Patient Quality, Safety and Outcomes Committee

Wed 26 July 2023, 09:30 - 12:30

Microsoft Teams

Agenda

09:30 - 09:40
10 min

1. Preliminary Matters

1.1. Welcome and Introductions

Oral   Chair

1.2. Apologies for Absence

Oral   Chair

1.3. Declarations of Interest

Oral   Chair

1.4. Draft Minutes of the last Meeting held on 20th June 2023

Attached   Chair

📄 1.4 Draft PQSOC Minutes 20th June 2023.pdf (6 pages)

1.5. Committee Action Log - July 2023

Attached   Chair

📄 1.5 PQSOC Action Log July 2023 UPDATED 27.06.23.pdf (6 pages)

09:40 - 09:40
0 min

2. Items for Approval/Ratification

2.1. No agenda items for this section

09:40 - 12:05
145 min

3. Items for Discussion

3.1. Patient Quality and Safety Outcomes Performance Report, July 2023

Clinical Executive Directors

- Patient and staff experience and stories
- Incident reporting- falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding
- Data Highlighting the specific number of falls of patients who are medically fit for discharge
- Additional Risks and Issues
- Overview of the HIW Inspection of Ty Lafant including the Health Board's response

  📄 3.1 PQSOC Performance Report - July 2023.pdf (104 pages)

3.2. Next Steps for the Quality Strategy

Attached   *Director of Nursing*

    a. Quality Outcomes Framework
    b. Quality Delivery Plan
    c. Quality Assurance Framework
    d. Forward Work Programme

  📄 3.2 Final PQSOC Covering paper Delivering the Quality Strategy July 2023.pdf (6 pages)
  📄 3.2a Quality operating framwork Final July 2023.pdf (13 pages)
  📄 3.2b PQSOC Quality Strategy - Implementation Plan Final July 2023.pdf (13 pages)
  📄 3.2c ABUHB Quality Governance Framework July 2023 Final.pdf (10 pages)
  📄 3.2d PQSO_Committee Work Programme 2023-24.pdf (7 pages)

3.3. Infection Prevention and Control Annual Report

Attached   *Director of Nursing*

  📄 3.3 IP Decon AMR Annual report 2022 - 23 v001.pdf (43 pages)

12:05 - 12:20
15 min

4. Items for Information

4.1. Highlight Reports

Attached   *Clinical Executive Directors*

4.1.1. Safeguarding Group Highlight Report

Attached   *Clinical Executive Directors*

  📄 4.1a Safeguarding Highlight Report - June 2023.pdf (3 pages)

4.1.2. Clinical Effectiveness and Standards Committee Report

Attached   *Clinical Executive Directors*

  📄 4.1b CSEG May 23 meeting notes for July 2023.pdf (13 pages)
  📄 4.1b PQSOC Final Clinical Audit Activity Report July 2023.pdf (35 pages)

4.2. Groundhog Day 2: an opportunity for cultural change in complaint handling?

Attached   *Director of Nursing*

  📄 4.2 Aneurin Bevan UHB.pdf (1 pages)
  📄 4.2 Groundhog-Day-2-Report_PSOW_UNDER-EMBARGO.pdf (36 pages)
  📄 4.2 SBAR re PSOW Report Groundhog Day 2.pdf (3 pages)

4.3. Time Critical Medication in Parkinson's Disease

Attached   *Director of Nursing*

  📄 4.3 Draft PQSOC Time Critical Meds paper July 2023.pdf (17 pages)

4.4. Early detection of type 1 diabetes in children and young people

Attached   *Director of Therapies and Health Sciences*

  📄 4.4 a Diabetes - Policy - Paediatrics - DKA at Diagnosis - ltr from DCMO - 2023-03.pdf (2 pages)
  📄 4.4 b Response.pdf (1 pages)

4.5. WHSCC Quality Patient Safety Committee Chair's Report and Appendix 1 - Summary of Services in Escalation

Attached   *Head of Corporate Governance*

📄 4.5 WHSCC Quality Patient Safety Committee Chairs Report v1.pdf (5 pages)

📄 4.5 WHSCC Appendix 1 - Summary of Services in Escalation.pdf (10 pages)

12:20 - 12:30
10 min

5. Other Matters

5.1. Items to be Brought to the Attention of the Board and other Committees

Oral   *Chair*

5.2. Any Other Urgent Business

Oral   *Chair*

5.3. Date of the Next Meeting

Wednesday 11th October 2023

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN/ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

MINUTES OF THE PATIENT QUALITY, SAFETY AND OUTCOMES COMMITTEE MEETING

DATE OF MEETING	Tuesday 20th June 2023
VENUE	Microsoft Teams

PRESENT	Pippa Britton, Independent Member, Committee Chair Louise Wright- Independent Member, Vice Chair Paul Deneen- Independent Member Helen Sweetland- Independent Member
IN ATTENDANCE	Jennifer Winslade, Director of Nursing Rani Dash- Director of Corporate Governance Peter Carr, Director of Therapies & Health Science James Calvert, Medical Director Tracey Partridge-Wilson, Assistant Director of Nursing Leeanne Lewis, Assistant Director of Quality & Patient Safety Karen Hatch- Assistant Director of Therapies and Health Science Deb Jackson- Assistant Director of Nursing, IPAC Moira Bevan- Head of Infection and Prevention Garvin Jones- Head of Legal Services Howard Stanley- Head of Safeguarding Jayne Beasley- Head of Midwifery and Gynaecology Linda Joseph- Deputy Regional Director- Llais Stephen Chaney- Deputy Head of Internal Audit Emma Guscott, Committee Secretariat
APOLOGIES	Nicola Prygodzicz- Chief Executive

PQSOC 2006/1	**Preliminary Matters**
PQSOC 2006/1.1	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
PQSOC 2006/1.2	**Apologies for Absence** Apologies for absence were noted.
PQSOC 2006/1.3	**Declarations of Interest** There were no declarations of interest raised to record.

PQSOC 2006/1.4	**Minutes of the previous meeting**
	The minutes of the meeting held on the 25th of April 2023 were agreed as a true and accurate record.
PQSOC 2006/1.5	**Committee Action Log- June 2023**
	The Committee received the action log. Members were content with progress made in relation to completed actions and against any outstanding actions.
	The Medical Director discussed action *PQSOC/2504/3.3.2 Pharmacy and Medicines Management: Action Plan in relation to Pharmacy Robot to be presented to future meeting with the Committee.* The Director of Corporate Governance and the Medical Director to discuss the reporting of the mitigation of any associated risk outside of the meeting. Action to remain.
PQSOC 2006/2	**Items for Approval/Ratification**
PQSOC 2006/2.1	**Clinical Audit** **Annual Clinical Audit Activity Report 2022/23**
	James Calvert (JC), Medical Director, supported by Leeanne Lewis (LL), Assistant Director of Quality & Patient Safety, provided an overview of the report, outlining the Health Board's participation in the National Clinical Audit and Outcomes Review Plan for the financial year, April 2022 to March 2023.
	Helen Sweetland (HS), Independent Member, requested assurance that learning from National Audits was fed back to Health Board staff. JC informed members that there were several ways in which the Health Board engaged staff with learning from data, and that there was a mandatory requirement for clinical staff to attend Divisional and Directorate Governance meetings, where audit reports were discussed in detail.
	The Committee noted the standardised template for national clinical audits.
	The Committee **RECIEVED** the report for **ASSURANCE.**
	Clinical Audit Plan JC supported by LL provided an overview of the report. Members were assured by the following Health Board plans; - • The Clinical Audit team to develop a clinical audit programme for 2023/2024.

	• Update the Health Board policy on Clinical Audit. • Collation of all Health Board Audit Reports. • AMaT audit management system to be implemented across the Health Board. Jennifer Winsalde (JW), Director of Nursing, informed members that the Health Board's Patient Experience and Involvement Strategy outlined clear expectations for patient experience feedback and, where deemed appropriate, patient engagement in audits. Members requested that future audit reports included clear timelines of actions and triangulation of all relevant Health Board data in relation to the audit subject **Action: Assistant Director of Quality and Patient Safety** A discussion on the inclusion of patient voice in Clinical Audits to come back to a future meeting. **Action: Medical Director** JC suggested to members that future audits included input from local partners such as Llias Cymru. JW informed members that the Person-Centred Care Team currently work alongside Llias Cymru, as outlined in the Patient Experience and Involvement Strategy. Further discussion on the involvement of Llias Cymru in future audits to take place outside of the meeting. **Action: Medical Director/Head of Nursing Person Centred Care/Llias Cymru** The Committee **RECIEVED** the report for **ASSURANCE**.
PQSOC 2006/3	**Items for Discussion**
PQSOC 2006/3.1	**Patient Quality and Safety Outcomes Performance Report, June 2023** Clinical Executives presented the Patient Quality & Safety Outcomes Performance Report for June 2023 to the Committee. The report provided an update on the work being undertaken relating to: • Incident reporting and severity of harm. • Duty of Candour, Falls, Thematic reviews and learning. • Next steps - pressure ulcers, medicines management and mortality. • Patient Experience and Staff Feedback. • Civica in place. • Patient Experience and Involvement Strategy being implemented. • Business case to PIP for PALs (June 2023). • Complaints and concerns.

- Health, Safety and Security.
- Infection Prevention and Control, Covid-19 investigations.
- Safeguarding.
- Urgent and Emergency Care.
- Planned Care.
- Cancer Pathways.
- Escalated risk concerns.

Jennifer Winslade (JW), Director of Nursing, provided a brief overview of the implementation of the Quality Strategy. The full delivery plan for the Quality Strategy, including the Quality Outcomes Framework will be presented at the July PQSOC. **Action: Director of Nursing**

Members were informed of good practice and learning from patient feedback, with a focus on the Primary Care and Community Division. Members welcomed the 'Division by Division' focus on patient experience and involvement for future meetings. Pippa Britton (PB), Committee Chair, noted the unsuccessful capital bid for bed side chairs, based upon audit feedback and requested further information. JW assured members that Clinical Directors were working with Capital programme leads to ensure that there is robust clinical escalation in order to mitigate risk. Members were informed that the nursing and physiotherapy teams were reassessing the requirement of the bed side chairs.

Inpatient falls were discussed, including reduction of harm and falls management, noting that national benchmarking data was utilised to inform best practice. Louise Wright (LW), Independent Member, requested further information on correlation between the impact of patients waiting to be discharged and the risk of falls. Peter Carr (PC), Director of Therapies and Health Science, informed members that evaluation of harm related to delayed discharge was ongoing. Data highlighting the specific number of falls of patients who are medically fit for discharge to be included in a future report. **Action: Director of Therapies and Health Sciences**

Members requested that a glossary of acronyms be included at the end of future presentations and reports. **Action: Director of Nursing**

Escalated risk concerns were discussed. Members were informed of the recent HIW inspection of the Ty-Lafant Learning Disability and Inpatient Unit. An overview of the HIW Inspection of Ty Lafant, including the Health Board's planned response to actions, to be presented at the next

	committee meeting for discussion. **Action: Director of Nursing**
PQSOC 2006/3.2	**MBRRACE UK Perinatal Mortality Data** Jennifer Winslade (JW), Director of Nursing, supported by Jayne Beasley (JB), Head of Midwifery and Gynaecology, provided an overview of the report to the Committee. The MBRRACE report for 2021 indicated that the Health Board had an increased rate for stillbirths, 5% higher than similar Trusts and Health Boards, and that Neonatal deaths were 15% lower than similar Trusts and Health Boards. All cases were reviewed utilising the Perinatal Mortality Review Tool, and action had been taken for any identified themes and trends. Members were informed that an overview of updated data for 2022/23 would be presented to a future meeting for discussion. **Action: Director of Nursing/Head of Midwifery and Gynaecology** Helen Sweetland (HS), Independent Member, noted the resource implications for Ultrasound, as listed in the report, and requested assurance on progress. Members were informed of the good progress made with ultrasound, noting the number of Health Board Midwives training for, and qualifying as, Sonographers. Members were assured that any resource implications would be reported to the Executive Committee. JW informed members of a recent HIW inspection of Health Board maternity services in May 2023. An overview of the recommendations and Health Board response to the HIW inspection of Maternity Services in May 2023 would be presented to a future meeting. **Action: Director of Nursing/Head of Midwifery and Gynaecology** The Committee noted the following recommendations for next steps to help reduce rates of stillbirths and improve outcomes for mothers and babies; - • Continue to monitor all cases of small for gestational age babies through audit. • The newly appointed bereavement midwife to support timely reporting of deaths to MBBRACE. • Ongoing work re PeriPrem programme. • Ongoing work re Gap and Grow training. • Ensure continued use of the Perinatal Mortality Review Tool, case review and audit of 2022 cases. • Public Health agenda.

PQSOC 2006/4	Items for Information
PQSOC 2006/4.1	**Highlight Reports** The Committee received the following Highlight Reports for Information: - • Quality and Patient Safety Operational Group • Children's Rights Participation Forum • Safeguarding Group Highlight Report • Clinical Effectiveness and Standards Committee Report • WHSSC QPS Committee Report • ABUHB Community PROMPT Wales Quality Assurance Report
PQSOC 2006/5	Other Matters
PQSOC 2006/5.1	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no matters arising.

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
6th December 2022	**PQSOC 0612/14**	**Health & Safety Compliance Report:** Members requested a detailed report on violence and aggression, including comparative data across Wales and the impact of negative social media comments on the health and safety of staff members.	**Head of Health and Safety/ Secretariat**	**Q1, 2023/24**	Added to PQSO Committee Workplan for 2023/24
7th February 2023	**PQSOC 0702/3.3**	**HIW Inspection Review to include Tracking of Improvement Actions Arising from Inspections and Review**: Committee Chair to discuss with Health Board Chair if a review of different patient record systems was required and if this should be presented to the Board.	**Committee Chair**		Added to Board Development work programme December 2023

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
7th February 2023	**PQSOC 0702/3.4**	**Clinical Audit**: The Committee Chair requested this report is provided at each PQSOC Committee meetings.	**Director of Nursing**	June 2023	Added to PQSO Committee Workplan for 2023/24
7th February 2023	**PQSOC 0702/3.5**	**Annual Reports – Health Board Organ Donation Report**: In line with the ToR the National Organ Annual Report will need to be presented to the August/October PQSOC	**Medical Director**	June 2023	Added to PQSO Committee Workplan for 2023/24
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** Nurse Staffing Levels Improvement Plan/ progress report to be reported to the next Committee meeting.	**Director of Nursing**	June 2023	This is in progress; improvement actions are reported with the PQSOC report.
25th April 2023	**PQSOC/2504/3.1**	**Patient Quality and Safety Outcomes Measures Report, March 2023:** A breakdown of Violence and Aggression incidents to be provided in future reports	**Director of Therapies and Health Sciences**	June 2023	Included within future reports

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
25th April 2023	**PQSOC/2504/3.3.2**	**Pharmacy and Medicines Management:** Action Plan in relation to Pharmacy Robot to be presented to future meeting	**Medical Director**		To be included in work programme 2023/24 June 2023; Director of Corporate Governance and Medical Director to pick up with the Chief Operating Officer outside of the meeting.
25th April 2023	**PQSOC/2504/3.5**	**National Review of Consent to Examination and Treatment Standards in NHS Wales: Welsh Risk Pool Report and Management Response:** Update on the Action Plan to be presented to a future meeting.	**Medical Director**		Added to PQSO Committee Workplan for 2023/24
20th June 2023	**PQSOC/2006/2.1**	**Clinical Audit; Annual Clinical Audit Activity Report 2022/23** Members provided feedback, as requested. The following to be included in future reports; - • Clear timelines. • Benchmarking data for all audits against each Health Board.	**Assistant Director for Quality and Patient safety**	tbc	Noted and will be included in future reports

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
		• Recommendations at the end of the report.			
20th June 2023	**PQSOC/2006/2.1.1**	**Clinical Audit; Annual Clinical Audit Activity Report 2022/23** A discussion on the use of patient voice within Clinical Audits to come back to a future meeting.	**Assistant Director for Quality and Patient safety/Director of Nursing**	tbc	Meeting being arranged with patient centred care team and Llais to take this forward
20th June 2023	**PQSOC/2006/3.1**	**Patient Quality and Safety Outcomes Performance Report, June 2023-** Data highlighting the specific number of falls of patients who are medically fit for discharge to be included in the next report.	**Director of Therapies and Health Sciences**	July 2023	In progress. To be added to future reports once robust data available
20th June 2023	**PQSOC/2006/3.1.1**	**Patient Quality and Safety Outcomes Performance Report, June 2023-** Glossary of acronyms to be included at the end of the report.	**Director of Nursing**	July 2023	Noted and included in future reports

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
20th June 2023	**PQSOC/2006/3.1.2**	**Patient Quality and Safety Outcomes Performance Report, June 2023** An overview of the HIW Inspection of Ty Lafant, including the Health Boards planned response to actions, to be presented at the next committee meeting for discussion.	**Director of Nursing**	July 2023	Complete – on agenda
20th June 2023	**PQSOC/2006/3.2**	**MMBRACE UK Perinatal Mortality Data** An overview of updated data for 2022/23 to come back to the committee for discussion.	**Director of Nursing/Head of Midwifery and Gynaecology**	tbc	Added to Work Programme
20th June 2023	**PQSOC/2006/3.3**	**MMBRACE UK Perinatal Mortality Data** An overview of the recommendations and Health Board response to the HIW inspection of Maternity Services in May 2023, to come back to the Committee.	**Director of Nursing/Head of Midwifery and Gynaecology**	tbc	Report awaited

All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.

Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.

Patient Quality, Safety and Outcomes Committee

Performance Report

JULY 2023

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Overview

The Patient, Quality and Safety performance report provides the Committee with an overview of the Health Board's quality and safety metrics and summary of performance. It is aligned to the Ministerial priorities and key challenges, which are:

Quality and Safety Pillars

- Patient Experience and Staff Feedback, will include compliments
  - Civica underway in community hospitals, roll out plan
  - Patient Experience and Involvement Strategy being implemented
  - Business case to PIP for PALs (June 2023)
- Incident reporting and severity of harm
  - Thematic reviews and learning
  - Next steps - pressure ulcers (validating data)
  - Reporting mortality
  - Duty of Candour – reporting timeframes via Datix
- Complaints and concerns
  - Focusing on closure of historical complaints of over 12 months
- Health, Safety and Security
- Infection Prevention and Control
- Safeguarding

Urgent Care

Planned Care

Cancer

Good Practice and Learning from Feedback

Ward Accreditation Pilot Ysbyty Aneurin Bevan

Section 2

Ward Accreditation Pilot

Ysbyty Aneurin Bevan

PURPOSE

- Can be used as a tool to encourage ownership of continuous quality improvement at ward level.

- Reduces variation (By providing an evidenced based, standardised approach to care and improving quality).

- Provides ward-to-board assurance on the quality of care.

- Demonstrates compliance with Professional, Governmental and Local Standards.

- Provides a platform for shared learning-so that wards can learn from each other and share excellence.

- Enables preparedness for external inspection.

BENEFITS

- Creates a culture for continuous improvement.

- Increases staff pride and team working within the ward areas.

- Improves staff moral and reduces staff turn over and sickness.

- Supports collective leadership and personal and professional development.

- Improves accountability.

Accreditation Framework:

- Based on evidence of best practice and use of a range of existing metrics, such as national indicators of quality and workforce performance and agreed local standards.
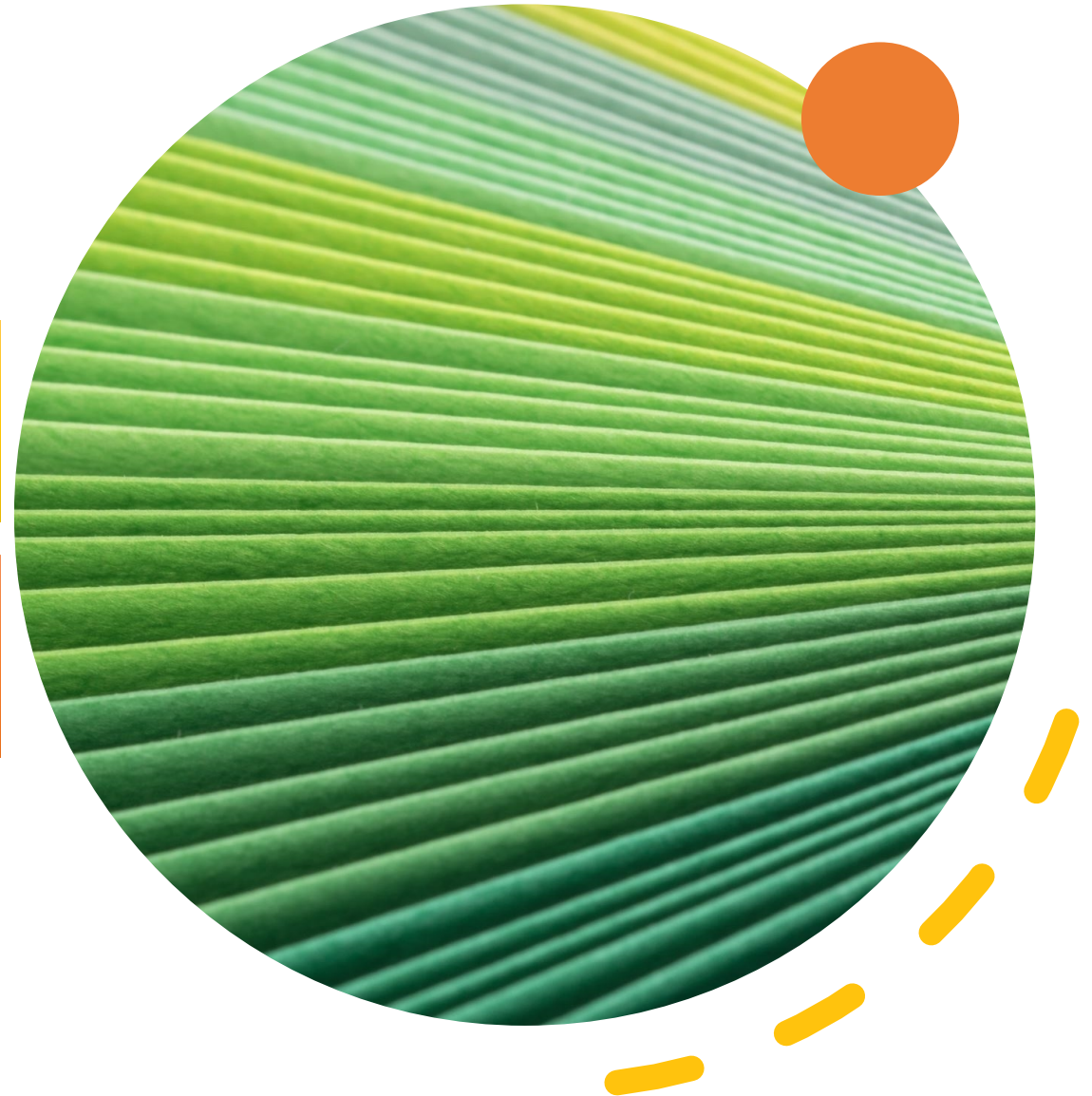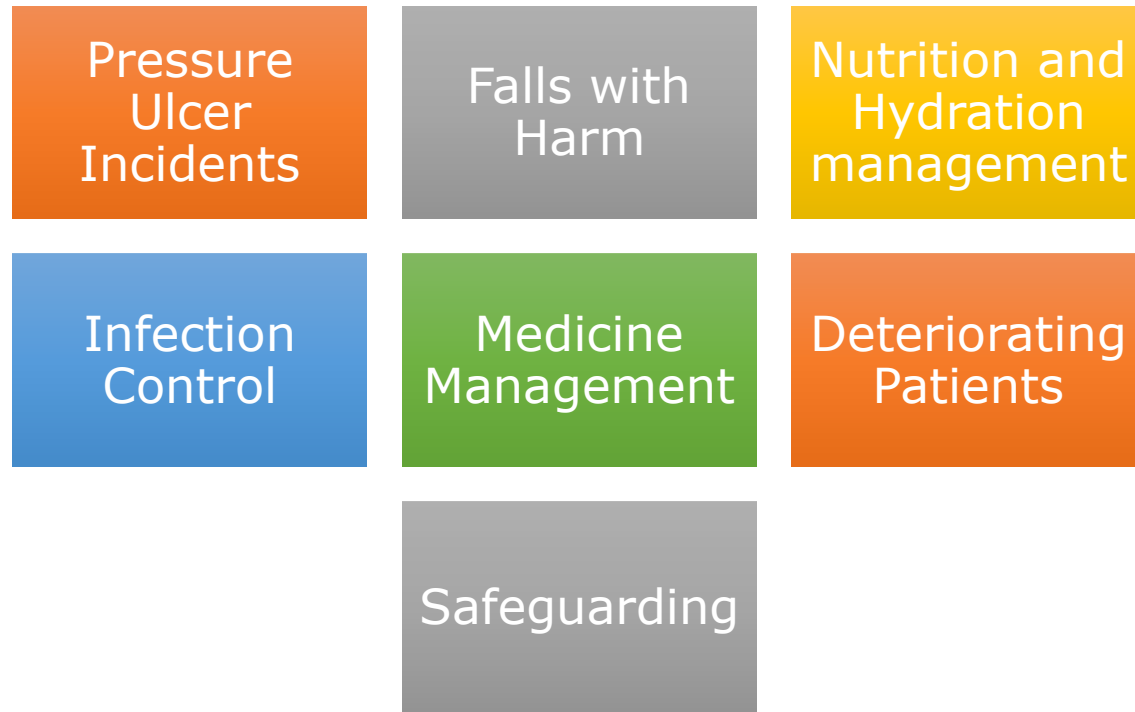
To Gain Accreditation:

- Demonstrate consistent practice and performance over a two year period.
- Wards/Departments must progress through bronze, silver and gold standards.
- Regular monitoring and assessment of designated targets set out in the Health & Social Care (Quality & Engagement) Wales Act 2020 including the six domains of quality: person centred, safe, timely, effective, efficient & equitable.
- Supported by six quality enablers; leadership, workforce, culture, information, learning, improvement & research.

DATA COLLECTION: AMaT: Audit Management & Tracking Programme

- Web based tool that provides an easy to use platform for managing clinical audits.

- Easy to implement and simple to use.

- Data can be input and accessed in real time.

- Designed around a dashboard system, which means the results of your audit and improvement data can be seen at a glance in easy-to-read graphical presentations.

Quality Measures

Pressure Ulcer Incidents

Falls with Harm

Nutrition and Hydration management

Infection Control

Medicine Management

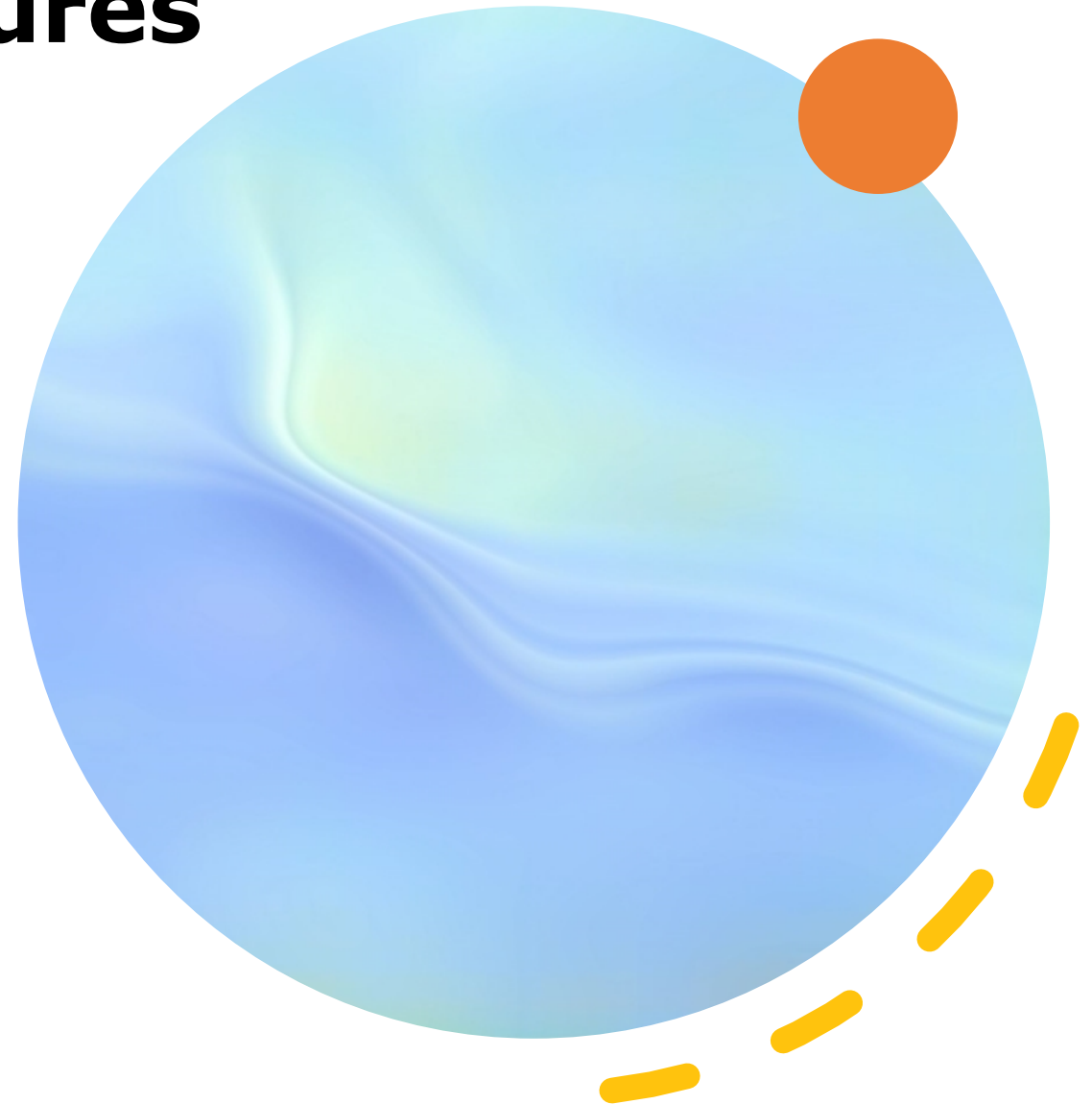Deteriorating Patients

Safeguarding

Organisational Measures

Record/keeping/Risk Assessment

Complaints/Compliments

Patient Flow/Length of Stay

Effective workforce

Risk Management

Serious Incidents

Award Recognition Matrix*

Award	Frequency of Assessment	Definition of Award
Baseline Audit		Working towards
Bronze	3 months	Maintained compliance of 85% in all standards for a consecutive 3 month period
Silver	6 months	Maintained compliance of 85% in all standards for a consecutive 6 month period
Gold	9 months	Maintained compliance of 85% in all standards for a consecutive 9 month period
Platinum (Full Accreditation)	Annual	Maintained compliance of 85% in all standards for a consecutive 1 year period

*Dependent on pilot review

Project Plan

Action	Timescale	Enablers
Test Core Audits	1st July – Sept 30th 2023	• Familiarise staff with the audit and system. • Register staff on AMaT • On-going support and monitoring
Evaluate Audits	1st - 15th October 2023	• Senior nurse and project leads
Implement Ward Accreditation at YAB	1st November 2023	• Ward Teams YAB • Senior Nurse • Project Leads
Implementation of audit to next Community Hospital as per implementation plan	15th November 2023	• Project Leads • Senior Nurses • Ward Teams

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

Person Centred Care

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Equality and Diversity **(Stroke Services)**	People who have experienced stroke wish to have an opportunity to volunteer.	Meeting held with Head of Services Neurological Rehab to have an initial discussion about patients becoming volunteers and supporting stroke patients	Co-production will allow people who have experienced a stroke to gain an opportunity in volunteering	Neurological Rehab Team have forward PCCT details to those patients interested and these have now commenced our volunteer recruitment process. Volunteer manager to meet with Neurological Rehab support group to discuss volunteering opportunities.
Equality and Diversity **Volunteering for people with additional needs**	Providing volunteers with opportunities who may need adjustments or additional support	Supporting volunteers that may require adjustments or additional support to gain volunteer experience Providing a volunteer experience for a lady with MS. Supporting two students and a gentleman with Autism in recruitment process. Supporting a lady supported by the Domestic Abuse Service with recruitment.	Offering volunteer opportunities will provide people to gain a sense of purpose.	Supporting volunteer inductions and ensuring appropriate steps are in place to make the environment is a safe place for them.
Cancer Café's	More support is needed for people in the community living with cancer.	Meetings held with Cancer Project Officer to establish Cancer Cafés to support patients in the community. Emails sent to existing volunteers for expression of interest in supporting cafés.	People in the community diagnosed with/living with cancer will have better access to cancer support	Await contact from existing volunteers. Ongoing discussions around peer support through the Cancer Covid Recovery Steering Group

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Endoscopy DNA Rates in Cancer Services	There are high numbers of DNAs with endoscopy.	Discussion held with Cancer Project Officer to discuss establishing telephone befrienders to contact patients with upcoming Endoscopy appointments as a reminder. Aim is to reduce DNA rates (proof of concept) Emails sent to existing volunteers for expression of interest.	Telephone 'befrienders' will contact patients to remind them of their appointments at endoscopy.	Await contact from existing volunteers. Ongoing discussions around peer support through the Cancer Covid Recovery Steering Group Presenting at the Helpforce Cymru meeting 18th July 2023
Volunteer to Career	People with additional learning needs and those who have not worked in the NHS need support to gain work experience.	Met with Additional Learning Needs Tutor from Coleg Gwent to support pathway 3 students in patient experience. Met with Workforce to update with work plan who in turn signposted personnel to discuss volunteer Wellbeing Assistant Signposted a volunteer to Work Experience team to shadow Phlebotomy team at GUH	People with additional learning needs and those with no experience of working in the NHS will be provided with volunteer opportunities to gain experience.	Ongoing collaboration with WOD, colleges and job centres. Promotion of the Volunteer to Career Programme. Delivering Workshops at the The Tipping Point: Where next for health and care? Conference run by Bevan Commission 5th July 2023
Patient Experience (CIVICA)	CIVICA roll out across the community hospital wards with the person-centred care survey.	Baseline data collected from all 11 community hospital wards, totalling 84 surveys. Findings fed back to senior nurse and deputy heads of nursing. Findings also shared with PC&C QPS team in readiness for data to be collected for monthly QPS reports.	Training offered to all wards and CIVICA posters sent out in readiness to go live. Supported wards to have a designated area so patient feedback process is easily accessible to patients and family.	To ensure all training is completed and wards are offering surveys to patients. Data collected and actioned by ward manager. Data to be shared via QPS. Next focus will be completing the same process for YYF wards mid-July onwards.

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Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Dementia and Hospital Care	The meaningful engagement and activities programme is being evaluated. Asking patients, carers, and staff what they feel the impact this program is having on patient care and patient wellbeing. Patients and carers offered us the opportunity to hear their experience of receiving a diagnosis of Dementia and the impact that this has had on them as patients but also as wives and subsequently carers. Raising awareness of Dementia Standards and Hospital charter. Feedback from Carer, re patient moves between hospitals and John's Campaign. Loneliness, isolation, and lack of meaningful activity remains a theme in patient, carers, and staff feedback. Build on available resources to support improvements in Knowledge and understanding linked to Goodwork Framework.	An evaluation survey is being shared through paper format and the Microsoft teams form to gain feedback. Patients and staff are also being asked for their views during ward walk arounds. Feedback from the survey will be collated and reported upon to the Head of person-centred care and the respective boards. Identifying staff understanding and awareness of how future ordering systems can be secured. Video recordings were filmed, added subtitles. Learning plans were developed and a module of learning presented," Anticipatory Loss and Grief in dementia care". Presentation to Communication Champion Network of Dementia Standards, including hospital charter animation. Medicine Induction Day session on "How ABUHB supports Dementia Care". Met with Carer, responded to concerns. Actions for improvement agreed with ward teams, and senior MDT. Benefits of Meaningful Activities video produced by Communications team and shared on Pulse, Facebook, and Twitter. Bite size learning sessions offered to all staff via Teams. Consent, oral care, audiology.	The impact of this programme will be evaluated from the perspective of the patient, carer, and staff. Staff will have a greater understanding of the impact that having a diagnosis has on patients, carers, and family's life. This will improve understanding, compassionate care, and develop skills. Raised awareness, extending network. Carer felt listened to and happy with response and actions. Patient transfer to hospital nearer to carer and flexible visiting/ support plan in place. Positive feedback/ comments received by communications team from public.	Review this through the PCCT and the Dementia Hospital steering group. A planning meeting will be arranged with MEC (mapping and Education team) to arrange a delivery plan for training sessions. Request from YYFM to do interview alongside Cardiff University to share work of dementia standards of care in Gwent. Regular attendance on Medicine induction programme continues and extend to unscheduled care division. Following Conference use feedback to inform actions and objectives of Dementia Board Priorities. Expand bite size learning topics to include Nutrition & Hydration and Pain Management in Dementia. Arrange dates and venues to deliver sessions.

Person Centred Care: Listening and Learning from Feedback

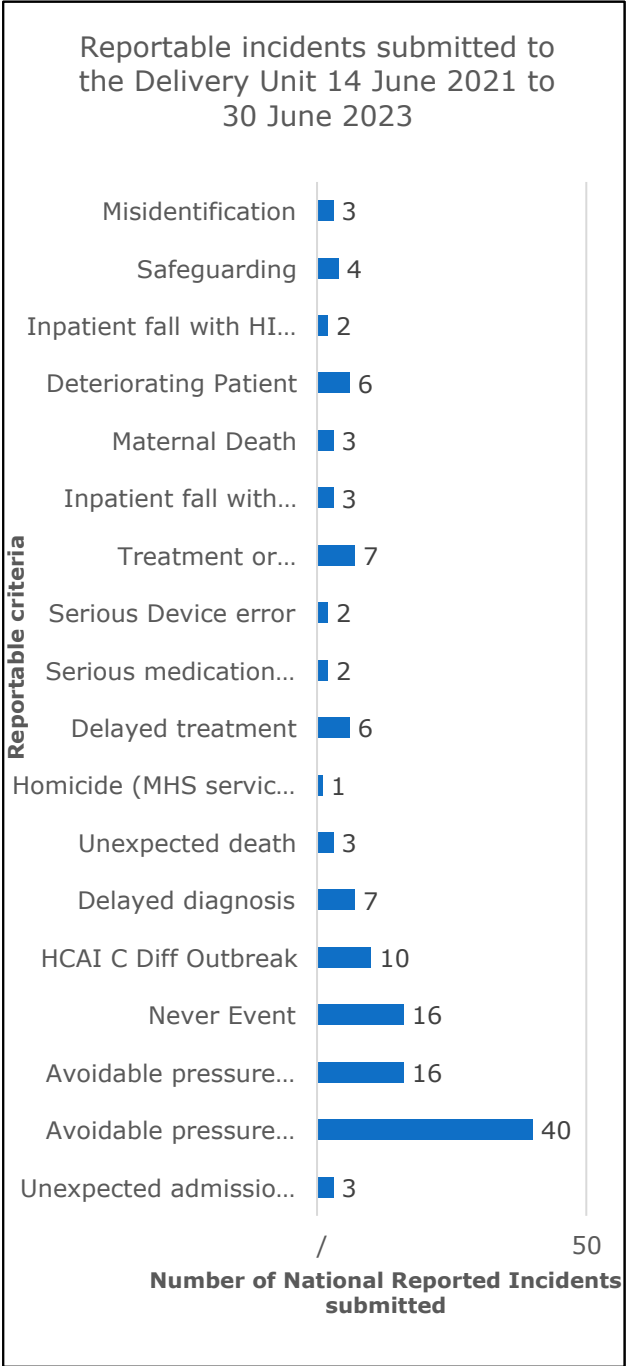| Theme	Feedback	Action Taken	Impact	Next Steps
Dementia VIPS	The VIP ward toolkit based on 25 indicators of best practice related to Person Centred Care. Enables areas to self-assess and work on improvement projects to ensure the best levels of care within their areas. It also gives access to resources for staff.	15 wards identified to implement VIPS in their area. Introduction presentation and getting started meeting. Monthly support group for all areas. Initial visit to each area carried out by Dementia practitioner to support implementation. Pilot workshop for 2 areas scheduled for 11th July to support staff with using the toolkit. Feedback forms for each area completed following initial visit to highlight what support is required. Nearly all areas have completed initial assessments. 15 wards have identified key individuals to lead in their areas. VIPS poster designed and displayed in the implementation areas. Virtual Dementia tour training opportunity provided to staff.	Raised awareness. Increased opportunities to meet with individuals to capture feedback and learning. Opportunity to review ward areas to make improvements and support a person-centred approach to care. Positive feedback from staff following training.	To continue monthly support groups – each area requires different levels of support. To pilot workshop day and to evaluate impact of this – if successful to run more sessions. To continue in person visits from Dementia practitioner for ongoing support. To pilot new equipment and evidence impact through toolkit. To provide further training opportunities. To continue in person engagement in all hospital sites.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Dementia Engagement	The appointment of the Dementia Programme manager on the 9th May 2023. There has already been attendance at the Mens Group and the carers groups in Maindee Newport for consultation around the dementia standards of care and to recruit Community Listeners. The Programme Manager attended a Carers Group in the Riverfront in Newport to discuss the Dementia Standards of Care and to recruit Community Listeners.	A scoping plan is being produced to identify key stakeholders within the community of Maindee and Caerleon, the 2 areas identified for the workstream 1, engagement. Both the Programme manager and the project manager have clear objectives to priorities this workstream in these 2 communities of Newport.	People have been welcoming of the team within the groups attended. There has been useful feedback about services in the community.	Further engagement opportunities will be sought through the scoping opportunities and the Dementia Friendly Communities. A meeting with the Cllr Hughes who is the Cabinet member in Newport for adult services is taking place to discuss recruiting local political representatives as Community Listeners. Attendance at Other groups in Caerleon and Maindee is being arranged. Working with schools as Community Listeners will be done jointly with Erin in the RPB – this is being arranged.

Person Centred Care: Listening and Learning from Feedback

Theme	Feedback	Action Taken	Impact	Next Steps
Mental Capacity Act (MCA)	Concerns identified relating to compliance to the Mental Capacity Act across the Health Board.	Programme of training available to all staff via ESR and short virtual sessions. Virtual MCA and DoLS sessions held weekly. Bespoke short sessions provided at various locations including number of sessions at YAB, RGH, Ty Siriol, YTC, St Woolos, CCU X10 ongoing and CALDS – Psychology. Workshop for staff involved in decision making (full day). Bespoke workshop sessions provided on request. • NHH X 3 • Care at home team x2 Rolling programmes: JoE, QPS, Dementia Champions, Band 4 Assistant Practitioners, Doctors' lunchtime, Rotational doctors, Grand Round Planning to provide training to Carers via MECS and Third sector agencies MCA Practitioners make themselves available in clinical areas to support staff to implement MCA into clinical day-to-day practice. Advice and support completing capacity assessments. Advice and attending BIM e.g., Discharge and medical treatment. Advice relating to the eligibility for DoLS. Mental Capacity Act Policy updated and approved. New capacity assessment and Best Interest form developed – awaiting feedback to circulate. Quarterly MCA forum staff across the health board opportunity for individual case discuss and raise areas of concern that team can approach and offer training and support. Team to attend training to develop their own knowledge in specialist areas. This can then be used to develop further training packages. Team have received AMaT training to support auditing compliance with the Act. To commence auditing compliance of MCA.	By improving organisational compliance with MCA, patients who lack capacity will receive the appropriate care and treatment through the principles of the Act. Provide staff with an overview of the legislation. Training will support staff to develop their knowledge and skills, and therefore feel confident and competent to undertake capacity assessments. To provide support in clinical areas. Feedback from clinical areas, has been positive. Staff reporting, they feel confident to undertake capacity assessments, and challenge poor assessments. To ensure that patients eligible for DoLs are referred to the team. Now available on sharepoint. Sharing of information good and poor practice, and the team activity. Increase teams' knowledge of specialist areas, and then support staff working in these areas. To enable the team to undertake audits of compliance with the MCA.	Continue to provide training both open sessions and requests for bespoke training. Promote training via media and during visits to clinical areas. Engagement events at various locations sites to promote the training and support that the team can provide. Further delay to the implementation of LPS, vital that we continue to educate staff in relation to the current DoLS framework. Animation video relating to consent. To continue to promote and deliver training. Practitioners to continue to provide support in clinical areas. Highlights areas of concern where team can focus time and support. Training to be arranged.

National Reportable Incidents

Reportable incidents submitted to the Delivery Unit 14 June 2021 to 30 June 2023

Reportable criteria	Number of National Reported Incidents submitted
Misidentification	3
Safeguarding	4
Inpatient fall with HI...	2
Deteriorating Patient	6
Maternal Death	3
Inpatient fall with...	3
Treatment or...	7
Serious Device error	2
Serious medication...	2
Delayed treatment	6
Homicide (MHS servic...	1
Unexpected death	3
Delayed diagnosis	7
HCAI C Diff Outbreak	10
Never Event	16
Avoidable pressure...	16
Avoidable pressure...	40
Unexpected admissio...	3

Change to NRI Policy May 2023-Retrospective reporting of certain types of patient safety incidents as Nationally Reportable Incidents

There are a small number of designated incident types that are acceptable to be retrospectively reported following the completion of the investigation. These are:

- avoidable pressure damage
- avoidable falls resulting in any fracture or significant injury
- medically unexpected deaths in the community of patients who have been in contact with Mental Health and/or Learning Disability Services in the last year-It does NOT include deaths of service users where the cause of death is immediately known and not relevant to the healthcare being provided (e.g. the service user dies unexpectedly in a car accident, or as the result of a diagnosed terminal illness).
- Retrospective reporting means that these incidents require reporting as a Nationally Reported Incident where the local investigation has identified a causal or contributory factor.

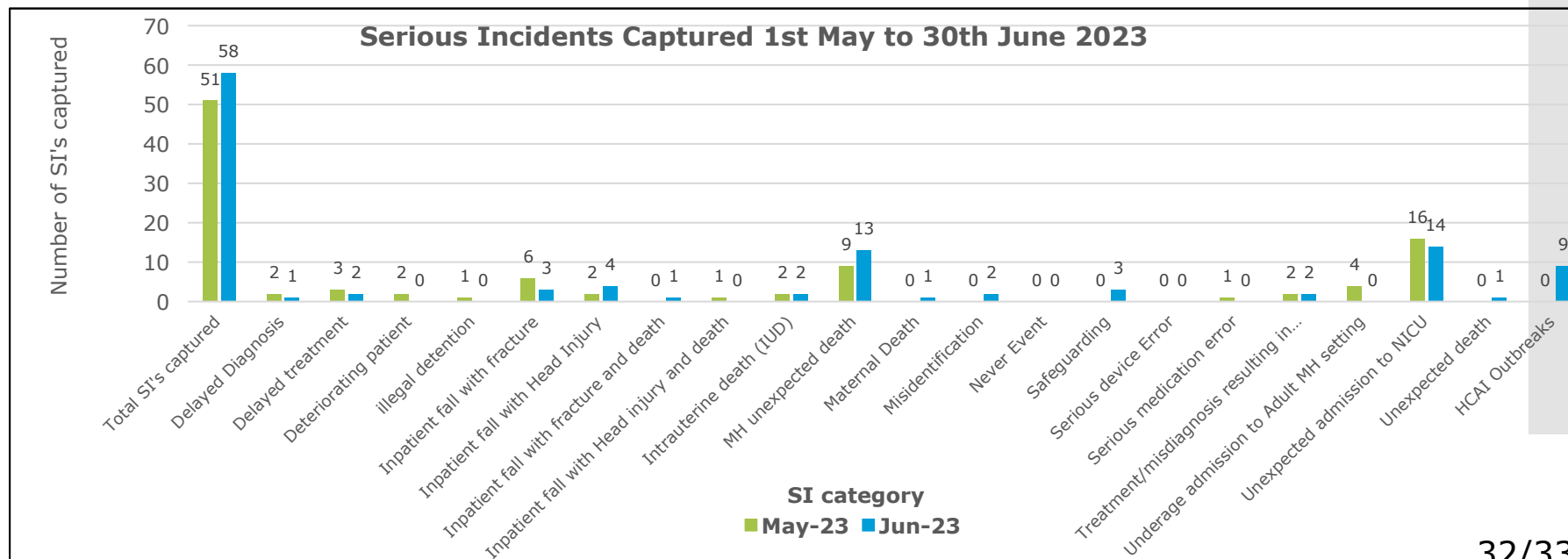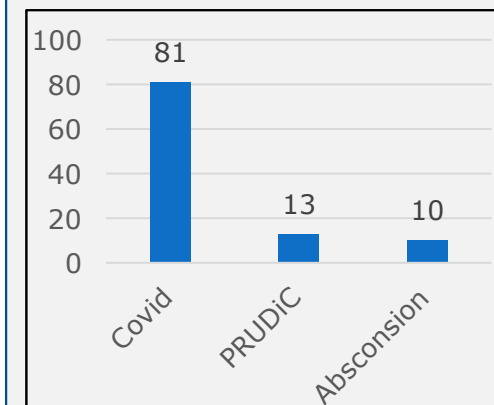| Learning	Improvement
Prescribing errors caused by accidentally using another patient's medication history continue to happen, albeit with low or no harm	• ALERT to all prescribers has been re-circulated.
Recognition and management of deteriorating patients continues to be a concern.	• Focused work led by Senior Executive continues to focus upon cross-organisational improvements in this area. • There have been notable improvements at YAB.
A number of investigations have highlighted Human Factors as significant.	• Human factors simulation training ongoing in theatre and being taken up by cardiology.
Increase in incidents encompassing both clinical care and practitioner concerns.	• Greater links formed between SI and safeguarding teams.
Increase in focus upon nutrition and diagnostics access in Learning Disabilities patients.	• Focused task and finish group to formulate organisational plan for LD patients within secondary care environments.
Increase in complex multi-divisional/organisational investigations.	• Review planned by ADoN of QPS resource across the Health Board to foster greater collaborative working.
Delays in Divisional engagement in population of the DoC information leading to delays in reporting of Nationally Reporting Incidents to NHS executive.	• PTR Concerns Officer overseeing DoC dashboards and linking in with Divisional Lead contacts.

As of the 1 July 2023 the Corporate Serious Incidents Team were managing 55 live Red 1 SI's, with 26 in meeting stages. Discussion with the NHS Executive highlighted an issue with the Health Board potentially under reporting under the New Framework. Following discussion, the incidents are being appropriately managed, but hadn't been reported, due to interpretation of the amended Policy as of June 2021 and rejection by NHS Executive of submitted reporting forms. There has been agreement that the Health Board should report if they feel it is necessary. Follow-up meeting to be arranged later this year.
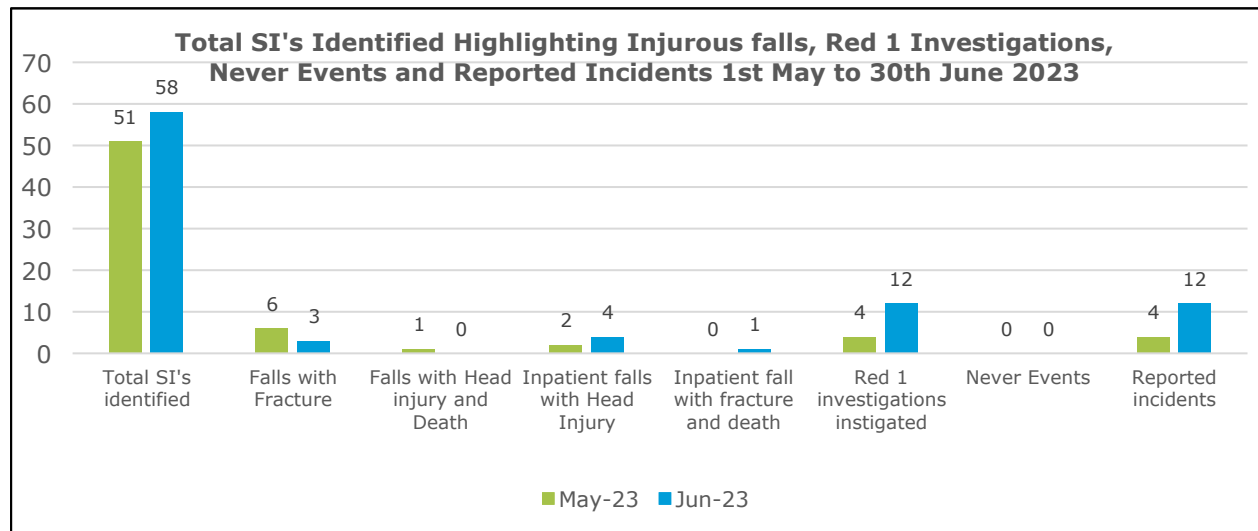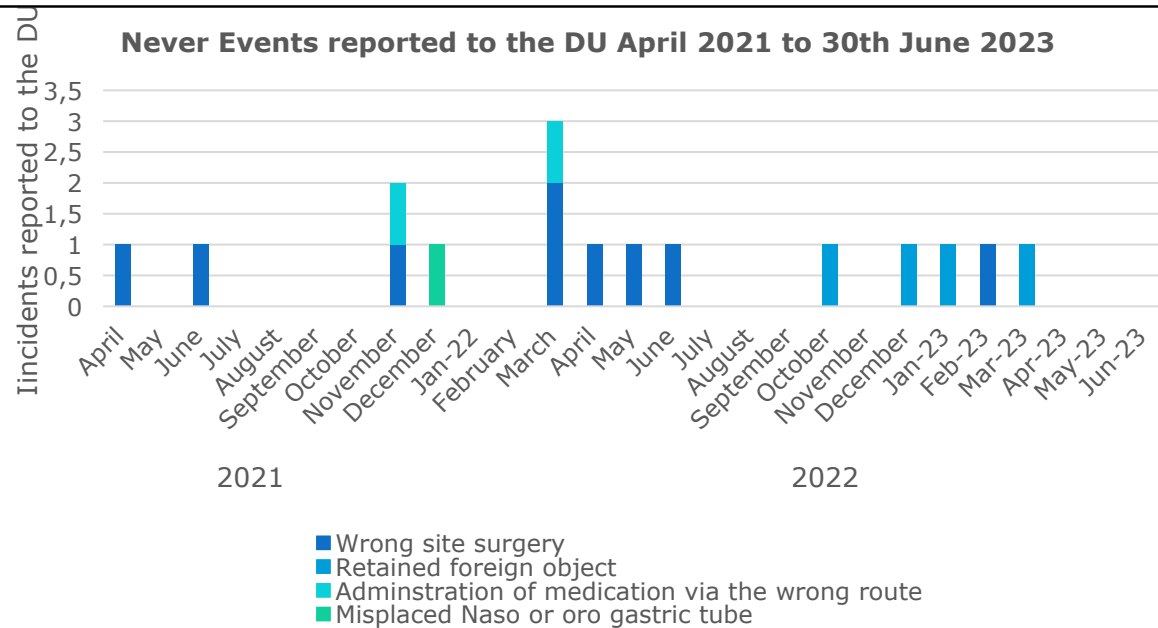
153 EWN have been submitted since July 2022. Of those 153 more than 50% related to Covid-19 outbreaks. Followed by PRUDiC's and Absconsion.

On review there were 25 themes identified, which spanned all Divisions along with Safeguarding and Corporate.

Total SI's Identified Highlighting Injurous falls, Red 1 Investigations, Never Events and Reported Incidents 1st May to 30th June 2023

Serious Incidents Captured 1st May to 30th June 2023

Serious Incidents

Never Events

Never Events reported to the DU April 2021 to 30th June 2023

Iincidents reported to the DU

Legend:
- Wrong site surgery
- Retained foreign object
- Adminstration of medication via the wrong route
- Misplaced Naso or oro gastric tube

- There have been no new never events during this reporting period.
- There has been good engagement from all Divisions re attempts to reduce the number of never events.
- Self-assessment form and e-learning module for areas performing regional anaesthesia are under development.
- Scenario wrong site block simulation being run in theatre.
- SI Team working with Anaesthetics and ABCi using systems tools (SEIPS and STEW) to review system issues re wrong site blocks.
- ERASE posters being used to embed learning.

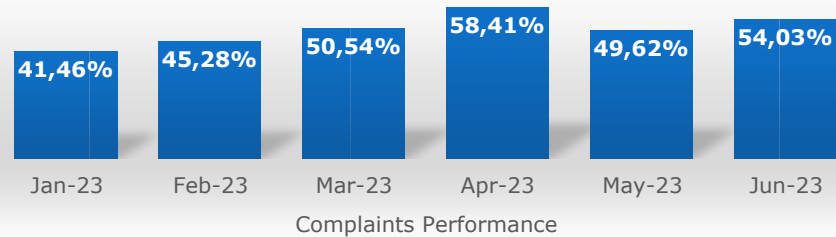| Issue	Cause	Remedial Action	Who	When
Since July 2022 NHS Wales Never Event reporting criteria have changed	Directive from Welsh Government in line with NHS England Removed incidents: Wrong tooth extraction Oesophageal intubation Intravenous administration of medicines intended for epidural route -during implementation of NRfit	SI Team still monitor RLDATIX for these incidents	PTR SI Team	Ongoing
		Improved search capability on DATIX for key words in these incidents – **THIS IS WORKING WELL**	ABUHB H&S Team	
		Liaise with Divisions when these incidents are identified	Divisional QPS leads	
Embedding of organisational learning from Never Events/SIs and complaints	Organisational memory Turnover of staff	Meeting TBA with Clinical Execs to discuss Never Events and thematic reviews to identify overarching risks and recurrent incidents.	PTR and Clinical Execs	Complete
	Learning from Never Events not embedded within the organisational culture.	Explore a repository of completed and appropriately redacted investigations and action plans – Intranet page.		
		Undertake a review of most recent Never Events focusing on learning. Additionally, a meeting is to be arranged with Theatre Senior Management Team.	Medical Director	Complete
		Monthly Theatre Safety Meetings have been reinstated.	Scheduled Care Triumvirate	Ongoing

Duty of Candour

Progress

- Good strategic engagement within the Health Board leading to identified Duty of Candour (DoC) leads within the Divisions. Regular meetings are being held to monitor the implementation of DoC.

- To assist Divisions, a DoC Dashboard has been created within the Datix system. The dashboard highlights incidents that have triggered the duty and those that need to be reviewed.

- The Putting Things Right Team are validating the DoC data within the dashboard.

- Strong engagement in the national implementation programme.

- Next steps is to further embed DoC and performance reporting, including against DoC timeframes. Currently reviewing as a reporting measure for Q2.
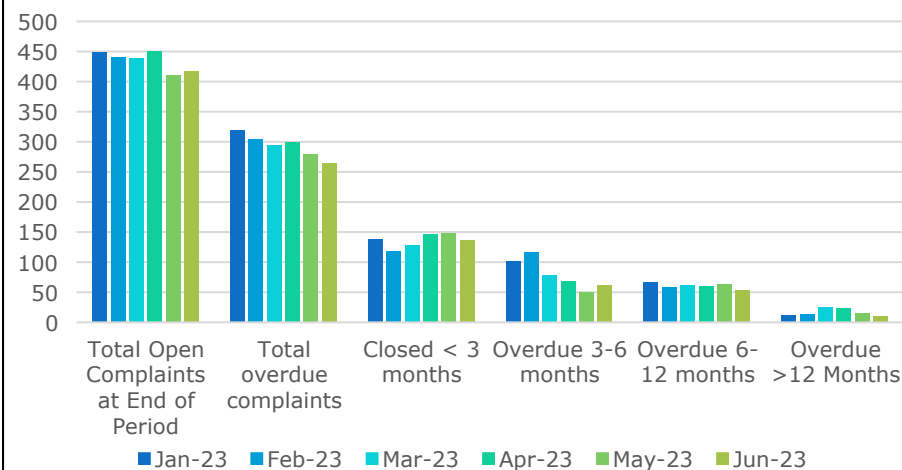
Complaints

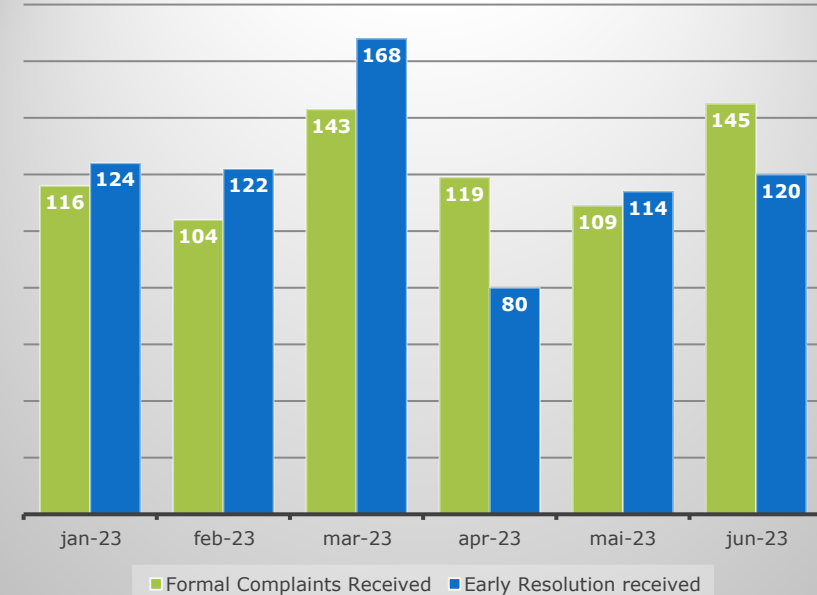## Early Resolution Performance January- June 2023

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
66,90%	60,80%	56,31%	74,49%	66,37%	67,39%

Early Resolution Performance
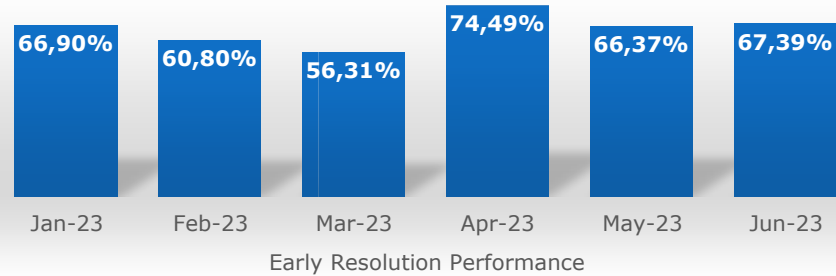
Formal Complaints Performance January –June 2023

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
41,46%	45,28%	50,54%	58,41%	49,62%	54,03%

Complaints Performance

Total Open Complaints and Overdue complaints January- June 2023

Categories: Total Open Complaints at End of Period; Total overdue complaints; Closed < 3 months; Overdue 3-6 months; Overdue 6-12 months; Overdue >12 Months

Legend: Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23

Complaints Received January- June 2023

	jan-23	feb-23	mar-23	apr-23	mai-23	jun-23
Formal Complaints Received	116	104	143	119	109	145
Early Resolution received	124	122	168	80	114	120

Enquiries Reordered by PLO's January -June 2023

Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
990	699	847	693	721	757

Enquiries Recorded by Patient Liaison Officers
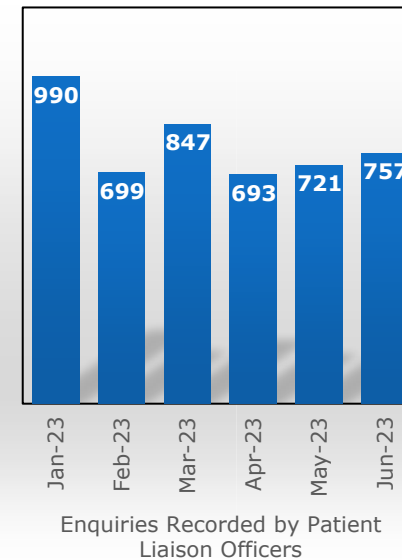
Historic Concerns

A focused piece of work was led corporately working with divisional colleagues to close historic concerns more than 12 months old, e.g. pre May 2022. To date there are 41 have been closed. 4 remain open, with plan for closure.
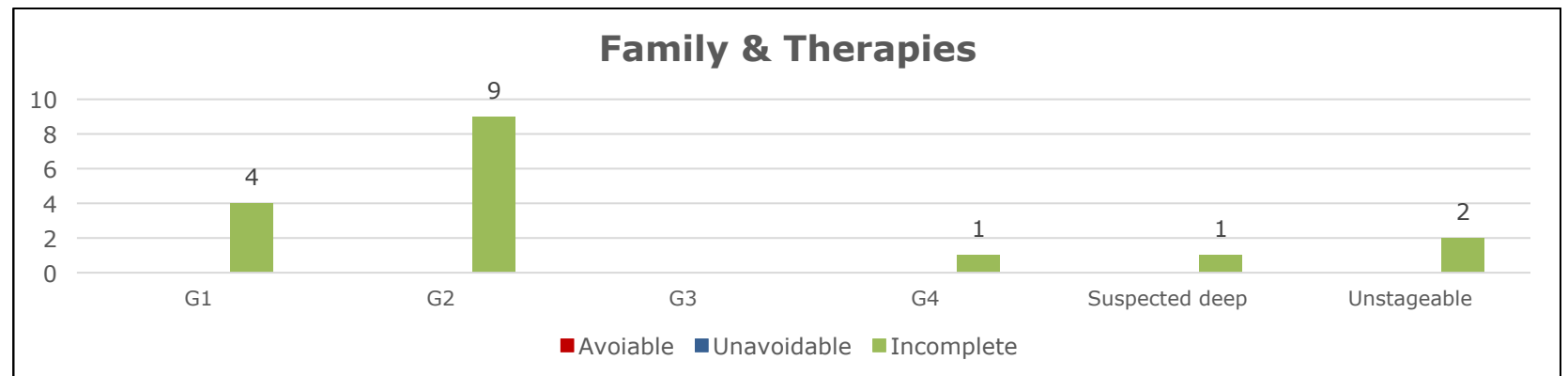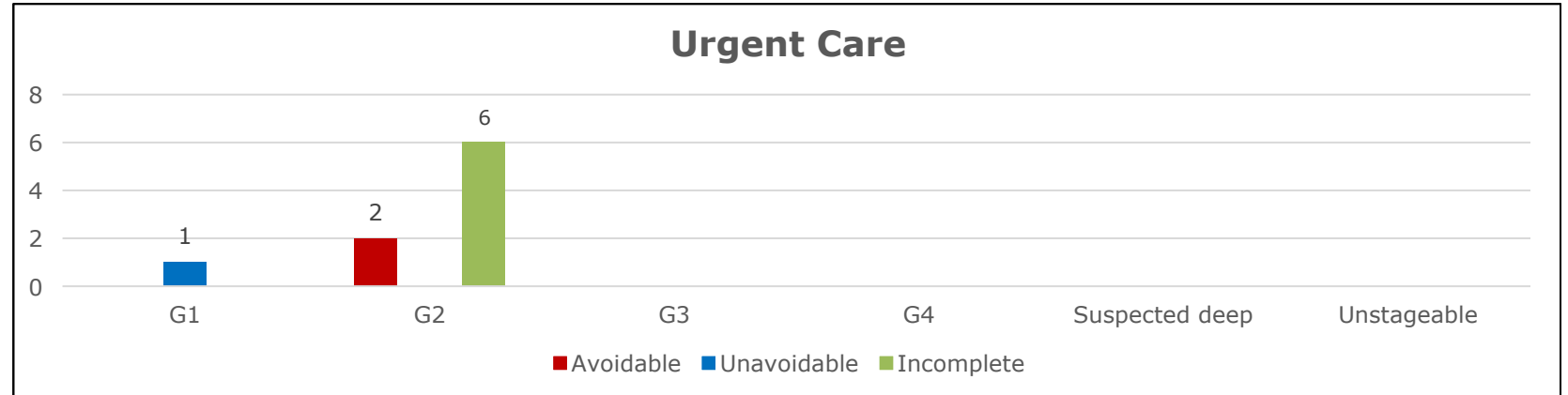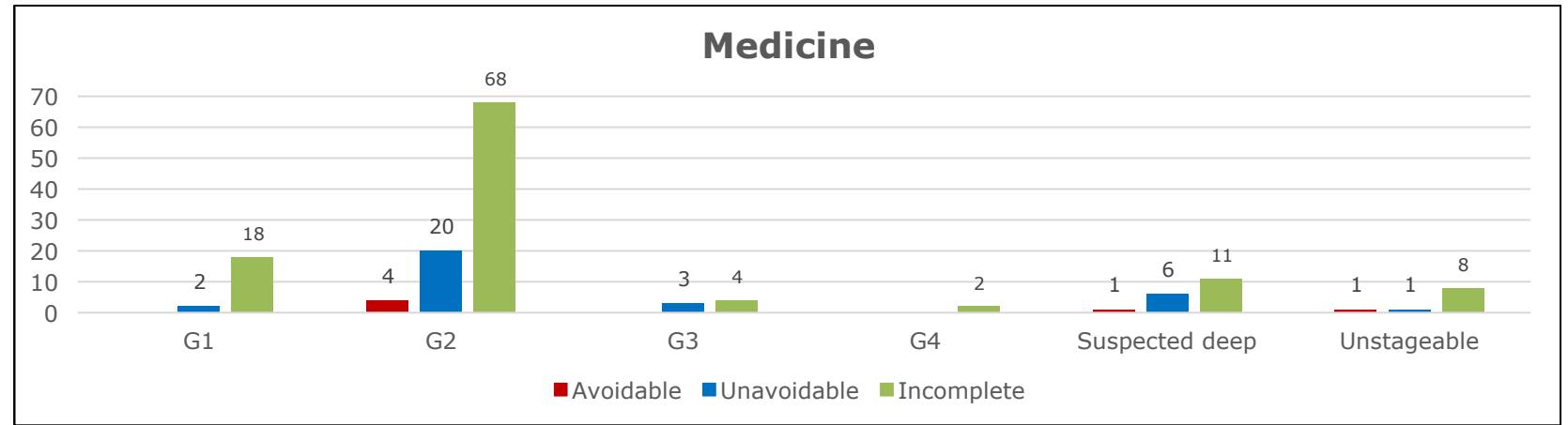
Focus is now underway on concerns 9-12 months old.
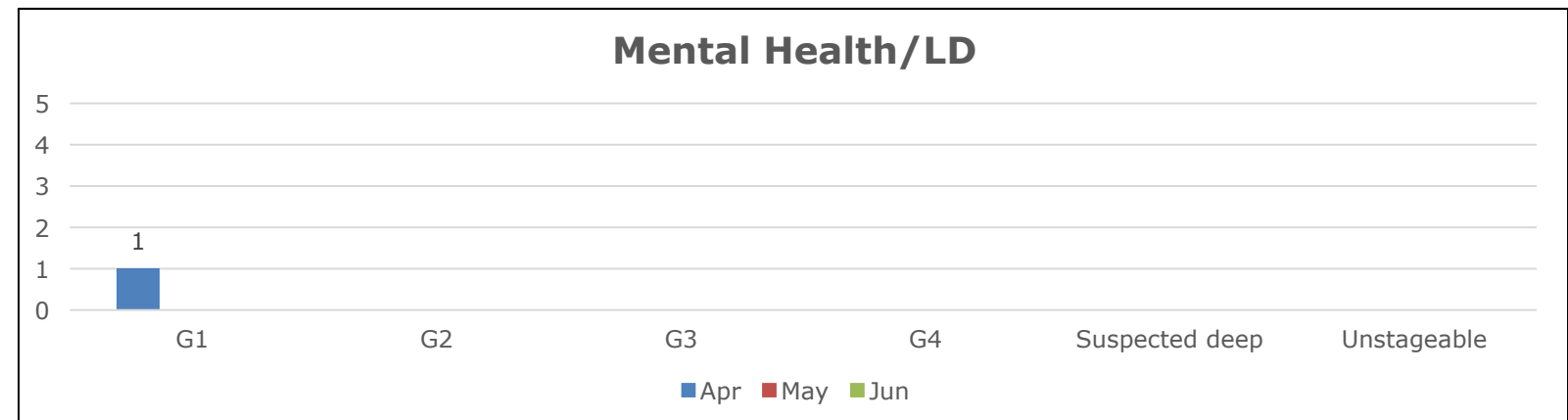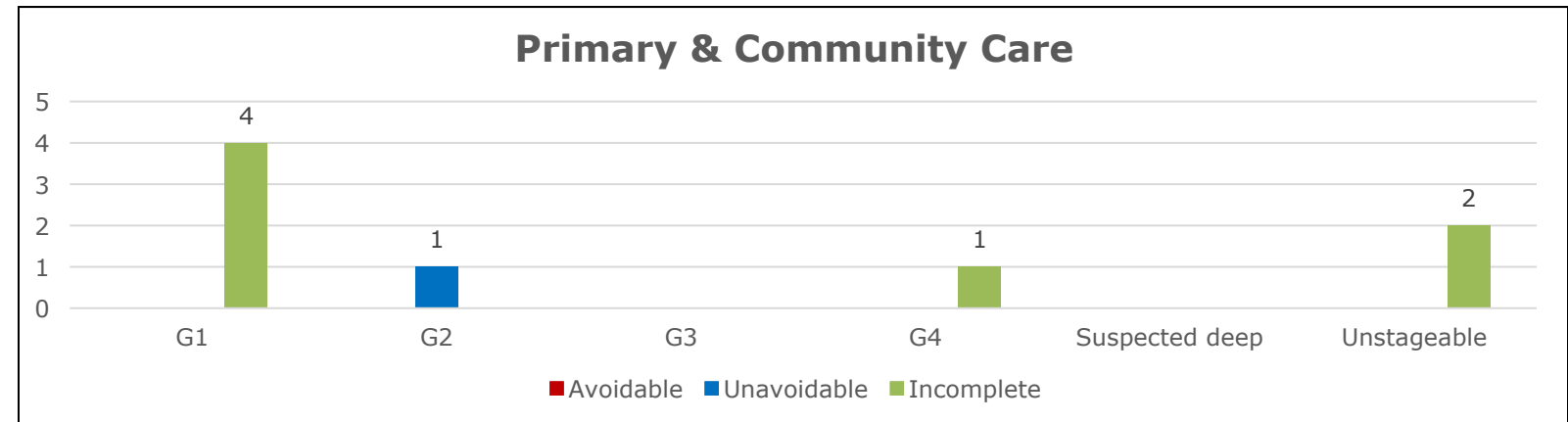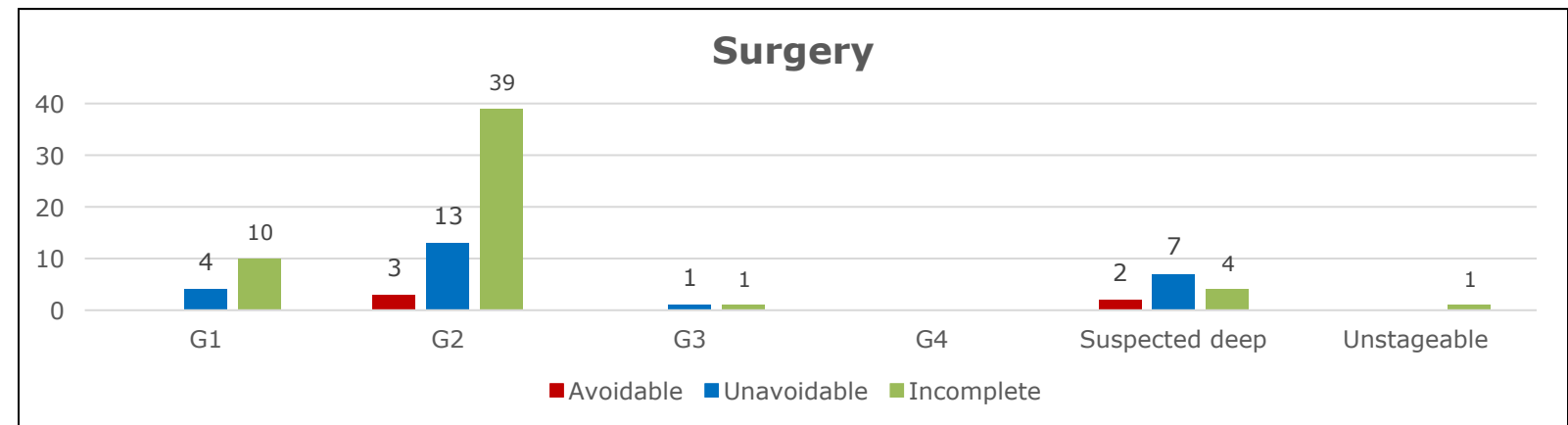
Hospital Acquired Pressure Ulcer (HAPU)

April – June 2023

Issue	Cause	Remedial Action	Who	When
Data collection	Duplication reporting on Datix	• Developed guidelines for pressure ulcer reporting – to be approved by QPS	Assistant Director of Nursing - IPAC	May 2023
		• Create a standard dashboard • Process to de-duplicate incidents	HAPU steering group	August 2023
Pressure Ulcer care bundles	Sub optimal documentation e.g. skin bundles, water low	• Planning started to establish QI programme/ collaborative to reduce pressure ulcers	Assistant Director of Nursing/ Head of Nursing IPAC/ ABCi	By August 2023
Recording incidents as avoidable or unavoidable	Incidents not being updated following review to identify if Avoidable or Unavoidable	• Exception reporting to the HAPU Steering Group	HAPU	August 2023

Divisional Incidents of Pressure ulcer damage developed or worsened in the clinical area/ caseload

Medicine

	G1	G2	G3	G4	Suspected deep	Unstageable
Avoidable		4			1	1
Unavoidable	2	20	3		6	1
Incomplete	18	68	4	2	11	8

Urgent Care

	G1	G2	G3	G4	Suspected deep	Unstageable
Avoidable		2				
Unavoidable	1					
Incomplete		6				

Family & Therapies

	G1	G2	G3	G4	Suspected deep	Unstageable
Avoiable						
Unavoidable						
Incomplete	4	9		1	1	2

Divisional Incidents of Pressure ulcer damage developed or worsened in the clinical area/ caseload

Surgery

	G1	G2	G3	G4	Suspected deep	Unstageable
Avoidable		3			2	
Unavoidable	4	13	1		7	
Incomplete	10	39	1		4	1

■ Avoidable ■ Unavoidable ■ Incomplete

Primary & Community Care

	G1	G2	G3	G4	Suspected deep	Unstageable
Unavoidable		1				
Incomplete	4			1		2

■ Avoidable ■ Unavoidable ■ Incomplete

Mental Health/LD

	G1	G2	G3	G4	Suspected deep	Unstageable
Apr	1					

■ Apr ■ May ■ Jun

Medication Safety Strategy: Progress Goal 1

OVERVIEW

During March 2022, the Medication Safety Group (MSG) launched a Medication Safety Strategy with endorsement from the Medicines and Therapeutic Committee (MTC) and the Quality and Patient Safety Operational Group (QPSOG). The Medication Safety Strategy set out the ambitions of the MSG over a three-year period and focuses on five priority goals, each of which has their own set of objectives and measures to support their delivery:

1. Improve reporting and learning from medication incidents and good practice.
2. Support the safe use and secure storage of medicines.
3. Reduce harm from high-risk medication and transition of care.
4. Learn from and contribute to the national medication safety agenda.
5. Develop and implement strategies to improve the medicines safety culture across the Health Board.

