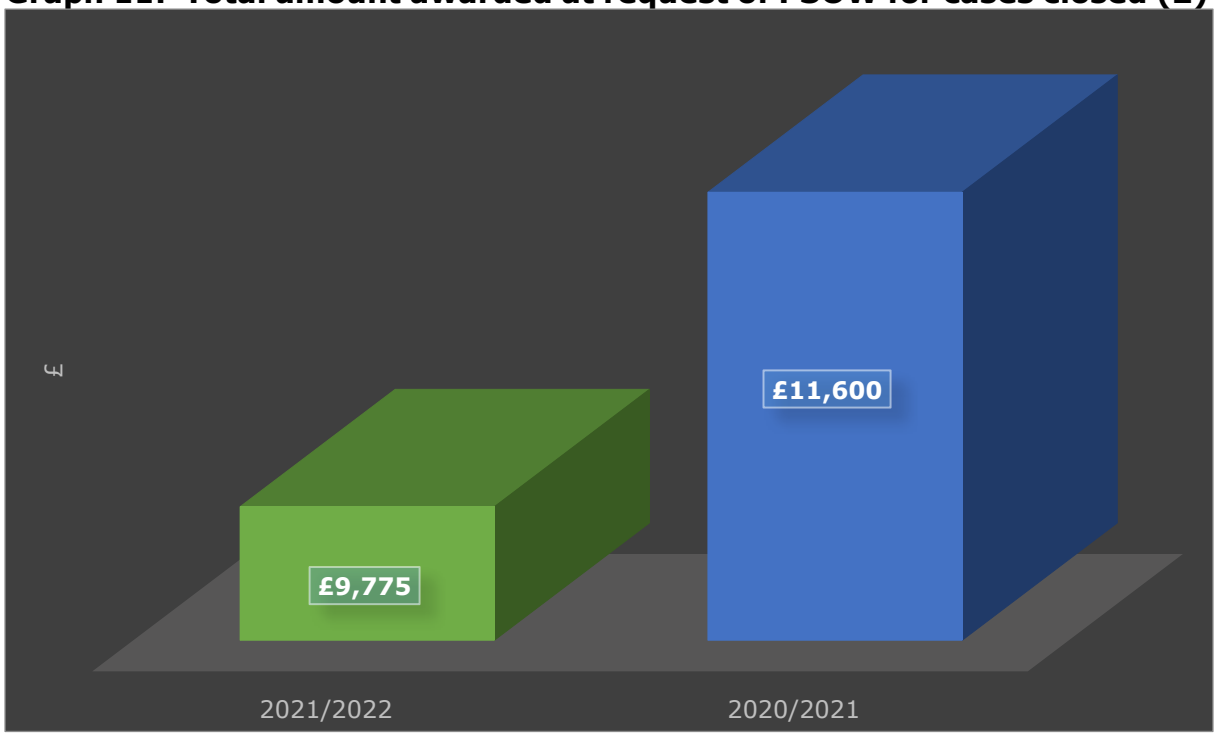
When the PSOW office decides not to investigate a case, it could be for a variety of reasons. A portion of these cases are deemed "premature," which means the Health Board has yet to complete its investigation, while others are deemed out of time or outside the Ombudsman's jurisdiction. The majority of these cases are deemed "premature" because the PSOW believes that no further investigation can be gained and that the Health Board was thorough in their response.

Settlements are also known as 'early resolutions,' in which the Health Board agrees to respond to the complainant or complete a specific action in order to "settle" the case and avoid a full PSOW investigation.

PSOW financial settlements

Where the PSOW believes there has been an injustice, they can recommend a financial payment. This can happen at any point, such as part of a settlement or as part of the recommendations following a thorough investigation. The table below shows the financial amount paid out by the Health Board at the request of the PSOW over the last two years, indicating a decrease in payments in 2021/22.

Graph 11: Total amount awarded at request of PSOW for cases closed (£)



The Corporate PTR Team follow-up all recommendations to ensure implementation with but there is ongoing discussion as to which quality management system will be used to audit this going forward.

Examples of Learning and Actions from PSOW Cases

The front door physiotherapy team at Grange University Hospital (GUH) screens all patients in admission areas admitted with a fall. Clinical reasoning is used in the screening process with consideration of the mechanism of the fall. However, despite this screening, some patients admitted with falls who should be seen by Physiotherapy (as per NICE guidelines) are sent home prior to their assessments being completed. Physiotherapy do advise doctors in these circumstances that they should refer to the Community Falls Teams for assessments.

To assist patients with decreased mobility, there are posters up in admissions areas in GUH to highlight to staff how to contact the front door physiotherapy team.

Inappropriate care and treatment in pregnancy and labour - Learning and Actions

A complaint was made to the Ombudsman that the HB failed to provide appropriate care and treatment in pregnancy and labour.

Following this the Birth Place Decision leaflet is now shared via a number of routes:

- Generic email to all women once they have booked with a midwife.
- On the ABUHB Healthier Together online platform.
- The ABUHB Maternity pages of ABUHB website.
- In the ABUHB Maternity Links and resources group on Facebook.
- Reminders shared frequently across social media platforms for women and families.
- The Birth place decisions leaflet is shared and discussed in ABUHB maternity antenatal classes.
- All community midwives document in handheld records that the woman has received the Birth Place decisions leaflet and this has been discussed.
- All community midwives have access to paper copies to distribute.
- Staff are reminded via private staff platforms and NHS email addresses that this is important.

In addition, there has been a pilot of a 'birth decisions' pro-forma, discussed with women at 36 weeks gestation, in Blaenau Gwent. This pro-forma includes a section on 'have you received the Birth Place decisions leaflet' (as a safety net although would have been given out earlier in pregnancy). The data is currently undergoing analysis.

The "Birth Place decisions leaflet" has been included in the process mapping for the new electronic maternity system and once in place, the leaflet will be sent as a push notification to all women.

Redress

Under the framework for investigating concerns, including patient safety incidents, there is an obligation on the Health Board, where harm has occurred or is alleged to have occurred, to consider whether there is a qualifying liability in tort i.e., are there failings in care which amount to a breach of duty of care and has that breach of duty led to the harm suffered or materially contributed to it. The test of a breach of duty of care is the same as the legal test and is based on the Bolam principles i.e., were the decisions and actions taken reasonable and appropriate as judged by a body of peers?

The Health Board has a well-established Redress Panel to make the determinations in those cases where it feels there have been failings and the failings may have led to harm. The Redress Panel convenes monthly to ensure cases are considered on an ongoing basis. Whilst making determinations as to whether a qualifying liability exists, there is also a strong emphasis on ensuring that learning has taken

place that is robust and has been shared as widely as possible. Areas of good practice are also highlighted and shared.

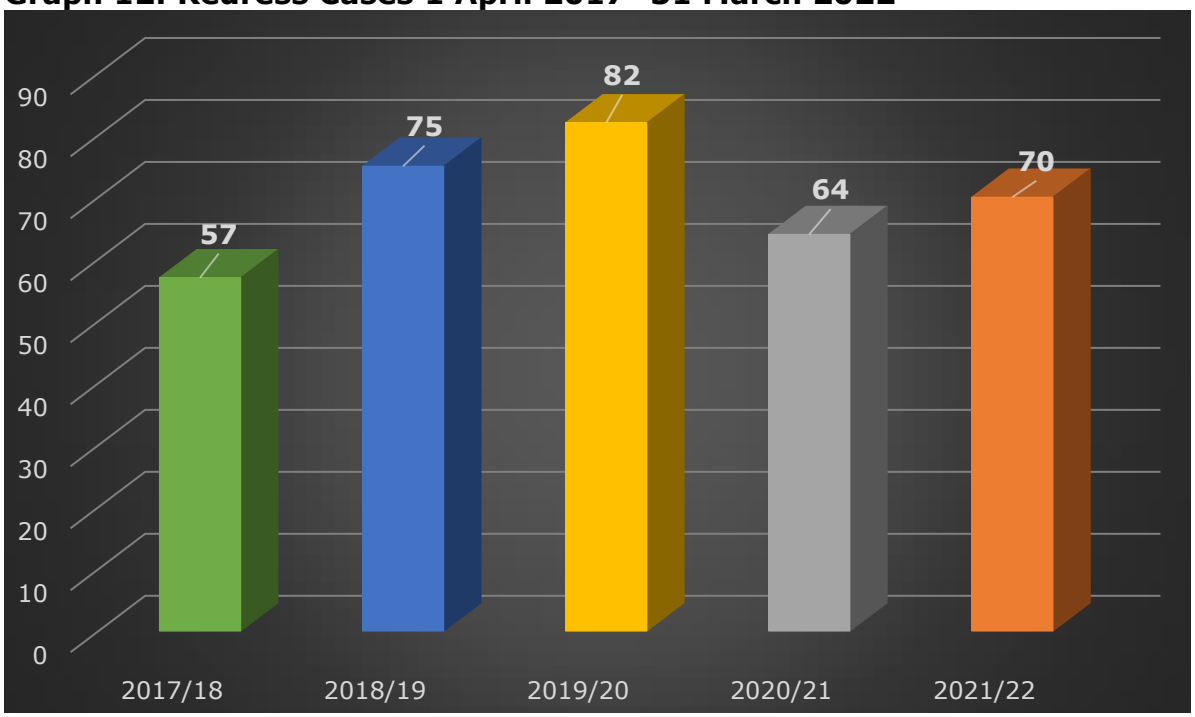
Redress Panel, like many other activities, was affected by the Covid-19 pandemic and was suspended for a time until relaunched as the 'Virtual Redress Panel'. Prior to the Panel, cases are scrutinised by the Legal Services Team to ensure that the Panel have all the requisite information to enable them to make their decisions. This is a high-level panel with quorate membership for Medical, Nursing and Therapies Executives or nominees, together with Chair.

ABUHB Redress Panel has always been held in high regard nationally across Wales, hosting observational visits from colleagues across Health Boards. The Virtual Panel has enabled for greater creative use of time and easing pressures on clinical attendance to support cases. It is nationally recognised that the Redress aspect of the All-Wales 'Putting Things Right Regulations' has provided a much-needed alternative to formal legal proceedings for patients and their families, achieving resolution within much shorter timeframes, and costs of legal proceedings.

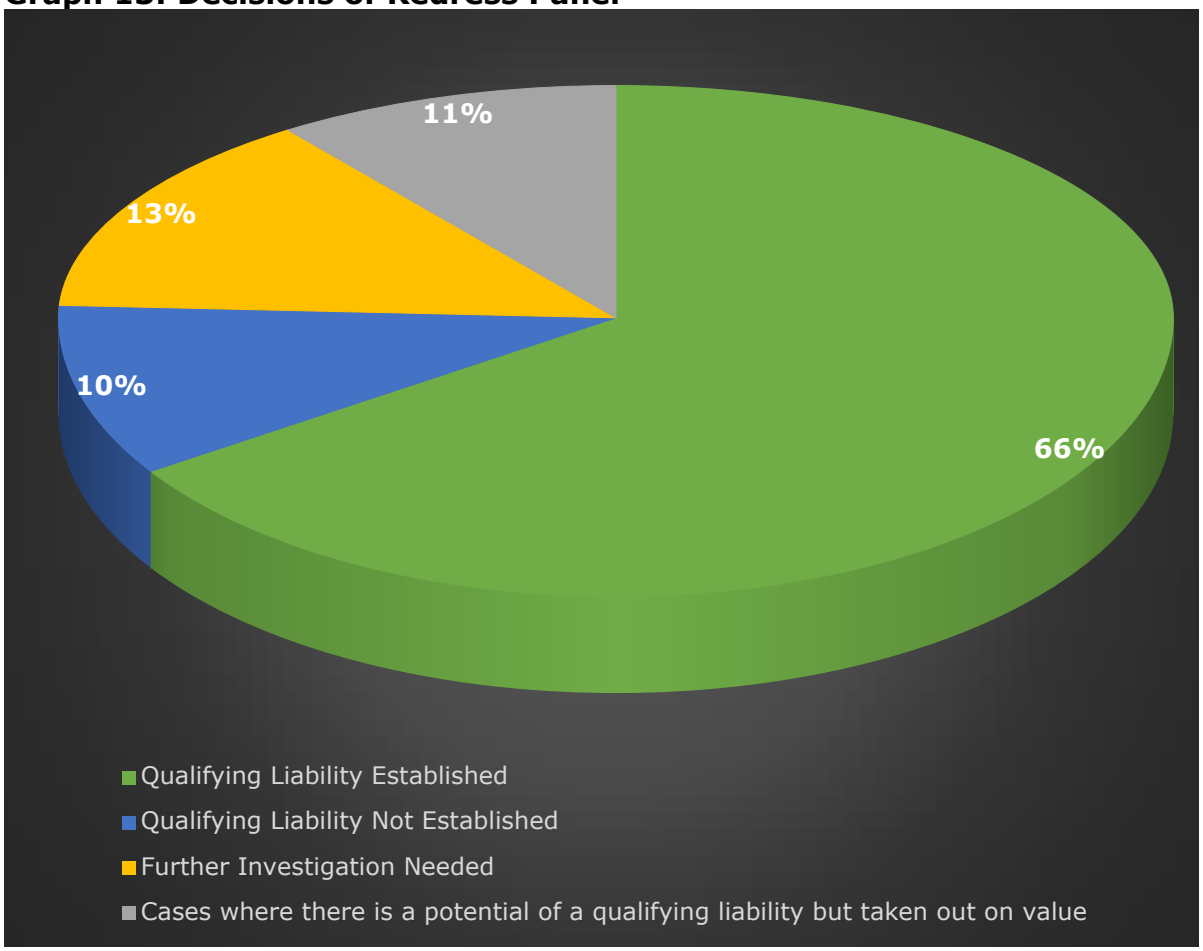
For the Index Year 2021-22, the Health Board has convened: -