The focus of these slides are to demonstrate how the Medication Safety Group has used medication incidents report to trend and theme types of errors to allow organisational learning and progress. This relates to goal 1; **1.4 Use established medication reports to identify themes for targeted learning.**

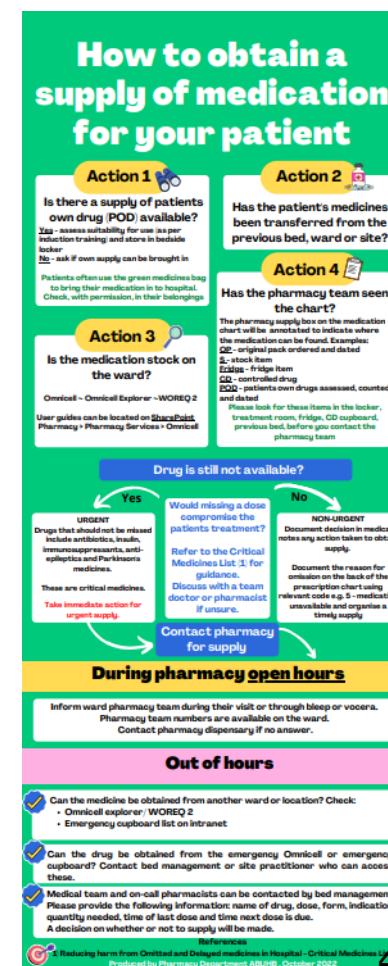| Report	Review	Action
Quarterly incident reports support trend analysis to target high risk or high-volume incidents.	Thematic review, using other data sources supports a detailed root cause analysis and an action plan focused on areas of biggest impact	Data is collated to ensure positive impact has been delivered and organisational learning is embedded

Medication: Omitted and delayed medication

Administration incidents are frequently the highest type of incidents identified in our monthly reports. During April to November 2022, all administration incidents along with their contributory factors were collated and analysed. Within the sub-types of administration incidents, delayed and omitted medication incidents contributed the most. Recurring contributory factors included lack of knowledge on time critical medication, where to locate a mediation in and out of hours and how to escalate a concern when a medication is delayed or missed.
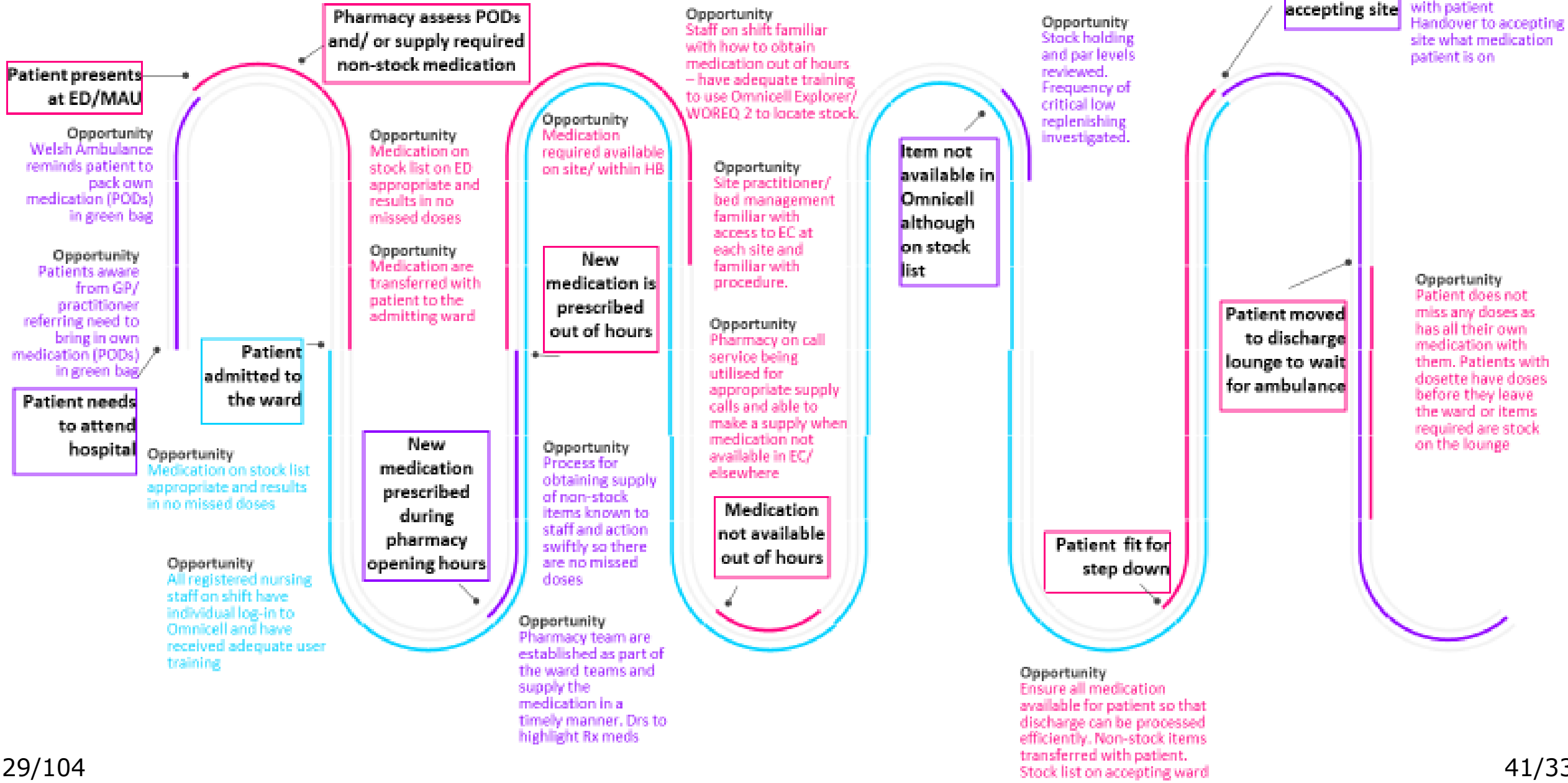
A patient journey was mapped out and opportunities to improve access to mediation identified.

An action plan was developed and completed, examples of which include:

- Medication stocklist reviewed at each point of entry and transfer
- Access and training to Omnicells streamlined
- Communication around how to obtain a medication supply shared and a QI project to improve understanding of the emergency pharmacy duties out of hours
- Update and relaunch "Reducing harm from delayed or omitted medication" policy during medication safety week
- Benchmarking against Time Critical Medication standards
- (Parkinson's UK) undertaken and further actions identified to enable standards to be met.

Perfect patient journey – availability of medication

Patient presents at ED/MAU

Opportunity Welsh Ambulance reminds patient to pack own medication (PODs) in green bag

Opportunity Patients aware from GP/ practitioner referring need to bring in own medication (PODs) in green bag

Patient needs to attend hospital

Opportunity Medication on stock list appropriate and results in no missed doses

Patient admitted to the ward

Opportunity All registered nursing staff on shift have individual log-in to Omnicell and have received adequate user training

Pharmacy assess PODs and/ or supply required non-stock medication

Opportunity Medication on stock list on ED appropriate and results in no missed doses

Opportunity Medication are transferred with patient to the admitting ward

New medication prescribed during pharmacy opening hours

Opportunity Medication required available on site/ within HB

New medication is prescribed out of hours

Opportunity Process for obtaining supply of non-stock items known to staff and action swiftly so there are no missed doses

Opportunity Pharmacy team are established as part of the ward teams and supply the medication in a timely manner. Drs to highlight Rx meds

Opportunity Staff on shift familiar with how to obtain medication out of hours – have adequate training to use Omnicell Explorer/ WOREQ 2 to locate stock.

Opportunity Site practitioner/ bed management familiar with access to EC at each site and familiar with procedure.

Opportunity Pharmacy on call service being utilised for appropriate supply calls and able to make a supply when medication not available in EC/ elsewhere

Medication not available out of hours

Opportunity Stock holding and par levels reviewed. Frequency of critical low replenishing investigated.

Item not available in Omnicell although on stock list

Medication available at accepting site

Opportunity Timely transfers Send non-stock items with patient Handover to accepting site what medication patient is on

Patient moved to discharge lounge to wait for ambulance

Opportunity Patient does not miss any doses as has all their own medication with them. Patients with dosette have doses before they leave the ward or items required are stock on the lounge

Patient fit for step down

Opportunity Ensure all medication available for patient so that discharge can be processed efficiently. Non-stock items transferred with patient. Stock list on accepting ward

Medication Safety Strategy: Progress Goal 1

1.5 Embrace the culture of speaking up for safety and encourage the prompt reporting of incidents and adverse drug reactions

Promote annual World Health Organisation (WHO) World Patient Safety Day Campaign

Week-long celebration 7-13th November with daily sessions, including:
- The Five Rights of Medicines Administration
- Administering medicines on time and access to critically timed medicines
- Launch of the ABUHB Medicines Safety Strategy
- How to report a medicines error via Datix
- The importance of reflection and a Just Culture
- A Learning Organisation in ABUHB
- The role of the AB Medicines Safety Officer and how to get involved
- Medication errors across the interface and they can be improved
- Safer prescribing for high-risk medicines

Rolling programme for Yellow Card (Adverse Drug Reaction) reporting
- Cross-sector group established to set actions against key prescribing indicators
- Target specific groups to increase capacity to report – focus currently on pharmacy technicians, physician associates, vaccination nurses.
- Regular training sessions to motivate teams e.g., ED team, practice nurses, junior doctors, non-medical prescribers.
- Improve accessibility of reporting by using bar codes and develop speciality specific posters/ cards to including commonly prescribed black triangle drugs which require automatic reporting of ADRs.
- Align with Yellow Card Centre (YCC) Wales to run national campaigns and share good practice
- ABUHB Yellow Card Champions attended the Medication Safety Day at Cardiff City Stadium to celebrate 40 years of YCC Wales.

Medication

Issue	Cause	Remedial Action	Who	When
Outstanding action plan from benchmarking exercise	Awaiting discussion at PQSOC and outstanding policies to be signed off	Engagement with PQSOC and update MSG with progress.	Hayley Saunders	November 2023
Yellow card reporting not meeting key performance indicators	Competing prioritise and lack of motivation to report	Cross-sector group established to develop action plan, which includes training sessions, enabling easy access to YC app.	Yellow Card Group	Quarterly

Health, Safety & Security

Health and Safety Executive Engagement

The Health Board received confirmation from the HSE Specialist Inspector that the response provided relating to the recommendations arising from the inspection of Pathology at Royal Gwent Hospital provided sufficient assurance to close the file.

The Health and Safety Executive (HSE) have **one active case** with the Health Board relating to an investigation of a patient fall at Nevill Hall Hospital, which occurred in 2019.

Health, Safety & Security

Health and Safety Executive Engagement

The HSE visited Nevill Hall Hospital on 15 June 2023 to review the patient fall that they are currently investigating.

Overall, the visit was positive with recognition of the significant improvements in documentation, processes and governance. The staff providing evidence were well prepared providing a wealth of evidence in support of the changes that have taken place.

The HSE visited both Wards 4/1 and 3/1 and were able to see the changing environment in which staff are now operating. They were positive in relation to how we undertake the '1-patient 1-day' audits and the information this provides and in relation to how coordination and flow works through the MDT.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

During the period July 2022 to June 2023 the Health Board have reported **93 incidents** to the HSE in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
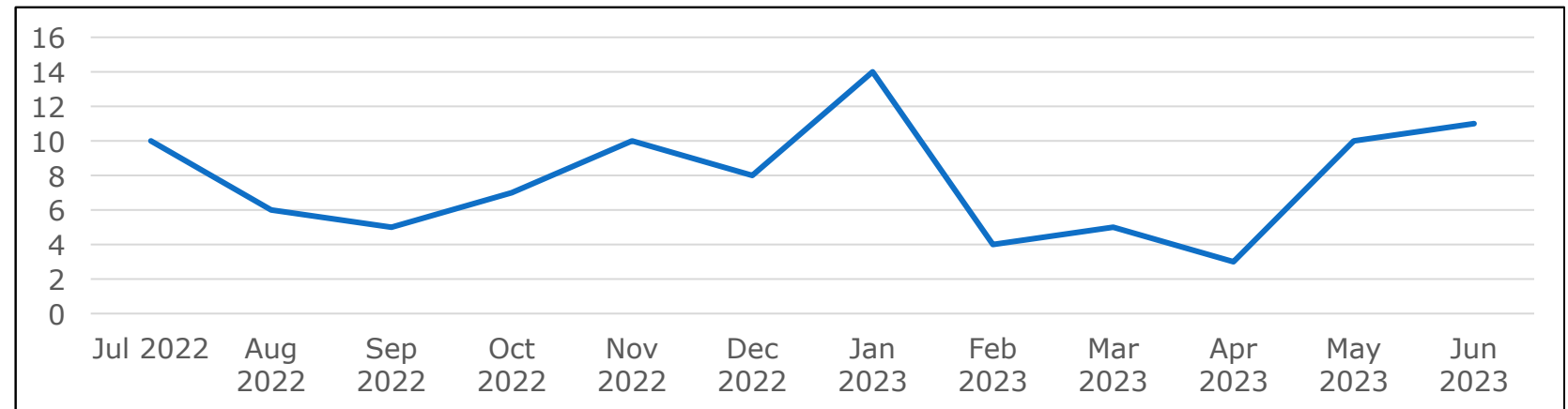
58% of these cases were reported within the legal timeframes within the legislation. This is an **increase of 9%** from the previous report.

Health, Safety & Security

Health, Safety & Security

Health and Safety Statutory and Mandatory Training

At end of May 2023 training compliance was for the Health Board was reported as:

Health and Safety	84%
Violence and Aggression	82%
Fire Safety	79%
Manual Handling	52%

A review of all health and safety training strategies is being undertaken to ensure an increase in compliance. Particular support is required for manual handling and active engagement with the Divisions to implement the training model is happening.

Health, Safety & Security

Traffic Management on Healthcare Premises

A Traffic Management Working Group has been established to review and assess the risks at our hospital sites.

This follows concerns raised at the Royal Gwent Hospital and the fatal incident in Withybush Hospital.

Infection Prevention/ Decontamination

May/June

Escalated risk concerns

Section 3

Escalated Risk Concerns

- Quality, patient safety and governance escalation process Mental Health and Learning Disabilities Division due to escalation of concerns which go to governance, leadership and culture.

- Increased number of Serious Incidents over the last quarter this is a positive indication of transparency and reporting, but capacity is of concern.

- Continuation of a theme of deteriorating patient and surgical Never Events.

- Further work is required on end of life and bereavement pathways.

MH&LD Improvement Actions

- Improvement plan developed;

- A bi-weekly meeting has been established;

- A review of Datix, practitioner concerns, workforce issues, PTR & SI concerns, Health & Safety issues and Inquests/Redress;

- Improved reporting in terms of the timeliness of escalation of concerns with clear expectations for early reporting;

- The Chief Executive has been briefed and has subsequently briefed the Chairman;

- The Executive Team has been briefed;

- The Chair of the PQSOC has been briefed by the EDoN;

- Welsh Government and the NHS Wales Executive have been informed formally and informally of concerns and a process for challenge and oversight has been agreed;

- As described in supporting documents, a number of immediate make safe actions have been taken to ensure that Service Users are safe;

- Oversight visits have been completed at each unit where concerns have been escalated with further visits of all units to be completed;

- Two initial briefings of senior staff in the Division have been undertaken with further engagement to be planned;

- HIW have been informally briefed and have requested further assurance in relation to Cedar Park;

- Further benchmarking of risks, incidents, suicides, PTR and inquests are to be undertaken.

Governance & Assurance

- The Quality, Safety & Governance Escalation Process for Mental Health & Learning Disability has been established with clear ToR.

- Responsibilities:-

  - Consistent application of the objectives throughout the process

  - Assurance of the delivery and completion of the improvement plan escalating concerns

  - Ensure all concerns are mitigated through improvement actions and assurance on safety

  - Assessing risk to service users and staff and risks to organisational governance and assurance

  - Identify trends/themes and collating learning

  - Identify and log new risks or concerns

- This is a formal process which will report to the Executive Committee, through PQSOC to Board.

- This process has been supported by NHS Executive Colleagues.
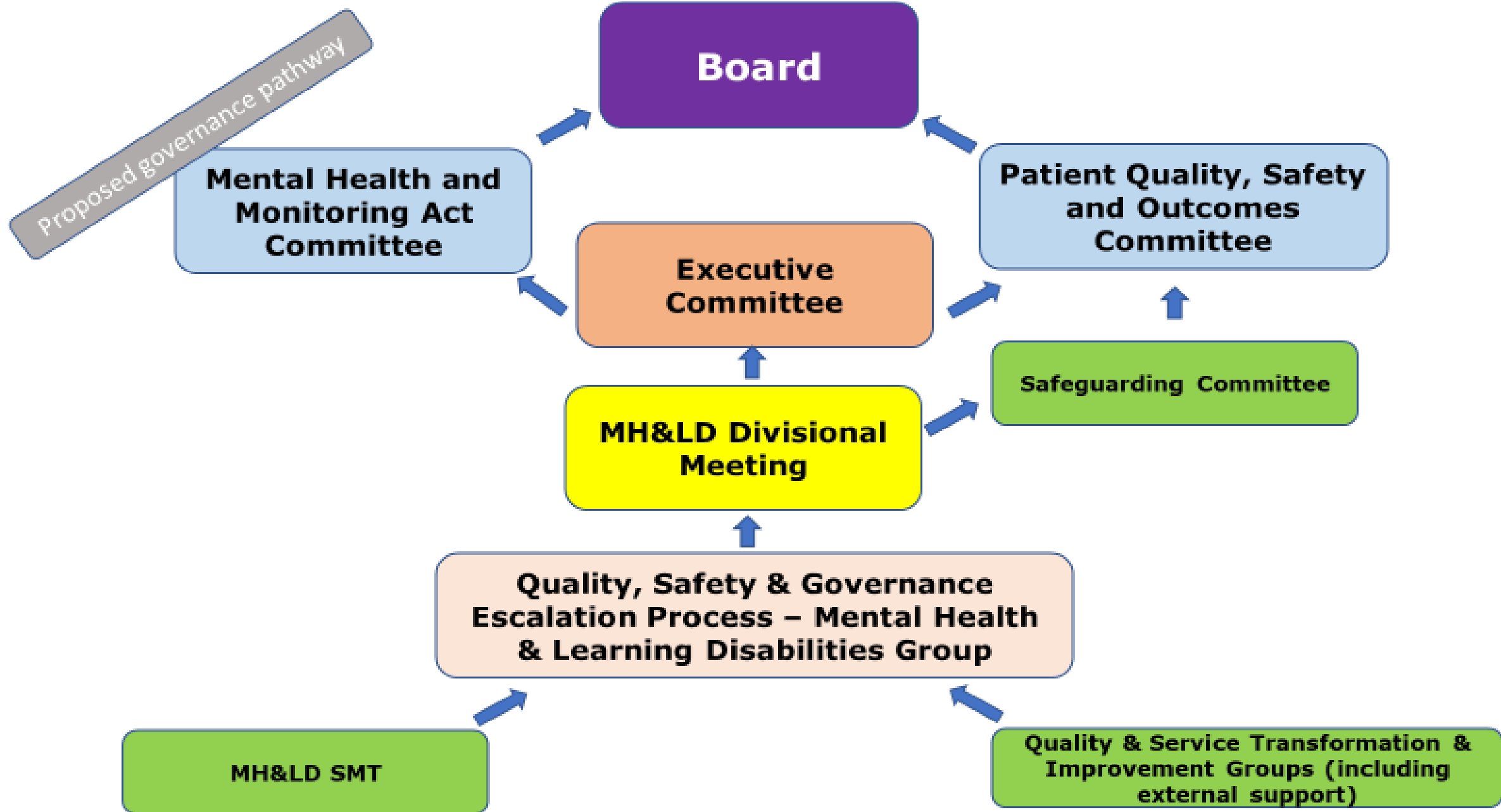
Overview of the Health Inspectorate Wales' Inspection of Ty Lafant, Llanfrechfa Grange

31 January – 1 February 2023

- Health Inspectorate Wales undertook an Unannounced Inspection to Ty Lafant, Llanfrechfa Grange on 31 January and 1 February 2023.

- An Immediate Assurance notice was issued.

1 No. of Outstanding Actions (out of date)

No. of Recommendations identified by HIW **8**

0 No. of Outstanding Actions (in date)

No. of Actions identified by Division **28**
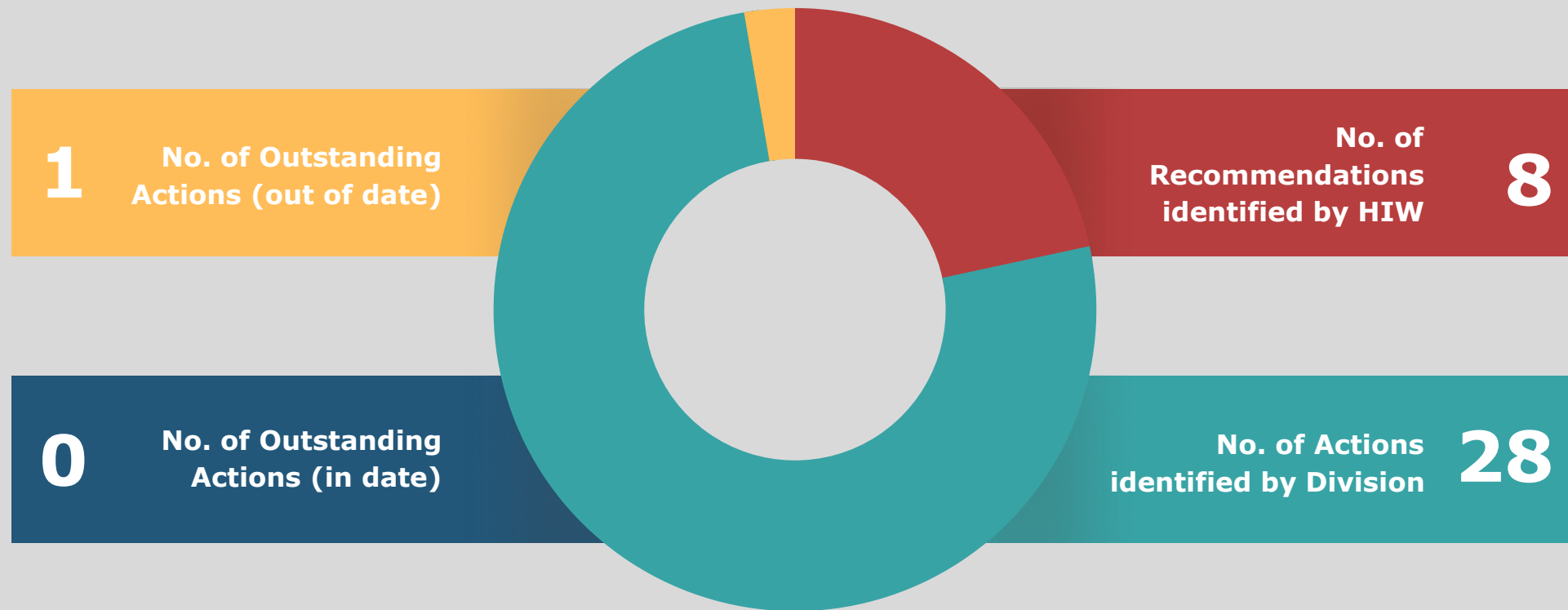
- Overarching improvement plan and draft Inspection Report issued by Health Inspectorate Wales on 23 March 2023.

2 No. of Outstanding Actions (out of date)

No. of Recommendations identified by HIW 50

3 No. of Outstanding Actions (in date)

No. of Actions identified by Division 88
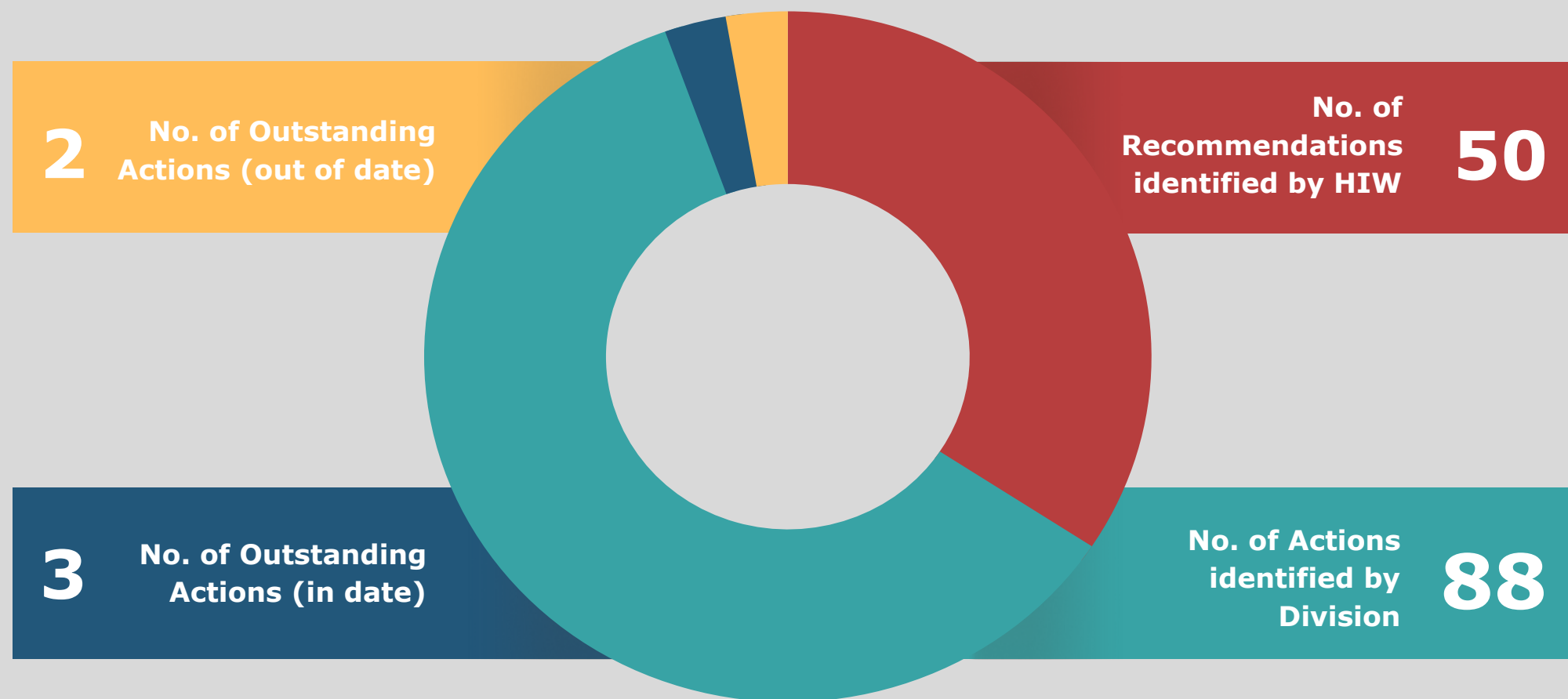
Outstanding actions

HIW Recommendation	Service Action	Timescale	Update – July 2023
The health board must provide HIW with details of how it will ensure that robust processes are put in place to ensure that restraint incidents are being effectively recorded, investigated, managed and scrutinised in order to prevent reoccurrence and encourage shared learning. Measures must be taken to ensure that all relevant details of restraint incidents are captured and recorded to include all involved members of staff and their actions throughout the incident.	The Health and Safety team has reviewed the Restrictive Physical Intervention Policy. This is due to be presented to the Health Board's Health & Safety Committee on 9 February. Following a period of consultation, it is anticipated this will be in place in March/April 2023.	~~April 2023~~ September 2023	Current policy is fit for purpose. The revised policy is currently out for consultation and likely to be approved by September 2023.
Decorative measures should be undertaken to make the communal areas of the unit a more pleasant therapeutic environment for patients.	Meeting held with furniture provider on 24/03/23. Paper will be developed and provided to the Health Board for funding for the new furniture. Awaiting options & costings from furniture provider who are visiting on 22/6/23.	~~June 2023~~ August 2023	The Directorate has linked with a company who provide specialist furniture but also specialise in acoustics which is something HIW picked up on. The rep has cancelled 3 meetings now. The Directorate is keen to work with this company because of their specialism so is arranging a further meeting, but may need to look elsewhere.
Measures should be taken to reduce the noise levels on the unit for the comfort of patients, staff and visitors.	Meeting held with furniture provider on 24/03/23. Paper will be developed for Divisional/ Health Board approval to fund new furniture and acoustic tiles.		
We recommend that healthy eating initiatives are implemented on the unit for the benefit of patients.	Catering Dietician has approached the Division to discuss and share guidance around healthy choices. To be discussed at Divisional QPS meeting.	July 2023	On QPS agenda for 26/07/23.
Pictures of the menu choices should be provided so that patients can view a pictorial and written menu.	Division to liaise with Facilities Division to create a visual library of menu options.	July 2023	Division have chased Facilities Division for an update.
The practice of using the visitors room as additional bedroom when the unit is at full capacity must be avoided, to ensure the safety of patients and staff.	The directorate will ensure that in future, the room will not be used as a bedroom and will include this in the Ty Lafant operational policy.	July 2023	Directorate updating – on track for completion by end of the month.

Initial steps taken for Assurance

- **IPAC**
  - Initial assessment undertaken on 10 February 2023
  - Weekly assessments are ongoing

- **W&E/Facilities**
  - Assessment undertaken in collaboration with IPAC on 15 February 2023

- **Health & Safety**
  - Review of environment undertaken w/c 20 March 2023

- **Safeguarding**
  - All serious incidents reviewed, to ensure all necessary safeguarding action had been taken.

Health Inspectorate Wales Inspections Update

Overview

To provide the Patient Quality, Safety & Outcomes Committee with progress on : -

- Inspections undertaken since January 2023

- Improvement plans with outstanding actions

ABUHB Inspections undertaken since January 2023

Ty Lafant, Llanfrechfa Grange
31 January – 1 February 2023
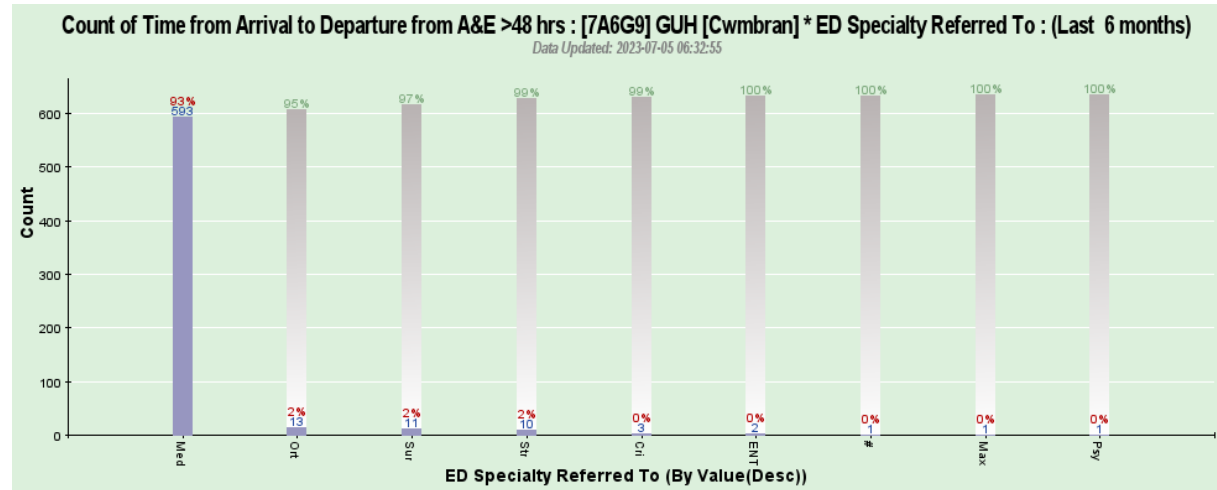Immediate assurance: 8 recommendations
Report Publication Date: (Issued to ABUHB) 4 April 2023

Ionising Radiation (Medical Exposure) Regulations, Nevill Hall Hospital
25 – 26 April 2023
Immediate assurance: None
Report Publication Date: (Issued to ABUHB) 4 July 2023

D2 East & West, Royal Gwent Hospital
3 – 4 May 2023
Immediate assurance: None
Report Publication Date: 4 August 2023

Maternity, Grange University Hospital
6 – 8 June 2023
Immediate assurance: 4 recommendations
Report Publication Date: To be confirmed

Existing Improvement Plans with Outstanding Actions

Division		In-Date	Out-of-Date	Total
Mental Health & LD				
Ty Lafant	Immediate	0	1	**6**
	Overarching	3	2	
Ty Cyfannol & Annwylfan Wards		0	6	**6**
Urgent Care				
Emergency Department – GUH (1-3/11/21)		0	4	**4**
Emergency Department - GUH (1-3/08/22)		0	3	**3**
Family & Therapies				
Review of Healthcare Services for Young People		0	1	**1**
Maternity - GUH		3	0	**3**
Scheduled Care				
D2 East & West – RGH		5	0	**5**
Diagnostics & Therapies				
Ionising Radiation (Medical Exposure) Regulations - NHH		12	0	**12**

Urgent & Emergency Care

Count of Time from Arrival to Departure from A&E >12 hrs : [7A6G9] GUH [Cwmbran] : (Weekly - 2 years, prediction)

Count of Time from Arrival to Departure from A&E >24 hrs : [7A6G9] GUH [Cwmbran] : (Weekly - 2 years, prediction)

Count of Time from Arrival to Departure from A&E >48 hrs : [7A6G9] GUH [Cwmbran] : (Weekly - 2 years, prediction)

Urgent and Emergency Care

Count of Time from Arrival to Departure from A&E >48 hrs : [7A6G9] GUH [Cwmbran] * ED Specialty Referred To : (Last 6 months)
Data Updated: 2023-07-05 06:32:55

Count of Time from Arrival to Departure from A&E >48 hrs : [7A6G9] GUH [Cwmbran] * Med : (Weekly - 2 years, prediction)
Data Updated: 2023-07-05 06:32:55

93% of the 48+ hour waits in ED are for medical specialties. The time to departure for medical specialties over 48 hours are normally occurring at around 18.

Numbers were ranging from 20-37 from 30th January until 17th April, but have been lower for the past 3 weeks.

Urgent & Emergency Care

>60 Minute Handover at GUH, Feb 2023 - June 2023

>6 Hour Handover at GUH, Feb 2023 - June 2023
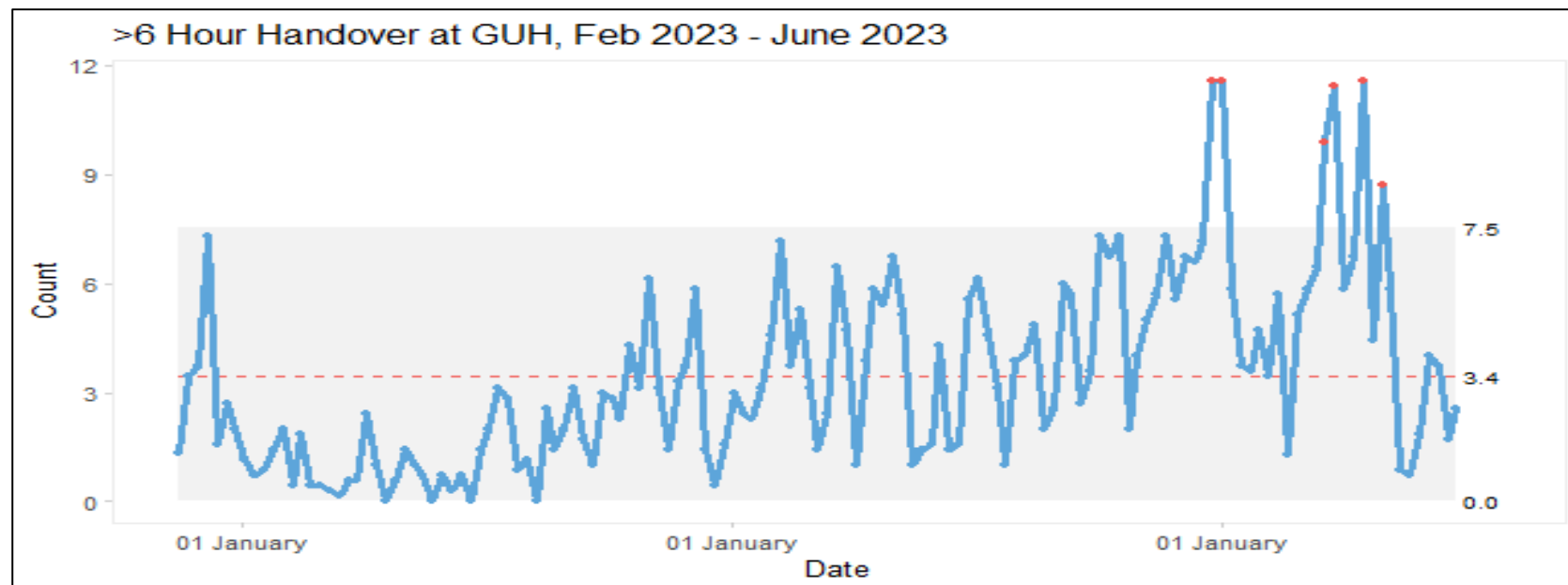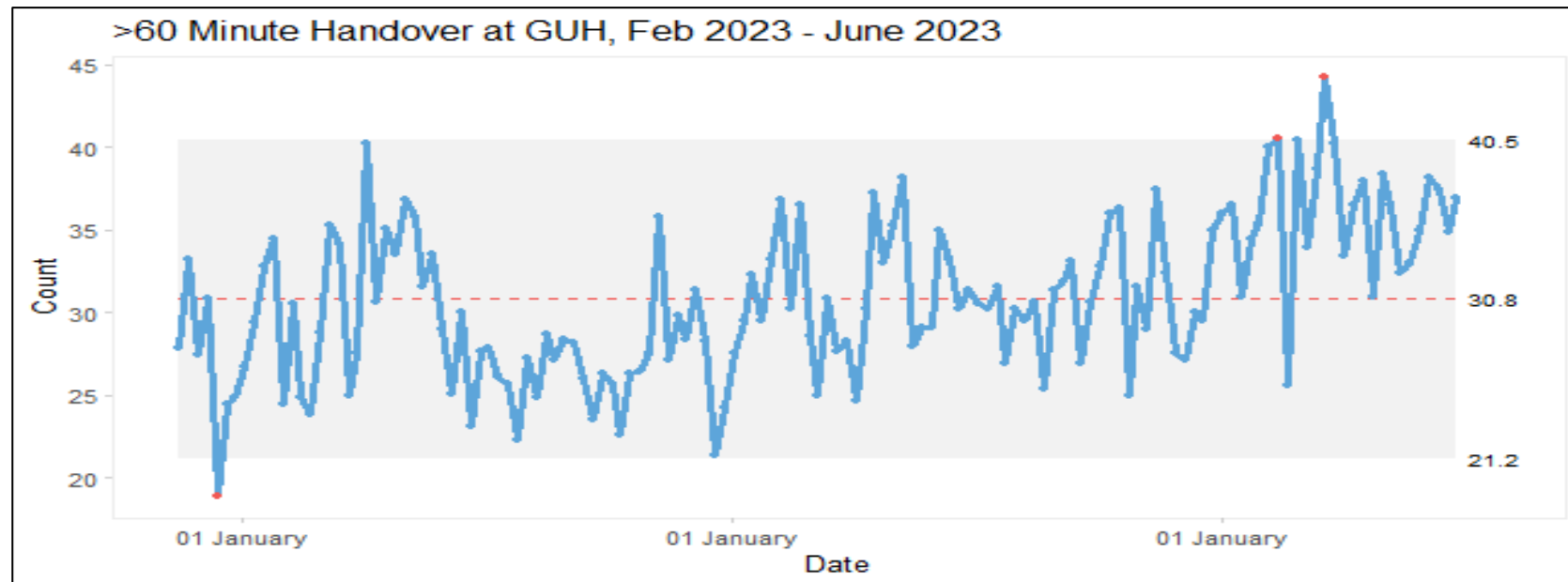
Urgent & Emergency Care

| Issue	Cause	Remedial Action	Who	When
Medical Staffing: Medical Staffing to support the Emergency Department (Demand & Capacity modelling showing deficit for demand)	• Increased activity	• Locum processes in place and reviewed weekly with management team and monthly within Directorate • Ongoing recruitment	General Manager / Divisional Director / Divisional Management Team	Ongoing
	• Vacancies	• Regular review of medical rotas to match demand within financial envelope are in place with site leads.		
	• Implementation of different models of care	• Explore alternative roles e.g. Physicians Assistants, ANPs etc.		
Nurse Staffing: Vacancies with increased number of patients causing additional staffing pressures and associated governance and costs.	• National shortage of registered nurses • Emergency Department Establishment was increased following the move to the GUH • Challenging place to work due to increased attendances, increased acuity, environmental challenges, inadequate flow.	• Recruitments drives for Registered Nurses and HCSWs • Student streamlining • Recruitment of internationally trained nurses • Robust sickness management • Practice Educators working clinically alongside junior staffing • Senior Nurse Point of Contact (POC) • Block-booking of staff secured and robust processes in place to manage roster	Divisional Nurse / Divisional Management Team	Ongoing
Patient Flow: Congestion within the ED (and Assessment Units). Increased presentations / Long lengths of stay / Ambulance delays	• Increased demand • Poor patient flow • Pathways of Care • Increased Delayed Discharges of Care	• Red Line (24/4) in place from 15 May 2023 to support ambulance offloads and long waits in ED • Escalation plan in place to support movement of patients • Comprehensive review of available spaces with Capital Planning colleagues at GUH (Main Wait, Sub-wait and SDEC) • Expansion of ED Main Wait being progressed through Capital Bid Application with Welsh Government • SDEC in GUH open. Predominantly scheduled care utilising but imminent plan to increase medicine usage now AMU has moved to SAU footprint	General Manager / Divisional Director / Divisional Nurse / Divisional Management Team	Ongoing

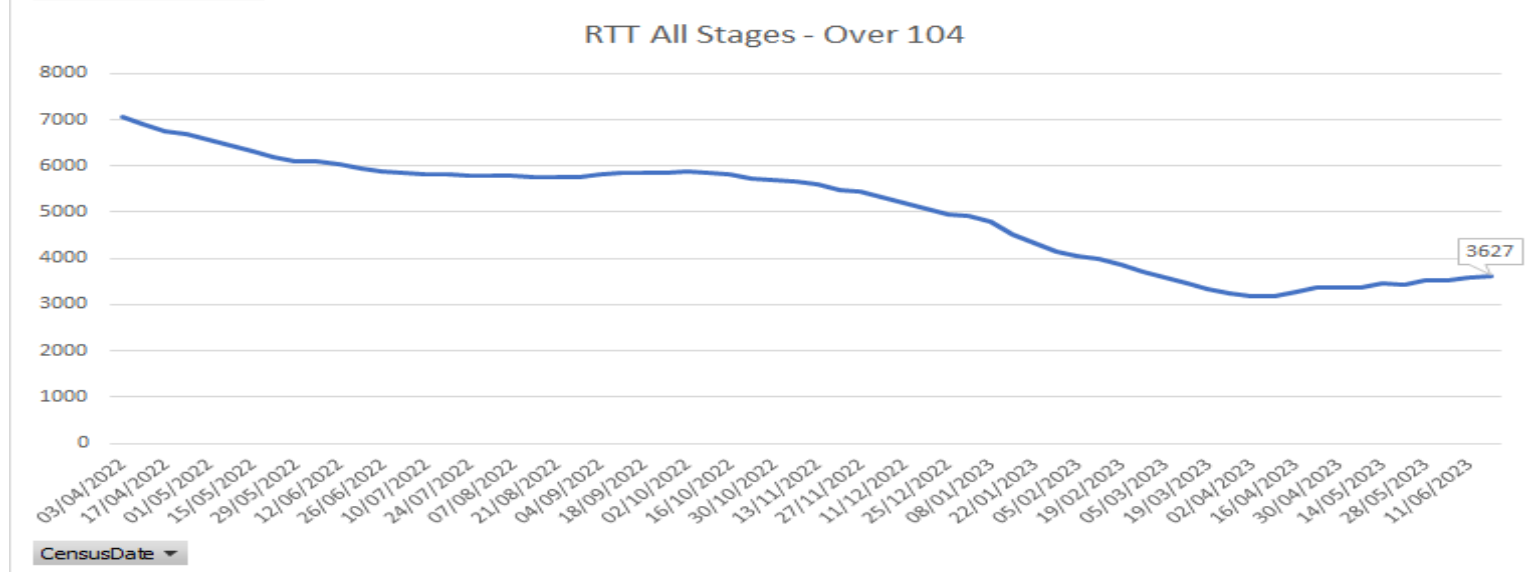# A note on the AB model and its success for Planned Care during Urgent Care pressures

Number of patients waiting over 52 weeks for new outpatient appointment

Number of patients waiting over 104 weeks from referral to treatment
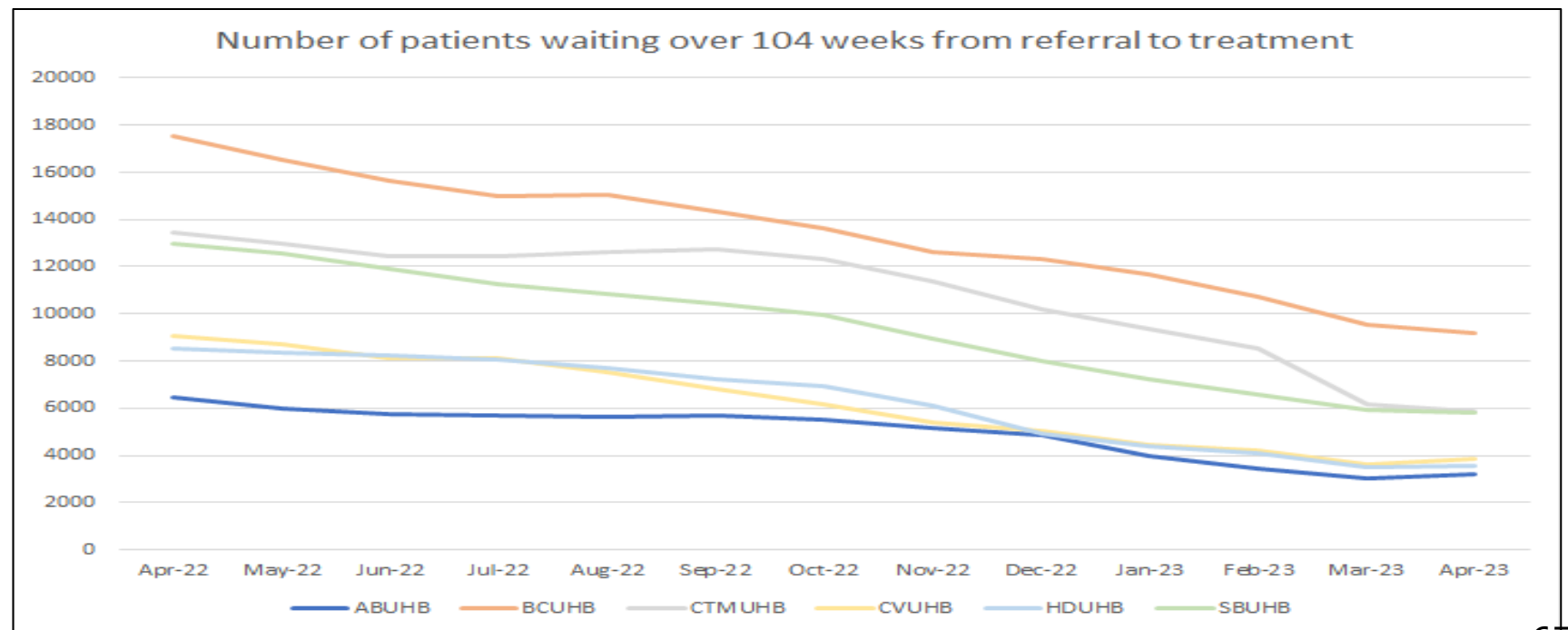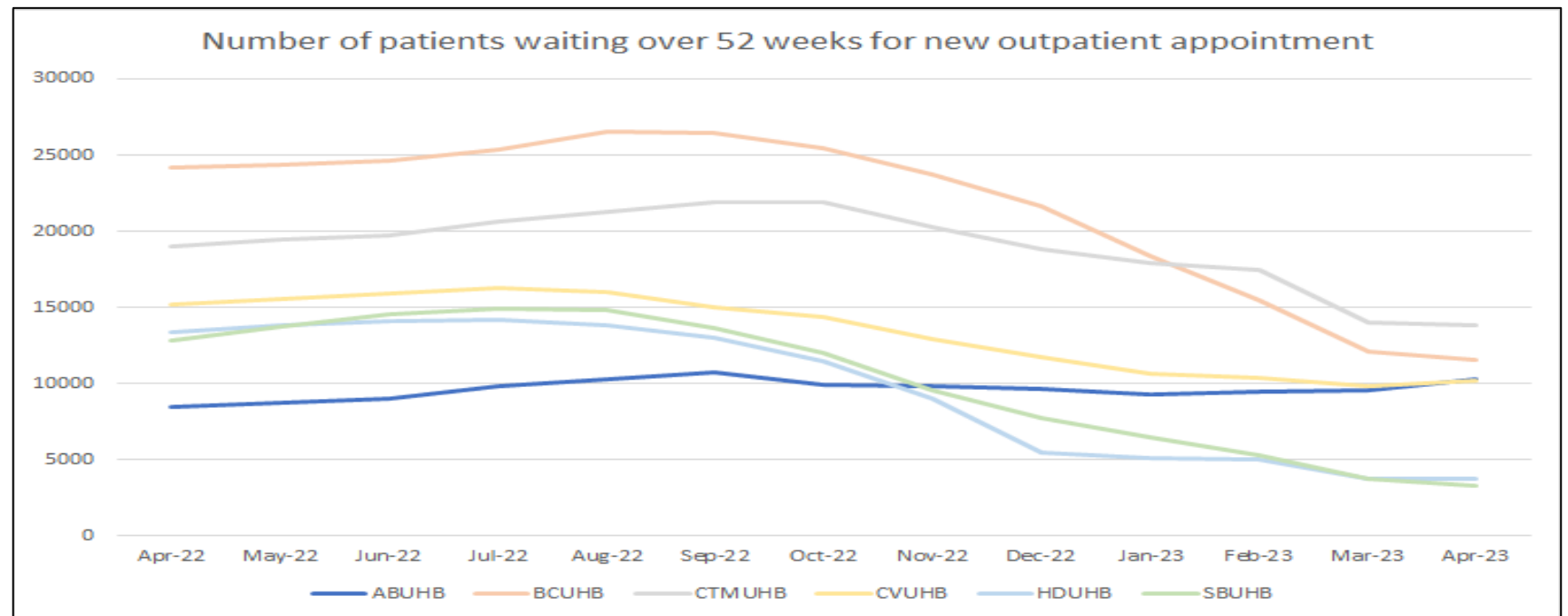
Planned Care

RTT Weekly Snapshot
(reportable activity only)

RTT – Stage 1 (New Outpatients) Over 52 Weeks
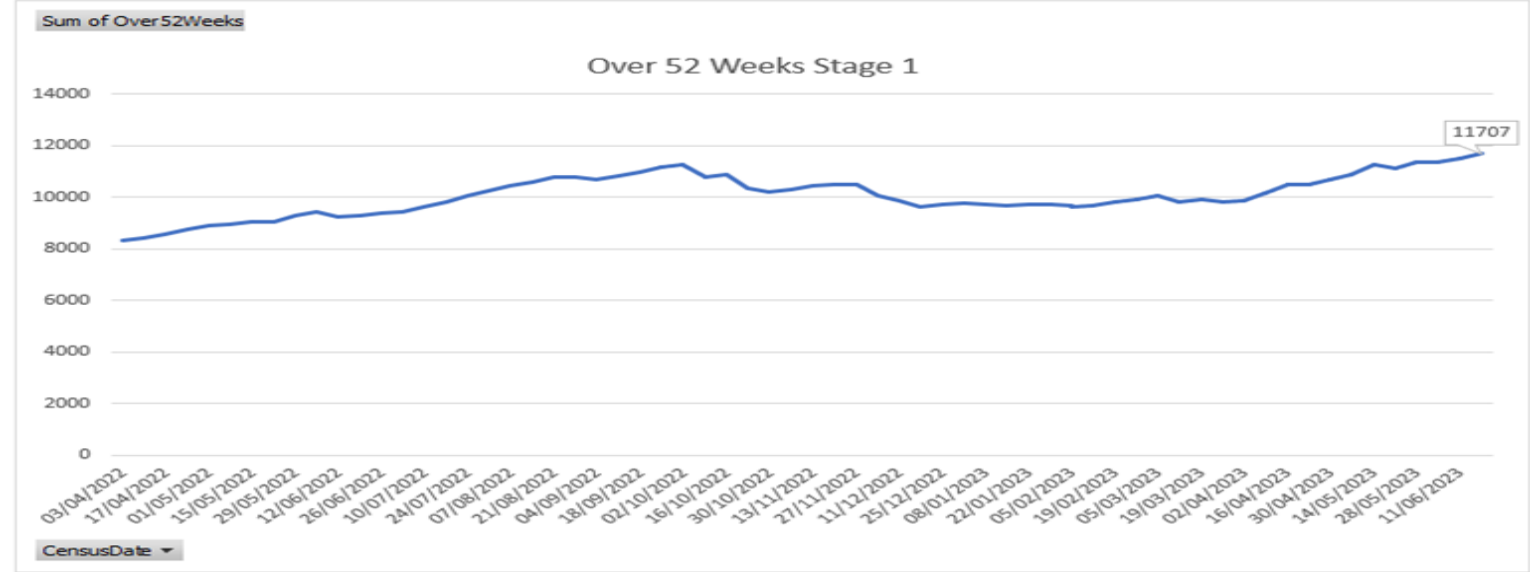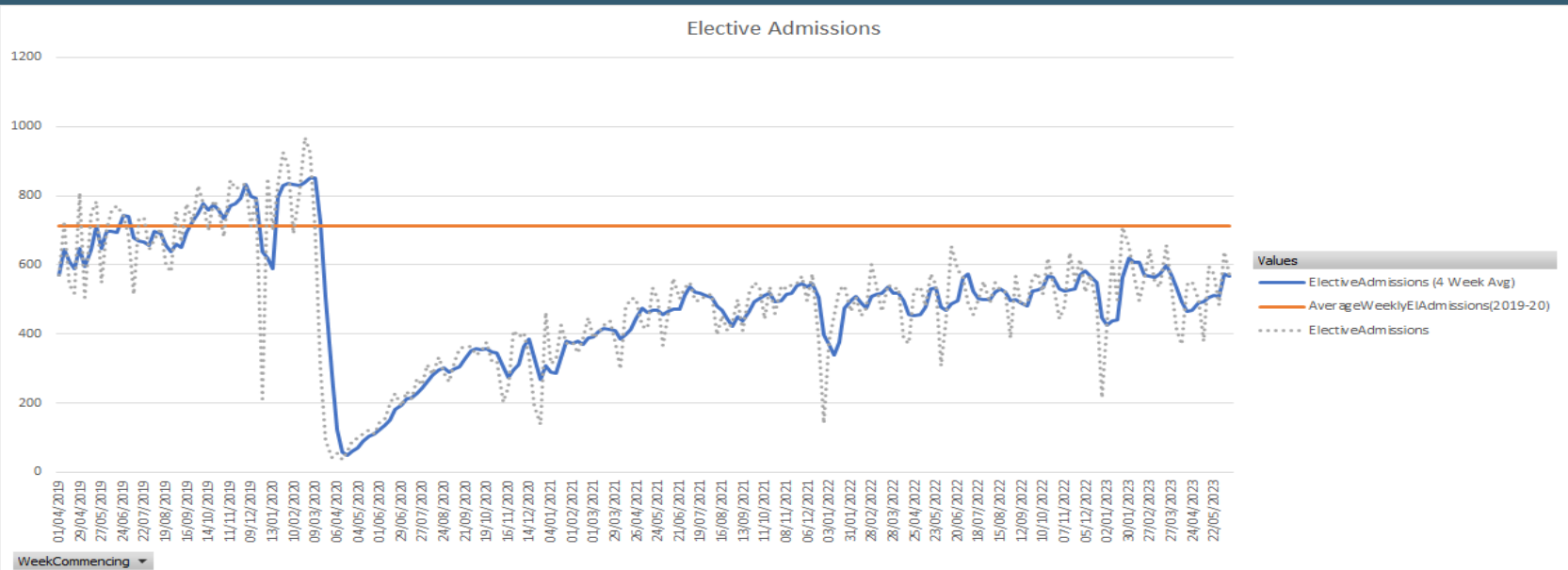

RTT – All Stages Over 104 Weeks

Planned Care

Activity Summary

New Outpatient Attendances (RTT Specialties Only)
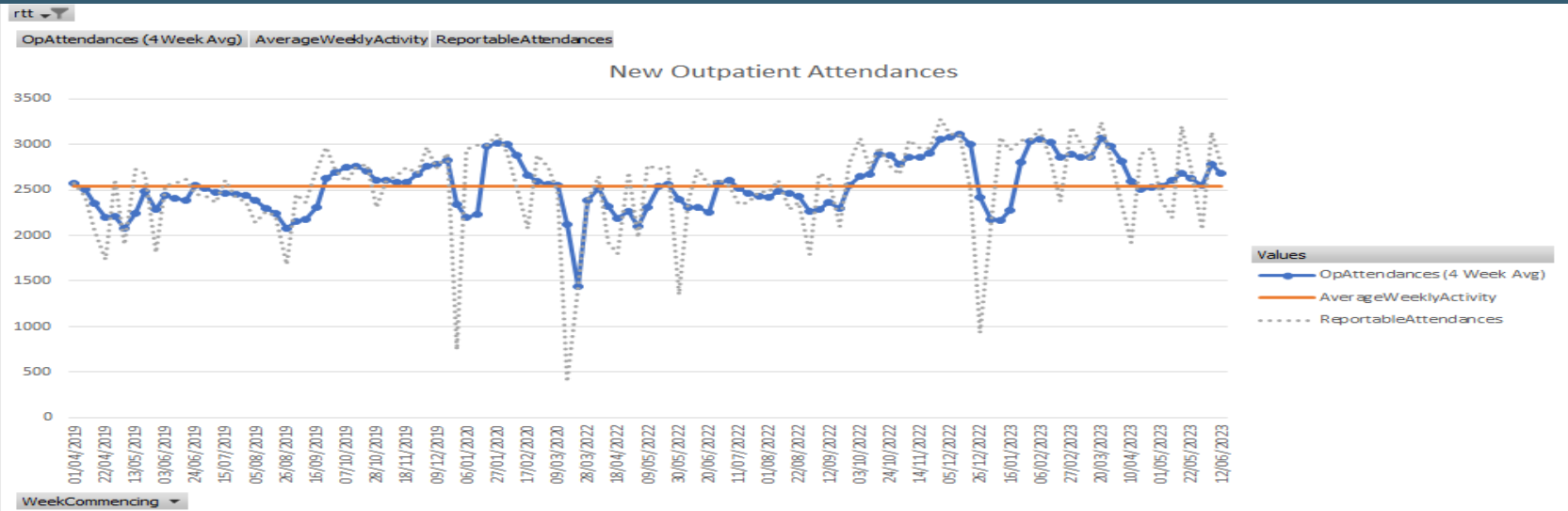
Elective Admissions (Surgical Specialties Only)

Planned Care

Performance Overview – Actual (Waiting List Snapshot 30/04/23) against Model Forecast

Outpatients

Over 52 Weeks Stage1(Current Week)	Change Stage 1 Over 52 Weeks (past 5 weeks)	Model Forecast Over 52 Weeks St 1 (Current Month)
11707	451	10729
		978

reporting_category	RTT Reportable

Over 104 Weeks Stage1 (Current Week)	Change Stage 1 Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks St 1 (Current Month)
1443	246	625

Division/specialty	Over 52 Weeks Stage1 (CurrentWeek)	Model Forecast Over 52 Weeks St 1 (CurrentMonth)	Variance Against Model New Over 52 Weeks	% Var Againt Model St 1 52W Status	Change Stage 1 Over 52 Weeks (past 5 weeks)
⊞ Clinical Support Services	40		40	🔴	0
⊞ Family and Therapies	48		48	🔴	-21
⊞ Medicine	8		8	🔴	2
⊟ Scheduled Care					
Ear Nose & Throat	4033	3722	311	🔴	224
General Surgery	20		20	🔴	-6
Maxillo-Facial	485	168	317	🔴	72
Ophthalmology	4133	4492	-359	🟢	225
Orthodontics	124		124	🔴	-23
Trauma & Orthopaedic	1870	1409	461	🔴	-53
Urology	946	938	8	🟡	32
Grand Total	11707	10729	978	🔴	452

Stage 4 Treatments

Over 104 Weeks (Current Week)	Change Over 104 Weeks (past 5 weeks)	Model Forecast Over 104 Weeks (Current Month)
1648	-56	1260
		388

Over 156 Weeks (Current Week)	Change Over 156 Weeks (past 5 weeks)	Model Forecast Over 156 Weeks (Current Month)
485	-121	306
		179

Division/specialty	Over 104 Weeks All Stages (Current Week)	Model Forecast Over 104 Weeks (CurrentMonth)	Variance Against Model Over 104 Weeks	% Var Against St 4 104	Change Over 104 Weeks (past 5 weeks)
⊟ Scheduled Care					
Ear Nose & Throat	223	215	8	🟡	-18
General Surgery	97	0	97	🔴	21
Maxillo-Facial	10	0	10	🔴	1
Ophthalmology	61	0	61	🔴	48
Trauma & Orthop	1089	1045	44	🟡	-85
Urology	168	0	168	🔴	-23
Grand Total	1648	1260	388	🔴	-56

Planned Care Recovery Programme

Exec Lead:	Hannah Evans	SRO:	Rich Morgan Evans

Programme Objective

The Planned Care Recovery Programme brings together 6 goals (**Outpatients, Maximising Elective Capacity, Patient Access and Activation, Health Pathways, Planned Care Academy and Diagnostics**) in line with the WG national programme and planned care response. Progress in each of the workstreams is being made, which feed into the overall HB and national agenda.

What Went Well this Period

- **Diagnostics** board instigated
- **Theatres** stakeholder event took place- detailing improvements being rolled out across teams
- **Patient Access and Activation-** website now live and QR codes added to patient letters
- **Health Pathways-** Clinical Editors recruited and due to start 3rd July
- **Outpatients** continue to develop response plans and roll out
- **Planned Care Academy** – task and finish groups agreed and leads nominated
- RTT reporting developed, with consistent information in dashboard format, shared with DU

Key Milestones and Deliverables for the Next Period

- Development of Planned Care Academy task and finish groups
- Patient Access and Activation – opportunity to apply for WG funding to develop waiting well services
- Health Pathways – pathway development to begin and timeline for go live to be detailed
- Further development of consistent RTT reporting

Key Risks

- Ongoing challenges of capacity of system
- Utilising core activity with the removal of WLIs to deliver to targets
- National, regional and local initiatives pose risk to pull organisation in differing directions.

For Information

Section 4

Quality Strategy Implementation Plan

- ➢ Attending Divisional meetings to discuss embedding Quality Strategy.

- ➢ Patient Experience & Involvement Strategy being implemented with roll out plan.

- ➢ Executive team meeting with QI leads – Maxine Power and David Doulton.

- ➢ Interntaional Quality Conference in Copenhagen – sharing themes and experience.

- ➢ Developing annual operating framework, implementation plan and assurance framework. To ensure triangulation of data.

- ➢ Workplan being refined, including deteriorating patients, NRIs and never events in theatres and radiology.

- ➢ Reviewing PQSOG and establishing forum for learning. Including membership and purpose of the Group (additional members to include WF & OD).

- ➢ Safe Care Collaborative ongoing.

Quality pillars as defined in the Quality Strategy:

1 Patient and staff experience and stories	Health, Safety and Security 4
2 Incident Reporting – falls, pressure ulcers, medicines management, mortality	Infection Control and Prevention 5
3 Complaint, concerns and compliments	Safeguarding 6

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will review our performance.

Next Steps

- Person centred approach – 'what matters to me' directly involve our patients and staff in improvement, service delivery and change

- Review and monitor WG Quality & Engagement Act deliverables as part of the delivery of the Quality Strategy

- Refine key objectives for Quality & Safety for the next twelve months for monitoring, review and evaluation.

- Delivery plan as part of Quality Strategy will map goals and timeframes with SMART objectives and a Quality Outcomes Framework. Including workplan for PQSOC.

- Safety walk arounds reinstated from May 2023.

- Ongoing review of QPS/ QI resources.

- 'Big conversation' around Quality Improvement in Autumn.

- Safety First - a redesigned approach to incident/ serious incident management and decision making. First meeting in August.

- PTR and QPS teams working together to develop a plan for learning and sharing of incidents. Strengthened Divisional learning / reporting through Governance structures.

- Embed an open and transparent learning organisation, with a just culture, incorporating psychological safety, human factors and wellbeing.