- 10 Redress Virtual Panels
- 6 Panels were cancelled as cases were not ready for determination
- 70 cases were deliberated and determined
- 46 cases had a Qualifying Liability confirmed

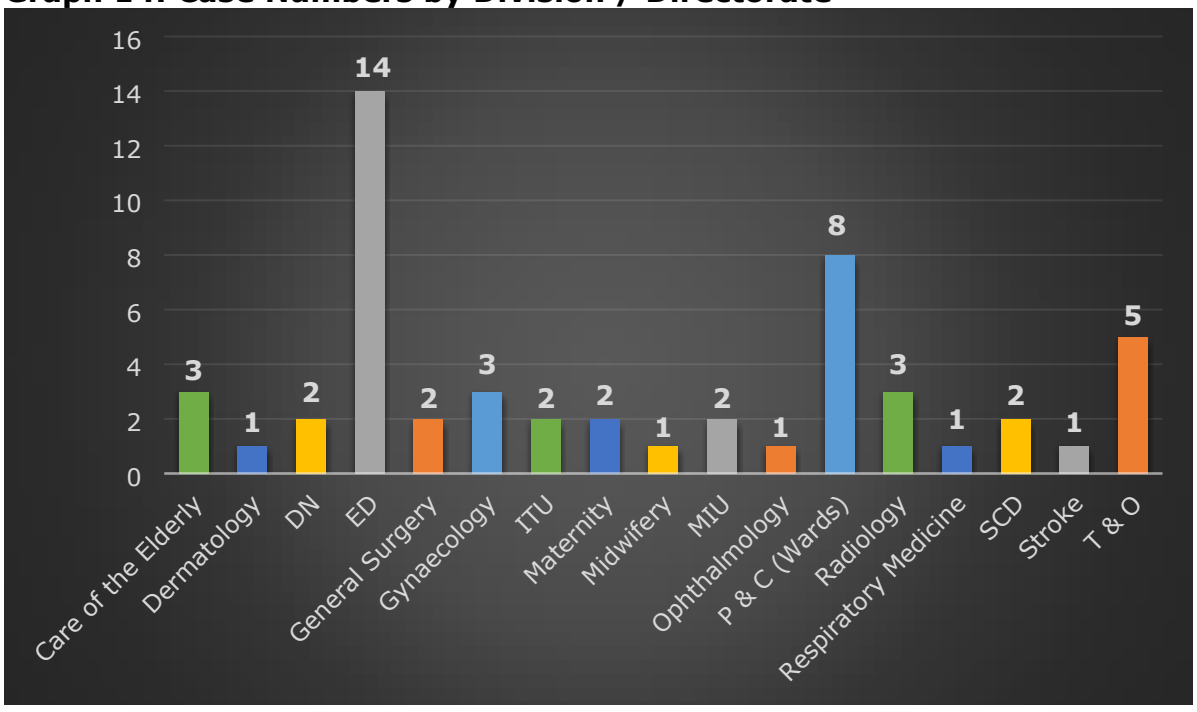
Graph 12: Redress Cases 1 April 2017 -31 March 2022



Graph 13: Decisions of Redress Panel



Graph 14: Case Numbers by Division / Directorate



Themes of cases taken to Redress Panel

The majority of cases heard involved concerns regarding clinical treatment. Several cases were linked to issues encountered with or during procedures undertaken; failures to undertake investigations, failures to escalate and a lack of senior review. Whilst clinical treatment, including delays of treatment, were the largest class of cases, there was a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with no evident area of concern or outlier identified.

Cases involving falls prevention and management were the second class of cases at 11, although down on the previous year when 16 cases were presented to panel in 2020/21. In the majority of cases there were failures to complete the Multi-Factorial Risk Assessment, failure to complete care plans or update, and issues in relation to enhanced care (failures to implement, failure to identify where this was needed). Most cases were in the Community Hospital Wards in YAB and YYF.

The number of cases heard at Panel involving pressure damage were down by 50% on 2020/21, with only 5 cases coming to Panel over the course of the year.

Lessons learnt from Redress

In addition to making determinations of a qualifying liability, Redress Panel considers the learning from each case to ensure that learning is meaningful and adequate to help address the issues identified.

Learning routinely takes place on an individual and at directorate level (through reflection, discussions and education sessions). However, in several cases the learning has underpinned the work that is being undertaken at Health Board/Corporate level. For example, in relation to the Health Board's Falls Prevention Management work and Corporate Action Plan, information on themes and issues identified through Redress cases, as well as falls which are the subject of a Coroner inquest, have been shared to assist with data for areas of ongoing focus and further improvement. This has included the necessity for compliance with observations and scanning requirements when a head injury has been sustained following a fall.

Every case taken to panel is the subject of consideration of any immediate actions or follow up actions to prevent future patient harm or improvement in services, including the assurance of personal learning and reflections where appropriate. Much of the work undertaken is subject to regular audit to ensure that work undertaken is effective and efficacious. A' Learning From Events Report' (LFER) is produced for each case and is then subject to extensive scrutiny from the Welsh Risk Pool where a liability has been identified, to provide assurance on actions taken. This year has seen several cases involving x-rays, where there have been problems/delays in terms of ED and Radiology reporting, and interaction between the two.

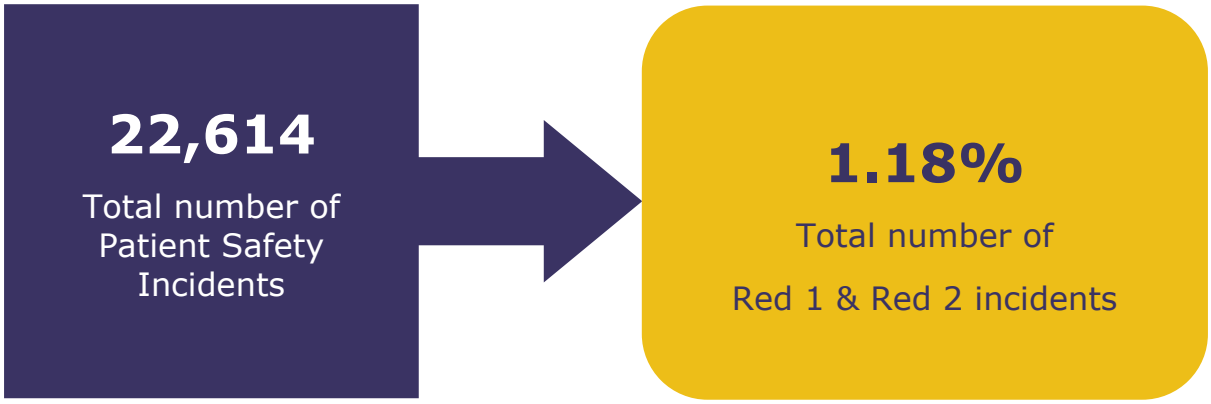
In an index case, the radiology was reported in a timely manner, but was missed by ED/not picked up. ED now has an electronic sign off process, meaning that it less likely that radiology reports will be missed. As a direct result of the positive learning from this case this new process has been reported to the Welsh Risk Pool as assurance and earning from events has occurred.

Serious Incidents

A Serious Incident is defined as ***"an event which has involved either an act or an omission in relation to NHS funded care which has caused an adverse outcome, resulting in severe or permanent harm or death"***.

A patient safety incident should be nationally reported within 7 working days from the occurrence or point of knowledge, if it is assessed or suspected an action of inaction in the course of a service user's treatment or care, in any healthcare setting, has or is likely to have caused or contributed to their unexpected or unavoidable death or caused or contributed to severe harm.

From 14 June 2021, The National Reporting Framework replaced the Welsh Government Serious Incident Reporting criteria. Historically, the focus of incident reporting at a national level had been to examine in detail Serious Incidents as out in NHS (Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011 (the Regulations), primarily through the utilisation of Root Cause Analysis. The new National Patient Safety Incident Reporting Policy (2021) aims to bring about several key changes to national incident reporting.



The total number of Patient Safety incidents that have occurred during the period 1 April 2021 to 31 March 2022 is 22,614.

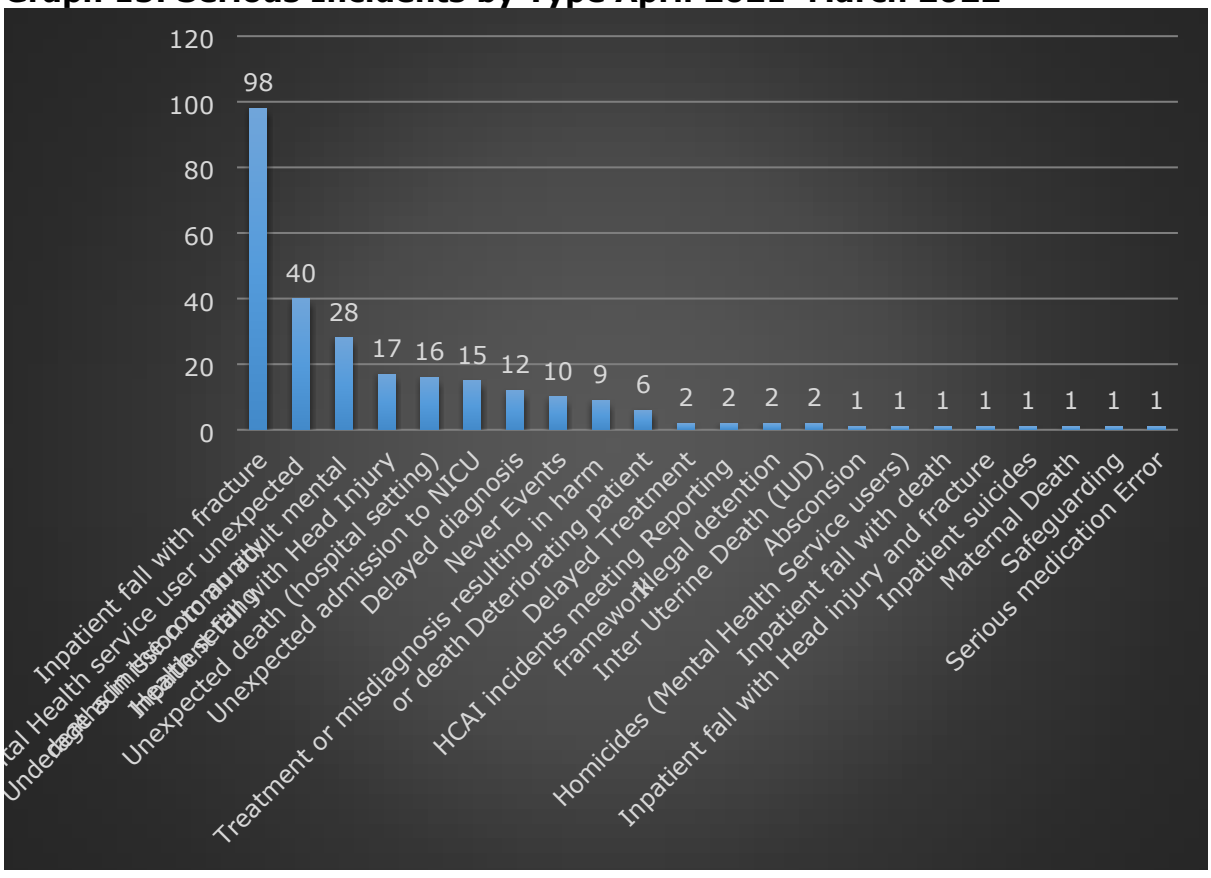
All Serious Incidents are reported to Welsh Government's Delivery Unit (DU) and managed through the Serious Incident Process either as Red 1 (corporately led) or Red 2 (divisionally led) investigation. In 2021/22, there were 25 reportable incidents, 21 of which were managed through the Red 1 process, whilst the remaining 4 were managed as Red 2's. Prior to the Welsh Government steer that occurred during the Covid-19 pandemic, and continued through the introduction of the Policy, reportable criteria were reduced from 23 to 6. These are: noted below.

1. Never Events
2. Inpatient Suicide
3. Maternal Death
4. Neonatal Death
5. Homicide
6. Any other incident of high impact (for local decision)

The new Policy allows Health Boards to determine when a proportionate investigation will be conducted. This can range between 30 and 120 days.

For the 242 additional incidents that would have previously been reportable to the DU, the Health Board is continuing to conduct a thorough internal investigation in collaboration with external partners to ensure that actions, and more importantly, learning, continue.