Inpatient Falls Data

Severity of Harm

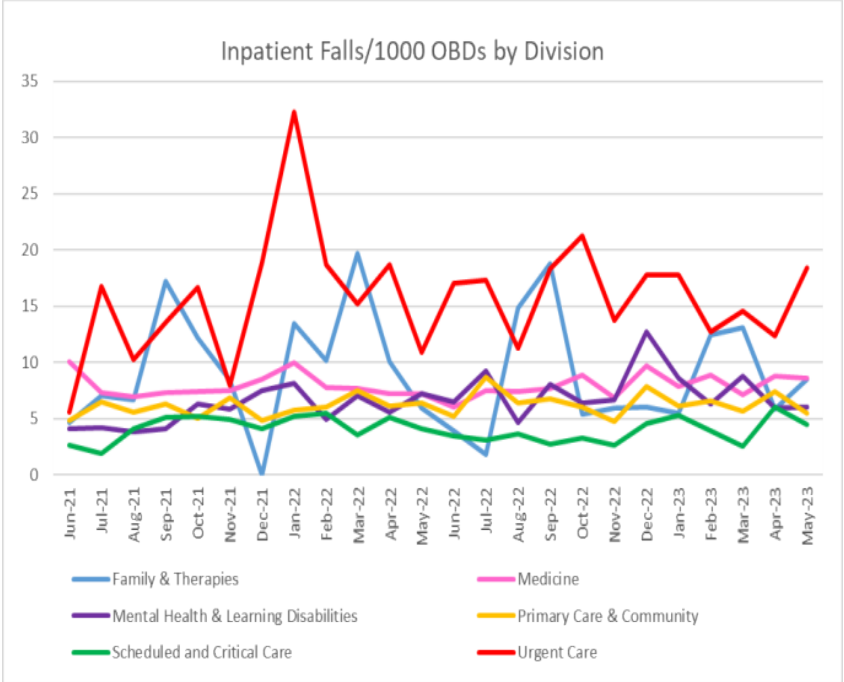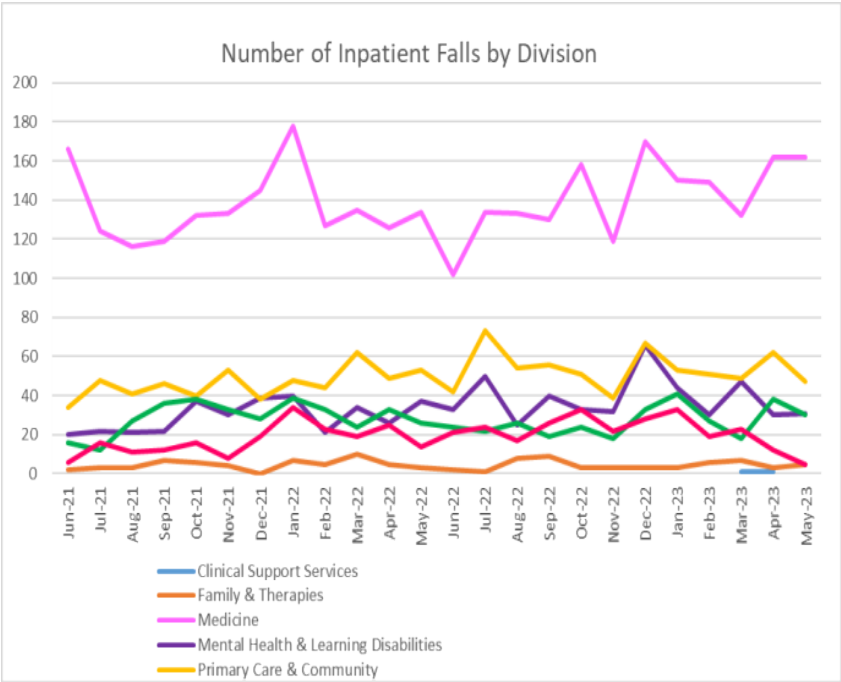| Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	Of the total numbers of falls incidents reported the severity of harm is categorised as follows: • 39% - No harm • 50% - low harm • 10% - Moderate harm • 0.9 % Severe harm • 0.1 Catastrophic	

Total Numbers of Inpatient Falls

Total Numbers of Inpatient Falls May 2021- 2023

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• The mean average number of monthly falls for ABUHB has seen a marginal increase from 270 to 272. • For the year 2022-23 incident reporting numbers remain subject to a greater degree of variation as compared to 2021-22.	December 2022 saw the highest numbers of reported falls incidents since January 2022 at 369. April 2023 represents the second highest value for reported incidents in the given period.

Inpatient Falls Data by Division

July 2023 - Context

The data used in this chart has been retrieved from Datix.

Definitions	What the chart tells us	Variation
Reported fall incidents in Aneurin Bevan University Health Board (ABUHB). This data was retrieved from Datix as the information source.	• When looking at total number of falls occurring in each Division, the wards that have the higher number of frail, older patients and longer lengths of stay, have the highest number of falls (medicine and community wards), which is not entirely unexpected. • When looking at the rate of falls by Division (falls per 1000 occupied bed days) then it highlights Divisions that have an unexpected higher rate (urgent care and family & therapy)	• The variation for urgent care and family & therapy Divisions suggests patients are either staying longer in these areas than is expected or that the patient cohort is not as expected, i.e. patients on wards outside their specialty • The two Divisions showing an unexpected higher rate of falls, also show more variation in rate over time.

Inpatient Falls

- Continue to scrutinise inpatient falls data to identify trends and abnormal variation, at individual ward level, which informs targeted intervention and support for those areas of concern and to highlight areas of improvement and good practice.

- Routine ward level audit of falls assessment and care plan compliance.

- Ongoing programme of multidisciplinary training and awareness raising at ward level, to support compliance with the Hospital Falls Policy.

- Weekly focus at Executive Safety Huddle on individual falls incidents and trends.
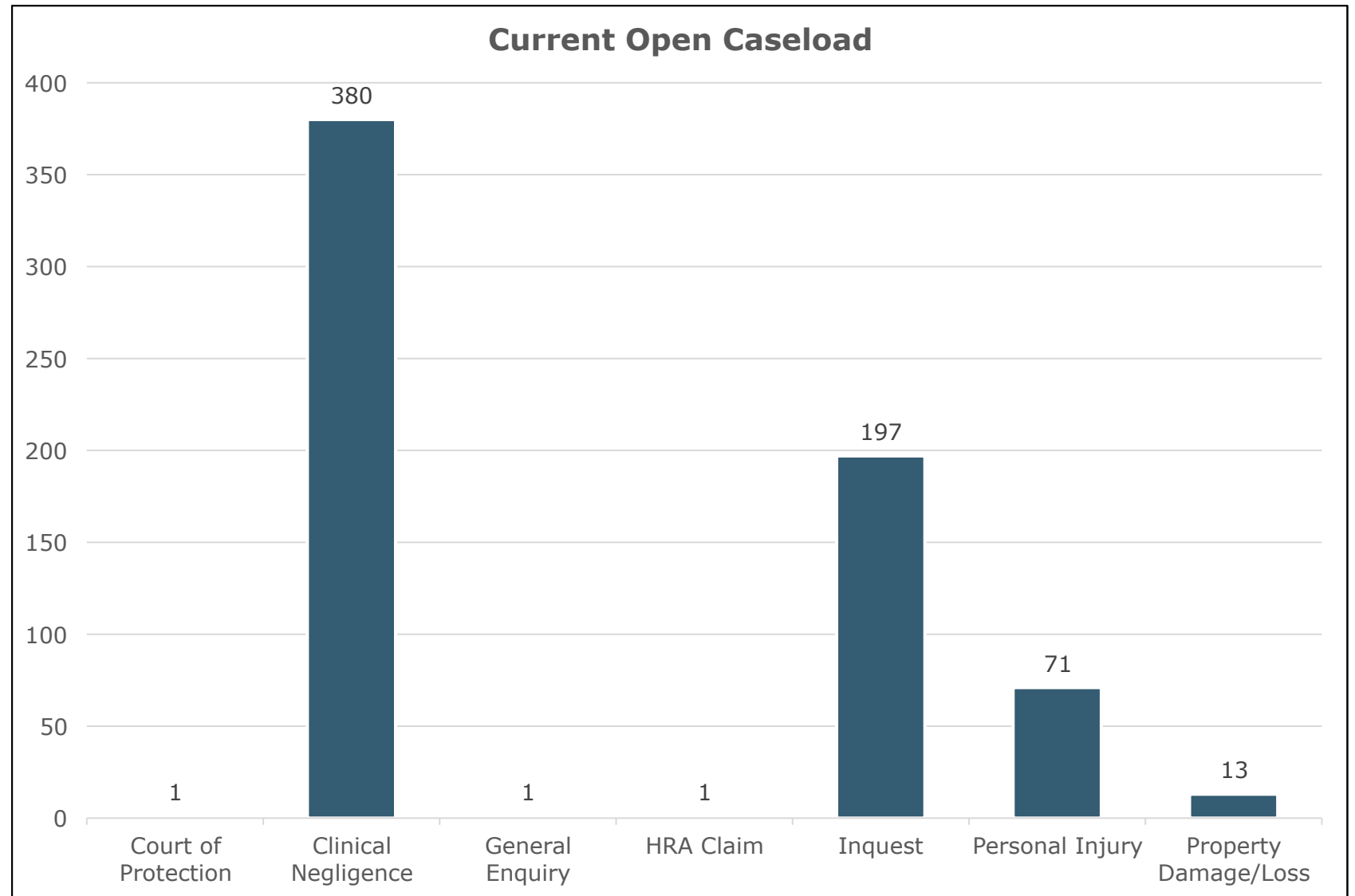
Learning from Complaints

Issue	Cause	Remedial Action	Who	When
Families not being updated in a timely manner regarding patient care and management plans.	Poor/inadequate communication	A pilot scheme is being introduced with dedicated time slots within the ward so that families/carers can meet with the members of the medical team to discuss any concerns and receive updates on management plans	COTE	C4 June 2023 – trial for two months with plan to rollout to D4 West if successful
Lost patient property	Inadequate monitoring, process	Sign in process introduced for all property that is input and removed from the safe. Ensuring appropriate logging and tracking of items.	Anwylfan Ward	December 2022
Care and treatment of gentleman at the GUH and RGH	Poor communication, between Primary and Secondary Care, and the family 2805	To assist with improving communication staff attending 'Sage and Thyme training' which teaches Health Board professionals to recognise and respond to the emotional distress of patients and their families. It is an evidence-based course that aims to increase participants' confidence and competence in listening and responding to the concerns of those who are distressed and to communicate honestly and compassionately.	Senior Nurse	Staff are attending this course, with further dates planned
Manner and tone of staff, e.g. rude attitude	Inappropriate behaviour	Patient and family satisfaction questionnaires have been implemented on all wards to identify areas for improvement. Patient and family feedback has also been actioned through the Fundamentals of Care Annual Audit. Following feedback, patient call bells are now within easy reach for patients, this is being monitored and documented in the notes.	Risca Ward (YYF)	The patient questionnaires were implemented April 23 With CIVICA surveys/QR codes planned for July 2023

Claims, Redress & Inquests

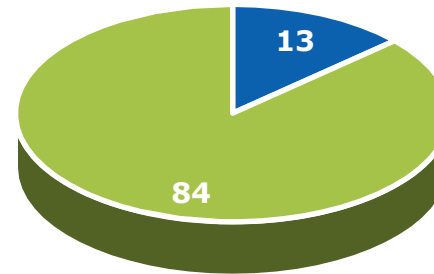## Highlight Events May – June 2023

- 3 Redress Panels held in period

- WRP Penalties applied across Welsh Health Boards

- Spike in new Coroner inquests (over 200 live matters)

- Attendance All Wales Networks (Claims; Redress; Inquests)

- Submission of data for PTR Annual Report 2022-23
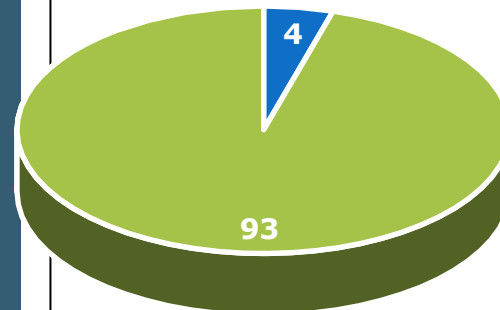
Claims, Redress & Inquests

Current Open Caseload

Category	Value
Court of Protection	1
Clinical Negligence	380
General Enquiry	1
HRA Claim	1
Inquest	197
Personal Injury	71
Property Damage/Loss	13

Claims, Redress & Inquests

WRP Case Penalties Pre Appeal

- 13
- 84

■ ABUHB ■ Other Health Boards (As applicable)

WRP Case Penalties Post Appeal
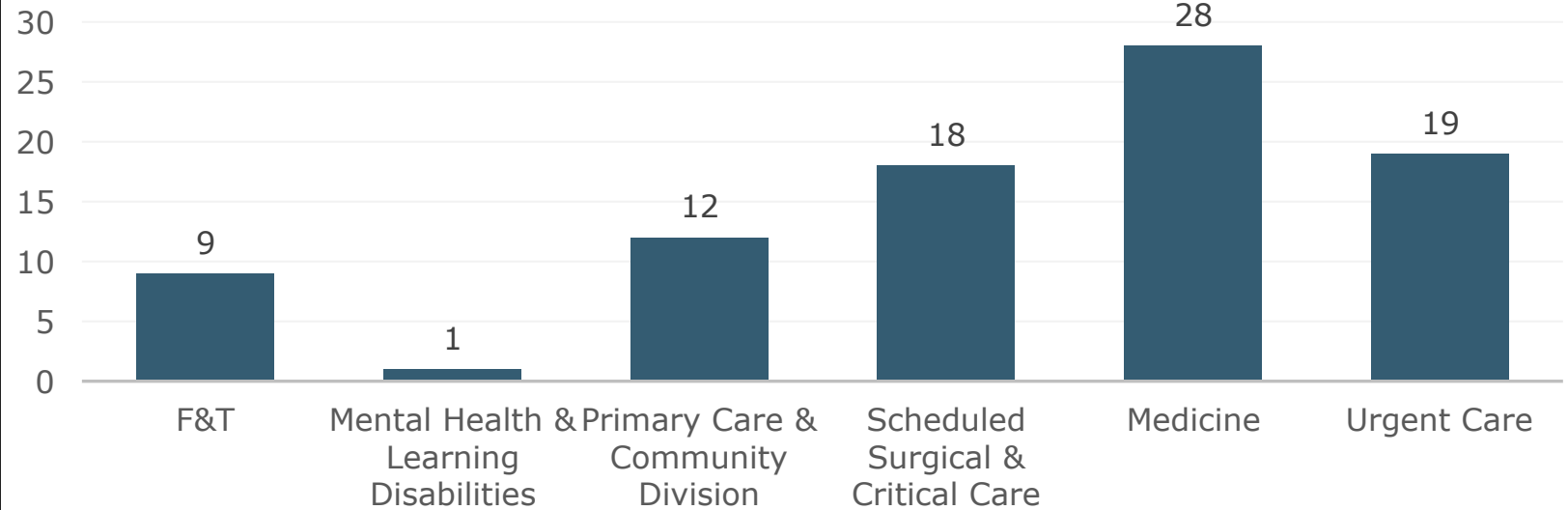

- 4
- 93

■ ABUHB ■ Other Health Boards (As applicable)
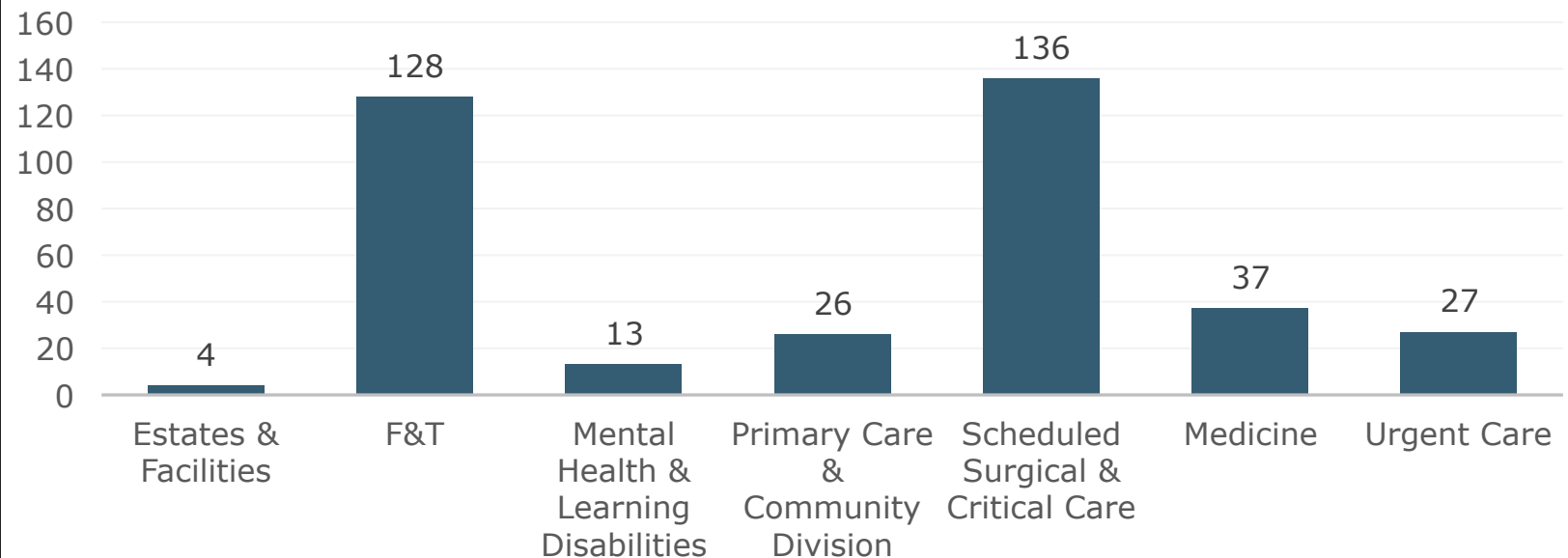
WRP May Committee

- All Wales Penalties for late submission of learning information

- ABUHB – 13 of All-Wales Penalties

- On appeal – reduced to 4

- SBAR presented to Executive Team

- SOP under development

- Team conducting rolling review to target and complete outstanding matters

Claims, Redress & Inquests

Redress by Division

Clinical Negligence by Division

Claims, Redress & Inquests

Issue	Cause	Remedial Action	Who	When
Regulation 28 Reports issued by HM Coroner: Health Board assurance as to prevention of future deaths.	On conclusion of inquest Coroner has identified areas of concern that could give rise to future patient harm/deaths requiring attention/assurance from the Health Board	• Submission of detailed learning/Actions Plans ahead of inquest; identify suitable witnesses to give evidence at inquest. • Process introduced for timely internal management and QA following receipt of Coroner report. • Monitor and Tracking Report to ensure compliance.	Head of Legal Services	Ongoing
Responsiveness to Coroner requests; timely submission of witness statements & SI reports; meeting expectation of Coroner and families; risk of reputational harm.	ABUHB has high numbers of Coroner requests and inquests held within the Gwent area. This has a significant impact on staff numbers involved in an inquest, time and resources.	• Members of team have been dedicated to Coroner work to reduce backlog and provide timely responses. • Support provided to staff across the Health Board during their inquest journey. • Regular meetings with Coroner to address issues and work constructively together.	Head of Legal Services	Ongoing
Learning and Financial Reimbursement submissions to Welsh Risk Pool within prescribed timeframes. Financial penalty and/or risk of refusal to reimburse.	Every claim requires submission of learning. Financial reimbursement only granted once full vetting and assurance of all learning/actions	• LFER status tracked on rolling basis to meet deadlines. • Monthly reporting to track all payments made • Monthly updates on upcoming submission deadlines	Head of Legal Services	Ongoing

COVID-19 Investigations

	Wave 1 (27/02/2020 – 26/07/2020)	Wave 2 (27/07/2020 – 16/05/2021)	Wave 3 (17/08/2021 – 19/12/2021)	Wave 4 (20/12/2021 – 30/04/2022)**
Total Incidents	316	1120	321	1023
Investigations Not Started	0	913	144	733
Under Investigation	0	37	5	22
Downgraded/ Recatergorised	32	39	122	194
Referred to Scrutiny Panel	0	51	7	35
Completed Investigations	284	80	43	39
Check +/-	0	0	0	0
Deaths	147	373	50	116

Wave 1: 100% complete

Wave 2: 33% complete

Wave 3: 93% complete

Wave 4: 36% complete

Highlights:

- Team performance tracking required trajectory to complete programme on time with staff resource in post
- No cases referred to Legal & Risk
- Recruitment of vacancies complete
- Incoming enquiries from patients and/or relatives extremely low
- No queries post investigation outcome responses
- No increase in support requests to Llais

Challenges:

- Retention of FTC staff
- General record keeping and access to information

Mitigating Actions:

- Early conversations regarding staff plans and redeployment
- Working with divisional colleagues

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Retention of fixed term contract staff	High Fixed term contract resource & high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion. Non-Clinical Investigator strategy tried & tested, recruited into vacancies. Early conversations with staff re: next steps and redeployment.	COVID-19 Investigation Team (CIT)	Ongoing
Investigation resource to undertake live wave in line with Duty of Candour.	Out of scope of the NNCP framework.	Actions with IP&C	IP&C	Ongoing
General record keeping & access to information	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues. Improvement seen late June.	COVID-19 Investigation Team (CIT)	Ongoing

COVID-19 Investigations Programme Risks

Issue	Cause	Remedial Action	Who	When
Delayed start to programme & resource to complete programme on time.	High FTC resource and high risk of losing resource prior to 31 March 2024.	Requested 3 Month extension (to 30 June 2024) for critical resource to secure programme completion. Non-Clinical Investigator strategy tried & tested outcome positive. Further recruitment in progress.	COVID-19 Investigation Team (CIT)	Ongoing
Investigation resource to undertake live wave in line with Duty of Candour.	Out of scope of the NNCP framework.	Actions with IP&C	IP&C	Ongoing
Availability and time to locate clinical notes.	Mental Health notes in off-site storage facilities.	Liaising with Health Records colleagues	COVID-19 Investigation Team (CIT)	Ongoing

Safeguarding

Data Analysis and Safeguarding System Assurance

Following the launch of the Quality Strategy, the Corporate Safeguarding Team is exploring what measures it can put in place to monitor quality and performance.

These will include: -

- Training Data

- Activity Data
  – Child Protection Medicals
  – PRUDiC's
  – Child Strategy Discussions
  – Section 5 Practitioner Concerns

- Audit Schedule

- Service User Feedback

Whilst processes are in place to monitor quality and performance systems of independent contractors, these need to be strengthened in relation to safeguarding, in order for ABUHB to be assured.

Safeguarding

Current Practice Reviews

The Corporate Safeguarding Team are currently supporting Safeguarding Boards with:

- ➢ 4 Child Practice Reviews
- ➢ 1 Adult Practice Review
- ➢ 4 Domestic Homicide Reviews

Recently published reviews have been presented to Safeguarding Committee, which have highlighted the need to formalise how learning is embedded in to practice.

The Safeguarding Committee has established a Sub Group to maintain a composite action plan in relation to the published reviews and to monitor progress.

A developing theme from the Domestic Homicide Reviews is around professional curiosity and how we encourage staff to have wider conversations with patient and their carers in regard of general welfare/safety. This is being addressed through Safeguarding Level 3 training and Ask and Act Training.

Safeguarding

Training and Development

- ABUHB is required to provide Safeguarding Training in relation to Children and Adults in line with national standards.
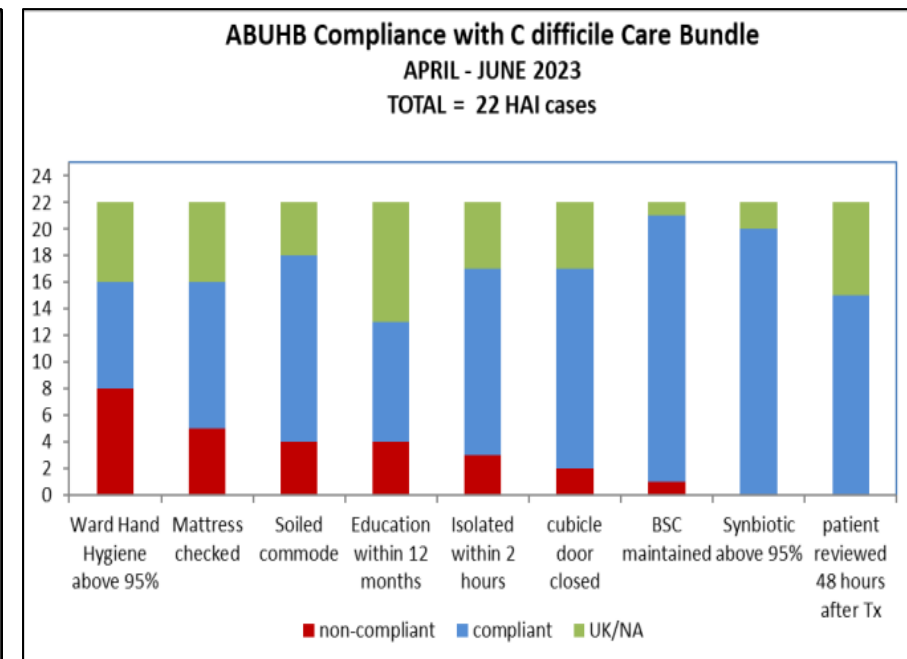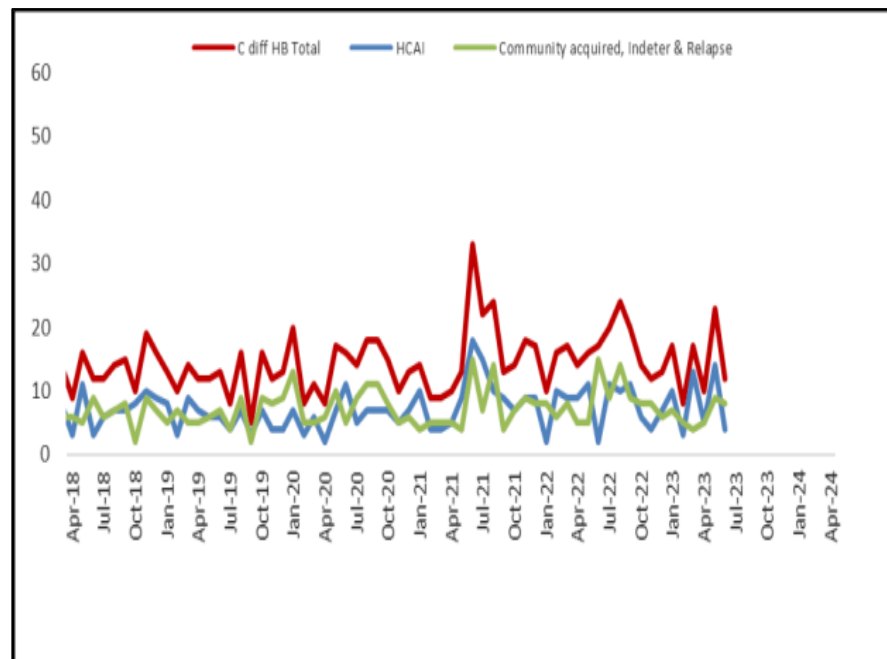
- Current training compliance:

Level	Adult	Children
1	84.07%	83.05%
2	84.57%	82.03%

- Safeguarding level 3 training packages have been revised and commenced in April 2023. Evaluating well at the current time.

- Divisional leads urged to support the training plan by encouraging staff to book on to training. To ensure this is manageable it has been suggested that higher banded staff (6-7s) attend first then gradually working down to their Band 5 staff.

Safeguarding

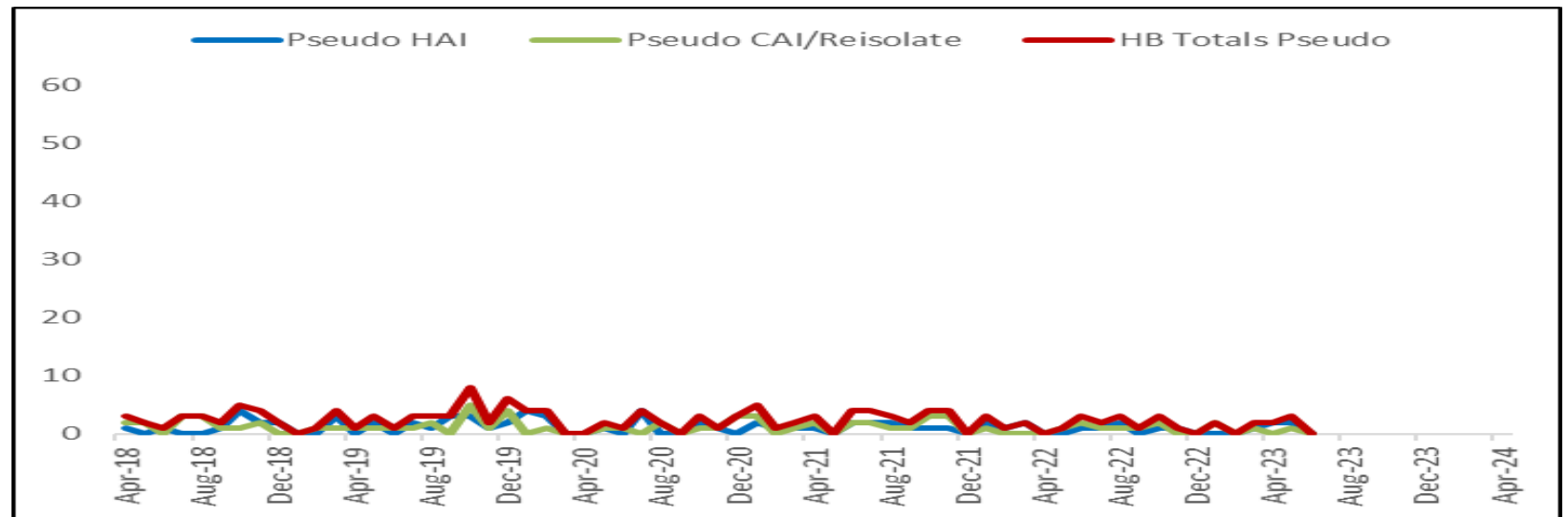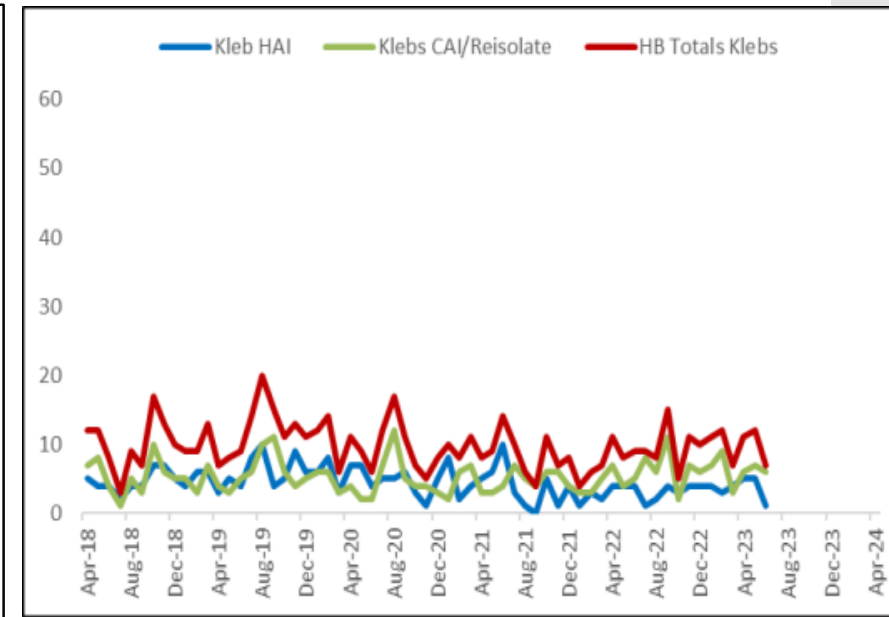| Issue	Cause	Remedial Action	Who	When
Timeliness and Quality of Safeguarding Referrals from ABUHB Professionals	Practitioners are not always recognising the requirement to refer or prioritising the completion of the DTR forms. Some staff do not feel confident I reporting concerns, therefore await management approval/assistance to do so.	• Head of Safeguarding to write to Divisional Nurses and ask that the importance of timely completion of DTR's is shared • Models of Safeguarding Supervision to be explored in some priority areas.	Corporate Safeguarding Team All Divisions	Ongoing
Poor compliance/ uptake of Adult Level 3 Training	• Staff shortages impacting volume able to attend training • Understanding the value of the training for staff groups identified in the intercollegiate document • Training not mandated via ESR	• Mapping of staff groups requiring level three safeguarding training now complete • Discussion at Safeguarding Committee and request to Divisions to actively encourage engagement • Discussions with ESR to have Level Three training added to this platform ongoing	Corporate Safeguarding Team	Ongoing
Concerns regarding findings of Child Protection Medicals not always influencing outcomes for children believed to be at risk of harm	• Multi agency partners do not always unde4stand the terminology used in reports. • Report Authors are not always invited to present their report at Initial Child Protection Conferences (ICPC) • ABUIHB staff not aware of escalation procedure where they feel that the outcome of the ICPC may not be safe.	• Head of Safeguarding to present to managers of Children's Services and Police regarding our concerns. • Local authorities to ensure report author is invited so they can attend or send a deputy • Gwent Safeguarding Professional Escalation Policy to be circulated to those attending meetings on behalf of ABUHB and to be highlighted in Safeguarding Supervision	Corporate Safeguarding Team	August 2023

C difficile

ABUHB Compliance with C difficile Care Bundle
APRIL - JUNE 2023
TOTAL = 22 HAI cases

Issue	Cause	Remedial Action	Who	When
Cluster of C difficile – RGH & NHH	Suboptimal prescribing Fundamentals of care	• HPV clean • Practical demonstrations • Promote HB App for Antx presx • National strategy – Gap analysis	IPT AMR Pharmacists RNTG	June 2023 July 2034
Increase of relapse C difficile cases	Request for clearance lack of Antx review	• Promote clearance screens not required • Deep dive to review learning	IPT Consultant Microbiologist AMR Pharmacist	Ongoing June/July 2023

Staph Aureus
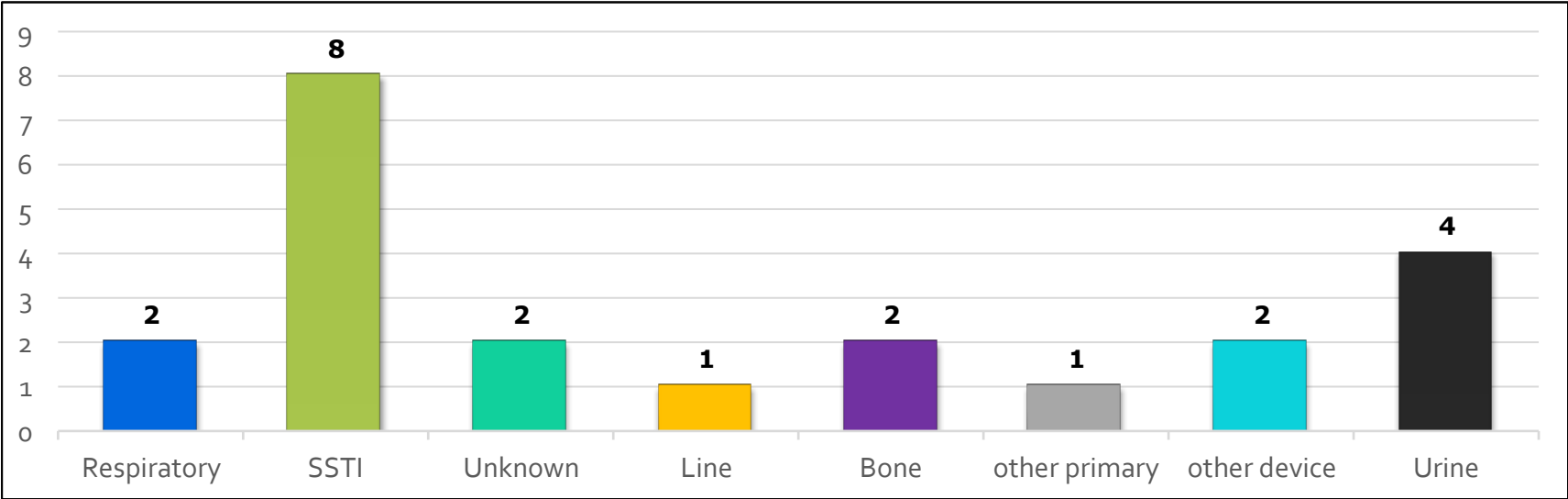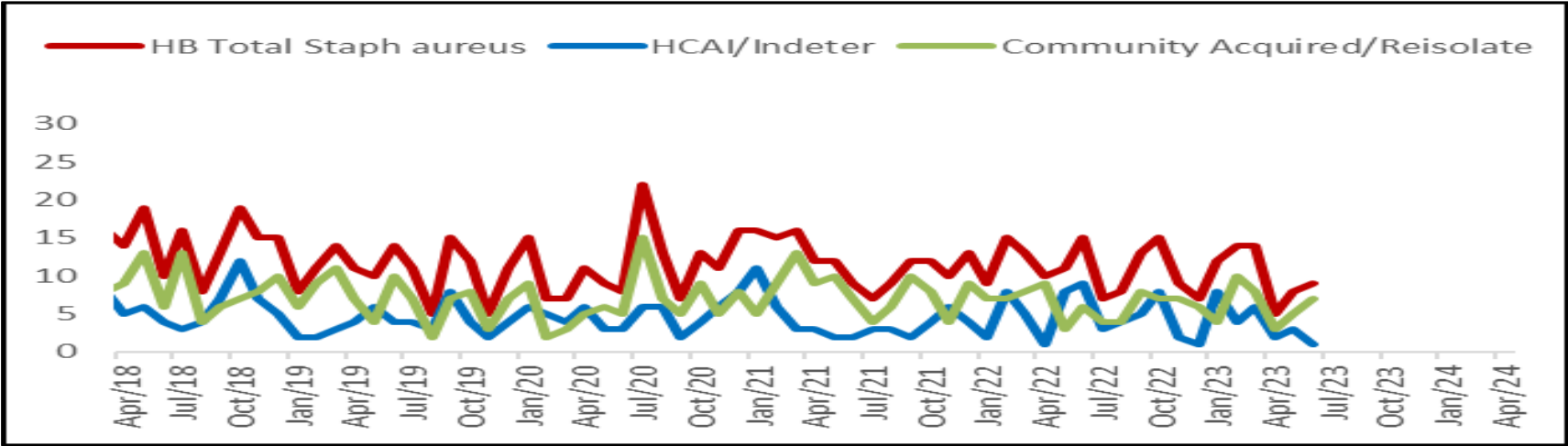
Issue	Cause	Remedial Action	Who	When
2 cases of MRSA bacteraemia (May)	Post urinary catheter change Line infection	Promote Aseptic non touch technique MRSA Screening audits, feedback and ward action plans	MDT IPT	June

Gram Negative Blood Stream Infections
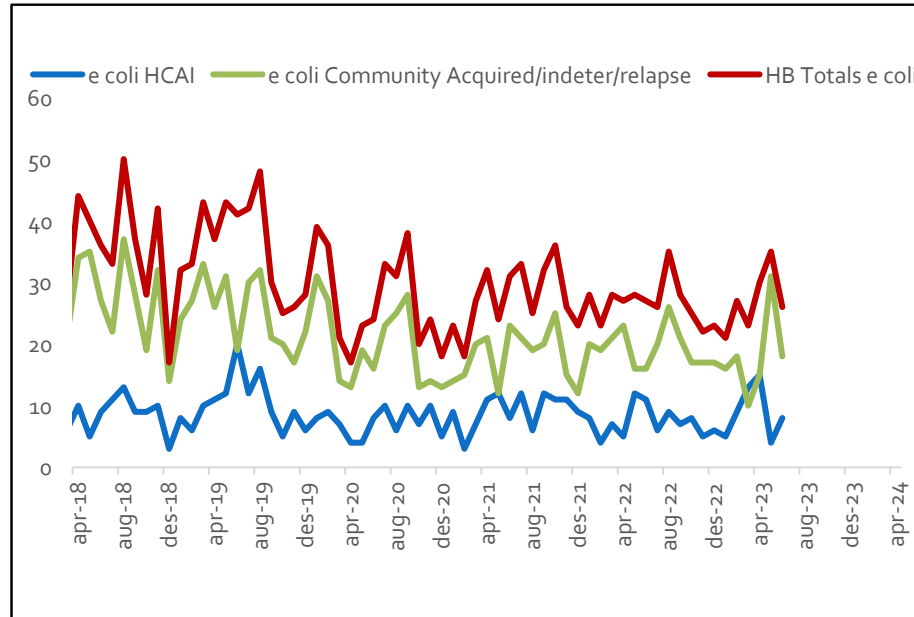
Gram Negative Blood Stream Infections
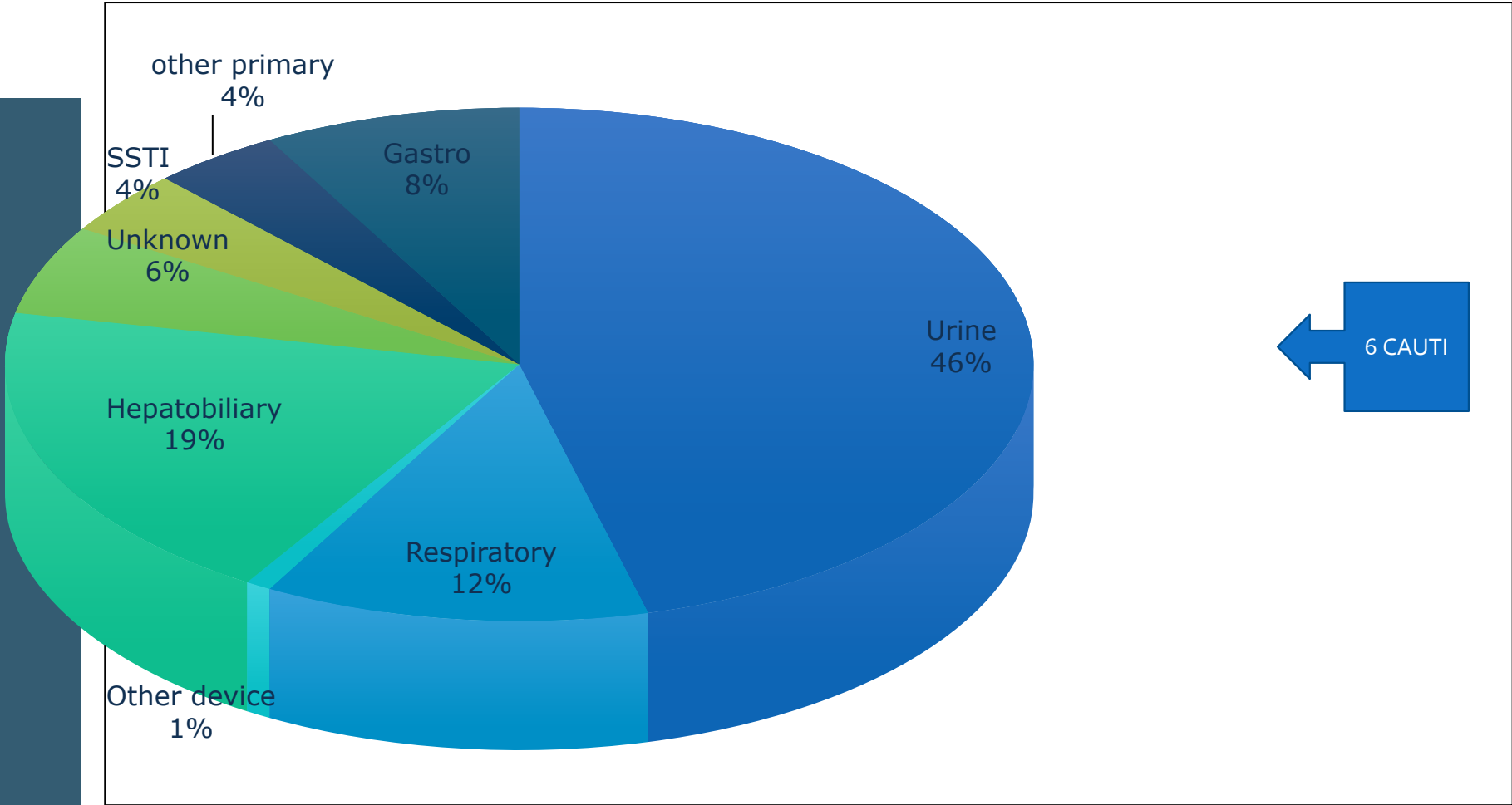
Issue	Cause	Remedial Action	Who	When
Increase in GNB infection	Seasonal variation linked to AKI and UTI	Promote patient hydration Initiatives to reduce unnecessary use of urinary catheters (increased risk of CAUTI and BSI): Community Nursing Trial Without Catheter, HOUDINI Dehydration e-learning package for Care Homes (Public Health Wales)	MDT	Ongoing

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
Ty Lafant	31/01/23-01/02/23	✓	9	28	**1**	50	88	**6**

Outstanding Actions			
The health board must provide HIW with details of how it will ensure that robust processes are put in place to ensure that restraint incidents are being effectively recorded, investigated, managed and scrutinised in order to prevent reoccurrence and encourage shared learning. Measures must be taken to ensure that all relevant details of restraint incidents are captured and recorded to include all involved members of staff and their actions throughout the incident.	The Health and Safety team has reviewed the Restrictive Physical Intervention Policy. This is due to be presented to the Health Board's Health & Safety Committee on 9 February. Following a period of consultation, it is anticipated this will be in place in March/April 2023.	~~April 2023~~ September 2023	Current policy is fit for purpose. The revised policy is currently out for consultation and likely to be approved by September 2023.
Decorative measures should be undertaken to make the communal areas of the unit a more pleasant therapeutic environment for patients.	Meeting held with furniture provider on 24/03/23. Paper will be developed and provided to the Health Board for funding for the new furniture. Awaiting options & costings from furniture provider who are visiting on 22/6/23.	~~June 2023~~ August 2023	The Directorate has linked with a company who provide specialist furniture but also specialise in acoustics which is something HIW picked up on. The rep has cancelled 3 meetings now. The Directorate is keen to work with this company because of their specialism so is arranging a further meeting, but may need to look elsewhere.
Measures should be taken to reduce the noise levels on the unit for the comfort of patients, staff and visitors.	Meeting held with furniture provider on 24/03/23. Paper will be developed for Divisional/ Health Board approval to fund new furniture and acoustic tiles.		
We recommend that healthy eating initiatives are implemented on the unit for the benefit of patients.	Catering Dietician has approached the Division to discuss and share guidance around healthy choices. To be discussed at Divisional QPS meeting.	July 2023	On QPS agenda for 26/07/23.
Pictures of the menu choices should be provided so that patients can view a pictorial and written menu.	Division to liaise with Facilities Division to create a visual library of menu options.	July 2023	Division have chased Facilities Division for an update.
The practice of using the visitors room as additional bedroom when the unit is at full capacity must be avoided, to ensure the safety of patients and staff.	The directorate will ensure that in future, the room will not be used as a bedroom and will include this in the Ty Lafant operational policy.	July 2023	Directorate updating – on track for completion by end of the month.

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
Ty Cyfannol & Annwylfan Wards	5-7/09/22	✓	3	7	0	44	78	**6**

Outstanding Actions			
The health board should ensure that relevant policies are reviewed and kept up to date prior to their expiration date. This includes the Equality and Diversity Policy which expired in November 2021.	Policy is currently being updated.	March 2023	Corporate policy under review.
The health board should implement a process for gathering and obtaining feedback from patients, carers and families on Annwylfan.	Schedule and plan for obtaining feedback to be discussed at the next Directorate QPS meeting.	December 2022	Commence July 2023 - OAMH Ward Managers Group has identified Patient and Carer feedback forms. Process has been agreed on how to circulate these. Discussions ongoing with Directorate team re collation and sharing.
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.	This policy will be reviewed by the end of December 2022.	December 2022	Current policy is fit for purpose. The revised policy is currently out for consultation and likely to be approved by September 2023.
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.	Seclusion & Segregation policy currently being drafted.	December 2022	In progress
	ECA guidelines to be included as appendices, to include required documentation to record ECA stays.	December 2022	In progress
Photographs of detained patients undertaking Section 17 Leave should be kept on record.	This is not currently Health Board policy. This will be discussed at the MH/LD Division's QPS meeting for decision.	November 2022	In progress - this has been raised with the MHLD Partnership Manager for exploration with service users for their views on this suggested policy.

Urgent Care 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
Emergency Department, GUH	1-3/11/21	✓	12	23	0	58	87	**4**

Outstanding Actions			
Ensure a system wide solution to poor flow and overcrowding at the ED waiting rooms.	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	Ongoing - 24/4 implemented to reduce congestion in ED and minimise crew delays
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.	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	Ongoing education and information for the public to access the right service first time.
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.	The Health Board will provide HIW with an update on flow improvements.	November 2022	Ongoing - 24/4 implemented to reduce congestion in ED and minimise crew delays
Clinical supervision is completed annually.	The Health Board is currently reviewing a new model for Clinical Supervision.	October 2022	Ongoing piece of work across Health Board.

Urgent Care 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
Emergency Department, GUH	1-3/08/22	✓	3	26	0	20	75	**3**
Outstanding Actions								
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.	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.	January 2023	Ongoing24/4 implemented to reduce congestion in ED and minimise crew delays					
The health board must ensure that there is an area available to facilitate red release calls at all times.	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.	January 2023	Ongoing - Immediate release space is available in ED					
The health board must ensure that action is taken to improve compliance with staff appraisals.	Improvement plan in place for annual appraisals.	December 2022	Ongoing					

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 Action			
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	**July 2023** **AWAITING UPDATE FROM DIVISON** **Update January 2023** Early February, the Senior Nurse and team to pull the plan together and one of the COT/ELT staff are liaising directly with the ward, once Divisional Nurse has cleared it, following a meeting. We are also refurbishing a ward in St Cadoc's (Bettws Ward) specifically for those young people who present at GUH in crisis but are not admitted. This action has taken longer than expected as there has been a focus on Windmill Farm a Provision for C&YP to stay to overt admission to an acute ward. **Update September 2022** Unit was used for another function during Covid-19; however funding has been secured and approved. Plans extended to December 2022.

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
Maternity, GUH	6-8/06/23	✓	4	27	**3**	Not yet received		

Outstanding Actions		
The health board is required to provide HIW with details of the action it will take to ensure mandatory training is completed in a timely manner and to the recommended health board compliance levels to maintain patient safety.	Fetal physiology/surveillance is normally provided twice yearly. One session has taken place this year. A further session will be facilitated September 2023, this is the earliest opportunity due to availability of appropriate speakers/ experts.	September 2023
	GAP and GROW will be mandated as of September 23.	September 2023
	Lead Midwife to review the current database and to replace with a more interactive, visual and accurate representation of staff training. The new database is currently in development, with the added functionality to prompt staff when nearing renewal date.	Roll-out September 2023

Scheduled Care 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
D2 East & West	3&4/5/23	N/A	N/A	N/A	N/A	4	12	**5**

Outstanding Actions		
The health board is required to provide HIW with details of the action taken to review the provision of signage used on the wards to ensure it meets the needs of patients with sensory impairment or cognitive difficulties.	Arrangements made for the Patient Centred Care Team to visit the wards to provide advice on additional signage and resources to support patients with sensory impairment or cognitive difficulties.	31 August 2023
The health board is required to provide HIW with details of the action taken to improve staff compliance with mandatory moving and handling training.	Number of transfer specialists increased across the Divison	30 September 2023
	Education/Study leave rostered to provide staff the opportunity to complete manual handling training	30 September 2023
The health board must ensure that all staff adhere to the regulations and bare below the elbow in clinical areas.	Hand hygiene audits increased to daily until compliance is above 95%.	31 August 2023
	Actions and learning to be fed back at ward meeting, ward mangers meetings and urology directorate meetings	31 August 2023

Diagnostics & Therapies

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
IR(ME)R, NHH	25-26/04/23	N/A	N/A	N/A	N/A	19	29	**12**

Outstanding Actions		
The employer needs to establish a procedure to ensure radiographers are fully trained and competent to carry out pregnancy tests on patients.	Radiology will review their involvement and role in pregnancy testing. ABUHB have engaged with Professional Leads across Wales to discuss current practice. If it is agreed that we require direct involvement in the pregnancy testing process, a draft SOP has been developed to address training needs for radiography staff.	30/09/23
The employer is to ensure that the DAGs clearly reference that they cover both paediatric and adult patients.	The current DAG's in place will be updated to reflect they relate to patients 16 years of age or older and that paediatric requests will be justified by Radiologists.	31/07/23
The employer is to ensure the entitlement table in EP (b)(i) is updated to include all lines of operator entitlement accountability.	Employer procedure document 2(b)(i) will be updated to include the entitlement of operators for clinical evaluation under the non-reporting agreements. Following the update the document will be ratified by RPC.	31/08/23
Evidence of the in-house quality control testing for the mini C-arm used in theatres is completed as a matter of urgency	Staff have been identified to be trained on the Level A QA testing and this will begin on 17th July 2023 with the help of the MPE. A baseline of results will be established to allow the monthly testing to be implemented.	31/07/23
The quality control testing of the mini C-arm is completed in a timely manner in the future	A QA programme has been established within the theatre department for regular QA testing of the mini c-arm and there is a training plan to ensure this programme can be maintained.	31/07/23
The employer is to ensure that following the completion of the relevant training and competency assessment, the advance practice nurse is entitled as a non-medical referrer before they refer for future chest X-rays.	A non-medical referrer protocol will be written to identify the scope of practice for the advanced practice nurse to refer for chest x-rays. Following acceptance of the protocol and relevant training the individual will be entitled as a referrer with a defined scope of referral.	31/07/23
The employer is to ensure that the relevant procedure relating to the clinically significant, accidental and unintended exposures is updated. This is to include who makes the decision on what is clinically significant and in defining when the patient is informed or not and where this is recorded.	Procedure document 2(l) will be updated to reflect that the Clinical Director of Radiology, or a named Deputy, will make the decision on whether an incident is clinically significant based on the information presented to them. This decision will be included in the investigation report associated with any SAUE or CSAUE investigation. In ABUHB, all patients involved in SAUE or CSAUE incidents are informed.	31/08/23
The health board needs to ensure that the remedial work in the department including the split chairs and missing ceiling tiles is completed.	The split chairs will be removed from use and replacement, non-upholstered chairs procured.	30/09/23
	The Estates lead in NHH has been contacted to ensure the ceiling tiles are replaced.	30/09/23
The health board need to ensure that that the large yellow bin is secured and put in a more appropriate place.	The Estates lead has been contacted and the existing bin will be replaced with a secured clinical waste bin. This will be located in an appropriate location.	31/07/23
The training records of non-medical referrers needs to be completed in full.	The date of entitlement for non-medical referrers will be included on the non-medical referrer matrix.	31/12/23
The health board are to ensure that staff receive appropriate training on the duty of candour.	The Health Board have provided on line training via the ESR system for all staff and we will ensure all staff have completed the training within 3 months.	30/09/23

Nursing Staffing Levels Wales Act 2016

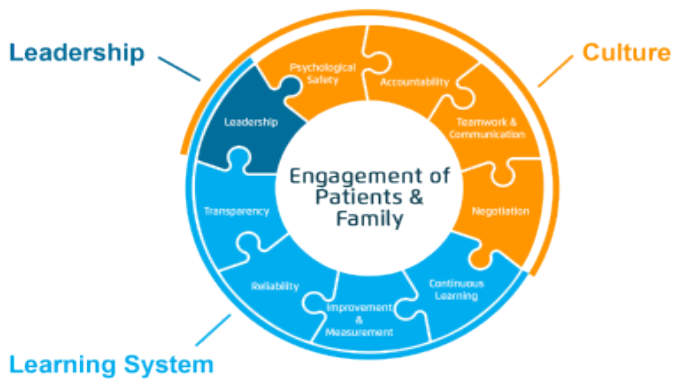| Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical/surgical and paediatric inpatients wards					
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	Total number of incidents/ complaints – May/June 2023	Number of closed incidents/ complaints - May/June 2023	Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained	Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
Hospital acquired pressure damage (grade 3, 4 and unstageable)	12	3 (3 of which deemed unavoidable)	9	0 (out of the 3 closed) (1- staffing questions not answered)	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	10	3	7	1 (Out of the 3 closed incidents)	1
Medication errors never events	0	0	0	0	0
Any complaints about nursing care	15 Adult (1 0f which pertains to 2020) 2 Paeds	0	15 Adult 2 Paeds (Some of the June complaints could still be closed under early resolution)	Not known at this time	Not known at this time
Infiltration/ extravasation injuries	0	0	0	0	0

Nursing Staffing Levels Wales Act 2016

Issue	Cause	Remedial Action	Who	When
Delay in undertaking timely RCA of pressure ulcers	Staff require further training on how to undertake a manager review and focussed review	Further education and training of the correct process and emphasis on timely reviews	Divisional Nurses Nurse Staffing Programme Lead	July 2023
Some datix have been closed with incorrect level of harm	Staff require further training on attributing level of harm prior to closure of datix	Further education and training on closing datix with correct level of harm	Divisional Nurses PQS teams	July 2023
Investigation section not fully completed to determine nurse staffing levels and whether they contributed to the incident	Staff unfamiliar with requirements of the new system to meet NSLWA requirements. The question "Is this related to nursing care" -Datix defaults to NO in the drop-down box- resulting in the question being missed- trying to address this in the All-Wales group.	Further education and training for divisions on correct process.	Divisional Nurses Nurse Staffing Programme Lead	July 2023
Requirement to report nurse staffing levels aligned to complaints is ambiguous	Complaints often multifaceted, spanning different wards, specialities, divisions and hospitals.	Staff reminded of the requirement to determine the root cause of a complaint and to complete the NSLWA component on Datix to determine nurse staffing levels at the time and whether this was considered a contributing factor.	Divisional Nurses Nurse Staffing Programme Lead	July 2023
Delay in undertaking timely RCA of pressure ulcers	Staff require further training on how to undertake a manager review and focussed review	Further education and training of the correct process and emphasis on timely reviews	Divisional Nurses Nurse Staffing Programme Lead	July 2023

All Wales Patient Safety Solutions:

Compliance Status

Alert	Estimated date for compliance	Action to achieve compliance	Status
PSA008 NG Tube misplacement: continuing risk of death & severe harm Compliance deadline: 29/09/2023	29/09/2023 (**In-progress**)	An extension for this alert has been issued to all Health Boards in Wales, following a Task and Finish Group assembled specifically for PSA008. A new workplan for ABUHB to declare compliance with this alert is in progress.	**In progress** **Aim: Sept 2023**
PSN066 Safer Temporary Identification Criteria for Unknown or Unidentified Patients Compliance deadline: 29/09/2023	29/09/2023 (**In-progress**)	This notice requires HBs to ensure that a plan is in place for the development of a system with a unique temporary identification of unknown patients using the system outlined in the notice. Sex, DOB + estimated age range, non-sequential unique ID number and first and last name based on an edited phonetic alphabet. This project is kindly being lead by Peggy Edwards, we have a working group at ABUHB and are meeting approximately 8 weekly.	**In progress** **Aim: Sept 2023**

Framework for Safe & Reliable Care

Based on https://www.safeandreliablecare.com/blog/2016/11/29/s-r-sociotechnical-framework-ihi-minicourse

Safe Care Collaborative – update

Organisational Update:

- Learning Session 2 in June: Organisational Storyboards – Workstream coaching sessions – Team time to plan – Psychological Safety
- Leadership programme of work scoping and workplan. Schedule of executive walkarounds started. 4 completed in May, 5 planned for June.
- Stage – Action Period 4, next calls July 12th/13th
- Commencement of the capability and capacity building programme developed – working with Improvement Cymru to deliver training; Junior Dr's Improvement Forum, bespoke CLT, PocED QI, PocED Measurement sessions.
- Prof Maxine Power session with senior leadership on measurement for QI.
- Quality Strategy delivery plan and Outcomes Framework in development.

Team Update:

- 70% of teams identified specific SMART aim for their respective workstreams. Charters in development.
- Charters being developed to describe QI teams work and measurement strategies.
- 3 new teams joining collaborative, Monmouthshire North, Glaslyn Care Homes, Theatres.
- CATCH team on pause due to staffing issues.
- Recruitment and training of additional Safety Coaches, in particular to support Theatres workstream.
- Data lead working with coaches and teams identified measures and baseline for the Acute and Ambulatory workstream.

| Workstream	ABUHB Team	IHI Score
Acute	Medical Assessment Unit at GUH	1.5
	Ward C0 (ENT surgical ward) at GUH	2
	Theatres – Human Factors	NEW TEAM
Ambulatory	Gastro-intestinal Ambulatory Care Unit (GACU) at RGH	1.5
	Monmouthshire Integrated Team	1.5
Community	Glaslyn Care Homes	NEW TEAM
	Mental Health OT Team	1.0
Leadership	Executives, Leaders for Safety, Faculty	2

0.5 Intent to participate	Project identified, charter/contract of intent not yet complete, team still forming.
1.0 forming team	Team forming (key individuals assigned) or formed; aim or charter/contract of intent, focus determined; initial plans made.
1.5 Project plan begun	Project Planning documentation (rationale, aims, scope, resources, timescales, measures, expected outcomes, initial focus) begun and project team formed. Team have met.
2.0 Activity but no changes	Initial cycles for team learning begun. Project planning, measurement, data collection, obtain baseline data, study of processes, current state capture.

Welsh Nursing Care Record

Rollout started in RGH from 5th June 2023 (three wards live at time of reporting) to be complete by mid September.

YYF / St Woolos to follow the RGH implementation.

Version 2.3 release due September 2023 with a single instance across Wales; no new form but several key changes requested e.g. falls assessment.
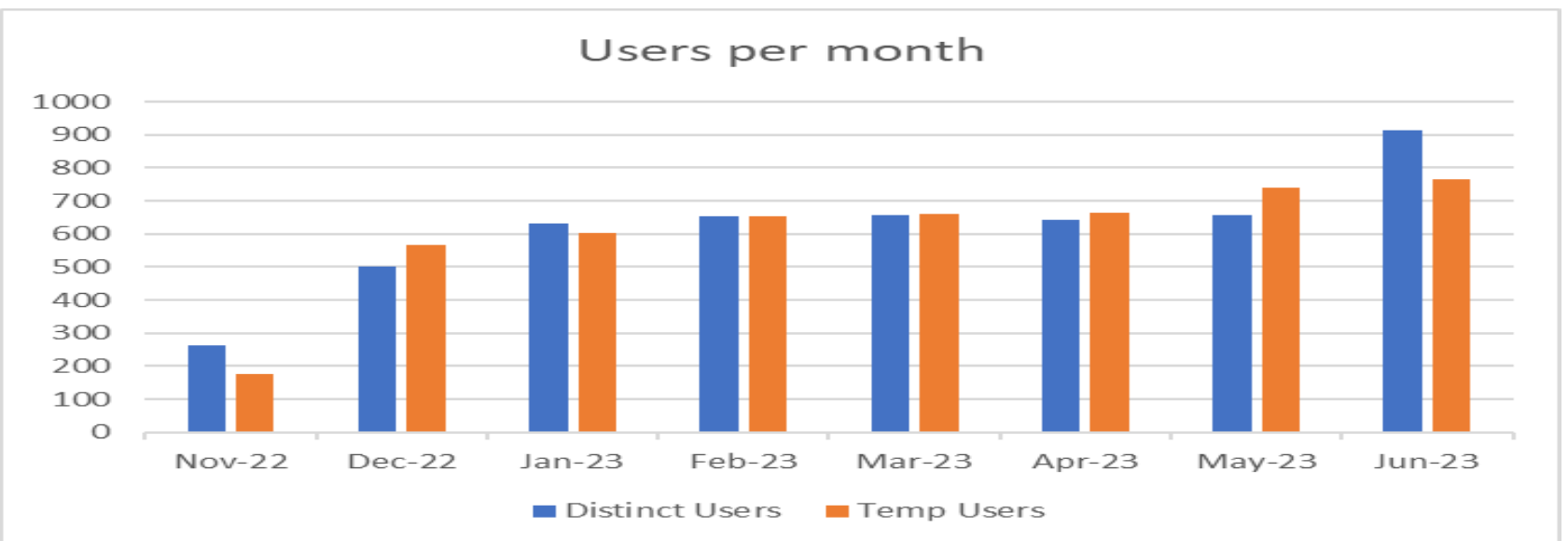

Records created per month

Nursing notes
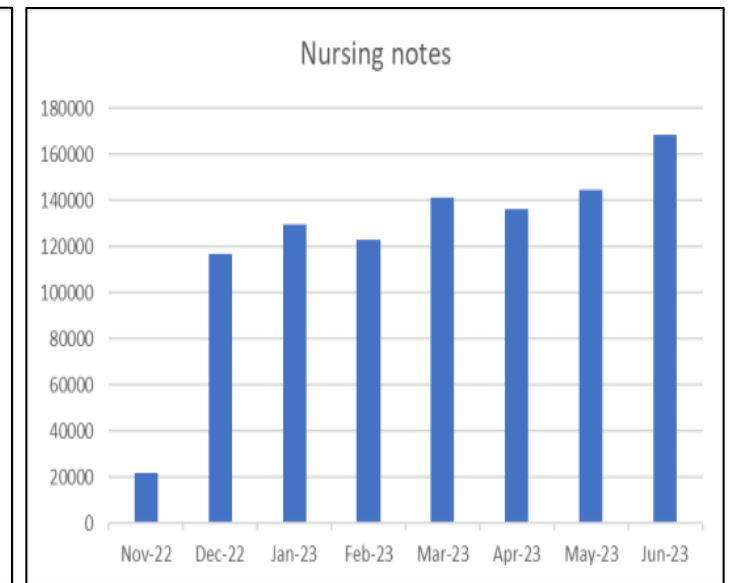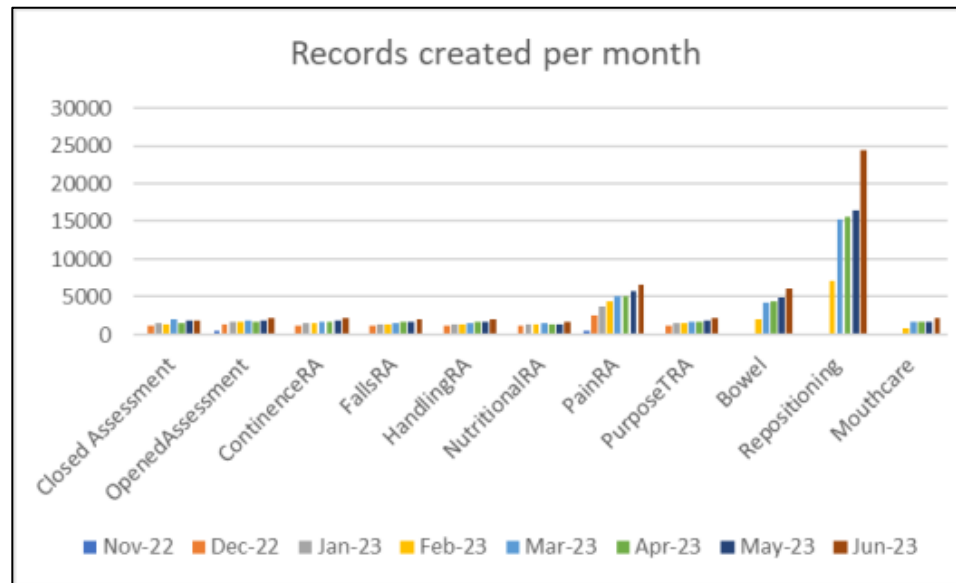
Welsh Nursing Care Record

Temporary user accounts out weigh permanent staff accounts; students, agency and some bank staff.

Robot Processing automation should be used for agency accounts, bank staff have Nadex so the temp accounts should be minimal.

Need to investigate reasons behind high numbers

Increase in users in June due to RGH roll out.

Welsh Nursing Care Record

| Issue	Cause	Remedial Action	Who	When
Delay in getting a WNCR record started on one wards (one ward resolved)	One wards have issues where the patient pathway on WPAS is not completed for semi-elective patients	Training has been provided to support WPAS pathway selection when booking patients	CNIO	ASAP - ongoing
Dual running across the health board of paper and digital system	The digital patient assessment is only available via Welsh Clinical Portal upon step down	Digital Health and Care Wales are to provide integration with the documents data base (delayed) WCP provided for all nursing staff	DHCW	Q3
Not currently providing qualitative data to ward managers	Dashboard output from data warehouse not yet available	Requirements gathering ongoing and mechanisms to provide dashboard being explored – outline measures identified to be available in June	CNIO	Q1
Need a business case for final health board in patient areas	Funding only provided in phases	Business case for equipment for final roll out areas (NHH, Community estate)	Project Manager	Q2
Duplication of recording nursing information	Not all information requirements in WNCR. Impression all data needed on TCAB.	Request for change process for WNCR. Review of what data items recorded in multiple areas e.g. observations	Digitalisation Nursing Documents Group	Q2

SDEC GUH at a Glance 08/08/22 – 30/06/23

Weekly Patient Volume
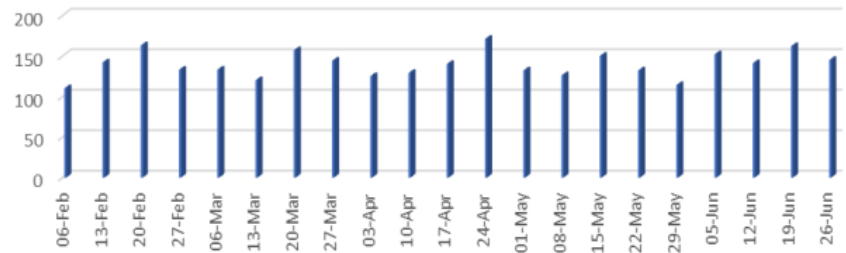
Time Spent in SDEC
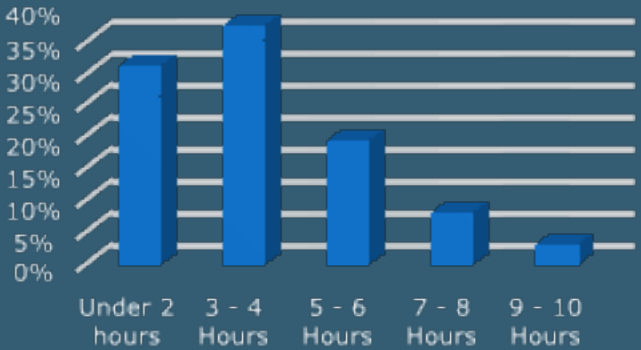
SDEC by Speciality
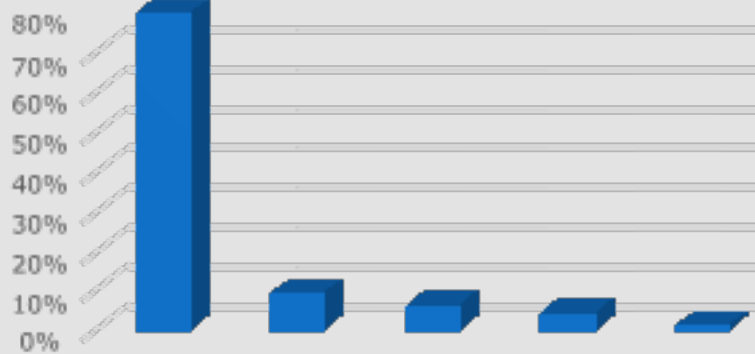
5441 Patients seen

Average 33 Patients per day

434 Next day Returners

Median time 4 hours

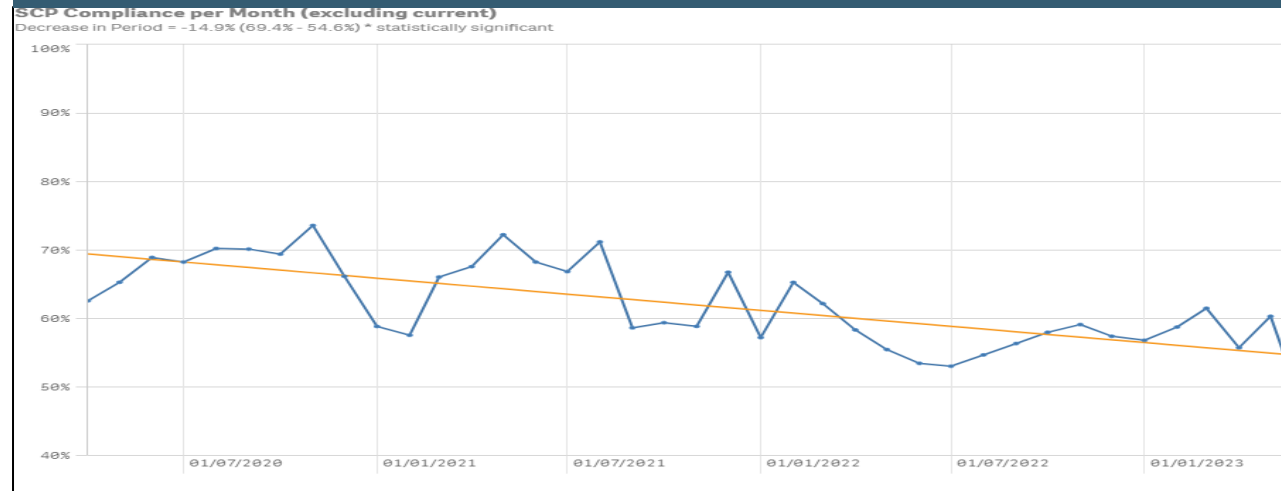**4592 patients Discharged Same Day (82%)**
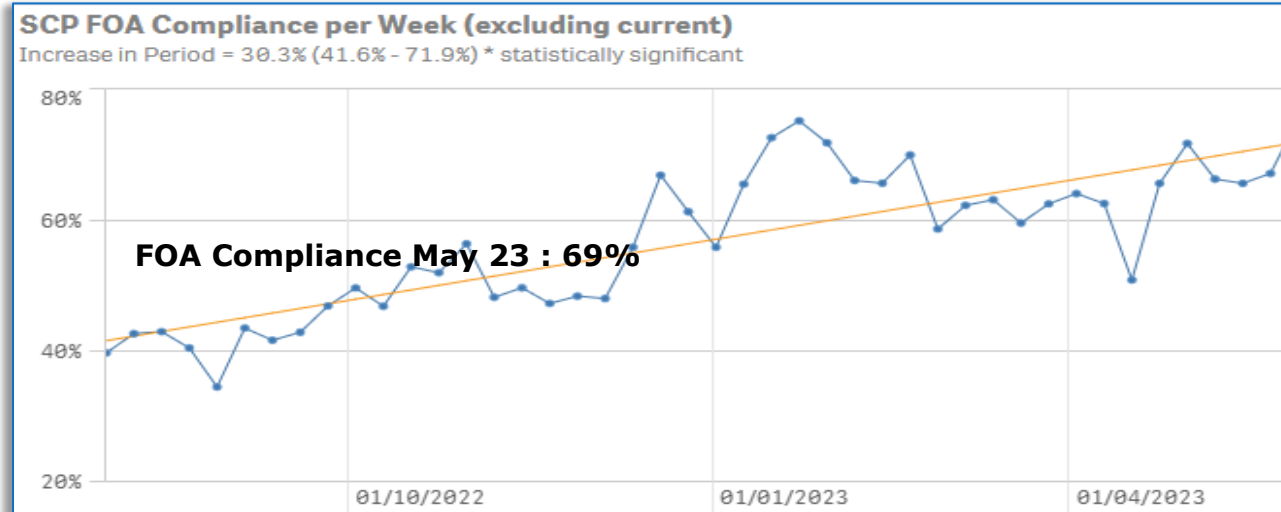
761 Admissions

Progress Summary:
- Average daily patient throughput up from 29 to 33
- Surgical model working very well:
  - Established GP referral process via Flow Centre
  - T&O pathway established
  - ENT Pathway in pilot for 3 months
- Consistent Positive feedback from patients and SAU staff
- General medicine utilization continues to increase since Jan 23
- Pathway for Maxfax, Gynae and Gastro also established
- SDEC has never been used for in-patient capacity

Cancer – 62 Day Performance

SCP Compliance: May 2023

SCP Compliance per Month (excluding current)
Decrease in Period = -14.9% (69.4% - 54.6%) * statistically significant

MAY 2023 SCP compliance 60.3% better than April SCP compliance of 55%. However overall performance remains below the aspiration target of 75% SCP compliance.

SCP FOA Compliance per Week (excluding current)
Increase in Period = 30.3% (41.6% - 71.9%) * statistically significant

FOA Compliance May 23 : 69%

Improvement in FOA compliance continue to remain at decent levels within 14 days

Cancer Backlog

SCP Backlog per Week (excluding current)
Decrease in Period = -178 (482 - 304) * statistically significant

- *SCP Backlog: 384*
- *Colorectal, Urology and Gynae major contributor*
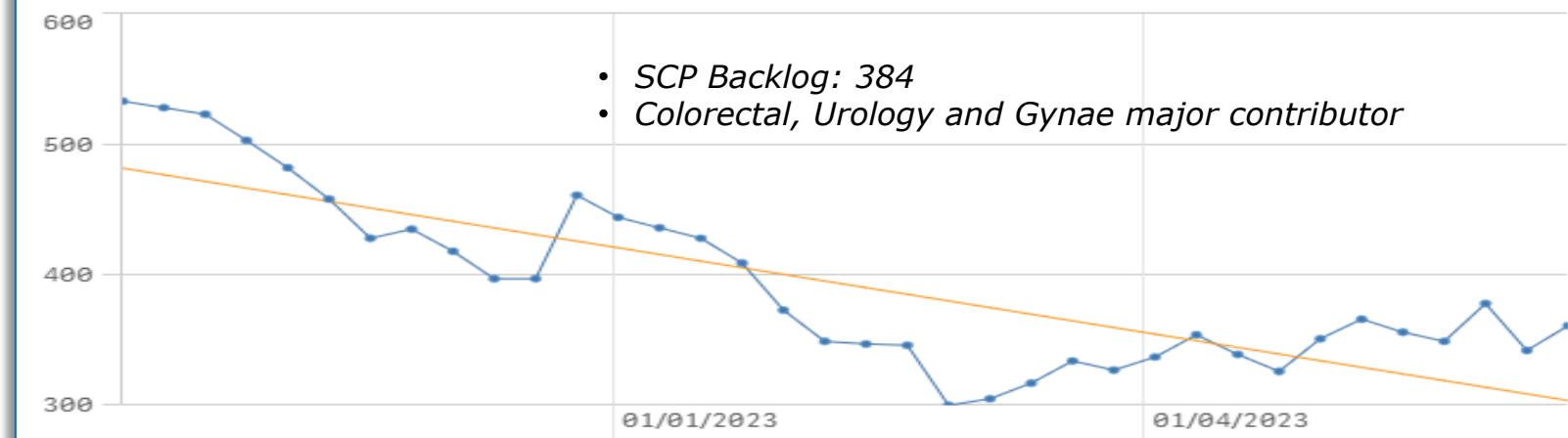
Over 104 Days per Week (excluding current)
Decrease in Period = -79 (171 - 92) * statistically significant

- *SCP 104 day backlog = 120 pts*

SCP Demand

SCP Census per Month (excluding current)
Increase in Period = 1,007 (2,593 - 3,600) * statistically significant
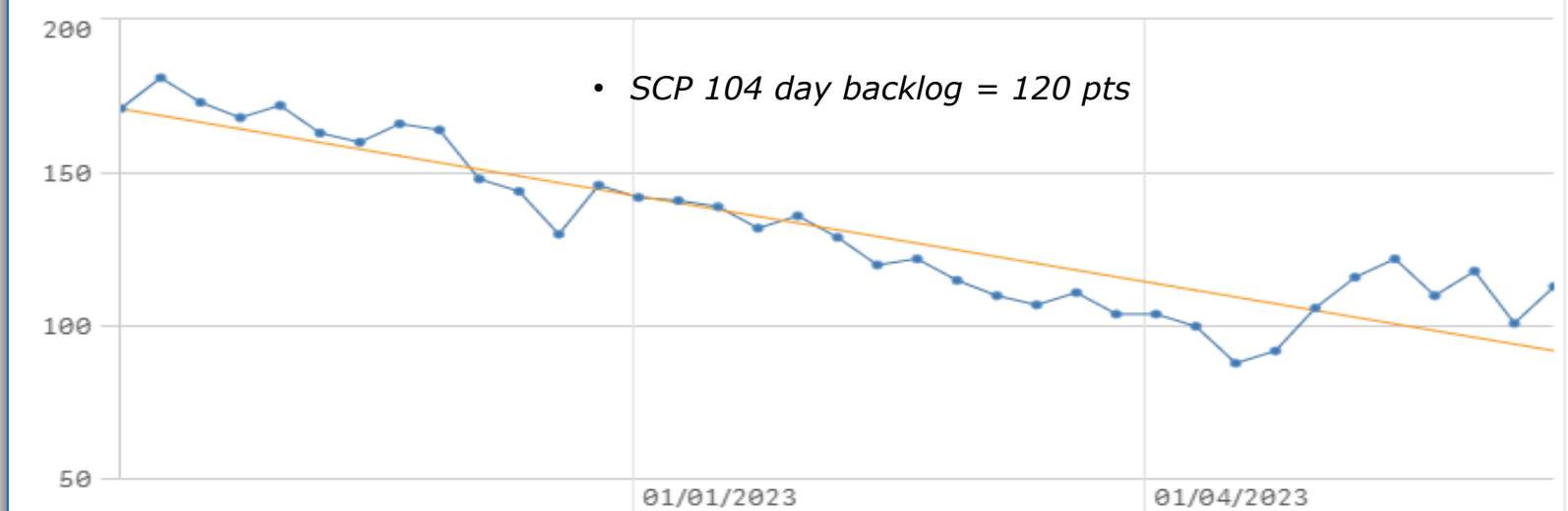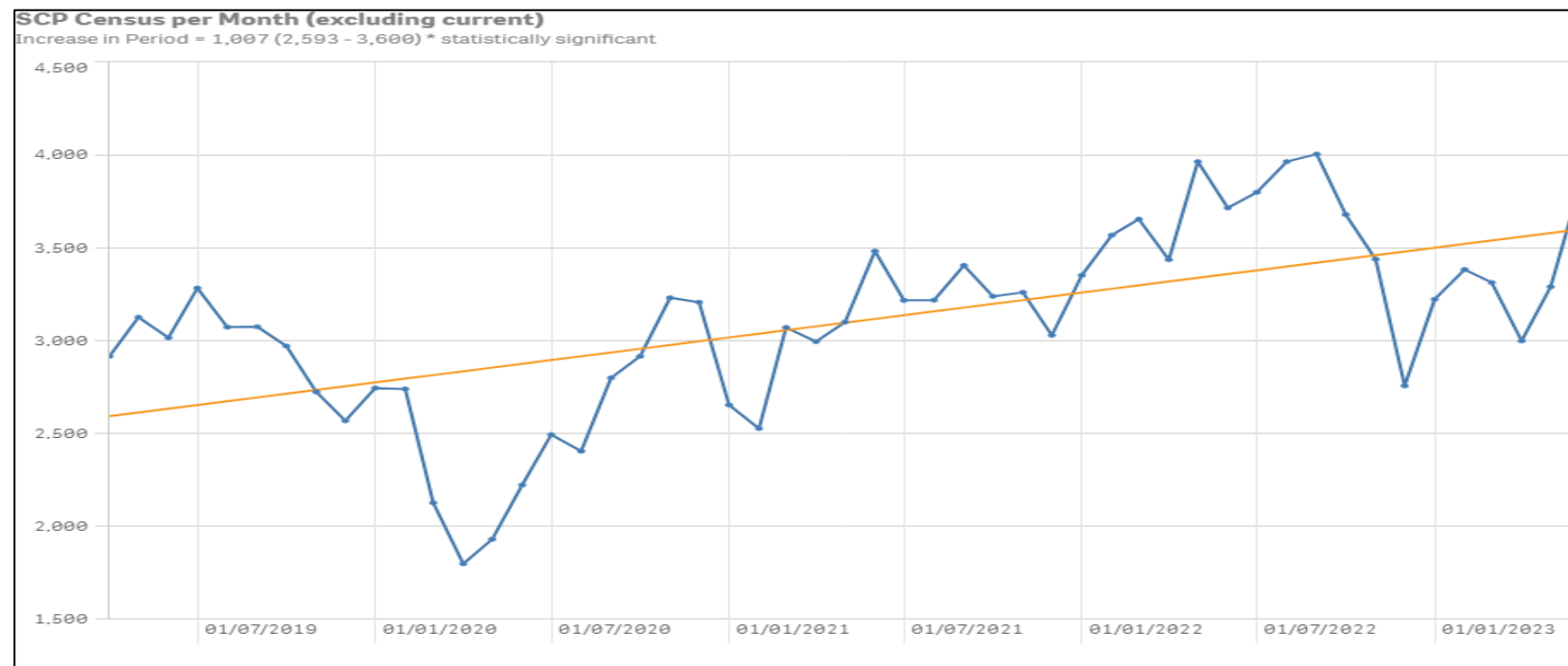
Demand continues to remain high with another spike in referrals in May in most tumour sites but significant increase noted in Gynae and Skin. Other tumours sites Urology, H&N and UGI increased demand trend continues.

Recovery Challenges

Issue	Cause	Remedial Action	Who	When
Colorectal theatre waiting times	Demand/Capacity shortfall	New job plans created to redistribute cancer workloads evenly amongst clinicians. Additional locum appointed however will not be undertaking Cancer work to begin with.	Dawn Baker-Lari	ongoing
Rising Cancer Backlog	Loss of activity over end of financial year, Easter holidays and May Bank holidays	Backlog scrutiny exercise being undertaken in all major tumour sites. Renewed push on start of pathway to prevent further growth	Cancer Services & all tumour sites	Weekly meetings
Cancer SCP compliance /Backlog Priorities Non compliance	Insufficient capacity/ Prioritisation all tumour sites	Weekly monitoring PTL meetings Speciality T&F meetings	T&F group meetings Cancer Delivery Group meetings	Ongoing

Questions

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN MEETING	

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 July 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Implementation of the Quality Strategy and Patient Experience & Involvement Strategy: Quality Operating Framework Implementation plan Quality Governance and Assurance Framework
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Assistant Director of Nursing Trish Chalk - Assistant Director of ABCi & Interim Deputy Director of Planning

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation
In April 2023, the Health Board launched its first Quality Strategy and Patient Experience & Involvement Strategy. As part of ensuring successful implementation of both Strategies, a Quality Outcomes Framework (QOF), implementation plan and Quality Governance and Assurance Framework has been developed. This will enable us to deliver the objectives within the Strategies, demonstrating our commitment to deliver the highest quality healthcare to our local communities and how we are putting Quality, Safety and Learning at the heart of everything we do.

Cefndir / Background

The primary objective of implementing a quality outcomes framework is to drive continuous improvement in the delivery of healthcare services by focusing on measurable outcomes. The framework aims to:

- Identify areas of improvement and potential risks to patient safety.
- Establish quality indicators and benchmarks to measure and compare performance.
- Promote evidence-based practices and standardise care processes.
- Enhance patient satisfaction and experience.
- Ensure compliance with regulatory standards and accreditation requirements.
- Facilitate data-driven decision-making and resource allocation.
- Foster a culture of accountability, transparency, and learning.

The implementation plan details the deliverable and the timescales over the next financial year.

Our governance systems are being reviewed and aligned to deliver the Quality Strategy. A new oversight and reporting structure will be implemented to provide transparency and oversight of our performance and progress.

We will ensure we have a quality governance framework that provides Board assurance through a systematic approach to maintaining high quality care and standards. We will refine the combination of structures and processes, at and below Board level, to lead on Health Board quality performance. This framework must therefore address the following:

- To define quality governance and give shape to what it means to govern for quality across an organisation.
- Seek to provide support to Board in achieving and delivering this quality governance.
- Support clarity in lines of reporting.
- Increases the level of assurance through its implementation, with the aim of increasing public trust and confidence.

Asesiad / Assessment

As part of delivering the Strategy, reporting across the Health Board has been reviewed. The Outcomes Framework for the first iteration will stand alone and will be produced for Board, the Executive and PQSOC. The proposed indicators have been drawn from existing Service, Ward and National Reporting benchmarking against best practice.

The Quality Indicators have been aligned to the Duty of Quality, the six domains of quality: person-centred, safe, timely, effective, efficient and equitable. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health Board's priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

The indicators detailed in the Quality Operating Framework (QOF) in Appendix One bring together a wide variety of data sets into one report. This has been normal practice when developing and shaping Health Board and system wide reports. The aim is to ensure all data is fed into the warehouse in the future to enable one integrated report to be produced. There is a need for resource and capability to link data sets for insight through enabling the feeds into existing platforms. This will provide a deeper understanding of pathway performance and causes of variation to develop our Quality Management System and inform quality improvement.

It is vital through the reporting and analysing of outcomes that a feedback loop is established by continuously monitoring the impact of improvement initiatives and quality indicators. Regular evaluation of the effectiveness of implemented changes, identify barriers to success, with the ability to make the necessary adjustments. The outcomes and indicators will also help us to deliver and complete the Annual Quality Report to Welsh Government and support future reports to NHS Executive.

The Outcomes and Indicators have been set for the next financial year to establish the goals for the ongoing quarters for Year One 2023/24. This can be seen in the implementation plan in Appendix Two. The implementation plan for the quality strategy will support the PQSOC work planner and tracking of progress for the Quality Outcomes Framework and Performance report for PQSOC meetings. This will be reviewed over the course of the year for their effectiveness and ability to draw insight for learning and improvement.

The Quality Goverance and Assurance Framework in Appendix Three details how the Board will be provided with assurance of effective and sustainable management of quality throughout the Health Board. This framework is designed to support the delivery of our vision for quality to provide an outstanding experience for our patients, relatives, carers, staff and communities by a Health Board that is well managed, cost effective and has a skilled and motivated workforce.

The following actions are being taken as part of implementing this Framework:
- The existing structure of Groups and Committees are being reviewed to understand the function and purpose.
- A new oversight and reporting structure will be implemented. These will sit under Safety, Clinical Effectiveness and Patient Experience. See

Appendix One for the updated framework proposal and Appendix Two for existing Groups and functions.

- Groups and Committees are being asked to define their purpose, terms of reference and reporting mechanisms. See Appendix Three for the current scoping exercise to enable the framework to be reviewed.

The framework provides the narrative of existing work underway with reviewing resource within the Quality and Patient Safety teams to enable a standardised patient safety, quality and risk reported to be developed within the Divisions. The interdependencies around clinical engagement and leadership are being defined with Clinical Goverance leads, QPS and the Divisions.

Both the Clinical Lead for Governance and QPS lead with be jointly responsible for creating the conditions and embedding Quality Improvement and developing the capacity with ABCi support in the Divisions using the Model for Improvement.

The workplan for PQSOC will be updated with a timeline for when reports will need to be submitted to the Committee and details of what reports are expected from each of the Groups. Reports that are not part of the quality operating framework will be on a rolling agenda from the Groups to provide narrative of outputs and delivery. The agenda will be set to allow discussion on the pillars of quality and time dedicated to areas for escalation. Annual reports will be scheduled throughout the year. See Appendix Four.

Argymhelliad / Recommendation

This report is to provide assurance for the committee on the ongoing work to implement and deliver the Quality Strategy and Patient Experience & Involvement Strategy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback 2.6 Medicines Management
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well

Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper?
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working**	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

https://futuregenerations.wales/about-us/future-generations-act/	

Quality Outcomes

Framework

Introduction

In April 2023, the Health Board launched its first Strategy for Quality and Patient Experience & Involvement Strategy. A key focus during the development of these Strategies was building on our existing structures and current accomplishments throughout the organisation.   This is to ensure Quality is embedded in our culture, and we are committed to continually improving and learning.

Our commitment to Care Aims Principles through integrated decision making underpins our ambition to embed a person-centred approach to service provision. The Health Board has adopted, at scale, the 'Care Aims' model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value, and choice. This is key to understanding if we are meeting our purpose, aims and objectives. We are developing metrics which measure outcomes, including experience and evidence of feedback influencing service plans, delivery, and improvement.

As part of ensuring the successful implementation of both the Quality Strategy and the Patient Experience and Involvement Strategy, a Quality Outcomes Framework (QOF) has been developed. The indicators in the outcomes framework will be used to provide a systematic approach to measure, monitor, and enhance the quality of our healthcare services.

The Outcomes Framework and indicators will be our measure or our commitment to deliver the highest quality healthcare to our local communities and how we are putting Quality, Safety and Learning at the heart of everything we do.

Purpose

The primary objective of implementing a quality outcomes framework is to drive continuous improvement in the delivery of healthcare services by focusing on measurable outcomes. The framework aims to:

- Identify areas of improvement and potential risks to patient safety.
- Establish quality indicators and benchmarks to measure and compare performance.
- Promote evidence-based practices and standardise care processes.

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- Enhance patient satisfaction and experience.
- Ensure compliance with regulatory standards and accreditation requirements.
- Facilitate data-driven decision-making and resource allocation.
- Foster a culture of accountability, transparency, and learning.

There are known benefits to implementing a quality outcomes framework, some of which include:

- Improved patient outcomes and safety through analysing and learning from the insight.
- Enhanced patient experience and satisfaction through the improvements made.
- Increased adherence to evidence-based practices across our services,
- Better utilisation of resources and increased efficiency in the right areas.
- Compliance with regulatory standards and accreditation requirements.
- Improved staff engagement, morale, and professional development.
- Accountability and transparency in delivery of our care.

Reporting Framework

As part of developing this Framework, reporting across the Health Board has been reviewed. Currently the Board and Executive receive a quarterly outcomes and performance report with some quality indicators. Patient Quality and Safety Outcomes Committee (PQSOC) receive an indicator performance report. Divisional, service and ward reporting is determined by the local area.

The Outcomes Framework for the first iteration will stand alone and will be produced for Board, the Executive and PQSOC, the proposed indicators have been drawn from existing Service, Ward and National Reporting benchmarking against best practice.

Working with the delivery teams Quality Indicators have been aligned to the Duty of Quality (The Health and Social Care (Quality and Engagement) Wales Act (2020)). These are the six domains of quality: person-centred, safe, timely, effective, efficient and equitable. These outcomes and indicators collaboratively establish a set of quality indicators that align with the Health

Boards, priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

The recommendation is for this to remain as a standalone report alongside the Quarterly Outcomes and Performance report but replace the current PQSOC Performance report. This recommendation is set in the context of the role of a Health Board and the life course approach we have taken to measuring outcomes across our system and the Life Course Priorities.

The QOF will be mapped to ensure we are delivering on the six pillars of quality as detailed in the Quality Strategy. These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will allow us to triangulate data and review our performance:

- Patient and staff experience and stories

- Incident reporting (falls, pressure ulcers, medicines)

- Complaints, concerns and compliments

- Health, safety and security

- Infection control and prevention

- Safeguarding

The indicators below are brought together from a wide variety of data sets into one report. This has been normal practice when developing and shaping Health Board and system wide reports. The aim must be to ensure all data is fed into the warehouse in the future to be able to provide one integrated report, and resource the capability to link data sets for insight through enabling the feeds into existing platforms to provide a deeper understanding of pathway performance and causes of variation to develop our Quality Management System and inform quality improvement.

The following Outcomes and Indicators are recommended for Year 1 2023/24 and will be reviewed over the course of the year for their effectiveness and ability to draw insight for learning and improvement:

Quality Priority 1- Deliver PERSON CENTRED care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

Outcome Description	Indicator	Able to report Q2
Our patients, their families, and carers receive an experience that not only meets but exceeds their expectations	General experience rating of episode of care	Community only
	Balance of complaints received and closed by grade score	Y
	Compliments - Themes identified for improvement	N
	Reduction in the complaints backlog	Y
Increased patient, public and staff involvement.	Increase in number of responses in Civica	In part
Learning from complaints is implemented	Qualitative feedback use of the learning section in Datix	N
	Increase in the number of actions plans completed	N

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Quality Priority 2 - Provide SAFE care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information.

Outcome Description	Indicator	Able to report now
Fewer repetitive incidents in the priority areas and across the Health Board	Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events	Y
	Improvement in the time to respond and close incidents	Y
	Decrease in the number of reportable IPAC incidents	Y
	The number of incidents with no harm themes identified	Y
	Increase in the compliance of Health and Safety Statutory and Mandatory Training	Y
Improved clinical outcomes,	Decrease in the time to complete safety alerts	Y
	Improvement in the severity of harm following a fall in hospital	Y
	Decrease in the number of Falls by 10,000 occupied IP Bed days	Y
	Decrease in the number of falls treated in ED which have had a previous admission - reattendance	Y

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Improved clinical outcomes,	Decrease in Hospital Acquired Venous Thrombosis incidents	Y
	Decrease in the number of HA pressure ulcers by grade	Y
	Decrease in the number of HA pressure ulcers	Y
	Decrease in the severity of medicines incidents	Y
	Decrease in the number of incidents under - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations	Y
	Reviewed Cardiac Arrest calls by 10,000 bed days	Y
	Improved RAMI	Y
	Improved Crude mortality by hospital	Y

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Quality Priority 3 - Provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time.

Outcome Description	Indicator	Able to report in Q2
Maximising and individuals time and outcomes	Reduce time from admission to surgery for emergency admissions	Y
	Reduce time from surgery to discharge	Y
	Reduce Time spent on a waiting list	Y
	Reduction of handovers >1 hour	Y
	Reduction in time for patients to be seen by first clinician	Y
	Reduction in time for bed allocation from request	Y
	Decrease in ED waits >12hrs	Y
	Increase in discharges before midday;	Y
	Decrease in LoS OVER 21 DAYS	Y
	Time from Flow Centre call to discharge/ admission from assessment?	Y
	Number of emergency admissions in hospital over 7 days	Y
	Decrease in the time from request to step up/down to a different site	Y
	Decrease Overnight bed moves and patient transfers	Y

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| Maximising cancer outcomes | Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion | Y |
| | Increase in 5 year cancer survival rates | Y |

Quality Priority 4 - Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to improve outcome.

Outcome Description	Indicator	Available for Q2
Reduced variation in Care	Increased Get It Right First Time (GIRFT) implementation by area	In part
Reduced variation in Care	Increase in the SMART action plans with accountability in National Clinical Audit	N
Increased understanding of variation to focus Improvements	Increase in the numbers of wards participating in accreditation (Audits via AMaT)	Y
	Increase in the actionable audit recommendations by National Clinical Audits	In Part
Increased understanding of	Decrease in the number of Medicine incidents by Severity and Division	Y
	Number of INNUS's being completed	Y

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variation to focus Improvements	Compliance the number of incidents triggering Duty of Candor within 5 days	Y
Improvement is part of the AB way	Number of QI projects known and completed	N
Improvement is part of the AB way	Increase numbers of people trained	N
	Outcomes of the SCP teams	In part

Quality Priority 5 - Provide care that is **EFFICIENT** by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste.

Outcome Description	Indicator	Available for Q2
Patient experiences are visible and acted on	Increase in the number of PREM Audit and actions	?
	Decrease in the number of personal injury cases	Y
	Decrease in the number of claims and redress	Y
	Decrease in the number of inquests open and closed	Y
	Decrease in the DNA's and CNA'S	Y
	Response time to Public Services Ombudsman for Wales(PSOW)	Y

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Quality Priority 6 - Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory.

Outcome Description	Indicator	Available for Q2
Improve care at the end of life	Decrease in the % of hospital as a place of death	Y
	Increase in compliance of issuing of Medical Certificates within 5 days	Y
Improving quality of life and equitable access	Increase in the access to Safeguarding Training	N
	Narrowing of the life expectancy Gap across our Health Board	Y
	Timely closure of Safeguarding incidents	N
	Decrease in the incidents of violence and aggression towards staff	Y

Data Limitations

At this point, out of the sixty-two indicators, an initial assessment indicated thirteen are actively available through the warehouse. There needs to be a further assessment of the scope and reach of each indicator and data available for analysis. This will be carried out through the Quality Improvement networks, Quality and Patient Safety and accreditation structures to improve the level of input and recording.

Once agreed, a robust strategy is required to improve the robustness of data collection and capture for each quality indicator. This may involve integration of systems electronic health records, patient surveys, incident reporting systems, and other relevant sources, to be able to analyse the collected data to identify trends, patterns, and areas requiring improvement.

Benchmarking and comparison will be important and will aim to be in place by the end of Q4 to compare performance against internal and external benchmarks, including national and international standards.

It is vital through the reporting and analysing of outcomes we establish a feedback loop by continuously monitoring the impact of improvement initiatives and quality indicators. Regular evaluation of the effectiveness of implemented changes, identify barriers to success, with the ability to make the necessary adjustments.

Regular reports on performance on quality indicators and sharing them with relevant stakeholders is important for transparency with clear communication of progress and areas for improvement helps build trust and engage stakeholders in the quality improvement process.

This report will be generated quarterly for this year and as infrastructure improves monthly and needs to be reviewed against the Welsh Care Record and Ward Accreditation Measures.

Following approval of the indicators the measure of improvement and progress will be agreed taking into account the scope of the input and data quality available.

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The outcomes and indicators will also help us to deliver and complete the Annual Quality Report to Welsh Government and support future reports to NHS Executive.

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Introduction

This implementation plan for the new Quality Strategy will be delivered throughout Aneurin Bevan University Health Board throughout 2023.

A key focus in the development of this Strategy is progressing on what we have already accomplished and building on existing structures throughout the organisation. Quality is embedded in our culture, and we are committed to continually improving. Delivering the highest quality healthcare to our local communities and putting Quality, Safety and Learning at the heart of everything we do. We have fantastic teams delivering safe, timely, effective, efficient, and person-centred care. Every day we hear positive stories about how they go above and beyond.

Our commitment to Care Aims Principles (integrated decision making) underpins our ambition to embed a person-centred approach to service provision. The Health Board will adopt, at scale, the 'Care Aims' model across multi-disciplinary teams by truly embedding 'what matters' principles, improving patient experience, voice, value, and choice. This will provide us with improved metrics for patience experience and evidence of feedback influencing service plans, delivery, and improvement.

Our Strategy and this implementation plan was developed in collaboration with a diverse group of people, ranging from healthcare partners to patients and colleagues, and we are grateful for the feedback and insights provided by everyone involved. This collaborative approach is critical to our journey of improvement. We are committed to delivering an open, learning organisation with a 'Just Culture'. We all have the same common goal of improving quality, and by working together, we can enable the organisation to accomplish much more.

This Implementation Plan for the Quality Strategy will be delivered over the next three years, we are in an excellent position to implement it.

We will continue to review the strategy and plan annually as we know this is a ten-year ambition to evolve and sustain its development by our teams. Ultimately, it is about people, and the measure of its success will be determined by the experiences of our patients and staff.
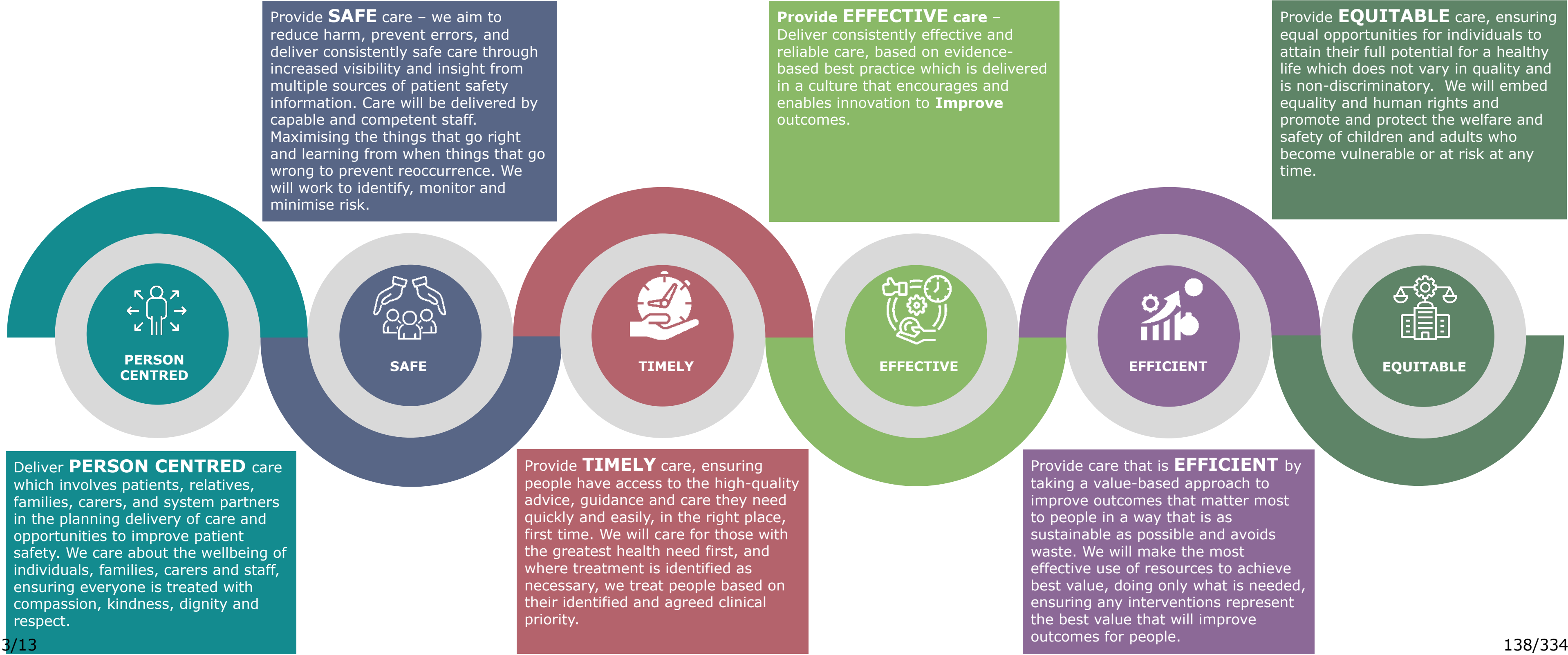
Our Quality Strategy Commitment

- Aneurin Bevan University Health Board will be a learning organisation where staff members work towards delivering high quality clinical care every day.

- We will strive to better understand our systems of care, build capability through an all teach/all learn philosophy, encourage innovation and engage patients, relatives, carers, staff and communities in improvement endeavours, whilst learning from mistakes.

- We will ensure that quality is embedded throughout the organisation creating a culture of openness and transparency where people are supported to raise concerns

- Our patients, relatives, carers, staff and communities will partner with us to achieve this vision.

Six Domains of Quality

The Quality vision of Aneurin Bevan University Hospital Board (ABUHB) is to be "widely recognised for delivering safe, timely, effective, efficient, equitable and person-centred care." Our first and most important commitment to our patients is to keep them safe. Over the next three years, this Quality Strategy will improve the delivery within these six domains of quality, while continuing to improve patient and staff experience and outcomes.

The experiences of our patients, relatives, carers, staff and communities will continue to be the most important measure of our progress. It is the delivery of this Strategy, together with the supporting strategies of patient experience, risk management, clinical effectiveness and employee wellbeing to deliver high quality care, person centred and effective health and care services for our local population.

Provide **SAFE** care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information. Care will be delivered by capable and competent staff. Maximising the things that go right and learning from when things that go wrong to prevent reoccurrence. We will work to identify, monitor and minimise risk.

Provide **EFFECTIVE care** – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to **Improve** outcomes.

Provide **EQUITABLE** care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory. We will embed equality and human rights and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

PERSON CENTRED

SAFE

TIMELY

EFFECTIVE

EFFICIENT

EQUITABLE

Deliver **PERSON CENTRED** care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety. We care about the wellbeing of individuals, families, carers and staff, ensuring everyone is treated with compassion, kindness, dignity and respect.

Provide **TIMELY** care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We will care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

Provide care that is **EFFICIENT** by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We will make the most effective use of resources to achieve best value, doing only what is needed, ensuring any interventions represent the best value that will improve outcomes for people.

Deliverables - The goals of the implementation plan include:

1. Enabling staff to improve quality

The aim of the delivery plan is to enable staff to improve the services they for our patients and staff. This plan will ensure that we can answer the 'who', 'what', 'when', 'how', and 'why' we have focused on key projects and areas and how this will deliver our strategy. Improve patient and staff experience and embedding improvement into daily practice.

Collectively the measures and actions will help us to move forward towards the integration and sustainability aspirations for the Health Board. Ensuring we are putting quality and safety above all else, driving improvements in health and social care and leading to better outcomes that matter most to the people of Gwent.

2. Implement the Duty of Quality

The duty requires the Health Board to develop leadership and management systems with a view to securing improvement in the quality of services. Through continuous improvement of our services over time, ensuring that quality challenges are improved upon, we will report our learning through our annual quality report.

3. Meet the requirements of the Duty of Candour

This duty will support the Health Board when things go wrong in providing care or our services fail to meet expectations or the standards that they should.
Through this Duty, the Health Board must be honest in informing patients and their families when things do not go right. We will be obligated to find out what went wrong; and, to make sure the same mistake does not happen again.

A culture of openness, transparency and candour is widely associated with good quality care. This must encourage learning and be achieved without apportion of blame.

Quality Strategy Performance Monitoring

To successfully implement our Quality Strategy, the implementation plan will form a cohesive approach. This is grounded in a commitment to develop the underpinning foundations of quality through the six domains which can be mapped to our 'pillars of quality' programme.

This means that the way in which we report our quality performance is under development and will be periodically reviewed as a matter of course.

A Quality Outcomes Framework will be used and a report will cover all the performance indicators. This will be available through monthly summary data, more detailed quarterly data and insight, and annual performance review data.

These quality outcome indicators will be the foundations of our Quality Management System and transforming services which will assist in improving quality learning and reducing inequality and risk across the system.

Continuously Improving Patient Safety

Improve our understanding of safety by drawing insight from multiple sources of patient safety information

People have the skills and opportunities to improve patient safety, throughout the whole system.

Improvement programmes enable effective and sustainable change in the most important areas.

INSIGHT
- Measurement
- Incident response
- Medical Examiners
- Alerts
- Litigation

INVOLVEMENT
- Patient safety partners
- Curriculum and training
- Specialists
- Safety II

IMPROVEMENT
- Deterioration
- Spread
- Maternity
- Medication
- Mental health
- Older people
- Learning disability
- Antimicrobial resistance
- Research

A patient safety *culture*
A patient safety *system*

Key objectives for the next year

- Delivery of an approved strategy for Quality, Framework and Delivery Plan with a clear understanding of priorities.

- Through the launch of the new system for patient experience and the Health and Well-being survey, put in place mechanisms to learn from the insight gained.

- Establish a framework for learning and skills at all levels and the capacity and capability to grow and develop our skills and learning networks.

- Deliver the Safe Care Partnership, Faculty workstreams and the outcomes as set by each team.

- Agree and implement the measures and reporting structures.

- Review the capability of our data capture systems for resilience and suitability.

- Implement new systems to provide insight and support for delivery.

- Review our quality and safety structures and teams along with the reporting structures to ensure learning at every level and appropriate assurance and governance.

QUALITY PRIORITY 1: Deliver PERSON CENTRED care which involves patients, relatives, families, carers, and system partners in the planning delivery of care and opportunities to improve patient safety.

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	**Q2**	**Q3**	**Q4**		
			Patient and Staff Experience			
Launch a system to capture Patient Experience across the Health Board (CIVICA)	• Launch the CIVICA system in Community Hospitals. • Divisional awareness campaign commences. • Training and user programme commences. • Define measures	• Generate and review first reports and insight	• Define and redesign the questions if required	• CIVICA available in all acute and community areas	• Opportunities to receive direct patient feedback to inform learning	• General experience rating of episode of care • Increase in number of responses in Civica
To respond and learn from complaints	• Review of resources and processes available to respond to complaints	• Recommendations finalised for approval, and implementation complete by the end of the quarter. • Reduction in complaints backlog	• Reduction in complaints backlog	• Backlog of complaints resolved	• Timely feedback and response to concerns • Opportunities to learn and focus improvement	• Compliments - themes identified for improvement • Reduction in the complaints backlog • Qualitative feedback use of the learning section in Datix • Increase in the number of actions plans completed
To listen to feedback from staff	• Employee wellbeing survey undertaken by workforce	• Results available from survey • Capture ideas for improvement generated by staff	• Analyse results	• Themes for improvement • You said, we did approach for ideas	• Timely feedback to ideas for staff • Enhance staff wellbeing	• Triangulate staff experience with data
To ensure that the "Voice of the Child" and the principles of "Making Safeguarding Personal" are integral to safeguarding practices within the Health Board	• Develop key messages to be delivered via Safeguarding Level 3 Training	• Develop key messages to be delivered via Safeguarding Level 3 Training	• Develop mechanisms for feedback from patients on their experience of safeguarding processes	• Undertake case file audit to determine if principles are embedded in process and provide formal feedback to clinical teams	• Care is planned and delivered respecting the views of the individual	• Evidence of person centred care in safeguarding care plans

QUALITY PRIORITY 2: Provide SAFE care – we aim to reduce harm, prevent errors, and deliver consistently safe care through increased visibility and insight from multiple sources of patient safety information

Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure
	Q1	**Q2**	**Q3**	**Q4**		
Theatre Quality and Safety Programme	• Scope, define and design improvement role and objectives with QPS and Division	• Advertise and appoint • Define work programme to include: – Reducing never events – Building quality improvement capability – Human Factors in Safety programme – Safe Care Collaborative – Acute Workstream	• Progress reporting commences		• Dedicated time for improvement and accountability from within the Division	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
Implement Human Factors as a HB wide approach	• Define programme of work and scope of the simulation programme	• Schedule sessions and design of QI programme	• Training and wider team engagement • Reporting the QI action plan established	• Publication of case studies	• Training and simulation programme in place with improvement programme of work	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
To implement Datix as the main method of reporting	• Awareness campaign to Divisions about the reporting requirements	• Review of reports and incidents • rolling action plan in place • Review of informatics requirements	• Implementation of informatics infrastructure as required	• Include learning in the Annual Learning festival	• The ability to report and highlight incidents to improve patient safety	• Reduction in the number of SI's, by harm category, National Reportable Incidents and Never Events
Reporting – redesign the reports and implement an outcome framework	• Scope and define the outcomes and measures • Align with the Assurance Governance Framework	• Approval at Exec and Board • First report produced • Realign the PQSOC reporting	• Refine and design the report • Implement the new reporting processes	• Review and revise Action Plan as a result of learning from the indicators	• Improved oversight governance and assurance to provide learning and insight to be able to make improvements	• QOF • Updated Board and PQSOC paper format
Review the QPS infrastructure to drive and spread improvement and learning	• QPS resource being mapped within Divisions • Working with HR to devise the OCP	• Draft proposal • Undertake OCP for staff with HR	• Review structure and interdependencies with Divisions and QPS		• An infrastructure designed for improvement	• Standardised agenda for Divisions on Patietns Safety, QUlaity and risk
To complete a Mortality Review to learn and identify improvement	• Through morbidity and mortality reviews and findings from the Medical Examiner Mortality Reviews • Mortality framework being developed	• Action Plan and reporting in place • Validate mortality measures • Work collaboratively with All Wales Mortality group and NHS Exec to define measures	• Devise a report for Board and Divisions on mortality data • Drill into CHKS data for improvements and deteriorating data	• Refine mortality report and measures	• Identification and learning opportunities used to focus improvements	• RAMI • Crude mortality rare
Pressure Ulcers Improvement Programme		• Revisit and refresh the learning from the collaborative • Redesign the information extracted from Datix	• Datix learning report established		• Improvement in the numbers of HA pressure ulcers and a reduction in harm.	• Decrease in the number of HA pressure ulcers by grade • Decrease in the number of HA pressure ulcers • Decrease in the severity of medicines incidents • Decrease in the number of incidents under • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
Falls Improvement Programme	• Embed the multifactorial risk assessment • Falls prevention training • Falls review panel in place	• From the Fall Review Pannel, Themes identified to inform an improvement action plan • Review the Community Falls action plan and revise and update improvement action plan	• Hold a learning and design event for Community and Inpatient falls		• Reduced risk and prevalence of falls • Prevention of risk for those vulnerable to fall	• Decrease in the number of falls treated in ED which have had a previous admission – reattendance • Improvement in the severity of harm following a fall in hospital • Decrease in the number of Falls by 10,000 occupied IP Bed days

QUALITY PRIORITY 3: Provide TIMELY care, ensuring people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place first time

Objective	Actions for each Quarter for 2023				Delivering (so what)	Indicators
	Q1	Q2	Q3	Q4		
Discharge Programme Board programme	• Delivery of Move it May campaign. • Visit to Swansea to view Signal IT system • Short term digital solution – design and analysis	• Away Day RGH Hub • Trusted Assessor workshop • Short term digital solution – development • Prepare operational process for capturing D2RA/Red to Green • Roll out of Nurse Led Discharge	• Short term digital solution – development • Continue to prepare operational process for D2RA/Red to Green • Implement Trusted Assessor model • Full role out of Optimising Patient Flow Framework	• Implement Trusted Assessor model • Short term digital solution – test and run • Continue to develop and review the RGH Discharge Hub	• Optimal hospital care and discharge practice at the point of admission • A Home First approach to reduce re-admission	• Reduce time from surgery to discharge • Reduce Time spent on a waiting list • Reduction of handovers >1 hour • Reduction in time for patients to be seen by first clinician
Support individuals to stay at home or close to home	• Pilot for extended hours • Start OCP	• Conclude OCP • Publish navigable pathway for ambulatory care offer • Produce strategy and action plan for Community Hospitals	• Service transition to extended hours • Develop the professional hub • Changes to ambulatory care model	• Continuation of existing workstreams • Commence Phase 2	• To support individuals to stay at home or close to home, where this is both safe and appropriate. To support all health care professionals to engage with what is right for individuals, first time.	• Reduction in time for bed allocation from request • Decrease in ED waits >12hrs • Increase in discharges before midday; • Decrease in LoS OVER 21 DAYS • Time from Flow Centre call to discharge/ admission from assessment? • Number of emergency admissions in hospital over 7 days • Decrease in the time from request to step up/down to a different site • Decrease Overnight bed moves and patient transfers
Improve Ambulance handovers	• Review Q4 APP pilot and whether permanent roll out beneficial or justifiable • Implement outcome of PRU winter service activity • Complete recruitment process and on-board remaining therapy practitioners, OT and Physio • Identify and recruit Care of the elderly (COTE) locum for duration of the pilot	• System wide engagement on risk stratification and subsequent effect of regular patient flow from ED utilizing eLGH and community sites • Recruitment of locum resilience to enable Frailty assessment • Feasibility assessment of GP resilience to eLGH and GUH front door, possibly utilizing SDEC space	• Procure e-Triage solution and focus on the long lead time aspect (relating to technical integration with Welsh Patient Administration System (WPAS)) • Agree mechanism to be used (i.e. CWS watchlist) and risk management approach for a pilot of a new ED referral process	• Utilize lessons learned from Same Day Emergency Care (SDEC), Integrated Assessment Centre (IAC) and early e-Triage experience to shape new ways of working • Continuous Data and PREM Review	• Maximising and individuals time and outcomes and improving system safety	
Improved Cancer outcomes	• Programme priorities agreed • Programme structure agreed	• Prehabilitation Business Case • Establishment of NHH working groups	• WG approval of NHH Cancer Centre • Patient Group initiated	• Acute Oncology Regional model rolled out • ABUHB Cancer 'Blueprint' agreed	• Maximising cancer outcomes	• Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion • Increase in 5 year cancer survival rates
Timely completion of Duty to Report	• Meet with Local Authorities to understand the prevalence of delayed referrals	• Work with clinical teams to understand the barriers to timely referral	• Review of pathways for referral with Safeguarding committee and Partnership Boards	• Update clinical teams with changes to referral process to strengthen practice	• Referrals will be made via the appropriate route in a timely way, to ensure appropriate and suitable responses	• Reduction in complaints from local authorities in regard of delay in reporting

QUALITY PRIORITY 4: Provide EFFECTIVE care – Deliver consistently effective and reliable care, based on evidence-based best practice which is delivered in a culture that encourages and enables innovation to Improve outcome

Objective	Actions for each Quarter for 2023				Delivering (So what)	Indicators
	Q1	Q2	Q3	Q4		
Increased Get It Right First Time (GIRFT) implementation by area		• Establish a reporting mechanism with Ops to track the progress and implementation			• Clear programme by specialty designed to improve the treatment and care of patients	• Increased Get It Right First Time (GIRFT) implementation actions by area • Number of INNUS's being completed
Implement robust Audit processes and plans	• Develop action plan and agreed forward work plan for audit • Implement AMAT as a reporting and analysis tool	• Compliance with the audit plan	• Compliance with the audit plan	• Compliance with the audit plan	• Reduced variation in Care • Increased understanding of variation to focus Improvements	• Increase in the SMART action plans with accountability in National Clinical Audit • Increase in the numbers of wards participating in accreditation (Audits via AMaT) • Increase in the actionable audit recommendations by National Clinical Audits
Implement Duty of Candor reporting	• Awareness campaign to Divisions about the reporting requirements	• Review the DoC reports and effectiveness of the process	• Compliance with DoC audit requirements	• Compliance with DoC audit requirements	• Increased understanding of variation to focus Improvements	• Implement Duty of Candour reporting • Compliance the number of incidents triggering Duty of Candour within 5 days
Ward accreditation	• Test the ward accreditation programme	• Increase in the numbers of wards participating in accreditation	• Reporting against the implementation of the accreditation	• Roll out to clinical areas areas	• Reduced variation in Care • Increased understanding of variation to focus Improvements	• Audit report available via AMaT to include quality measures and organisational measures
Safe Care Collaborative (also Safe Care)	• Driver diagrams completed for teams • Leadership work plan agreed • Training programme agreed	• Charter complete • Attend action calls and learning session • Monthly reporting • Measurement of progress • Project score	• Leaders for Safety Improvement starting training programme • Safety Coaches starting coaching training		• Reduced variation in Care • Increased understanding of variation to focus Improvements	
Implement a Quality Training Programme to drive and spread improvement	• Define and share the programmes available.	• Safety Coaches starting coaching training	• Implement a Quality Training Programme to drive and spread improvement • Leaders for Safety Improvement starting training programme	• Define and share the programmes available.	• Leadership and skills at all levels and part of what we do to embed our QMS and culture of continuous improvement	• Implement a Quality Training Programme to drive and spread improvement
Medicine Management	• Validate incidents via Datix • Implement medicines safety strategy	• Track progress with medicines safety strategy	• Track progress with medicines safety strategy	• Track progress with medicines safety strategy	• Reporting and action plan via Medicines Safety Group	• Delivery of objectives set medicines safety strategy

QUALITY PRIORITY 5: Provide care that is **EFFICIENT** by taking a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste

Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure
	Q1	**Q2**	**Q3**	**Q4**		
Datix infrastructure	• Review resources and infrastructure for Datix management and reporting	• Establish reporting processes • Datix awareness and use training	• Datix awareness and use training	• Datix awareness and use training	• Patient experiences are visible and acted on	• Qualitative feedback use of the learning section in Datix • Increase in the number of actions plans completed
Falls (also an Objective under Safe)	• Embed the multifactorial risk assessment • Falls prevention training • Falls review panel in place	• From the Fall Review Pannel, Themes identified to inform an improvement action plan • Review the Community Falls action plan and revise and update improvement action plan	• Hold a learning and design event for Community and Inpatient falls		• Reduced risk and prevalence of falls • Prevention of risk for those vulnerable to fall	• Decrease in the number of falls treated in ED which have had a previous admission – reattendance • Improvement in the severity of harm following a fall in hospital • Decrease in the number of Falls by 10,000 occupied IP Bed days
Maximising capacity and resources in outpatients	• As part of the Outpatient Transformation programme, improvement programme targeting DNA's commences 23/24 actions	• Continue Implementation of Did not attend (DNA) action Plan. 5% target. Plan also linked in with Cancer Services DNA improvement plans	• Continue Implementation of Did not attend (DNA) action Plan. 5% target. Plan also linked in with Cancer Services DNA improvement plans	• Review sustained DNA improvements and success of the interventions	• Improved utilisation of capacity reducing waste and access to care	• Decrease in the DNA's and CNA'S

QUALITY PRIORITY 6: Provide EQUITABLE care, ensuring equal opportunities for individuals to attain their full potential for a healthy life which does not vary in quality and is non-discriminatory.

Objective	Actions for each Quarter for 2023				Delivering (so what)	Measure
	Q1	**Q2**	**Q3**	**Q4**		
Improve care at the end of life	• Completion of the mortality review	• Learning and theme action plan agreed • Meet compliance of issuing of Medical Certificates within 5 days	• Meet compliance of issuing of Medical Certificates within 5 days	• Meet compliance of issuing of Medical Certificates within 5 days	• Improving quality at the end of life for people and families	• Decrease in the % of hospital as a place of death • Increase in compliance of issuing of Medical Certificates within 5 days
Safeguarding resources and processes	• Review of resources and processes for reporting, staff and patients • Review of training available to different staff groups within the Health Board	• Actions from reviews communicated and action plan development with Operations, Workforce and OD and leadership teams • Develop and mandate safeguarding training in line with All Wales Guidance. • Develop a model of safeguarding supervision for Adult Safeguarding	• Delivery of Safeguarding Training • Role out of Safeguarding Supervision in targeted teams	• Formal evaluation of Safeguarding Training continued delivery • Evaluation of safeguarding supervision • Roll out of additional safeguarding supervision • Continued delivery of Safeguarding Training	• Improving quality of life and equitable access • Timely response to concerns • People and staff able to raise concerns to prevent as well as address • Staff will better understand their role and duty in the safeguarding of children and adults. • Staff will feel supported to support and manage the care of patients who require safeguarding	• Increase in the access to Safeguarding Training • Timely closure of Safeguarding incidents • Appropriate responses irrespective of where the patient presents
Violence and aggression incidents	• Review and analyse V&A incidents • Return to face-to-face Management of Violence & Aggression training	• Review and update the ABUHB Violence & Aggression Policy and develop supporting procedures & protocols, including the internal sanctions procedure	• Launch Violence & Aggression campaign across the Health Board	• Conduct staff survey relating to violence and aggression incidents • Continued delivery of Management of Violence & Aggression Training	• Improving staff experience	• Decrease in the incidents of violence and aggression towards staff

Next Steps

➢ Establish limitations with reporting of the data and quality limitations.

➢ Increase validity of the data.

➢ Develop PQSOC work planner for when reports will be presented to PQSOC.

➢ Devise timeline will be produced for when reports will need to be submitted to the Committee and details of what reports are expected from each of the Groups.

➢ Reports that are not part of the quality operating framework will be on a rolling agenda from the Groups to provide narrative of outputs and delivery.

Quality Governance and Assurance Framework

Introduction

Our Strategy for Quality is being implemented throughout Aneurin Bevan University Health Board, ensuring quality is embedded in our culture and demonstrating our commitment to continually improving. We are developing our Governance and Assurance Framework for Quality to enable our Health Board to function as a Quality Management System (QMS) at every level.

Individuals working in clinical teams providing NHS services are at the frontline of ensuring quality of care to patients. Many of these frontline staff work within a framework of professional regulation that makes them personally accountable for the quality and safety of care they provide to individual patients. However, ultimately, it must be the Board and leaders of provider organisations that take final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care.

The Board has overall responsibility for the activity, integrity and strategy of the Health Board and has a statutory duty to ensure high standards of clinical governance. Groups and Committees can report concerns and escalate risks to the Board. The rationale for this Framework is to enable a governance structure that permits efficient flow for escalation.

Purpose

Governance is how the Health Board controls and directs the organisation and its supporting structures, to identify and manage risk and ensure the successful delivery of the organisation's objectives. Quality Governance is the combination of structures and processes at and below Board level to lead on Health Board-wide quality performance.

The principal aim is to maintain a robust framework for Clinical Governance with realistic goals that take into account the Health Board context and strive for continual improvement. The structure will allow monitoring systems and process to provide assurance of patient safety and quality of care throughout the Health Board. This will ensure that care meets the Health and Care Quality Standards as documented in the Health and Social Care (Quality and Engagement) (Wales) Act (2020).

Our governance systems are being reviewed and aligned to deliver the Quality Strategy. A new oversight and reporting structure will be implemented to provide transparency and oversight of our performance and progress.

We will ensure we have a quality governance framework that provides Board assurance through a systematic approach to maintaining high quality care and standards. We will refine the combination of structures and

1

processes, at and below Board level, to lead on Health Board quality performance. This framework must therefore address the following:

- To define quality governance and give shape to what it means to govern for quality across an organisation.

- Seek to provide support to Board in achieving and delivering this quality governance.

- Support clarity in lines of reporting.

- Increases the level of assurance through its implementation, with the aim of increasing public trust and confidence.

Clinical Goverance Assurance and Escalation Framework

The framework is an important part of the Board Assurance Framework and links with the Health Board risk management strategy. It will provide the Board with assurance of effective and sustainable management of quality throughout the Health Board. This framework is designed to support the delivery of our vision for quality to provide an outstanding experience for our patients, relatives, carers, staff and communities by a Health Board that is well managed, cost effective and has a skilled and motivated workforce.

It is important that the Board is able to monitor the implementation of strategic objectives set out in its Integrated Medium-Term Plan. Assurance is provided through committee structures. Within the clinical governance structure there are committees, sub committees and groups; each have delegated responsibility to deliver the Health Board's strategic goals and objectives via compliance with performance and quality indicators and monitoring of associated risks. There is inter-dependency between the committees, through sharing of minutes, standard agenda items for escalation and action logs.

The following actions are being taken as part of implementing this Framework:

1. The existing structure of Groups and Committees are being reviewed to understand the function and purpose.
2. A new oversight and reporting structure will be implemented. These will sit under Safety, Clinical Effectiveness and Patient Experience. See Appendix One for the updated framework proposal and Appendix Two for existing Groups and functions.
3. Groups and Committees are being asked to define their purpose, terms of reference and reporting mechanisms. See Appendix Three for the current scoping exercise to enable the framework to be reviewed.

2

Divisions

The current proposal is for the Quality and Patient Safety (QPS) resource to be redefined as a business partner model. QPS leads will develop standardised patient safety, quality and risk reports for the Divisional Management Team. The interdependencies with QPS and the Divisions around clinical engagement and leadership are being defined. A governance structure for the QPS resource is being developed to set expectations of the Divisions and clarify how assurance is sought.
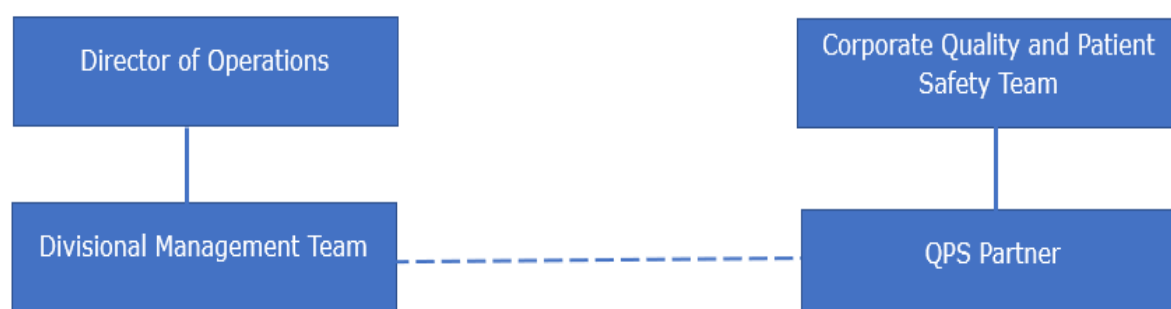

Figure 1. QPS governance structure currently under review

The QPS partner model will produce a report to enable oversight and assurance on the delivery of safe and high-quality care by scrutinising the following:

- Reported incidents e.g. Datix including thematic reviews and opportunities for learning
- Incident investigations e.g. Inquests & litigation, never events, RCA, safeguarding, infection control
- Specialty attributable elements of Health Board register
- Specialty audit & QI activity e.g. national audit, local audit
- Patient & relative feedback e.g. CIVICA, Friends & Family, complaints/compliments, local resolution meetings
- Specialty morbidity & mortality review
- Review of new national, Health Board wide and local policies, SOP & clinical guidelines
- Review of national and local safety alerts
- Health & safety issues
- Specialty operational performance
- Dissemination of learning from Divisional & Corporate Governance
- Research governance
- Specialty's quality dashboard

3

A format for standardised agendas will be agreed by QPS working with Divisions. This will incorporate terms of reference for governance and safety meetings and a framework for meetings to ensure patient safety concerns and risks are documented and escalated as appropriate.

There will be a Clinical Lead for Governance within each of the Divisions ensuring engagement with the QPS team. The annual operating framework will ensure indicators and measures are available for Divisions as part of the Quality Management System.   A Safety and Governance report will be produced for the Divisions. See Appendix for example. Divisions are required to have monthly meetings to discuss and oversee all governance issues within Directorates or Specialties.

Both the Clinical Lead for Governance and QPS lead with be jointly responsible for creating the conditions and embedding Quality Improvement and developing the capacity with ABCi support in the Divisions using the Model for Improvement.

Reporting

The implementation plan for the quality strategy will support the PQSOC work planner and tracking of progress for the Quality Outcomes Framework and Performance report for PQSOC meetings.   The framework will compliment this with the Groups and Committees who are expected to produce reports for PQSOC. A timeline will be produced for when reports will need to be submitted to the Committee and details of what reports are expected from each of the Groups. This will include escalation of risk. Reports that are not part of the quality operating framework will be on a rolling agenda from the Groups to provide narrative of outputs and delivery.

Assurance and learning for improvement

We are committed to creating and leading a culture and an environment that drives improvement from learning.   The Quality and Patient Safety Operational Group is being reviewed as a learning forum and the purpose of the group is being re-established.

Raising quality concerns Outlier reporting

As the annual operating framework is being developed there will be an expectation of reporting business as usual. When the Division needs to raise quality concern issues a framework is being developed to enable the Board to draw on for assurance. This will allow any clinical areas that are underperforming to raise quality concerns and escalate patient safety issues.

4

Outlier reporting

A Standard Operating Procedure (SOP) is currently in use to enable an effective response to the National Clinical Audit Outlier Procedure.   The purpose of the SOP is to ensure a standardised approach to considering and responding to outlier notification in relation to national clinical audits.

Multiprofessional Clinical Forum

Over the next six months a Clinical Forum will be established in partnership with the Clinical Executives. This will enable a clinical professional group to be created to sit under the Board or the Executive Team. As a Clinical Reference Group this will be multiprofessional and its role and purpose will be to support the implementation of Quality and Professional Strategies.

In other Health Boards, Trusts and organisations this 'Clinical Senate' approach has been established to be a source of independent strategic advice and guidance to assist in making the best decisions for the populations they present. This enables the formation of a multi-professional steering group and maintains a strategic overview across the organisation.

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Appendix 1 – Proposed Assurance Framework

ASSURANCE FRAMEWORK 2023
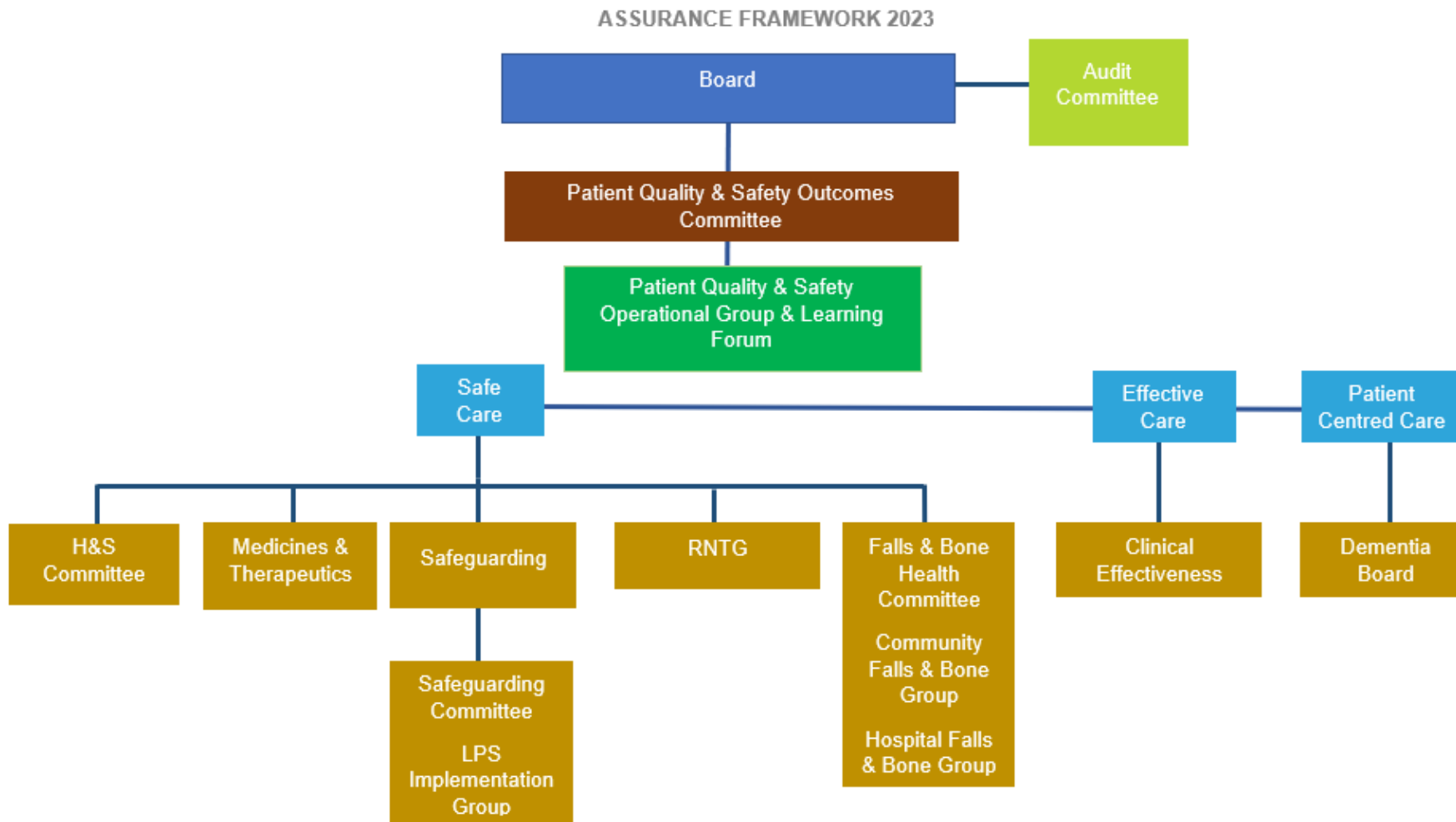
Appendix Two – Current Groups and Functions

	Sub Committees	Groups	Function
Safe Care	Health and Safety	Statutory Compliance Group	
		Fire Safety Committee	Fire
		Manual Handling Group	Manual Handling
		Security Group	Non Clinical Investigations
		Violence & Aggression Security Group	Mortality Reviews
	Falls & Bone Health Community Falls & Bone Hospital Falls & Bone	Falls Review Panel	Falls
	Medicines & Therapeutics	Medication Safety	Medicines Management
		Medical Gases	
		Patient Group Directives	
		Non-Medical Prescribing	
		Homecare Group	
		Local Intelligence Network Controlled Drugs	
		Datix Operational Group	Datix Incident Management System
		Datix Project Group	Datix Incident Management System
		Acute Deterioration Group	
		Hospital Transfusion	
		Thrombosis Committee	
		Human Tissues Authority	
		Resuscitation Committee	
		Mortality Review Panel	Medical Examiner
		Nutrition and Hydration	
	Safeguarding	MCA Forum	

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	LPS Implementation		
		Cleaning Standards Group	
	RNTG	Decontamination Group	
		Antimicrobial Group	
Effective Care		Clinical Policy & Standards	Policies
		Clinical Standards & Effectiveness	Clinical Audit & Measurements
		Medical Devices	Medical Devices
		Point of Care Testing	Regulatory Framework
		Ultra Sound Governance	
		R&D Committee	
		Risk Review Panel	
		R&D Education	
		Intellectual Property	Consent
Patient Centred Care	Dementia Board	Dementia Connector	
		MAS/LD & MCI	
		Carers Education Programme	
		Community Engagement	
		Hospital Charter DCM Inpatient	
		Workforce Development	
		Measurement & Leads Group	
		Redress Panel	

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Appendix Three

Questions for Groups and Committees to establish purpose

- Name of Group/Committee
- Does your Group/ Committee have a relationship with a WG national workstream, are any reports required for this
- Please can you submit a Terms of Reference of your Group/Committee
- How frequently do you meet
- Who do you report to
- What reports do you produce as part of your Group/ Committee
- Do you produce an annual report
- Do you produce a report of quality or governance
- How do you escalate concerns
- Is your Group / Committee multidisciplinary
- Does your Group/ Committee have representation from all Divisions
- Does your Group represent, Primary Care, Secondary Care (acute) or both
- If you have any comments, please add them here

PATIENT QUALITY, SAFETY & OUTCOMES COMMITTEE
PROGRAMME OF BUSINESS 2023/24

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 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
Attendance and Apologies	Standing Item	Chair	✓	✓	✓	✓
Declarations of Interest		All Members	✓	✓	✓	✓
Minutes of the Previous Meeting		Chair	✓	✓	✓	✓
Action Log and Matters Arising		Chair	✓	✓	✓	✓
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 2023/24	Annually	Chair & Director of CG				
Annual Review of Committee Effectiveness 2023/24	Annually	Chair & Director of CG				
Committee Annual Report 2023/24	Annually	Chair & Director of CG				
Pharmacy and Medicines Management Annual Report	Annually	Medical Director				
Internal Audit Review: Medicines Management (Reasonable Assurance) – Update on actions	Annually	Medical Director				
Focus on Pillars of Quality - Infection Prevention and Control and Safeguarding - Incident report and Health Safety and Security - Patient and staff feedback and Complaints and Concerns				✓	✓	✓

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
Mental health and learning disabilities assurance			✓	✓	✓	✓
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				
Falls Prevention and 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			✓	

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
Infection Prevention and Control Report	Quarterly	Director of Nursing			✓	✓
Blood Management Annual Report	Annually	Medical Director				
Organ Donation Annual Report	Annually	Medical Director				
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				✓
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 Planning				
Research and Development Annual Report	Annually	Medical Director				
Medical Devices Annual Report	Annually	Director of Therapies & HS				

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
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	✓	✓	✓	✓
Patient Story	Standing Item	Clinical Executives	✓	✓	✓	✓
Putting Things Right Policy	Every 3-yrs (2022)	Director of Nursing				✓
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				✓

[1] Via Quality and Safety Outcomes Report

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
Patient Safety Incidents and Learning	Standing Item[2]	Director of Therapies & HS	✓	✓	✓	✓
Covid-19 Concerns and Claims	Bi-Annually	Director of Nursing		✓		
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				
Primary Care Quality	Bi-Annually	Director of PCCMH				
Internal Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				
External Audit Reports relevant to the remit of the Committee	Ad-hoc	Clinical Executives				
Action Plan for "*Review of Quality Governance Arrangements*" Audit, Wales Review (2021/22)	Bi-Annually	Clinical Executives		✓		

Matter to be Considered by Committee	Frequency	Responsible Lead	Scheduled Committee Dates 2023/24			
			26th July	13th Sept	16th Nov	7th Feb
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			✓	
Overview of Audit Recommendation Tracking (relevant to the Committee)	Quarterly	Director of Corporate Gov			✓	
Inspections of Healthcare Inspectorate Wales	Ad-hoc	Director of Nursing				
Inspections of the Community Health Council	Ad-hoc	Director of Nursing				
Tracking of Improvement Actions Arising from Inspections and Reviews	Quarterly	Director of Nursing		✓		✓
Healthcare Inspectorate Wales Operational Plan	Annually	Director of Nursing			✓	
Healthcare Inspectorate Wales Annual Report	Annually	Director of Nursing				
WRP Report and Management Response/Action Plan: National Review of Consent to examination and treatment standards in NHS Wales		Medical Director				

INFECTION PREVENTION & CONTROL, DECONTAMINATION & ANTIMICROBIAL RESISTANCE

Annual Report 2022-2023

Aneurin Bevan University Health Board (ABUHB) is committed to ensuring that a consistent high standard of infection prevention and control practice is a priority and is an essential requirement of assuring high quality, safe and effective care and minimising avoidable harm.

Executive Lead: Director of Nursing

May 2023

Contents

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Purpose

The purpose of the Infection Prevention and Control, Decontamination and Antimicrobial stewardship annual report is to provide an overview of themes and learning. This report will cover the period from April 2022 to March 2023 of the Aneurin Bevan University Health Board performance and assurance against the following: -

- ➢ Infection Prevention Team and Governance Arrangements
- ➢ Welsh Government Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HAI) Improvement Goals
- ➢ Respiratory Infections (Covid-19, Influenza, Respiratory syncytial virus (RSV)
- ➢ Covid Investigation Team
- ➢ Decontamination strategy
- ➢ Infection Prevention Incidents

Introduction

Aneurin Bevan University Health Board recognises the prevention of infection is fundamental to the delivery of high quality care. The Health Board is committed to ensuring that evidence-based practice in conjunction with a high standard of care is achieved by implementing fundamental infection prevention and control into general practice.

Aneurin Bevan University Health Board maintains a zero-tolerance approach toward all preventable HCAIs and is committed to minimising risks to patients. Welsh Government AMR and HCAI Improvement Goals 2022-23 set out 2 main aims namely:

- ➢ Optimise the use of antimicrobials
- ➢ Lower the burden of healthcare associated infection

Progress against these 'improvement goals' is monitored through the Health Board Reducing Nosocomial Transmission Group (RNTG).

The table below demonstrates compliance with the Welsh Government goals for the reporting period and a comparison with all Wales rates. The Health Board has lower rates in all areas of reporting against the all Wales position.

Pathogen	Welsh Government Target per 100,000 population	Health Board Rate	All Wales rate
C *difficile*	25.00	32.26	36.82
MSSA	20.00	21.06	25.68
MRSA	0.00	2.1	2.24
E coli	67.00	52.66	67.04
Klebsiella	10% reduction	19.73	22.31
Pseudomonas	10% reduction	3.01	6.15

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The Annual Report is underpinned by Health and Care Standard 2.4 Safe Care. Within this standard, effective infection prevention and control (IPC) is identified as everybody's business and must be part of everyday healthcare practice, based on the best available evidence, so people are protected from preventable healthcare associated infections.

The "Code of Practice for the Prevention and Control of Healthcare Associated Infections" (2014) builds on the 2011 Welsh Government "Commitment to Purpose – eliminating preventable healthcare associated infections (HCAIs)". This framework sets out the minimum necessary infection prevention and control arrangements for NHS healthcare providers in Wales, whereby organisations are expected to meet nine core elements.