Graph 15: Serious Incidents by Type April 2021–March 2022



Learning from Serious Incidents

The top three categories of reported incidents were:

1. Inpatient Falls with Fractures
2. Mental Health Service User Unexpected Death in the Community
3. Underage Admission to an Adult Mental Health Setting

Learning identified from these are outline below: -

Inpatient Falls with Fractures

It is recognised that the prevention of falls, and effective management of patients following a fall, is an important patient safety challenge. To minimise falls, and as far as possible, their impact on patients and staff, the Health Board has adopted the National Institute of Health and Care Excellence (NICE) clinical guidance.

Despite this, inpatient falls with fractures remain the top serious incident reported and therefore this requires a coordinated, multi-disciplinary/ agency approach across all settings to support the reduction of falls.

A revised Health Board approach has seen a review of its governance structure to falls management with the establishment of both 'Hospital and Community Falls and Bone Health Groups.' which reports to the Falls and Bone Heath Committee. This aims to promote coordination across Primary and Secondary Care whilst taking account of prevention. The key aim is to develop an infrastructure which informs and empowers all in support of sustainable solution to falls reduction and prevention.

A review of falls management was completed in line with the 2021/22 Internal Audit Plan for Aneurin Bevan University Health Board. The review sought to provide the Health Board with assurance that falls management procedures are appropriately implemented and monitored within the Health Board.

Findings include:

- The updated Falls Policy is hosted on the intranet site, with supporting links to the document correctly referenced. The audit found the revised Policy to be comprehensive, with a multi-disciplinary approach adopted, additional medication review tools, a head injury pathway, nutritional risk screening tool and frailty referral forms included. Each of these have the potential to improve inpatient falls management. The Policy includes a MFRA, which is more detailed than the previous version.
- A programme of falls management training was commenced when the Grange University Hospital (GUH) opened. This was to assist with the different nursing practices required for single rooms, as opposed to the multiple occupancy bays predominantly used at the other hospital sites. Since the delivery of the training and the introduction of the Policy there has been a noticeable decline in the number of falls recorded. This has continued

month on month in the total number of falls and the number of falls per 1,000 bed days.

- There is Health Board representation within the Welsh Government initiative, 'The National Inpatient Falls Network'. This is a forum for the sharing of best practice, which has taken place with the medicine review tools and the head injury pathway.
- Through the newly established structure in support of falls management an ongoing awareness campaign has been established. The further development of the intranet pages provides enhanced communication approaches.
- A falls network has been developed providing a platform to share good practice, research and act as a resource depository. Through this the concept of falls champions will be promoted. This will support quality improvement initiatives across the falls pathways. The agendas set for the fall's forums will look to ensure such good practice, learning and necessary change initiatives continue to promote the requirements to manage falls.
- Should non-compliance concerns be identified the findings are shared with the Nurse in Charge, Ward Manager along with the Senior Nurse and QPS Lead. The outcomes are relayed to the member of staff responsible for the care of the patient and the wider team as a means of learning. The responsible member of staff looks to action any requirements to rectify non-compliance. The QPS Lead subsequently undertakes a more extensive focussed audit to identify any systemic concerns within the given ward and to inform the Divisional 'deep dive' discussions.
- Work is underway to look at how the data can be cross referenced with the overarching falls management data and on the reinstatement of the Health and Care Standards Audits. This approach will look to be supported by the training strategy.

Practice change in response to falls in GUH ED

The GUH Emergency Department have identified that there have been several cases where elderly patients following falls were discharged or admitted to medicine with normal x-rays and had fractures identified at later stage. With colleagues in Trauma and Orthopaedics and Radiology a care pathway has been developed so that cross-sectional imaging obtained in ED in cases where patients with a normal x –ray, but who have ongoing pain on mobilisation get earlier recognition of fractures. This reduces the risk of missing injuries.

Underage Admissions to an Adult Mental Health Setting

Much work has been done by the Division following the detention of a number of young people who have been detained several times, sometimes over a short space of time in the adult mental health setting. Approximately 50% of young people detained during this period are looked after. Many of the detentions can be linked to later 'social' admissions to hospital, where there were complex external issues impacting upon the young person's mental health.

During the spring and summer of 2021, there were a relatively high percentage of detentions, however since August 2021 up until March 2022, this has reduced significantly.

There have been a number of measures that have been in place to facilitate this reduction:

- CAMHS Intensive Support and Engagement Team (ISET), and the CAMHS Crisis Outreach Team (COT) input. The ISET and COT teams have been designed to work with young people and families, in the community, at different stages of crisis. COT work with the families initially, during the most complex part of each young person's crisis presentation, providing support and evolving risk management. ISET work with young people on a more long-term basis, when an element of stability has returned to the young person's life but they are still in a vulnerable position.
- Both COT and ISET are working in a much more responsive way, and have been able to offer direct, in the moment support to young people when a crisis emerges. This has almost certainly prevented a number of young people from reaching the stage where they need to be detained on a section 136.
- Better multi-agency working with support networks to be able to provide direct support to young people, preventing unsafe discharges and therefore reducing the risk of a 136 detention.
- Development of integrated management plans that ensure that responses from emergency services are co-ordinated and risk assessed, yet do not immediately result in either hospital admission or section 136 detentions.
- Direct work with placements offering supervision to staff. This allows them to different approach to how they respond to distress, this has undoubtedly reduced the frequency of detentions.

Unlawful Detentions – Actions

Due to an increased number of incidents raised relating to patients being detained on acute wards, the following actions were undertaken: -

- Corporate Services at all acute sites to take responsibility of detention papers, delivering of patient rights and appeals. Posters on wards with these instructions
- The Corporate Team will liaise with the MHA team and ensure the papers, appeals etc. are sent by courier to the department
- Mandatory training will be provided by the MHA Team to all Corporate service managers
- All Legal papers, rights, appeals and patient information leaflets will be kept within Corporate services Hub at each site
- MHA Admin and Corporate services to establish links with the liaison Team for out of hours support

Additional learning from Serious Incidents

Therapies Incident

A patient was practising walking up the stairs and a metal walking stick fell from around 2 floors up and struck the patient's hand – Actions and Learning

- The team distributed an alert to all ABUHB physio staff
- It is also being raised at all operational managers meetings
- The Health and Safety reps have also been made aware so they can circulate, and it was included in the 'Physio Focus' May 2021 Newsletter that goes to all staff

Nutrition and Hydration (Dementia Care)

Several developments are taking place to support improvement in nutrition and hydration which include Dementia care. The use of the "Red Tray" to alert staff to patients who require support around mealtimes have been re-introduced to the ward. Training incudes raising staff awareness of the benefits of snacks and finger foods to support people who like to eat little and often, often whilst walking, was limited.

The Nutrition and Hydration Group are now auditing this aspect of care, as well as supporting training around nutrition and hydration for staff and the Red Robin Volunteers.

Medicines Incidents

Incidents relating to Gentamicin Administration - Actions and Learning

In July 2021, the antimicrobial pharmacy team launched a gentamicin dosing calculator and new guidelines on monitoring gentamicin levels to support best prescribing and monitoring practices. These have been shown to reduce the number and severity of incidents reported since August 2021.

Incidents Relating to Heparin - Actions and Learning

Strengths of heparin stock held in all clinical locations are reviewed and rationalised. Work is underway to revamp the heparin chart to provide more information to aid prescribing, monitoring and dose adjustments.

Incidents Relating to Morphine Sulphate - Actions and Learning

The pharmacy team have worked with theatres to review the strengths and volumes of morphine sulphate ordered to reduce the risk of picking and administration errors for look-alike products. Theatres have rolled out pre-filled syringes of metaraminol to improve safety:

- Negates need to dilute concentrated solution for injection
- Reduces risk of contamination during dilution process
- Reduces risk of inadvertently administering an unintended dose
- Supports rapid access
- Reduces waste from discarded pre-drawn metaraminol

Incidents Relating to Insulin - Actions and Learning

- Two campaigns to look at informing staff about insulin safety (Insulin Safety Week May 2021 and Celebrating 100 years of insulin).
- Six steps to insulin safety mandatory training on wards.

Medication reconciliation training and education for prescribers has been expanded to include a taught session for junior doctors, a virtual summary presentation on key messages available through the junior doctor app and intranet, and incorporation of these messages into the junior doctor booklet.

The Pharmacy team collaborated with the surgical teams at GUH to identify contributing factors in prescribing incidents, which were addressed by escalating concerns to the division and providing individual support.

The Medicines Safety Group has also created a Medication Safety Strategy that places a strong emphasis on learning.

Through audits, training, internal alerts, and newsletters, pharmacy has also supported compliance with National Patient Safety Notices and Alerts for high dose steroids, anticoagulants, phenobarbital, oral medications, and safe medication storage.

Family and Therapies Division

Maternal Death of a high-risk pregnant lady - Actions and Learning

- To implement a low threshold for Obstetric review when high risk women present to Triage
- improve communication between tiers of on-call team members with clearer guidance from senior members in management of complex high-risk cases
- Ensure accurate documentation when women are reviewed by a Doctor, Doctors/ Midwives to ensure patient review when prescribing drugs such as syntocinon rather than giving verbal orders
- Develop a robust AKI protocol with senior medical decision making in collaboration with the obstetric team

The Medical Examiner Panel

Medical Examiners have been appointed across Wales to undertake reviews of all deaths in all health care settings, other than those that are addressed by the coronial service. After consultation with professionals and family members, they have opportunity to raise any concerns or feedback with the Health Board, who will be required to have processes in place to ensure that the concern is appropriately managed.

Their purpose is to ensure an integrated and multi-disciplinary approach to the management of mortality cases to ensure that reviews are conducted once, and robustly across the entire patient's care pathway. The aim is to avoid silo working and to provide the opportunity to instigate collaborative and whole healthcare system learning.
The Panel was formally convened July 2021 and has Corporate PTR team representation. Cases are discussed and if appropriate the concerns or incidents are managed in accordance with PTR regulations. Cases are reviewed on an individual basis and any requisite actions resulting from Investigations will be the responsibility of the relevant Division to monitor and progress.

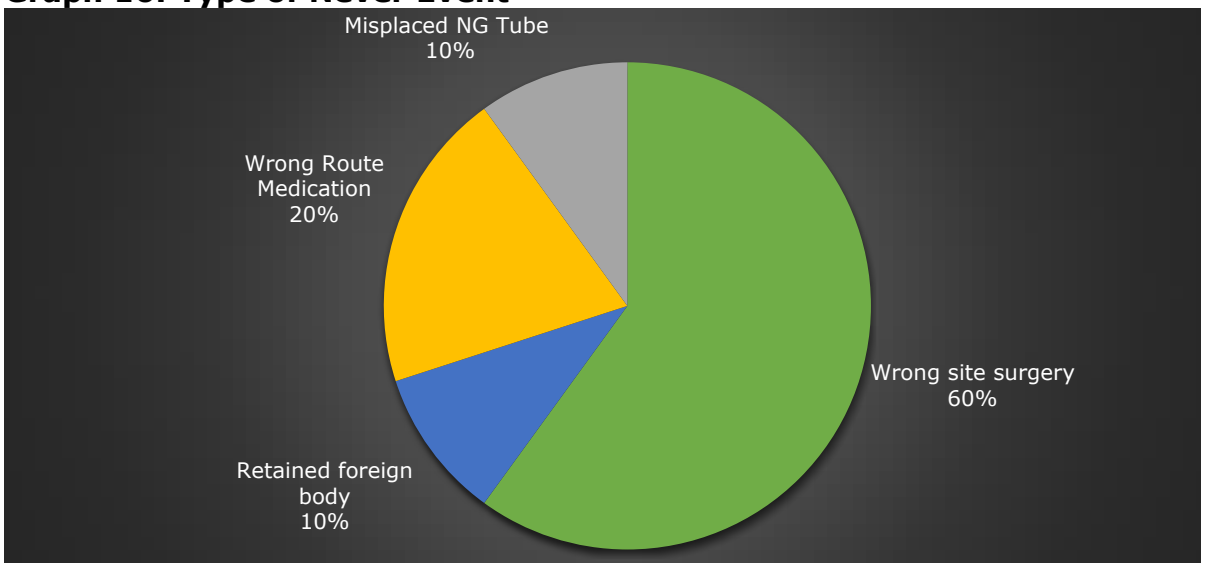
In the near future the decisions and actions associated with all Mortality Review Referrals will be recorded on the All Wales Learning from Mortality Reviews System (RLDatix).

Never Events

Never Events can be defined as ***"Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers".***

A total of 10 Never Events were reported by Aneurin Bevan in 2021/22, as shown in the below pre-chart.