Other guidance, key documents and policies outline evidence-based practice to support organisations in the prevention of healthcare associated infection (including Covid-19) and to reduce the burden of antimicrobial resistance, these include: -

- Infection Prevention Policies local and national
- Communicable Disease Outbreak Plan for Wales
- All-Wales Infection Prevention and Control Training, Learning and Development framework
- National Standards for Cleaning in NHS Wales
- Aseptic Non-Touch Technique (ANTT)

The consistent implementation and maintenance of these key national standards is vital to prevent the transmission of harmful micro-organisms to patients and staff and minimise harm.

HCAI's have the potential to cause significant harm. As well as the more obvious consequence of a local infection requiring treatment or life-threatening infections such as sepsis and endocarditis. Infections can also cause chronic illness leading to long term pain and disability. There is also an adverse impact on the health service due to extended lengths of patient stay in hospital and time away from home, the costs of diagnosis, treatment and complications of infections coupled with the costs of specific IPC measures. Hence, the prevention and control of infection is a national and organisational priority, and this is reflected in the Welsh Government Quality Act moving forward.

Governance and Assurance

This section covers progress from the previous year's work plan, a summary of the team establishment and financial position, overview of Executive reporting mechanisms, case management and compliance with training and education.

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Update on progress from previous year work plan 2022/2023

Based on the 2022/23 issues, a work programme was developed for focus during this period. The table below outlines progress:

Priority 1:	Introduce systems to manage and monitor the prevention and control of surgical site infection (SSI). These systems use risk assessments and map the patient's pathway within secondary and primary care maximising the use of ICNet.	Focus week in Nov achieved Linked with IT re SSI module for ICNET
Priority 2:	Provide and maintain a clean and appropriate environment in managed premises that facilitates robust compliance to the prevention and control of infections.	Environmental audits indicate 90% or above for all clinical areas Some slippage in the annual proactive HPV clean due to bed occupancy and capacity
Priority 3:	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance, through the roll out of Antibiotic Review Kit (ARK) project.	ARK roll out to the main Aneurin Bevan University Health Board hospitals is complete. Where more complete data is available, YYF & NHH, review of antimicrobial prescriptions, and documentation of a review date reached 100% from baselines around 50%. Ongoing work is required to ensure data collection is embedded by directorates and divisions, in particular GUH & RGH
Priority 4:	Provide suitable and accurate information on infections for service users.	Maintained intranet page. All policies in date
Priority 5:	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.	Results reviewed timely through seven-day week service.
Priority 6:	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. Systems to ensure that all care workers (including contractors and	Maintained face to face educational sessions also promoted E learning

	volunteers) are aware of and discharge their responsibilities through education and training.	
Priority 7:	Ensure all IPC policies are up-to-date and evidence-based.	All available on the intranet
Priority 8:	Undertake outbreak reviews from Covid/C difficile and other pathogens ensuring learning is shared across the HB.	Achieved either via formal meeting or email. Learning incorporated within QPS operational group reports
Priority 9:	Actively support the Covid-19 Investigation Team	Support monthly data and active members of the MDT review panels
Priority 10:	Support the business case for line care with an overall aim to reduce Staph aureus bacteraemia.	Linked with radiology who are progressing this work, additional resource currently secured.
Priority 11:	Recruitment and stabilisation of the IPC team supporting HB agenda.	Reviewed team model and integrated service adopted in January due to inability to recruit
Priority 12:	Review evidence and research for electronic hand hygiene monitoring. Develop a cost analysis to implement to support the reduction of hospital acquired infections.	Review undertaken, costed and currently not viable

Infection Prevention Team establishment and financial position

The Infection Prevention Team (IPT) was successful in achieving Regional Integration funding (RIF) for this financial year however recruitment was difficult, and the team was unable to recruit. Following feedback from a Health Board Infection Prevention user survey, in January 2023 the existing team formed an integrated service across the Health Board. This approach is to support the team with succession planning plus enhance their confidence by having expert knowledge covering primary and secondary care. The team can establish a more focused case load with timely assessment, less travelling and becoming more efficient.

Hopefully this approach will benefit the Health Board and clinical teams by having an identified nurse/practitioner building on previous relationships, collaborative working, and timely response to incident management.

Continuing the same approach over the next twelve months will incur an estimated 30K overspend. The rational for the overspend is due to the opening of The Grange University Hospital (GUH) and redeployment into the team without substantive finance. One of the team objectives will be to develop a business case to support the sustainability of the team going forward.

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The team undertook a user survey to understand what Health Board staff/users request from the team with the overall aim to improve the service results below:-

You said:	We did:
¨ We need greater access to the team ¨ The team needs to be more approachable ¨ We would welcome a greater IPaC presence on our ward, to offer proactive support and advice	¨ We have reconfigured the team by area to enable increased time in clinical areas (please see table overleaf) ¨ We have developed a Team Ethos ¨ We have reviewed our process for internal emails ¨ We are re-energising our Infection Prevention Link Champions ¨ We have introduced a Practice Facilitator Role (Job Share) and are advertising training sessions ¨ We are reviewing our Intranet and website pages

The team developed a Mission Statement and Team Strategy: -

Reducing Nosocomial Transmission Group (RNTG)

The Health Board has a well-established RNTG which feeds directly into the Executive Team. The purpose of this clinically led group is to oversee the reduction of HAIs and AMR. To actively monitor compliance with the Health Board's Welsh Government HAI AMR goals action plan, directing action where necessary and escalating matters to the Executive Team as appropriate. Key function of the RNTG is to review evidence and provide advice, guidance, and direction to the Health Board.

Infection prevention policies are in line with national guidelines. A library of policies is available on the intranet. Policies are reviewed every 3 years or updated routinely if new guidance emerges. Reviewed and new policies are approved via RNTG. All policies are currently in date.

ICNET

The IPT has continued to use the ICNET which is an electronic infection case management and surveillance software which has been adopted by IPC's across Wales. The system provides a comprehensive overview of patients' laboratory results and documented IPC interventions. Patient records on ICNET are available to IPC teams across Welsh Health Boards improving the communication around infections both between and within IPC teams, and the data feeds into local and national surveillance programmes.

Over the last 12 months, ICNET has proved vital in the management and control of Covid-19, enabling the team to manage patients and support clinical teams promptly and efficiently. It has enabled the team to work remotely, which has proved invaluable when needing to provide support over a large geographical area.

The team has shared access with the Health Boards Testing and Covid Investigations Teams to support collaborative working and review processes. Unfortunately, the team is still awaiting access to the surgical site infection module which is being reviewed across Wales and internally via our informatics department. From April 2023, the team will enhance the use of ICNET to support route cause analysis investigations and will become the primary platform for patient caseload and documentation. The team will also be engaging with the use of the Health Boards Risk Management reporting platform - RLDatix to support the Duty of Candour assessment.

Education and Training

The IPT has continued to offer face to face education sessions plus promote the national E learning platform on ESR. The table below demonstrates activity over the last 12 months. In addition to this method, the team have also supported education via ward/department visits using opportunities to speak and discuss infection prevention with our staff. Within this reporting period, the team also adopted the role of Practice Educators who have also worked clinically observing and promoting best practice at ward level.

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Figure 1: Staff trained for Infection Prevention
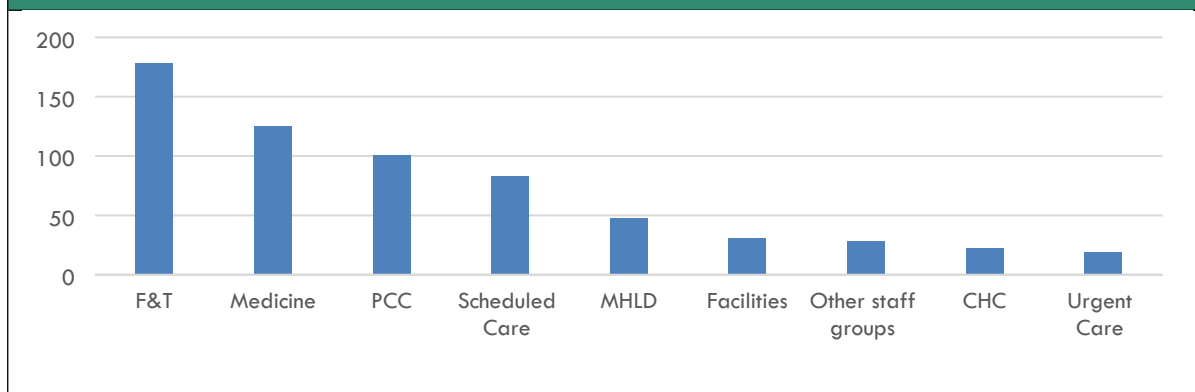
The team education has been promoted by participating in two emerging leadership days to encourage collaborate working and engagement of staff across the Health Board.

Infection Surveillance – Welsh Government Expectation Reduction

This section provides a summary of Aneurin Bevan University Health Board's performance against the Welsh Government Expectation Reduction Goals, identifies themes from outbreak management

C difficile

*Clostridium difficile (*CDI*)* is a bacterium that can be found in the lower gastro intestinal tract. The severity of illness can vary from a simple bout of diarrhoea to a severe infection causing potentially life-threatening inflammation of the bowel.

The organism can live harmlessly in the gut of young children and around 3 in 100 of adults. In healthy people it generally causes no harm as its growth is controlled by a healthy gut flora. However, when the natural balance of the intestine is disrupted by antibiotics, other medications or illness, the bacteria can multiply and produce toxins causing acute infection.

CDI can be minimised by good antibiotic stewardship and medicines management, particularly in those people who have specific risk factors (e.g. with previous history of CDI or chronic illness). The risks of transmission from one person to another in hospital and care settings can be reduced by adherence to infection control precautions such as prompt isolation of people with symptoms, hand hygiene and cleaning of the environment and equipment.

A total of 192 cases of *CDI* were reported from April 2022 - March 2023. This is -6% fewer as than the equivalent period 2021/22. Provisional rate is 32.26 per 100,000 population. Despite Health Board improvement, this has exceeded the national reduction expectation trajectory.

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Figure 2a: Health Board Performance – C difficile
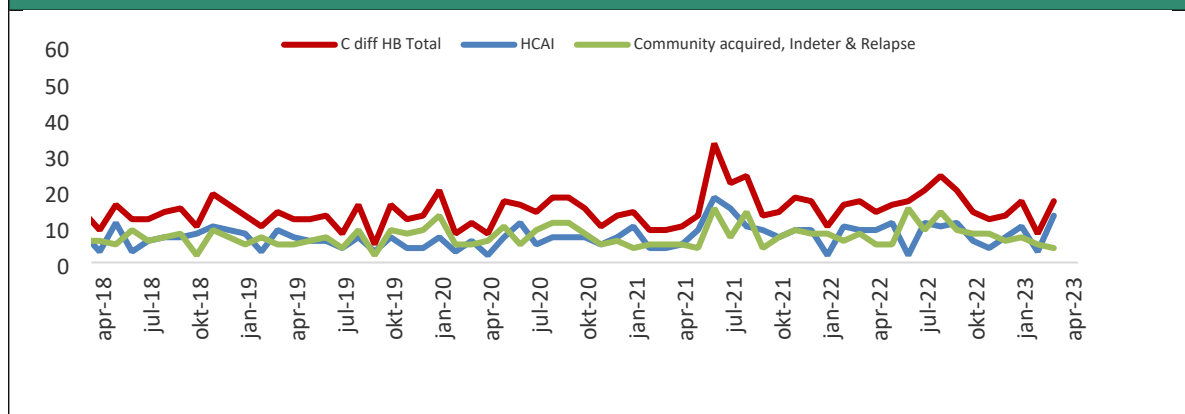
Across the Health Board, three wards experienced clusters of CDI where genotyping has indicated hospital ward transmission. Outbreak review meetings indicated learning in terms of lapse with fundamental infection prevention measures and antimicrobial stewardship. Another isolated contributing factor was a patient who required enhanced care could not remain in isolation facilities continuously during their infected period which increased the risk of environmental contamination.

Hospital onset CDI

Each healthcare associated CDI case is subject to a root cause analysis (RCA). Learning from RCA process for hospital acquired cases was:-

- 27% of patients were not isolated on development of symptoms
- 5% of wards did not have robust mattress checks in place
- 15% of wards reported contaminated commodes
- 63% of wards assessed as having nursing cleaning schedules below 95%
- 27% of patients experienced a delay in treatment once diagnosed

The IPT have been working with the wards to reinforce and where necessary, improve fundamental infection prevention measures. More recently, the IPC Practice Educators have been working clinical shifts to understand the barriers and challenges to practicing infection prevention measures in the workplace.

Infection prevention audit tools have been encompassed onto the Audit Management and Tracking (AMaT) tool. Going forward, AMaT will support the IPT and local teams to achieve quality improvement through real time data and action control.

Two key aspects of the care bundle to prevent CDI within a hospital setting is antimicrobial stewardship and fundamental infection prevention practice (hand hygiene and environmental cleanliness). Wards are required to undertake regular hand hygiene and cleanliness audits as optimum compliance is key to minimise cross infection. Data is captured via the NHS Health and Care Monitoring Tool.

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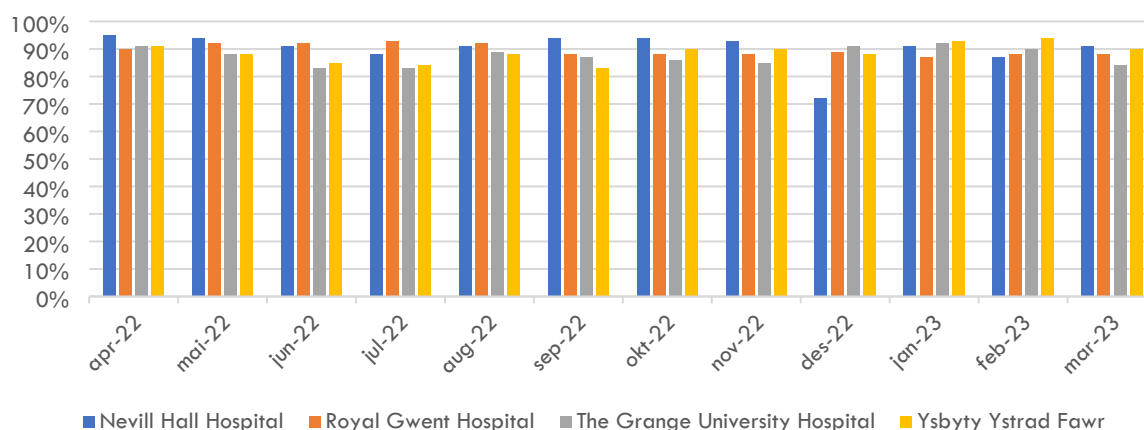## Figure 2b: Compliance with 5 Moments for hand hygiene – Acute Services

Legend: Nevill Hall Hospital, Royal Gwent Hospital, The Grange University Hospital, Ysbyty Ystrad Fawr

Figure 2c: Compliance with 5 Moments for hand hygiene – Community

Legend: Chepstow Hospital, County Hospital, Monnow Vale Health and Social Care Facility, Rhymney Integrated Health Care Centre, St Woolos Community Hospital, Ysbyty Aneurin Bevan
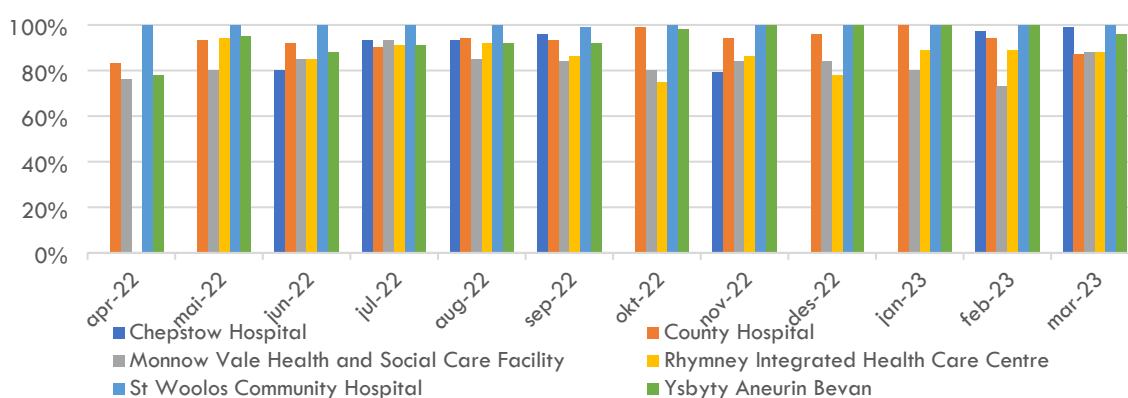
Figure 2d: Compliance with cleaning schedules – Acute services

Legend: Nevill Hall Hospital, Royal Gwent Hospital, The Grange University Hospital, Ysbyty Ystrad Fawr

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Figure 2e: Compliance with cleaning schedules - Community

Figure 2e: Compliance with cleaning schedules - Community

Legend:
- Chepstow Hospital
- County Hospital
- Monnow Vale Health and Social Care Facility
- Rhymney Integrated Health Care Centre
- St Woolos Community Hospital
- Ysbyty Aneurin Bevan
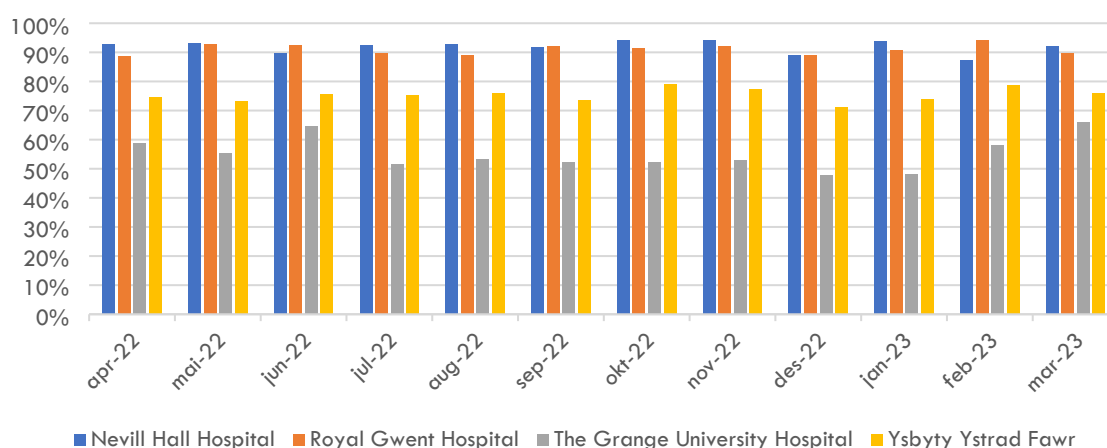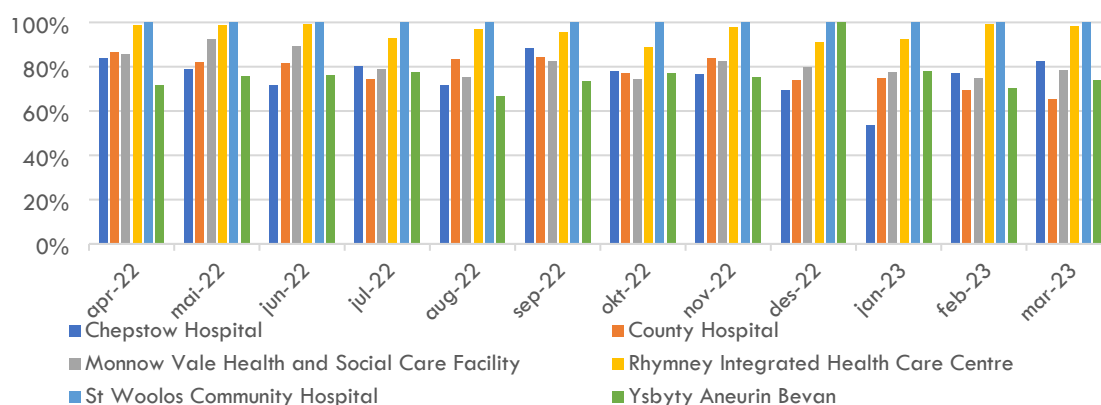
Community Acquired Transmission

Out of the 192 community acquired CDI cases, 59 cases (30%) were attributed to Primary Care. RCA forms are sent to GP Practices requesting any history of antibiotic and/or proton pump inhibitor (PPI) usage within the 3-month period prior to the CDI infection. During this reporting period 42 (71%) of RCA's have been returned by the GP.

From the 42 cases of CDI where GP's returned the RCA tool, 9 incidences were associated with sub-optimal antibiotic prescribing. Of this; 7 cases were associated with prescribing prior to the CDI and 2 cases where CDI treatment was found to be suboptimal. 7 out of 42 cases associated with PPI's which were not reviewed or stopped when antibiotics prescribed. The Health Board Antimicrobial Pharmacists provided constructive feedback to the GP Practices involved.

17 out of 59 community acquired CDI cases presented to hospital (2 associated with known suboptimal antibiotic prescribing).

Staph aureus bacteraemia

Staphylococcus aureus bacteria (SA) lives on (or colonises) the skin and in the nose of many people; it can also colonise chronic wounds. Most of the time it does not cause any harm but can cause infection if it multiplies or enters the body (e.g. via an invasive device or wound). Staph infections can be either methicillin-resistant Staph aureus (MRSA) or methicillin-susceptible Staph aureus (MSSA).

Both types of SA can go on to cause severe infection (e.g. sepsis, endocarditis) particularly in susceptible people vulnerable to infection (e.g. older people, those with acute illness or chronic conditions).

MSSA infections are more easily treatable with antibiotics. However, MRSA infections are resistant to many standard antimicrobials. The Health Board have a target to reduce the number of SA cases related to blood stream infections (BSI).

A total of 137 cases of Staph aureus blood stream infections (BSI) reported from April 2022 - March 2023. This is 3% more than the equivalent period 2022/22. Provisional rate is 23.26 per 100,000 population, which exceeds the national trajectory of 20 per 100,000 population.

Figure 3a: Health Board Performance – Staph aureus
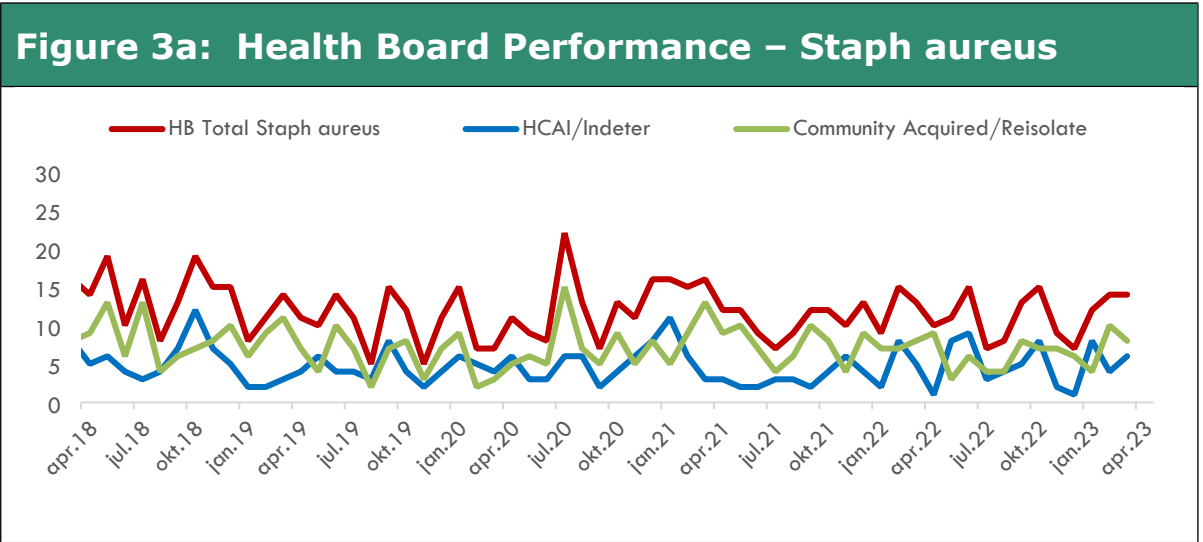
From the 137 cases, 12 cases were reported as MRSA BSI of which 6 patients were identified on admission (community acquired) and 6 cases were hospital acquired.

Figure 3b: Source of infection - MRSA
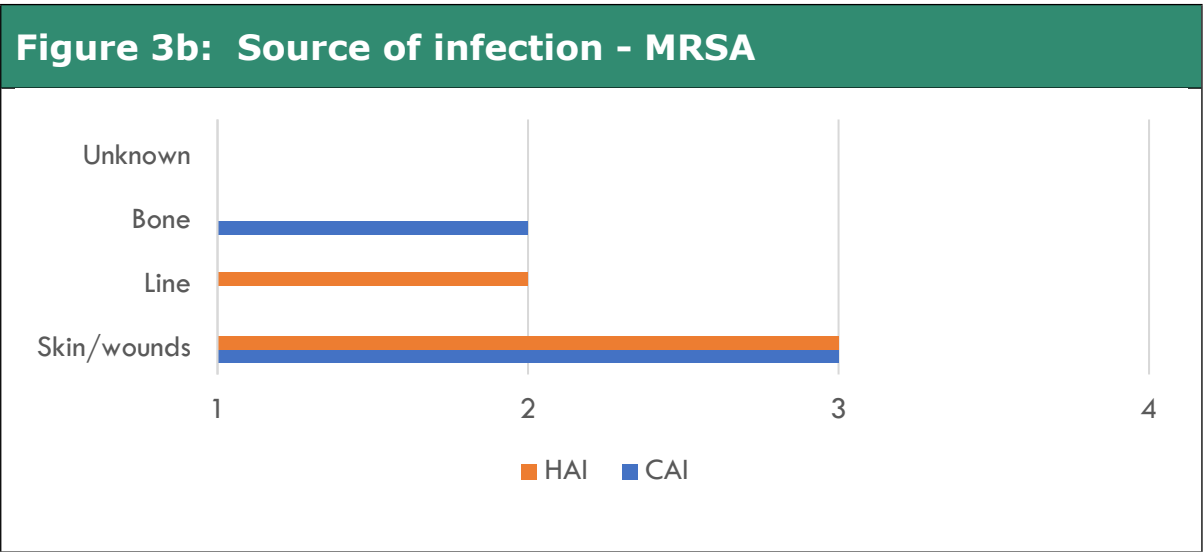
MRSA BSI increased significantly during 2022/23. A deep dive was undertaken to recognise themes and areas for improvement. The following themes were identified:-

➢ Screening on admission was missed for 3 of the 6 HCAI cases (according to current Aneurin Bevan University Health Board guidance).
➢ 100% of patients with line infections had peripheral vascular catheter (PVC) bundles in place.
➢ When looking at all cases with PVC or other lines/indwelling devices,

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- o 33% had PVC bundles in place (3 patients with line infections),
- o 33% did not (3 patients with HCAI skin and soft tissue infections (SSTI),
- o 33% were unknown (3 patients with CAI SSTI infections).
- ➢ Cleaning documentation and hand hygiene compliance was found to be less than 95% on several wards reviewed.
- ➢ Two wards had Aseptic Non Touch Technique (ANTT) and IP training at or above 95% compliance. 8 wards were not compliant.

MRSA treatment and eradication is another area of focus. The Health Board policy is currently under review and the Infection Prevention Team will be undertaking a hospital wide audit and review findings accordingly.

A period of increased incidence affecting the neonatal unit was reported to the Welsh Government Delivery Unit as an Early Warning Notification. Two cases (twin babies) were transferred from another Health Board. On arrival to Aneurin Bevan University Health Board, cannulas were removed as the device site was observed to be red and inflamed and therefore the likely source of infection. However, a blood culture to support the identification was not taken until 48 hours later. Learning was shared with the Unit and the other Health Board involved.

During the reporting period, the Health Board re-established the ANTT Steering Group. Resources on the intranet have been refreshed to promote best practice. The ANTT audit has also been made available onto AMaT audit so that the Divisions can gain assurance in terms of local practice. The IPT continue to monitor line infections and undertake three monthly PVC audits. This work will continue to be a priority over the next twelve month. Following a refreshed focus, Aneurin Bevan University Health Board are working towards achieving Bronze accreditation with the patient protection accreditation for healthcare providers.

Figure 3c: Source of infection - MSSA
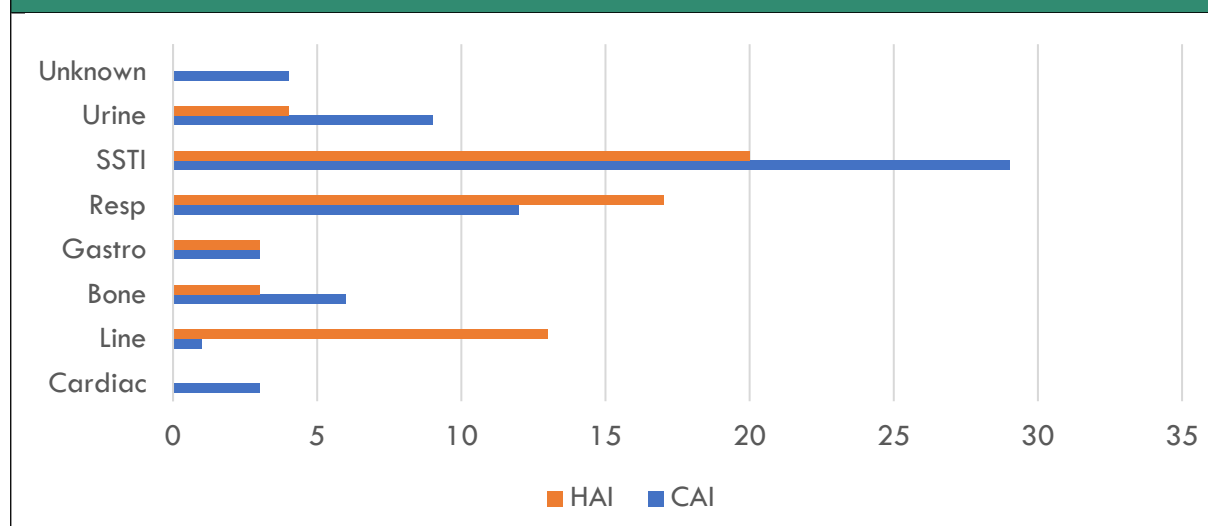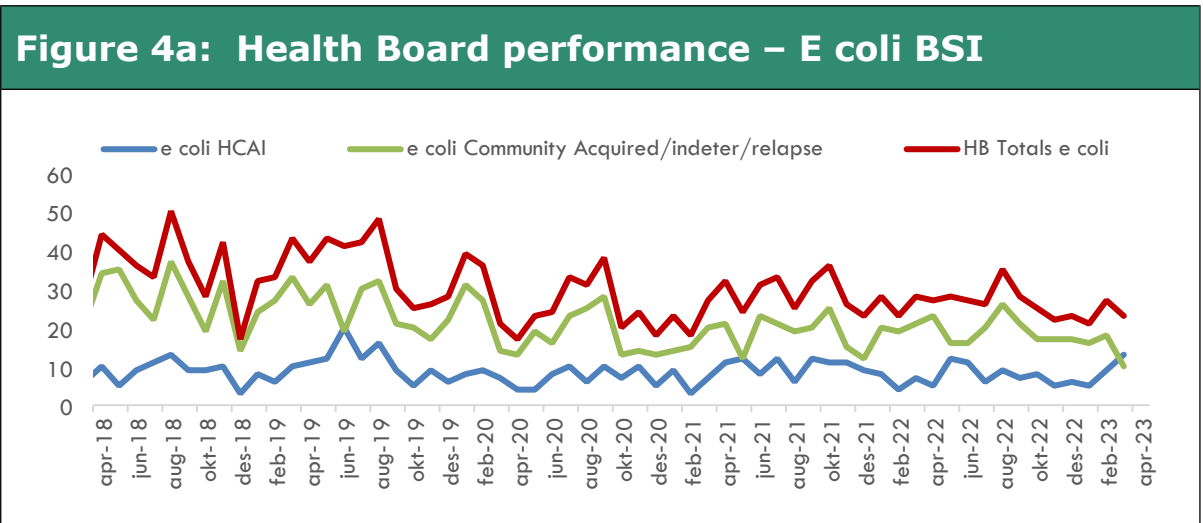

Gram Negative blood stream infections

Gram-negative infections include those caused by *Klebsiella sp., Pseudomonas aeruginosa,* and *E. coli*. These are organisms which live harmlessly in the gut but

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if they grow and multiply in other parts of the body, they can cause a range of infections with varying severity and significant associated mortality.

Gram-negative bacteria (GNB) are the leading cause of healthcare associated BSI. It is known that GNB are becoming increasingly resistant to antibiotics and therefore more difficult to treat. Lowering the burden of infection is key to reducing the development of antimicrobial resistance.

E coli blood stream infections

A total of 314 cases of E coli BSI were reported from April 2022 to March 2023. This is -9% fewer than the equivalent period 2021/22. Provisional rate is 52.66 per 100,000 population, which achieves the national reduction expectation, and the Health Board has the lowest rate in Wales.

Figure 4a: Health Board performance – E coli BSI

An RCA is carried out for each case of E coli BSI. The most common likely source of infection for hospital onset cases is linked to urine.
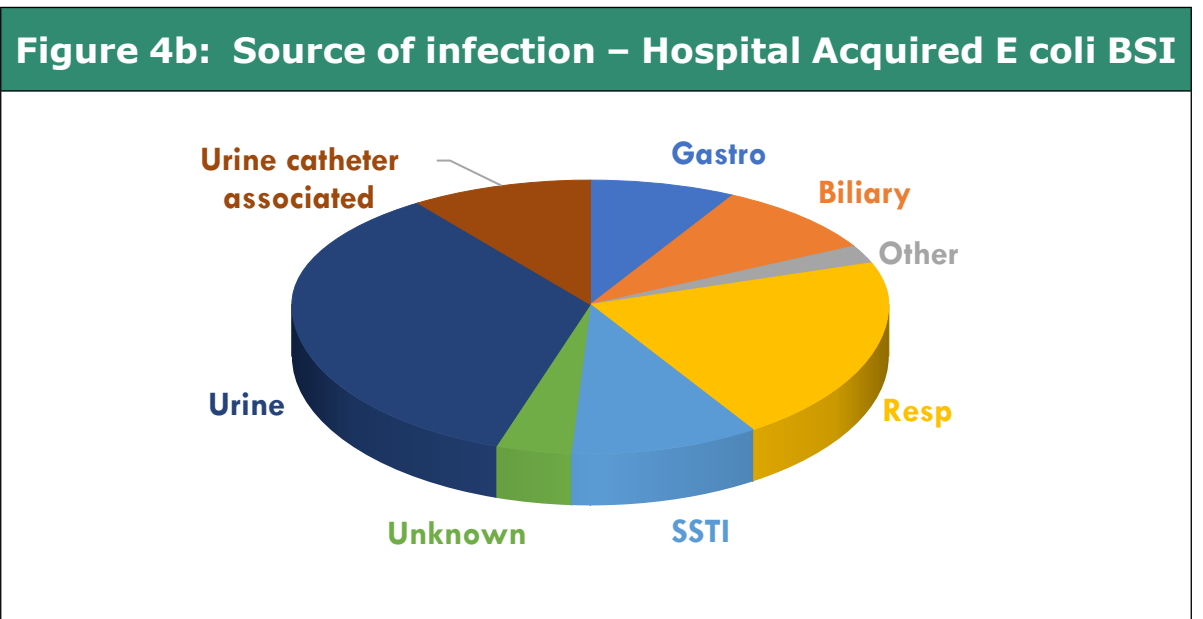
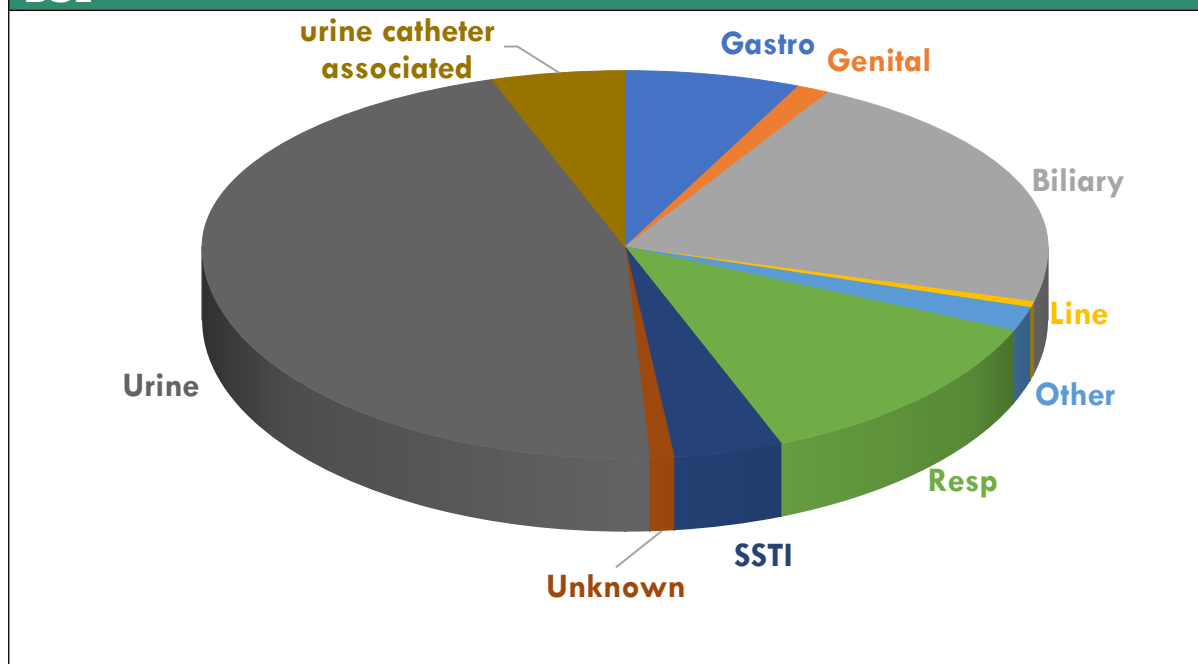### Figure 4b: Source of infection – Hospital Acquired E coli BSI

Figure 4c: Source of infection – Community acquired E coli BSI

Klebsiella blood stream infections

A total of 118 cases of Klebsiella BSI were reported from April 2022 to March 2023. This is 27% more than the equivalent period 2021/22. Provisional rate is 19.73 per 100,000 population. This has exceeded the national trajectory.

Figure 5a: Health Board Performance – Klebsiella BSI
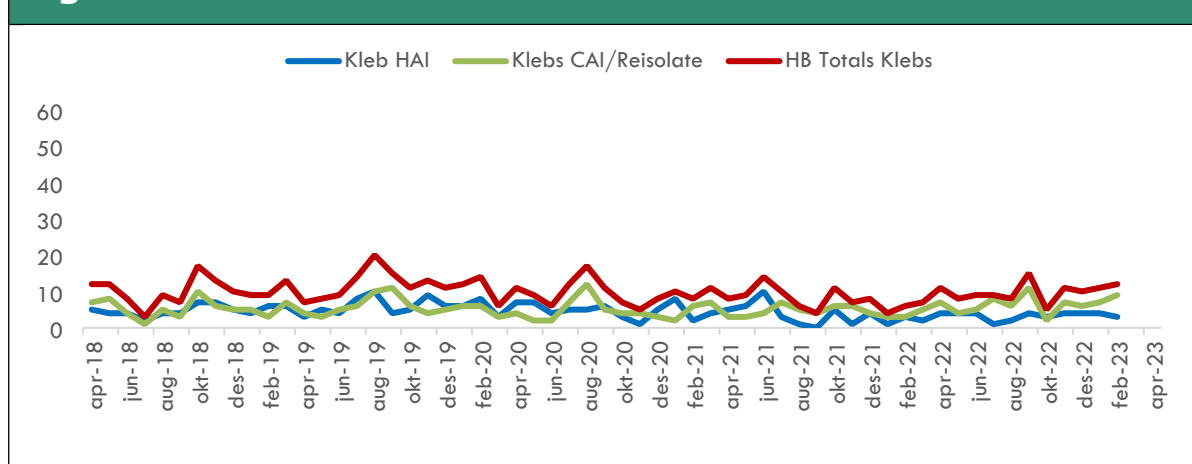
Many Klebsiella BSI occur in individuals already colonised with the bacteria and cause infection opportunistically. There are several risk factors which increase the risk for klebsiella infection. There are also strains of klebsiella, dubbed hypervirulent strains, which are significantly more likely to cause infection in younger, healthier patients. Hypervirulent strains are more likely to cause pneumonia, meningitis, and/or liver abscesses compared to less virulent klebsiella infections.

In the UK, there has been an increase in incidences of klebsiella infection in recent years. In recent months an increase in klebsiella blood stream infection has been identified and a deep dive was implemented in the Health Board.

Figure 5b: Source of infection – Klebsiella BSI
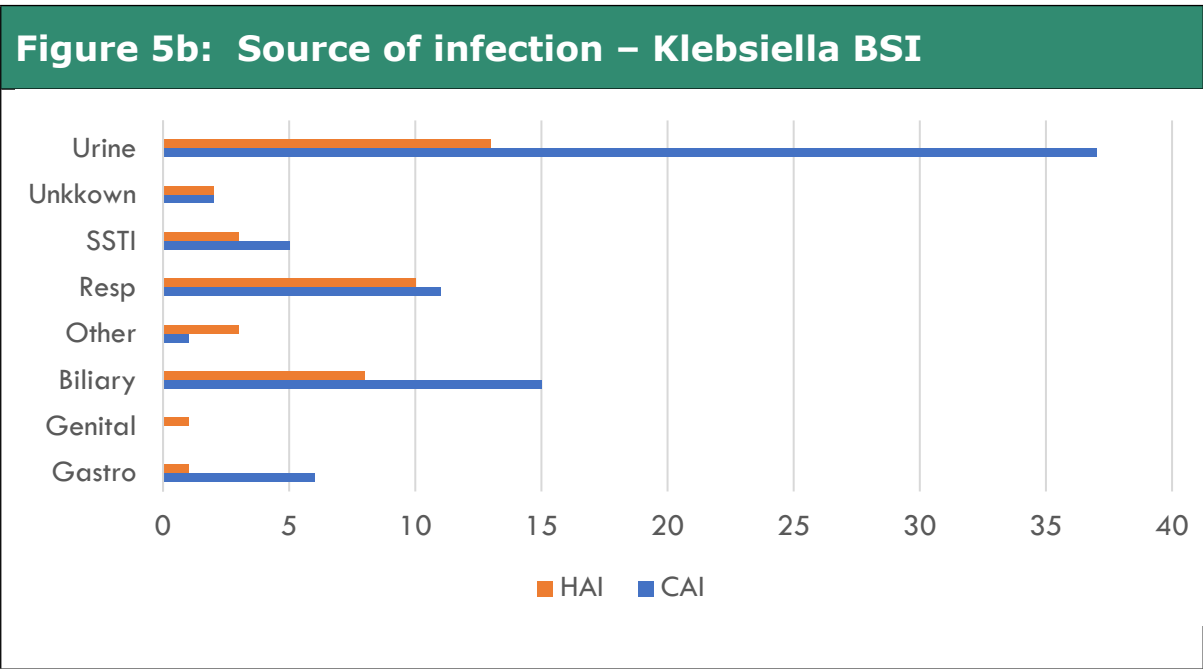
Urine is the largest burden of infection. Of the 37 community acquired cases, 12 were associated with a urinary catheter and 7 linked to hospital onset.

Five wards had two or more cases acquired whilst an inpatient (hospital onset).

Figure 5c: Cluster cases hospital onset – Klebsiella BSI
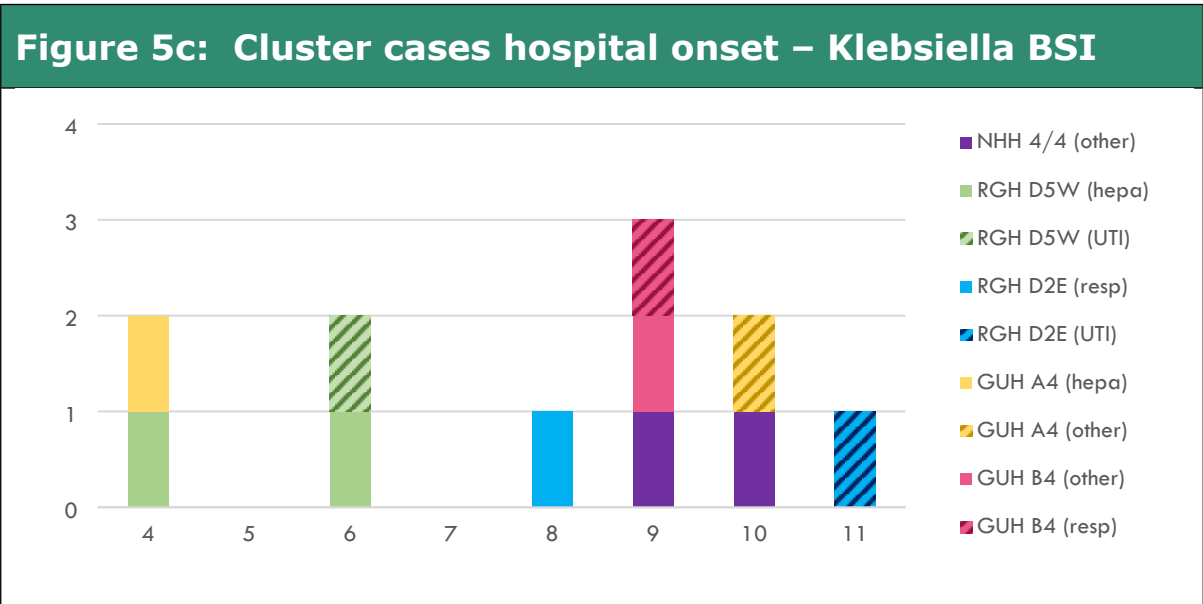
The cases for Ward A4, GUH and Ward D2E, Royal Gwent Hospital (RGH) had prolonged time period between cases so are unlikely relating to a cluster.

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Ward 4/4, Nevill Hall Hospital (NHH) and ward B4, GUH had two cases acquired on the ward within a 28-day period, however in both instances two separate organisms were detected, indicating no transmission occurred on either ward.

One ward at RGH had three cases of Klebsiella pneumoniae detected in April and two in June. This may be linked to hospital transmission.

Klebsiella is often a pathogen that is multi drug resistant which may also be increasing the burden of infection as patients are not responding to first line treatment of antimicrobials.

There were 13 incidences where GNB was a contributing factor to a patient's death. This represents 18% of overall cases.

Community acquired infection cases had a lower case fatality (12%) compared to HCAI cases (28%).

Of the cases who died with a GNB BSI, Klebsiella pneumoniae was detected in 85% of the cases.   Although the most common infection source linked to all Klebsiella BSI patients was urinary tract infections, for those who died with a GNB BSI, respiratory was the main source of infection for 38% of the cases. This may be due to secondary infection post winter respiratory virus.

Cancer was recorded in nearly half of the cases that died following klebsiella BSI, which is higher than the prevalence in cases overall. There were no other risk factors which appeared at notably different frequencies when compared to all cases overall.

Pseudomonas blood stream infections

A total of 18 cases of Pseudomonas BSIs reported from April 2022 to March 2023. This is -42% fewer than the equivalent period 2021/22. Provisional rate is 3.01 per 100,000 population. The Health Board achieved the national reduction expectation target.

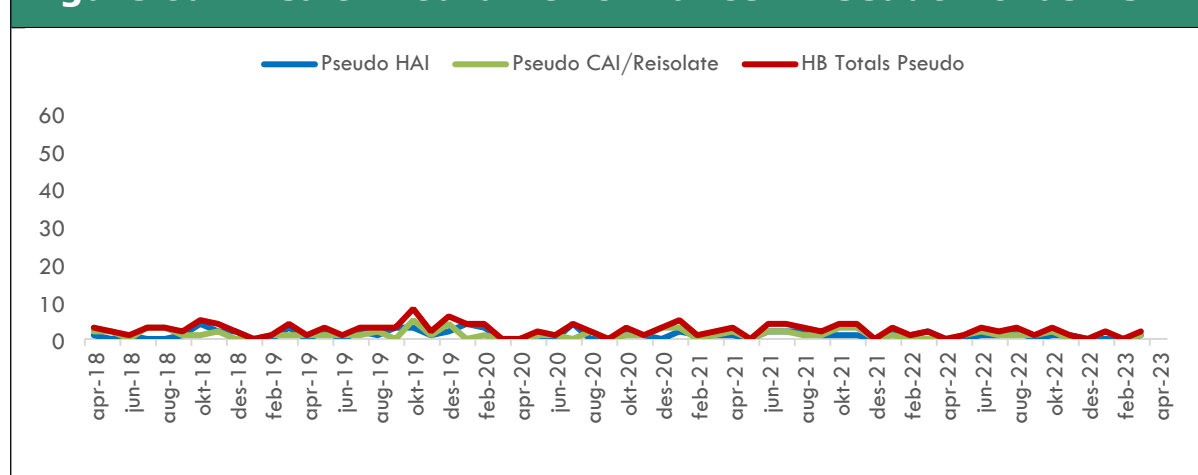### Figure 6a: Health Board Performance – Pseudomonas BSI

Figure 6b: Source of infection – Pseudomonas BSI
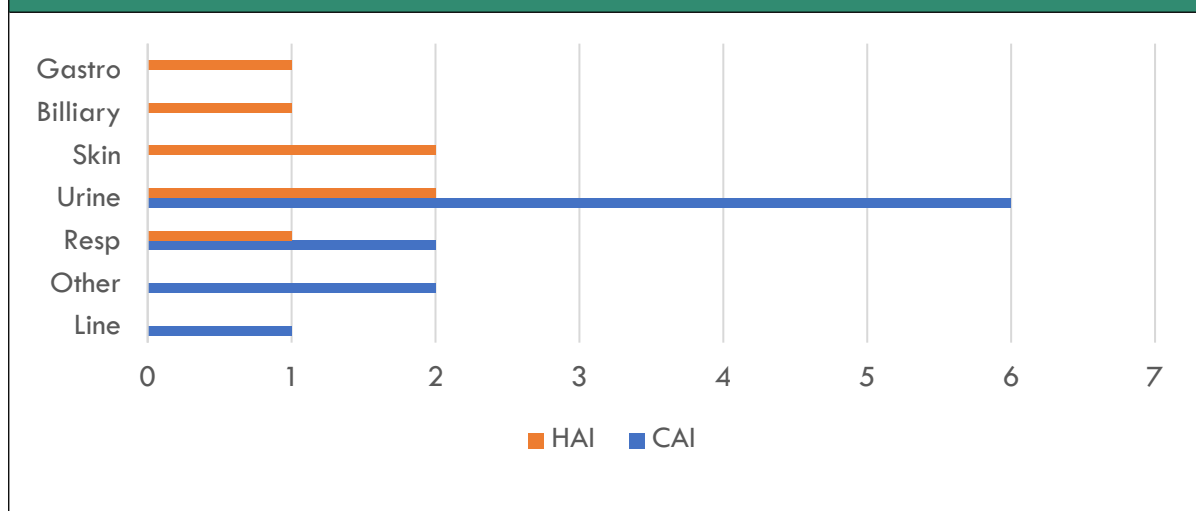
Numbers remain small with the largest burden of infection linked to urinary infections. The Health Board are participating in the HOUDINI Project: 'Make that catheter disappear' which aims to remove a catheter more quickly.

The project entails monitoring the number of catheter days per week, an education programme and introduction of a new catheter care bundle.

Initial pilot of the project on two wards in County Hospital (started January 2022) achieved a 32% and 12% reduction in the number of 'catheter days per week'. Plus a 50% reduction in the median number of positive catheter specimens of urine (CSU's) on one the wards comparing pre and post implementation data.

There are ongoing projects in other areas as part of plans to support the Division to roll the project out to all in-patient areas working collaboratively with Practice Educators and Education leads.

In the Community a 'trial without catheter' Project is being piloted. This is a Nursing initiative to remove any urinary catheters which are no longer required as soon as possible in the patient's own home without the need for many of them to wait for or attend a Urology out-patient appointment.

The graph below indicates a reduced frequency of catheter associated UTI gram negative bloodstream infections overall but also indicates increased frequency of cases in the summer months.

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Figure 6c: Community acquired CAUTI associated GNBSI days since last case
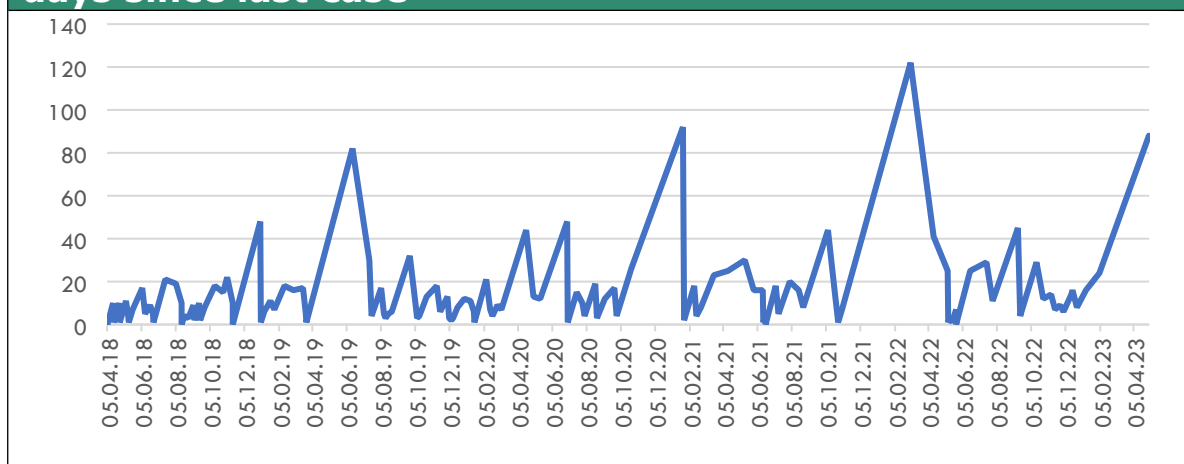
Surgical Site Infection Mandated data

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place. SSIs are often superficial infections involving the skin or superficial tissue only, however they can cause deep infections leading to sepsis, increased pain, discomfort and general suffering to the patient. Below is the mandatory surveillance for caesarean sections.

Figure 7: Quarterly rates of SSI
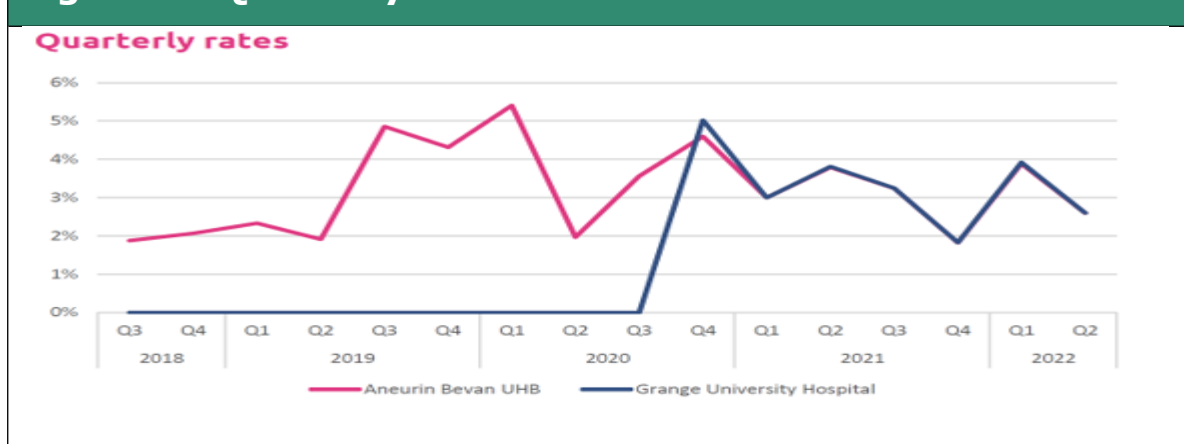
Current Health Board rate is 2.9% which is the same as the previous reporting year. Each lady is reviewed to establish organisation learning and the following recommendations have been made by the Division:-

 ➢ Review of ANTT rates in elective theatre.
 ➢ Review the number of people in elective theatre.
 ➢ Demographics of local data includes post codes / surgery codes.
 ➢ To work with IPC to support community colleagues.
 ➢ Explore IPC electronic data capture for sustainable data interrogation

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Antimicrobial Stewardship

Antimicrobial resistance (AMR) is already a leading cause of death across the world, therefore antimicrobial stewardship activities, to optimise the use of these agents is key in preventing untreatable infections in the future, as well as reducing adverse effects, including CDI now.

The Antimicrobial Working Group (AWG) continues to monitor antimicrobial usage and implement strategies to optimise use of antibiotics across the Health Board. This is supported by the Antimicrobial Guideline Group which works to develop & review local treatment guidelines.

Key achievements this year include:
- Completion of roll out of the Antibiotic Review Kit (ARK) to GUH and RGH, meaning all four main sites are now live. ARK is a toolkit, including an online training tool, decision aid and audit programme, designed to safely stop antibiotics in patients who no longer need them, and change prescriber behaviours. Work is now ongoing to embed the audits as a rolling programme, fed back via divisional quality & patient safety groups, with audit completion rates fed back at RNTG for oversight.
- Ongoing antimicrobial ward rounds at key sites, where complex infection cases are reviewed by a Consultant Microbiologist and an Antimicrobial Pharmacist. Since these ward rounds were introduced in December 2020 over 2000 patients have been reviewed and over 3000 interventions made, including stopping treatment in 21% of patients.
- Introduction of an app to ensure last-line antimicrobials are only supplied with appropriate authorisation for use.
- Introduction of antimicrobial educational sessions for 5th year medical students and pharmacy technicians

In addition to ongoing workstreams the team has also spent significant time implementing COVID-19 therapies, and supporting the Strep A outbreak in Q3. The latter has had a profound adverse impact on prescribing rates, which it is hoped will not change patient behaviours in the long run.

The team has carried significant vacancies over the past year, but reached full establishment in March 2023.

The Consultant Pharmacist for Antimicrobials is also one of three Welsh members of the Malawi-Wales Antimicrobial Pharmacy Partnership, who were highly commended in the Best New Partnership category of the Hub Cymru Africa awards 2022. The partnership have successfully bid for almost £100k to expand the work in Malawi across over the next 18 months from April 2023.

Antimicrobial Prescribing Performance

Welsh Government improvement goals for antibiotic usage remained the same:
- A minimum 25% reduction in antimicrobial usage in primary care from the 2013/14 baseline by the end of 2023/24 FY.
- In secondary care, increase to or maintain the proportion of antibiotic usage within the WHO 'Access' category to ≥55% of total antibiotic consumption

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Primary Care Prescribing

Data are only available to the end of Q3, however the following graph demonstrates the significant increase in antibiotic volume in Q3 caused by the Strep A outbreak and associated public health messaging.

Figure 8a: Antibiotic volume in Q3
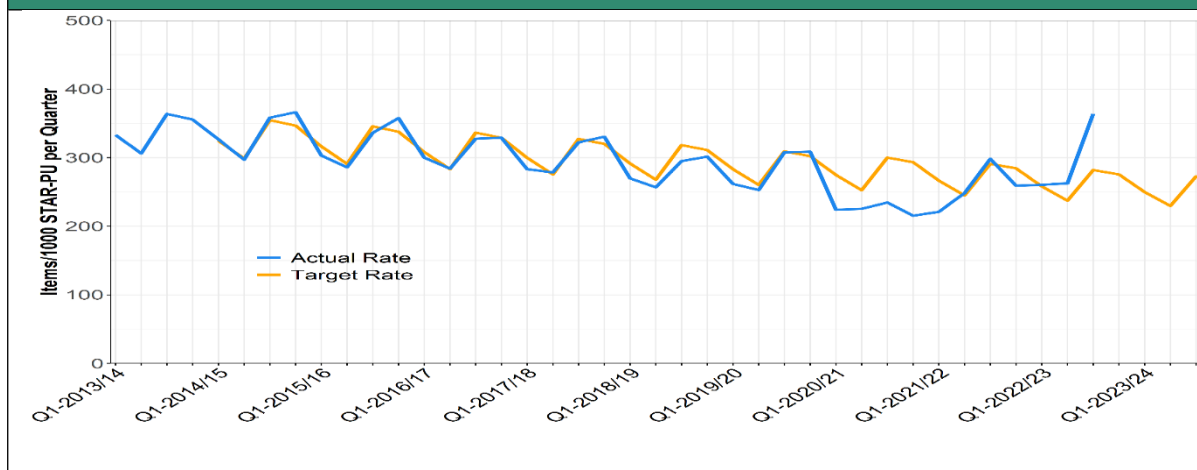
The Welsh Government reduction target is to be achieved by the end of the 23/24 FY, so it is hoped that significant effort over the coming FY will reverse the trend and achieve the 25% reduction.

Looking at total volume of use compared to other health boards, it can be seen that Aneurin Bevan University Health Board (the yellow line) generally tracks trends in other health boards, but is now slightly above the all-Wales average (black line).

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Figure 8b: Total antibacterial items per 1,000 STAR-Pus (Specific Therapeutic group Age-sex Related Prescribing Unit)
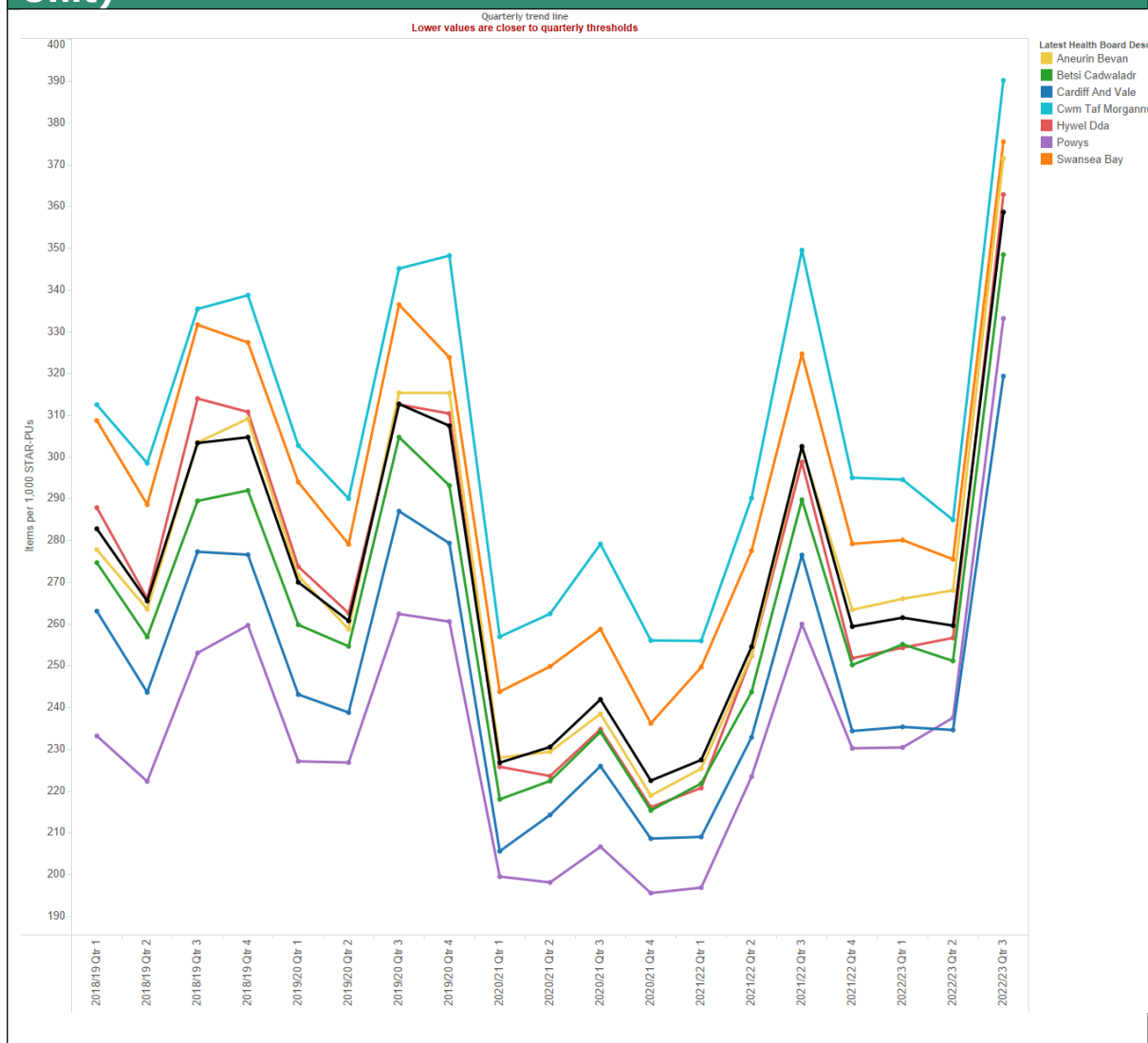
This relative increase is mostly due to a relative increase in use in Blaenau Gwent and Torfaen, which are now the highest prescribing localities of antibiotics in Wales by volume.

The term '4C antimicrobials' refers collectively to four broad-spectrum antibiotics (co-amoxiclav, cephalosporins, fluoroquinolones and clindamycin). Avoidance of these broad-spectrum antibiotics helps minimise development of resistance and reduces the risk of *C. difficile*, MRSA and resistant urinary tract infections.

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The following graph demonstrates that whilst Aneurin Bevan University Health Board were amongst the lowest prescribers of 4C agents in Wales, use has increased over the past couple of years:

Figure 8c: Number of 4C antimicrobials per 1,000 patients
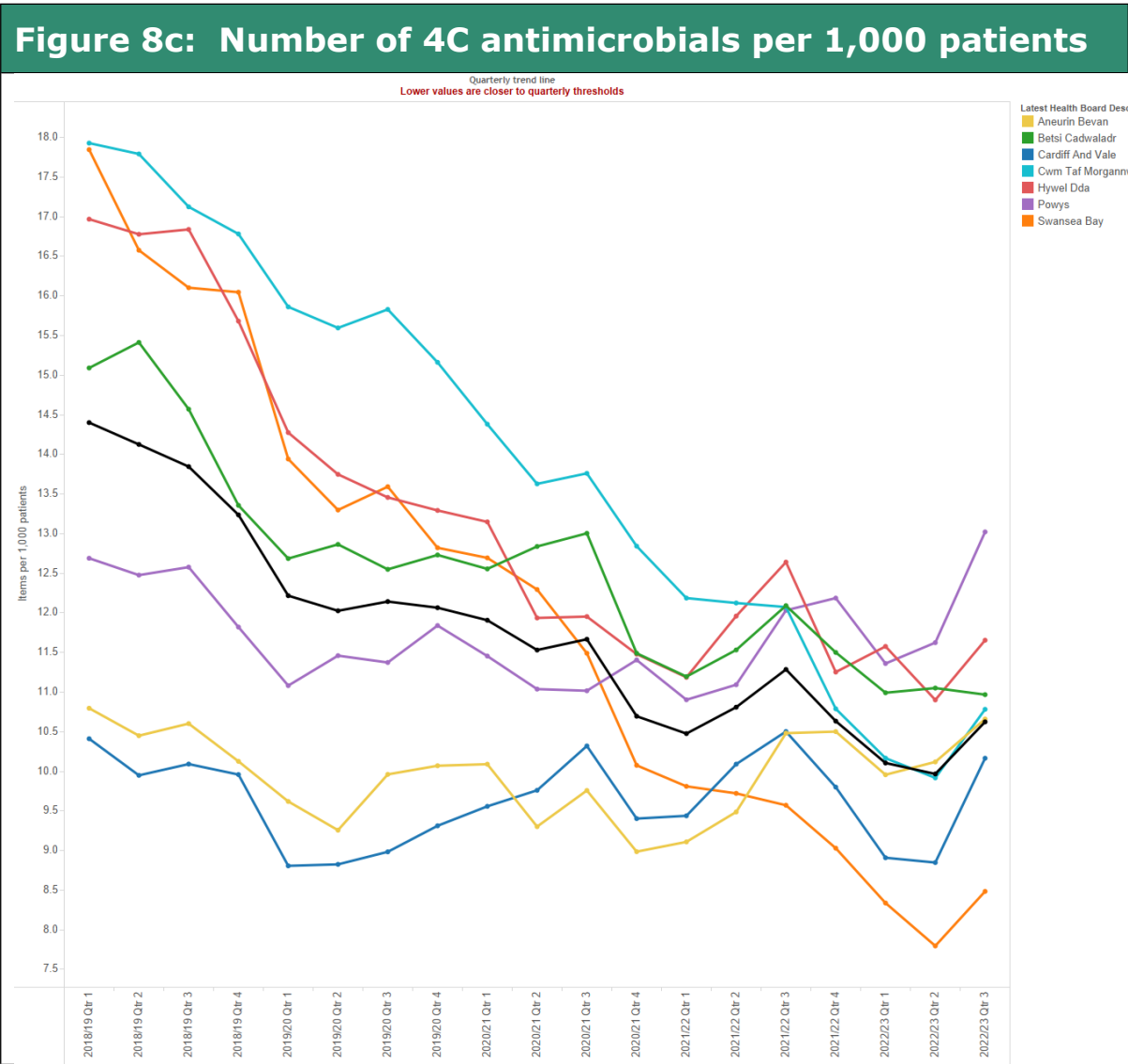
Again, this is in part due to an increase in use in Blaenau Gwent, who are now amongst the highest prescribers of 4C antimicrobials in Wales. Taking into account both the volume and 4C use in Blaenau Gwent, this area will be the area of highest focus going forward. Work by the newly appointed primary care Antimicrobial Pharmacist has already begun in this area.

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Secondary Care Prescribing

Antibiotics within the WHO 'Access' category are narrow spectrum antibiotics that carry a lower risk of resistance and other adverse effects. The aim is therefore to use as great a proportion of these agents as possible.

Data for secondary care usage are not available from Public Health Wales, who report on achievement of Welsh Government goals, due to data quality issues relating to the roll out of the new pharmacy system across Wales. Data reporting will resume from Q1 23/24, however local data suggests that all Aneurin Bevan University Health Board sites have met the 55% target, with some achieving 60% of total use.

Figure 8d: Access group usage as a proportion of total antimicrobial use
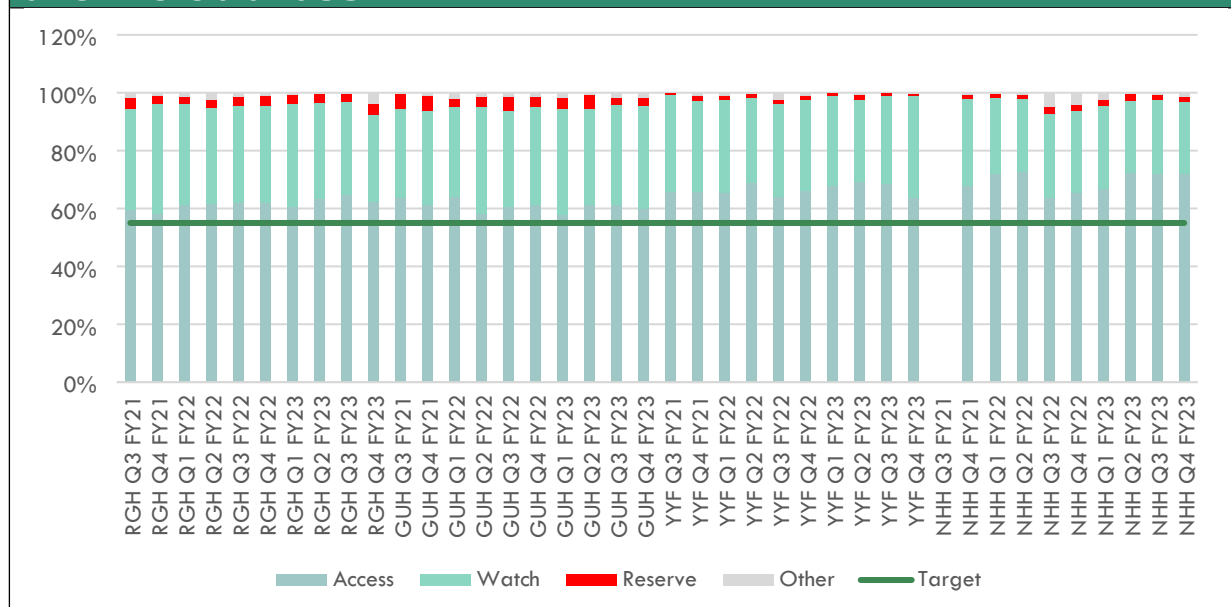
Respiratory Viruses

The next outlines activity in terms of respiratory viruses that have potential to cause patient harm and disrupt services.

The inpatient testing strategy has been reviewed to comply with Welsh Government national testing framework. Multiplex point of care testing machines have been installed in each of the eLGHs to support early identification of respiratory infections and to ensure patients are managed on the correct pathway.