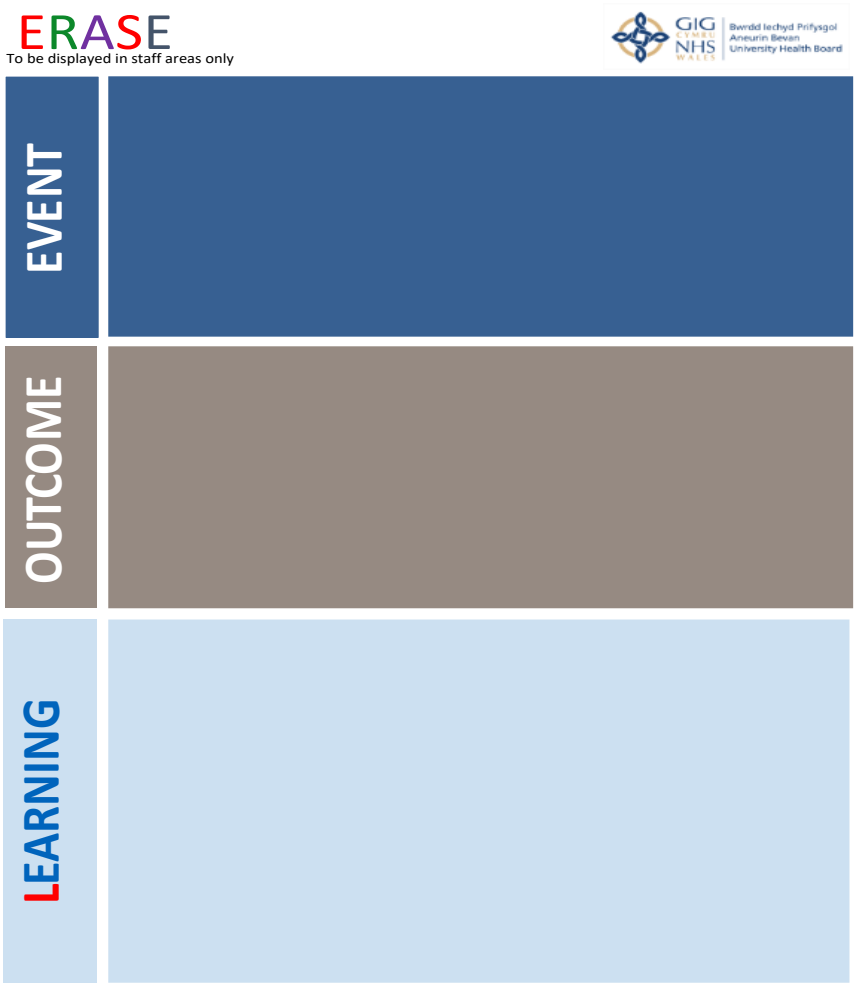
Graph 16: Type of Never Event



Learning from Never Events

A National Never Events Invasive Procedures and Human Factors Symposium was held on the 24 of November 2021. This National Event was attended by Aneurin Bevan staff.

ERASE (Educating & Recommendations After Significant Event's) posters have been developed to highlight learning from events that came from Never Events.



Theatres - Actions and Learning

- Checking of equipment integrity in theatre, correct patient identification (this went across all divisions), managing a diathermy burn in theatre and Stop before you block (SBYB).
- Human factors simulation training has been commenced in theatre at GUH to learn from incidents and near misses.
- Much has been undertaken for SBYB: LocSSIPS and NatSSIP implemented into clinical areas outside of theatres.
- WHO checklist updated, reviewed at Theatre Safety Meeting and patient consent process discussed.

Learning following NG Insertion - Actions and Learning

- In ITU the NG tube insertion Protocol has been amended to reflect high risk in proned, intubated patients. As a result, all patients have X-ray to confirm placement of NGT in ICU.
- There is a plan to implement NR fit needles and syringes to epidural sets to increase safety when administering epidural medication.

Deteriorating Patient - Actions and Learning

- There is a deteriorating patient QI project starting on ward C0 to look at the improving the recognition / early escalation / prompt response to deteriorating patients. This is supported by ABCi.
- An SBAR handover pilot for escalation of deteriorating patients on some surgical and medical wards.

Learning Events and Learning Framework

Due to Covid-19 constraints and the impact on operational pressures, some scheduled learning events have had to be postponed over the last year. With the easing of these, it is hoped that postponed Leaning Events will be rescheduled for the coming year. Some learning events have been held.

Learning Event – Medicine, RGH

A Learning Event was held at the Royal Gwent hospital during November 2021. A complex complaint was thoroughly investigated and identified the following themes: -

1. Communication
2. Nutrition and hydration
3. Oral care
4. Covid testing
5. Discharge
6. Multiple ward moves
7. Staff attitude

Clear areas for improvement were shared, highlighting powerful reflections and considerations to ensure an enhanced patient and family experience. In addition, the following measures were implemented:

- Hydration monitors were piloted on one of the medical wards, with one HCSW identified each shift to oversee that all fluid balance charts were completed. Early feedback showed there was an improvement.
- The Ward Manager implemented training for staff on appropriate mouth care. This was completed in February 2022.

Diabetes Learning Event

A Virtual Learning Event was held on 18 May 2021, coinciding with Insulin Safety week. It was evident through incidents raised that Covid-19 was impacting upon diabetic patients. The two hour session included presentations from, Dr Leo Pinto, Dr Anurag Pinto and Dr Sam Beckett. A training video was shared, and a case presented by Sian Bodman and Gwyneth Radcliffe on 'Diabetes Ketoacidosis (Euglycaemic) Following Surgery'

Over 50 active participants join for the session, including Gynaecology Nursing staff, Obstetricians, Gynaecologists, Specialist Nurses, Anaesthetics, Critical Care staff and colleagues from GP surgeries.

'Thank you for an excellent training session this afternoon on diabetes, I felt that I learnt a lot'.

Compliments

Compliments are received within a variety of ways, including letters, emails, telephone calls, thank you cards and conversations. The new RLDatix module also has a facility to log compliments. Compliments are useful for measuring and tracking feedback. They can demonstrate improvements in performance and provide a baseline for measuring patient satisfaction, generating meaningful data can help drive continuous improvement. Compliments acknowledge, reward and promote desirable behaviours and practices, also providing staff with social recognition. Positive feedback is pivotal for morale and wellbeing and reinforces what the Health Board is striving to provide. Complainants often contain a compliment within, areas are encouraged to share these with staff.

125 compliments were also posted to the Wall of Thanks during this period.

Appreciation Station

Compliments to RGH, D3

"After a cancer diagnosis I was swiftly seen by a consultant with minimal delay. At all times I have been treated with care, consideration and understanding by all including nurses, catering, pharmacy and domestic staff I would like to offer my thanks for this excellent service."

Thank you MH Team

"Thank you for the outstanding care I received throughout my pregnancy. I was always listened to, supported and my feeling considered at all times."

Compliment to Breast Clinic at NHH

"After a cancer diagnosis I would like to compliment the team on my thorough care and treatment. It couldn't have been any better."

Thank you to USC and A & E

"Thank you to staff for the care, compassion and excellent communication I received after sadly experiencing a miscarriage."

Compliment to NHH

"In a world where the NHS can seem broken by the pandemic I am in complete awe of your team. The care and compassion experienced by my father in law was outstanding. I cannot thank you all enough."

Compliment Urology Department, RGH

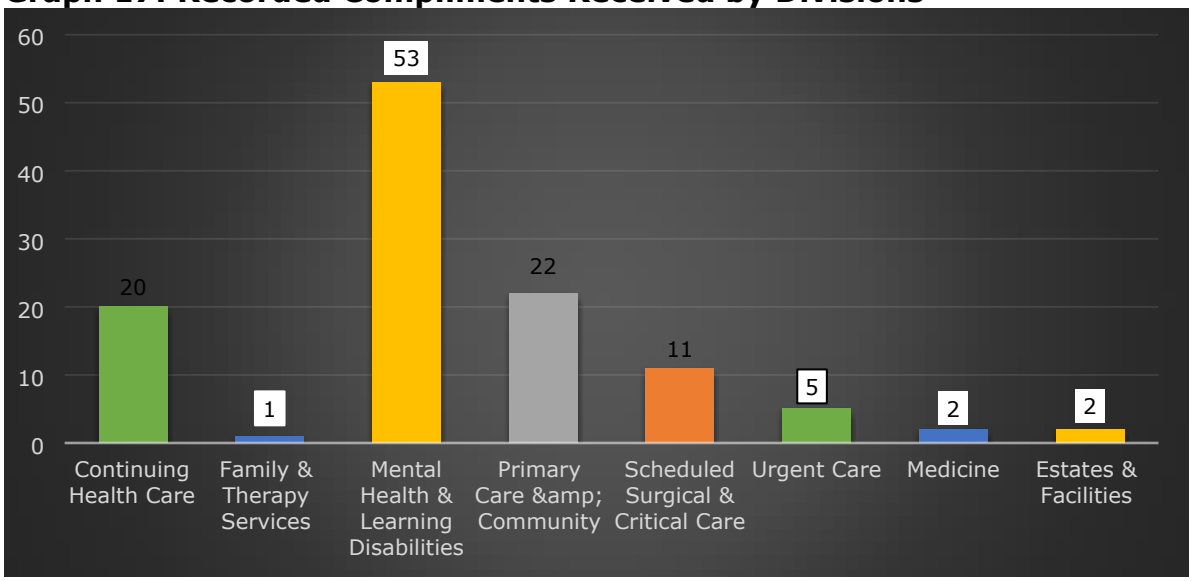
"I would like to share that the care I received was outstanding. I have been treated with great medical expertise, kindness and skill by staff who were always cheerful and kind."

Thank you to SC & Surgical Team

"Thank you for the kind, caring treatment we received after losing my husband. Everyone from the security staff, receptionist and surgeon made a sad situation a little more bearable."

For example, since opening the Grange ED had received in excess of 86 thanks you cards and messages. The following graph illustrates the number of compliments that have been recorded on the Datix system.

Graph 17: Recorded Compliments Received by Divisions



Families also choose to write directly to the CEO, with 30 letters received during this reporting period. These are always shared with the areas identified, with a request that they are forwarded to the staff named within.

Conclusion

2021/22 has been a challenging year for ABUHB as the community it serves and beyond progressed through the second year of the Covid-19 pandemic.

The Health Board has continued to use a "proportionate approach" to ensure rapid handling of concerns/complaints/serious incidents and de-escalation where possible. The changes primarily focussed on any investigations being proportionate, reinforcing the importance of honest communication with people raising concerns, but critically not raising expectations.

Despite the challenges, successes have been secured:

- Implementation of RLDatix Feedback and Incident Modules
- Implementation of the National Incident Reporting Modules
- Funding Secured to Transfer the Concerns Component of the Customer Management Centre to the Corporate PTR Team
- Vacancies within PTR Team reduced and skill mix introduced.
- MDT training conducted, with learning events held.
- Good relationships have been developed with CHC and PSOW.

A work programme has been developed for focus during 2022/'23, as outlined in the following table.

PTR Annual Work Programme
2022 - 2023

Priority 1	Care Aims	▪ In line with the ABUHB IMTP 22/25, the focus will be on **older people** as part of the life-course approach. ▪ For the first two years (in accordance with the IMTP review timelines), the strategic focus will align to Cancer, Dementia and End of Life Care. Each of these defined areas has dedicated Boards. ▪ By April 2022, Cancer Board, End of Life Care Board and the Dementia Board will all have Care Aims as a priority focus ▪ The 4 day Care Aims Training will be secured for the Leads of these Boards and Team Leaders. Health Board staff have been identified to attend. ▪ Four Health Board staff have been identified to attend a Train the Trainer course in July 2022 in order to establish sustainability - the Educational Leads for Nursing, Medical and Therapies will develop a training strategy to support roll out and identify the resources required ▪ In June 2022, a Care Aims Development Session for the Board will be delivered. Development Sessions for the Dementia, End of Life Care and Cancer Board will follow this.
Priority 2	Introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020	▪ Preparedness is underway with a public consultation on the guidance and draft regulations scheduled for Spring 2022 ▪ Guidance and draft regulations will be finalised and laid in October 2022 ▪ An e-learning package, cascade training and awareness sessions will be delivered by the National central team across NHS bodies ▪ They will also prepare and deliver a public awareness campaign, to increase public awareness of the duty of candour, empowering individuals to ask questions about the care and services they receive. ▪ They will also develop easy read information leaflets in preparation for the duty coming into force April 2023.

Priority 3	Covid Investigations	An All-Wales approach is being taken to deal with Covid complaints and claims. In preparedness the Health Board is planning to: ▪ Recruit a programme manager to oversee the Covid investigations ▪ Recruit a team of investigators and admin staff to support the programme. ▪ Comply with the national requirement to investigate nosocomial cases.
Priority 4	Embedding New Staff and further Development of the PTR Team	▪ A team development programme will be introduced strengthening team work and clarifying roles and responsibilities.
Priority 5	Improve Complaint Handling	▪ Set up regular SI and Concern 'drop-in clinics' for Divisions to allow opportunity to network and promote collaborative working to improve quality of responses and investigations at source. ▪ Reinstate face to face IO training to promote networking and embedding of learning. ▪ With closer working divisional/corporate relationships, reduce the backlog of outstanding complaints. ▪ Foster improved early resolution rates through centralisation of Customer Management Complaint calls to the Corporate PTR team, actioning straightforward enquiries and concerns, thus minimising escalation to the formal complaint stage. ▪ With the lifting of Covid restrictions, the Corporate PTR team will be able to directly meet with divisional colleagues to support and improve processes. ▪ Introduce improvement trajectories for all Divisions. ▪ A robust process of thematic analysis will be implemented for concerns.