To support systems risk and protect the workforce because of respiratory viruses, the RNTG reviewed the staff testing strategy. A decision was reached to stop testing asymptomatic individuals at the end on December 2022.

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Covid -19

The COVID-19 pandemic has continued to evolve and present significant challenges across the system within the organisation. The Health Board has been required to continue delivering elective care, however waiting lists for surgery and treatment have grown. This is partly due to the backlog from the previous year when elective services were suspended, but operational capacity and productivity has also been affected by the introduction of infection prevention and control measures. However, it was absolutely key that the IPT took a pragmatic assessment balancing whole systems risk rather than purest infection prevention advice due to non covid harm. This approach was also supported and reflected in national updates.

Covid-19 is reported to have an incubation period (the time between catching the infection and showing symptoms) between 1-11 days. This means someone can be admitted to hospital with no symptoms and test negative for Covid-19, despite having already caught the infection. National guidance sets out the following definitions for categorising Covid-19 infections which are detected during admission to hospital:

Community acquired	Onset day 0-2
Hospital onset – indeterminate acquisition	Onset Day 3-7
Hospital onset – probable hospital acquired	Onset day 8-14
Hospital onset – definite hospital acquired	Onset day 15 onwards

*The day of admission is Day Zero.

Covid-19 Data

The IPT has been extremely busy during the year reviewing and supporting the clinical teams for the management of Covid-19 patients. The data below demonstrates the daily activity for Covid-19 for the reporting period.

Figure 9a: Covid-19 in patient daily activity

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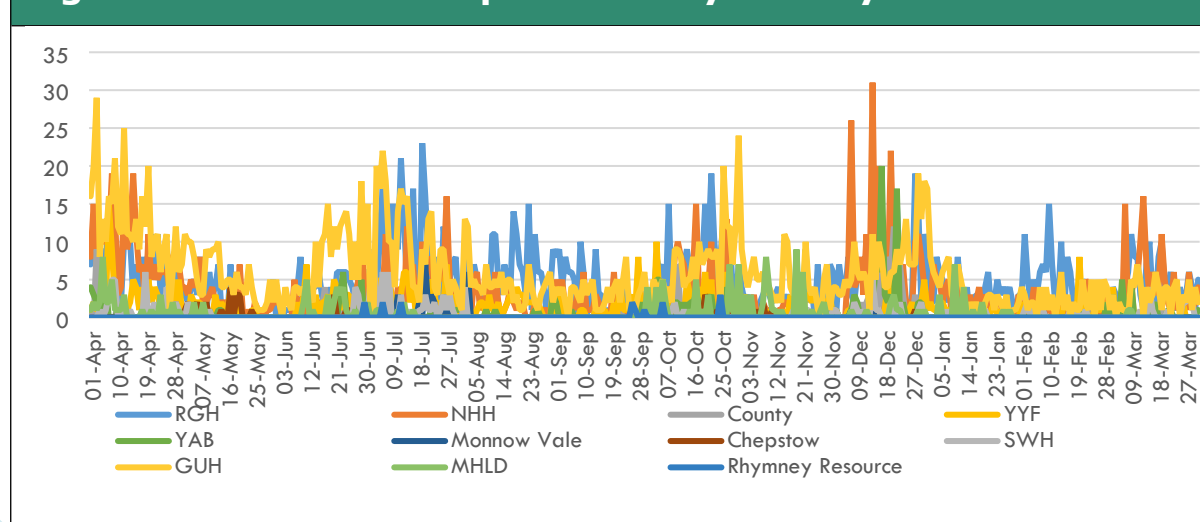
Throughout the pandemic, the IPT have actively reviewed and responded to the many changes in national guidance, rapidly putting in place a wide range of measures to prevent and control the spread of infection and provide a safe patient environment, some of which include:

➢ Regularly review patient placement with confirmed or suspected Covid-19 infection.
➢ Hand hygiene messages reinforced regularly to encourage staff, patients and visitors to clean hands more often than normal.
➢ Provide enhanced cleaning on all wards and departments, utilising disinfectant products that are effective against the Covid-19 virus.
➢ Constantly reviewing visiting restrictions in line with most up to date guidance.
➢ Implemented admission assessment for testing of symptomatic patients
➢ Infection Prevention Nurses/Practitioners/Assistants visit wards regularly to perform Covid-19 checklists ensuring standards remain high.
➢ Expedite rapid action if an outbreak of Covid-19 is detected to stop further spread of infection. This includes deep cleaning the ward, pre shift swabbing of all staff and any patients who become symptomatic in the affected area.

The data below indicates the Health Board position compared to others across Wales (3 month comparison). This data is influenced by the number of hospital outbreaks across the Health Board.

Figure 9b: Hospital onset – All Wales comparison (3-month period)

Rolling 7 day sum of hospitalised hospital acquired cases, by health board of admission
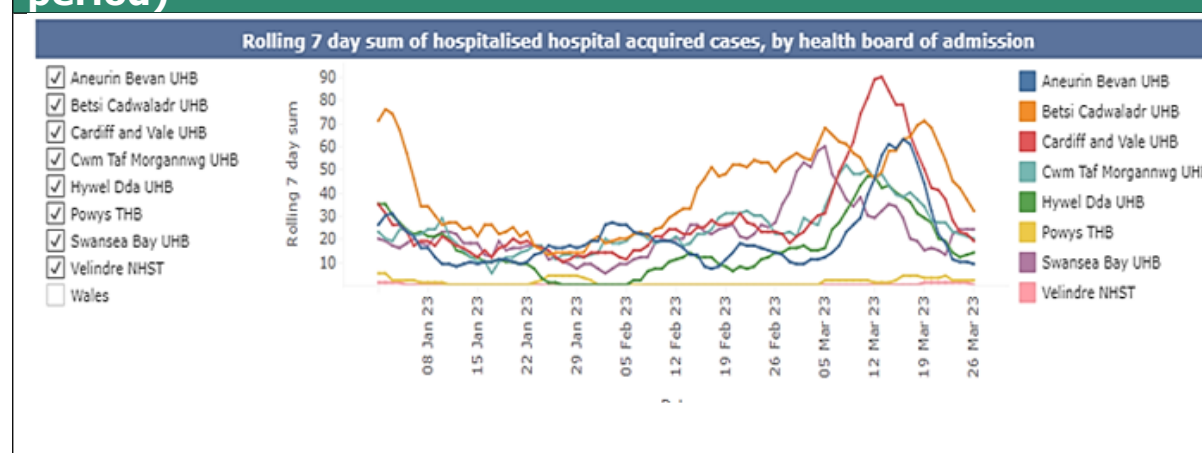
Hospital Outbreaks

An outbreak, as defined by Public Health Wales (PHW) is two or more linked cases occurring in the same ward environment within a specific timeframe and is a notifiable incident. Covid-19 prevalence tends to peak in Wales every three months. This is then reflected in the number of hospital ward outbreaks as demonstrated in the data below. Most outbreaks have occurred within the local general hospitals where patients are sharing facilities. The acuity of patients, level of enhanced care, workforce constraints and visitors has contributed to the number of outbreaks, reduced staffing has also contributed to the number of

outbreaks. Because of reduced workforce, outbreak control measures have been monitored through email correspondence and validated by the Infection Prevention Team. The visitors screening questions have been reviewed and a poster developed promoting best practice.

Graph below displays the number of ongoing outbreaks (blue line) and number of new cases (red dot) plotted on a daily basis.

Figure 9c: Hospital outbreaks – Covid-19
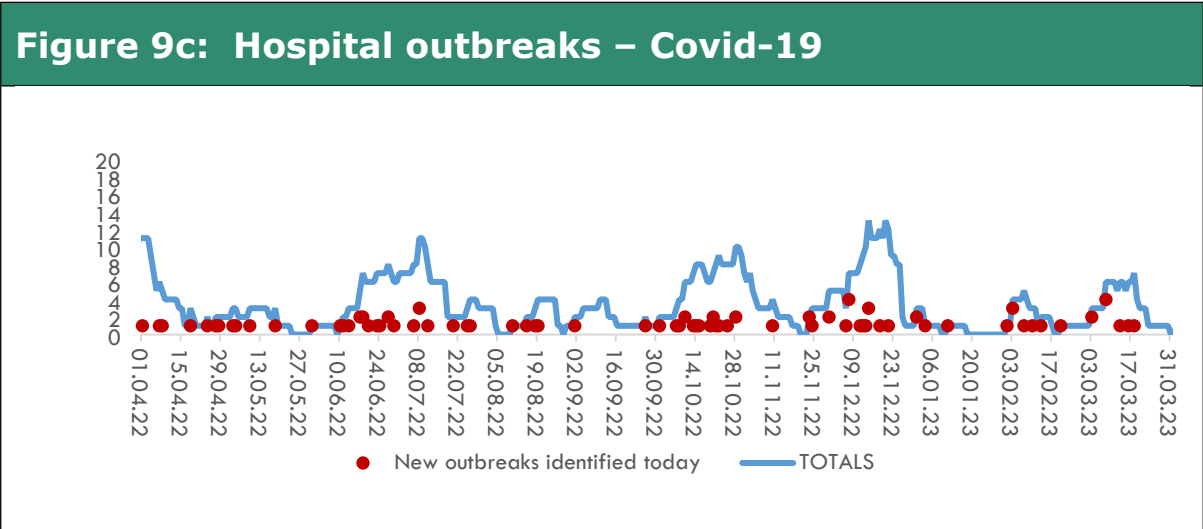
The approach agreed by RNTG was to stop testing in-patients exposed to respiratory viruses with an aim to open closed wards earlier.

In December 2022, Welsh Government issued a directive advocating respiratory viruses could be mixed within the same bay if all measures to prevent onward transmission can be robustly implemented. Following Executive approval, the IPT developed guidance to manage this approach in extreme circumstances only.

Covid-19 Mortality

The IPT review all patients who have died within 28 days of an indeterminate, probable and definite healthcare associated Covid-19 infection. A total of 184 incidences have occurred during the reporting period, overall the mortality prevalence correlates with the number of outbreaks identified. The majority of patients reviewed have died of other causes, but Covid has been cited on the death certification.

Graph below displays the number of mortalities that occurred each month during the reporting period where a patient had died within days of a positive Covid-19 result.

Figure 9d: Mortality per month within 28 days of positive result
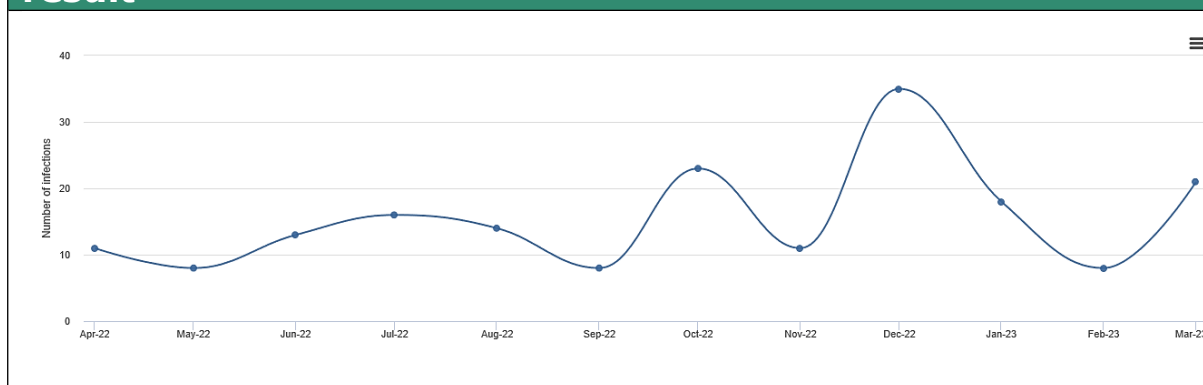
COVID-19 Investigation Team

The National Nosocomial Covid-19 Programme (NNCP) was established in April 2022 to support NHS organisations to conduct proportionate investigations into patient safety incidents of nosocomial Covid-19 which occurred between March 2020-April 2022, governed by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – Putting Things Right (PTR).

A National Framework for the Management of Patient Safety Incidents following Nosocomial Transmission of Covid-19 was developed, to ensure, as far as reasonably possible, a consistent approach applied. The objective of the programme being to drive quality and safety improvements, reducing chances of reoccurrence and improving patient and family experience.

Commencement of the initial Covid-19 Investigation Team was delayed by three months into the programme timeframe due to significant recruitment challenges. Despite this delay the team delivered key objectives in respect of the NNCP National Roadmap actions relating to; Programme Assurance & Governance, Operational Delivery and Communication.

Workforce

The planned and recruited workforce transpired to not meet the required skillset resulting in a second recruitment. The newly appointed staff commenced in post beginning April 2023 bolstering the investigative team with a split between clinical and non-clinical investigative staff proportionately aligned to identified caseload severity.

Recognising the delayed commencement of the team, reduced operational timeframe available and combined with the Fixed Term Contract status for most of the team, completion of the program within timeframe is high risk.

Clinical systems

Issues identified across multiple systems resulting in escalation for remedy has impacted the investigative process in respect of time to identify, extract and assess information as well as record investigations appropriately.

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Workforce Records

Workforce and Organisational Development have provided available substantive, bank & agency staff data, however workforce records for medical and facilities staff are unavailable.

Clinical Records

Quality of clinical records has broadly been poor, likewise the quality of scanned documents in Clinical Workstation.

Availability and access to Mental Health and Learning Disability patient records is poor on clinical systems and require sourcing from off-site storage facilities. This process is time consuming and sadly does not often illicit any further detail to support the investigative process.

Acknowledgment of COVID-19 diagnosis and treatment documentation in later waves is less prominent than in wave 1 investigations, impacting assessment.

Highlights

- NNCP Roadmap Objectives achieved
- 'Relatives' Digital Story Produced contributing to national learning
- Wave 1 – 100% Complete*
- Wave 2 – 13% complete*
- Wave 3 – 48% complete*
- Wave 4 – 9% complete*
- Currently no referrals to Legal & Risk**   *As of Friday 21 April 2023

Graph below displays areas of good practice identified during the first wave.

Figure 10a: Areas of good practice

Adherence to Policies and Procedures 27%

Communication 16%

Good Palliative Care 4%

IP&C 41%

Compassion 12%
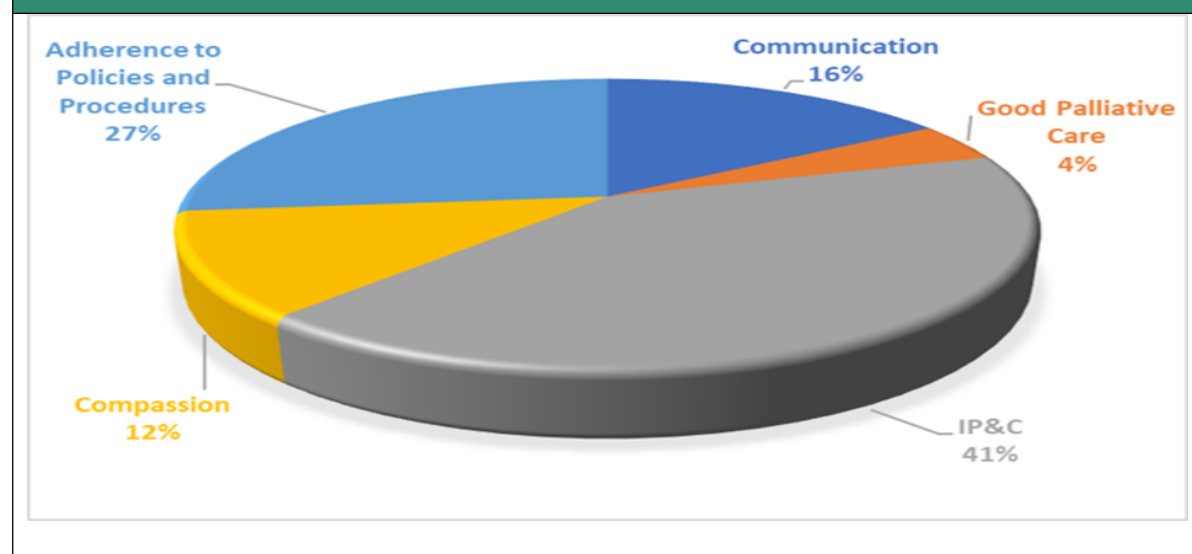
Key Learning

The graph below demonstrates the areas of Learning from Wave 1 case analysis.

Figure 10b: Areas of learning from wave 1
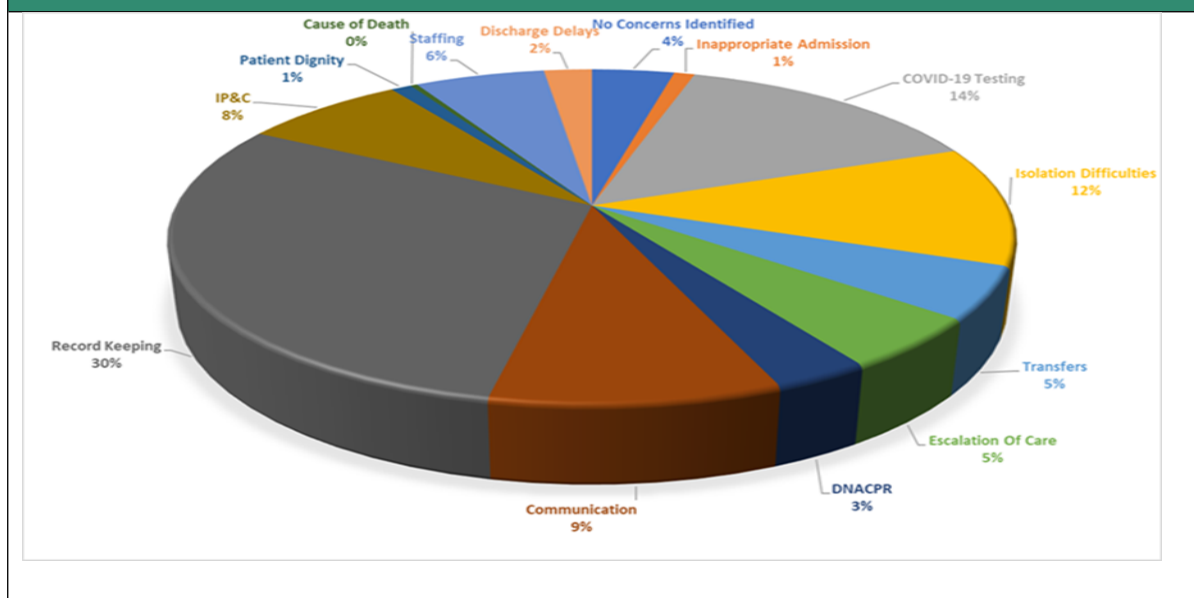
The top 3 were:-
- ➢ Record Keeping: 30%
- ➢ Isolation Difficulties:12%
- ➢ COVID-19 Testing: 14%

Influenza

Influenza (flu) is a viral infection that attacks the respiratory system namely the nose, throat and lungs. Flu, like other infections, causes minor illness, but can be much more severe in vulnerable people, causing significant morbidity and mortality.

Cases varied from 0 to 38 new cases per day at the peak of the winter season. Patient pathways were adopted to maintain segregation of patients with different respiratory viruses. Unfortunately, the Health Board did identify sporadic incidences which resulted in hospital bay closures. The same principles apply to reducing the risk for flu as Covid-19 with the addition of risk assessing the patients for antiviral treatment (Tamiflu).

The data below demonstrates the impact across the Health Board Hospitals. Cases peaked mid-December and tapered off quite quickly.

Figure 11a: Influenza daily activity
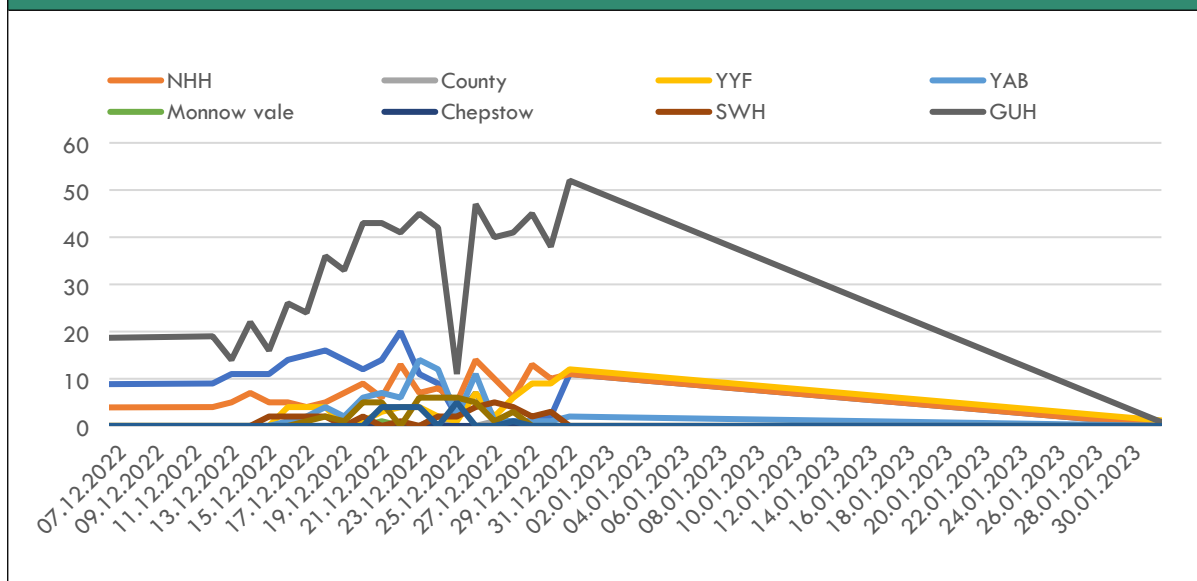
Vaccination against flu is a vital intervention to protect staff and patients from flu. The chart below indicates the Health Board compliance is below previous years uptake. That said, Flu Champions, Occupational Health team and Working Group colleagues, have worked extremely hard during a very challenging season which has led to Aneurin Bevan University Health Board reporting the highest uptake rate in staff across all Welsh Health Boards.

Figure 11b: Flu vaccination year on year comparison
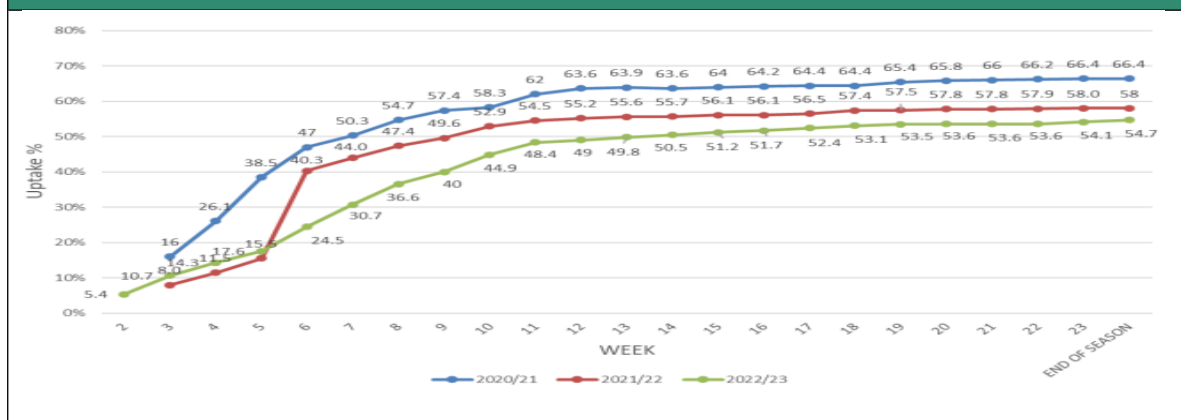
All Wales comparison indicates that Aneurin Bevan University Health Board had the lowest rate of hospital acquired influenza.

Figure 11c: Hospital onset – All Wales comparison (3-month period)

Daily number of inpatient cases in hospital, by health board of admission
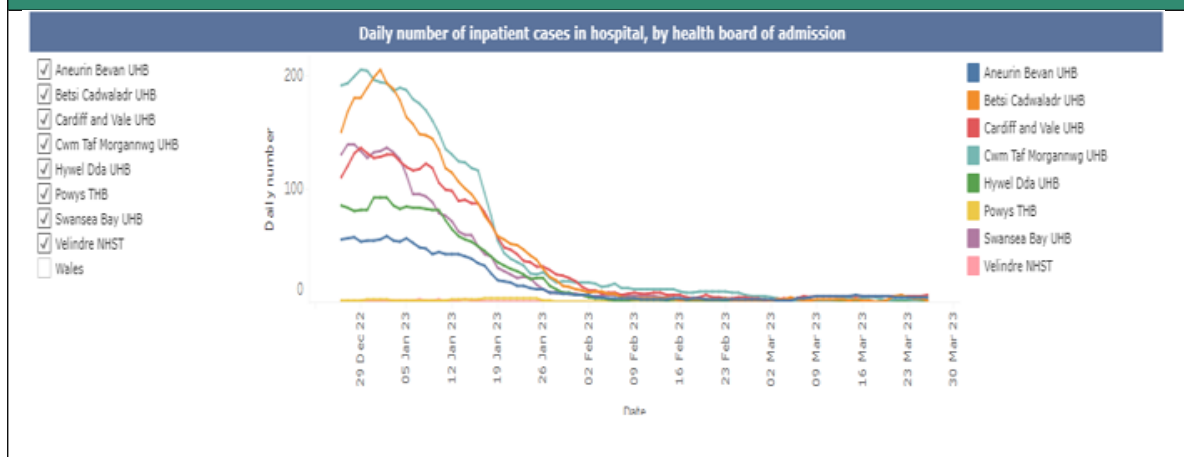
During this winter period, two wards were affected by an outbreak of flu where two or more cases were linked. Learning from the outbreak reviews included patient's sharing facilities and unable to tolerate face coverings increased the risk of onward transmission and high acuity of patient requiring enhanced care.

Influenza Mortality

The team adopted the same process for influenza as implemented for Covid for all hospital acquired cases. The data below demonstrates small numbers, however any death associated with a hospital acquired infection is concerning. Similar to Covid-19, most patients died of other causes and flu was cited on the death certificate as a contributory factor.

The graph below displays the total number of HAI cases per day (blue line) and the number of patients who died within 28 days of a positive result (red dot).

Figure 11d: Mortality within 28 days of a positive flu result

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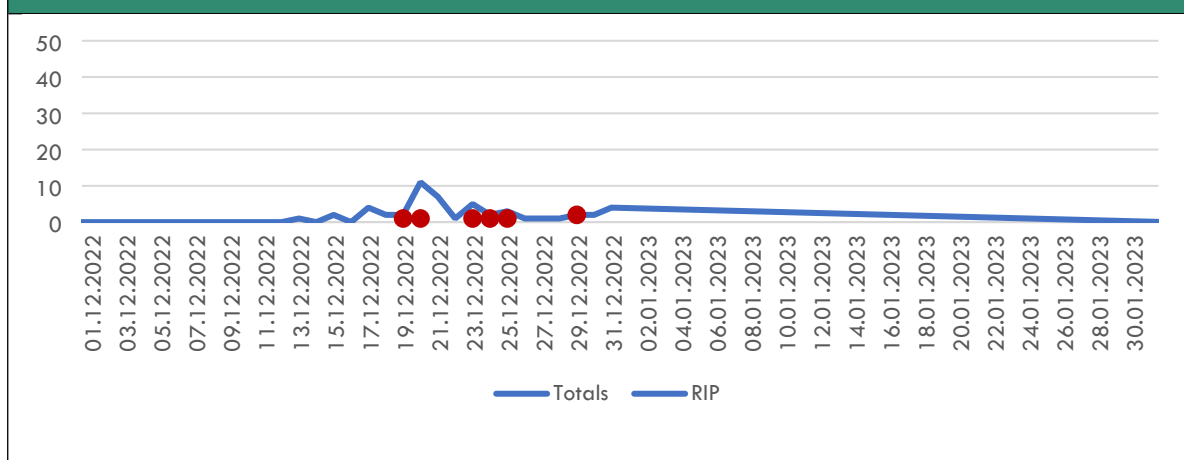
Respiratory Syncytial Virus (RSV)

Respiratory Syncytial Virus (RSV) is a respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a brief period; however, RSV can be serious, especially for infants under the age of 5 and older adults. RSV is the most common cause of bronchiolitis and pneumonia in children.

In all in probability, RSV activity peaked earlier than anticipated during week 49, (December 2022) as the trend across Wales declined moving into 2023. During the reporting period, RSV activity within Aneurin Bevan University Health Board remained stable.

Figure12a: RSV Activity
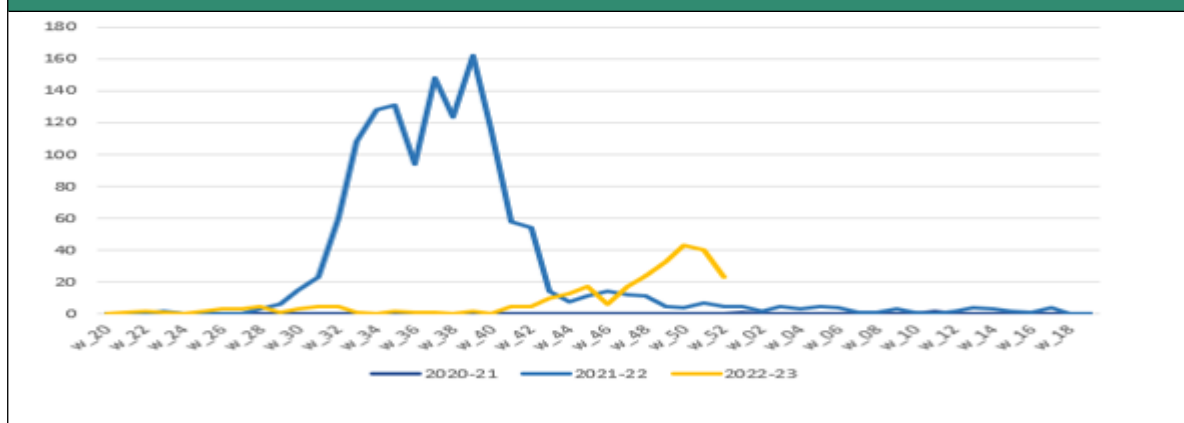
Within Aneurin Bevan University Health Board, fortunately, the number of RSV cases remained relatively low. The largest prevalence was in the under 5-year age category. The Health Board established a Task and Finish group to implement previous recommendations from the Chief Medical Officer issued in 2012 for the management of RSV. Interventions included: -

- ➢ Daily sitrep report
- ➢ Paediatric pathways
- ➢ Review staffing levels
- ➢ Availability of Equipment
- ➢ Apply the principles of mutual aid
- ➢ Education and training

Unusually, there was a small number of adults presenting unwell with symptoms and testing positive for RSV. This resulted in a small number of bay closures due to patient exposure.

The graph below indicates Aneurin Bevan University Health Board had the lowest rates of hospital acquired in patient cases.

Figure 12b: Hospital onset – All Wales comparison (3-month period)

Daily number of inpatient cases in hospital, by health board of admission
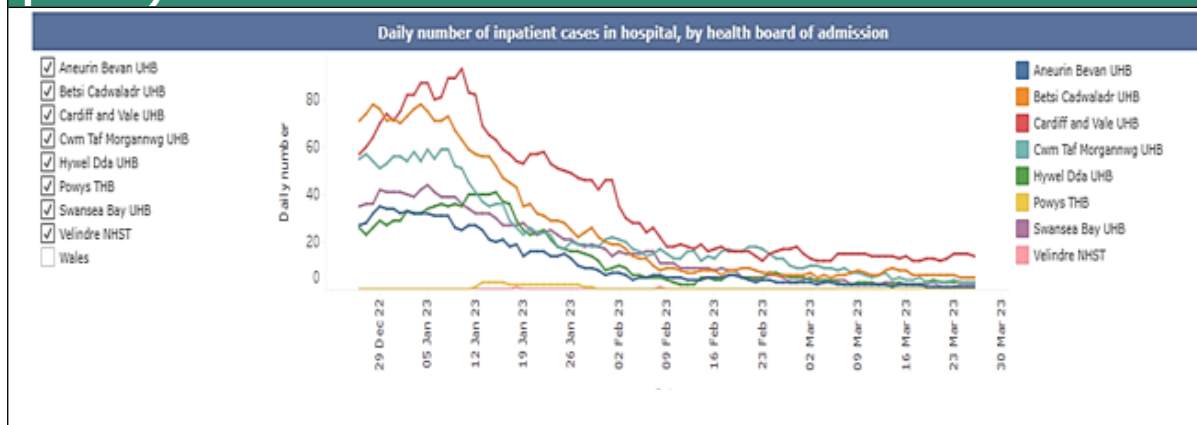
Environmental Audit compliance

The graph below demonstrates the average audit score by hospital over the reporting period.

Figure13: Environmental audit scores

	Nevill Hall	Royal Gwent Hospital	Grange University Hospital	Ysbyty Ystrad Fawr	St Woolos Hospital	County Hospital	Chepstow Community Hospital	Ysbyty Aneurin Bevan	Monnow Vale Hospital	Aneurin Bevan UHB
Series1	98,6%	98,6%	98,9%	98,5%	98,4%	99,3%	99,2%	99,2%	97,9%	98,8%
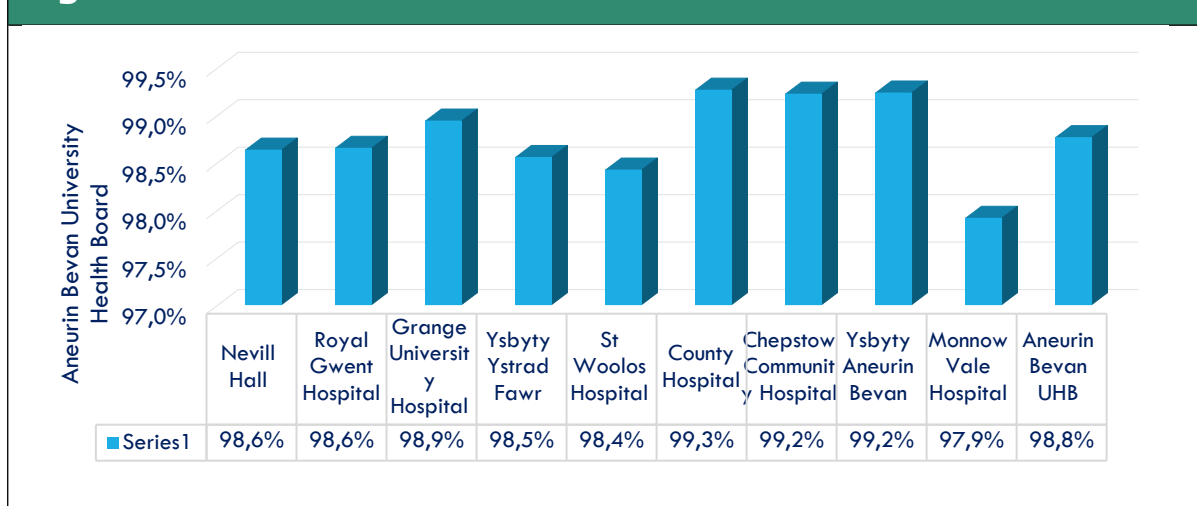
Unfortunately, there was slippage with the proactive Hydrogen Peroxide Vapour (HPV) clean at County and the Grange University Hospital due to capacity and environmental factors. The IPT will work in collaboration with Facilities to review alternative methods of enhanced cleaning products to support future proactive and reactive in the future.

Decontamination update

As the Covid-19 demands on the Infection Prevention Team (IPT) lessened throughout 2022 / 2023, the Decontamination Manager was able to recommence the role, with the aim to familiarise all members of the IPT with basic aspects of decontamination. This was a slow initiation as demands on the IPT fluctuated, with Directorates across the Health Board recommissioning services and the winter pressures.

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Due to these restrictions, two decontamination audits were undertaken jointly with the Authorised Engineer (Decontamination) for Wales NHS Wales Shared Services Partnership (NWSSP). These took place at the Endoscopy Decontamination Unit Ysbyty Ystrad Fawr (YYF) as part of Joint Advisory Group (JAG) and the Urology Department in the RGH. The review has reiterated further work needed around electronic traceability of instruments, weekly testing process requirements and chemical monitoring and storage. These continue to be monitored through the Strategic Decontamination Group. A further Infection Prevention Society (IPS) audit was undertaken at YYF supporting compliance aim with JAG accreditation status.

A total of 7 Community Dentistry Service audits were undertaken, with Infection Prevention Advisers supporting as part of decontamination learning.

The Decontamination Manager was able to increase support to the Divisions to promote best practice and compliance with national standards; Welsh Health Technical Memorandums (WHTMs) and ISO EN BS standards. The WHTMs is an indicator that decontamination processes are compliant within an organisation.

The Decontamination Manager continues to contribute toward National decontamination progress such as WHTMs.

In the report year, building of the four-theatre suite endoscopy unit at the RGH commenced with handover to the Gastroscopy Directorate expected in October / November 2023. The existing Endoscopy unit at the RGH will then be decommissioned and plans for the centralised decontamination unit to be built in its place. A business case has been drafted for its proposed build with input from the decontamination manager.

The completion of the HSDU GUH, together with its endoscopy decontamination services, stands as a state of the art unit. There is significant interest from the other Health Boards and the All Wales Decontamination & Sterilisation Advisory Group (AWDSAG). The unit complies with required WHTM standards and the ISO accredited status for HSDU in Wales.

Work continues to improve decontamination processes including:

➤ The continuation of service and testing contracts with procurement for all scope services, such as endoscopy, urology, ENT, to ensure compliance with WHTM 01-06 testing criteria.
➤ Working in Partnership with NHS Shared Services Authorised Person for Decontamination to support services across the HB.
➤ The ongoing concerns of less authorised persons (Decontamination) (APD) within the Health Board due to the retirement of 2 AP(D)s within the reporting period, and the lack of ability of Works & Estates decontamination strategy to support both HSDU and endoscopy services.
➤ The purchase of 2 environmental chemical storage cupboards at endoscopy units, with installation of 1 at YYF and 1 in RGH in line with Joint Advisory Group (JAG) accreditation standards and WHTM 01-06.

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- The installation of 2 further environmental drying cabinets for scope storage at YYF in line with Joint Advisory Group (JAG) accreditation standards and WHTM 01-06.
- Appropriate management of soiled used trays and their timely transport continues to be monitored.
- The review of and continued engagement for suitable probe decontamination methods in Radiology, considering 'Trophon 2' and ultraviolet.
- The installation of 2 'Trophon 2' decontamination machines in sexual health Directorate to ensure compliance with WHTM 01-06 testing criteria.
- HSDU departments continue to be monitored as per WG requirement and remain accredited to national ISO standards.
- Ongoing monitoring of facilities/theatres for best practice re tray and decontamination of surgical instruments.
- Ongoing monitoring of weekly water quality sampling through Standard Operating Procedures (SOPs).
- The building and commissioning of Ringland Community Centre (Community Dental Service) and General Dental Practice (GDP) where best practice facilities will be available and where the Clytha Clinic services will be transferred to and decontamination support for two further CDS clinics, ensuring compliance with WHTM 01-05 and reflect the CDS strategy of decontamination hubs.

Meetings with other NHS organisations across Wales have recommenced, with the decontamination team at NWSSP SES and the AWDSAG facilitating National discussion on continual improvements throughout Wales during the reporting period.

Next steps include a review of all decontamination services across the Health Board together with each Directorate, to establish compliance to the required standards, and the implementation of all members of the IPT to embed decontamination as part of their role and align with each decontamination service within their designated borough allocation. This includes Primary and Community Division, Care Homes and GPs.

Water Safety

In line with national guidance, Aneurin Bevan University Health Board continue with a robust routine water testing programme for early indication of Legionella and Pseudomonas. Throughout the year water safety continues to be a concern at The Grange Hospital.

Works and Estates investigatory work to combat legionella in Maternity theatres and Neonatal clinical areas is ongoing. Previous local disinfections of the suspect pipework have been via a silver-stabilised hydrogen peroxide (brand name Sanosil) at levels where the potable hot and cold water systems could remain in operation, clearing the issue for a short time only however the issue returned. The latest round of sampling results received indicated three reduced counts in Maternity theatres and one in Neonatal Unit; these results, coupled with the advanced flushing staff have been undertaking having an impact on the CFU counts but not eliminating the issue in this area, therefore indicates potential biofilm in the pipework.

The Water Safety Group believe the next course of action needs to be more invasive and proposal is to split the systems pipework in half via the installation of a valve array complete with isolation and non-return valves, and chemical dosing injection points. This will ensure any future issues in the pipework in Maternity theatres will not contaminate Neonatal, and will also allow for any future local disinfection of the Maternity pipework without affecting NICU.

Furthermore, we propose treating the entirety of the hot and cold systems with chlorine dioxide which we have been advised will remove the biofilm in the system in maternity theatres, as well as providing assurance that the pipework has been similarly treated. The Health Board Water Safety Group is closely monitoring the situation which the infection prevention team are key members of the forum.

Infection Prevention Incidents

This section provides a summary of incidents that had the potential to cause patient harm and disruption to services.

MPOX

MPOX is a rare zoonotic infection that is mainly found in parts of Central and West Africa. Recently, there have been cases of the West African clade of MPOX within the UK, but the risk of widespread transmission remains low.

MPOX infection is usually a self-limiting disease with the symptoms lasting from 2 to 4 weeks. However, as with many infectious diseases, additional precautions may be required for those individuals who are at increased risk of more severe illness. MPOX is currently classified as a high consequence disease.

Aneurin Bevan University Health Board established an Incident Management Team (IMT) to review the following key components:
 ➢ Patient pathways
 ➢ Screening and Testing
 ➢ Vaccination
 ➢ Staff risk assessment
 ➢ Communication plan
 ➢ Infection Prevention requirements

From April to September 2022, there has been 5 reportable cases within the locality of Aneurin Bevan University Health Board and a total of 46 confirmed cases in Wales. There have been no concerns noted with onward transmission and all cases have been managed appropriately.

Aneurin Bevan University Health Board continues to advocate the MPOX vaccine strategy, in response to the outbreak, recommending a selective vaccination programme for individuals at higher risk of exposure. This includes some gay, bisexual and men who have sex with men (GBMSM) as well as healthcare workers in specific settings such as High Consequence Infectious Diseases (HCID) centres and sexual health services.

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Sporadic Creutzfeldt-Jakob Disease (sCJD)

Patient was confirmed by the National CJD Research and Surveillance Unit in February as sCJD positive. The index case underwent Functional Endoscopic Sinus Surgery in 2014 and 2019. Following extensive consultation with ENT Surgeons and Public Health, the procedure in 2014 was classified as low risk, therefore no further action was required. However, information received from the ENT surgeon regarding the procedure performed in 2019 was reviewed with advice from UKHSA. The conclusion was that there was a possibility that the instruments from 2019 could have been in the region of the olfactory epithelium, which is classed as medium infectivity tissue.

A small Task and Finish group was established with Public Health Wales, ENT specialist, Emergency Planning Team, Putting Things Right Team, and Infection Prevention team. This resulted in six patients being followed up by a specialist neurologist due to the potential exposure through surgical instruments.

Surgical instruments involved had previously been used on another patient who was recently identified as having CJD but who was not suspected of having CJD at the time of their surgery. Whilst the equipment was sterilised after use in that patient at least three sterilisations are required where it is known there has been exposure to CJD. Public Health Guidance advocates a requirement to follow up patients.

Patients have been advised of the following, and they received a follow up letter detailing,

1. Not to donate blood, organs or tissues.
2. To tell the doctor, dentist or nurse in charge of their care, when it is related to any surgery or invasive medical procedure, that they are in an 'at risk' group for CJD.
3. To tell their family in case they require emergency surgery/ treatment.

To date, none of the patients affected have indicated any further follow up or concerns is required.

Increase in Wound Infections (Trauma & Orthopaedics)

The IPT highlighted a period of increased SSIs in Trauma/Elective orthopaedics during the summer months. A total of 8 patients isolated multiple organisms following surgery while on Ward A0 at GUH and C7W at the RGH.

A meeting was arranged with Consultants, Ward Managers, Theatre Manager and Senior Nurses to review the SSI care bundle in line with national guidance. An agreed action plan was developed reviewing the patients journey from ward, theatre, recovery, ward, and community. Works and Estates also provided assurance that the laminar flow and ventilation systems in theatres are functioning correctly.

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The following learning was shared with the Directorate and the Division:-
- ➢ Standardisation of processes
- ➢ Improve documentation
- ➢ Review theatre environment at RGH due to aged estate

The IPT implemented a focus campaign in January 2023 to promote the surgical site care bundle namely One Together. Engagement from the theatre teams was overwhelming with a highly successful recruitment of new Infection Prevention link champions. Next steps include:-

- ➢ Promotion of One Together components and resources
- ➢ Follow up on works and estates issues identified in local site team audits.
- ➢ Re-visit cleaning rota contents and completion to target corridor and high-risk items
- ➢ Sustain engagement through focused visits, notice boards and information sharing
- ➢ Promote ward staff to visit theatres from a patient journey perspective to generate understanding and respect for their mutual areas and the roles they play for the reduction of SSI

Shigella Outbreak

Shigella infection (shigellosis) is an intestinal infection caused by a family of bacteria known as Shigella. The main symptom of Shigella infection is diarrhoea. It is not life threatening, although in some cases it may result in hospitalisation, but symptoms usually clear up within four to five days.

Public Health are investigating cases of Shigella infection (shigellosis) associated with a single fast-food premises in Abergavenny. To date, there have been 13 confirmed cases and several suspected cases are still being investigated. Appropriate public health measures have been undertaken including tracing contacts of those affected and offering testing for contacts with relevant symptoms. A small number of patients have required hospitalisation for a short period of time and the GP out of Hours and admission areas have been alerted accordingly.

Group A Strep (GAS)

In December 2022, the UK Health Security Agency issued a notification to alert Health Boards to an increase in invasive group A streptococcus infections including empyema in children.

In conjunction with Public Health Wales, Aneurin Bevan University Health Board quickly established a task and finish group to monitor the situation within healthcare settings. Healthcare professionals were asked to have a low threshold to consider and empirically prescribe antibiotics to children presenting with features of GAS.

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While the directive had an impact on availability of antimicrobials for timely treatment, Aneurin Bevan University Health Board managed to assess and support the patients presenting with iGAS due to the collaborative working.

Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for NHS Wales and Aneurin Bevan University Health Board. It has been an extremely difficult year for the Infection Prevention Team with most of the work focused on responding to the ongoing Covid situation, influenza and RSV with infection prevention and control playing a central and fundamental role.

The IPT are thankful to Divisions and other teams for supporting the IPT to deliver the infection prevention agenda, in particular; Health and Safety for managing the mask fit testing programme, Site Operational teams for prompt patient placement and Facilities colleagues for keeping hospitals clean collaboratively providing a safe patient environment.

Recognising the Health Board did not achieve all the targets, the accomplishment of a reducing rates within most areas of the Welsh Government expectation goals during 2022/23 has been encouraging, reporting lower averages in all areas of measurement. This was achieved through good collaboration against the ongoing backdrop of Covid-19 and the pressure this presented across the Health Board.

As the organisation continues to transition into "business as usual", it is important to refocus on the fundamental principles of infection prevention and control, strengthening cleaning and the HPV programme, reviewing enhanced technology and re-embedding the agenda as being everyone business.

Programme of Work 2023/24

A work programme has been developed for focus during 2023/24.

Priority 1:	Systems to manage and monitor the prevention and control of surgical site infection (SSI). These systems use risk assessments, mapping the patients pathway within secondary and primary care maximising the use of ICNet.
Priority 2:	Review the enhanced technology available to our facilities teams to ensure patients are cared for in a clean environment.
Priority 3:	Commence antimicrobial audit and feedback cycles for high prescribing, outlying, GP practices
Priority 4:	Modernise the resources ensuring suitable and accurate information on infections for service users/staff and residents within the Aneurin Bevan University Health Board area.
Priority 5:	Ensure prompt identification of people who have or are at risk of developing an infection so they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people.

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Priority 6:	Aim to achieve ANTT bronze accreditation for the Health Board
Priority 7:	Ensure all IPC policies are up-to-date and evidence-based.
Priority 8:	Undertake Route Cause analysis and outbreak reviews from reduction expectation, SSI and respiratory pathogens and other pathogens ensuring learning is shared across the HB.
Priority 9:	Actively support the Covid-19 Investigation Team
Priority 10:	Support the business case for infection prevention team with an overall aim to supports sustainability/succession planning and reduce health care associated infection across the Health Board
Priority 11:	Support a business case to enhance ventilation with the overall aim to reduce healthcare associate infection that is transmitted via the air
Priority 12:	Undertake a quality improvement project for the reduction of hospital acquired pneumonia

Appendix

Appendix 1 – Annual Programme of Work 2023/24

PDF
Annual
Programme of ...

Appendix 2 – Education Strategy

PDF
Infection
Prevention and ...

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	Highlight Report

Group Name:	ABUHB Safeguarding Committee
Group Aim:	The Safeguarding Committee has delegated authority to establish and implement the strategic direction of safeguarding activity across the Health Board, providing assurance that legal requirements and national guidance are incorporated in to policy.
Date Completed:	12 July 2023 **Date of last meeting:** 27 June 2023
Completed By:	Howard Stanley – Head of Safeguarding
Distribution:	PQSOC
Summary:	This highlight report contains a brief summary of discussions at the ABUHB Safeguarding Committee.

Named Doctor Roles/Responsibilities/Resources

The Committee discussed the current provision of Named Doctor, noting that there is currently only provision for a Named Doctor for Children's Safeguarding.

It was agreed that there needed to be discussions regarding whether, due to increased demand, there needed to be formal consideration of whether there is adequate resource for the Named Doctor Role in Children's Safeguarding and whether there needs to be the development of a similar role for Adult Safeguarding.

Next steps are a formal discussion with the Medical Director, prior to any formal review of roles and potential development of any business case.

Safeguarding Training

ABUHB is currently non-compliant in its duty to ensure that staff have received safeguarding training at the level appropriate to their role, in line with the Wales National Safeguarding Training Standards.

Compliance with Levels 1 and 2 is very close to the expected level of compliance and a programme has now been put in place to deliver Level 3 Training to a large cohort of staff.

Non-compliance with training is already an open risk on the corporate risk register and is subject to regular review.

A timetable for delivery of Level 3 Training has been developed. Divisions were asked to promote Level 3 Adult Training sessions to enhance attendance.

A Safeguarding Development Session has been prioritised to clarify duties and responsibilities for Health Board Members.

Multi Agency Task and Co-ordination (MATAC)

Gwent Police have invited ABUHB to commit to being attendees at the Multi Agency Task and Coordination meetings (MATAC).

Whilst ABUHB are committed to tackling the issue of Domestic Abuse and working in partnership to protect the people of Gwent from harm, there are a number of issues which need to be considered before making any commitment to the MATAC Process. The most significant of these are:

- Access to the "whole" health record for the individuals involved in the MATAC process .

- The resources available to undertake research for MATAC and to attend the meetings.

- Sharing of patient information without consent and potentially without a statutory duty.

It was agreed that, as this a new non statutory initiative, it would not be possible to fully support this request at present. However, the Head of Safeguarding will undertake further scoping and this decision would be reviewed in Quarter 3 2023/24.

Safeguarding Risk Register

A Safeguarding Risk Register is in development. It will become a standing agenda item for future Safeguarding Committee meetings.

Items for Escalation

- Ongoing monitoring of Safeguarding Training Compliance.

Aneurin Bevan University Health Board

Clinical Standards Effectiveness Group

Minutes of the Meeting of the Clinical Standards Effectiveness Group held
on Thursday, 25th May 2023 at 14:00-16:00, via Microsoft Teams

In attendance:

Leeanne Lewis (LL)	Asst. Dir. of Quality & Patient Safety (Vice Chair)
Joanne Stimpson (JSt)	Quality & Patient Safety Lead for NCA
Stephen Edwards (SE)	Consultant Anaesthetist, & Deputy Med. Director
Gareth Morgan (GMo)	Senior Information Manager, QPS Team
William Batten (WB)	Clinical Effectiveness & Formulary Pharmacist
Seema Sindhakar (SS)	Consultant Anaesthetist
Glenys Mansfield (GMa)	General Manager, Scheduled Care
Richard Stubbs (RS)	Risk Manager, Corporate QPS Team
Dr Clifford Jones (CJ)	Primary Care Clinical Director Division
Caroline Rowlands (CR)	Deputy Head of Nursing, QPS and Nurse Education Locality Offices
Carly Cole (CC)	Divisional Operations Manager Scheduled Care
Tom Morgan-Jones (TMJ)	Consultant Anaesthetist & Scheduled Care Div. Dir.
Kylie Crooks	Senior Nurse Quality & Patient Safety, Unscheduled Care
Sarah Cadman (SC)	Head of Quality & Improvement, MH&LD
Susan Dinsdale	Assistant Divisional Nurse, Family and Therapies

Apologies:

Jonathan Simms (JSi)	Clinical Director of Pharmacy
Dawn Baker Lari (DBL)	Directorate Manager, Scheduled Care
Dr Leo Pinto (LP)	Asst Med. Dir. for Clinical Effectiveness & Consultant Physician (Chair)

Guests:

Dr Mat Jones (MJ)	Consultant in Medicine
Dr Inder Singh (IS)	Consultant in Care of the Elderly
Mr Adam Cox (AC)	Consultant Urological Surgery

CSEG 2505/01 Welcome and Introductions

The Vice Chair welcomed everyone to the meeting, providing apologies for Dr Pinto (Chair).

LL informed the group that work has been undertaken to standardise and improve the documentation from presentations to the group. It has been inserted into a template, which is being approved by Dr James Calvert, Medical Director.

Feedback from users is welcomed during the time of transition of recording results.

The Group were happy for the meeting to be recorded via Microsoft Teams.

Introductions were received.

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 March 2023

The draft minutes of the meeting held on 26th January 2023 were considered by the group. JS noted an omission to the attendees which had been corrected.

CSEG 2505/02 - National Prostate Cancer Audit (NPCA) Annual Report 2022 - Prostate Cancer service during the COVID-19 pandemic

Mr Adam Cox (AC) – Clinical Lead & Consultant in Urological Surgery stated that the data from this report is inaccurate due to the report issues with CANISC.

AC stated that the Health Board has a larger proportion of metastatic disease, Performance Indicator 1 (PI1), at 30% compared to the 17% National average.

Disease Presentation

	Specialist MDT	National
No. of men with disease status determined	178	23477
Percentage of men diagnosed with metastatic disease	30%	17%
No. of men diagnosed with M1 (metastases)	54	N/A

PI2, the proportion of patients who had an emergency readmission within 90 days of radical prostate cancer surgery is reported as 24% (21 cases), AC stated that this figure is not accurate as there is not ¼ readmitted and hasn't seen anyone readmitted within the last 3 years. AC looked at local data and states the number of cases is between 60-65 cases every year, not 21 as the report states.

AC states that PI3, the proportion of patients experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy is inaccurate and the data requires investigation as the expected result is about 1-2%.

Outcome

	Treatment Centre
No. of men who received radical prostatectomy (2020-2021)	21
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy (%)	24%
No. of men who received radical prostatectomy (2019)	58
Adjusted percentage of men experiencing at least one GU complication (%)	10%

There is no local data for PI4, the proportion of patients receiving a procedure of the large bowel and a diagnosis indicating radiation toxicity (gastrointestinal (GI) complication) up to 2 years following radical prostate radiotherapy as these are seen in Velindre and recorded as Cardiff & Vale UHB.

PI5 the proportion of men with low-risk localised prostate cancer undergoing radical prostate cancer therapy is reported as 1 patient, 4.2% (n. 24), more patients are placed on active surveillance. PI6 the proportion of men with locally advanced disease receiving radical prostate cancer, the Health Board is 75.1% compared the Wales average of 72.3%.

Specialist MDT	Performance indicator 5			Performance indicator 6		
	No. of men diagnosed with low-risk localised disease	No. of men with low-risk localised disease receiving radical treatment		No. of men diagnosed with locally advanced disease	No. of men with locally advanced disease receiving radical treatment	
		N	%		N	%
Overall	92	8	8.7	487	352	72.3
Aneurin Bevan University Health Board	24	1	4.2	48	37	75.1
Betsi Cadwaladr University Health Board	5	0	0.0	161	119	73.3
Cardiff and Vale University Health Board	40	4	10.0	94	80	81.7
Swansea Bay University Health Board	23	3	12.0	184	116	65.3

The issues with data reported may change with the new iteration of CANISC, this would need to be clarified by Cancer Services. AC stated that the number of men with prostate cancer diagnosed for a year in the Health Board is approximately 180, which is more cases than the average centre. There are concerns from clinicians in other Health Boards.

AC confirmed that the local data requires further investigation for accuracy.

Through the pandemic the Health Board ceased MRI as suspected high mode of transmission of COVID-19 and there was a halt to surgery.

AC informed the group that surgery is performed by a Health Board collective team at Cardiff and Vale UHB premises as there is a surgical robot where 90-

95% of the Health Boards cases go for surgery. GM stated that a business case has gone to PIP and will go to Executive Board early June, to secure a surgical robot for use at the Health Board. It was discussed that the robot would improve waiting lists, reduce Length of Stay (LoS) and improve patient outcomes therefore it is financially viable.

Report National Recommendations:

Recommendations:	
Data quality	
R1	Aim to achieve high completeness of key data items at the point of collection by NHS organisations in England, particularly TNM staging variables. A clinician responsible for reviewing and checking their team's data returns should be identified, mirroring the approach in Wales where data completeness remains high.
R2	Review recording of whether lymphadenectomy was carried out, working with data specialists.
Disease status	
R3	Seek advice from a doctor if any of the following new symptoms are experienced: urinary symptoms, erectile problems, blood in their urine or unexplained back pain, as early diagnosis improves outcomes.
R4	Ensure that a family history of prostate, breast or ovarian cancer is reported to a healthcare provider as it should precipitate a genetic counselling referral.
Outcomes of treatment	
R5	Undertake internal audit and review of radiotherapy treatment delivery processes; target volume delineation, margins, dosimetric constraints, online imaging, and patient setup. In England, participation in the RT Operational Delivery Networks may support this.
R6	Initiate routine integration of radiotherapy peer review as standard for radical prostate cancer cases.
R7	Consider establishing radiotherapy centre specialist gastrointestinal services to offer advice to people with bowel-related side effects of radiotherapy.
R8	Consider initiation of routine hospital level PROMS programmes as part of post treatment follow up to support the identification of these side effects.
R9	Support radiotherapy centres to integrate IMRT into standard radiotherapy practice for primary radical RT.
R10	Ensure that men who are offered prostate cancer treatment are made aware of the side effects including: loss of libido, problems getting or keeping erections, loss of ejaculatory function, a worsening of sexual experience, urinary incontinence and/or bowel side effects.
R11	Empower patients to ask to be referred to specialist support services if they are experiencing physical or psychological side

	effects during, or following, prostate cancer treatment. These should be offered early and on an ongoing basis, in keeping with national recommendations.
R12	Make available sources of further information and support for men with prostate cancer and carers. These are accessible via GP services and from prostate cancer charities including Prostate Cancer UK (www.prostatecanceruk.org) and Tackle Prostate Cancer (www.tackleprostate.org). Both of these charities operate nationwide support networks.
Treatment allocation: recommendations on the basis of Welsh data	
R13	Continue to advocate active surveillance in the first instance for men with low-risk prostate cancer.
R14	Discuss with your clinical specialist the option of disease monitoring with active surveillance in the first instance.
R15	Investigate why men with high-risk/locally advanced disease are not considered for radical local treatment.
R16	Discuss with your clinical specialist the radical treatment options available to men with high-risk/ locally advanced disease.
Overall recommendations	
R17	Review of the NPCA indicators for providers should be undertaken within the region and nationally, and fed through to providers. Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes. Where variation is apparent, agree quality improvement action plans and present these to the Trusts and Health Boards which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.
R18	Ensure that radiotherapy and surgical treatment centres continue to integrate and upgrade evidence based treatments and support services for patients.
Impact of COVID-19: recommendations, key findings and related national guidance	
CR1	Review the diagnostic and treatment activity for your region during 2020 and 2021 illustrating how your service responded during this time and to support decision making in response to current changes in demand.
CR2	Monitor adherence to the recommended diagnostic pathway for suspected prostate cancer.
Hypofractionation	
CR3	Continue to increase the use of hypofractionated radiotherapy.
CR4	Offer enzalutamide (or apalutamide) with androgen deprivation therapy (or abiraterone for patients intolerant of enzalutamide) to people with newly diagnosed metastatic disease instead of docetaxel, where appropriate.

Actions: *(Specific, Measurable, Achievable, Relevant, Timely)*
1. Contact with NPCA and SBUHB to discuss the data published versus local data/CANISC to ensure accuracy of data within the next annual report published early 2024.
2. Chase up on contact with Head of Cancer Services for Wales for discussion regarding data immediately.

Please see AMaT summary report for NPCA - NPCA - ClinicalAuditSummary

CSEG 2505/03 – Fracture Liaison Service Database (FLS-DB) Annual report: Rebuilding FLSs to meet local patient need
Data from January to December 2021

Dr Singh (IS) updated the group on the background of the Fracture Liaison Service (FLS) relating to osteoporosis and the fractures resulting from falls. IS stated that the service is heavily supported by Care of the Elderly (COTE) and Rheumatology colleagues. IS noted that he was thankful of the medical directorate for supporting this work, which will hopefully reap the benefits in the next year report.

Key points:
The FLS should pick up all fragility fractures across the Health Board. IS stated that the Health Board are doing well against the Key Performance Indicators (KPI's).
IS explained the 80/50/80 model of how the service should work. Identifying at least 80% of the fractures in patient 50+, should commence treatment on 50%, and monitor 80% of those treated. The Health Board is identifying 22.7%, National benchmark is at 40%. Spine fractures are easier to identify as the team work closely with Radiology who record the term 'fracture' in the report. Once identified, treatment can be commenced, bone treatment (KPI7) is only based on the 22.7% of patients identified. IS has met with colleagues in Primary Care (PC), regarding the after-treatment monitoring, which PC have their own challenges, so follow up is not at a good level. IS provided a breakdown of numbers and percentages of the Health Boards results:
(as per the 80% rule)
- Missed 58% of patients with fractures
- Only treating 12% of identified patients
- 0.1% reviewed at 16 weeks
- 1.2% reviewed drug adherence at one year
- Missed opportunity of 99% of patients

IS stated this is negative but there are opportunities to improving the service which is cross divisional and has been discussed with the medical directorate. IS started that 1 in 3 of these patients will fracture again using up resource which could be avoided.

The Health Board is also not doing well in the KPI's for assessment within 90 days, Dexa Scan within 90 days, Falls risk assessment and Strength and balance by 16 weeks.

Report National Recommendations:

KPI2	Identification (all fragility fractures) - All FLSs submitting less than 80% of their expected caseload to the FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates.
KPI 3	Identification (spine fractures) - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures.
KPI 7	Bone therapy recommended - All FLSs with less than 50% treatment recommendation should review their pathways in line with NICE technology appraisals and guidance (NICE CG146, QS86, TA161, TA204, TA464, TA791), the NOGG 2021 clinical guideline for the prevention and treatment of osteoporosis and the Royal Osteoporosis Society (ROS) clinical standards for FLSs.
KPIs 9, 10 and 11	Monitoring, follow up and adherence - All FLSs should continue to aim for monitoring performance for at least 80% patients who are recommended or referred for therapy. This includes patients who receive injectable therapies after referral to other clinical teams, to ensure the treatment recommendations have been actioned.
All FLSs should have regular monthly governance meetings that report to their organisation's executive teams, and use FLS-DB data in these meetings to prioritise areas for service improvement.	
All FLSs should have an active service improvement team that includes at least two patients/ carers and representation from clinicians, administration and management to complete at least one quality improvement cycle every year.	
All FLSs should use the regional benchmarking function to develop regional networks that share good practice and drive service improvement. All FLSs should engage with the ROS and local decision makers to ensure their FLS is resourced based on local need. The ROS FLS implementation toolkit offers support for the development of services from business case right through to outcomes and performance measurement, including providing an FLS benefits calculation to cost pathways for the local population.	

IS updated the group on the Welsh Government written statement, that the expectation that all Health Boards (HB) will achieve 100% Coverage by September 2024. Currently, the only other HB's formerly registered to the audit are Cardiff and Vale and Swansea Bay, the other HB's are delivering the service to some degree. Rheumatology and COTE have built working partnerships and a new cost centre created for COTE to progress the service.

IS informed the group of the increase in the older population particularly in the HB localities, stating that Royal Osteoporosis Society (ROS) recommends 1 Whole Time Equivalent (WTE) CNS for between 40,000-46,00 which in equates to 5.3 WTE CNS for the Health Board (currently 2.2 WTE) with 2.7 WTE admin support to run the service effectively and if this is not made available the same results will be provided next year.

CR requested the requirements needed from PC to support, IS stated that initially the drug adherence checks, which might be being done, but not recorded in the audit. Also, PC have the knowledge of the fractures in the last two years, risk is still very high, and PC could identify and refer patients. CJ stated that the information is in PC but needs to be brought into processes and re-enforced.
SE stated that the recognition, frontloading the 80% is vital and WG statement being enforced for just over 12 months' time. LL suggested thinking about taking the results to the AB Bone Health Group and if these can support with the business case. Using the audit results to drive the business case, and ensuring this is highlighted on a risk register. LL also queried the use of real time data. IS stated that the HB is represented at the All-Wales FLS Quality and Assurance Group however this does require improved attendance from HB colleagues. The Medical Division shared live data, which shows continuous improvement since the employment of the two CNS for the pilot, hence the pilot approved for a further six months. IS stated that Peter Carr would be sponsor for the business case.

Actions:
- Formal business case for FLS
- Two Clinical Nurse Specialist (CNS) posts as pilot, need to be made permanent – development and support
- Administrative support for FLS
- Although encouraging support from Emergency & Trauma and Orthopaedic, but further collaboration across the HB is required.
- Maintain close working with radiology regarding the correct terminology used in reports.

FLS-DB
ClinicalAuditSummary

Please see AMaT summary report for FLS-DB -

CSEG 2505/04 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Study of End-of-Life Care

LL informed the group that the latest study being undertaken by NCEPOD was relating to End-of-Life Care. Usually, a study will focus on one specialty, however, End of Life is HB wide, and this should be raised within the divisions and directorates to ensure HB participation.

CSEG 2505/05 National Lung Cancer Audit (NLCA) State of the Nation Report 2023 Results of the National Lung Cancer Audit for patients in England during 2021 and Wales during 2020-2021

Mat Jones (MJ), Clinical Lead for the Lung Cancer Team stated that they are a large Multidisciplinary Team (MDT) diagnosing over 400 cases for Lung Cancer per year, the majority of patient are referred with end stage disease and with multiple co-morbidities placing a strain on the workforce. Early stage across Wales is very similar.

The data relates to 2020-2021 during the pandemic and is the first publication since the HB joined two MDT's, NHH and RGH, which had been pursued for a few years previously. Data show the HB compared to national figures.

Data quality shows the reduced numbers during 2020 and increased in 2021, and the HB is the second largest MDT in Wales. MJ informed of the key data items and the HB good performance against these in the graph below. We are reliant upon Velindre Cancer Centre for oncology support and Cardiff & Vale for surgical support, this is where data integrity can cause issues.
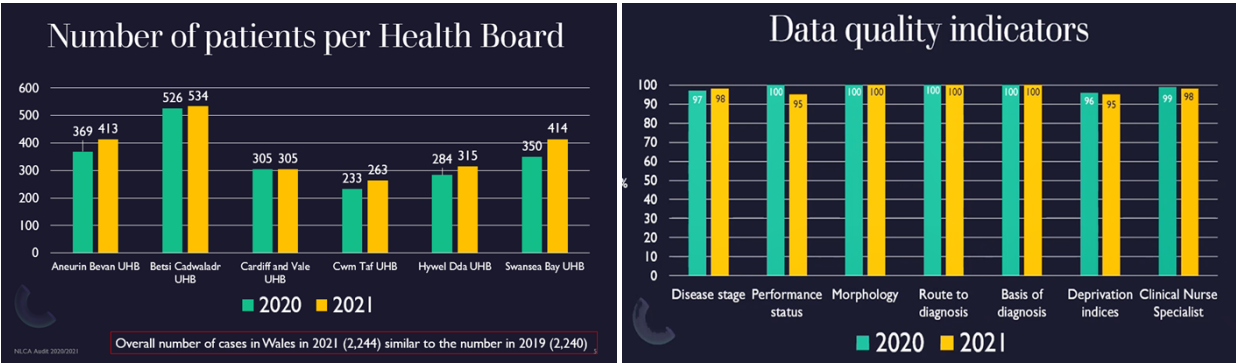
The Performance Status (PS) is based on what the patient can do day to day and frailty index. This determines the type of investigations patient can tolerate and reflect their overall health status, the majority of the HB patient represented with stage two disease.

MJ stated that for PS three and four, the HB is lower than the mean across Wales, and for PS two, the HB is above the Welsh mean, with the highest number of by individual HB and queried the optimism of the PS.

MJ informed that the target is high for patients with pathological confirmation of early-stage disease, Good PS lung cancer at 90% with the Health Board at 73% in 2020 and 75%, with the Wales mean at 83.3% and 84.8% for the same years, other characteristics of the

patient can influence this result. For surgical resection target at 17%, however the HB was 11.5% and 9.5%, versus the Wales mean of 11% and 13.2%, below NLCA targets for both years, declining in 2021. The only HB performing well is Betsi Cadwaladr UHB. It is notable that this is the only HB where surgery is carried out in England.

Patients with Stage I/II with PS 0-1
Confirmed pathological staging

- ABUHB patients with pathological confirmation of early stage, good PS lung cancer *below* All Wales mean in both 2020 and 2021:
  - 2020 (n=44): 73.9%   **Wales mean = 83.3%**
  - 2021 (n=42): 74.5%   **Wales mean = 84.8%**
- NLCA target is ≥ 90%
- *Lowest proportion within any health board in Wales*

Needs exploratory audit of data compared to NLCA target and then set recommendations

NSCLC patients having surgical resection

- ABUHB patients with NSCLC having surgical resection:
  - 2020 (n=38): 11.5%   Wales mean = 11%
  - 2021 (n=35): 9.5%   Wales mean = 13.2%
- NLCA target is ≥ 17%
- Significantly below NLCA targets for both years, declining in 2021
- *Are patients receiving other means of radical treatment with radiotherapy?*

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage I/II with PS 0-2 having curative treatment

- ABUHB patients with good performance status, early stage NSCLC having curative treatment:
  - 2020 (n=75):   66.7%   **Wales mean = 66.1%**
  - 2021 (n=72):   56.9%   **Wales mean = 64.8%**
- NLCA target is ≥ 80%

  Role of pre-habilitation in these patients (particularly PS2)

- Significantly below NLCA targets for both years, declining in 2021
- Could this relate in part to higher proportions of patients with PS2 not receiving curative treatment
- ? Integrity of data   ? effect of co-morbidities/patient choice

Needs exploratory audit of treatment and decisions and then set recommendations

SCLC patients having chemotherapy

- ABUHB patients with SCLC receiving chemotherapy:
  - 2020 (n=32):   50%   Wales mean = 57.5%
  - 2021 (n=37):   67.6%   Wales mean = 70.82%
- NLCA target is ≥ 70%
- Below NLCA targets for both years, improving in 2021 - ?Covid related
- Highly variable presentation with differences in PS and stage of disease potentially accounting for differences

Need to ensure rapid prioritisation of patients for investigation and treatment

NSCLC patients Stage IIIA with PS 0-2 having curative treatment

- ABUHB patients with good performance status, Stage IIIA NSCLC having curative treatment:
  - 2020 (n=29:   44.8%   **Wales mean = 46.8%**
  - 2021 (n=41):   31.7%   **Wales mean = 60.6%**
- No set NLCA target - England mean = 60% in 2021

  Heterogeneous population of patients with expanding treatment options

- Declining proportion of patients in 2021 compared to 2020
- Could this in part relate to higher proportions of patients with PS2 not receiving treatment
- ?Integrity of data   ?effect of co-morbidities/patient choice

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage IIIB/IV with PS 0-1 having SACT

- ABUHB patients with good performance status, Stage IIIB NSCLC having SACT:
  - 2020 (n=69):   50.7%   **Wales mean = 52.5%**
  - 2021 (n=68):   48.5%   **Wales mean = 56.6%**
- NLCA target > 60%
- Below NLCA target and Wales mean in both years
- *Could this relate to delays in obtaining pathology results on patients, oncology access, patient choice – many potential aspects to explore*

Needs exploratory audit of treatment and decisions and then set recommendations

Non-Small Cell Lung Cancer (NSCLC) patients Stage I/II with PS 0-2 having curative treatment, below NLCA targets for both years, declining in 2021, at 56.9% compared the Wales mean of 64.8% and the target of 80%. The Stage IIIA with PS 0-2 having curative treatment has no set target although England's mean is 60% and the HB saw a decline in 2021 compared to 2020 and 2021 almost half the Wales mean of 60.6% at 31.7%. This could be low for many reasons such as HB access to oncology, access to treatment options for these patients, effects of comorbidities, patient choice, documentation of data and potentially not offering patients curative therapy. NSCLC patients Stage IIIB/IV with PS 0-1 advanced disease where it's metastatic, spreading to outside of the lungs, having Systemic Anti-Cancer Therapy (SACT) below NLCA target and Wales mean in both years, this can also be impacted on by other factors such as co-morbidities and the HB has delays in the pathology pathway and rely on sending samples to Cardiff, if this was done within the HB, this would speed up

the pathway getting results to patients quicker and possibly providing an option for oncological intervention before deteriorating to a lesser PS. Possible issues regarding therapeutic nihilism and patient choice, for exploration.

Small Cell Lung Cancer (SCLC) is below NLCA targets for both years, improving in 2021 in the HB and across Wales. There is a need to ensure rapid prioritisation of patients for investigation and treatment.

The HB currently has 5, and not all WTE, Lung Clinical Nurse Specialists (LCNS) working tirelessly to back up the service daily, and the number of patients seen exceeds the NLCA target of >90%.

Patients diagnosed after emergency admission has always been about 40-50% and it was surprising to see a reduction to 6.3% in 2021, which saw the patients as a referral of an inpatient by a consultant, which is then not captured as part of this, so highlights data integrity issues. Patients who present as an emergency presentation usually often have greater co-morbidities and poorer performance status. This will be investigated when validating the data for the 2022 report.

Patient with adjusted one year survival rate for the HB is low and of concern and requires investigating the factors driving these figures.

MJ stated that the successes are the merged MDT and the Lung Cancer Physician of the week (LCPOW) who see all the referral and prep for MDT and will do most of the clinics. Also, the excellent support for the LCNS and high throughput of patients from multiple referrals.

The concerns that we need looking into at greater detail are the low numbers of patients with histological data for early-stage disease with good performance status, meaning we are using biopsy at a much lesser rate than other HBs and we need to look at these patients to assess their management. The issue with having a high proportion of PS2 and how this is impacting on the results. Also being below on the target treatment rates for surgical resection in NSCLC and SCLC chemotherapy rates.

Data integrity issues, such as resources and validation are concerning. This exercise has been very useful in highlighting these areas. Data is vast and often incomplete, and we work on this retrospectively, which needs investigating. MJ stated that he believes our data is better than what has been published, however the audit results need to be respected and used to improve the service.

LL asked about the plan to look at this data with regards to the next round of data result, however MJ stated that the issue with data for the next audit, is it has already been populated. MJ stated that he will be sharing this data with the MDT in two weeks' time to collectively investigate the data and are we providing

the oncology services as well as we should, the service has been disjointed recently due to organisation of clinical resources and there are many challenges in service development ahead.

LL also asked about the benchmarking across the network area and comparisons against other HBs, considering the vast populations differences in South Wales. MJ stated that the benchmarking target has increased every year as an indication that we should be treating Lung Cancer more aggressively, but does not wholly take into account deprivation and co-morbidities or the differences in what treatment is appropriate based on individual patient circumstances.

Report National Recommendations:

5.3 Recommendations for Wales

Ref. No	Recommendation	Standard	Key audience
W1.	Health boards should examine the route of referral and stage at presentation for their population and look at ways to increase the numbers of patients diagnosed who are presenting with early-stage disease	NICE quality statement 1 (QS17):[1] local authorities and healthcare commissioning groups use coordinated campaigns to raise awareness of the symptoms and signs of lung cancer and encourage people to seek medical advice if needed	Health boards
W2.	The UK National Screening Committee should review the most up to date evidence on CT screening for lung cancer to inform decisions on implementation of a national programme, in order that the proportion of patients diagnosed with lung cancer at an early stage can be increased	This audit shows that 48% of patients in Wales are diagnosed with stage IV disease in 2019. The NHS Long Term Plan seeks to diagnose at least 75% of all cancers at stage I/II by 2028	UK National Screening Committee
W3.	Health boards with lower than expected surgical resection rates should review their processes for selection of patients for surgery, in order that a rate of at least 17% is achieved	NICE quality statement 5 (QS17):[1] adults with NSCLC stage I or II and good PS have treatment with curative intent	Health boards Multidisciplinary team Clinical lead Cancer manager

Actions:
- Explore the data integrity.
- Discuss with MDT.

PDF

NLCA - ClinicalAuditSummary

Please see AMaT summary Report for NLCA -

Next meeting Thursday 20th July 2023 @ 14:00 – 16:00

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 July 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Effectiveness and Standards Group Clinical Audit Activity Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Dr James Calvert, Medical Director
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Stimpson – Clinical Audit Lead Leeanne Lewis, Assistant Director for Quality & Patient Safety

Pwrpas yr Adroddiad **Purpose of the Report**
Er Sicrwydd/For Assurance

ADRODDIAD SCAA **SBAR REPORT**
Sefyllfa / Situation

National Clinical Audit Reports are presented to the Clinical Standards and Effectiveness Group (CSEG) following publication. Clinical Lead(s) for the service(s) are informed of the report due date on publication. The Quality and Patient Safety (QPS) clinical audit team register the audit in the Clinical Audit Area via the web-based Audit Management and Tracking system (AMaT). The relevant documentation is provided to Clinical Leads, who provide CSEG with an analysis of local performance benchmarked against national recommendations. They then provide a "SMART" improvement plan for the Health Board which is available in AMaT so completion deadlines can be tracked.

CSEG also review governance arrangements for introduction of new clinical practices/procedures, not previously undertaken within the Health Board, as set out in the Policy for Implementation of New Clinical Procedures. The Group makes an assessment of the safety and effectiveness of the proposed procedure, taking into account known benefits/ risks and proposed arrangement for training/supervision, informed consent and clinical audit.

Cefndir / Background

Clinical audit is an essential tool in ensuring that services continually evolve and develop and are responsive to quality and safety risks. The results of clinical audit are one input into a wider Quality Management System designed to achieve continuous organisational learning and improvement in delivery of safe and effective care. When conducted in accordance with best practice standards, clinical audit provides assurance of compliance with clinical standards, identifies and minimises risk, waste, and variation in clinical practice from guidelines and defined standards of care. It also improves the quality of care and patient outcomes.

CSEG is held bi-monthly. On 25th May 2023, the audit reports reviewed were:
- National Prostate Cancer Audit (NPCA) Annual Report 2022 - Prostate Cancer service during the COVID-19 pandemic
- Fracture Liaison Service Database (FLS-DB) Annual report: Rebuilding FLSs to meet local patient need.   Data from January to December 2021
- National Lung Cancer Audit (NLCA) State of the Nation Report 2023 Results of the National Lung Cancer Audit for patients in England during 2021 and Wales during 2020-2021
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Study of End-of-Life Care

For future CSEG meetings, Clinical Leads have been asked to ensure that Audit reports include a summary of areas of practice that already meet guideline/audit standards and an action plan for areas requiring improvement that are specific, measurable, achievable, realistic and time bound so that their implementation can be tracked. Divisional governance teams are required to oversee the formulation of audit action plans by directorates for approval at CSEG.

Asesiad / Assessment

A standardised template has been produced via AMaT to present National Clinical Audit results. The audit report is uploaded to AMaT to ensure a SMART action plan has been produced by the Clinical Lead. The Clinical Lead is requested to discuss this with the Directorate and Division in a timely manner, before or after CSEG. We are utilising the full capability of AMaT to record all audit information and using the reporting functionality, allowing more efficient tracking of audit results and actions.

The attached Appendices provides the above information for all National Clinical Audits.
- Appendix One National Prostate Cancer Audit (NPCA)
- Appendix Two - Fracture Liaison Service Database (FLS-DB)
- Appendix Three - National Lung Cancer Audit (NLCA)

CSEG also overseas governance behind introduction of new devices and clinical procedures. There were no new Procedures Policy requests in May.

There was a discussion on how to enable full participation in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Study of End-of-Life Care. The latest study being undertaken by NCEPOD was relating to End-of-Life Care. Usually, a study focused on one specialty, however, End of Life is Health Board wide. The Chair of the Group asked for support and suggestions on ensuring this is raised

within the Divisions and Directorates to ensure Health Board participation. See Appendix Four.

Following feedback from the PQSOC's June meeting, the Clinical Audit team will be working closely with the patient centred care team to consider how we triangulate patient feedback and stories with audit results.   Some national audits have established methods of capturing patient input into national reports. For those that do not, we will work with the team to capture patient experience as a theme in the audit results. With a realisation this will not be possible for all national clinical audits, there will be a discussion to decide on the priority which audit will include this qualitative data. This includes collaborating with Llais to feed into the results of national audits, improving the Annual Audit report.

We will look at the feasibility of capturing any further data within our Quality Management System that can be used to triangulate information from databases (e.g DATIX, CIVICA).   This will enable us to improve the audit results and recommendations with national clinical audits.

The process flow for national clinical audit will be reviewed to encompass this new aspect of data triangulation. Once a robust process has been agreed, this will be brought back as a short SBAR to a future PQSOC summarising the recommendations.

Argymhelliad / Recommendation

Assurance is given by all Clinical Leads presenting specialty data that Quality Improvement work is always at the forefront and to improve the quality of care for the patients across the localities. All recommendations, successes, concerns and action plans will be added to AMaT.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety 2.6 Medicines Management 2.9 Medical Devices, Equipment and Diagnostic Systems 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Adults in Gwent live well healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse
Strategic Equality Objectives 2020-24	Choose an item.
	Choose an item.
	Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	NA – National Average CA – Case Ascertainment
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Clinical Standards and Effectiveness Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Choose an item.

https://futuregenerations.wales/about-us/future-generations-act/	

Title: National Prostate Cancer Audit Annual Report 2021Results of the NPCA Prospective Audit in England and Wales for men diagnosed from 1 April 2019 to 31 March 2020 and the Impact of COVID-19 in England during 2020

Code: GS/CA/2019-20/02   **Date registered:** 01/03/2023

Speciality: General Surgery   **Other associated specialities:** N/A

Business unit: General Surgery   **Division:** Scheduled Care

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP)   **Reported type(s):** Clinical Standards Effectiveness Group, Patient
Quality, Safety and Outcomes Committee

Lead participant: Adam Cox   **Audit lead:** Charlotte Thomas

Rationale

The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The audit determines whether prostate cancer care is consistent with current recommended practice, and it provides information to support healthcare providers, commissioners, regulators, patient groups and patients in helping to improve prostate cancer diagnosis and treatment.

Clinical project summary

Objectives

This report presents results from the prospective audit for men diagnosed with, or treated for, prostate cancer between 1st April 2020 and 31st March 2021 in England and Wales. 4 The basis of the audit is routine data sources. However, this year, as last year, data flows have been subject to COVID19-related disruption and standard (fully processed) cancer registration data for the reporting period are currently unavailable.

Guidance

Code	Title
NG131	Prostate cancer: diagnosis and management (May 2019)

Project progress

Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

Clinical project summary

Results

The Clinical Lead (CL) stated that the Health Board has a larger proportion of metastatic disease, Performance Indicator 1 (PI1), at 30% compared to the 17% National average.

Disease Presentation

	Specialist MDT	National
No. of men with disease status determined	178	23477
Percentage of men diagnosed with metastatic disease	30%	17%
No. of men diagnosed with M1 (metastases)	54	N/A

PI2, the proportion of patients who had an emergency readmission within 90 days of radical prostate cancer surgery is reported as 24% (21 cases), AC stated that this figure is not accurate as there is not ¼ readmitted and hasn't seen anyone readmitted within the last 3 years. AC looked at local data and states the number of cases is between 60-65 cases
every year, not 21 as the report states. If the Health Board had their own robot, these numbers would be higher, but the anaesthetic team will not allow patients to be operated on in UHW if they are of questionable fitness.

Outcome

	Treatment Centre
No. of men who received radical prostatectomy (2020-2021)	21
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy (%)	24%
No. of men who received radical prostatectomy (2019)	58
Adjusted percentage of men experiencing at least one GU complication (%)	10%

The CL stated that PI3, the proportion of patients experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy is inaccurate and the data requires investigation as the expected result is about 1-2%.

Outcome

	Treatment Centre
No. of men who received radical prostatectomy (2020-2021)	21
Adjusted percentage of men who had an emergency readmission within 90 days of radical prostatectomy (%)	24%
No. of men who received radical prostatectomy (2019)	58
Adjusted percentage of men experiencing at least one GU complication (%)	10%

There is no local data for PI4, the proportion of patients receiving a procedure of the large bowel and a diagnosis

Clinical project summary

indicating radiation toxicity (gastrointestinal (GI) complication) up to 2 years following radical prostate radiotherapy as these are seen in Velindre and recorded as Cardiff & Vale UHB.

PI5 the proportion of men with low-risk localised prostate cancer undergoing radical prostate cancer therapy is reported as 1 patient, 4.2% (n. 24), more patients are placed on active surveillance. PI6 the proportion of men with locally advanced disease receiving radical prostate cancer, the Health Board is 75.1% compared the Wales average of 72.3%.

Specialist MDT	Performance indicator 5			Performance indicator 6		
	No. of men diagnosed with low-risk localised disease	No. of men with low-risk localised disease receiving radical treatment		No. of men diagnosed with locally advanced disease	No. of men with locally advanced disease receiving radical treatment	
		N	%		N	%
Overall	92	8	8.7	487	352	72.3
Aneurin Bevan University Health Board	24	1	4.2	48	37	75.1
Betsi Cadwaladr University Health Board	5	0	0.0	161	119	73.3
Cardiff and Vale University Health Board	40	4	10.0	94	80	81.7
Swansea Bay University Health Board	23	3	12.0	184	116	65.3

The issues with data reported may change with the new iteration of CANISC, this would need to be clarified by Cancer Services. The CL stated that the number of men with prostate cancer diagnosed for a year in the Health Board is approximately 180, which is more cases than the average centre. There are concerns from clinicians in other Health Boards.

The CL confirmed that the local data requires further investigation for accuracy, however this requires the appropriate workforce which currently is not in existence.

Through the pandemic the Health Board ceased MRI as suspected high mode of transmission of COVID-19 and there was a halt to surgery.

The CL informed the group that surgery is performed by a Health Board collective team at Cardiff and Vale UHB premises as

Clinical project summary

there is a surgical robot where 90-95% of the Health Boards cases go for surgery. The divisional management stated that a business case has gone to PIP and will go to Executive Board early June, to secure a surgical robot for use at the Health Board. It was discussed that the robot would improve waiting lists, reduce Length of Stay (LoS) and improve patient outcomes therefore it is financially viable.

Assurance & risk

Assurance Assurance not selected.

Risk

Risk not selected.

Key successes & concerns

Successes

Description
The proportion of men with locally advanced disease receiving radical prostate cancer, the Health Board is 75.1% compared the Wales average of 72.3%.

Clinical project summary

Concerns

Description
Data reported is not accurate and there are concerns flagged from other Health Boards.
Lack of surgical robot in ABUHB which has gone to PIP and going to June Executive Board which will improve waiting lists, LoS and improve patient's outcome.
Emergency re-admission rate within 90 days of radical prostate cancer surgery is reported at 24% (21 cases) this is not the case as a re-admission has not been seen in the last 3 years.
More case of radical prostate cancer surgery happen that is reported, local data evidences 60-65 cases (not 21 as reported)
The proportion of patients experiencing at least one genitourinary (GU) complication requiring a procedural/surgical intervention within 2 years of radical prostatectomy is inaccurate and the data requires investigation as the expected result is about 1-2% not 10% as reported.

AMaT

Clinical project summary

Action plan

	National Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	R17 Review of the NPCA indicators for providers should be undertaken within the region and nationally, and fed through to providers. Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes. Where variation is apparent, agree quality improvement action plans and present these to the Trusts and Health Boards which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.	To Contact NPCA and SBUHB to discuss the data published versus local data/ CANISC to ensure accuracy of data within the next annual report published early 2024.	Mr Adam Cox	01/06/2023	20/07/2023	🟠	Partially complete
2	R17 Review of the NPCA indicators for providers should be undertaken within the region and nationally, and fed through to providers. Pay particular attention to variations in service provision (diagnostics, treatment and support services) and treatment outcomes. Where variation is apparent, agree quality	Chase up on contact with Head of Cancer Services for Wales for discussion regarding data immediately	Mr Adam Cox	01/06/2023	20/07/2023	🟠	New

Clinical project summary

improvement action plans and present these to the Trusts and Health Boards which should put in place follow-up procedures to monitor the implementation of practice changes to address problems identified.

Clinical Audit Summary Checklist:

Date of CSEG attendance:	25th May 2023
Risk register (as above) Provide details:	**CL asked to provide assurance and risk (27/06/2023)**
Action plan signed off by Directorate:	
Patient Centred Care Group comments:	
Llais involvement:	
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT	

AMaT

Clinical project summary

Appendix Two
National Clinical Audit reporting template (AMaT)

Title: Fracture Liaison Service Database

Code: Med/CA/2020-21/01   **Date registered:** 14/02/2023

Speciality: Medicine   **Other associated specialities:** Rheumatology

Business unit: General Medicine   **Division:** Medicine

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP)   **Reported type(s):** Clinical Standards Effectiveness Group

Lead participant: Inder Singh   **Audit lead:** Andrew Yeoman

Rationale

A fracture liaison service (FLS) ensures that patients aged 50 and over with a broken bone after a fall have their bone health and falls risk checked and managed to lower their risk of a subsequent fracture.

Objectives

Made up of a team of healthcare professionals, FLSs bring clear benefits to the patient in the long term and have been shown to be clinically and cost-effective.

AMaT

Clinical project summary

Guidance

Code	Title
CG161	Falls in older people: assessing risk and prevention
CG146	Osteoporosis: Assessing the risk of fragility fracture

Presentations

Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

Results

Identification KPIs 2 and 3

KPI 2 - All FLSs submitting less than 80% of their expected caseload to the

FLS-DB should review the underlying causes for this and agree an action plan to improve identification rates - **ABUHB performing at 22.7%**

KPI 3 - All FLSs should prioritise identifying patients with spine fractures over those with fractures below the knee, given that they have a higher risk of subsequent fractures - **The target is 20% with ABUHB above target at 26.1%**

Clinical project summary

Monitoring, follow up and adherence (KPIs 9, 10 and 11)

All three KPIs for monitoring and follow up have improved in 2021 in comparison with 2019. For example, the percentage of patients who were followed up within 16 weeks of their fragility fracture has increased from 41% in 2019 to 47% in 2021 – **These performance targets in ABUHB are much lower than the National Average (NA)**

Clinical project summary
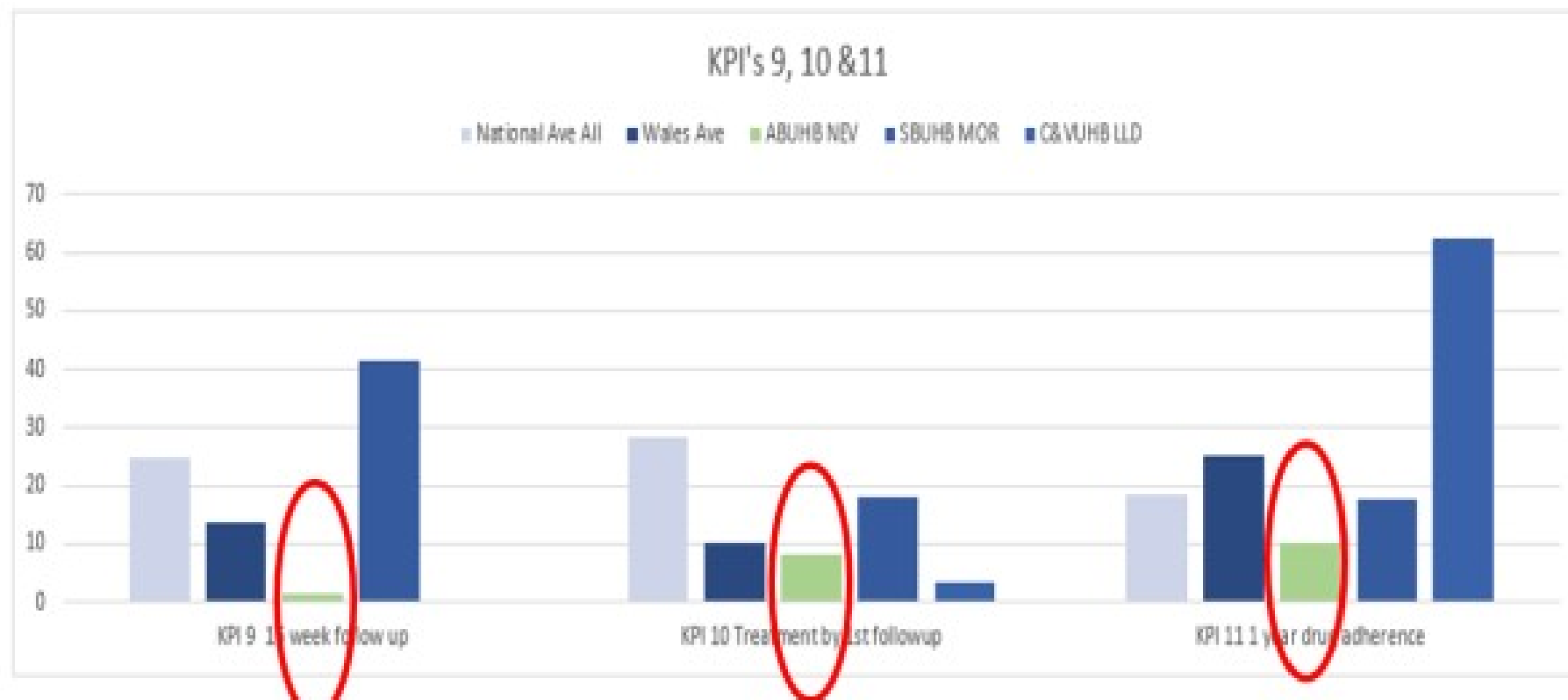
Bone therapy recommended (KPI 7)

More patients were recommended anti-osteoporosis medication in 2021 than in 2019 (56% vs 52%).

Once we identify a fragility fracture, we do commence treatment
ABUHB is performing at the Welsh average of 57.5% which is better than the National Average of 55.8%

Clinical project summary
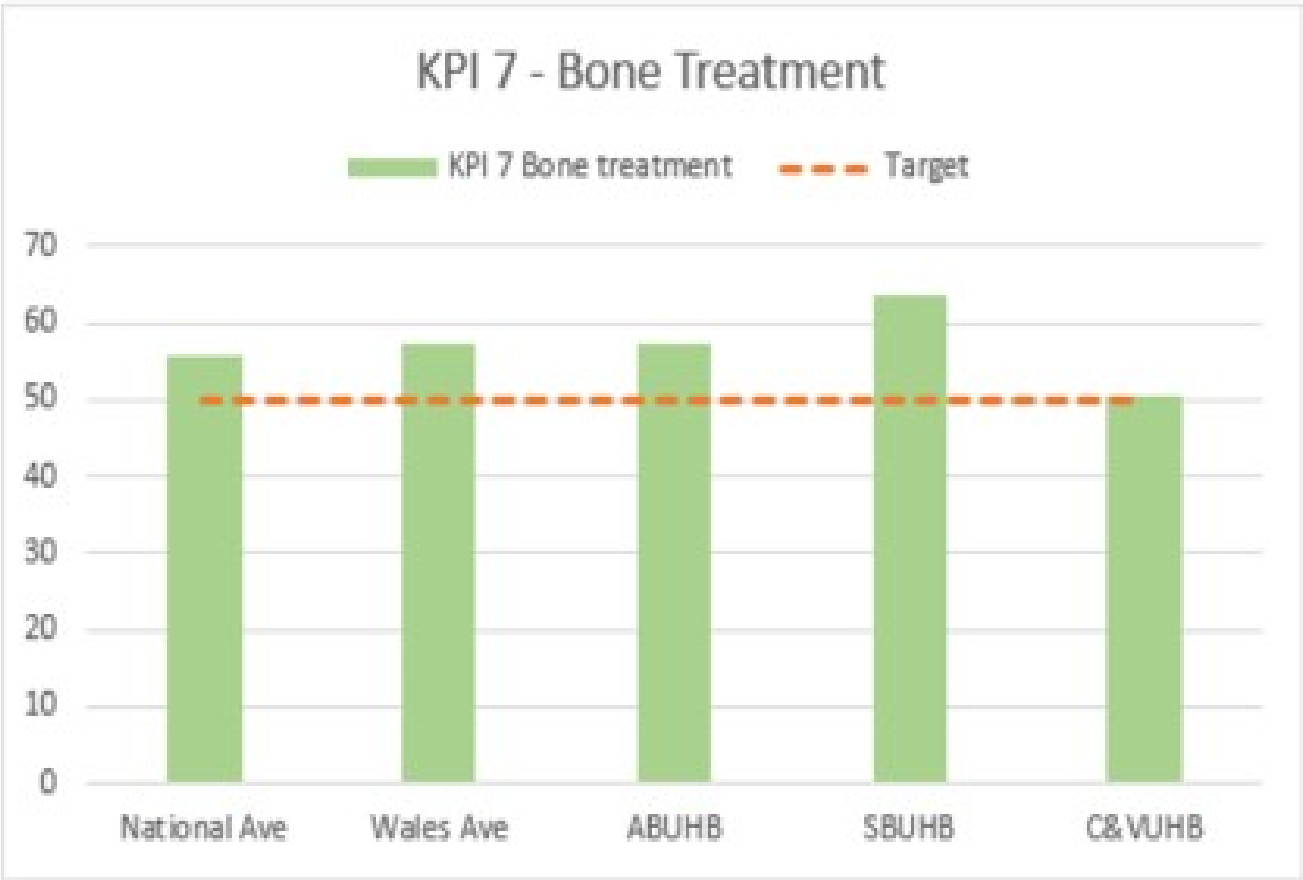
Missed opportunity for ABUHB

- We identified – 22% of patients (n=875) (missed 58% as per rule) – **Expected fragility fractures – ABUHB = 3875**
- We treated 56% - so treated 12% of identified patients
- We reviewed 1.4% patients at 16 weeks = 0.1% patients reviewed at 16 weeks
- We reviewed 10.1% - one year drug adherence = 1.2%

- **Missed opportunity = 99%**

KPI's 4, 5, 6 & 8

Legend: National Ave All, Wales Ave, ABUHB NEV, SBUHB MOR, C&VUHB LLD

Categories: KPI 4 Assessment within 90 days, KPI 5 DXA within 90 days, KPI 6 Falls risk assessment, KPI 8 Strength & Balance by 16 weeks

Clinical project summary

Written Statement: Update on Fracture Liaison Services in Wales (24 February 2023) | GOV.WALES

WG expects all Health Boards to achieve 100% coverage by September 2024

Clinical project summary

Assurance & risk

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Moderate	Repeated failure to meet internal standards/Major patient safety implications if findings are not acted on

Add to risk register: Yes

Key successes & concerns

Successes

Description
KPI 3 Spine Fracture - A major improvement was observed both in comparison to the previous and also against the national benchmark for spine fracture improved from 26% to 35% (National average=21%);
KPI 7 Bone Treatment - Bone treatment improved from 58% to 66% (National average=54%)

AMaT

Clinical project summary

Description

FLS-DB showed 42.6% (n=1651) patients identified in the year 2022, Case volume has increased by 88% compared to previous year 2021

Process mapping supported the establishment of the two FLS-DB pathways: Rheumatology team to provide care for patients under 75 with the current Clinical Nurse Specialist (CNS) and COTE team to assess all patients above 75 years. Medical Division supported the pilot for 12 months by funding two new CNS. Collaboration with the Radiology assisted to generate separate weekly fracture data for the Rheumatology and COTE teams.

Falls assessment improved from 35% to 81% (National average=61%)

Concerns

Description

KPI 2 Cases identified - Only 22.7% (n=879) of patients were identified by the FLS team, Aneurin Bevan University Health Board, Wales in 2021 (National average=40%).

KPI 4 Assessment within 90 days

KPI 5 DXA within 90 days

KPI 6 Falls Risk Assessment

KPI 8 Strength and Balance by 16 weeks

KPI 9 - 16 weeks Follow Up

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KPI 10 - Treatment by first Follow Up

KPI 11 - 1 year drug adherence - with ABUHB, we are not able to review patients at 1 year and currently working to improve for follow ups

Cases remains lower than the national recommendation of 50% (currently seeing 43% in ABUHB)

Further resource required for CNS/Admin

Wider partnership with radiology and T&O and A&E to identify new fragility fractures

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Action plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	To write a business case	Write a business case for CNS support and Admin support for the team and review consultant sessions	Dr Inder Singh	30/03/2023	01/09/2023	🔴	New
2	To write a business case	We will continue to collaborate with the ROS and ensure that Health Board's focus on the strategic planning for the FLS is delivered	Dr Inder Singh	11/04/2023	01/09/2023	🟢	New
3	To write a business case	Medical Division is supporting us with the two WTE CNS and have funded and have been supported us to write a business case. The initial results of the pilot have already supported the further extension of the pilot for another year with the aim of drug adherence by engaging with the Community and Primary care teams. This pilot also highlights the importance of improving culture and multi-professional awareness of fragility fractures and FLS.	Dr Inder Singh	11/04/2023	01/09/2023	🟢	New

Clinical Audit Summary Checklist:			
Date of CSEG attendance:	25th May 2023		
Risk register (as above) Provide details:	**Yes**	**Limited Assurance**	**Major Risk**
Action plan signed off by Directorate:			
Patient Centred Care Group comments:			
Llais involvement:			
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT			

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Appendix Three
National Clinical Audit reporting template (AMaT)

Title: National Lung Cancer Audit (NLCA) State of the Nation Report 2023

Code: GS/CA/2020-21/02   **Date registered:** 27/04/2023

Speciality: General Surgery   **Other associated specialities:** N/A

Business unit: General Surgery   **Division:** Scheduled Care

Is your project related to particular sites?: No

Is your project related to particular wards/areas?: No

Category: National (NCAORP) **Reported type(s):** Clinical Standards Effectiveness Group

Lead participant: Mat Jones   **Audit lead:** Charlotte Thomas

Rationale

The aim of the NLCA is to evaluate the patterns of care and outcomes for patients with lung cancer in England and Wales, and to support services to improve the quality of care for these patients. National guidelines underpin the management of patients with lung cancer and the NLCA evaluates current patterns of care against these standards.

Objectives

The NLCA is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) is response to the need for better information about the quality of services and care provided to patients with prostate cancer in England and Wales.

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Guidance

Code	Title
QS17	Lung cancer in adults (March 2012)

Presentations

Meeting title	Date & time	Location	Status
Clinical Standards and Effectiveness Group	25/05/2023 14:00	Teams	Awaiting approval

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Results

The Clinical Lead for this audit is Mr Mat Jones and the Health Board (HB) has a large Multidisciplinary Team (MDT) diagnosing over 400 cases for Lung Cancer per year, and the HB is the second largest MDT in Wales. The majority of patients are referred with end stage disease and with multiple co-morbidities placing a strain on the workforce. Early stage across Wales is very similar.

This data relates to 2020-2021 during the pandemic and is the first publication since the HB joined two MDT's, NHH and RGH, which had been pursued for a few years previously.

Data shows reduced numbers during 2020 and increased in 2021 and the HB is performing well in relation to Data Quality Indicators (graph below). The HB MDT are reliant upon Velindre Cancer Centre for oncology support and Cardiff & Vale for surgical support, this is where data integrity can cause issues.
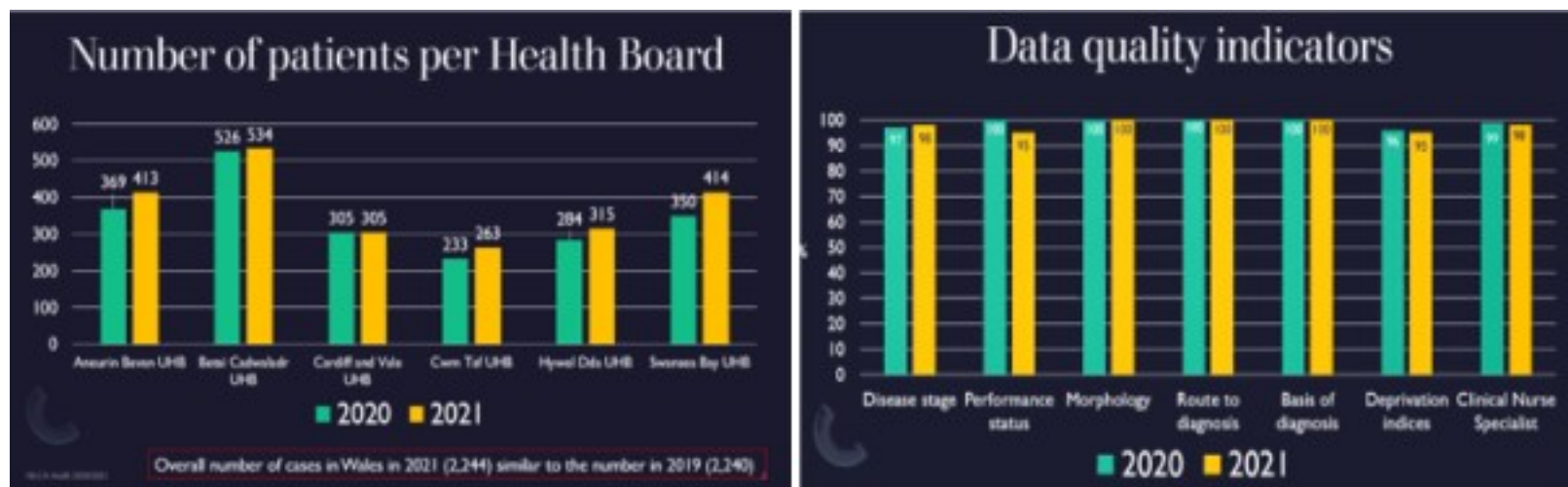
The Performance Status (PS) is based on what the patient can do day to day and frailty index. This determines the type of investigations patient can tolerate and reflect their overall health status, the majority of the HB patients represented with stage

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two disease.

PS three and four, the HB is lower than the mean across Wales, and for PS two, the HB is above the Welsh mean.

ECOG PERFORMANCE STATUS

ECOG Performance Status
Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.*

GRADE	ECOG PERFORMANCE STATUS
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair
5	Dead

*Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol 1982; 5:649-655.

The target is high for patients with pathological confirmation of early-stage disease, Good PS lung cancer at 90% with the Health Board at 73% in 2020 and 75%, with the Wales mean at 83.3% and 84.8% for the same years, other characteristics of the patient can influence this result. For surgical resection target at 17%, however the HB was 11.5% and 9.5%, versus the Wales mean of 11% and 13.2%, below NLCA targets for both years, declining in 2021. The only HB performing well is Betsi Cadwaladr UHB. It is notable that this is the only HB where surgery is carried out in England.

Patients with Stage I/II with PS 0-1
Confirmed pathological staging

- ABUHB patients with pathological confirmation of early stage, good PS lung cancer below All Wales mean in both 2020 and 2021:
  - 2020 (n=44): 73.9%   **Wales mean = 83.3%**
  - 2021 (n=42): 74.5%   **Wales mean = 84.8%**
- NLCA target is ≥ 90%
- Lowest proportion within any health board in Wales

Needs exploratory audit of data compared to NLCA target and then set recommendations

NSCLC patients having surgical resection

- ABUHB patients with NSCLC having surgical resection:
  - 2020 (n=38): 11.5%   Wales mean = 11%
  - 2021 (n=35): 9.5%   Wales mean = 13.2%
- NLCA target is ≥ 17%
- Significantly below NLCA targets for both years, declining in 2021
- *Are patients receiving other means of radical treatment with radiotherapy?*

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage I/II with PS 0-2 having curative treatment

- ABUHB patients with good performance status, early stage NSCLC having curative treatment:
  - 2020 (n=75): 66.7%   **Wales mean = 66.1%**
  - 2021 (n=72): 56.9%   **Wales mean = 64.8%**
- NLCA target is > 80%
- Significantly below NLCA targets for both years, declining in 2021
- Could this relate in part to higher proportions of patients with PS2 not receiving curative treatment
- ? Integrity of data   ? effect of co-morbidities/patient choice

Role of pre-habilitation in these patients (particularly PS2)

Needs exploratory audit of treatment and decisions and then set recommendations

SCLC patients having chemotherapy

- ABUHB patients with SCLC receiving chemotherapy:
  - 2020 (n=32): 50%   Wales mean = 57.5%
  - 2021 (n=37): 67.6% Wales mean = 70.82%
- NLCA target is > 70%
- Below NLCA targets for both years, improving in 2021 - ?Covid related
- Highly variable presentation with differences in PS and stage of disease potentially accounting for differences

Need to ensure rapid prioritisation of patients for investigation and treatment

NSCLC patients Stage IIIA with PS 0-2 having curative treatment

- ABUHB patients with good performance status, Stage IIIA NSCLC having curative treatment:
  - 2020 (n=29): 44.8%   **Wales mean = 46.8%**
  - 2021 (n=41): 31.7%   **Wales mean = 48.6%**
- No set NLCA target - England mean = 60% in 2021
- Declining proportion of patients in 2021 compared to 2020
- Could this in part relate to higher proportions of patients with **PS2** not receiving treatment
- ? integrity of data   ? effect of co-morbidities/patient choice

Heterogeneous population of patients with expanding treatment options

Needs exploratory audit of treatment and decisions and then set recommendations

NSCLC patients Stage IIIB/IV with PS 0-1 having SACT

- ABUHB patients with good performance status, Stage IIIB NSCLC having SACT:
  - 2020 (n=69): 50.7%   **Wales mean = 52.5%**
  - 2021 (n=68): 48.5%   **Wales mean = 56.6%**
- NLCA target > 60%
- Below NLCA target and Wales mean in both years
- *Could this relate to delays in obtaining pathology results on patients, oncology access, patient choice – many potential aspects to explore*

Needs exploratory audit of treatment and decisions and then set recommendations

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Non-Small Cell Lung Cancer (NSCLC) patients Stage I/II with PS 0-2 having curative treatment, are below NLCA targets for both years, declining in 2021, at 56.9% compared the Wales mean of 64.8% and the target of 80%. The Stage IIIA with PS 0-2 having curative treatment has no set target although England's mean is 60% and the HB saw a decline in 2021 compared to 2020 and 2021 by almost half. The Welsh mean of 60.6% at 31.7%. This could be low for many reasons such as HB access to oncology, access to treatment options for these patients, effects of comorbidities, patient choice, documentation of data and potentially not offering patients curative therapy.

NSCLC patients Stage IIIB/IV with PS 0-1 advanced disease where it's metastatic, spreading to outside of the lungs, having Systemic Anti-Cancer Therapy (SACT) below NLCA target and Wales mean in both years, this can also be impacted on by other factors such as co-morbidities and the HB has delays in the pathology pathway and rely on sending samples to Cardiff, if this was done within the HB, this would speed up the pathway getting results to patients quicker and possibly providing an option for oncological intervention before deteriorating to a lesser PS. Possible issues regarding therapeutic nihilism and patient choice, for exploration.

Small Cell Lung Cancer (SCLC) is below NLCA targets for both years, improving in 2021 in the HB and across Wales. There is a need to ensure rapid prioritisation of patients for investigation and treatment.

The HB currently has 5, and not all WTE, Lung Clinical Nurse Specialists (LCNS) working tirelessly to back up the service daily, and the number of patients seen exceeds the NLCA target of >90%.

Patients diagnosed after emergency admission has always been about 40-50% and it was surprising to see a reduction to 6.3% in 2021, which saw the patients as a referral of an inpatient by a consultant, which is then not captured as part of this, so highlights data integrity issues. Patients who present as an emergency presentation usually often have greater co-morbidities and poorer performance status. This will be investigated when validating the data for the 2022 report.

Patient with adjusted one year survival rate for the HB is low and of concern and requires investigating the factors driving these figures.

Bench marking across the network area and comparisons against other HB's, does not take into account the vast populations differences in South Wales. The bench marking target has increased every year and is an indication that we should be treating

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Lung Cancer more aggressively but does not wholly take into account deprivation and co-morbidities or the differences in what treatment is appropriate based on individual patient circumstances.

Conclusions

Exploration analysis and recommendations for practice required.

Assurance & risk

Assurance

Assurance level	Description
Limited	The project did not achieve the standards or criteria being audited against

Risk

Risk level	Description
Minor	Single failure to meet internal standards/Minor implications for patient safety if unresolved

Add to risk register: **Yes**

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Key successes & concerns

Successes

Description
Successes: • Merging of MDTs across health board   • Structured and streamlined services with adoption of Lung Cancer Physician of the Week (LCPOW)   • High throughput of patients from multiple referral sources   • Excellent input to patient care from nurse specialists

Concerns

Description
Concerns: • High proportion of PS 2 patients   • Low proportion of confirmed pathological staging for good PS, early stage disease   • Below target treatment rates for surgical resection in NSCLC, SCLC chemotherapy, NSCLC Stage IIIA and NSCLC advanced stage good PS treated with SACT   • Issues on data integrity – sources, validation

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Action plan

	Recommendation(s)	Action	Responsible	Date raised	Due date	Action RAG	Progress
1	1. Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies).	Explore the data integrity	Mr Mat Jones	20/06/2023	31/12/2023	🟢	New
2	1. Aim to achieve high levels of data completeness in the cancer registration datasets, particularly the Rapid Cancer Registration Dataset and COSD in England. - Completeness should be at least 95% for performance status (PS), ethnicity and disease stage, and at least 90% for "trust first seen", route to diagnosis, seen by a lung cancer clinical nurse specialist (LCNS) at diagnosis and smoking status (to highlight inequalities and inform future strategies).	Discuss at MDT	Mr Mat Jones	20/06/2023	08/06/2023	🟢	Fully Complete

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2. Ensure at least 85% of patients with stage I/II PS 0–2 NSCLC undergo curative intent treatment in line with NICE guidance. 3. Ensure at least 70% of patients with NSCLC stage IIIB-IV and PS 0-1 receive systemic anti-cancer therapy in line with NICE guidance. 4. Ensure at least 90% of lung cancer patients are seen by a lung cancer clinical nurse specialist at diagnosis. NHS 5Resource lung cancer MDTs according to the commissioning guidance set out by the Lung Cancer Clinical Expert Group, and update the guidance to reflect current best practice.						

Clinical Audit Summary Checklist:			
Date of CSEG attendance:	25th May 2023		
Risk register (as above) Provide details:	**Yes**	**Assurance - Limited**	**Risk - Minor**
Action plan signed off by Directorate:			
Patient Centred Care Group comments:			
Llais involvement:			
Specific, **M**easurable, **A**chievable, **R**elevant, **T**ime actions **MUST** be updated on AMaT			

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Appendix Four
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Study of End-of-Life Care

Name of Study:	End of Life Care Study			

Date of initial correspondence from NCEPOD	22/05/2023	Has inclusion specifics been provided?		Yes/No
Date NCEPOD request data returned?	07/07/2023	Date inclusion specifics sent to informatics:		23/05/2023
Date Division informed of pending study:		Division	Covers all divisions as deaths is hospital settings	

Has a Clinical Lead been requested by QPS?	Yes/No	Name of Clinical Lead:	

Date data returned from informatics:		Date data sent to NCEPOD: (via secure portal)	
Date added to NCEPOD platform:			

Is there and Organisational Questionnaire	Yes/No	How many OQ? (Site dependant)	
Deadline for OQ(s):			
Are there Clinical Questionnaires?	Yes/No	How many CQ? (No. of patients in study)	
Deadline for CQs:			

Have all patients been allocated to a clinician?	Yes/No	By whom in QPS CAT?	
Date allocated to a clinician:		Has the Division and CL been informed?	Yes/No
Once a CQ has been completed by a clinician, this triggers and email to the QPS CAT who will collect relevant case notes and submit to NCEPOD via the secure portal			
Comments:			
1. Need to agree how to take forward the community deaths element of the study – emailed LL/SE 23/05/2023.			

Clinical project summary

**Ombwdsmon
Ombudsman**
Cymru · Wales

Your ref:

Our ref: MAM/mm

Date: 15 June 2023

Ask for: Michelle Morris

☏ 01656 641152

✉ marilyn.morgan@ombudsman.wales

By email only
Nicola.Prygodzicz@wales.nhs.uk

Dear Nicola

Report "Groundhog Day 2'

I have today published a report "Groundhog Day 2: An opportunity for cultural change in complaint handling?" which highlights themes and learning points arising from our casework.

In accordance with the PSOW Act 2019, the report includes a number of general recommendations to all Health Boards in Wales which, I trust, will be helpful as your organisation implements its Duty of Candour. Please share the report with your Quality & Patient Safety Committee and draw its attention to the recommendations which are outlined at page 22 of the Report.

If you or members of the Committee would like to discuss the report or recommendations please get in touch. My office will be following up on the recommendations in our Annual Letter to the Health Board and as part of our ongoing engagement with your nominated liaison officer.

Yours sincerely

MM. Morris.

Michelle Morris
Public Services Ombudsman

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We are happy to accept and respond
to correspondence in Welsh.

Page **1** of 1

**Ombwdsmon
Ombudsman**

Cymru · Wales

Groundhog Day 2: An opportunity for cultural change in complaint handling?

June 2023

We can provide a summary of this document in accessible formats, including Braille, large print and Easy Read.
To request, please contact us:

Public Services Ombudsman for Wales
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Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

This document is also available in Welsh.

Groundhog Day 2: An opportunity for cultural change in complaint handling?

The Ombudsman is publishing this report as an extraordinary report
in accordance with paragraph 15 of Schedule 1
of the Public Services Ombudsman (Wales) Act 2019.

Foreword

This is the first Thematic Report I have issued since being appointed as the Public Services Ombudsman for Wales in April 2022.

During my first year as Ombudsman, I have been struck by the similar pattern of complaint handling failings which my office has identified in cases involving Health Boards across Wales.

In March 2017, my predecessor issued a Thematic Report 'Ending Groundhog Day: Lessons from Poor Complaint Handling.'

The lessons highlighted in that report remain relevant today. All too often, public bodies respond to complaints defensively rather than seeing them as an opportunity for learning and improving the services they deliver. This report focusses on cases involving Health Boards in Wales, which represent a significant proportion of the complaints made to my office.

The new 'Duty of Candour' on health organisations in Wales, which was introduced on 1 April 2023, requires them to be open and transparent with service users when they experience harm whilst receiving health care. This duty provides a fresh opportunity for cultural change - to promote candour and openness with service users and ensure there is systemic learning when things have gone wrong.

Although most health care across Wales is delivered in an excellent and professional manner, inevitably, sometimes organisations make mistakes. When mistakes happen, we expect health bodies to respond openly and honestly to patients and their families.

This ethos underpins our work as Complaints Standards Authority for Wales. Our statutory Guidance to public bodies in Wales: 'Principles of Good Administration' outlines that "putting things right" is a key principle of good administration, which includes investigating complaints thoroughly and acknowledging when things go wrong.

Our complaints standards training to Health Boards and the requirements of the Duty of Candour provide a fresh opportunity for changes to the ways in which health bodies engage with their patients and respond to complaints.

I hope that the guidance and lessons highlighted in this Report will be helpful and will remind Health Boards why honesty and openness is so important when responding to complaints.

Michelle Morris
Public Services
Ombudsman for Wales

15 June 2023

Contents

Our role

As the Public Services Ombudsman for Wales, we have legal powers to look at complaints about public services.

We can look at complaints about all health care providers and independent care providers in Wales, including Health Boards, Trusts, GPs and dentists.

We have a team of people who consider and investigate complaints.

We are independent of all government bodies and our service is impartial and free of charge.

Background

Introduction

When we issued the first 'Groundhog Day' report, our aim was to highlight to public bodies in Wales that the complaints they receive provide an opportunity for learning and improvement. We also wanted to show that, all too often, we have seen that public bodies have been overly defensive and not objective enough when responding to complaints.

We also highlighted that, in too many cases, when organisations made mistakes, they made the situation worse by not looking into complaints correctly. We urged public bodies to embrace the cultural change which was needed to ensure that they learned from complaints and improved services. Although we see many examples of good practice in complaint handling, evidence from our casework suggests that more needs to be done. This is especially true in relation to health complaints which are handled by Health Boards.

The 'Duty of Candour' was introduced in addition to the 'Duty of Quality', which requires NHS organisations (and Welsh Ministers) to take new steps to improve the quality of health services.[1] The overarching aim of the Duty of Candour is to ensure that a person receiving care from the NHS (or from a regulated provider of health care services) can have confidence that they will be dealt with in an open, transparent and honest way. If something goes wrong, they should be told about it, receive an apology, offered support and be assured that their issue will be investigated properly, under the Putting Things Right scheme.[2]

Under the Duties of Quality and Candour, Health Boards must report every year on how they comply with these duties. Quality and Patient Safety Committees within Health Boards also have a role in ensuring that the Health Boards discharge these duties, learn lessons and escalate concerns to the Board, if appropriate.

The learning from our cases should also inform NHS bodies' assessments of how effectively they are complying with the Duty of Candour. If, for example, we find that an NHS body has not complied with the Duty of Candour in relation to any individual complaint, this should form part of the Board's monitoring and assurance processes.

This is what we would like to see when we consider how public bodies have handled complaints.

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1 Appendix 2 – explanation of Duties of Candour and Quality

2 Appendix 2 – explanation of the NHS Complaints Process: the Putting Things Right scheme

People who contact us want organisations to put things right for them; however, sometimes, even more importantly, they also want to make sure that the same issue will not affect someone else in the future.

When public bodies respond to complaints poorly and defensively, sometimes after a lengthy complaints process, they compound the feeling of injustice that prompted people to complain in the first place. It is also exhausting for complainants to have to escalate their concerns to us. The way in which organisations deal with complaints is very important and can make a huge difference to people's experiences and to their ongoing relationship with, and trust in, their care provider and public services.

Our work as Complaints Standard Authority

Since our original 'Groundhog Day' report, we have used our proactive powers under the Public Services Ombudsman (Wales) Act 2019, to publish our Statement of Principles for complaints handling by public bodies. These include our expectation that effective complaints handling processes should be fair and objective, accountable and committed to continuous improvement.

We have also supported Health Boards by providing extensive training in complaint handling for their staff and begun capturing data from organisations about the complaints they deal with under the NHS complaints procedure: the 'Putting Things Right scheme' ('PTR'). By publishing this data, we have introduced more transparency and accountability for Health Boards handling complaints.

Since February 2021, we have provided over 120 training sessions for Health Boards on Complaint Handling, Investigation Skills and Communications Skills. We now expect health bodies to reflect upon and implement this good practice.

When we uphold complaints, we may make recommendations to the relevant organisation to put things right for the person who has suffered injustice - and to ensure that the body learns from what went wrong. The case examples included in this report demonstrate how things can go wrong and why a cultural change in approach to complaint handling is needed.

Capturing data from organisations about the complaints they deal with.

Over 120 training sessions provided on Complaint Handling, Investigation Skills and Communication Skills.

Complaints about Health Boards

Complaints about health services continue to represent a large part of our work. During 2022/23, 37% of all complaints about public bodies made to us were health cases, of which 75% were about Health Boards. They accounted for 81% of the cases we investigated. This is because we often need to obtain clinical records and independent clinical advice to inform our decisions on these cases. Even on health cases that we do not fully investigate, we often agree to resolve things early.

We continue to see increases in complaints about poor complaint handling by Health Boards. For example, when complaints responses are delayed or inadequate, we can recommend that a full and reasoned response is provided to the complainant. Overall, our intervention rate[3] on complaints about Health Boards we receive ranges from between 22% and 41%, depending on the Health Board area.[4]
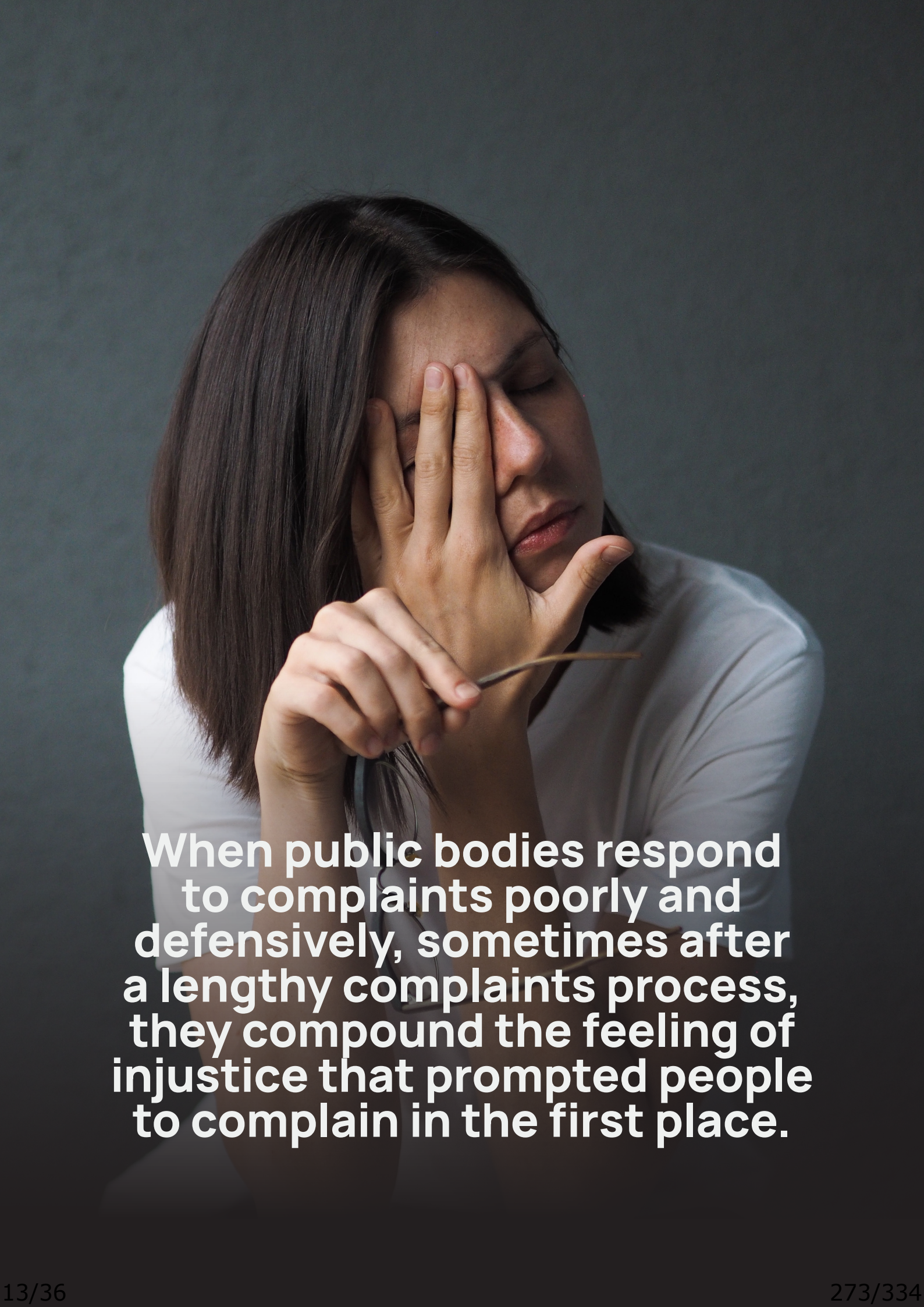
We uphold complaints when we decide the organisation made mistakes which had a negative impact on the person who received care. We apply our Clinical Standard and consider whether the care and treatment were appropriate. We also consider the facts of the case, relevant clinical guidance or other codes of practice or policies in place at the time, as well as explanations provided by the clinician or organisation delivering the care.

The case examples (set out in full in Appendix 1) included in this report are recent cases we have determined over the last 12 months. This is a small, but representative, sample of cases which highlight the apparent lack of rigour and openness in complaints investigations. It reflects the pattern of failings we see in local investigations which are undertaken in Health Boards under the PTR scheme.

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3   Our 'intervention' rate reflects an outcome in complaints in public services when we decide that something has gone wrong, and things must be put right. This could be by making recommendations or agreeing early resolution or settlement of a complaint.

4   Data on our intervention rates, early resolutions and upheld complaints per health board is in our Annual Report 2022/23.

When public bodies respond to complaints poorly and defensively, sometimes after a lengthy complaints process, they compound the feeling of injustice that prompted people to complain in the first place.

Themes & learning points

A lack of openness and candour - clear evidence of maladministration or service failure not identified during local investigations

Even when, following investigation, the facts of a case clearly show that the Health Board made a mistake, we see that organisations do not acknowledge this in their complaint responses. This should be an obvious step. That it often does not happen suggests that there is a need for cultural change for staff investigating complaints, so that they feel they can respond to and uphold complaints when the evidence supports this, in an honest and open way.

Mrs A's complaint concerned this kind of failing (**case example 2**). Even when the Betsi Cadwaladr University Health Board had acknowledged that it had not offered Mrs A's relative the bowel care she needed and had discharged her too soon, its initial response supported the discharge decision. Even when it issued a second response to the complaint, the Health Board did not acknowledge the failings fully. We considered that the initial review of the patient's care was not detailed, rigorous, open and transparent enough. This contributed to a lack of candour on the part of the Health Board.

In Mr D's complaint (**case example 3**), the Swansea Bay University Health Board acknowledged in its complaints response that there was no record of Mr D being given an appropriate discharge letter. Still, even after agreeing to our proposal for settlement, it took detailed discussions with the Health Board and its legal department for it to finally accept the modest settlement we proposed in recognition of this failure.

In Mr J's case (**case example 4**), we found that the Aneurin Bevan University Health Board had mishandled arrangements for the surgery Mr J needed. This resulted in an avoidable 5 week delay until the surgery took place (which breached the National Pathway guidelines for colorectal cancer). This had a very negative impact on Mr J. Rather than accept that it had made this mistake, the Health Board's complaint response lacked candour and openness. It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. The Health Board should have been open with Mr J about this from the start, when it responded to his complaint.

A lack of objective review of clinical care and treatment

When we consider health complaints, we rely on advice from our clinical advisers, apply our Clinical Standard and decide whether the care and treatment provided to any individual was appropriate.

We often find that, when Health Boards respond to complaints, they have not objectively assessed the care and treatment provided. Sometimes, the individual clinicians who have delivered the care are involved in complaints responses. However, even when there has been a review of the care and treatment by other clinicians within the body, failings which are immediately apparent to our own clinical advisers were not identified during the local peer review.

When we share the clinical advice we have received with Health Boards, we find that, in most cases, our recommendations are accepted. Although we welcome this, we are concerned that this pattern suggests that the care and treatment is not reviewed openly and objectively during local investigations.

For example, despite us finding that the Cwm Taf University Health Board made serious mistakes in the case of Mrs V's relative (**case example 5**), its own investigation of Ms V's complaint did not find any failings. This was despite the case being discussed "at length" at a Surgical Clinical Governance meeting. The view at the meeting was that the patient had received "...the standard treatment, as the other surgeons would have provided...".

We found that the Health Board missed opportunities during the complaint response process to identify failings at an earlier stage and avoid the need for the patient's family to escalate their complaint to us. However, when we shared our draft report and clinical advice with the Health Board, it accepted our recommendations.

Likewise, in **case example 6,** the Cardiff and Vale University Health Board's response to Miss X's original complaint only acknowledged that the Health Board did not communicate with Miss X's family as it should have. However, its own investigation did not identify that it missed several opportunities to treat Miss X's father and that his care was not good enough – all identified by our clinical adviser. This meant that the family had to

pursue their complaint through our office, causing them additional time and distress.

It is worth pointing out that we very rarely, if ever, see evidence of Health Boards considering if the person investigating the matter on their behalf requires independent medical advice to assist them during their investigation. This option is available to NHS bodies as specified in the PTR Scheme.

Sometimes, the individual clinicians who have delivered the care are involved in complaints responses.

We are concerned that the care and treatment is not always reviewed openly and objectively during local investigations.

Importance of timeliness and good communications

Good communication is key to ensuring that complainants do not lose trust and confidence in the complaints process. Complainants should be kept well informed throughout the complaints process and Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales for responding to complaints – staff within their complaints teams need to be well informed by their colleagues, have the support of the Health Board as a whole and have the capacity and resources to respond in a timely way.

In Mr T's case (**case example 1**), it took our intervention and over 16 months for the Hywel Dda University Health Board to respond to Mr T's complaint about the care his late mother received. This delay was well beyond the 30 day time limit, or 6-month time scale (for complex cases), set out in the PTR Scheme. This was wholly unacceptable and distressing for Mr T at a time when he was also grieving for the loss of his mother. Mr T explained to us how the ongoing delay had affected him personally and his family.

Such delays are especially concerning when complaints raise concerns about the care provided to a family member before they died. Families are entitled to receive answers to their concerns and sufficient resource should be dedicated to complaint handling within Health Boards.

In Mr T's case, and in many others we see, even after we have intervened in cases, Health Boards do not respond to complaints in line with the timescales agreed with us and complainants are not kept well informed about the reasons for this.

Complainants should be kept well informed throughout the complaints process.

Health Boards should ensure that staff throughout the organisation understand the importance of meeting the PTR or agreed timescales.

Acting fairly and proportionately – the need for robust investigations

Health Boards should give complainants a reasoned explanation, so that it is clear why they made a decision and on what facts they drew their conclusions. All of the case examples included in this report provide examples of Health Boards failing to ensure that they robustly investigated complaints and delivered fair outcomes for complainants, in line with the PTR scheme.

Health Boards should always carefully establish the facts of any case. Before coming to a decision, they should consider the evidence from the complainant and the accounts of staff members who delivered the care. This is especially important in cases when there has been a loss of life. Otherwise, complainants may completely lose trust in the investigation process and the outcome of their complaint.

Future considerations

As Health Boards across Wales embrace and implement their organisational Duty of Candour, we trust that the themes outlined in this report will provide a timely reminder of lessons which they should learn from our recent complaints.

The organisational Duty of Candour on Health Boards should also bring a cultural change to the way in which Health Boards respond to complaints and concerns. If we see that a Health Board made an error that had a negative impact on the complainant, we can recommend that it reviews how it has handled the complaint, in line with the Duty.

Also, when Health Boards' Quality and Patient Safety Committees review how effectively they have complied with the Duty, we expect them to consider details of any cases we have settled or upheld when we consider the Duty of Candour should have been engaged. Learning from our cases should also be included in Health Boards' annual reports on how effectively they have complied with the Duty of Candour and form part of Health Boards' wider monitoring and assurance processes.

Consideration of the Duty of Candour may be appropriate at all stages of our process:

- **at assessment stage**, when we are agreeing an early resolution of a complaint

- **when we have started an investigation** and we are agreeing a voluntary settlement with the body and discontinuing our investigation

- **when we have fully investigated a complaint** and we are issuing a public interest or non-public interest report.

We recommend that this report is shared with Quality & Patient Safety Committees in Health Boards and that they:

- review the resources available to complaints teams in their Health Board

- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis

- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling

- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

We trust that the Duty of Candour will have a positive and transformational impact on the way in which complaints are handled within Health Boards.

Appendix 1

Case example 1

Mr T's complaint (202206990 & 20230420)

Hywel Dda University Health Board

In December 2021, Mr T complained to the Hywel Dda University Health Board about the treatment his late mother received when in hospital. In his complaint to us, Mr T explained how the loss of his mother had affected him and that it was unacceptable that the Health Board had not responded to his complaint. He had been waiting for a response for 13 months before he first contacted us in February 2023.

Because of that significant delay, we agreed an early settlement of the complaint with the Health Board. The Health Board agreed to pay Mr T £250 in recognition of the delay and to respond to his complaint within four weeks (by 20 March).

The Health Board then contacted us requesting more time because a senior member of staff had identified an issue which needed to be resolved before the Health Board could respond. We agreed that the Health Board could have 3 more weeks (by 7 April), if it apologised again to Mr T and explained the reason for the further delay.

On 5 April, the Health Board contacted us again to say that it still could not issue its complaint response to Mr T.

The Health Board agreed to make a further payment of £100 to Mr T in recognition of the ongoing unacceptable delay and to issue its complaint response to Mr T by 28 April, which it then complied with.

Case example 2

Mrs A's complaint (202101000)

Betsi Cadwalladr University Health Board

Mrs A complained about the care her late sister, Ms B, received at Ysbyty Glan Clwyd ("the Hospital", within Betsi Cadwaladr University Health Board) between May 2019 and May 2020.

Mrs A was concerned that her sister did not receive appropriate bowel care when she was in the Hospital in April and May 2020. Ms B needed a specific type of bowel care but did not receive it, as no skilled staff were available to provide it. Nurses did not update doctors that it had not been done.

Ms B then developed some new symptoms. These new symptoms may have meant that Ms B had a bowel blockage, but this was not considered. She was discharged from the Hospital on 5 May without being seen by a doctor and sadly died.

We could not be sure that the inadequate bowel care, or poor communication about this, contributed to Ms B's death, as she was very unwell with other problems. However, these failings meant that

there was a loss of dignity for Ms B. We also identified that the Health Board should have considered Ms B and Mrs A's rights under the Human Rights Act – Article 8, the right to respect for private and family life. In our investigation, we also saw that record keeping fell short of the requirements expected for both doctors and nurses.

Concerningly, we saw similar failings in basic nursing care, in record keeping and in communication in previous cases we have investigated about this Hospital.

We acknowledged that Ms B was in hospital during the early days of the COVID-19 pandemic. Still, Ms B's care should have been better.

We were concerned that the Health Board did not respond to Mrs A's complaint well and robustly enough. Its first response did not identify everything that the Health Board did wrong. Its second response also did not fully acknowledge all the failings. Overall, we decided

that the Health Board did not review Ms B's care in a detailed, rigorous, open and transparent way. The way it handled the complaint put Mrs A to unnecessary additional time and trouble in pursuing her concerns, at a time of bereavement. This contributed to a lack of candour on the part of the Health Board.

To remedy the injustice to Mrs A, and ensure that lessons were learned, we recommended that the Health Board reviewed its complaint handling and responses, in light of the Duty of Candour.

Case example 3

Mr D's complaint (202205762)

Swansea Bay University Health Board

Mr D complained that he was not informed of his positive COVID-19 test when he was a patient at X Hospital. He also said that he was not given the right discharge advice about self-isolation.

Shortly after Mr D was discharged, his wife, Mrs A, caught COVID-19 and sadly died. We could not be sure how Mrs A caught COVID-19; we focussed only on whether the ward procedures which were in place at the time of Mr A's discharge were followed.

The Health Board acknowledged in its complaints response that there was no record of Mr D being given information in an appropriate discharge letter.

We were concerned that Swansea Bay University Health Board could not provide us with evidence to show that it told Mr D about the positive COVID-19 test or gave him information and advice about the self-isolation period, as it should have done, according to its ward policy at the time.

We recommended that the Health Board should apologise to Mr D and pay him £750 in recognition of these failings. The Health Board agreed to this as an alternative to our investigation.

However, although the Health Board accepted that it's records were incomplete and agreed to our recommendations, it took further detailed discussions (also with its legal department) before the full settlement, including the modest financial payment, was finally accepted.

Case example 4

Mrs H's complaint (202203723)

Aneurin Bevan University Health Board

We investigated Mrs H's complaint, on behalf of her brother (Mr J), that the Health Board had unreasonably delayed Mr J's treatment for colorectal cancer.

We found that, although the Health Board had informed Mr J on 1 February 2022 that he would have surgery on 21 March, it did not schedule the surgery, as it had indicated. Mr J only found this out when he contacted the ward the day before he was due to be admitted to hospital. The Health Board then took no action to resolve the matter until it was prompted to reschedule the surgery, after telephone calls and a complaint from Mr J's family.

This resulted in an avoidable 5-week delay until the surgery took place. The overall time between suspected cancer referral to the start of the treatment was outside the National Pathway guidelines for colorectal cancer. This caused injustice to Mr J. For him to find out the day before that the surgery he was expecting to take place, and for which he had prepared, was not in fact going ahead, must have been devastating, particularly as it turned out that this was due to an error by the Health Board in not booking the surgery in the first place.

Although the records clearly indicated that the Health Board made a mistake, its complaint response to Mr J was not candid and was contrary to the Putting

Things Right (PTR) scheme, which places a "duty to be open" on the Health Board.

It was only in response to our investigation that the Health Board acknowledged that the surgery had not been booked. It should have been open with Mr J abut this from the start, when it responded to his complaint.

The Health Board agreed to our recommendation that it should apologise for the failings and complete an audit of its colorectal scheduling processes and controls.

Case example 5

Mrs V's complaint (202006310)

Cwm Taf University Health Board

Mrs V complained to us about the care and treatment provided to her cousin, Ms F, by Cwm Taf Morgannwg University Health Board.

We found that the Health Board missed opportunities to identify and treat the appendicitis that caused Ms F's ruptured appendix. When Ms F attended the Ambulatory Emergency Surgical Unit at Princess of Wales Hospital on 17 July, appendicitis was not suspected, despite symptoms including severe abdominal pain, unusually low blood pressure and blood test results which indicated the presence of a significant infection. Instead of being admitted to hospital, Ms F was sent home without being prescribed antibiotics and without the

Health Board arranging appropriate and timely investigations, including scans.

When Ms F returned for a review and further investigations on 20 July, the scan ruled out gallstones as the cause of her symptoms, but again she was not admitted to hospital, and told to return 2 days later.

Sadly, Ms F did not return for further review, and she died at home on 1 August 2020.

We found that, on the balance of probabilities, if the Health Board had provided appropriate care on 17 or 20 July, Ms F's appendicitis would have been identified and treated and her

death would have been avoided.

Although we found serious failings in this case, we were concerned that the Health Board's own investigation into Ms V's complaint did not find that it had done anything wrong, despite the case being discussed "at length" at a Surgical Clinical Governance meeting. On the contrary, the view at the meeting was that Ms F had received," ...the standard treatment, as the other surgeons would have provided...". In our view, the Health Board missed clear opportunities during the complaints response

process to identify failings at an earlier stage and avoid the need for Ms F's family to escalate their complaint to us. However, when we shared the draft version of our report and our clinical advice with the Health Board, it accepted our recommendations.

We recommended that the Health Board should apologise and provide legal support to secure appropriate financial redress for Ms F's family. We also recommended that our findings should be reviewed by the Surgical Clinical Governance Team. The Health Board agreed to comply with our recommendations.

Case example 6

Miss X's complaint (202102028)

Cardiff & Vale University Health Board

Miss X complained about the care and treatment her late father, Mr Y, received at Cardiff and Vale University Hospital of Wales ("the Hospital") in March 2020.

He went to the Emergency Department ("the ED") but was sent home. Two days later, he was admitted to the Hospital but sadly died a few days later, after emergency surgery.

We found that Mr Y should not have been discharged from the ED as he was, because his clinical history had not been assessed. Also, the Health Board did not take enough information about Mr Y's bladder symptoms, constipation and new large groin lump. These symptoms pointed to an obstructed hernia which needed treatment, but Mr Y was discharged without adequate assessment. If the

Health Board assessed and admitted him at the time, the outcome for him might have been different.

Mr Y was admitted to the Hospital 2 days later. We found that his symptoms were again not promptly examined and recognised. This led to a delay before Mr Y underwent surgery, which meant that his condition worsened. When a delayed scan led to the diagnosis of a strangulated hernia, Mr Y needed emergency surgery.

Mr Y was very ill following surgery, but we found that he was not moved to the Intensive Care Unit ("ICU"), as it was determined that he would not benefit from this. We found that this decision reduced his chances of survival. Had the clinical failings not occurred, and had Mr Y received ICU care following surgery, his deterioration and death might have been prevented.

We acknowledged that the COVID-19 pandemic was beginning at the time Mr Y was admitted. This was creating extreme pressure for the Hospital staff. Even so, Mr Y was an emergency case and he did not receive the appropriate standard of care.

We made several recommendations, which the Health Board accepted, including an apology and carrying out a case review to discuss assessment and diagnosis of strangulated hernias.

The Health Board's response to the original complaint accepted that communication with Mr Y's family was poor. However, we were concerned that its investigation did not identify that there were several missed opportunities to treat Mr Y and that there were therefore failings in the care provided to him.

The Health Board could have identified actions to remedy these failings sooner. Instead, the family had to pursue their complaint through our office, costing them additional time and causing more distress. Overall, we questioned the robustness of the Health Board's investigation.

Appendix 2

Duty of Candour and Quality

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 includes the Duties of Candour and Quality, provisions in the Act aim to:

- strengthen the existing Duty of Quality on NHS bodies and extend this to the Welsh Ministers in relation to their health service functions.

- establish an organisational Duty of Candour on providers of NHS services, requiring them to be open and honest with patients and service users when things go wrong.

The Act:

- places an overarching Duty of Quality on the Welsh Ministers; and

- reframes and broadens the existing Duty on NHS bodies.

The Duty seeks to strengthen governance arrangements by requiring the Welsh Ministers and NHS bodies to report annually on the steps they have taken to comply with the Duty and assess the extent of any improvement in outcomes.

The Act also places a Duty of Candour on providers of NHS services (NHS bodies and primary care) - supporting existing professional duties.

The Duty requires NHS providers to follow a process –set out in Regulations – when a service user suffers an adverse outcome which has or could result in unexpected or unintended harm that is more than minimal and the provision of health care was or may have been a factor. There is no element of fault, enabling a focus on learning and improvement, not blame.

Welsh Ministers have issued statutory guidance in relation to the Duty of Candour.

The Duty seeks to promote a culture of openness and improves the quality of care within the health service by encouraging organisational learning, avoiding future incidents.

The Act requires NHS providers to report annually about when the Duty has come into effect - how often the Duty has been triggered, a description of the circumstances leading to the event and the steps taken by the provider with view to preventing any further occurrence.

NHS Complaints Process

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 came into force in April 2011. They prescribe arrangements for complaint handling in all NHS bodies in Wales and were supplemented by guidance entitled "Putting Things Right". Complaints must be investigated properly and appropriately and details of complaints should be shared with the staff member involved "where appropriate". A complainant should generally receive a response within 30 working days; if this is not possible, the response should be sent within six months and the complainant kept informed of the delay and the reason for it. Lessons should be learned from complaints and complainants informed of action which has been taken as a result of the complaint.

An NHS body must investigate matters raised in a concern in the manner which appears to the body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to the matters listed in Regulation 23 of the Regulations, including whether the person investigating the matters raised required independent medical or other advice.

The Regulations contain provision for the payment of redress in certain circumstances if the investigation concludes that harm may have been caused to the complainant through the fault of the organisation. Further investigation may be necessary if the initial investigation concludes that this may be the case and extended timescales apply to the consideration of redress.

Public Services Ombudsman for Wales

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	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN **ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 July 2023
CYFARFOD O: **MEETING OF:**	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Public Service Ombudsman for Wales Report Groundhog Day 2: An opportunity for cultural change in complaint handling?
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade – Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tracey Partridge-Wilson – Assistant Director of Nursing

Pwrpas yr Adroddiad **Purpose of the Report**
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA **SBAR REPORT**

Sefyllfa / Situation

Following the publication of the Public Service Ombudsman for Wales' Thematic Report 'Groundhog Day 2: An opportunity for cultural change in complaint handling?', the Health Board need to consider the recommendations set out within said report.

Cefndir / Background

In March 2017, the Public Service Ombudsman for Wales issued a Thematic Report 'Ending Groundhog Day: Lessons from Poor Complaint Handling', with the aim of highlighting to public bodies in Wales that the complaints they receive provide an opportunity for learning and improvement. It reported the PSOW had noted public bodies had been overly defensive and not objective enough when responding to complaints.

Groundhog Day 2: An opportunity for cultural change in complaint handling? is the first Thematic Report issued by the Public Services Ombudsman for Wales, who was appointed in April 2022.

Asesiad / Assessment

With the introduction of Duty of Candour and Quality, the Patient Safety and Quality Outcomes Committee has a role in ensuring the Health Board discharges these duties, learn lessons and escalate concerns to the Board, if appropriate.

The main themes and learning identified within the report are:

- A lack of openness and candour – clear evidence of maladministration or service failure not identified during local investigations.
- A lack of objective review of clinical care and treatment
- Importance of timeliness and good communications
- Acting fairly and proportionately – the need for robust investigations

Argymhelliad / Recommendation

1. **Review the resources available to complaints teams in their Health Board:** *this will be addressed through implementation of the review of the QPS Resources.*

2. **Consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case-by-case basis:** *review of PTR Policies and Procedures.*

3. **Reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling:** *this will be addressed through the QS Implementation.*

4. **Ensure that lessons learned from the Public Service Ombudsman for Wales' findings and recommendations are included in the Health Board's annual report on the Duty of Candour and Quality:** *noted and will be included.*

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.5 Record Keeping 3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety

Amcanion cydraddoldeb strategol Strategic Equality Objectives [Strategic Equality Objectives 2020-24](#)	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Public Service Ombudsman for Wales Report Groundhog Day 2: An opportunity for cultural change in complaint handling?
Rhestr Termau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

	CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 July 2023
CYFARFOD O: MEETING OF:	Patient Quality, Safety and Outcomes Committee
TEITL YR ADRODDIAD: TITLE OF REPORT:	Health Board Response to a Benchmarking Exercise – Time Critical Medicines in Parkinson's Disease
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Jennifer Winslade - Executive Director of Nursing
SWYDDOG ADRODD: REPORTING OFFICER:	Hayley Saunders – Senior Nurse for Professional Practice Leeanne Lewis – Assistant Director for Quality and Patient Safety

Pwrpas yr Adroddiad Purpose of the Report
Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board has submitted a response to the NHS Executive in relation to the benchmarking exercise, 'Time Critical Medicines in Parkinson's Disease'.

Cefndir / Background

Delayed, or missed doses of Parkinson's medication can have serious effects on patients' health, affecting their ability to walk, talk, move or swallow. The timing of their medication regimes varies from person to person and often does not correspond with the traditional ward medication round timings. Parkinson's UK launched the 'Get it On Time' campaign in 2006 and called on all UK hospitals to ensure that all patients with Parkinson's disease receives their medication on time, every time.

As part of the second phase of the campaign, and to coincide with World Parkinson's Day on 11th April 2023, the NHS Executive endorsed the request from the

Parkinson's Excellence Network that all NHS Wales Health Boards and Trusts participate in a benchmarking exercise against the ten patient safety recommendations.

On 13th April, email correspondence was received into the Health Board from the Chief Nursing Officer and the Deputy Director of Quality and Safety Assurance, requesting the Health Board's input with this key quality, safety and patient experience initiative. The responses received from across Wales will be analysed to assist the NHS Executive in their ongoing work identifying any further quality improvement actions that are required.

Members of both the corporate nursing team and the quality and patient safety team were asked to lead on collating the Health Board's response. This was undertaken with a multi-disciplinary approach, involving nursing, pharmacy, and neurology representatives.

Asesiad / Assessment

A multidisciplinary group was formed to undertake the benchmarking exercise, with input from nursing, pharmacy, neurology and quality and patient safety representatives. See Appendices for compliance with the ten patient safety recommendations suggested by the Parkinson's Excellence Network and an action plan to improve the Health Board's compliance.

Aneurin Bevan University Health Board acknowledge that there are internal policy updates and All-Wales service development initiatives ongoing at the time of writing this response, which will significantly improve the Health Boards ability to comply with the recommendations. This includes the updating of the Health Board 'Self-Administration of Medicines Policy' and the ongoing work to develop and implement the All-Wales Digital Medicines Transformation Portfolio.

There has been a numerous quality improvement initiatives carried out throughout the Health Board in relation to time-critical medicines and care for patients with Parkinson's Disease. The Health Board began using the Parkinson's UK time-critical medicines resources in 2019, through clinical pilot sites identified in Ysbyty Ystrad Fawr and the Royal Gwent Hospital. Unfortunately, with the challenges experienced during the Covid-19 pandemic and the Clinical Futures redesign of the Health Board at this time, the impact of these resources has not been assessed.

In addition, due to the recent withdrawal of the pharmacy led 'All-Wales Medicines Thermometer Audit', the Health Board now has no ongoing data collection relating to compliance with the administration of time-critical medicines in the secondary care settings. Work is ongoing to examine the use of the AMaT (Audit, Management and Tracking Tool) platform to audit ABUHB performance in this area and target quality improvement work.

This action plan has been presented at the Health Board's Medicines Safety Group, with a plan to update the group on the status of the recommendations in 6 months' time. The corporate medication safety lead has also escalated this exercise to the All-Wales Medicines Safety Network (AWMSN), to ensure that areas of good practice

are shared at a national level. The AWMSN are collaborating on developing various bilingual, service-user resources to support patient education and empowerment in relation to their medicines.

The NHS Executive plan to analyse the responses from across Wales to identify any further quality improvement actions that are required. Health Boards will be kept up to date with these actions as they are developed. The corporate medication safety lead will continue to work collaboratively with pharmacy, nursing, medical and patient experience colleagues to implement the action plan developed as part of this work, strengthening the Health Boards compliance with each of the safety recommendations. This work will be presented via the Medicines Safety Group to ensure oversight of the progress. The Health Board will await any additional service improvement requirements from the NHS Executive as a result of the benchmarking exercise.

Argymhelliad / Recommendation

This report is for information for the committee.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback 2.6 Medicines Management
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	

Ar sail tystiolaeth: Evidence Base:	Time Critical Meds response.docx [Reducing Harm from Omitted and Delayed Medicines in Hospital - Critical Medicines List](#)
Rhestr Termau: Glossary of Terms:	Not applicable
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Medicines Safety Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper?
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

Appendix 1 <u>Aneurin Bevan University Health Board Response to the Benchmarking exercise - Time Critical Medication in Parkinson's Disease</u>

For anyone with Parkinson's Disease, the impact of not receiving their medication on time when in hospital, can be severe. The consequences can be debilitating, causing stress, anxiety, immobility and severe tremors. In the worst cases, a delay, or omission of their time-critical medicines can be fatal. A group of NHS professional who live with Parkinson's Disease, in collaboration with the Parkinson's Excellence Network, have developed a set of 10 recommendations for all Health Boards, to enable NHS staff to support the timely, safe and appropriate management of medicines for people with Parkinson's.

To coincide with World Parkinson's Day on 11th April 2023 and the second year of the 'Time Critical Medication' campaign, the NHS Wales Executive and the Chief Nursing Officer for Wales, have requested that all NHS Wales Health Boards and Trusts participate in a benchmarking exercise against the ten patient safety recommendations.

This document provides the benchmarking responses for Aneurin Bevan University Health Board and sets out an action plan to support the Health Board in the full implementation of the recommendations.

Time critical medication, on time, every time. Ten recommendations for your hospital

1) Parkinson's medication is time critical medication. Time critical medications must be given within 30 minutes of when they are due, highlighted as a risk to patient safety and added to every hospital risk register. Compliance is audited and any dose over 30 minutes should be reported as an adverse event.
2019 Get It On Time report
NICE quality statement

Time-critical medicines are not currently recorded as a patient safety risk on the corporate, or Divisional risk registers, at this time. Current ABUHB Parkinson's Disease (PD) documentation emphasises the need to report omitted time-critical medicines as an adverse event after a second missed dose. The Parkinson's Disease Lead Consultant has been contacted to discuss changing the Health Board intranet guidance to support reporting after a single delayed or omitted dose.

Compliance with adherence to time critical medicines administration has historically been audited monthly by pharmacy, through the snapshot, All-Wales 'Medicines Thermometer' audit. Results have then been presented via the Medicines Safety Group and action plans developed if required. However, completion of the Medicines Thermometer audit has now been paused whilst the data metrics and how these feed in to work at an All-Wales level are investigated.

As a result, the Health Board is exploring the creation of a standardised audit proforma that would allow regular audits of all time critical medicines, as part of local audit plans.

All medication related patient safety incidents reported through the DATIX reporting system are collated by the Medicines Safety Officer and reviewed by the multi-professional Medicines Safety Group on a quarterly basis. Divisional medicines incidents and themes are also presented to the group by the Quality and Patient Safety Leads. These themes are available to Ward Managers, Senior Nurses, and Division heads, through the Healthcare Monitoring System and presented to the individual Divisions monthly, through the Quality and Patient Safety Team.

2) All hospital staff are made aware of time critical medication. Make this 3 minute video Time Matters: It's Critical mandatory viewing for all staff.

All new nursing and midwifery employees of ABUHB are required to complete the All-Wales medicines management e-learning package and receive a medicines management training session, which includes information on the importance of the correct management of time-critical medicines.

All medics are provided with 5 training sessions from pharmacy, as part of their training programme. Two of these sessions are mandatory for new trainee medics and one of these sessions includes training on the prescribing of time-critical medications.

The 'Time Matters: It's Critical' video has been added to the nursing, midwifery and medical staff training and disseminated to all non-medical prescribers via the Health Board communication channels. In addition, the Health Board will liaise with the Communication and Engagement team to have it added to the intranet carousel to create a general awareness amongst staff.

3) Hospitals identify which staff are to undertake further Parkinson's medication training. Recommended online training courses are available via the Parkinson's Excellence Network's Learning Hub:
a) Parkinson's UK 15 minute Educational Video
b) Parkinson's UK Medication Educational Module produced by Lancashire
Teaching Hospitals
c) Parkinson's medication for staff who don't administer medications

Specific clinical areas which need targeted education are currently identified by the Parkinson's Disease Clinical Nurse Specialist team, when reviewing patients in the clinical areas. How training is delivered by the CNS team and how the team receive training requests is being examined currently.

The CNS team have been asked to consider delivering a staff training session as part of the Journey of Excellence (JoE) programme for all newly qualified nursing staff who enter the Health Board.

The Health Board is exploring opportunities to gather feedback from patients with Parkinson's Disease, in conjunction with the patient experience team, using the CIVICA system (a patient feedback platform), which may support the Health Board to target local education more effectively.

In addition, all ward managers in the Health Board will be asked to provide information on the current use of these resources in their clinical areas and the knowledge of their staff in relation to time-critical medicines.

4) Hospitals develop, maintain and update a self-administration policy for patients who can administer their own medication. The policy should be reviewed regularly.
See NHS Guidance and the Welsh Medicines Advice Service.

ABUHB self-administration policy was withdrawn recently, and all self-administration of medicines in the secondary care setting was stopped, whilst investigations into the safety and logistics of managing patient's own medication lockers were undertaken. Several security and logistical challenges to the safe implementation of the policy were identified.

A new version of the policy is currently being produced with multi-disciplinary input, which will include robust risk-assessments and requirements for review, to enable Aneurin Bevan University Health Board (ABUHB) to safely implement self-administration of time-critical medicines for suitable patients.

5) Hospitals identify all patients on Time Critical Medication when they arrive in the Emergency Department (ED) or through an elective or emergency admissions unit.

Currently, the yellow 'get it on time' stickers are attached to individual patients' drug charts by the emergency department pharmacist, ward pharmacy teams and the Parkinson's Clinical Nurse Specialists in the inpatient clinical areas.

As part of this benchmarking exercise, the feasibility of adding a 'time critical medication' banner to specific patients on the hospital patient system (WPAS) is being examined. This would make patients on these medications clearly identifiable to all involved in their care at the point of admission, encouraging Health Board staff to enquire about patients' medications early on in their care.

6) EDs and admissions units develop and update an agreed list of Time Critical Medication visible to patients when they arrive so they feel empowered to inform staff that they take Time Critical Medication. For elective admissions, people with

Parkinson's will have prepared themselves. Parkinson's UK Guidance.

ABUHB has an existing list of time critical medication within the Health Board policy.
ABUHB (2022) Reducing Harm from Omitted and Delayed Medicines in Hospital - Critical Medicines List

The emergency department pharmacist has undertaken a lot of work with the Welsh Ambulance Service and Health Board forums to increase the numbers of patients who attend the emergency department with their own medications. There is further work that can be done in this area and the team are looking to take this forward following the recent expansion of an emergency department pharmacy team.

There is currently no signage for patients or carers regarding time-critical medicines within the emergency department. As part of this exercise, Health Board representatives will take the development of a bilingual, service-user friendly poster to the All-Wales Medicines Safety Network to develop a resource that can be used throughout the country, and for all time-critical medicines.

7) Hospitals have a designated pharmacist who is responsible for ordering and stocking the Time Critical Medications in the ED and on appropriate admissions units and wards to ensure they are always available.

The emergency department have a dedicated pharmacist who is responsible for the department's medication. There has been recent investment into the expansion of an emergency department pharmacy team, who will provide pharmacy cover to the department 12 hours a day, 7 days a week.

The ordering, storage and dispensing of medication in the emergency department is electronically controlled through automated medication cupboards, call the Omnicell system. These automated cupboards monitor the stock inventory, ordering medications when required, preventing the ward area from depleting their medication stock.

There are 'How to Obtain a Supply of Medications' posters displayed in all medication storage areas, which signpost medical and nursing staff to the correct procedures to ensure there is always access to required medications. The poster specifically highlights time-critical medicines supply.

An emergency medication cupboard on the Grange University Hospital site contains additional stock if required during out of hours periods, to ensure 24-hour access to time-critical medicines. Additionally, there is an 'out-of-hours' on-call pharmacist available at all times, should ward staff need to discuss access to medication.

8) Where appropriate, the prescribing of a patient's Time Critical Medication should reflect their normal daily schedule

and should continue during the full admission period. Hospital systems, including electronic prescribing where available, should be maximised to support this.

The current 'All-Wales' inpatient medication charts allows for prescribers to state a time for medication administration.

As part of the National digital transformation strategy, ABUHB are currently completing preparatory work for the procurement process, prior to the implementation of an Electronic Prescribing Medicines Administration system (EPMA). The ability to continue normal daily schedules of time-critical medicines has been highlighted as an essential requirement in the tender process, for potential suppliers to demonstrate to us how this will be achieved. The introduction of a secondary care EPMA system will allow the Health Board to undertake real-time data collection and audit, allowing us to have greater oversight over the management of time-critical medicines and develop opportunities for learning from these results.

In addition, work has been commenced within the HB to develop an audit proforma to examine the management of time-critical medication whilst patients are in the secondary care setting.

9) Ensure that hospitals have a Standard Operating Procedure / guideline for all Time Critical Medication, including patients who are nil by mouth (NBM) or require a nasogastric (NG) tube. This should signpost to one of the NBM medication calculators.

The ABUHB intranet site provides access for all Health Board staff to detailed guidance, created using NICE guidance and Parkinson's UK resources, for the care of patients with Parkinson's Disease. These are accessible as individual documents on the HB intranet, but not specifically termed a 'Standard Operating Procedure'.

The documents cover:

-the management of Parkinson's Disease in A+E
-Parkinson's Disease management in acute admissions
-Symptomatic management of patients with Parkinson's Disease
-Medication management during the first 48 hours of admission
-Preparing Parkinson's medication for NGT/PEG tube use
-Managing Parkinson's medications in patients with swallowing difficulties
-Conversion tables if only on Levodopa preparations
-Patients on complex therapies
-Rotigotine patch placement charts
-Medications to be avoided in patients with Parkinson's Disease (including those on specific regimes)
-Management of worsening confusion / agitation / hallucinations / psychosis; and
-Palliative/end-of-life care in patients with Parkinson's Disease

The guidance refers staff to the Parkinson's UK website and the PD 'nil by mouth' calculator.

10) Ensure hospitals devise and implement a system so that staff can administer all Time Critical Medications outside of normal medication rounds if self-administration is not appropriate. See a successful example from Leeds Hospitals and resources available from Parkinson's UK.

Resources to ensure timely Parkinson's disease medication administration were implemented in ABUHB in 2019, including laminated wall clocks and yellow 'get it on time' medication stickers. Implementation of these resources have not been audited following complexities associated with the opening of the Grange University Hospital, in line with the Clinical Futures Plan and difficulties encountered during the Covid-19 pandemic.

Work is underway to create an audit proforma to undertake a targeted review of current hospital in-patients with Parkinson's Disease. This will examine how these resources are being utilised in practice and enable ABUHB to re-establish the 'Get it on Time' campaign and share evidence of good practice across the Health Board.

Appendix 2 -   Action Plan

The following table details the action plan that needs to be carried out by Divisions within Aneurin Bevan University Health Board.

Recommendation	Action Needed	Progress and Evidence	Monitoring Arrangements (State HB group where progress is reported)	Status	Deadline Date / Date of Completion
Safety Recommendation 1: Add time-critical medicines to Divisional risk registers to ensure they are highlighted as a risk to patient safety and that late (>30 minutes), or omitted doses are reported as an adverse event. Devise a robust method of auditing the Health Board's compliance with the administration of time-critical medicines. The previous audit method (the All-Wales Medicines Thermometer) is no longer in use. Edit current Health Board guidance to reflect the requirement for incident reporting via the DATIX system after a single late, or omitted dose.	Agree thought Medicines Safety with Divisional QPS leads how this will be recorded on risk registers. Create an audit proforma within the Audit and Management Tool (AMaT) system and results presented via the Medicines Safety Group.	The absence of time critical medicines on the hospital risk registers has been confirmed by the corporate and Divisional Quality and Patient Safety teams and Divisional general managers. Audit proforma is being created.	AB Medicines Safety Group		November 2023

Safety Recommendation 2: Incorporate the 'Time-Matters:It's Critical' video into current mandatory medicines management training.	Liaise with all staff group who deliver medicines management training in the Health Board and disseminate the video as required. Disseminate the video through established Health Board communication channels.	The video has been incorporated into nursing and midwifery staff medicines management training. The video has been disseminated to practice educators for inclusion in local medicines management training sessions within Divisions, as part of the Journey of Excellence programme for newly qualified nurses. The video has been incorporated into pharmacy training sessions for medics, delivered as part of	Medicines Safety Group		19/05/2023

| | | their training programme.

The video has been disseminated to all Health Board non-medical prescribers through their dedicated Teams communication channel. | | | |
|---|---|---|---|---|---|
| Safety Recommendation 3:

Investigate how the Health Board can better target educational resources at staff who require additional training in Parkinson's Disease medication. | Work with the patient experience team and the Parkinson's Disease Clinical Nurse Specialists to consider how the Health Board can utilise patient stories and feedback to better identify clinical areas that would benefit from additional Parkinson's Disease specific training. | Consider using the CIVICA system (a patient feedback platform), to ensure that the Health Board listens and learns from feedback. | Medicines Safety Group | | November 2023 |

Safety Recommendation 4: Complete and embed the medicines self-administration policy within the Health Board, to allow service-users to maintain autonomy with their time-critical medicines.	Complete and submit the Medicines Self-Administration Policy for ratification through the Clinical Policy and Standards Group. Engage Divisional nursing teams to identify and implement safe methods of managing 'patients own medicines' (POM) lockers in the clinical areas. Create a Standard Operating Procedure (SOP) to make clear the roles and responsibilities in relation to the safe management of POM lockers.	The Medicines Self-Administration Policy is currently being re-written by pharmacy leads. Patients own medicines (POM) locker management is being reviewed by Divisional nurses and the corporate nursing teams.	Medicines Safety Group Divisional Nursing Group Clinical Policy and Standards Group		November 2023

Safety Recommendation 5: Devise a robust method for Health Board staff to identify those patients who take time-critical medicines. This will allow prescribers to ensure timely prescribing of this medication. Empower all service-users to highlight their time-critical medicines to staff at the point of admission	Submit an application to the clinical applications team to create a 'time-critical' medicines alert to WPAS which will pull through to Clinical Work-Station and be immediately visible to staff. Explore the opinions of the multi-disciplinary teams in relation to a 'time-critical medicines' alert. Pursue an All-Wales approach, via the All-Wales Medicines Safety Network to develop a bi-lingual poster resource for emergency departments encouraging patients to inform staff of this time-critical medicines	Possible option for medication alerts discussed with a Senior Clinical Applications Officer Joanne Brown. Application for the alert made to the applications team. Requirement for an All-Wales service user poster has been escalated to the All-Wales Medicines Safety Network chair, Lynette James. This will be added as an agenda item for the next face-to-face meeting.	Medicines Safety Group		November 2023

Safety Recommendation 6: Develop a list of time-critical medicines, visible to service-users in the emergency departments to make them aware of time-critical medicines and empower them to raise this with staff.	Pursue an All-Wales approach, via the All-Wales Medicines Safety Network to develop a bi-lingual poster resource for display in emergency departments.	Requirement for an All-Wales service user poster has been escalated to the All-Wales Medicines Safety network chair, Lynette James. This will be added as an agenda item for the next face-to-face meeting.	Medicines Safety Group		November 2023
Safety Recommendation 8: Ensure adhering to patients own time-critical medication schedule is supported by any electronic prescribing and medicines administration (EPMA) system implemented with the Health Board	Highlight this requirement for any future Health Board EPMA system as part of the procurement process.	Supporting time-critical medicines administration schedules is an essential criterion of each of the 'suppliers on the All-Wales EPMA framework. It has been scored as an essential requirement in our local Health Board's requirements.	ABUHB EPMA Clinical Reference Group. Medicines and Therapeutics Committee.		26/04/2023

Safety Recommendation 10: Review the current Health Board systems in place to support the administration of Parkinson's medicines outside of normal medicine administration round times.	Undertake a targeted audit of the medicines management for in-patient service-users who are prescribed Parkinson's medication. This will allow the Health Board to review the use of resources previously implemented in 2019 as part of the 'Get it on Time' campaign.	Audit proforma is being created. Results to be presented at the Medicines Safety Group.	Medicines Safety Group		September 2023

Status of action:

GREEN	Complete
AMBER	In progress
RED	Missed deadline for completion - escalate

Professor Chris Jones
Cyfarwyddwr Clinigol Cenedlaethol, GIG Cymru
National Clinical Director, NHS Wales
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To:

Medical Directors, Local Health Boards

CC:

Medical Director of Health Education and Improvement Wales
Directors of Primary Care, Local Health Boards

16 March 2023

Dear Colleagues

Diagnosis of type 1 diabetes

The National Paediatric Diabetes Audit reported on 9 March 2023 that 25.6% of children and young people newly diagnosed with type 1 diabetes presented with DKA at diagnosis in 2021-22, compared to 25.8% in 2020-21 and 22.9% in 2019-20.

DKA requires intensive medical intervention, is traumatising to the child and family, and may cause long-term adverse effects on their diabetes management. I wrote to health boards in June 2018 to highlight the rate of DKA at diagnosis demonstrated in the 2017 audit report and requested health boards implement the all-Wales pathway for the Referral and Ongoing Care for Children with Suspected Diabetes. I also highlighted at the time healthcare professional education that was available from the Primary Care Diabetes Society and public awareness materials available from Diabetes UK Cymru.

It is therefore disappointing that these rates have risen in recent years. In light of the rates of DKA at the time of diagnosis, and a number of isolated but tragic patient deaths in recent years, I would like to seek your organisation's assurance that the national pathway has been implemented in your health boards. It is also important all practices and GP out of hours services have appropriate capillary glucose testing devices to deliver this pathway.
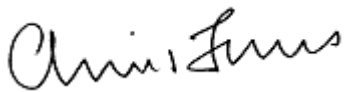
I would like draw your attention to the Cambridge Diabetes Education Programme for health and social care workers which has been commissioned for use in Wales by the National Clinical Leads for diabetes. If your health board requires any support or advice with regard to this matter, then please contact:

National clinical lead for diabetes: Julia.Platts2@wales.nhs.uk
Diabetes paediatric network lead: Davida.Hawkes@wales.nhs.uk
All Wales primary care diabetes lead: Sarah.Davies78@wales.nhs.uk

You may also wish to be aware that the Diabetes Delivery Plan for Wales has been
retired and the Quality Statement for Diabetes is due to be published on or around
15 June 2023. I would like to encourage you to engage with the national leads on its
publication, particularly with regard to the preventative programmes contained within,
including diabetes prevention and remission services.

Thank you for your assistance with these areas.

Yours sincerely,

PROF CHRIS JONES

Dear Anthony,

As Executive lead for Diabetes in Aneurin Bevan University Health Board (ABUHB), I have pulled together our response to the letter from the Deputy CMO about the diagnosis of Type 1 Diabetes in children and young people. I am sorry for our delay in providing you with this response.

With the incidence of type 1 diabetes in children and young people having increased significantly over the last 2-3 years, the Health Board recognises the importance of implementing the all-Wales pathway for the referral and ongoing care for suspected Diabetes in this patient cohort. In ABUHB, Dr Rebekah Pryce (Consultant Paediatrician) engaged with the Primary Care Division when the All Wales pathway for children and young people with suspected Type 1 Diabetes was first launched.

Following the previous communication regarding the pathway, and two serious incidents in recent years of children precenting with Diabetic Ketoacidosis, the Health Board's Primary Care Division has highlighted this issue to primary care teams on more than one occasion in the last two years. We have further shared the national guidance on recognition and assessment of suspected diabetes and have carried out significant event reviews and shared the learning from these with practices. We will repeat this process following the most recent communication from the DCMO and share educational resources with clinicians.

In addition to this, in ABUHB, all cases of newly presenting children and young people with Type 1 Diabetes are reviewed by the Paediatric Diabetes Team to identify delay in presentation and or diagnosis, and we use the sample letters to Primary Care within the pathway inviting practices to reflect on each case of newly diagnosed diabetes.

The team in Cardiff & Vale University Health Board has also developed a presentation for primary care education and the ABUHB Paediatric Diabetes Consultants have offered to deliver this teaching to Primary Care colleagues across the Health Board.

I trust that this response provides you with the assurance that you are seeking, but please do get in touch if you need any further information.

Llawer o ddiolch
Many thanks

Peter Carr

Cyfarwyddwr Gweithredol Therapïau a Gwyddor Iechyd/ Executive Director of Therapies and Health Science
Bwrdd Iechyd Prifysgol Aneurin Bevan / Aneurin Bevan University Health Board
Ysbyty Sant Cadog, Caerllion, NP18 3XQ / St Cadocs Hospital, Caerleon, NP18 3XQ
Ffôn/Tel: 01633 435954 (Ext 55954) / 07900925166
e-bost/e-mail: peter.carr@wales.nhs.uk

Mae Bwrdd Iechyd Prifysgol Aneurin Bevan yn croesawu gohebiaeth yn Gymraeg ac yn Saesneg.
Aneurin Bevan University Health Board welcomes correspondence in Welsh and English.

Reporting Committee	Quality Patient Safety Committee (QPSC)
Chaired by	Ceri Phillips
Lead Executive Director	Director of Nursing & Quality
Date of Meeting	14 June 2023

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

1.0 IMMUNOLOGY PATIENT STORY

Members received an informative patient story on the benefits of self-administering subcutaneous immunoglobulin infusions at home. The patient story highlighted the positive impact that the Immunology Services had made to the patient's quality of life.

2.0 WELSH KIDNEY NETWORK (WKN)

Members received a report outlining the current Quality Patient Safety (QPS) issues within the services that are commissioned by the Welsh Kidney Network (WKN) across Wales.

Members noted that the risk register for the WKN had been reviewed and discussed in the WKN QPS meeting on 2 May 2023 and the WKN Board meeting on 31 May 2023. It was noted that there were 13 items on the current WKN risk register. One risk related to COVID-19 had recently closed.

Members noted the updates to the Renal Funding risk and the limited outpatient dialysis capacity risk in Swansea and it was highlighted that these risks remain on the Corporate Risk Assurance Framework (CRAF).

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 and updates regarding services in escalation are attached in the table at the end of the report.

- **Cancer & Blood**
The main issue to note was the traction on the performance issues within the all Wales Lymphoma Panel service. The Escalation meetings were closely monitoring progress against the action plan. Arrangements were being put in

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place to look at the sustainability of the service model and clinical leadership as part of the WHSSC planning work.

The North Wales Plastic Surgery service remains an area of concern. WHSSC is contributing to the Welsh Government escalation arrangements and officers continue to attend the local Task and Finish Group as an advisor. The Harm review is underway and there is traction with the operational issues within the context of the wider issues within BCUHB.

South Wales Plastic Surgery - It was noted that Plastic Surgery waiting times continue to breach the Ministerial measures waiting times for treatment at Swansea Bay UHB and this remains a concern for WHSSC, with escalation levels being reviewed.

Workforce issues within the Neuro Endocrine Tumour Service (NETS) have been addressed with the support of a visiting consultant with NET expertise to oversee the delivery of the service. A full review of the service with stakeholders is planned in June 2023 with the aim of finding a sustainable solution going forward.

- **Neurosciences**

There were no changes in risks since the last update, with no red risks in the portfolio and no services are in escalation.

- **Cardiac**

Within the Cardiac surgery services, there have been significant improvements in both South Wales services. No new risks for the portfolio have been added to the Risk Register since the last report.

Members noted that SBUHB and CVUHB Cardiac Services have been de-escalated from level 3 to level 2 following the improvements put in place. The services will continue to be monitored through their action plans. The Cardiff service was recently de-escalated to Level 2 in May 2023 and will be reviewed in 6 months for assurance that the improvement actions have been fully embedded.

- **Fertility Service South Wales**

Members noted that a number of concerns had been raised following a relicensing inspection by the Human Fertilisation and Embryology Authority (HFEA) of the Women's Fertility Institute (WFI) in Neath Port Talbot Hospital, which was undertaken in January 2023. A new risk has been added to the CRAF and the escalation level is being reviewed.

- **Paediatric Surgery**

The service remains in Escalation Level 3 and the Risk remains on the CRAF. Members noted the issues in relation to the waiting list and the actions in place to improve the situation. It was noted that CVUHB have provided assurance that

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they will meet the contract volumes and they have committed to producing a revised demand and capacity plan and waiting times trajectory.

Waiting times have decreased and the service is meeting the Ministerial measures for waiting times. However, because this relates to children WHSSC have set an objective for further significant reduction over the next year. Outsourcing arrangements to NHS England and the private sector will remain in place to support this.

- **Paediatric Intensive Care Unit (PICU)**

The Paediatric Intensive Care service remains in escalation Level 2 due to concerns regarding capacity, staffing levels, quality and contract monitoring. In line with the WHSSC Escalation Framework clear objectives have been set for improvement and an action plan was received in June 2023. Members advised they were unable to be assured on the pressure damage report from the Health Board as this had been shared in summary by letter. The DoN undertook to write to the UHB to request the full report. An update will be provided at the next QPSC meeting.

- **Neonatal Cot Availability in South Wales**

The Neonatal Cots Reconfiguration recommendations were approved by the Joint Committee in March 2023 and members noted that the investment as agreed in this year's ICP had been released which should stabilise the position and see the reduction in risk over the next year.

- **Mental Health & Vulnerable Groups**

Members noted that there were currently two Mental Health services in escalation. Ty Llidiard remains at Escalation Level 3 and FACTS is currently in escalation Level 2.

The committee received an update regarding the Gender Development Service (GIDS) for Children and Young People. NHS England have published an update on their progress towards improving and expanding services for children and young people experiencing gender incongruence and gender dysphoria and it is anticipated that the early stages of service provision at the Southern Hub will begin in autumn this year (2023) – with the Northern Hub mobilising by April 2024.

The Cass Review published a journal entry detailing the research programme and made some recommendations with regard to Hormone Therapy for Children.

- **Intestinal Failure (IF) – Home Parenteral Nutrition**

Members noted the report highlighting the new risk related to sustainability and delivery of the service due to workforce issues. Alternative options were being explored and outsourcing to a service in Bristol is being considered.

4.0 OTHER REPORTS RECEIVED

Members received reports on the following:

4.1 Services in Escalation Summary

Members noted the content of the report and the new format template. The new format of the report aims to provide an escalation trajectory to capture both the historical picture and movement within the escalation level. Members noted the three services in escalation level 3 and above and the updates:

- Ty Llidiard had been lowered to escalation level 3 from 4 in December 2022,
- Paediatric Surgery C&VUHB had been escalated to level 3 in March2023,
- Burns service in SBUHB remains in Escalation level 3.

Members provided very positive comments on the report and found it very helpful providing an overall snapshot with the narrative for the detail. A copy of each of the services in escalation is attached to the report *Appendix 1*

4.2 WHSSC Committee Effectiveness Survey Results

Members received a report providing feedback from the Annual Committee Effectiveness Self-Assessment 2022-2023.

4.3 CRAF Risk Assurance Framework

Members received a report outlining WHSSC's current risks scoring 15 or above on the commissioning teams and directorate risk registers. Members noted the updates in red.

4.4 Care Quality Commission (CQC)/ Health Inspectorate Wales (HIW) Summary Update

A briefing on Healthcare Inspectorate Wales (HIW) and Care Quality Commission (CQC) reports published during the period April to June 2023 was presented to the committee.

4.5 Incident and Concerns report

Members received a report outlining the incidents and concerns reported to WHSSC and the actions taken for assurance. A request was made to include an in-depth review of the women and children's incidents. This was following queries raised by members as to whether there were any themes linked to these concerns.

Members noted the content of the report.

5.0 ITEMS FOR INFORMATION:

Members received a number of documents for information only:
- Chair's Report and Escalation Summary to Joint Committee 16 May 2023

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- WHC/2003/017 National Policy on Patient Safety Incident Reporting
- 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
- Attached (***Appendix 1***)

Matters requiring Committee level consideration and/or approval
- N/A

Matters referred to other Committees
As above.

Confirmed minutes for the meeting are available upon request

Date of Next Scheduled Meeting	16 August 2023 at 14.00hrs

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GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Service in Escalation: Burns

Executive Director Lead: Nicola Johnson
Commissioning Lead: Luke Archard
Commissioning Team: Cancer and Blood

Date of Escalation Meetings: 27/09/22, 01/12/2022, 03/03/2023, 03/05/2023
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔
↔	Escalation remains the same	May 2023
↑	Escalation level escalated	

Escalation Trajectory:
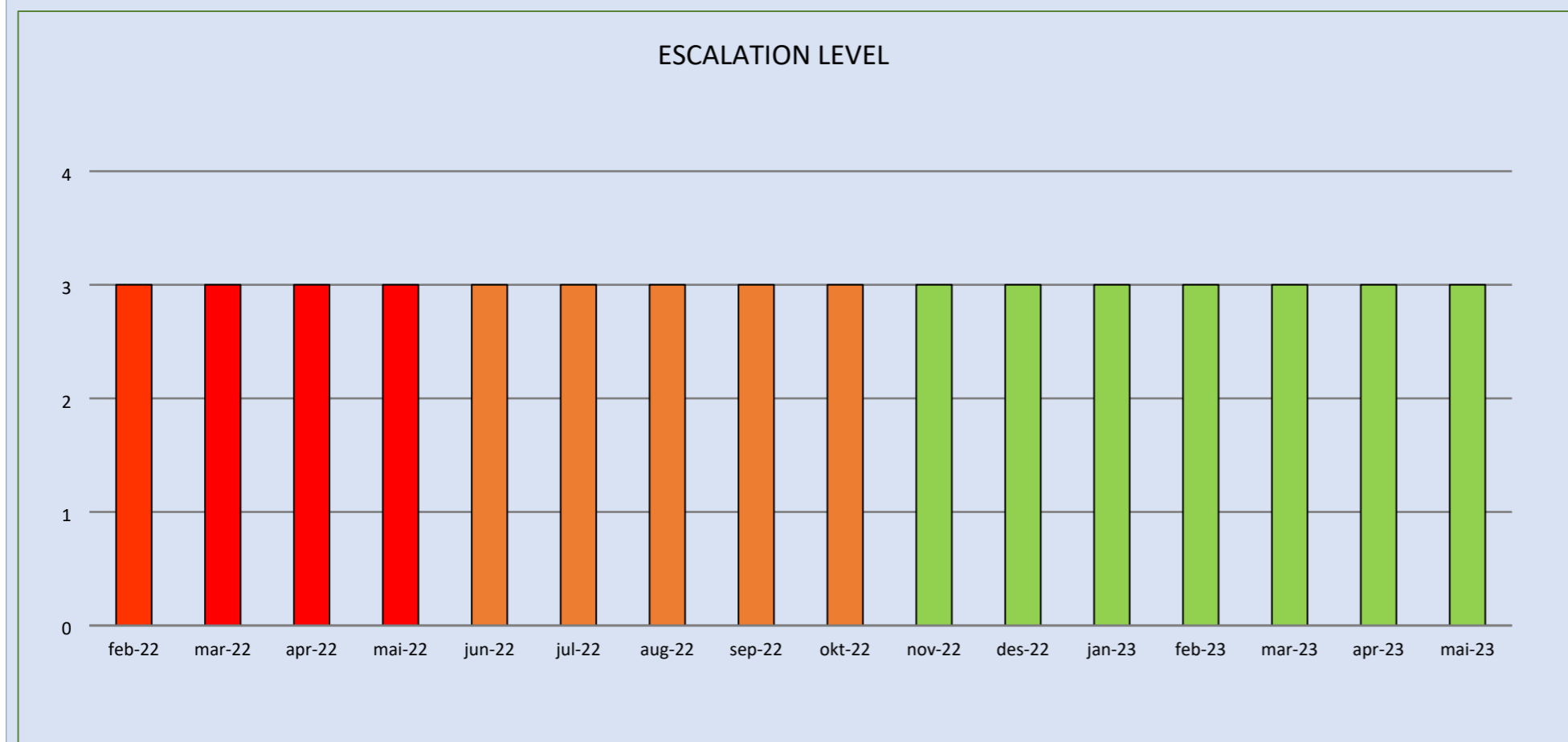
ESCALATION LEVEL

Escalation History:

Date	Escalation Level
November 2021 – South West Burns Network escalation	4
February 2022 – WHSSC escalation	3
August 2022 – WHSSC escalation	3
September 2022 – WHSSC escalation	3
December 2022 – WHSSC escalation	3

Rationale for Escalation Status :
Remains at level 3.
The current timeline for completion of the capital works to enable relocation of burns ITU to general ITU at Morriston Hospital is the end of 2023.
The capital case remains on target with the planned timeline.

Summary of Services in Escalation
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Background Information:

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 2022. The current escalation concerns the progress of the capital case for the long term solution and sustainability of the interim model.

Actions:

Action	Lead	Action Due Date	Completion Date
To escalate and liaise with SBUHB at CEO and MD level with regard to the immediate actions needed to provide continued access to burns care for patients in Wales and the Network.	MD/ CEO		Completed
To work with NHS England south west commissioners and the SWW Burns Network to support clear pathways and ensure continued access to burns care for patients in Wales and the Network.	MD/Exec Lead WHSSC		Completed
To monitor the SBUHB action plan through formal escalation meetings.	MD/ Exec Lead WHSSC		Ongoing
The peer review report was received by WHSSC and discussed at the Burns Network meeting on the 16th December 21. The interim mitigations are still in place at present.	Senior Planner		Completed
SBUHB are to provide a plan based on the recent peer review by the end of January 22.	Senior Planner		Completed
A series of monitoring meetings are being put in place and LA to ask SBUHB if they are confident as to whether 2 beds meets their requirements. The unit has reopened with reduced capacity, i.e. 2 ITU beds instead of 3. Full capacity will return in the longer term. WHSSC has responsibility for monitoring implementation rather than the burns network. It was agreed that the risk score could be reduced to 9 (3 x 3) and considered for further reduction when assurance as to whether the service considered the reduced capacity to be sufficient for their needs.	Senior Planner WHSSC/ Service Manager SBUHB		Completed
Interim arrangements to sustain burns service are in place while the business case is developed to collocate burns intensive care with the general intensive care unit. Interim arrangements appear to have taken effect. Risk may be reduced once escalation meetings can be confirmed.	Senior Manager/ Senior Planner WHSSC	Ongoing	
WHSSC to look at the business continuity plan in the event of potential loss of staff.	Senior Planner WHSSC	Ongoing	
Since the last escalation meeting, there has been a degree of delay relating to the process of Welsh Government scrutiny of the case which will go their Investment in Infrastructure Board on 22nd July. It had been hoped that the works would commence in May. There may therefore be a 2 month or so departure from original timelines. At the SLA with Swansea on Monday of this week, it was confirmed that this message had been conveyed to the staff supporting the interim rota arrangements (one of the concerns has been to ensure the resilience of this rota which in turn is felt to depend in part on there being demonstrable progress with the business case so they can see the finish line).	Senior Team SBUHB/ Senior Planner WHSSC	Ongoing	

Issues/Risks:

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Service in Escalation: Ty Llidiard

Executive Director Lead: Nicola Johnson
Commissioning Lead: Emma King
Commissioning Team: Mental Health & Vulnerable Groups

Date of Escalation Meetings: 12/07/21, 10/08/21, 14/09/21, 12/10/21, 09/11/21, 14/12/21, 11/01/22, 08/02/22, 08/03/22, 12/04/22, 03/05/22, 14/06/22, 20/07/22, 09/08/22, 13/09/22, 14/10/22, 05/12/22, 10/01/23, 12/06/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

Current Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔
↔	Escalation remains the same	May 2023
↑	Escalation level escalated	

Escalation Trajectory:
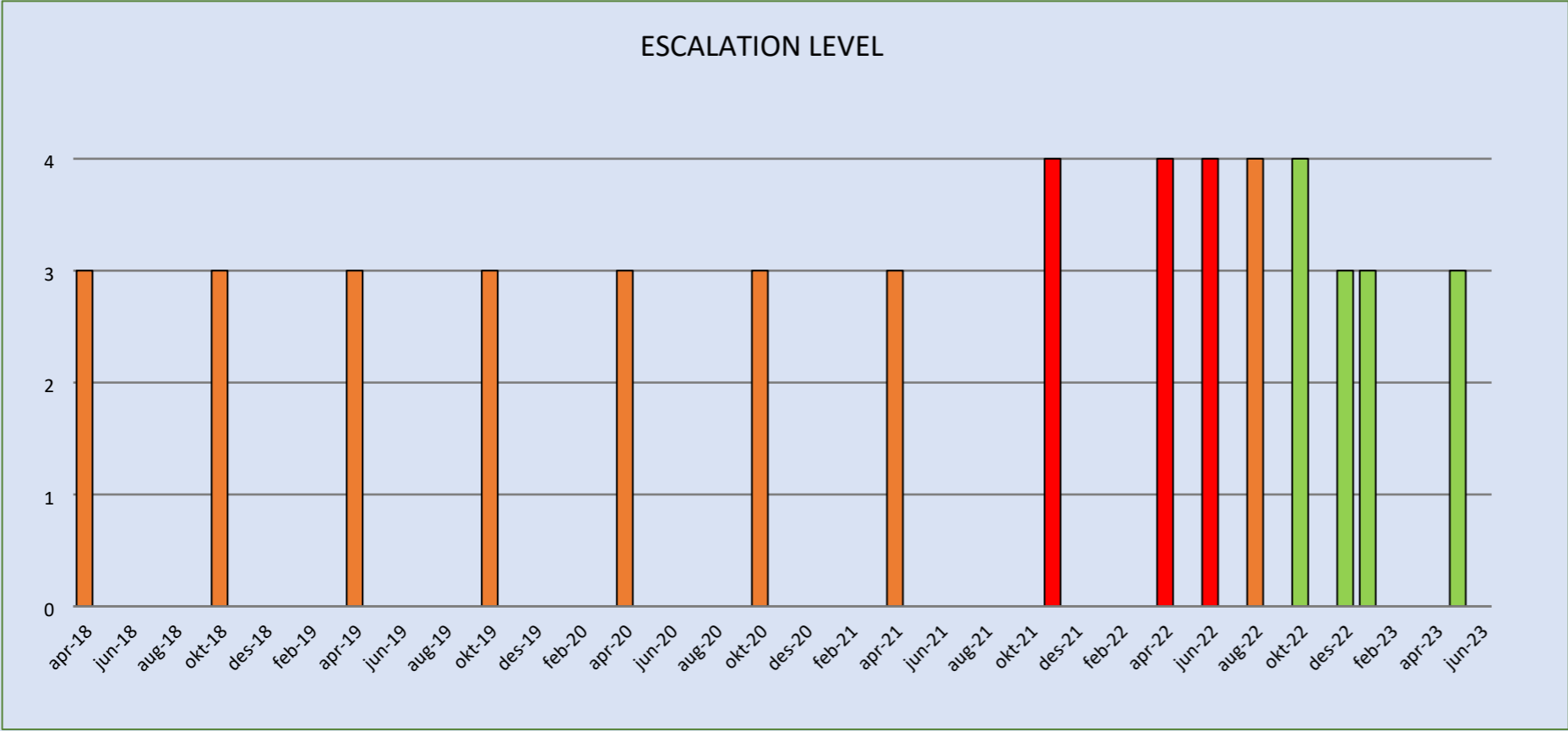
ESCALATION LEVEL

Escalation History:

Date	Escalation Level
Mar 2018 – WHSSC escalation	3
Sept 2020 - WHSSC escalation	3
Nov 2021 - WHSSC escalation	Escalation level increased to level 4
December 2022 - WHSSC escalation	De-escalated to level 3

Rationale for Escalation Status :
De-escalated to level 3.

Background Information:

March 2018 - Unexpected Patient death and frequent SUI's revealed patient safety concerns due to environmental shortfalls and poor governance.
September 2020 - SUI reported to Welsh Government.
September 2022 - Recruitment plan underway with all vacancies out to advert; interview dates arranged.
December 2022 - This service has been de-escalated to Level 3 as agreed by CDGB on 14th December.

Actions:

Action	Lead	Action Due Date	Completion Date
Escalation meetings held monthly, however these have been escalated to Executive level discussions following the report on a visit from NCCU into the unit.	Senior Planner		Completed March 22
Service specification action plan agreed.	Senior Planner		Completed March 22
Implementation of Medical Emergency Response SOP by CTM took place on 03/05/22.	Senior Planner		Completed May 22
Recruitment of all staff to be in place.	Senior Planner / Service Leads		Completed
Estates issues being addressed and meeting to map these and plan a timeline.	Senior Planner / Service Manager	Ongoing	
Executive lead for CTMUHB leading on the current escalation and development plan alongside WHSSC Executive lead with regular updates in between Escalation meetings.	Senior Planner	Ongoing	
NCCU CAMHS review to provide the driver for the CAMHS work stream of the mental health strategy.	Senior Planning Manager		Completed
Reviewed service specification.	Senior Planning Manager		Completed
Monitor training status of the staff by QAIS.	Shane Mills		Completed
Submission of a discussion papers followed by a business plan for Clinical Director Dr Krishna Menon for a Physician Associate.	Dr Krishna Menon		Completed
Confirm funding arrangements on staffing position for Nursing, Therapies, Medical Staff and Service Business Manager.	Director of Finance		Completed
Action plan developed following QAIS review conducted in March 2022 and managed under escalation process.	NCCU Director	March 2023	
Review of patient referrals admissions refusals and outcomes from March 2022 being undertaken.	NCCU Director and Team	April 2023	Ongoing

Issues/Risks:

This is a significant risk and is captured on WHSSC CRAF ref: MH/21/02 There is a risk that tier 4 providers for CAMHS cannot meet the service specification due to environmental and workforce issues, with a consequence that children could abscond/come to harm.

July 21- The commissioning team reviewed the risk scores and agreed to lower the target score from 12 to 8 as it was originally scored too high
April 22 – Score to remain as it is subject to impact of completed actions
June 22 – Risk remains at current level as risk of absconding is still prevalent
December 22 – Service de-escalated to Level 3 however work continues to consider referral processes and assessments
May 23 - There has been no change to the Ty Llidiard escalation status and no meetings have been held pending a report from NCCU next meeting planned for June 12 2023.

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Executive Director Lead: Nicola Johnson
Commissioning Lead: Richard Palmer
Commissioning Team: Cardiac

Date of Escalation Meetings: 01/06/22, 20/07/22, 21/11/22, 05/04/23
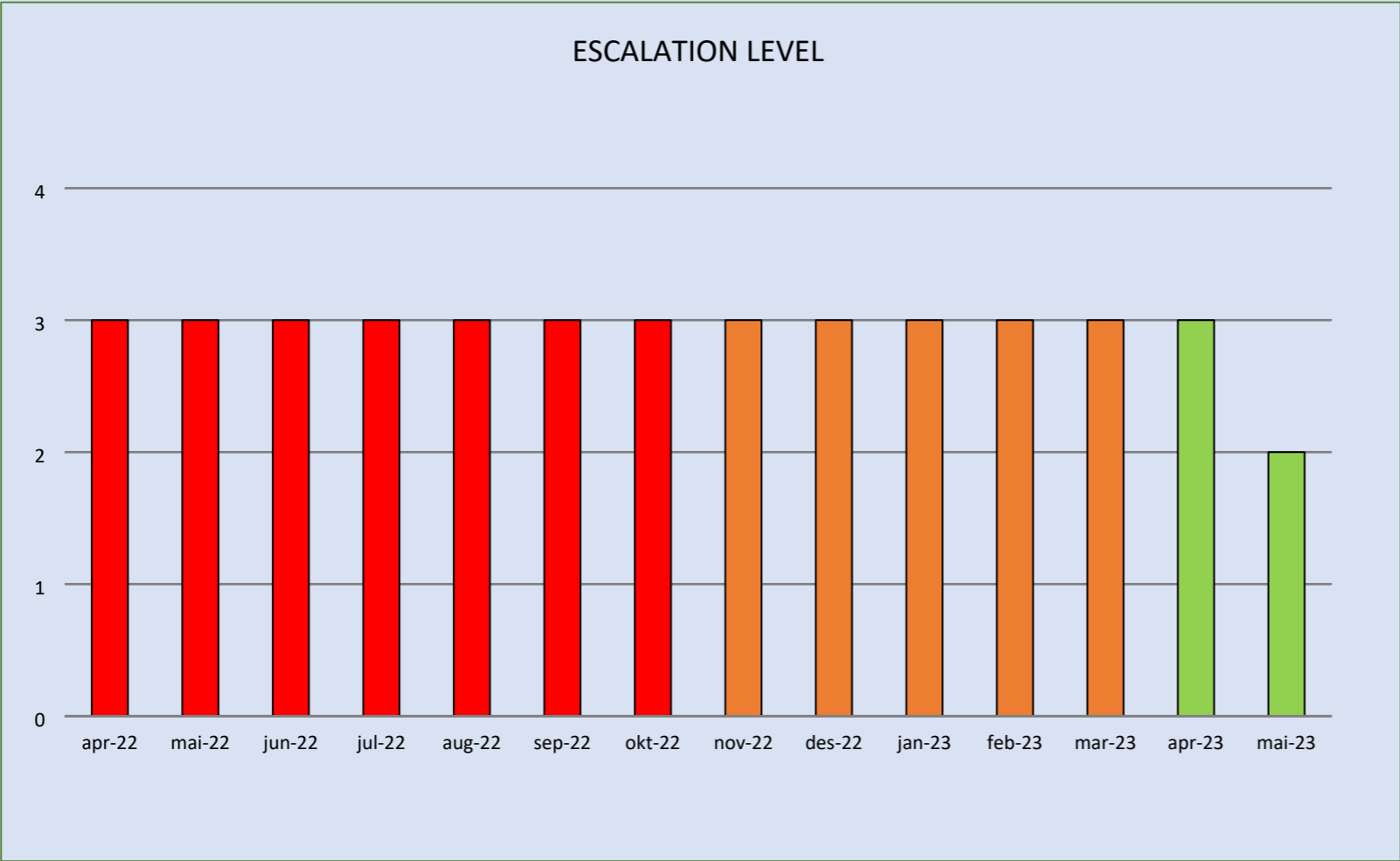**Date Last Reviewed by Quality & Patient Safety Committee: 18/04/23**

Service in Escalation: Cardiac CVUHB

Current Escalation Level
2

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↓
↔	Escalation remains the same	May 2023
↑	Escalation level escalated	

Escalation Trajectory:

Escalation History:

Date	Escalation Level
April 2022– WHSSC escalation	3
June 2022– WHSSC escalation	3
November 2022– WHSSC escalation	3
May 2023 – WHSSC escalation	2

Rationale for Escalation Status :
Following an escalation meeting on 5 April 2023, the escalation status of the Cardiff and Vale Cardiac Surgery service was considered by the Cardiac Commission Team, which recommended a reduction to Level 2. When considering the service's escalation status, the Cardiac Commissioning Team found that:

- The majority of the actions contained in the GIRFT/HEIW action plan were complete and that there had been evident progress towards the delivery of the GIRFT indicators
- Those actions that remained outstanding were subject to a number of interdependencies that may delay delivery
- The requested HEIW report had been received, and the Cardiac Surgery service had shared detail of progress against the report's recommendations and follow-up visits via Level 3 escalation meetings

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- There had been had been improved engagement from the Health Board senior team in respect of escalation issues.

Background Information:

Owing to the failure of Cardiff and Vale University Health Board to...
1. Implement the outcomes of the GIRFT review (June 2021), for which no appropriate SMART action plan has been shared with WHSSC
2. Communicate and address (via a SMART action plan) the additional issues recently identified by HEIW, arising from the concerns with the cardiac surgical service raised by trainees

...there is a risk that people waiting for Cardiac Surgery delivered by Cardiff and Vale University Health Board may receive suboptimal or delayed treatment, and that WHSSC will be unable to effectively monitor.

The following controls have thus been put in place:
- Instituting of regular (every 6 weeks) Stage 3 escalation meetings with Cardiff and Vale University Health Board – with monitoring to be taken forward via regular Cardiac Services Risk, Assurance and Recovery meetings following de-escalation to Level 2, and with a formal review planned for October 2023.
- HEIW report and action plan shared with WHSSC and discussed in escalation meetings.
- Development of SMART action plan to take forward the recommendations of the GIRFT review, shared with WHSSC at escalation meetings to enable the monitoring of progress and identification of any required remedial actions.

WHSSC assurance and confidence level in developments:

Medium – Although the service has been de-escalated and commended both for the improvements made and the engagement of the senior team since the service was escalated to Level 3 in April 2022, further de-escalation will depend on the delivery of a number of interdependent actions, including the repatriation of the Cardiac Surgery service from UHL to UHW and additional

Actions:

Action	Lead	Action Due Date	Completion Date
De-escalate service to Stage 2 of the WHSSC escalation process	Director of Planning		Completed
Utilise regular bi-monthly Cardiac Services Risk, Assurance and Recovery meetings to oversee escalation process	Senior Planning Manager		Completed
Receive a SMART action plan from the service that addresses the recommendations contained in the GIRFT report.	Senior Planning Manager	In progress - chased 10/06/22	Completed
Receive HEIW report concerning issues with the cardiac surgical service raised by trainees.	Senior Planning Manager		Completed
Monitor implementation of the SMART action plan at escalation meetings.	Senior Planning Manager	In progress	
Development of de-escalation criteria based on recommendations in GIRFT report and action plan.	Associate Medical Director		Completed

recruitment. Although appropriate planning has been undertaken and progress will be monitored, any delay in the interdependent actions will see consideration of further de-escalation similarly delayed.

Issues/Risks:

June 2022 – Service escalated to Stage 3 of the WHSSC escalation process in April 2022 owing to continuing concerns with engagement; agreed at the 28 June 2022 Cardiac Commissioning Team meeting that the escalation constituted a risk (as opposed to an issue) owing to concern that the failure to implement GIRFT/HEIW recommendations will impact on patients, but that the accompanying narrative should be revised to clarify the precise concerns; escalation meeting held on 01 June 2022, at which an apparently extant action plan was discussed, but not subsequently shared.

July 2022 – Action plan now shared with WHSSC. Second escalation meeting held on 20 July 2022 at which – mindful of the long-term nature of many of the HB's objectives – progress was noted. Agreed that WHSSC would refer to both the GIRFT report and the action plan in order to develop de-escalation criteria in time for the next escalation meeting (September). No change to risk score.

August 2022 – Draft de-escalation criteria shared with Health Board in readiness for discussion at September escalation meeting. No change to risk level.

September 2022 – The de-escalation criteria was discussed with the Health Board in the September escalation meeting. It was agreed in the meeting that the Health Board would provide a formal response in regards to the proposed de-escalation criteria. No change to the risk score.

October 2022 - Health Board had not yet provided formal response to proposed de-escalation criteria. Planned October escalation meeting had been rescheduled to Monday 21 November owing to Health Board availability; Health Board had submitted updated action plan in lieu of meeting. No change to risk score.

November 2022 – Further progress was noted at November escalation meeting; de-escalation criteria discussed – agreed that focus would be on evidencing positive trajectory, assisted by cardiac surgery dashboard; risk score unchanged.

December 2022 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.

January 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.

February 2023 – No escalation meetings since the last CRAF review. Risk/escalation level unchanged.

March 2023 – No escalation meetings since the last CRAF review. Risk level remains unchanged; next meeting scheduled for 5 April 2023.

May 2023 – Following the de-escalation of the service (from Level 3 to 2 in May 2023) and the subsequent review of the risk by the Commissioning Team, the risk score has been reduced to 9. Regular monitoring will continue through the Cardiac Risk, Assurance and Recovery meetings. The Health Boards position will be formally be reviewed in six months' time following an assessment of progress against the actions as outlined in the de-escalation letter.

|	Service in Escalation: Paediatric Surgery	Escalation Trend Level		

Executive Director Lead: Nicola Johnson
Commissioning Lead: Kimberley Meringolo
Commissioning Team: Women and Children

Date of Escalation Meetings: 26/04/23, 23/05/23
Date Last Reviewed by Quality & Patient Safety Committee: 18/04/2023

Service in Escalation: Paediatric Surgery

Current
Escalation Level 3

Escalation Trend Level

Trend	Rationale	Current Trend Level
↓	Escalation level lowered	↔
↔	Escalation remains the same	May 2023
↑	Escalation level escalated	

Escalation Trajectory:

ESCALATION LEVEL

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Level	2	2	3	3	3	3
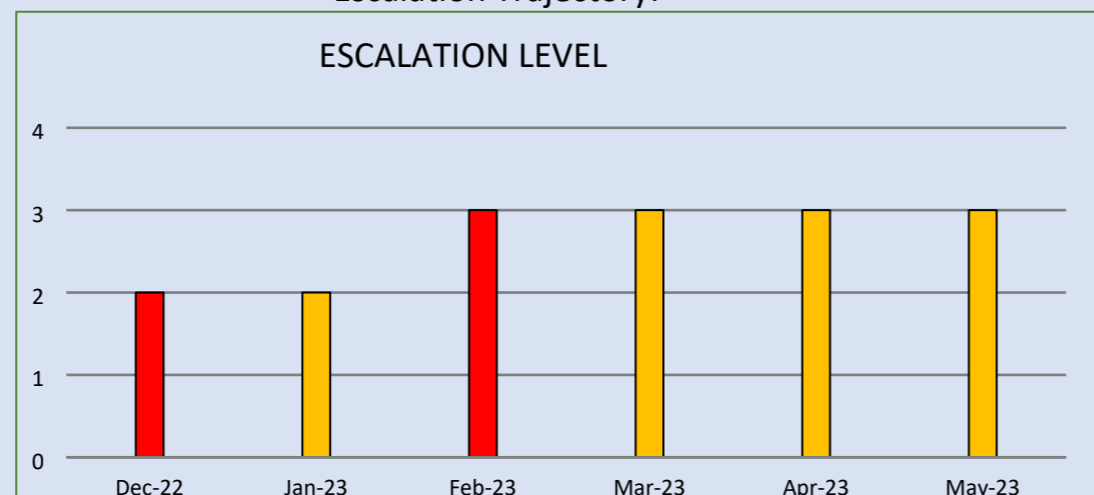
Escalation History:

Date	Escalation Level
March 2023 – WHSSC escalation	3

Rationale for Escalation Status :
As a result of the service failing to engage fully with WHSSC regarding the weekly submission of contract delivery and waiting time profiles, it was agreed that the C&VUHB Paediatric Surgery service should be further escalated from Level 1 to Level 3 of the WHSSC Escalation Framework.

Background Information:

There is a risk that Paediatric patients waiting for surgery in the Children's Hospital of Wales are waiting in excess of 36 weeks due to COVID-19. The consequence is the condition of the patient could worsen and that the current infrastructure is insufficient to meet the backlog.
• Recovery plan trajectories have reflected a nominal improvement on the waiting list position, and clarity is required on zero waits > 104 weeks,
• The current plan does not deliver contracted volumes,
• Timely assurance on delivery against the baseline for future recovery, via weekly reports, as opposed to monthly reporting suggested by the UHB.

WHSSC assurance and confidence level in developments:

Medium – Action plan developed and positive progress made in implementing a number of new pilot schemes and securing additional capacity. Currently it is premature to consider the de-escalation of the service as these pilot schemes need to roll out and additional lists undertaken to measure success against the waiting list position. Commitment to re-cast trajectories in light of action plan with ultimate aim to meet contracted volumes.

Actions:

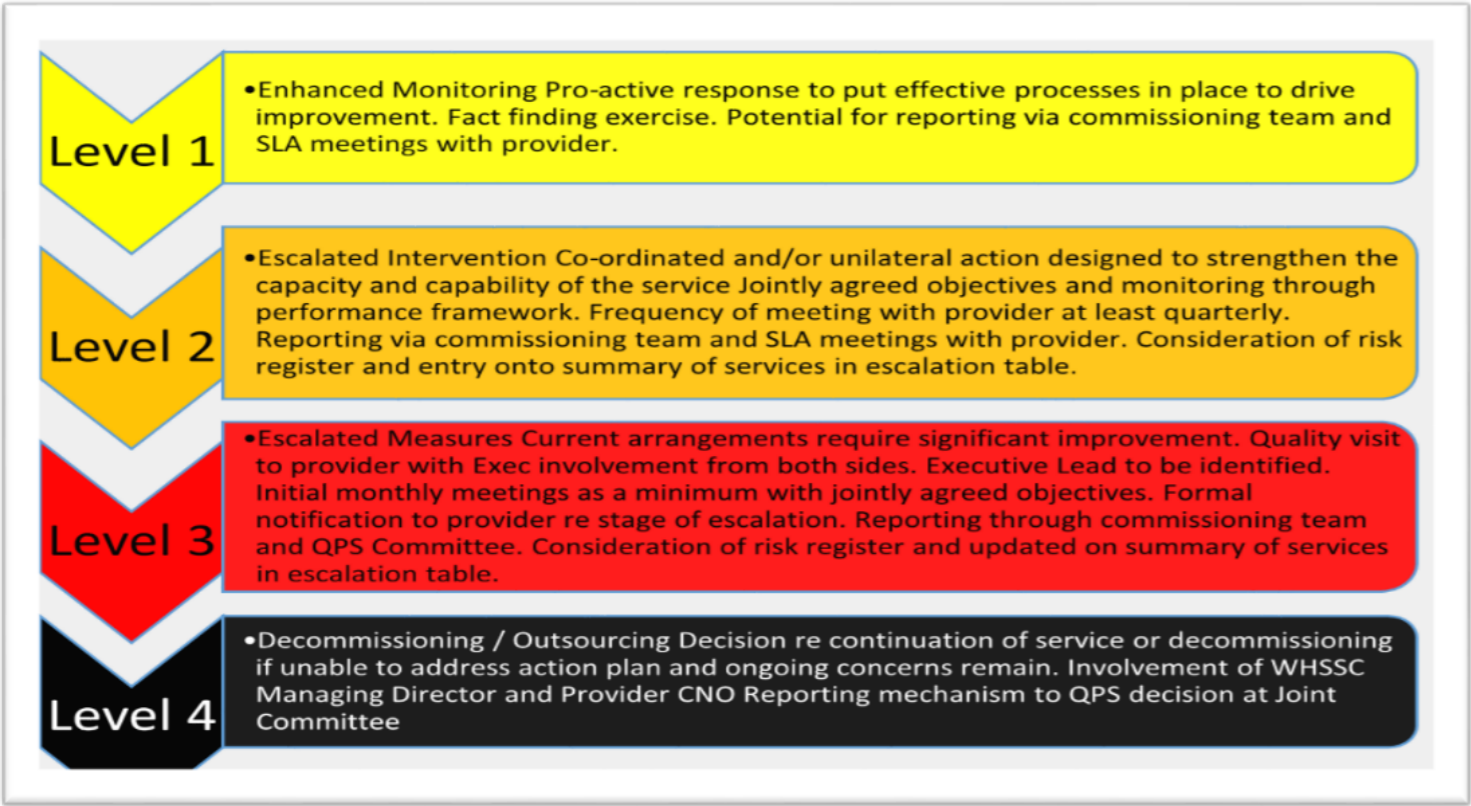| Action	Lead	Action Due Date	Completion Date
To establish monthly escalation meetings with CVUHB to review progress against the improvement plan.	Senior Planning Manager	Monthly	
Action plan to be monitored through the monthly escalation meetings and when data shows improvement consideration will be given to de-escalation.	Senior Planning Manager	Monthly	
Requested revised trajectories to be issued to WHSSC by the end of June 2023.	Senior Planning Manager	30 June 2023	

Issues/Risks:
April 2023 – Action plan presented by HB and actions agreed to progress in time for next meeting.

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May 2023 – a number of actions within the action plan are in progress, action at meeting to update trajectories in time for the July meeting in order to allow measurement of improvement.

Level 1 ENHANCED MONITORING	Any quality or performance concern will be reviewed by the Commissioning Team. Enhanced monitoring is a pro-active response to put effective processes in place to drive improvement. It is an initial fact finding exercise which should ideally be led by the provider and closely monitored and reviewed by the commissioning team. The enquiry will lead to one of the following possible outcomes: • No further action is required routine monitoring will continue. The concern which raised the indication for inquiry will be logged and referred to during the routine monitoring process to ensure this has not developed any further. • Continued intervention is required at level 1 and a review date agreed. • Escalation to Level 2 if further intervention is required There is the potential for reporting via commissioning team report to Quality Patient Safety Committee and through SLA meetings with provider
Level 2 ESCALATED INTERVENTION	Escalated intervention will be initiated if Level I Enhanced Monitoring identifies the need for further investigation/intervention. There should be a Co-ordinated and/or unilateral action designed to strengthen the capacity and capability of the service. At this stage there should be jointly agreed objectives between the provider and commissioner and monitored through the relevant commissioning team. Frequency of meeting with provider should be at least quarterly and possible interventions will include • Provider performance meetings • Triangulation of data with other quality indicators • Advice from external advisors • Monitoring of any action plans A risk assessment should be undertaken, and logged on the Commissioning Team Risk Register. Where appropriate the risk will be included on the WHSSC Risk Management Framework. Reporting is via commissioning team report to Quality Patient Safety Committee report and SLA meetings with provider. The investigation will lead to on to the following possible outcomes: • Action plan and monitoring are completed within the allocated timeframe, evidence of progress and assurance the concern has been addressed. De-escalation to Level 1 for ongoing monitoring. • If the action plan is not adhered to and further concerns are raised by the Commissioning team or by the provider team or further concerns are identified it may be necessary to move to Level 3 Escalated Measures
Level 3 ESCALATED MEASURES	Where there is evidence that the Action Plan developed following Level 2 has failed to meet the required outcomes or a serious concern is identified a service will be placed in escalated Level 3. At this stage the quality of the service requires significant action/improvement and will require Executive input. In addition to routine reporting through QPS a formal paper will be considered by the WHSSC Corporate Directors Group (CDG) and an Executive Lead nominated. Formal notification will be sent to the provider re the Level of escalation and a request made for an Executive lead from the provider to be identified. An initial meeting will be set up as soon as possible dependant on the severity of the concern. Meetings should take place at least monthly thereafter or more frequently if determined necessary with jointly agreed objectives. Provider representation will depend on the nature of the issue but the meetings should ideally comprise of the following personnel as a minimum: • Chair (WHSSC Executive Lead) • Associate Medical Director - Commissioning Team • Senior Planning Lead – Commissioning Team • WHSSC Head of Quality • Executive Lead from provider Health Board/Trust • Clinical representative from provider Health Board/Trust • Management representative from provider Health Board/Trust An agreed agenda should be shared prior to the meeting with a request for evidence as necessary. At the conclusion of the meeting a clear timeline for agreed actions will be identified for future monitoring and confirmed in writing if appropriate. Reporting will be through commissioning team to QPS Committee. Consideration of entry on the risk register and summary of services in escalation table for Chairs report to Joint Committee. Consideration to involve and have a discussion with Welsh Government may be considered appropriate at this stage. If there is ongoing concern relating patient care and safety with no clear progress then further escalation will be required to Level 4. On the other hand if progress is made through the escalation Level 3 evidence of this should be presented to CDG/QPS and a formal decision made with the provider to de-escalate to Level 2.

Level 4 DECOMISSIONING/OUTSOURCING	Where services have been unable to meet specific targets or demonstrate evidence of improvement a number of actions need to be considered at this stage. This stage will require notification and involvement of the WHSSC Managing Director and CEO from the provider organisation. Both Quality Patient Safety Committee and Joint Committee should be cited on the level of escalation.
	The following areas will need to be considered and the most appropriate sanction applied to help resolve the issue:
	1. De-commissioning of the service
	2. Outsourcing from an alternative provider. This may be permanent or temporary
	3. Contractual realignment to take into account the potential need to maintain and agree an alternative provider.
	Involvement with Welsh Government and the Community Health Council is critical at this stage as often there are political drivers and levers that need to be considered and articulated as part of the decision making. Moving in and out of escalation and between Levels In addition to the Levels described above the process has introduced a traffic light guide within each level. The purpose of this is to help demonstrate the direction of travel within the level. It sets out an approach to help identify progress within the level and lays out the steps required for movement either upwards (escalation) or downwards (de-escalation) through the level.
	At every stage a red, amber or green colour will be applied to the level to illustrate whether more or less intervention is in place. Red being a higher level of intervention moving down to green. It will also help determine the easing of the escalated measures described and inform movement within the stages of escalation. As the evidence and understanding of the risks from a provider and commissioner become evident decisions can be made to reduce the level of intervention or there may be a need to reintroduce intervention should conditions worsen and trigger the re-introduction of measures if progress is unacceptable. In this way organisations will be able to understand what is being asked of them, progress will be easily identified and it will help avoid any confusion. It will also help in the reporting to provide assurance that action is being taken to meet the agreed timescales.

SERVICES IN ESCALATION

 Level of escalation reducing / improving position

 Level of escalation unchanged from previous report/month